CDEP FINAL LOCAL EVALUATION REPORT

LOCAL EVALUATION TIME PERIOD:
JANUARY 1, 2018 – JUNE 30, 2021

IPP NAME: Gender Health Center
CDEP NAME: Mental Health, Health Advocacy, Community-Building, Social and Recreational Programming
PRIORITY POPULATION: LGBTQ

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ABOUT THE CALIFORNIA REDUCING DISPARITIES PROJECT

The idea for the California Reducing Disparities Project (CRDP) was born in 2009 out of former United States Surgeon General David Satcher's call for national action to reduce mental health disparities among minority populations. The program was later launched in California as a statewide prevention and early intervention effort to ensure a truly community-focused approach to reducing the disparities of poorer health outcomes and experiences of minority populations. CRDP focuses on five populations:

- African Americans
- Asians and Pacific Islanders (API)
- Latinos
- Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Individuals (LGBTQ)
- Native Americans

In the first phase of CRDP, each population developed its own community-participatory strategic plan to identify culturally appropriate strategies to improve access to services, quality of care, and mental health outcomes. Phase II of CRDP was launched in 2015 with the release of the request for proposals to community organizations serving CRDP populations. In a landmark breakthrough for minority populations' mental health concerns in California, the Office of Health Equity within the California Department of Public Health announced this $60 million funding initiative to advance the strategies documented in the strategic reports.

The concept of Phase II retained the CRDP community-focus by making $1.18 million available to community organizations to expand and evaluate mental health programs that are culturally congruent with community needs. The program recognized that, while hundreds of millions of dollars from the Mental Health Services Act flow through mainstream public agencies, these agencies offer almost no programs designed to meet the unique needs of CRDP populations. Culturally rooted programs almost always lack a formal evidence base, and yet historically, they have been created by the community and for the community in the face of the public system's failure to take their needs into account. CRDP honored the lived experience of the communities and allowed funding based on community defined evidence of effectiveness.

This program, extraordinary by any measure, is strategically designed so that upon completion, these community programs, such as the Gender Health Center's Mental Health, Health Advocacy, Community-Building, Social and Recreational Programming, will have the beginnings of a more formal evidence base. The hope is that this will provide a breakthrough for community organizations to begin qualifying for mainstream funding and expand and replicate services to meet what the strategic plans showed to be an enormous need for culturally rooted mental health services for the LGBTQ+ community. This report aims to present evidence of effectiveness for GHC's program, which is based in the Sacramento and serves individuals throughout the region and state.

For updates and more information about CRDP, please visit the CDPH Office of Health Equity website.

EXECUTIVE SUMMARY

In 2016, Gender Health Center (GHC) was selected as one of 35 community-based organizations to participate in Phase II of the California Reducing Disparities Project (CRDP), described above, to address disparities in mental health among the LGBTQ+ population. With the funding from this grant, GHC launched its Community-Defined Evidence Program (CDEP), a holistic and comprehensive prevention and early intervention program. The CDEP aimed to prevent and reduce risk of mental illness consequences resulting from systemic violence—such as suicide, depression, isolation, anxiety, unemployment, unstable housing, school failure and dropout—for LGBTQ+ populations by decreasing stigma and social isolation, and increasing access to affirming relationships, including cultural and community connections and mental health care. GHC's CDEP had three primary goals:

1. **Enhance Community Members' (CMs') mental health**

2. **Improve the capability of intern mental health practitioners to deliver culturally competent, responsive care**

3. **Build on community strengths to increase capacity and empowerment**

These goals were addressed through five program components:

1. Queer-Informed Narrative Therapy Sessions
GHC's Queer-Informed Narrative Therapy (QINT) model combines queer theory and narrative therapy. Narrative therapy is an evidence-based practice that provides a respectful, non-blaming, non-pathologizing approach to therapy and recognizes the CM as the expert. Queer theory helps reframe gender and sexuality within the context of narrative therapy by critiquing binaries and centering the lived realities of LGBTQ+ people who transgress dominant cultural expectations pertaining to sexuality and gender. It allows counselors to open space for CMs to imagine previously unmapped landscapes of attraction, sexual expression, and gender performance. This changes the way counselors and CMs conceptualize treatment and intervention planning. The dominant mental health fields assert that changes in individuals' thinking, cognition, and behavior will alleviate symptomology, while GHC's approach puts the onus on the system and environment to change in order to alleviate mental health symptomology. For example, QINT positions mental distress experienced by many transgender and gender non-conforming (TGNC) people as an outcome of rampant systemic anti-queer and anti-trans discrimination rather than as a personal failing.

2. Mental Health Provider Internships

The goal of these internships is to increase capacity of community providers who are culturally responsive to LGBTQ+ community members' needs. GHC partners with local universities to provide long-term (8-12 months), in-house student internship placements, primarily for Master's level social workers, Master's level Marriage and Family Therapists, and Master of Counseling students. The model of care GHC strives for is one of learning and exposure, leading to professional development opportunities. These opportunities are heavily focused on anti-oppression training, unpacking and avoiding weaponizing privilege, the gender binary, and an emphasis on the existence of social dysphoria rather than gender dysphoria. Placements took place onsite at GHC until March 2020. Internships were then conducted virtually due to the COVID-19 pandemic and resulting stay-at-home orders. Starting in April 2021, placements were offered in a hybrid format, with virtual and limited in-person settings. Interns received day to day supervision from staff, weekly individual supervision from an assigned volunteer clinical supervisor, and weekly group supervision & training from the clinical director.

3. Advocacy-Focused Case Management Sessions

GHC provides advocacy-focused case management that begins with an understanding of the medical, legal and psychiatric regulation that constrains our community member's abilities to live their authentic lives. GHC staff, volunteers, advocates and interns participate in ongoing advocacy and therapy trainings. Building on the understanding that mental distress is systematically and culturally produced, rather than evidence of internal pathology, advocacy-focused case management compliments counseling services by providing direct advocacy to address the systems of oppression that are impacting the daily lives of our community members, such as: discrimination and inequitable access to health insurance, healthcare services, mental health care, employment, housing, public benefits, and more. GHC offers individual and relational case management services in Spanish and English on a weekly basis for the duration needed. This component evolved during the CDEP and to be supported by the Trans Peer Advocacy component.

4. Trans Peer Advocacy

During CDEP implementation, GHC developed and staffed a peer advocacy program to run alongside the Advocacy-Focused Case Management program component and further center the experiences and mutual aid of TGNC CMs. Currently, GHC has two 0.8FTE staff working as trans peer advocates and providing intake and case management appointments alongside two case management interns. Both of these staff members are queer and transgender people of color (QTPOC) and one is also Spanish speaking. These peer advocates also staff the Community Support Services Programming. This positioned them at the heart of the agency and CDEP and helped them build relationships with CMs, and act as mentors and provide resources and supports for CMs. This program had no defined cycle. It was appointment based, with continuous enrollment based on community needs. GHC seeks to demonstrate that TGNC people are valuable to the mental health system as much more than service consumers, and the shift to trans peer advocacy helped better reflect this organizational value.

5. Community Support Programming

GHC developed community groups, with the goal of supporting the community collective wellbeing and preventing future mental distress beyond the therapy room. This group was formed to explore LGBTQ+ cultural practices, including narratives of resistance to state violence and the legacy of collective caring, with the eventual goal of using arts-based methods to disseminate LGBTQ+ cultural practices within the community. Given the performative nature of sexuality and gender identity, the arts have long been a part of LGBTQ+ culture. Coming together through these mediums reflect an LTBGQ+ cultural legacy and is held to be a cornerstone of TGNC survival because they open space for community members to connect through social opportunities that promote collective action, improve mental health outcomes, and strengthen community and cultural connection. At least 5 community members and a GHC staff members met twice per month to examine LGBTQ+ cultural traditions and ultimately develop a collective resistance project to be revealed to the LGBTQ+ and the broader communities.

As part of the CRDP, GHC followed CDEP participants over nearly five years, using a mixed-methods observational study design consisting of matched pre-post-tests, focus groups, and interviews to understand and evaluate how their participation in the CDEP had an impact on their mental health. This evaluation was structured using four core questions:

1. **To what degree is the implementation of the CDEP occurring as planned? How are challenges to program implementation addressed?**

2. **To what extent does implementation of the CDEP expand the reach of GHC services?**

3. **To what degree is participation in CDEP services (including access to a peer-led safe space) associated with improved mental health, increased housing stability, increased employment, increased self-sustainability, self-advocacy, positive interpersonal relationships, and/or improved physical health?**

4. **To what degree does GHC's approach of radical inclusivity and its programs result in progress toward a more culturally responsive continuum of care and long term improved mental health for transgender people?**

A strong theme in both the quantitative and qualitative data collected from this evaluation is that participation in CDEP programming significantly improved CMs' attitudes towards themselves and acceptance of their LGBTQ+ identities. While this theme was not originally intended to be assessed through the evaluation questions, CMs articulated that this shift in being able to embrace themselves more fully was linked to improvements in mental health. Quantitative data also showed that CMs, including TGNC and LGBQ+ CMs, had statistically significant increases in positive coping skills and resilience and improvement on their general outlook on life. There were too few matched pre-post-tests of black, indigenous, and

people of color (BIPOC) CMs to observe changes in mental health outcomes for this group, specifically, so may be a potential priority for future evaluation.

CDEP Programming:

Increased self-acceptance
Increased coping
Increased resilience
Improved outlook on life

No statistically significant changes were observed in housing stability or income due to participation in CDEP programs. While CMs had generally positive experiences with staff, CMs noted that interns were not always as knowledgeable about how to provide culturally competent care to TGNC community members and expressed that they sometimes felt burdened by having to educate their intern counselors about their identity. Additionally, some CMs stated that, because intern counselors are only at GHC for a few months during their internship period, it was difficult to get acquainted and form a trusting relationship with a new counselor.

For interns, GHC provided a meaningful exposure to and learning experiences in understanding how intersectional societal oppressions impact and influence individuals' mental health and how to utilize and tailor unique, person-centered treatment modalities to create spaces of authentic allyship and healing for LGBTQ+ people, especially TGNC people. The majority of these findings were from qualitative data, as there was too small of a sample size of interns to capture any statistically significant findings. Future evaluations may also examine the lasting and longer-term impacts of GHC's internship program on former interns.

During COVID-19, GHC offered services mostly through virtual settings, though still maintained some limited in-person advocacy and case management services. Qualitative data show that the COVID-19 pandemic had varying impacts on individuals' participation in the CDEP, with some having greater access to counseling due to the transition to virtual services. COVID-19 did, however, have a generally negative effect on CMs experiences of loneliness and isolation, both because of the general increased isolation they experienced during quarantine and the lack of community support programming offered by GHC during this time. Given qualitative data on CMs' need for community and friendships with other LGBTQ+ people, targeted programming and evaluation of community connectedness may help GHC better support CMs with these needs and lead to even more positive changes in mental health.

By providing CMs with an affirming, "radically inclusive" space where CMs can see themselves represented, GHC fills the need for supportive community mental health services for LGBTQ+ people, especially TGNC people, in Sacramento and beyond. GHC's unique approach to therapy—queer-informed narrative therapy—not only sets the experience of receiving mental health services apart for CMs, but it also better helps them develop healthy coping skills, enhance resilience, and improve mental health. Foundational to all of this is the fact that, with GHC's support, CMs embrace their identities and foster greater self-love. This impactful organizational culture carries over to the experiences of interns, who learn how to be better allies to and counselors for LGBQ and TGNC people

through mentorships at GHC. In addition to teaching newer modalities of treatment, like queer-informed narrative therapy and integrated responsive advocacy, these mentorships and experiences help interns learn to meet CMs where they are and ultimately increase the amount of local culturally responsive and affirming mental health services available to LGBTQ+ people.

INTRODUCTION

We envision a society where trans people are unbound from all facets of structural marginalization. We aim to manifest a world where trans people are recognized as experts of our own lives, and gender-affirming care is universally accessible. We aspire to build a community that supports trans people no matter where they choose to seek resources and care.

Not only do LGBTQ+ communities experience greater risk factors for mental illness—such as increased social stigma, harassment, rejection, and resulting trauma—current systems of mental health care and treatment modalities were not designed for LGBTQ+ people's unique needs and so often are incapable of meeting their needs.[1] This inability compounds these risk factors and furthers mental health disparities among LGBTQ+ people. According to the CRDP Phase I LGBTQ Population Report:

> *"Only 40% of LGBTQ respondents stated they were 'very satisfied,' with mental health services, although satisfaction rates differed among subgroups. Older adults reported the highest rate of satisfaction (60%), and youth the lowest (23%) for 'very satisfied'. Trans Spectrum (31%), Bisexual (32%), Queer (25%), AA & NHPI (24%), Latino (36%), Native American (29%) and rural (35%) subgroups all had even lower rates of 'very satisfied' than the overall sample."*

Additionally, the effects of interlocking systems of oppressions, like racism and xenophobia, impact LGBTQ+ persons who are racial, ethnic, and linguistic minorities, and those with different abilities or who are undocumented. A 2016 study assessing the quantitative intersectional impact of racism and LGBTQ+ discrimination on the mental health among LGBTQ+ BIPOC found that LGBTQ+ discrimination has an additive effect on racial discrimination experienced by BIPOC LGBTQ+ and further exacerbates their struggles with mental health.[2] According to the US Transgender Survey, "people of color, including Latino/a (43%), American Indian (41%), multiracial (40%), and Black (38%) respondents, were up to three times as likely as the U.S. population (14%) to be living in poverty. The unemployment rate among queer and transgender people of color (QTPOC) (20%) was four times higher than the U.S. unemployment rate (5%)."[3] Gender non-conforming youth were also found to have been physically threatened or harmed because of their identity at a rate of 25%.[4]

Symptoms of major depressive disorder were reported by 71% of the same population, the very highest rate of any LGBTQ+ identity found in the survey.[4] Additionally, respondents with disabilities also faced higher rates of economic instability and mistreatment. Nearly one-quarter (24%) were unemployed, and 45% were living in poverty.[4] Transgender people with

disabilities were more likely to be currently experiencing serious psychological distress (59%) and more likely to have attempted suicide in their lifetime (54%).[4] Respondents to the U.S. Transgender Survey also reported high rates of mistreatment by health care providers—42%.[4]

Unfortunately, little to no data exist detailing the specific experiences of LGBTQ+ people in Sacramento. A 2014 Gallup poll estimated that about 3.9% of residents in the City of Sacramento identify as LGBTQ+, making Sacramento one of the top cities in California with the highest percentage of LGBTQ+ people—though that number is likely to have grown since the poll was conducted.[5] Overall, residents of the Sacramento metropolitan area have the second highest income inequality of any region in California, right after the Bay Area. Additionally, a 2019 point-in-time estimate found that approximately 5,570 individuals on any given night in Sacramento County are unhoused, or 36 per 10,000 residents.[6] This was a 19% increase from the previous estimate collected in 2017. For the first time, information on gender identity and sexual orientation was collected during this point-in-time estimate, with 9% of unhoused individuals identifying as gay, lesbian, bisexual, or another sexual orientation other than straight (LGBQ+). Further, 1 in 6 unhoused young people in Sacramento County identified as LGBQ+ and 3% identified as gender non-conforming.[7] Given perceived stigma against LGBTQ+ individuals, it is likely that a larger number of unhoused individuals are part of the LGBTQ+ community but did not feel comfortable reporting their true identities. Again, though no hard data exist on the mental health of LGBTQ+ people in Sacramento, documented links between social inequality and mental health, especially for LGBTQ+ people, give reason to suspect these disparities contribute to poor mental health outcomes for LGBTQ+ in Sacramento.[8]

The CRDP Phase I LGBTQ+ Population Report points to a shortage of culturally competent mental health providers across the state.[9] To work effectively with diverse LGBTQ+ people, mental health practitioners must understand their own social status and identities as informed by race, class, gender, and sexuality. Internal, interpersonal, and systemic barriers like implicit bias, cis- and heterosexual dominance, capitalism, and white supremacy operate in conjunction with each other to shape both practitioners' and individuals' experiences in mental health care. For example, practitioners must be aware that the assumption that "coming out" is a normal and natural part of gender and sexual identity development does not account for the ways that a "closeted" LGBTQ+ person may be at risk for losing familial, religious, or cultural group membership, which may serve as protective factors. This is especially true for LGBTQ+ communities of color, where familial and/or cultural group membership are often protective factors against systemic racism. Additionally, given the historical and present-day harms committed by mental health practitioners against LGBTQ+ people—conversion therapy, gatekeeping to gender-affirming care, lack of support of youth autonomy, and provider-as-expert models of therapy—many LGBTQ+ individuals come into mental health care wary of traditional modes of mental health practice.[10] Access to and engagement in culturally competent services is critical to improve mental health and wellness behaviors among LGBTQ+ people.[11]

The Gender Health Center (GHC), was created in 2010 by transgender people and cisgender allies to address this critical gap in the mental and physical health needs of LGBTQ+ people,

with an emphasis on transgender and gender non-conforming (TGNC) people. Danelle Saldana, a student studying to be a marriage and family therapist and trainee, was GHC's founder and passed away in her sleep just prior to opening GHC. Saldana was a cisgender ally who saw a need in Sacramento for transgender-specific mental health resources. GHC started solely as a mental health site, with one counseling room, one office, and one lobby, that was entirely run by volunteers. In line with its approach to centering organizational equity and creating a collective structure, GHC refers to the individuals who engage in services as Community Members (CMs) and not clients because their participation in services is not transactional. The intentional structure of this language aligns with GHC's peer-led, community-based approach by challenging the provider-client dichotomy often seen in traditional mental health organizations. GHC believes that the levels of proximity between the provider and intervention and the CM and has an effect of strengthening the therapeutic alliance.

