May 22, 2014

Miranda Lynch Thomas
Children's Bureau
Administration on Children, Youth and Families
Administration for Children and Families
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Statewide Data Indicators and National Standards for Child and Family Services Reviews

Dear Ms. Thomas,

The National Gay and Lesbian Task Force (Task Force) is the oldest national organization advocating for the rights of lesbian, gay, bisexual, and transgender (LGBT) people and their families. We are pleased to have the opportunity to comment on the proposed Statewide Data Indicators (SDIs) and National Standards for Child and Family Services Reviews (CFSRs). We strongly support the CSFRs and believe the SDIs and National Standards are an invaluable means of helping child and family service providers improve outcomes. We strongly encourage you to further incorporate youth-related demographic data into the SDIs and your analysis as a whole. Particularly vulnerable populations, especially lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth experience significantly different outcomes in foster care systems than other youth populations. For LGBTQ youth, the disparities are most often caused by a lack of provider cultural competency or awareness of the unique issues facing this population both before they enter care and while in care.

We appreciate the Administration for Children and Families' ongoing commitment to improving the lives of LGBTQ families and youth. Most notably, we thank the Children's Bureau for their April 2011 memorandum highlighting the experiences of LGBTQ youth in foster care and encouraging child welfare agencies, foster and adoptive parents, and others who work with young people in foster care to ensure that children are protected and supported while in care. In addition, we applaud the Children's Bureau, through its training and technical assistance services, for providing resources such as the The National Resource Center's publication *In-Home Services for Families of LGBTQ Youth*, which provides background information on this vulnerable population and on the impact of familial rejection. Family rejection is often the cause of an LGBTQ youth's involvement in the child welfare system or their runaway or homeless status. The publication explains the critical need for in-home services for LGBTQ youth and provides examples of research-based, family-focused interventions and promising practice models.[i]

In response to your request for public comment, our comments below focus on suggested improvements to the CFSRs that would produce more usable data with regard to high-risk populations and the policies and programs designed to serve them. We also offer comments on more expansive revisions to the collection of CFSR data and highlight the general importance of demographic information to any meaningful analysis of the quality of services provided.

1. **Qualitative assessments of child welfare services are necessary to support effective improvement efforts**

We support the goal of the CFSRs, and understand the challenge of developing standardized metrics that can assess the substantial conformity of state child and family services programs across the country with title IV-B and IV-E plan requirements, implementing regulations, and relevant title IV-B and IV-E plans. And, to the extent that the revised CFSRs will more accurately capture incidences and reports of maltreatment and other quantitative measures, we support this data collection. More accurate collection of these measures is important for the overall safety and wellbeing of all youth, and will give us better information to advocate for resources, training, and policies to help improve outcomes. This is particularly important for LGBTQ youth as they are disproportionately represented in the system and are disproportionately subjected to maltreatment.

However, in their proposed and current form, the CFSRs collect insufficient information to allow targeted interventions aimed at improving outcomes for all youth, because they seek to minimize disparate outcomes between youth populations. Through quantitative analysis, we may arrive at a better understanding of *what* is happening across the country, but it will give us limited data about which youth are being served and how well they are being served. We agree that national assessment of these programs is necessary, but if the Children's Bureau intends to continue funding such a data collection, it should result in a national measurement of quality of services that gives states, advocates, and federal agencies the necessary information to understand precisely what practices and policies need to be changed in each jurisdiction to effect better outcomes for all youth in the system. **We encourage the addition of qualitative measures to the CFSRs, which would allow for a more nuanced understanding of the state of foster care in the United States.** This could include, for example, detailed information about the non-discrimination policies in place, as well as a detailed report of programming available that specifically targets high-risk populations. While the case file review and stakeholder interview portions of the CFSRs do provide some qualitative information, they are not sufficient.

2. **Demographic information is vital to reducing disparities in outcomes between youth populations**

The collection of demographic information and analysis of disparities in experiences in foster care settings is essential to reduce the negative outcomes currently experienced by LGBTQ youth in the system.