GHC is located in midtown Sacramento, within blocks of the Sacramento light rail, food bank, and the Department of Health and Human Services; an ideal location to support unhoused and under-resourced community members. GHC is also close to the freeway and has free parking, making the location accessible to CMs traveling from throughout the NorCal region. GHC is open for virtual appointment 9am-9pm from Monday to Friday, and recently expanded its hours for in person appointments to 9am-6pm Monday to Friday, and to 10am-6pm on Saturday to enable it to serve its community at times that meet their diverse needs, schedules and employment statuses. Of those who currently seek mental health care at GHC, about 70% self-identify as TGNC, 20% as cisgender and LGBQ+, and 10% as cisgender and straight. The number of TGNC CMs receiving mental health care at GHC has increased dramatically over time.

GHC connects CMs with resources and services that reflect their cultural and linguistic backgrounds to assist with early onset mental health distress and to prevent serious mental illness. In addition to affirming individual counseling, GHC provides family and relational counseling that supports CMs' life events and family formations, like letting loved ones into CMs' authentic gendered and sexual selves and affirming diverse family and relationship forms such as poly families, tribes, and kink or bondage, discipline, sadism, and masochistic (BDSM) relationships. Services are provided in English and Spanish and are also provided in an American Sign Language through live video interpretation. Further, because of the diversity and complexities of intersecting power and oppression that exist within the LGBTQ+ communities and traditional support services, GHC strategies start at the community-level to meet specific needs of TGNC people, in particular, BIPOC and people living in poverty and/or without insurance, while keeping in mind that TGNC people are also often LGBQ+ as well.

CDEP PURPOSE, DESCRIPTION, AND IMPLEMENTATION

CDEP Purpose

GHC's Community-Defined Evidence Program (CDEP) is a prevention and early-intervention program that aims to prevent and reduce risk of mental illness consequences resulting from systemic violence—such as suicide, depression, isolation, anxiety, unemployment, housing stability, school failure and dropout—for LGBTQ+ populations by decreasing stigma and social isolation, and increasing access to affirming relationships, including cultural and community connections and mental health care. GHC's CDEP was designed to address goals 1, 2, and 3 of the CRDP Strategic Plan to Reduce Mental Health Disparities.

> **Goal 1:** Increase access to mental health services. GHC is a hub for TGNC communities, especially "hard to reach" populations. These individuals experience access issues when seeking services from other providers due to a lack of insurance, inability to pay, and/or lack providers with culturally competent care and training, and they come to GHC for its services. The CRDP allowed GHC to expand these services under the CDEP.
>
> **Goal 2:** Improve quality of mental health services. GHC's internship and workforce development programming directly addresses this goal and was expanded under the CDEP.
>
> **Goal 3:** Build on community strengths. GHC hires directly from the communities it serves with the intention to improve quality of care and "de-privatize" therapy. Guiding this strategy is GHC's belief that healing happens in the setting of the overall organization in addition to the individual clinical setting and session. This also funnels resources, training, and development opportunities directly to the communities.

In advancing those goals through its CDEP, GHC had the following target outcomes:

Enhance Community Member's Mental Health

Improve the Capability of Interns to Deliver Culturally Competent, Responsive Care

Build on Community Strengths to Increase Capacity and Empowerment

1. Enhance Community Members' Mental Health – GHC proposed that prevention and early intervention counseling, using Queer-Informed Narrative Therapy (QINT) and advocacy-focused case management approaches, would reduce anxiety, depression, isolation, and suicidality. Additionally, GHC believed that increased mental and physical health, self-sustainability, self-advocacy, positive interpersonal relationships would also decrease housing instability and unemployment for GHC CMs.

2. Improve the Capability of Interns to Deliver Culturally Competent, Responsive Care – With its internship program, GHC expected improvements in access and linkage to care for prevention of early onset mental health symptoms and reductions in the duration of untreated mental illness. Access and linkage to culturally competent medical care, specifically transition-related medical care, reduces isolation, suicidality, and prolonged suffering. GHC aimed to increase the number of trained providers providing non-stigmatizing and non-discriminatory services, with the goal of systemic change to mental healthcare. GHC also hypothesized that CMs who worked with these interns would have changed knowledge, attitudes and behaviors related to mental illness and seeking out healthcare.

3. Build on Community Strengths to Increase Capacity and Empowerment – Resistance is part of the cultural legacy of the LGBTQ+ community and has been fundamental to its survival. Access to leadership opportunities that are culturally relevant and support LGBTQ+ community collaboration and self-determination were expected to increase community knowledge of the interlocking oppressions that disproportionately impact the LGBTQ+ community and provide an opportunity for members of the community to change the social conditions of their lives. It was anticipated that CMs participating in these activities will have greater awareness of mental health services, pathways to transition-related care, employment and housing, and other protective factors that prevent the onset or accumulation of mental distress, experience an increased sense of hope and connection to LGBTQ+ culture and community members, and feel reduced social isolation and reduced sense of powerlessness and lack of control.

CDEP Description and Implementation

In line with these desired outcomes, GHC's CDEP expanded and evaluated two core elements of GHC's services and programs: QINT sessions and mental health provider internships. CRDP funding also supported three additional GHC programs that intersect with QINT sessions and mental health provider internships: Advocacy-Focused Case Management, Trans Peer Advocacy, and Community Support Programs. These programs were not specifically evaluated and assessed as part of the CDEP, but CMs who engaged in QINT sessions may have also engaged in these services, however, no formal data were collected on this.

The narrative that follows outlines the original planned program structure and delivery for the two main program components over the course of the CRDP and evaluation—QINT sessions and mental health provider internships—as well as the additional program components that intersect with these. Given the long-term hope to scale and replicate the CDEP programs, documentation of the program model was treated with great importance. Enrollment varied, staff changed, enhancements were identified and implemented through quality improvement efforts, and in 2020, the COVID-19 pandemic disrupted every service in the CDEP, to some extent. The table at the end of this section tracks the true implementation of all program components and details any notable changes to program structure or content.

Queer-Informed Narrative Therapy Sessions

The Gender Health Center offers individual, group, relationship, and family therapy using a Queer-Informed Narrative Therapy (QINT) model. The model combines queer theory and narrative therapy. Using the Gender Health Center's QINT counseling model, mental health interns support community members in externalizing and deconstructing dominant stories. These dominant stories are often saturated with socially oppressive messages and disempowering problems. Mental health interns use narrative therapy approaches to help community members to separate problems from understandings of self to increase one's access to internal and external resources. Through this process, community members develop alternative narratives (e.g., "preferred" stories) that reinforce engaging in new ways of living. This process enables community members to have fuller access to their strengths, skills, and resources. Due to the influence of dominant narratives of transphobia and heterosexism in society, the process of externalizing and deconstructing is crucial for transgender and gender-diverse people. The GHC's Queer-informed Narrative Therapy model is fundamentally non-pathologizing, respectful, and recognizes community members as the experts and authors of their own lives. The QINT model affirms that there are no absolute truths or universal descriptions of people or problems. The counselor does not assume an expert role but rather a role as a sojourner who works with community members to explore their strengths, help community members re-discover exceptions to problems, and establish new traditions that fortify new narratives.

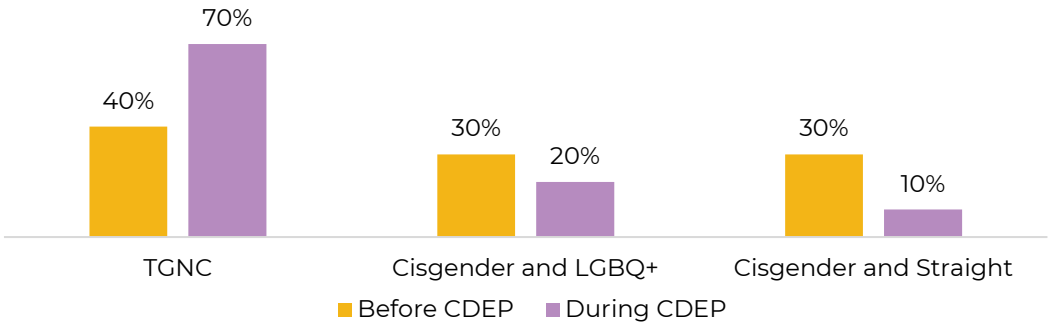
Queer theory also helps to inform the QINT model. Queer theory critiques and reframes gender and sexuality in a manner that transgresses dominant cultural expectations. There is an acknowledgment, validation, and celebration of the diversity of genders and sexualities in the human spectrum. This understanding allows CMs to explore previously unimaginable and unmapped landscapes of attraction, sexual expression, and gender performance. The process also promotes a distancing from oppressive and dominant discourses.

The Queer-Informed Narrative Therapy (QINT) model contrasts with traditional/dominant mental health frameworks in multiple ways. First, conventional mental health approaches consider mental health clinicians as "experts" who assess and treat mental illness as specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The counselor is often thought of as "treating," "diagnosing," or asserting that they know the truth of the client's experience and how to fix it using empirically support treatments. Second, traditional approaches often reinforce a "gatekeeping" process where clients must first be clinically diagnosed with a mental disorder to receive specific types of services. Lastly, conventional methods usually identify "pathology" as being rooted within an individual. Gender Health Center's QINT model rejects the idea that gender dysphoria and other clinical diagnoses are rooted in the individual and instead highlights the role of "societal dysphoria." QINT positions mental distress experienced by many TGNC people as an expected outcome of rampant, systemic anti-queer and anti-trans discrimination rather than a personal failing. In contrast to the clinical diagnosis of gender dysphoria, the GHC's QINT approach conceptualizes societal dysphoria as mental health distress due to societal and cultural responses to transness. Gender Health Center providers emphasize the impact

of social ills reflected in experiences of personal and systemic forms of racism, heterosexism, transphobia, classism, cissexism, and xenophobia. In plain terms, society is sick, and people respond the best way they can while residing in an ill community. Within this theoretical model, supported by extensive community-defined evidence, GHC's approach emphasizes the need for culturally humble and attuned mental health providers to advocate with TGNC people in their families, workplaces, schools, and healthcare systems. For TGNC people to experience reduced mental distress, community members must receive affirmative relationships in these critical aspects of daily living.

GHC staff, volunteers, advocates, and interns participate in ongoing advocacy and therapy trainings to ensure competency in providing QINT. Ongoing clinical and cultural competency training is provided by the clinical director and supervisors weekly and year-round, all of whom have years of training and experience serving LGBTQ+ persons. Weekly individual supervision is required one hour per week and group supervision is required two hours per week, in addition to a two-hour didactic seminar each week.

Community members participate in sessions according to their needs—typically one appointment per week. Not every counseling session may employ a QINT approach. No measures were used to assess the frequency or fidelity with which QINT was delivered through one-on-one counseling sessions. For the purposes of this evaluation, each CM receiving counseling from GHC was assumed to have received QINT. At the start of the CDEP, 348 people were actively receiving counseling at GHC. This number increased over time as detailed later in this section.



Racial and ethnic demographics of participants could not be captured during the CDEP because GHC transitioned to a new CM clinical database mid-way through the CDEP. However, before the CDEP, 52% of CMs receiving mental health services were white, 19% were Latinx, 14% were black, 7% Native American, 4% were east Asian, 2% were Hawaiian/Pacific Islander, and 1% were South Asian. Therapy sessions were delivered onsite at GHC. Starting March 2020, sessions moved to a virtual format because of the COVID-19 pandemic. Sessions were delivered by 20-30 intern counselors. Many, but not all, participants in the CDEP participated in more than just QINT. There is no particular order to participation in therapy, individuals may enter programming from any avenue. The Therapy program had no defined cycle and had rolling enrollment and flexible services.

Mental Health Provider Internships

GHC also serves as a training institute for mental health clinicians, medical practitioners and students, and undergraduate level social work students. It also assists local community-based agencies such as clinics, healthcare organizations, and schools with LGBTQ+-related needs and culturally competent care. The goal is to increase capacity of community providers who are culturally responsive to LGBTQ+ CMs' needs.

The core of this mission is to affect systemic change by utilizing and continuously developing GHC's student internship model. To make quality, affordable mental health services available to the local community, GHC created an intern/trainee model to provide individual, relationship, family, and group therapy. GHC partners with local universities to provide long-term (8-12 months), in-house student internship placements. Only Master's level students in social work, marriage and family therapy, and counseling programs provided therapy through mental health provider internships. The model of care GHC strives for is one of learning and exposure, leading to professional development opportunities. GHC effectively retains interns after graduation when they become pre-licensed mental health clinicians. Once licensed, clinicians are later offered a volunteer position as a supervisor once they are eligible to perform that role under licensing requirements. In turn, they can train incoming students, enabling GHC to increase the number of clinicians trained in TGNC-specific care. This model allows GHC to help clinicians develop culturally appropriate clinical skills specific to best practices working with TGNC populations to improve mental health outcomes.

Essential to the internship program is GHC's anti-oppressive, queer-informed, 45-hour core training through which interns gain insight into how capitalism, heteronormativity and white supremacy culture marginalize queer, transgender, and in particular, poor and racialized LGBTQ+ communities; how this contributes to poorer mental health; and how to provide culturally responsive care that results in socially just outcomes for these communities in the face of an unjust social and political landscape. This training is offered three times a year at the start of each internship cycle and consists of 5-hour trainings a few days a week over the course of four weeks and includes homework for interns to complete during off hours. All interns must participate in the full 45 hours unless they have reasonable conflicts. The trainings incorporate multi-modal teaching styles, including readings, group work and discussions, with an emphasis on case studies and role play to aid interns understanding of how to implement these theories and techniques in their work. Current and former CMs and staff are also brought in to present about their own experiences providing and receiving counseling at GHC. During COVID-19, this training was held virtually.