LGBTQ youth face increased rates of family rejection,[ii] victimization in schools,[iii] and criminalization. [iv] They are disproportionately represented in child welfare[v] and juvenile justice systems,[vi] and experience higher rates of mistreatment within those systems.[vii] As a result of these multiple system failures, LGBTQ youth represent as much as 40 percent of the homeless youth population, which contributes to a number of other disparities, including an increased risk of commercial sexual exploitation. Perhaps most notably, as many as 62 percent of LGBTQ homeless youth are likely to attempt suicide as compared to 29 percent of their straight peers.[viii]

LGBTQ youth also experience significant disparities in many health indicators such as smoking, obesity, experiences of abuse and violence, mental and behavioral health concerns, and HIV infection. Although data on the prevalence of substance use disorders within the LGBTQ community is not yet robust, SAMHSA has reported that between 20 and 30 percent of LGB people may abuse substances,[ix] as

compared to 8.9 percent of the general population.[x] Surveys of LGB youth suggest that they are more likely to smoke cigarettes, drink alcohol, smoke marijuana, use cocaine, use inhalants, use ecstasy, use heroin, and use methamphetamines than their heterosexual peers.[xi] These inequities may be even more pronounced for LGBTQ people who are also members of other groups that are disadvantaged on the basis of factors such as race, ethnicity, geography, or disability.

Suicide is a particularly critical issue for the LGBTQ youth population. Research has shown that LGB youth are four times more likely to attempt suicide as their straight peers, and questioning youth are three times more likely.[xii] Nearly half of young transgender people have seriously thought about taking their lives and one quarter report having made a suicide attempt.[xiii]

System-involved LGBTQ youth are at high risk of negative outcomes, and require culturally competent care across the spectrum of social service providers. A national assessment of child welfare service provider performance that does not provide for an opportunity to assess performance measures with regard to high risk populations (such as LGBTQ youth) against general population outcomes is significantly lacking.

We do not recommend at this point wholesale mandatory collection of sexual orientation and gender identity information in foster care settings, as provision of this information could put youth at risk in places without protections against discrimination, clear guidance on how to protect the confidentiality of that information, or adequate training for staff who are conducting intake. However, given the range of disparities experienced by this population, **we encourage the Children's Bureau to make standardized optional questions available to service providers who are equipped to safely use them, so that we can begin gathering better data to help advocates, providers, and the Children's Bureau understand where there are differences in outcomes and how to reduce them. We also encourage the Children's Bureau to disseminate guidance to child welfare providers to help implement LGBTQ-inclusive programming and data collection that protects confidentiality**

Beyond sexual orientation and gender identity data, we encourage the Children's Bureau to collect other standard demographic information about youth in foster care settings.

As previously mentioned, the SDIs serve as quantifiable measures that can be readily compared across states to gauge state-level performance and substantial conformity with relevant ACF regulations and statutes. Many of these collections would produce much more useful data and better measurements of actual service *quality* if demographic information were transparently included as part of the analysis. Even if the actual rating against the numerical National Standard is not amended, **we encourage you to make publicly available a cross-tabulated analysis of each SDI against a standard range of demographic variables.**

Given the disparities we know exist, we would expect to see differences between demographic groups in each outcome across the SDIs, and that data would be extremely valuable in and of itself. But it would also be very useful to know if there is a difference in the disparities experienced *across states* as well to help us understand which states are successfully implementing programming for high-risk youth.

For example, we could look at permanency outcomes in 12 months for children entering foster care for LGBTQ youth in each state, compare state success rates, and model LGBTQ family reunification programs after services offered in states with the best results.

3. **Risk Adjustment Variables may conceal failures to sufficiently meet the needs of high risk populations**

One area of concern for us is the proposed risk adjustment model, which would take children's individual risk factors into account and readjust a state's performance against the National Standard, controlling for "factors that differ across states and can affect outcomes regardless of the quality of services the state provides."[xiv] While we agree that some variables that ultimately drive youth outcomes are beyond the control of service providers, we caution against an overly permissive understanding of what those variables might be, and would suggest that some of the variables ACF has already tested for inclusion would be ill-advised.

It is true that some systemic indicators of likely negative outcomes for a young person will affect outcomes "regardless of the quality of [child welfare] services the state provides." For example, we know that people living below the poverty level are overrepresented in the child welfare system for a variety reasons. The broad effects of poverty, conceived of as a state-level characteristic, are beyond the individual control of child welfare services agencies. It would be unreasonable to compare child welfare outcomes in Mississippi (with an overall poverty rate of 24.2 as of 2011) to outcomes in New Hampshire (with an overall poverty rate of 10 as of 2011) without making an adjustment for the disproportionate impact of poverty in Mississippi.[xv] Each state should be assessed based on the quality of services provided given the resources available state-wide.