In-house professional development placements as part of the CDEP lasted 8-12 months, typically 16-24 hours per week, depending on school contract. There was no formal data collection on demographics of interns during the CDEP, but it was estimated that past interns were 80% white, 15% Latinx, 5% black, 50% LGBQ+, 50% straight, 90+% cisgender, and were graduate students in psychology, social work, and marriage and family therapy. Placements took place onsite at GHC until March 2020. Internships were then conducted virtually due to the COVID-19 pandemic and resulting stay-at-home orders. Starting in April 2021, placements were offered in a hybrid format, with virtual and limited in-person settings. Interns received day to day supervision from staff, weekly individual supervision from an

assigned volunteer clinical supervisor, and weekly group supervision & training from the GHC clinical director. This component occurred throughout the year and did not build on any other components. This program contained 2 cycles per year (6 total in the grant period) and included 5-15 participants per cycle. The start date was August 25, 2017, and the end date was May 14, 2021. The program cycle began at the end of August of each year and ended in May of the following year. One cycle lasted 8 months to correspond with the academic year.

At the core of GHC's philosophy is a deep understanding that gender and sexual minorities are not a homogenous cultural group. People who are served in the CDEP have different needs and experience multiple, interlocking oppressions. As such, GHC's CDEP programs not only address the many risk factors for mental illness within the LGBTQ+ population produced by systems not suitable or capable of meeting its needs, but also responded to the compounding effects of interlocking oppressions that impact LGBTQ+ individuals who are also racial, ethnic, and linguistic minorities, as well as those with different abilities, and those who are undocumented.

Included in these oppressions, for example, is the phenomena of "coming out" as an achievement. "Coming out," or "letting in," is a heterosexist behavior that is not used by GHC staff as a marker of positive mental health or outcome. GHC programs are aware of and sensitive to potential stronger adherence to heterosexuality, the gender binary, binary forms of expression among people of different cultures and demographic groups. GHC also affirms that often CMs of diverse sexual orientations and gender identities may choose not to share these identities with their communities as a protective mechanism. For example, greater access to "whiteness" or socioeconomic privilege may allow individuals greater safety to express something outside of the gender binary. Within the TGNC communities, there are great disparities in how people experience the world and can express their identities because of these social factors. This, in turn, shapes their mental health needs and how they can be supported through GHC's services.

GHC's programs are sensitive to and aware of these and other differences in the experiences of LGBQ+ and TGNC people. It is through these lenses that services are provided and that trainings for interns/trainees are provided. The trainings for interns/trainees are heavily focused on anti-oppression training, unpacking and avoiding weaponizing privilege, the gender binary, and an emphasis on the existence of social dysphoria rather than gender dysphoria. The evaluation explored the degree to which the people served in the CDEP perceive services and GHC to be aware of and sensitive to the differing needs of people who experience multiple interlocking oppressions.

Advocacy-Focused Case Management

GHC provides advocacy-focused case management that begins with an understanding of the medical, legal and psychiatric regulation that constrains CMs' ability to live their authentic lives. GHC staff, volunteers, peer advocates and interns participate in ongoing advocacy and therapy trainings. Building on the understanding that mental distress is systematically and culturally produced, rather than evidence of internal pathology, advocacy-focused case management compliments counseling services by providing direct advocacy to address the systems of oppression that are impacting the daily lives of CMs, such

as: discrimination and inequitable access to health insurance, healthcare services, mental health care, employment, housing, public benefits, and more.

The approach involves:

1. Providing CMs with information on their rights and the responsibilities of public institutions to uphold them;
2. Equipping CMs with knowledge and resources about the operation of systems so that they may advocate for themselves; and
3. Working in partnership with Legal Services of Northern California through a formal medical-legal partnership so that the community has direct access to an attorney when they experience discrimination and denials of their healthcare rights.

Staff manage a team of over 70 volunteers, trainees and interns comprised of licensed clinical providers, social workers, attorneys, HIV testing and outreach specialists, medical providers, and healthcare enrollers. Volunteers are also LGBTQ+-identified. Staff have extensive first-hand and lived experience overcoming barriers to mental wellbeing such as: unstable housing, economic and employment insecurity, sex work and substance misuse, as well as lived experience as advocates and helpers to other LGBTQ+ CMs. GHC offers individual and relational case management services in Spanish and English on a weekly basis for the duration needed. As an LGBTQ+ provider, GHC supports all families navigating life transitions, including those specific to LGBTQ+ persons such as "coming out" to friends, families, and workplaces, and navigating the medical, legal, and social transition processes. Case managers have experience working with poly families and members of the kink/BDSM communities. Case management is provided by specific case management staff and interns 6 days a week, 12 hours a day, Monday to Friday, and 8 hours on Saturdays. All staff, volunteers, and interns, including mental health provider interns, work with this case management team to refer for and respond to CMs' needs. Individuals access services according to their individual needs—typically 1 appointment per week.

Participation and demographic information on participants during the CDEP cannot be reported due to limitations with management software. Services were provided onsite at GHC. There was a designated staff person responsible for overseeing implementation of CDEP in the area of case management. At the start of the CDEP, services were delivered by three staff and eight intern case managers. Due to COVID-19, this was downsized to two staff and 2-4 intern case managers. This component was ongoing and continued throughout the grant and was not reliant on other components. Many participants in the evaluation participated in more than one component of the CDEP. There was no set sequence to CDEP participation, and community members entered programming via multiple avenues. The program had no defined cycle and incorporated rolling enrollment and flexible services.

Trans Peer Advocacy

During CDEP implementation, GHC developed and staffed a trans peer advocacy program to deliver alongside the Advocacy-Focused Case Management program component. This shift, which happened early in the CDEP, was made because of the observed high rates of social isolation in TGNC community. By having TGNC people in visible, compensated positions of leadership, and as knowledge holders, GHC believed they were better positioned to increase opportunities for community connections among TGNC people. Additionally, GHC found that this shift in focus to trans peer advocacy and centering TGNC people in efforts of mutual support was more reflective of their mission and vision as an organization.

GHC has two 0.8 FTE staff working as trans peer advocates and providing intake and case management appointments alongside the two case management interns also offering advocacy-focused case management. Both of these staff members are QTPOC and one is also Spanish speaking. These peer advocates also staff the Community Support Services Programming. This positions them at the heart of the agency and has helped them build relationships with CMs, act as mentors and provide resources and supports for CMs. With the shift to trans peer advocacy, GHC anticipates the numbers of peer advocacy staff to increase year by year, while decreasing the number of case management interns at the same time. This program had no defined cycle. It was appointment based, with continuous enrollment based on community needs. GHC recognized it was a risk to bring on new CDEP programming during implementation and modify the delivery of advocacy-focused case management in a significant way by supporting it with trans peer advocacy, but this shift meant potential improved alignment to meet the mental wellness needs of the community. Ultimately, GHC seeks to demonstrate that TGNC people are valuable to the mental health system as much more than service consumers, and the shift helped better reflect this organizational value.

Community Support Programming

GHC aims to be a mechanism for solidarity, social support, and prevention of mental health consequences that may result from social exclusion, and GHC is known in the community as a safe hub for LGBTQ+ people, in particular, TGNC people and QTPOC. The ongoing attacks on the community by the State, as well as the countless number of trans women of color murdered each year are salient examples that resistance is not only vital for survival, but TGNC people also need social opportunities that are safe from violence and promote cultural connection.

GHC developed community groups, with the goal of supporting the community collective wellbeing and preventing future mental distress beyond the therapy room. This group was formed to explore LGBTQ+ cultural practices, including narratives of resistance to State violence and the legacy of collective caring, with the eventual goal of using arts-based methods to disseminate LGBTQ+ cultural practices within the community. Given the performative nature of sexuality and gender identity, the arts have long been a part of LGBTQ+ culture. Coming together through these mediums reflect an LTBGQ+ cultural legacy and is held to be a cornerstone of TGNC survival because it opens space for CMs to connect through social opportunities that promote collective action, improve mental health

outcomes, and strengthen community and cultural connection. At least 5 CMs and a GHC staff members met twice per month to examine LGBTQ+ cultural traditions and ultimately develop collective resistance projects to be revealed to the LGBTQ+ and the broader community. The overall objectives of each project were to:

1. Prevent the onset of mental distress in LGBTQ+ persons;
2. Influence the broader social conditions that effectively result in negative mental health conditions for LGBTQ persons; and
3. Promote cultural and community connections and provide empowerment and leadership opportunities in the LGBTQ community.

The program ran continuously, producing one project each year.

Program Offerings, Participation, and Changes

The following table tracks the actual implementation of all program components, including the number of unique individuals who participated in each of the program components each year. The narrative provided after the table documents any shifts and details any other notable changes to program structure or content. Any notable changes in program structure or content are noted in the table and explained in the narrative that follows the table.

Unfortunately, given turnover in GHC staffing and transitions in clinical data management software, exact participant-level attrition from year-to-year of the CDEP could not be calculated. Community members dropped out of CDEP programs for various reasons—whether because their intern therapist left GHC after their internship and they were referred out of GHC for services, or they received the case management assistance they needed from peer advocates and no longer require additional case management services. Instead, program-level changes in participation can be seen in the table below, with most programs maintaining steady participation levels throughout the CDEP, then sharply dropping in 2020 and 2021 as a result of disruptions caused by the COVID-19 pandemic to both GHC's delivery of services and community members' lives and ability to participate in programs. Additionally, it is important to note that due to the informal, drop-in participation structure of the community support programming component, exact numbers of participants each year were not recorded, but it is estimated that approximately 300 unique individuals participated in this program component each year. Finally, it is not appropriate to calculate attrition rates for the mental health provider internships component because internships were for a fixed term; therefore, there was no carryover from year to year of interns. The three yearly cycles for mental health provider internships corresponded to the three terms of internships: fall semester, spring semester, and summer.

	Program Component	Queer-Informed Narrative Therapy	Mental Health Provider Internships	Advocacy-focused Case Management	Trans Peer Advocacy	Community Support Programming
		Sessions	Internships	Sessions	Sessions	Groups and workshops
2017	# of cycles	1 (ongoing)	3	1 (ongoing)	1 (ongoing)	1 (ongoing)
	Total unique individuals served	549	31	0	0	300
	Any major changes?	No	No	Not yet implemented	Not yet implemented	No
2018	# of cycles	1 (ongoing)	3	1 (ongoing)	1 (ongoing)	1 (ongoing)
	Total unique individuals served	512	32	279	436	300
	Any major changes?	No	No	Yes	Yes	Yes
2019	# of cycles	1 (ongoing)	3	1 (ongoing)	1 (ongoing)	1 (ongoing)
	Total unique individuals served	470	21	210	498	300
	Any major changes?	No	No	No	No	No
2020	# of cycles	1 (ongoing)	3	1 (ongoing)	1 (ongoing)	1 (ongoing)
	Total unique individuals served	246	30	188	76	0
	Any major changes?	Yes	Yes	Yes	Yes	Yes
2021	# of cycles	1 (ongoing)	3	1 (ongoing)	1 (ongoing)	1 (ongoing)
	Total unique individuals served	180	20	48	81	110
	Any major changes?	Yes	No	Yes	Yes	No

Explanation of Major Program Changes

2017 Program changes:

- Community Building and Social and Recreational Programming (turned Community Support Programing in 2018). In 2017, the initial plan was not implemented due to staff turnover, lack of time, and a need to re-organize and engage with community.

2018 Program Changes:

- Community Building and Recreational Programming component became Community Support Programing changing the focus from recreational activity to community group/workshop focus. Implementation did not begin yet due to capacity building and implementation of strategic plan.
- Two new program components were added, focusing on Advocacy-Focused Case Management included:
  - Advocacy-focused Case Management sessions: Case management had been taking place at GHC, but this component was specifically added so that it could eventually be evaluated in parallel to the QINT component.
  - Trans Peer Advocacy (case management sessions administered by a trans peer advocate): Peers are uniquely positioned to reduce isolation and create community engagement opportunities for trans folks. This program began in June 2018 and was added so that it could be evaluated in parallel to the QINT component. Eventually it replaced the Advocacy-Focused Case Management component above.

2020 Program Changes:

- Trans Peer Advocacy was implemented with few/moderate changes as a new trans peer advocate transitioned into the role in January 2020.
- Community Building and Recreational Programming events were moved to online platforms (Facebook Live), support groups were on hold due to the loss of volunteer facilitators that resulted from restrictions caused by the COVID-19 transition period.
- Due to the COVID-19 pandemic, GHC created two opening hours (virtual and in person). Virtual appointments are available 9am-9pm Monday-Friday, Saturdays 10-6 PM, and in-person appointments are available 9-12 PM, 1-6 PM Monday-Friday.

2021 Program Changes:

- Queer-Informed Narrative Therapy Sessions, Advocacy-Focused Case Management sessions, and Trans Peer Advocacy transitioned to a hybrid (in-person and telehealth) model in April as the vaccine became accessible to the general population.

Exact demographic information on the ages, races and ethnicities, gender identities, and sexual orientations of the CMs serviced by CDEP programs could not captured during the CDEP because GHC transitioned management databases during the CDEP. Programs served a wide range of community members across demographic groups; however, given the mission and vision of the organization to uplift and center the experiences of TGNC individuals and QTPOC individuals, GHC saw greater participation in CDEP programs and services by TGNC CMs and BIPOC CMs. Additionally, individuals served by

CDEP programs were generally, but not exclusively, younger adults in their early twenties to mid-thirties.

EVALUATION DESIGN AND METHODS

Design

Community-Based Participatory Research

The evaluation of the Gender Health Center (GHC) CDEP was designed to align with the goals, mission, and practices of GHC, centering community engagement and empowerment, cultural awareness and alignment, and social justice. It drew from the principals of community-based participatory research (CBPR), which emphasizes authentic engagement of and participation by the community in evaluation with the goal of generating valid, rigorous findings that are community-driven and result in increased capacity and expertise of community members to generate, understand, and use data to advocate for their needs.[12] GHC worked with Health Management Associates, Community Strategies® (HMACS), a national research and consulting firm skilled in conducting CBPR for the social determinants of health with LGBTQ+ communities, to develop and conduct this evaluation.

Community stakeholders were engaged throughout the process in many ways, ensuring that both the implementation of the CDEP and the evaluation were culturally and linguistically competent. First, a Community Advisory Board (CAB) was formed at the beginning of the project. GHC recruited CAB members, ensuring that it was made up of diverse LGBTQ+ community members, with specific representation from the TGNC community, and that it represented the diversity of the community that GHC serves and would like to serve—such as undocumented individuals, Spanish-speaking individuals, and individuals involved in survival economies. The CAB also included medical and mental health care providers and health care administrators from the community. While the primary focus of the CAB was to inform the evaluators and GHC about their experience and provide input into the evaluation, an additional purpose of the CAB was to support evaluation capacity building within the community, enhancing community empowerment. One initial diverse group of twelve CAB members was invited to participate in the group, and eight actively joined. The members who joined and maintained an active level of engagement over the years of the program were Jude Patton, Chantal Griffin, Margo Schulter, Malakai Coté, and Delphine Brody. Other members who joined and served on the CAB for a partial period of the evaluation were Suzanna Gee, Cody Grey, and Dom Fambro. CAB member participation ranged from highly engaged to low and moderately engaged with at least one gap in engagement for every member at some point. Meeting participation featured anywhere from two to eight members. Two CAB members led focus groups during the course of the evaluation.

The CAB met monthly at the beginning of the project to make key decisions about the evaluation structure and tools. To kick off its first meeting, the CAB explored the CDEP's visible elements (project, person, and place) as well as the invisible elements (concept, cause, and consequence) using the "culture cube", a conceptual tool developed during the CRDP to identify and articulate the cultural underpinnings of prevention and early intervention projects.[13] This helped level-set members' understanding of the CDEP, the evaluation, and research concepts to allow them to engage fully and provide informed input on the

evaluation questions and overall evaluation plan. The CAB also gave feedback on the proposed metrics, goals, data collection tools, and data collection protocols to make sure they effectively represented the needs of the communities served by GHC.

Th overall goal of the evaluation was to assess the impact of CDEP programming on CMs mental health, including isolation and loneliness, coping skills, resilience, and general outlook on life. Additionally, the evaluation sought to understand the impact of GHC's internship program on teaching cultural humility and how to employ unique therapy modalities to increase the number of culturally competent counselors for the LGBTQ+ community. This evaluation was structured with the following questions:

Evaluation Questions

1. **To what degree is the implementation of the CDEP occurring as planned? How are challenges to program implementation addressed?**

2. **To what extent does implementation of the CDEP expand the reach of GHC services?**

3. **To what degree is participation in CDEP services (including access to a peer-led safe space) associated with improved mental health, increased housing stability, increased employment, increased self-sustainability, self-advocacy, positive interpersonal relationships, and/or improved physical health?**

4. **To what degree does GHC's approach of radical inclusivity and its programs result in progress toward a more culturally responsive continuum of care and long term improved mental health for transgender people?**

The CAB was instrumental in this initial phase in ensuring that the evaluation was infused with an intersectional approach to data collection and analysis. The overall evaluation followed a mixed-methods, observational study design. CAB members helped design questions to understand how experiences of CMs are shaped by their multiple identities, such as "When you think about your multiple identities, what do you think is most important in terms of how you access health care?". CAB members also helped structure tools to measure the degree to which intern trainings had an impact on attitudes, beliefs and intended behaviors of interns as they began to serve TGNC CMs. In all tools created, demographic questions were intentionally designed to collect adequate data to analyze for variations by various points of identity. This analysis was then brought to the CAB for exploration. Qualitative data collection questions were also informed by CAB concerns based on emerging findings from initial quantitative data collection.

The feedback of the CAB was extensive, substantive, and had direct impact on the evaluation. There was detailed input on every data collection tool used in the evaluation that resulted in revisions to wording, question structure, adding "missing" questions, and more. Examples include:

- The suggestion to add encouraging messages to their process to convey to CMs that they are making progress in the survey(s), and that their input helps GHC improve its services. Another key message point adopted in response to this conversation was "If you're getting tired, you can take a break and come back to it at any time." This was underscored as particularly important as some of the questions can be re-traumatizing.
- CAB members discussed that there were no questions about the supervisor relationship with intern providers and GHC. Local evaluators addressed this in response.
- There was no indication that GHC valued honoring that the client is the expert on their own lives and the group strongly concurred that there should be. This was added in response.
- "Comfortable" is often the wrong word to use for measuring a provider's necessary awareness and knowledge. CAB members had strong consensus that it is not about an intern's "comfort" but rather if they are well-trained and proficient in the subject matter. The provider comfort is not as relevant and often they can do their job, even if it causes them discomfort. They cautioned that the evaluation be careful with this word and generally not use it, which drove edits.
- Awareness questions generally should be framed with careful structure to indicate that the responder "more fully" understands or has become "more aware" or "more sensitive to…" whatever the subject is. The idea that a cis-gender provider "fully" understands the transgender experience is an unrealistic expectation and is contrary to their theoretical premise that in this line of work they should always be growing, experiencing more, keeping an open mind and not think they know it all.

These are several examples of many dozens that could be provided. The input of the CAB was deep and meaningful. Dialogue on the most effective ways to engage CMs not only impacted wording and tool structure but drove meaningful discussion on how GHC can most effectively serve the needs of its community and guided staff and local evaluator efforts throughout the evaluation with the benefit of thoughtful, nuanced understanding.

The CAB continued to meet at least annually throughout the CDEP to comment on proposed new data collection tools or protocols, review data analysis and provide feedback on emerging findings to guide future analysis, participate in the development of presentations, and assist with presenting findings, including this final report.

Additionally, CAB members participated in activities outside the meetings and assisted with data collection. Several CAB members lead a focus group with trans CMs of color. After the first draft of the evaluation report was developed, one CAB member facilitated an internal focus group to present findings from the draft report to a former GHC intern. HMACS researchers also facilitated a similar meeting with past and present GHC CMs. During these conversations, the CAB member and HMACS researchers articulated the findings of the evaluation and worked with the intern and CMs to interpret results and shape the narrative

of the final report. In these ways, CAB members and CMs were incorporated into the evaluation as experts on their own lives, which helped enhance the validity of the evaluation by ensuring high levels of cultural competence and engagement. HMACS ensured that the research remained rigorous and unbiased by providing oversight, training, and technical assistance, and ultimately was responsible and accountable for all data collection and analysis tasks, as detailed further in this plan. The Institutional Review Board of the California Office of Statewide Health Planning and Development approved all study protocols and materials for this evaluation.

Surveys

Quantitative data were collected through pre and post survey instruments with no comparison group. CMs who participated in QINT sessions were eligible to take the Local Core pretest and posttest. Sampling followed a convenience format. The Local Core survey instrument was administered to adults and to adolescents. Participants took their pretest upon starting therapy and took a posttest every six months in follow up. Questions for the Local Core survey instrument were developed by the CAB and adapted from validated tools—including the UCLA Three-Item Loneliness Scale, the PHQ-9 Depression Scale, and the Brief Resilience Scale.[14,15,16] These questions assessed participants' reflections on their mental health, tools and coping skills they have learned through therapy, experiences of identity-based discrimination and harassment, and the degree to which staff at GHC understand and incorporate a culturally competent and intersectional approach in providing them services. These scales were specifically used to assess outcomes for QINT sessions, as reductions in isolation and loneliness and improvements in coping skills, resilience, and mental health are all goals of this CDEP program component.

Another pre-post survey instrument was developed for GHC's interns. Interns took a pretest at the beginning of their internship period and completed a posttest at the end of their internship period, either after 4 months for summer interns, 8 months for interns serving for the full academic year, or 12 months. Intern survey instrument questions were also designed by the CAB and included a mix of multiple choice, matrix, and open response questions. Questions asked about interns' understanding of how to provide culturally competent, intersectional mental health services to diverse LGBTQ+ individuals and the ways in which individuals' intersectional identities impact their receipt of those services. Open response questions asked interns to further explain their understanding of GHC's approach to therapy, including QINT, and how they incorporate those techniques into their practice.

Power Analysis

HMACS conducted power analysis to determine adequate sample sizes for matched pretest and posttest from the Local Core and Intern survey instruments for statistical significance. No studies were found that had the same or similar in population enrolled, intervention utilized, and outcome measures that would allow for use of an existing effect size. Therefore, HMACS relied on a few studies with some similarities to the CDEP.

One of these studies of a similar intervention was a community-based education program designed to promote health in people ages 52 years and older by decreasing loneliness and

stress. It showed an effect size of -0.45 and an estimated correlation between the pretest and posttest scores of 0.7.[17] Another similar intervention was a 20-week program for unhoused adolescents and young adults ages 16-24 in Edmonton, Canada.[18] The program provided one-on-one therapy support, group recreational activities, drop-in center availability, and other social supports. This intervention had an effect size of -0.34. Additionally, in a meta-analysis conducted by Masi et al. in 2011, a mean effect size of -0.37 was reported for 12 studies that used a single-group pre-post design to study the impact of various interventions on loneliness and social connectivity with a variety of populations.[19] Within this same meta-analysis, studies that specifically used the UCLA Loneliness Scale, which was used in this evaluation's Local Core survey, showed a mean effect size of -0.499. Based on these somewhat similar studies and interventions, HMACS's power analysis used both -0.34 to -0.50 as potential effect sizes.

Second, this power analysis assumed the evaluation looks at and compares continuous (ordinal but treated as interval) values of responses to questions about loneliness, connectivity, and mental health. Further, it assumed a one-group design, using pre and post measurements.

Third, HMACS used some standard statistical assumptions. The analysis plan used a two-tailed test because of the exploratory nature of the first round of analyses. Consistent with standard scientific practice, HMACS used a 0.20 risk of making a Type 2 error (80% power threshold) and a 0.05 (5%) risk of making a Type 1 error.

Based on these assumptions, and using a standard power calculator for a matched sample of Local Core pre-post-tests and t-tests as the basic test of significance, a minimum sample size of 52 matched pre-post-tests, assuming an effect size of -0.34—a more conservative approach—or at least 26 matched pre-post-tests, assuming an effect size of -0.5, was needed to provide sufficient power.

The final number of matched adult Local Core pre-post-tests in the CDEP evaluation (n=34) met the sample size requirement for a -0.5 assumed effect size but not for a -0.34 assumed affect size. The final number of matched adolescent Local Core matched pre-post-tests was 2, so it was not large enough to convey adequate power.

CDEP Component	Expected Number of Participants Per Cycle	Number of Cycles	Expected Total Number of Participants
Queer-Informed Narrative Therapy	250	5	500-750 (may not be new people each year)
Mental Health Provider Internships*	5-10	15	75-150

**Outcomes for providers are related to changes in knowledge, attitudes, intended behaviors and actual behaviors. A power analysis was not conducted for these outcomes.*

Focus Groups & Interviews

The qualitative design for this evaluation was phenomenological and included annual focus groups and interviews with GHC CMs. These focus groups were used to supplement quantitative data to explore the degree to which CMs perceive the therapy to be helpful, what could be improved, and what else is needed. These focus groups and interviews were also used to gather information from LGBTQ+ CMs, especially TGNC CMs, about their opinions about the competency of their providers. During the COVID-19 pandemic, additional questions were added to better understand the mental health impacts of the pandemic for CMs, new health and social needs, and barriers and challenges CMs faced in engaging with GHC's services. Using purposive sampling methods, GHC and HMACS worked to ensure a diverse and representative set of individuals participated in focus groups, including individuals from currently underserved segments of the LGBTQ+ population in the region, like individuals without permanent housing, Spanish-speaking individuals, and Latinx individuals. Focus groups and interviews were held at six months and twelve months in the first year of data collection, and then yearly until the end of data collection. Given scheduling, these focus groups occasionally were conducted as one-on-one interviews, using the same questions as an informal guide. The CAB participated in the development of interview and focus group guides and helped to ensure that findings were culturally valid. Information obtained from these focus groups and interviews, including ideas for program improvement, was used by GHC for continuous quality improvement of CDEP programming and services.

Annual interviews were also conducted with each cohort of mental health provider interns at GHC. These interviews explored emerging quantitative findings with interns and delved further into their experiences with QINT and the impact their time at GHC had on their practice. At the onset of the COVID-19 pandemic, questions were altered to ask about interns' experiences delivering therapy via telehealth and its impact on their work with CMs. The CAB also gave input to help with the formation of these interview guides and the development of the sample of people to interview.

Additionally, as part of the action research component of the study, CMs will have the opportunity to engage with the evaluation team and GHC staff to turn results into products for dissemination and use by the community to advocate for their own health care needs. This follows GHC's current model of providing CMs with information about their rights and needs when seeking mental health services and physical health services outside of GHC, in the larger community. The products could take the form of YouTube videos, printed documents that outlined key evaluation findings and promising practices uncovered through the CDEP evaluation, or other formats as determined by the community. This will happen after the draft report has been submitted.

Creative Testimonials

To supplement qualitative data collected through focus groups and interviews and quantitative data collected through surveys, GHC created an opportunity for CMs and interns to express how they have been impacted by the services, support, and community at GHC through multi-model forms of data collection. Participants were encouraged to submit

written, photo, video, or artwork as testimony for GHC. In keeping with the CBPR approach of this evaluation, GHC believed that these data enhanced representation of the community's voice in the program evaluation. Unfortunately, no creative testimonials were received prior to the end of the data collection period.

Implementation

Recruitment & Participation

Recruitment for services followed GHC's regular recruitment and outreach processes, including word of mouth and active recruitment from CAB members. All individuals who were receiving therapy from GHC at the time the CDEP started were recruited for participation in the evaluation and individuals who sought therapy from GHC throughout the CDEP period were recruited as they entered services. Most CMs who were approached, agreed to participate in the evaluation, though some did not. Recruitment became more challenging with the onset of COVID-19 and shift to virtual programming and services because it was harder to reach people through virtual mediums.

Recruitment included a full informed consent process in which trained GHC staff shared information about the evaluation, what participants would be asked to do, benefits, and other information. Evaluation materials, including consent materials, were translated into languages other than English if necessary. For people with lower literacy levels, GHC staff read materials to them and explained the materials, the program, and the evaluation a manner that individuals were able to understand, to ensure full informed consent. The recruitment materials were pilot tested with the CAB before they were implemented. CAB members provided feedback on the accessibility of materials and feedback was incorporated.

COVID-19 had a big impact on the number of CMs who were recruited into the evaluation and the continued participation of CMs already enrolled in the evaluation. Even CMs who continued receiving services from GHC were less likely to complete pretests or posttests due to general life disruptions they may have experienced because of COVID-19.

Programs

When the COVID-19 pandemic began in spring of 2020, GHC moved all in-person programs and services to a virtual environment. However, given varying levels of technology and computer access and literacy among participants and other factors—like increased isolation, dissatisfaction with virtual programming, lack of access to private space, and general disruption to routines—many original CDEP participants did not continue to engage in programs. While GHC staff continued to try to engage these individuals, the internal operational struggles caused by COVID-19 made it difficult to seamlessly transition services. GHC already had telehealth options during the transition period that it could lean on. However, the influx of online services led to many outages in the initial months of using Zoom and doxy.me. GHC's former facility was too small to safely hold in-person gatherings for groups of individuals, so support groups were on hold from March 2020 – January 2021. GHC also saw an increase in advocacy service engagement as CMs experienced an

increasing amount of renter, employment, and healthcare-based discrimination all relating to COVID-19—such as layoffs, eviction holds, surgery postponements, etc.

GHC's interns and staff were also affected by COVID-19. Many schools opted to pull their students from the internship entirely, some provided no guidance, and some allowed students to continue. Interns who were unable to provide teletherapy—due not having a HIPAA-compliant, private space at home—were unable to transition to virtual appointments. Most of these students were living in intergenerational households or sharing spaces with many roommates who all transitioned to work-from-home at the same time. This uncertainty drastically reduced the number of provider availability and provider capacity.

This massive disruption not only caused the quality of CDEP program delivery and participant responsiveness to suffer, it also caused disruptions and decreases in the planned "dose", or level of exposure and engagement that participants had in CDEP programming. In April 2021, GHC started offering in person services again, but most CMs opted to keep virtual appointments.

Throughout these challenges and changes, GHC and the CAB remained responsive to the needs of the community. Questions about community needs and experiences during COVID-19 were added to focus groups and interview guides and these responses helped inform the Center's outreach methods and programming. These prompted GHC to be more flexible in its delivery of CDEP programs to participants, while still maintaining fidelity to the true purpose of the CDEP. Additionally, given the reduced capacity and increased need, GHC shifted its energy to better support its Black and Brown TGNC communities, working on projects that included developing equity policy, starting a Black trans-specific support group, and foster youth leadership development for staff. No formal assessment of implementation fidelity was conducted.

Data Analysis

All analysis was completed in coordination with the CAB to ensure results are culturally and programmatically valid and relevant. Quantitative data from surveys were analyzed using rigorous analytic methods, using Stata for inferential analysis and for descriptive analyses—such as participant demographic descriptions and basic means for survey items. This analysis plan was developed alongside the survey instruments with continuous input from the CAB. Analyses include an exploration of differences in outcomes by demographics and type of services utilized, as possible. Analyses for intern survey tools explored changes in understanding of the QINT approach and changes in their perceived ability to provide culturally appropriate care to LGBTQ+ individuals.

For inferential analysis, t tests of significance of difference were used to assess changes in CMs' mean scores for measures of isolation and loneliness, coping, resilience, and mental health from pretest to posttest. T tests of significance of difference could not be used to assess changes in interns' perceived ability to provide culturally appropriate care because of the small sample of pre-post matched responses. Regression modelling and analysis of variance tests—ANOVA and ANCOVA—were originally proposed to test the impact of dependent variables relative to other independent demographic variables; however, there

were not adequate samples sizes of pretests and posttests across different demographic groups to allow for these tests. Unfortunately, inferential analyses could not be conducted on data stratified by pre and post onset of COVID-19 pandemic.