On the other hand, many high risk "variables" that result in a high probably of negative outcomes across the system are individual demographics, such as race, ethnicity, disability status, sexual orientation, gender identity, and family structure, among many others. This would include a child's age, sex, and number of removals – variables that the Children's Bureau has already tested for possible inclusion in the Risk Adjustment. **We would caution against including variables of this kind that categorize types of children coming into the system, when child welfare agencies arguably have a moderate degree of influence over the nature and adequacy of the services being provided to that population.**

In these cases, we believe providers should be expected to adapt services in a culturally competent way and develop targeted programming aimed at improving outcomes for especially high-risk youth. Quality services should adapt to the environment in which they are being offered.

For example, although a densely populated urban environment may serve a larger LGBTQ population, service providers in the area should be expected to develop culturally competent services that result in equal outcomes for LGBTQ and non-LGBTQ youth. They should not, through a Risk Adjustment, have expectations about overall outcomes lowered automatically because of the increased presence of a high-risk population.

Beyond the fact that such an adjustment would mask the disparately negative experiences of high-risk populations in many systems, it would also conceal the increased need in a particular state for federal-level intervention and increased advocacy efforts to assist with the development of appropriate programming and cultural competency training. Indeed, this kind of demographic information is some of the most useful data that could help states, federal agencies, and partner organizations understand where supportive resources are most needed.

A qualitative assessment of targeted programming would also serve to reward programs with effective and innovative approaches to meeting the needs of particularly high-risk populations, and as a means of

collecting and sharing information about best practices. It would also allow us to distinguish between systems that actively seek out the knowledge, expertise, and cultural competency to address the needs of specific populations and those who do not. This would help explain certain disparities in outcomes.

We encourage you to not adopt demographic Risk Adjustment Variables, and to instead focus on systemic and environmental variables at the state level. While it is important to find a reasonably equitable way of comparing providers across all fifty states, that analysis would become meaningless if in doing so we disregarded the fact that quality care should be responsive to the needs and demographics of the community being served.

4. Family reunification, family rejection, and permanency outcomes for LGBTQ youth

For LGBTQ youth in particular, permanency can be a difficult objective to achieve. Family rejection on the basis of sexual orientation and gender identity is all too common both in original families and in foster families. State welfare agencies should be contracting with competent individuals and organizations to provide vital family reunification efforts that are designed specifically to help parents become safe and accepting or seeking the necessary training to provide those services themselves. Family reunification supports are extremely important, because permanent family connections are one of the most protective factors against negative outcomes for LGBTQ youth, especially against negative mental health outcomes such as suicide.[xvi]

We are concerned that under this proposed SDI, which "recognizes that all forms of permanency represent equally successful outcomes for children," agencies will be dis-incentivized from working to provide culturally competent and LGBTQ-inclusive family reunification efforts. If all permanency outcomes are equal, then difficult family reunification cases become an unjustifiable use of limited resources if other permanency outcomes are more readily achievable. **We encourage you to better incorporate family reunification into Proposed Permanency Performance Area 1: Permanency in 12 Months for Children Entering Foster Care**

Relatedly, **cultural competency should be better incorporated into Proposed Permanency Performance Area 3: Re-Entry to Foster Care.** Here, the Children's Bureau emphasizes the importance of family reunification as quickly as possible, but only when "safe and appropriate and with sufficient supports in place to prevent a subsequent removal." Where a youth has been removed from the home as a result of family rejection of (actual or perceived) sexual orientation or gender identity, the "sufficient supports in place to prevent a subsequent removal" would need to include LGBTQ culturally competent family reunification services that emphasize acceptance and do not suggest that a youth should modify their appearance or identity in order to receive better treatment at home. **We encourage you to provide inclusive guidance to states outlining "safe and appropriate" reunification efforts with "sufficient supports" in place.**

New York City's Administration for Children's Services could serve as an example, and has been providing training for investigative workers on how family rejection of LGBTQ youth may be a basis for a finding of emotional harm or a contributing factor to physical harm, neglect, or other type of child maltreatment under state law. Another useful resource toward this end is the Substance Abuse and Mental Health Service's Administration (SAMHSA)'s recently released Practitioner's Resource Guide, "Helping Families to Support their LGBT Children," developed in conjunction with Dr. Caitlin Ryan of the Family Acceptance Project.[xvii]