Qualitative data collected from focus groups and interviews were recorded and transcribed. A set of initial codes through which to assess transcript was developed with the CAB and aligned with the focus group and interview guide questions. Transcriptions were then manually coded by researchers trained in qualitative analysis and thematically analyzed to capture emergent themes. Analyses of transcripts and themes were reviewed across researchers to minimize coder biases and reconcile discrepancies. These findings were then shared with GHC staff and the CAB to validate themes and ensure interpretation was culturally appropriate.

These varying data collection methods and analyses served to mutually inform and reinforce each other to ensure that findings were validated across all analyses. Given inherent differences in the experiences and identities of those captured through surveys versus focus groups and interviews there are some discrepancies in findings, which are explored in this analysis.

RESULTS

Community Members

Demographics

There were 140 unique adult CMs who took the Local Core pretest. See Appendix A for full demographic details of adults who took the Local Core pretest. There were 41 CMs who completed the Local Core posttest at 6 months. In total, there were 34 matched pre-post-tests.

While exact demographic information on overall CDEP program participants cannot be reported, the demographics of evaluation participants closely mirrors the demographics of CMs who participated in programs, especially across sexual orientation and gender identity. Qualitatively, there was a greater proportion of white CMs who participated in the evaluation relative CMs who participated in CDEP programs, as well as a somewhat lesser representation of Black and African American CMs in the evaluation compared to in GHC programs.

Presentation of Results

Findings from analyses of all data collected from CMs—pretests and posttests from the Adult Local Core survey instrument, focus groups, and interviews—are presented below and grouped into the following broad themes:

All themes are associated with specific scales and questions used in the Adult Local Core survey instrument. Several of these scales were also included in the Adolescent Local Core survey instrument. The Adult Local Core was primarily used to assess differences in scale composites through matched pair t tests of significance between CMs' pretest and 6-month posttest. Consistent with standard scientific practice, differences with p-values less than 0.05 are considered statistically significant. For t tests with fewer than 30 matched pairs, results are reported cautiously. There were not enough pretests or posttests of CMs for the Adolescent Local Core to provide comparative data, so these data were not analyzed. Qualitative data are mapped onto these themes to further illustrate, refine, and provide nuance to findings. When findings from qualitative data point to specific subthemes,

differences in individual items from the scales were assessed across matched pretests and posttests.

Each theme contains findings that help answer one or more evaluation questions, as shown below:

1. To what degree is the implementation of the CDEP occurring as planned? How are challenges to program implementation addressed?

    - Experiences with Staff, Organization, and Services

2. To what extent does implementation of the CDEP expand the reach of GHC services?

    - Experiences with Staff, Organization, and Services

3. To what degree is participation in CDEP services (including access to a peer-led safe space) associated with improved mental health, increased housing stability, increased employment, increased self- sustainability, self-advocacy, positive interpersonal relationships, and/or improved physical health?

    - Attitudes about Being LGBTQ+
    - Loneliness and Mental Health
    - Coping and Resilience
    - Income and Housing

4. To what degree does GHC's approach of radical inclusivity and its programs result in progress toward a more culturally responsive continuum of care and long term improved mental health for transgender people?

    - Experiences with Staff, Organization, and Services
    - Attitudes about Being LGBTQ+
    - Loneliness and Mental Health
    - Coping and Resilience

To answer evaluation questions 3 and 4, differences in pretest and posttest scale composite scores and individual scale item means are assessed through matched pair t tests of significance for CMs whose gender identity is something other than cisgender male or cisgender female (TGNC), as well as for individuals whose sexual orientation is something other than straight (LGBQ+). Important to note, these groups are intersectional, meaning that individuals may identify as TGNC and as LGBQ+, and therefore, are counted in analyses for both TGNC and LGBQ+ CMs. Sample sizes were too small to further separate out straight TGNC CMs, LGBQ+ TGNC CMs, straight cisgender CMs, and LGBQ+ cisgender CMs. These tests reveal statistically significant changes in outcomes for TNGC CMs and LGBQ+ CMs. The number of posttests and matched pre and posttests for cisgender CMs and straight CMs was too small to assess differences in outcomes and changes in outcomes between cisgender CMs and TGNC CMs, as well as differences in outcomes and in changes in outcomes between

straight CMs and LGBQ+ CMs. However, t tests of significance were used to compare pretest mean values between cis gender CMs and TGNC CMs and between straight CMs and LGBQ+ CMs to establish differences in baselines.

The number of posttests and matched pretests and posttests for CMs who identified themselves as BIPOC was too small to conduct tests of statistical significance between different racial and/or ethnic groups. Therefore, differences in outcomes and changes in outcomes between white CMs and BIPOC CMs could not be assessed. However, there was an adequate number of pretests for BIPOC CMs to assess differences in pretest means, or baselines, between white CMs and BIPOC CMs.

Finally, data from all sources were impacted by COVID-19. Pretest and posttest dates were not adequately captured during administration of survey instruments throughout the data collection period, so limited analysis of quantitative data can be done to assess the impact of COVID-19 on findings. However, findings from qualitative data that illustrate the impact of COVID are used to provide nuance to thematic findings and infer potential effects in quantitative data.

Experiences of Identity-Based Violence and Discrimination

Though not a direct measure of mental health, CMs were asked at pretest how often they experienced forms of harassment in the past 6 months. The mean response for CMs was about once (1.012) (Table 1.). The mean response was slightly lower (0.409) when asked how many times they experienced acts of discrimination against them and slightly higher (1.507) when asked how many times they experienced forms of bigotry (Table 1).

Table 1. Experiences of Harassment, Discrimination, and Bigotry at Pretest

	n	Mean	SD
Harassment Composite Score[i,ii]	139	1.012	0.796
TGNC CMs	119	0.973	0.805
LGBQ+ CMs	118	0.997	0.794
BIPOC CMs	59	1.076	0.837
Discrimination Composite Score[i,iii]	133	0.409	0.635
TGNC CMs	115	0.425	0.658
LGBQ+ CMs	117	0.407	0.659
BIPOC CMs	59	0.352	0.650
Bigotry Composite Score[iv,v]	137	1.507	0.854
TGNC CMs	117	1.551	0.977
LGBQ+ CMs	117	1.504	0.965
BIPOC CMs	59	1.418	0.971

[i] Responses followed a 0-3 scale format with 0 being "Never" and 3 being "Three or more times."
[ii] This composite score is an average of 8 items. These items ask how often in the past 6 months CMs: were verbally insulted; were threatened with physical violence; were punched, kicked, beaten, or had an object thrown at them; were attacked sexually; had someone threaten to out them to someone else; had their property damaged or destroyed; were hassled by the police; had someone tell another person about their gender identity and/or sexual orientation without their permission.
[iii] This composite score is an average of 4 items. These items ask how often in the past 6 months CMs: experienced a form of employment discrimination, were prevented from living in the

neighborhood they wanted, were denied or provided inferior healthcare, were refused services such as at a store or hotel.
[iv] Responses followed a 0-6 scale format with 0 being "Never" and 6 being "Almost every day."

T tests of significance between white CMs' and BIPOC CMs' mean harassment, discrimination, and bigotry composite scores showed no statistically significant differences. The same was true when comparing TGNC CMs and cisgender CMs as well as LGBQ+ CMs and straight CMs. However, TGNC CMs' (n=117) pretest mean bigotry composite score (1.551) was 0.375 points higher than cisgender CMs' (n=18) pretest mean bigotry composite score (1.551). With a p-value of 0.063, This difference can be considered substantial and approaching significant. CMs spoke to these experiences in their open-ended responses, with one CM explaining that they "experience plenty of discrimination online, and this does have a notable negative effect on [their] mental well-being."

"…[other therapists] would either assign all my issues to like dysphoria when that wasn't really accurate or they weren't really able to understand what's going on. And so it's been very affirming to have these people [GHC therapists] that share similar identities… I haven't really been able to find that elsewhere."

The minority stress model argues that the societal stigma or "stressors" that demographic minorities—including sexual, gender, and racial minorities—face contributes to poorer mental health for these groups.[20] When asked directly on the Local Core survey instrument about this potential link between experiences of harassment, discrimination, and bigotry and their need for mental health services, CMs generally felt that they were somewhat related. Using a 4-point scale (0 being "Not at all related" and 4 being "Very related"), the mean response for CMs at pretest was a 1.562 (n=137, SD=1.006). Using a t test of significance, TGNC CMs had a statistically significant higher (0.500) mean response at 1.618 (n=118, SD=0.995) compared to cisgender CMs at 1.118 (n=17, SD=0.993) (p-value=0.027). Neither LGBQ+ nor BIPOC CMs had statistically significant or substantial differences in their response to this question compared to their straight or white counterparts, respectively.

Though CMs expressed that they had a need for mental health services because of their experiences with harassment, discrimination, and bigotry, many expressed disappointment with previous mental health services. One person explained that in their previous experiences, they did not feel like their therapist understood them and that their therapist would inaccurately diagnose their mental health concerns because of their gender identity.

Experience with Organization, Staff, and Services

At GHC, CMs noted that staff are more knowledgeable about topics relevant to the LGBQ+ and TGNC populations compared to most therapists. Common language was also what made GHC distinct in the eyes of CMs, with several expressing that in traditional therapy or doctors' offices, they often had difficulties in explaining their needs and being understood, but at GHC, CMs said that that they feel more heard, their identities are more respected, and

they feel more attended to, because GHC staff understand and share the same language. Use of correct pronouns was one example of this common language, with one participant sharing "they're very, very good at pronouns, obviously. They are dead on. I've never, ever heard someone dead name or use the wrong one [pronoun]. I haven't even heard someone slip up on it, I don't think, ever." CMs said this allows them to feel more comfortable in therapy sessions with GHC staff.

Data from Local Core posttests also support this finding that CMs feel GHC has improved their access to culturally competent mental health care. When asked to rate how much GHC has improved their access on a 4-point scale, with 1 being "Not at all" and 4 being "Very much" the mean response for CMs was 3.243 (SD=1.038). Mean responses for TGNC CMs and LGBQ CMs, specifically, are shown in Table 2.

Table 2. How much do you think your involvement with Gender Health Center has resulted in improved access to mental health care that respects and acknowledges your identities?[i]

	n	Mean	SD
All CMs	37	3.243	1.038
TGNC CMs	35	3.229	1.060
LGBQ+ CMs	34	3.294	1.045

[i] Responses followed a 4-point scale format with 1 being "Not at all" and 5 being "Very much."

In focus groups, CMs noted that GHC staff and GHC as an organization does a great job at specifically supporting and affirming the TGNC community, which is not true of all LGBTQ+ organizations. Having TGNC people working at reception and at every juncture of service provision left a positive impact on many CMs, some of whom expressed never seeing TGNC people represented in their own communities.

"This is the first time that my therapist wasn't male and white and thin. It completely changed how I was supported as a non-binary, brown fat person. Thank you so much."

Table 3. Experiences with Staff Composite Score [i,ii]

	n	Mean	SD
All CMs	34	4.691	0.482
TGNC CMs	32	4.704	0.480
LGBQ+ CMs	31	4.690	0.503

[i] The composite score is an average of 11 items on a scale assessing CMs experience with staff. These items ask CMs to mark the extent to which they agree with the following statements: "the staff here treat me with respect," "the staff here don't think less of me because of the way I talk," "the staff here respect my race and/or ethnicity," "the staff here respect my religious and/or spiritual beliefs," "the staff here respect my gender identity," "the staff here respect my sexual orientation," "the people who work here respect my cultural beliefs, remedies, and healing practices," "staff here understand that people of my racial and/or ethnic group are not all alike," "staff here understand that people of my gender identity are not all alike," " staff here understand

that people of my sexual orientation are not all alike," and "staff here understand that people of my religious and spiritual background are not all alike."
[ii] Responses followed a 5-point scale format with 1 being "Strongly Disagree" and 5 being "Strongly Agree." Increases in composite scores indicate increases in resilience.

CMs consistently brought up in focus groups and Local Core open responses that at GHC, they feel that their identities across the LGBTQ+ spectrum are affirmed. BIPOC CMs did not always share the same level of sentiment about seeing themselves represented in GHC, noting in a focus group specifically for BIPOC CMs that they wished there were more counselors of color. There were not enough Local Core posttests from BIPOC CMs to assess any substantial or significant differences in their mean composite score of experiences with staff compared to white CMs' mean composite score.

CMs of all races and ethnicities also shared that they had some issues feeling fully understood by GHC interns. They shared experiences of having interns misgender or deadname them—contrasting with their experiences with GHC staff. One participant in a Local Core open response said that their "counselor was not very knowledgeable about gender and [they] ended up having to educate him which took away from the time [they were] getting mental health care." One CM even shared that they ended up stopping receiving mental health care from GHC because they felt that their intern counselor expected the CM to educate them. This shows that, while GHC staff members were seen as expertly culturally competent and humble in their work with CMs, interns, who often are learning how build cultural competency and humility into their practices, need additional training or support to ensure this lack of understanding does not impact their CMs' experience. Some CMs had positive experiences with counselors who were interns, but they then felt abandoned by their counselor once their internship at GHC was over. These CMs acknowledged that it was part of GHC's model but said that this change in counselors affected the care they received because they felt that they had to "re-explain themselves" and their relationships with new counselors were not always as good. Some CMs expressed that these factors were deterrents to care.

Though not expressly named as a deterrent, CMs also said that the months-long waitlist was a big barrier for them receiving services. Some CMs waited only a month, while others said they waited 6+ months. This caused some CMs who had private insurance to pursue other options. However, the wait did not seem to come as a surprise to any CMs. Both because of the popularity of GHC in the community and because they had similar experiences with waitlists at other mental health providers.

According to CMs in focus groups and Local Core open responses, COVID-19 had somewhat of an impact on their receipt of services from GHC, though no common themes emerged. Most CMs in focus groups said that they were able to continue therapy right away either virtually or by phone. A few CMs, however, said that their counseling services were put on hold when the COVID-19 started and they were not called back until months later, at which time they had already found services elsewhere.

> ***"It'd be really interesting to see if this [virtual services] could be something that became an option, moving forward. Like you could still go in person, if you want that kind of service, or you could opt for a virtual counseling session."***

Those who did continue with services during COVID-19 had mixed experiences. Some mentioned having difficulties with maintaining connectivity during virtual therapy sessions or trying to find a private space for their sessions. Some CMs noted that virtual therapy services were more accessible. One CM in a focus group was disabled and mentioned that before COVID-19 it was difficult for them to get to the actual building, so having virtual services was less physically and mentally exhausting. A few focus group members said that they did not live close to Sacramento, so virtual service options were the only way that they and potentially others could have access to GHC's services.

Attitudes about Being LGBTQ+

One of the services at GHC that CMs expressed they were most grateful for was advocacy related to gender identity—a unique program goal of QINT, advocacy-focused case management, and trans peer advocacy programming. This was another thing that set GHC apart for CMs. They expressed that therapists at GHC can help provide services that other counselors can't, such as legal advocacy, name changes, and guidance with navigating the healthcare system for culturally sensitive primary care or transition-related care. For some, this access and support at GHC helped them start their transition. In the Local Core posttest, when asked to rate the extent to which their involvement with GHC has resulted in improved access to transition related care on a 4-point scale with 1 being "Not at all" and 4 being "Very much", CMs had a mean rating of 3.25 (n=32, SD=0.984). When asked to rate the extent to which their involvement resulted in improved access to transition-related legal services using the same scale, they had a mean rating of 3.152 (n=26, SD=1.084). One focus group participant spoke to the impact these services had:

> ***"I'd say that the biggest one is that they've helped me be able to transition. I really don't know what I would have done without their help, with the help with the legal process and the help with the letter writing and the help with what are the steps [like] what do you need to do? What do you need a doctor's letter for? How do you change your name for the DMV and the birth certificate and Social Security and everything? They were so helpful with everything. I really don't know where I would be without them because so much of my mental health has improved because of my transition."***

By enhancing CMs' access to identity-affirming services, GHC also helped CMs with their self-acceptance and self-affirmation of their LGBTQ+ identity. One CM shared that "starting T and

changing [their] name and gender made [them] much more comfortable and happy, [they were] able to live authentically."

These feelings are in contrast to open responses in the Local Core pretest. Before starting services at GHC, many CMs said they felt "stressed" around being uncertain about their gender identity or wished that they "didn't have to deal with all [their] mental and gender dysphoric luggage." CMs also pointed to external pressures and societal stigma against LGBTQ+ people as exacerbating some of their feelings of shame, with one CM saying, "I hate being trans. It literally feels like the entire world hates me and it makes life a lot harder than it should be." T tests of significance showed statistically significant increases in the mean scores of CMs' comfort with their gender identity and comfort with their sexual orientation between pretest and posttest (Table 4.) Most substantial was the 0.407 increase in the mean composite score of TGNC CMs' (n=30) comfort with their gender identity between pretest and posttest, from 3.398 (SD=0.805) to 3.805 (SD=0.712) (p-value=0.001).

Table 4. Change in Comfort with about Gender Identity and Sexual Orientation[i]

	n	Pretest Mean (SD)	Posttest Mean (SD)	Difference	P-value
Comfort with Gender Identity[ii]	32	3.451 (0.806)	3.811 (0.689)	0.360	0.002
TGNC CMs	30	3.398 (0.805)	3.805 (0.712)	0.407	0.001
Comfort with Sexual Orientation[iii]	32	3.922 (0.774)	4.323 (0.093)	0.401	0.003
LGBQ+ CMs	31	3.927 (0.786)	4.333 (0.532)	0.406	0.004

[i] Responses followed a 5-point scale format with 1 being "Strongly Disagree" and 5 being "Strongly Agree." Increases in composite score indicate increases in comfort.
[ii] This composite score is an average of 5 items assessing CMs satisfaction with their gender identity. These items assess CMs level of agreement with the following statements: "I have a positive attitude about my gender identity," "I feel uneasy around people who are very open in public about being transgender" (reverse scored), "For the most part I enjoy being transgender," "I worry a lot about what other think about my gender identity" (reverse scored), "I feel proud about my gender identity."
[iii] This composite score is an average of 5 items assessing CMs comfort with their sexual orientation. These items assess CMs level of agreement with the following statements: "I have a positive attitude about my sexual orientation," "I feel uneasy around people who are very open in public about being lesbian, gay, or bisexual" (reverse scored), "For the most part I enjoy being lesbian, gay, or bisexual," "I worry a lot about what other think about my gender sexual orientation" (reverse scored), "I feel proud about my sexual orientation."

Qualitative data reflect this change. In Local Core open responses, CMs said that GHC helped them understand that their non-cis gender identity was valid and something of which to be proud. In addition to empowerment, Local Core open responses had strong themes of self-love and hope. CMs shared that GHC's services helped them feel like they were worthy of love and compassion and that they finally had the resources to achieve their goals. Using a metaphor to describe this feeling of hope, another CM said they "felt a door in [their] life open

that had been closed shut for so long." Again, many CMs attributed these feelings, in part, to the fact that they saw themselves and their identities reflected in the staff and organizational culture at GHC. One CM said in their Local Core open response that GHC "gives [them] hope to know that trans people are employable and can be treated with respect in a workplace."

> ***"Emotional and moral support is essential to any human, so when you receive this from the community, it makes you see things and goals more attainable. And when I can reach my objectives through the help of my community, that means the world to me."***

Loneliness and Mental Health

CMs in Local Core open responses and focus groups used the word "safe space" to describe GHC. They said they did not fear being judged in these circles and that they could be their "whole selves." With this space to share their identities and experiences, they felt they could come together and connect. CMs in focus groups frequently commented how "chill" GHC is and how great it is that there are "places for people to come and hang out." One CM, in their Local Core open response, said this community is "as simple as a place to meet and play games while all being open and true to [themselves]."

> ***"Bonding with the people at the GHC has really helped me feel connected to my queer community."***

Reduction in loneliness and isolation is a particular goal of GHC's s community support programming. T tests of significance, however, did not yield statistically significant or substantial decreases in mean composite scores of loneliness for all CMs, TGNC CMs, or LGBQ+ CMs between pretest and posttest, as shown in Table 5.

Table 5. Changes in Loneliness Composite Scores [i, ii]

	n	Pretest Mean (SD)	Posttest Mean (SD)	Difference	P-value
All CMs	34	2.264 (0.581)	2.196 (0.647)	-0.088	0.216
TGNC CMs	32	2.333 (0.549)	2.219 (0.659)	-0.115	0.165
LGBQ+ CMs	31	2.323 (0.587)	2.247 (0.638)	-0.075	0.267

[i] The composite score is an average of 3 items in the 3-Item UCLA Loneliness Scale. These items ask how often participants feel they lack companionship, feel left out, and feel isolated from others.
[ii] Responses followed a 3-point scale format with 1 being "Hardly Ever" and 3 being "Often." Decreases in composite scores indicate reductions in isolation and loneliness.

Though quantitative data could not be analyzed to determine if COVID-19 and the stay-at-home orders had any impact on these findings, qualitative data from Local Core open responses show that CMs felt very lonely and isolated during this time. CMs said that they

missed the community of the GHC space and that they didn't feel as connected as before the pandemic. GHC's former facility was too small to safely hold socially distant, in-person community gatherings even after the stay-at-home orders were lifted. One CM said that "the feeling of connection in other areas of my life are low and the services can't really help with the pandemic and social distancing."

CMs also said that feelings of loneliness and isolation stem from struggles with their mental health, citing social anxiety and depression as barriers to forming and maintaining connections with others. One CM shared that they are "an introvert and suffer from social anxiety" and while "much of [their] isolation is self-inflicted… it still hurts." CMs often said that these struggles with mental health amplified feelings of loneliness and not belonging.

The Local Core survey instrument did not directly assess CMs' changes in mental health but did ask participants how often they experience positive feelings using a 5-point scale with 1 being "Not at all" and 5 being "An extreme amount". T tests of significance showed a statistically significant change (0.437) in positive feelings between pretest (1.813) and posttest (2.250) (n=32, p-value=0.004). There were also statistically significant changes in TGNC CMs' and LGBQ+ CMs' experiences of positive feelings between pretest and posttest (Table 6.)

Table 6. Changes in Positive Feelings[i]

	n	Pretest Mean (SD)	Posttest Mean (SD)	Difference	P-value
All CMs	32	1.813 (0.738)	2.250 (0.842)	0.437	0.004
TGNC CMs	30	1.767 (0.728)	2.267 (0.868)	0.500	0.002
LGBQ+ CMs	29	1.724 (0.702)	2.172 (0.805)	0.448	0.007

[i] Responses followed a 5-point scale format with 1 being "Not at all" and 5 being "An extreme amount." Increases in mean indicate increases in positive feelings.

The Local Core survey instrument also asked how much CMs' enjoy life using the same 5-point scale. T tests of significance for this question did not show a statistically significant change (0.235) in enjoyment of life between pretest (1.794) and posttest (2.029) (n=34, p-value=0.073) (Table 7). There was, however, a statistically significant change (0.281) in TGNC CMs' (n=32) mean enjoyment of life between pretest and posttest, from 1.750 (SD=0.880) to 2.031 (SD=0.993) (p-value=0.048).

Table 7. Changes in Enjoyment of Life[i]

	n	Pretest Mean (SD)	Posttest Mean (SD)	Difference	P-value
All CMs	34	1.794 (0.880)	2.029 (0.904)	0.235	0.073
TGNC CMs	32	1.750 (0.880)	2.031 (0.933)	0.281	0.048

LGBQ+ CMs	31	1.774 (0.884)	2.000 (0.856)	0.226	0.099

[i] Responses followed a 5-point scale format with 1 being "Not at all" and 5 being "An extreme amount." Increases in mean indicate increases in enjoyment of life.

Even still, the posttest means for CMs' positive feelings and enjoyment of life were on the lower end of the 5-point scale, at 2.250 (n=32, SD=0.842) and 2.029 (n=34, SD=0.904) respectively. These both correspond to the intended outcomes of QINT sessions.

Coping and Resilience

Development of coping and resilience skills is also a major goal of QINT sessions. In their Local Core open responses, CMs expressed having a hard time coping with negative feelings. They expressed that being content and happy sometimes feels like a "constant battle." Many said they felt overwhelmed with their emotions or with specific life challenges, like lack of housing, stable employment, or abuse. CMs said that went they feel overwhelmed, trying to compartmentalize, and breaking down problems can feel "impossible." Some CMs shared that they have diagnosed mental health disorders like borderline personality disorder, obsessive compulsive disorder, and post-traumatic stress disorder that affect their ability to regulate emotions.

"It's hard to get out of the mental cycle of despair, and also its hard to ask for help."

Other CMs also named that they have challenges with getting emotional support from others when they need it. For some, it is because they do not have these support systems: "I need emotional support, but don't have anyone to ask for it." For others, is it because they struggle with reaching out to their support systems: "I have an extremely hard time putting my own needs first and feel like a burden asking for help or accepting help."

There was a statistically significant increase (0.182) in the mean composite score of all CMs in the coping skills scale in the Local Core survey instrument, from 2.134 (SD=0.375) to 2.316 (SD=0.392) (n=34, p-value=0.011). There were similar statistically significant increases in coping skills for TGNCs CMs and LGBQ+ CMs between pretest and posttest (Table 8).

Table 8. Changes in Coping Skills Composite Scores[i, ii]

	n	Pretest Mean (SD)	Posttest Mean (SD)	Difference	P-value
All CMs	34	2.134 (0.375)	2.316 (0.392)	0.182	0.011
TGNC CMs	32	2.132 (0.388)	2.309 (0.403)	0.176	0.019
LGBQ+ CMs	31	2.115 (0.380)	2.282 (0.365)	0.167	0.025

[i] The composite score is an average of 7 items in a scale assessing coping skills. These items ask CMs the extent to which they can: ask for emotional support when they need it, accept emotional support if it is offered, sort out what can be changed and what cannot be changed, find solutions

to their difficult problems, break an upsetting problem down into smaller parts, leave options open when things get stressful, and take their mind of unpleasant things.
[ii] Responses followed a 3-point scale format with 1 being "I cannot do at all" and 3 being "I can do." Increases in composite scores indicate increases in coping skills.

In focus groups, CMs' who received counseling services from GHC shared that even though their struggles persisted, these services helped them control their attitude, drink less, and feel less compelled to "cope in ways that are harmful." CMs also said that counseling helped them strengthen their ability to self-advocate and communicate their feelings with others.

"[counseling] helped me see things can be different, you know, if I want them to be. And to stop worrying so much about how I'm affecting friends or family, you know, people around me."

In addition to coping skills, the Local Core survey instrument assessed CMs' resilience. In pretest open responses, CMs' said that they have a hard time managing their stress and that it can take them a long time to process stressful events. Some CMs again mentioned specific mental health diagnoses as barriers to resilience. Other CMs said that, because of discrimination and life challenges—like unemployment and housing instability—they have had to be resilient, but that they have been dealing with these factors for so long that they are getting "tired of the fight" and feel they are losing their resiliency.

"Because so much shit has happened in my life, I tend to bounce back quickly and recover. But it does get exhausting and sometimes it takes a little longer."

There were statistically significant increases in mean resilience composite scores for all CMs and for TGNC and LGBQ+ CMs between pretest and posttest as shown in Table 9. TGNC CMs' (n=32) mean resilience composite score increased from 2.417 (SD=0.785) to 2.719 (SD=0.749) (p-value=0.010) and LGBQ+ CMs' (n=31) mean resilience composite score increased from 2.419 (SD=0.769) to 2.726 (SD=0.726) (p-value=0.011).

Table 9. Changes in Resilience Composite Scores

	n	Pretest Mean (SD)	Posttest Mean (SD)	Difference	P-value
All CMs	34	2.456 (0.784)	2.765 (0.760)	0.309	0.006
TGNC CMs	32	2.417 (0.785)	2.719 (0.749)	0.302	0.010
LGBQ+ CMs	31	2.419 (0.769)	2.726 (0.726)	0.306	0.011

[i] The composite score is an average of 6 items adapted from the Brief Resilience Scale. These items ask CMs to mark the extent to which they agree with the following statements: "I tend to bounce back quickly after hard times," "I have a hard time making it through stressful events"

(reverse scored), "It does not take me long to recover from a stressful event," "It is hard for me to snap back when something bad happens" (reverse scored), "I usually come through difficult times with little trouble," and "I tend to take a long time to get over set-backs in my life" (reverse scored). [ii] Responses followed a 5-point scale format with 1 being "Strongly Disagree" and 5 being "Strongly Agree." Increases in composite scores indicate increases in resilience.

There were limited qualitative data on how GHC has affected CMs' resilience, however, a few CMs said that the gains they made through GHC in accepting their LGBTQ+ identity and ability to live more authentically as themselves helped make it easier for them to deal with stress: "the longer I am in my chosen name, the easier it gets."

Income and Housing

Given that one of the defining features of GHC's approach to mental health services is integrated advocacy to help address the underlying social needs that may cause and exacerbate poor mental health, the Local Core survey instrument assessed CM's housing and income status at pretest and each posttest. CMs were asked to indicate their current housing situation by selecting as many of the following options as reflected their situation in the last 6 months:

1. I have been homeless or near eviction.
2. I have been living in transitional or temporary housing; or my rent/mortgage has not been affordable.
3. I have been living in stable housing, but it is unsafe, and it barely meets my needs.
4. I have been living in stable housing that is safe, but it barely meets my needs.
5. I have been living in housing that is safe and meets my needs, but I have needed help paying rent/mortgage.
6. I have been living in housing that is safe, meets my needs, and I have not needed payment assistance.

To differentiate housing status among these categorical options, CMs who marked any of the options 1-5 were considered "housing insecure" and CMs who marked option 6 were considered "housing secure". At pretest, 50.00% of CMs were housing insecure and 50.00% were housing secure (Table 10). At posttest test, 52.78% of CMs were housing insecure and 47.22% of CMs were housing secure (Table 10). When comparing CMs (n=36) between pretest and 6-month posttest using a Pearson Chi-Square test of significance, there was not a statistically significant correlation between housing status and time of test.

Table 10. Housing Status at Pretest and Posttest

	Housing Insecure	Housing Secure
Pretest	18 (50.00%)	18 (50.00%)
Posttest	19 (52.78%)	17 (47.22%)

While these results show that services did not specifically change CMs' housing status during the evaluation, they do not necessarily prove that GHC's services had no impact on CMs' housing status, in general. Integrated advocacy services offered at GHC may have helped some CMs gain more security in their housing situation for short periods of time or may have helped them access other resources to achieve housing stability in the future.

In the Local Core instrument, CMs were also asked to indicate their income status at pretest and posttest by selecting one of the following options that reflected their situation in the last 6 months:

1. I have no income.
2. I have some income, but it is not enough to meet my basic needs.
3. I have enough income to meet my basic needs with some help.
4. I have enough income to meet my basic needs without help.
5. I have more than enough income to meet my needs.

CMs who marked options 1-3 were considered "income insecure" and CMs who marked options 4-5 were considered "income secure". The same percentage of CMs (n=31) were income insecure (70.97%) and income secure (29.03%) at pretest and posttest. While CMs did move between income insecure and secure over the 6-month period, there was no statistically significant correlation between income status and time of test.

Interns

Demographics

There were 45 interns who took an Intern pretest. See Appendix B for full demographic details of interns who took a pretest. There were 19 interns who took an Intern posttest at the conclusion of their internship period. Between pretest and posttest, there were only 9 matched tests, therefore, t tests of significance could not be performed to assess changes in interns' responses between pretest and posttest. Again, while demographic information of individuals who participated in GHC's internship program during the CDEP were not collected, the demographics of the sample of interns who completed pretests and posttests is seemingly representative of interns who participated in the CDEP program component; however, compared to the population of CMs who accessed CDEP services, there were more interns who were cisgender women, white, and straight and fewer interns who were transgender and BIPOC.