CONCLUSION

We appreciate this opportunity to comment on the proposed Statewide Data Indicators and National Standards for Child and Family Services Reviews. Although we understand that the goal of the CFSRs is to quantitatively assess performance nationwide, we want to highlight the fact that the reviews are currently insufficient as a measure of the quality of services provided to high-risk populations. They provide a necessary quantitative overview of *what* is happening in the aggregate, but do not get at *why* it happens *to which* youth. Both of those elements would be necessary to ameliorate negative outcomes and effectively target programs to highest risk populations. If you have any questions regarding these comments, please contact Meghan Maury, Policy Counsel, at (202) 639-6322, or by email at mmaury@thetaskforce.org.

Sincerely,

National Gay and Lesbian Task Force

[i] https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=137&sectionid=20&articleid=3577

[ii] Ryan, C., Russell, S.T., Huebner, D, Diaz, R. Sanchez, J. (2009). Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. Journal of the American Academy of Pediatrics, 123, 346-352. (Finding that LGB young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to report illegal drug use, and 3.4 times more likely to report having engaged in unprotected sexual intercourse, compared with peers from families with no or low levels of family rejection.) http://pediatrics.aappublications.org/content/123/1/346.full.pdf+html

[iii] Kosciw, J. G., Greytak, E. A., Bartkiewicz, M. J., Boesen, M. J., & Palmer, N. A. (2012). The 2011 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York: GLSEN. (Finding that 63.5% of LGBTQ youth surveyed felt unsafe because of their sexual orientation, and 43.9% because of their gender expression.)

[iv] Katayoon Majd et al., "Hidden Injustice: Lesbian, Gay, Bisexual, and Transgender Youth in Juvenile Courts" (The Equity Project, 2009) (Finding that although LGBTQ youth only comprise about 5 to 7 percent of the nation's youth, 13 to 15 percent of youth in the juvenile justice system are LGBTQ).

[v] *See* Lambda Legal Defense and Education Fund, Youth in the Margins: A Report on the Unmet Needs of Lesbian, Gay, Bisexual, and Transgender Adolescents in Foster Care, 11, (2001) (citing Philadelphia Lesbian and Gay Task Force, Discrimination and Violence Against Lesbian Women and Gay Men in Philadelphia and the Commonwealth of Pennsylvania (1996)).

[vi] Id.

[vii] *See*, Al Desetta, In the system and in the life: A guide for teens and staff to the gay experience, Foster Care, 46-47 (2003); *See also* Urban Justice Center, Justice for All? A Report on Lesbian, Gay, Bisexual and Transgendered Youth in the New York Juvenile Justice System, 16 (2001) (citing Joint Task Force of New York City's Child Welfare Administration and the Council of Family and Child Caring Agencies, Improving Services for Gay and Lesbian youth in NYC's Child Welfare System: A Task Force Report (1994); *see generally* National Resource Center for Youth Development, available at: http://www.nrcyd.ou.edu/lgbtq-youth.

[viii]James M. Van Leeuwen et al., "Lesbian, Gay, and Bisexual Homeless Youth: An Eight City Public Health Perspective," Child Welfare 85 (2) (2005): 151-170

[ix] Office of Applied Studies (2010). OAS Data Spotlight, National Survey of Substance Abuse Treatment Services: *Substance Abuse Treatment Programs for Gays and Lesbians*. Available from http://www.samhsa.gov/data/spotlight/Spotlight004GayLesbians.pdf.

[x] Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

[xi] Kann, *supra* n. vi.

[xii] Kann, L, et al. 2011. "Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12 – Youth Risk Behavior Surveillance, selected sites, United States, 2001-2009." MMWR 60(SS07): 1-133. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6007a1.htm

[xiii] Arnold H. Grossman & Anthony R. D'Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37(5) SUICIDE LIFE THREAT BEHAV. 527 (2007).

[xiv] 79 FR 22604.

[xv] Current Population Survey 2011.

[xvi] *See, e.g.*, Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing 23*(4), 250-213; *see also*, Suicide Prevention Resource Center, Suicide Among College and University Students in the United States. Available at, http://www.sprc.org/sites/sprc.org/files/library/SuicideAmongCollegeStudentsInUS.pdf.

[xvii] Substance Abuse and Mental Health Services Administration, A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children. HHS Publication No. PEP14-LGBTKIDS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.