Presentation of Results

Findings from analyses of data from all intern data sources—pretests and posttests from the Intern survey instrument, focus groups, and interviews—are presented below and grouped into the following broad themes:

- Knowledge and Understanding of Providing Culturally Competent Mental Health Care
- Experience with Organization and Staff

These data do not specifically answer any of the evaluation questions but they provide important context and additional findings to assess GHC's intern training program, one of the CDEP components.

Findings presented in theme 1 are associated with a scale used in the Intern survey instrument assessing interns' knowledge and understanding of providing culturally competent mental health care for diverse LGBTQ+ people. There were fewer than 30 matched pair intern pretests and posttests (n=9). Because of this, findings from t tests of significance between pretests and posttests could not yield substantial or statistically significant results and therefore were not used in analysis. Instead, sample means for intern pretests and posttests are used to describe relative knowledge of interns at pretest and posttest. Findings from qualitative data are mapped onto these themes to further illustrate, refine, and provide nuance to findings. When findings from qualitative data point to specific subthemes, differences in individual items from the scale are assessed across matched pretests and posttests.

T tests of significance were used to compare pretest mean values between interns who marked their gender identity as cisgender and interns who marked their gender identity as something other than cisgender, noted as TGNC. These tests are used to compare baseline knowledge and understanding composite score between cisgender interns and TGNC interns. However, there are fewer than 30 pretests from TGNC interns (n=8), so results cannot be considered statistically significant. T tests of significance were also used to compare pretest mean values between interns who identified as straight/heterosexual, who identified as something other than straight/heterosexual (LGBQ+), as well as interns who identified as white and interns who identified as BIPOC. The number of posttests and matched pretests and posttests were too small to assess differences in outcomes and changes in outcomes between cisgender interns and TGNC interns, between straight interns and LGBQ+ interns, and between white and BIPOC interns.

Knowledge and Understanding of Providing Culturally Competent Mental Health Care

In focus groups, interns explained that one of their primary reasons for choosing to work at GHC was because they wanted to invest in their own personal exposure and learning to become better allies for the TGNC community. Some interns themselves identified as LGBTQ+. Some did not identify as LGBTQ+ but said they have family members or friends who are part of the LGBTQ+ community. Across these identities, interns expressed a distance from and lack of understanding of the experiences and viewpoints of TGNC individuals, especially in their own community of Sacramento.

The second common reason why interns chose to work at GHC was because they felt that, compared to other organizations, working at GHC provides an opportunity to engage with and incorporate social justice frameworks into their work. Interns felt that given the recent international attention on social injustices, particularly against the Black and Asian/Pacific Islander communities, they wanted to work at a place that allowed them to use macro-level social work skills and influence change beyond traditional one-on-one talk therapy. While some interns said that they were well versed in social justice work and activism, either through their studies or through their own personal lives, most interns said they did not have experience integrating social justice and activism into their work as a counselor.

> ***"Another internship could have given me the hours that I needed, but at GHC, I can look more deeply into things like critical race theory, queer theory, and other things that shape the experiences of my community members."***

The Intern survey instrument assessed interns' knowledge and understanding of providing culturally competent care using an 11-item scale, which included items that asked how much participants understood how social injustices affect mental health and their delivery of mental health services. Responses followed a 5-point scale format with 1 being "Not at all" and 5 being "A lot." Interns had a mean composite score of 3.762 (n=45, SD=0.745) pretest (Table 11). In a t test of significance of difference pretest composite score between TGNC and cisgender interns, TGNC interns scored 0.796 points higher (4.417, n=8, SD=0.526) than cisgender interns (3.621, n=37, SD=0.713). The p-value of this substantial difference was 0.002; however, the sample size of TGNC pretests was too small to merit statistical significance in baseline knowledge and understanding between TGNC intern and cisgender interns.

Within the scale, interns had the lowest knowledge and understanding of how to use the Columbia Suicide Scale (M=2.644, SD=1.449), the risks and benefits of taking gender affirming hormones (M=2.822, SD=1.173), and ways to support spaces for QTPOC without being tokenizing (M=3.022, SD=1.076). TGNC interns also had substantially, but not statistically significant, greater knowledge and understanding of these items.

Table 11. Baseline Knowledge and Understanding of Providing Culturally Competent Mental Health for Diverse LGBTQ+ people Composite Score[i, ii]

	n	Mean	SD
All Interns	45	3.762	0.745
TGNC interns	8	4.417	0.526
LGBQ+ interns	25	3.916	0.135
BIPOC Interns	28	3.810	0.708

[i] The composite score is an average of 11 items on a scale assessing CMs baseline understanding of how to provide culturally competent mental health care diverse LGBTQ+ people. These items ask CMs to mark how much they possess the following skills and abilities prior to their internship with GHC: "I understand the differences between sex, gender and sexuality," "I am aware of how my own gender, race, sexuality, and ability shape my lived experience," "I understand how gender expectations and stereotypes may influence the development of trans identity," "I understand how cultural factors such as race, class, ability, and sexuality influence gender expectations", "I understand how the mental health field can enforce gender roles and expectations," "I understand the reasons transgender people may seek mental health services that are different than LGBQ people," "I understand the processes and steps I need to follow as a mandated reporter," "I understand the ways in which I have privilege and the ways that I do not, in relation to the community that seeks services at GHC," "I understand how my privilege affects how I think and act, including in my role as a mental health provider," "I am able to name privilege and talk about differences with community members," "I can name some of the barriers that transgender people face in accessing healthcare," "I understand the ways that medicine and psychiatry have enacted violence against transgender people," "I understand Harm Reduction when it comes to needles and sex," "I understand the impact of HIV and AIDS on the transgender community," "I understand PrEP and how it relates to the transgender community," "I understand how to use an

informed consent framework in regard to accessing healthcare," "I understand the risks and benefits of taking gender affirming hormones," "I understand the difference between cultural exchange and cultural appropriation," "I understand the importance of respecting self-identification and representation," "I am able to recognize microaggressions and casual racism," "I understand the roles of racism in the development and perpetuation of LGBTQ stereotypes," "I have awareness and appreciation of diverse LGBTQ vocabulary, including different ways of speaking, and the value of code switching," "I understand there is cultural pressure for queer & trans people of color (QTPOC) to assimilate to white and homonormative cultural standards," "I can name ways to support QTPOC-inclusive spaces without being tokenizing," "I understand power dynamics in conversations and work to support and defer to POC talking about their experiences," "I understand that the role of mental health professionals, so long as it isn't contrary to their rules of conduct in their profession, can include using advocacy as a mental health tool through activities such as coordinating with physicians and providing clients with referrals or recommendation letters," and "I understand how to use the Columbia Suicide Severity Rating Scale."

[ii] Responses followed a 5-point scale format with 1 being "Not at all" and 5 being "A lot."

The sample size of matched pairs between pretest and posttest was too small to determine statistically significant changes in mean knowledge composite or individual changes in scale items. However, the mean knowledge composite score of all interns (n=20) at posttest was 4.134 (SD=0.751). At posttest, Interns (n=20) had greater mean knowledge and understanding of how to use the Columbia Suicide Scale (M=3.750, SD=1.517), the risks and benefits of taking gender affirming hormones (M=3.800, SD=1.105), and ways to support spaces for QTPOC without being tokenizing (M=3.450, SD=1.234).

When asked at posttest, interns (n=19) agreed to strongly agreed that their internship with GHC gave them the knowledge and skills they needed to serve LGBTQ+ individuals, make an impact on organizations working with TGNC individuals, and provide culturally appropriate services (Table 12).

Table 12. Intern Experience with Training[i,ii]

	n	Mean	SD
"Overall, this training gave me the knowledge I need to serve LGBQ+ and transgender clients."	19	4.631	0.496
"Overall, this training gave me the skills I need to serve LGBQ+ and transgender clients."	19	4.474	0.513
"Overall, this training will help me have an impact on organizations I work within, in terms of their work with transgender clients."	19	4.526	0.513
"Overall, this training will help me provide effective and culturally appropriate services."	19	4.474	0.513

[i] Responses followed a 5-point scale format asking participants the extent to which the agreed with the statements, with 1 being "Strongly Disagree" and 5 being "Strongly Agree."

In open responses, interns explained that one of the biggest things they learned at GHC was how to recognize and address their implicit biases when working with LGBTQ+ CMs. They described that the radically inclusive approach that GHC takes in providing services to CMs challenged them "unlearn the rigid and pervasive messages they received growing up in society" and start from a place of acceptance and validation when talking with CMs about their identities, the challenges society places on them because of these identities, and the impact this has on their mental health.

> ***"I will be far more conscious of my own biases in counseling and more sensitive to the differences of others. I think my experience will also help me actively work towards reducing the power differential in the therapy relationship. My work at the GHC also taught me to be more honest with my clients about my experiences and lack of knowledge in certain areas."***

Qualitative data from focus groups support these findings. Interns expressed that they felt like they got a greater understanding of the experiences and challenges TGNC individuals face when seeking mental health and social services at the system-level and individual provider-level.

At the system-level, interns remarked how insurance companies' lack of coverage of mental health services is highly prohibitive for TGNC individuals accessing long-term mental health services outside of GHC. Often times, interns' CMs were uninsured or struggling to pay for housing or food, so paying for mental health services was not a possibility for them. Several interns remarked that white privilege also plays a role in this, with white CMs tending to have more means to access and pay for services than BIPOC CMs. As one intern remarked, "there are holes in the system of who has access to mental health [services] and who doesn't."

At the provider-level, interns said that many of their CMs expressed that they were "savior-ed" in most of their previous experiences with mental health services, meaning that previous counselors treated CMs as socially lower and distant clients who were helped by benevolent counselors, erasing CMs' individual humanity. They equated this with the practice of gatekeeping as well, saying that this unequal power balance CMs experienced with other clinicians often made CMs feel like they could not get the support they needed. Interns found that a lot of their CMs had never been in situations where they felt fully seen by mental health and other health professionals. In hearing about these experiences, interns learned to treat CMs as equal individuals, offering them unconditional support, love, and acceptance, but not projecting that they knew the depths of their CMs' experiences and could "fix" their lives.

Queer-Informed Narrative Therapy

QINT was emphasized as a key element that makes GHC's approach unique. "The modality of narrative therapy has completely reinvigorated my love for therapy," one intern shared in a focus group. They shared that other treatment modalities ignore some of the larger societal "-isms" (racism, genderism, classism, etc.) and other factors that contribute to wellbeing and how individuals view themselves in the world. But QINT brings those into

counseling sessions and helps CMs see the problems in the world and how they are affected by them. Interns felt that this fosters a greater level of trust and honesty between therapists and CMs and makes it easier for CMs to deconstruct their individual life experiences.

In Local Core open responses, interns elaborated on this, saying that, where traditional therapy focuses on pathologizing the individual and internalizing mental health as "personal problems" for individuals to overcome, QINT helps CMs externalize their challenges and reframe CMs' problems as rooted in "external societal, system bias, expectations, and oppressions." By helping CMs externalize their problems, interns shared that they found it easier to work with CMs to "identify the relationship [of their problems] with [themselves], find its impact on their lives, and find the solution without being consumed by the problem."

> ***"Narrative therapy does not ignore the "presenting problems" but does not conclude that they are an internal aspect of the CM; they are externalized so that the CM can view them as outside themselves. They are no longer the problem; the problem is the problem."***

Integrated Responsive Advocacy

The second key element that interns felt made GHC unique in its approach to mental health care was integrated and responsive advocacy. Interns expressed in focus groups that with their work at GHC, they learned that advocacy goes hand-in-hand with narrative therapy. Where QINT helps to breakdown CMs' experiences with systemic injustices, incorporating advocacy into therapy helps them respond to the real and tangible challenges CMs face because of those injustices. These immediate challenges are oftentimes more pressing for CMs because they impact their ability to live. As one intern put it, "if you're hungry and unstably housed, you're not going to get help at therapy." But at GHC, this is different. Interns felt that integrating advocacy helped add critical macro-level social work skills to their toolbox, which ultimately was more beneficial for their CMs. GHC's advocacy services team is another example of how GHC has intentionally structured its services to respond to the needs of CMs. Advocacy services staff members act as navigators for CMs through health care, mental health, legal, and social resources based on their needs. GHC interns and other staff work closely with the advocacy services staff to ensure seamless referrals and support when needs are identified.

In the Local Core posttest, when asked to rate how much they understood that mental health professionals could include advocacy as a mental health tool on 5-point scale with 1 being "Not at all" and 5 being "A lot," interns had a mean score of 4.250 (n=20, SD=1.070). While the number of matched intern pretests and posttest was too small to test for significance, the 9 intern matched pretests and posttests (n=9) showed a 0.667 change in mean understanding. In their posttest open response, one intern shared how they will continue to integrate responsive advocacy into their work as a counselor moving forward.

Many interns also shared how COVID-19 had an impact on their ability to integrate advocacy into their work. When they were conducting counseling sessions in person with CMs, they

> ***"By looking at the CM in the context of their ecosystem, assessing all of their critical needs, their level of access and marginalization; working to connect them to services and reaching out (with their consent) on their behalf if their efforts are not respected or successful. It will continue to be important for me to personally advocate and demonstrate for greater equity and social justice."***

felt it was easier because they could send the CMs to advocacy services staff down the hall to get assistance with things like housing, food, or legal support. These referral processes were complicated when sessions were conducted virtually because advocacy services could not be provided on the spot at the time of visit, but had to be scheduled at a different time, which could be challenging for CMs to make.

In focus groups, interns shared that they also saw increases in the sheer number of social needs CMs had because of the pandemic. These included things like housing for quarantine or for safety, food deliveries, and assistance with unemployment. Interns said that, even though the advocacy team at GHC is "phenomenal", they are limited by the overly bureaucratic and administratively burdensome systems they are trying to navigate. Especially during the COVID-19 pandemic, interns were shocked by how long it took many of the CMs to get the assistance they needed. Interns shared that many CMs couldn't wait this long or depend on these systems for their support and so frequently had to resort to private fundraising or other methods to get the financial assistance they needed to live. Interns also felt frustrated because even if they "worked as hard as [they could] to help, sometimes the resources just [weren't] there."

Experience with Staff and Organization

First and foremost, interns commended the effort GHC staff put in to serving their community. Interns felt that since most GHC staff come from and represent the community they serve, they are better positioned to understand what the community's needs are and are actively working to shift the center's services, structures, and priorities to address those needs—something that interns felt was not true of most other agencies they had encountered. Because of this attention to the community's needs, interns emphasized that GHC is unique in that it offers CMs a "one-stop-shop" to support and connect CMs with referrals to clinical services, social services, and respite services, supply hormone therapy, and provide connections to other basic care for CMs. This approach is critical, because it helps to address the systems- and provider-level challenges that CMs often face that stop them from getting needed support.

Interns also felt this energy and support carried over to their own learning experiences at GHC. One intern said that "staff really want you to get it right. They are invested because it is not just their job, it is their lives." This support started from the interns' interview for the internship, with GHC staff helping interns learn about and question their own identities and implicit biases to ensure more culturally competent and aware work with CMs. GHC staff helped interns deconstruct normative thinking about the position of therapists and counselors to better relate to CMs on a human level. While interns expressed it was challenging to do this unlearning and relearning at times, they were appreciative of GHC's

commitment to this more ethical approach to therapy. Every step of the way, interns felt that GHC staff were also there to support them in their work, respecting interns' capabilities and inviting them to explore nontraditional concepts and modalities of therapy. Again, because GHC staff are from the community, they were better able to guide interns in using different approaches to serve CMs.

> ***"Staff really want you to get it right. They are invested because it is not just their job, it is their lives."***

Interns had almost no critiques of GHC staff and the organization, but they did have a few recommendations to enhance the organization. Because of the lack of trans-affirming providers in the area, interns wished that GHC could expand their capacity to take on more CMs. One way that interns suggested GHC could do this, without expanding staff, would be to develop a more concentrated intake and triage process that could help GHC direct CMs to more appropriate supports and services and increase staffs' capacity to help CMs who need specific services. One intern felt that, of her twelve CMs, five or six may have benefited more from group sessions than one-on-one therapy. Other interns shared this belief, saying that often times, CMs need more friends, social support networks, and accountability that can be better offered through groups than through individual counseling.

To address some of the challenges that CMs experience with finding trans-affirming care outside of GHC, interns also hoped that GHC could have a primary care physician and psychiatrist on staff. Interns shared that CMs commonly get prescriptions for hormones from GHC, especially CMs who have less access to health care. However, these prescriptions are a limited, one-month supply and interns had difficulty connecting their CMs with culturally competent providers in the area who could help refill these prescriptions.

DISCUSSION AND CONCLUSION

Discussion

For GHC CMs, CDEP programming significantly improved their attitudes towards and acceptance of their own identities. By helping CMs embrace themselves more fully, CDEP programming also supported CMs in developing positive coping skills, improving their resilience, and improving their general outlook on life—all positive intended mental health outcomes assessed through evaluation question 3. For interns, GHC provided a meaningful exposure to and learning experiences in understanding how intersectional societal oppressions impact and influence individuals' mental health and how to utilize and tailor unique, person-centered treatment modalities to create spaces of authentic allyship and healing for LGBTQ+ people, especially TGNC people.

Though CMs had mean scores on the lower ends of the harassment, discrimination, and violence scale, their scores still showed that they face instances of identity-based violence and discrimination at least 2-3 times a year because of their gender identity and/or sexual orientation. This was true for LGBQ+ CMs, BIPOC CMs, and even greater for TGNC CMs. There were not adequate numbers of BIPOC TGNC CMs, specifically, to assess their experiences of violence and discrimination, but recent national data show that this subgroup of the LGBTQ+ population has the highest rates of interpersonal violence and discrimination in health care, housing, and work settings.[21] These and other studies show the pronounced negative impact that these experiences have on the mental health of LGBTQ+, especially TGNC, people.[2] This was reflected by CMs as well, with many saying the experiences and challenges they have faced being LGBTQ+ have made them feel isolated, depressed, and anxious. For CMs who received mental health services elsewhere, these feelings were only amplified. In using traditional talk-therapy modalities, not only did previous counselors not understand CMs' experiences, they also pathologized CMs' identities and made them feel like they were the "problem" that needed to be fixed. This aligns with findings in the CDRP Phase 1 LGBTQ Population Report that showed LGBTQ+ people, especially trans people, had lower rates satisfaction with mental health services.[9]

Having been educated primarily in these modes of thinking, GHC interns carried some of this implicit bias and lack of knowledge into their internship. Some interns had a baseline understanding how society-level and individual-level stigma and discrimination against LGBQ+ people, TGNC people, and BIPOC people intersect and negatively impact mental health and how their own identities and positionality as a therapist can affect the receipt of mental health services. This was especially true for TGNC interns. Interns had less familiarity with some of the technical aspects of delivering therapy, like the Columbia Suicide Assessment, or on specific aspects unique to the TGNC or LGBQ+ experience, like hormones, HIV and harm reduction, and identity-based harassment. Through their internship and mentoring from GHC staff, interns learned more about both the technical aspects of treatment services and gained an understanding of the experiences of LGBTQ+ people and how that impacts their mental health. This learning that interns experienced may have come at the detriment to CMs sometimes, as some CMs felt they were often educating their intern counselors on their experiences and needs.

Still, interns were able to provide impactful, culturally responsive mental health care for CMs using GHC's unique treatment modality: QINT. With QINT, interns were able to help CMs externalize the challenges they face so CMs no longer viewed themselves as the "problems." Instead, CMs learned to shift the narrative and root their problems in the systems, people, and environments that cause these challenging personal experiences. In doing so, many CMs no longer felt self-blame or that changing themselves would solve their problems, but instead, were able to develop better coping skills and resilience to handle these struggles, even if their problems could not be solved.

By reframing this narrative, QINT also helped CMs gain greater self-acceptance and self-love for their LGBTQ+ identities. As documented in the Minority Stress Model and subsequent research, lower self-acceptance facilitates poorer mental health outcomes in LGBQ+ and TGNC populations.[24,22,23,24] Therefore, the significant positive impact CDEP programming had on CMs' attitudes about their gender identity and/or sexual orientation may have helped better their mental health. This was seen in equally positive changes in CMs' positive feelings and enjoyment of life. Many CMs felt that, with GHC's help, they had a better understanding of who they were and the love that they deserved. Again, this was especially true for TGNC CMs, who articulated greater feelings of shame and identity-based stress at pretest and also had marginally greater increases in positive feelings and enjoyment of life between pretest and posttest.

One of the most common reasons why CMs said they felt like they were able to be more comfortable with their identities at GHC was because the staff members reflected their identities, and the organizational values were explicitly welcoming to and affirming of them. By having staff members with whom they had shared experiences, CMs felt like they could be more authentic about their experiences and were able to learn from members of their own community about how to address similar personal challenges. This type of mutual support reflects research that shows increased community connectedness improves mental health of TGNC individuals by helping contextualize and normalize their experiences and provide emotional relief and safety through social interaction.[25] GHC's organizational representation of TGNC individuals was also beneficial for interns. As interns stressed, staff knew how to help them better their practice because they were from the community and therefore were intimately familiar with the needs of CMs and could better teach interns strategies to support CMs.

It is unclear how COVID-19 affected the impact of GHC's services on CMs' mental health outcomes. While CMs did experience some technical challenges with virtual counseling, like internet connection or lack of privacy, most who continued services virtually had positive experiences. Only a few CMs mentioned having negative experiences with virtual services. COVID-19 and the stay-at-home orders may have negatively impacted CMs feelings of isolation and loneliness, both by enhancing these feelings and by making it harder for GHC services to reduce these feelings. While CMs' mean score in isolation and loneliness decreased over the course of the CDEP, this decrease was not statistically significant. Before the pandemic, GHC's in-person support groups were a source of community bonding and socialization, but these were mostly suspended during the pandemic. Even when support groups resumed virtually, with the barrier of the screen, delays in video and audio, and lack

of physical presence, virtual support groups were not as conducive to fostering the same community connection or friendships that could develop through side conversations and impromptu gatherings after meetings during in-person groups.

Several limitations must be considered alongside these findings. First, there were not adequate sample sizes among BIPOC CMs at posttest to generalize findings across all racial/ethnic groups or understand specific changes in outcomes for BIPOC CMs. Within the LGBTQ+ community, race and ethnicity can serve as a moderator to individuals' feelings of community connectedness, with Black, Latinx, and other non-white racial/ethnic groups feeling less connected.[26] Lack of community connectedness is associated with poorer mental health, especially in TGNC individuals.[27] BIPOC LGBTQ+ individuals also face intersectional oppression and stigma based on their race/ethnicity, sexual orientation, and gender identity that may worsen trauma and mental health status.[28] Therefore, BIPOC CMs may experience lesser changes in outcomes than other CMs in this evaluation. This should be further investigated in future CDEP evaluations. Second, the sample size for matched intern pretests and posttests was not large enough to convey statistically significant results. While the mean scores for interns' knowledge and understanding of providing culturally appropriate and responsive services could be calculated individually at pretest and posttest, statistical analyses could not be performed to determine if there was a statistically significant quantitative change. Additionally, no analyses could be performed to examine changes in knowledge and understanding for specific subgroups of interns, like BIPOC interns, LGBQ+ interns, or TGNC interns. Third, while qualitative data collected can provide some context, the lack of timestamp for pretests and posttests means that no adjustments could be made on analyses of outcomes relative to the COVID-19 pandemic.

In addition to examining differences in outcomes for BIPOC CMs, future CDEP evaluations may consider assessing changes in CMs' community connectedness after engaging in services, especially support groups. Given qualitative data on CMs' need for community and friendships with other LGBTQ+ people, targeted programming and evaluation of community connectedness may help GHC better support CMs with these needs and lead to even more positive changes in mental health. Future evaluations may also examine the lasting and longer-term impacts of GHC's internship program on former interns. By understanding how former interns have applied the knowledge they gained from their internship into their practice and influenced other practitioners with the knowledge, this type of evaluation can help GHC better structure the learning goals of their internship program and assess how to broaden the reach of this learning and expand culturally responsive mental health practices outside of GHC.

Organizational Evolution

The Gender Health Center has undergone many changes since the start of the CRDP funding in 2017. While not all the changes are directly due to the CRDP funding, CRDP has been the biggest funding source, and therefore staff interviewed attribute much of the organizational change to it. The biggest changes that have occurred include expanded programming and staffing, professional development, policy change with increased focus on anti-racism, improved data collection, the implementation of a new HR system, website

improvements, seeking, receiving, and implementing feedback from community members and interns, and ultimately, structural, and structural process changes.

The CRDP funding was used to expand mail and delivery-based services (i.e., care packages, and groceries), make improvements to the website, and hire additional staff so as to allow the organization to have less reliance on students, and more on paid staff members. CDEP technical assistance was used to facilitate conversations with leadership, leading to changes in the leadership structure to be more flexible, and more involved in the day to day, which has been well received by staff and CMs: "They are here all the time, helping out all the time". Over time, more young trans people have transitioned into positions of leadership as well. Nearly all staff training has happened through CRDP including conflict resolution, supervision, facilitation skills, how to navigate organizational change and transition, grant writing, project management and budgeting. GHC implemented a new equity policy in 2020, focused on anti-racism. As a component of this policy change, an anti-racism statement is now included in the intake paperwork, so whenever a new community member completes the paperwork, they are agreeing to the terms of the community agreement. Because of its inclusion in the consent forms, intern clinicians have learned how to have conversations with CMs about antiracism and what it means to receive services from an anti-racist organization like GHC. Improvements have also been made in terms of the data collected throughout the organization. Prior to the CRDP, data collection was virtually non-existent. There have been major changes to data processes, for example, GHC recently analyzed data on appointments and was able to identify the busiest days and adjust staffing to better serve the community members. Prior to the CRDP, there was no process to know who was coming in and receiving services. GHC is also in the process of transferring all data to Salesforce, a platform partially paid for by the CRDP. Using Salesforce, GHC will institutionalize data collection an analysis processes. Other structures and processes have been formalized because of the CRDP as well: "Because of the CDEP, we have had to do things like look at the intake process, data storage, organizational development/board, handbooks and bylaws. Before the CDEP, these things just lived in people's heads and not on paper. The CDEP was helpful in making these things more tangible...made it easier to bring new people in and get them properly trained, which is more sustainable." said former Director of Mental Health, Ryan Tiêu Cītali. Many of these changes were influenced by feedback from CMs, staff, and interns collected as part of the CRDP. The summation of the aforementioned changes has been the accomplishment of GHC moving into a new, larger, and more accessible physical space.

Conclusion

By providing CMs with an affirming, "radically inclusive" space where CMs can see themselves represented, GHC fills the need in supportive community mental health services for LGBTQ+ people, especially TGNC people, in Sacramento and beyond. GHC's unique approach to therapy—QINT—not only sets the experience of receiving mental health services apart for CMs but also better helps them develop healthy coping skills, enhance resilience, and improve mental health. Foundational to all of this is the fact that, with GHC's support, CMs embrace their identities and foster greater self-love. This impactful organizational culture carries over to the experiences of interns, who learn how to be better allies to and counselors for LGBQ+ and TGNC people through mentorships at GHC. In addition to teaching newer modalities of treatment, like QINT and integrated responsive advocacy, these mentorships and experiences help interns learn to meet CMs where they are at and ultimate increase the amount of local culturally responsive and affirming mental health services for LGBTQ+ people.

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APPENDIX A

Adult Local Core Participant Demographics		
	n	**%**
Age	**148**	**100%**
18 to 29	81	61%
30 to 39	32	24%
40 to 49	14	11%
50 to 64	4	3%
65+	1	1%
Race/Ethnicity[i]	**148**	**100%**
American Indian/Alaskan Native	4	3%
Black/African American	8	6%
Latinx/Hispanic/Spanish	21	15%
Asian	5	4%
Native Hawaiian/Pacific Islander	3	2%
White	79	56%
Other	4	3%
Multi-Racial	20	14%
Refused	0	0%
Don't Know	0	0%
English Proficiency	**148**	**100%**
Fluent	129	98%
Know Some Vocab	1	1%
Somewhat Fluent	1	1%
Can Make Myself Understood	1	1%
Preferred Language[ii]	**148**	**100%**
American Sign Language	1	1%
English	121	98%
Spanish	1	1%
Place of Birth	**148**	**100%**
Inside US	129	93%
Outside US	9	7%
Refused	0	0%
Don't Know	0	0%
Gender Identity[i]	**148**	**100%**
Genderqueer/Non-binary	57	39%
Transgender Man/Male	47	32%
Transgender Woman/Female	36	24%
Questioning/Unsure	20	14%
Cisgender Woman/Female	11	7%
Cisgender Man/Male	8	5%
Sexual Orientation[i]	**148**	**100%**
Pansexual	39	28%
Queer	35	25%
Bisexual	35	25%
Lesbian	27	19%
Gay	20	14%

Straight	18	13%
Aromantic	15	10%
Asexual	14	10%
Questioning/Not sure	12	8%
Refused	3	2%

[i] Respondents could choose more than one response option. Therefore, the sum of the percentages of each response option may be greater than 100%.
[ii] Respondents wrote in their own responses.

APPENDIX B

Intern Participant Demographics		
	n	**%**
Age	**52**	**100%**
18 to 29	31	60%
30 to 39	9	17%
40 to 49	8	15%
50 to 64	4	8%
65+	0	0%
Race/Ethnicity[i]	**53**	**100%**
White	23	43%
Black/African American	6	11%
Latinx/Hispanic/Spanish	13	25%
American Indian/Alaska Native	1	2%
Asian	10	19%
Native Hawaiian/Pacific Islander	1	2%
Other	0	0%
Multi-Racial	3	6%
Refused	0	0%
Don't Know	1	2%
Education	**53**	**100%**
Associates Degree	1	2%
Bachelor's degree	31	58%
High School Diploma	1	2%
Master's degree	13	25%
Some College	7	13%
English Proficiency	**52**	**100%**
Fluent	51	98%
Somewhat Fluent	1	2%
Preferred Language[ii]	52	**100%**
Mandarin	1	2%
English	51	98%
Place of Birth	**53**	**100%**
Inside the US	48	91%
Outside the US	5	9%
Sexual Orientation[i]	**53**	**100%**
Straight	31	58%
Gay	7	13%
Lesbian	5	9%
Bisexual	9	17%
Queer	14	26%
Pansexual	8	15%
Asexual/Aromantic	0	0%
Questioning/Not sure	0	0%
Gender Identity[i]	**53**	**100%**
Cisgender Man/Male	7	13%
Cisgender Woman/Female	35	68%

Transgender Man/Male	2	4%
Transgender Woman/Female	3	6%
Genderqueer/Non-binary	11	20%
Questioning/Unsure	3	6%
Education	**53**	**100%**
No, I am a post graduate counselor	4	8%
Yes, currently enrolled (graduate)	42	79%
Yes, currently enrolled (under-graduate)	6	11%
N/A	1	2%
Number Years Providing MH Services	**47**	**100%**
0	31	66%
1 to 2	9	24%
3 to 4	1	3%
5 to 10	4	11%
10+	2	5%

[i] Respondents could choose more than one response option. Therefore, the sum of the percentages of each response option may be greater than 100%.
[ii] Respondents wrote in their own responses.