As we enter a new year, we find ourselves in a familiar position—more kids are entering foster care than are leaving. This means increasing caseloads, which affect every aspect of the child welfare system. Children’s attorneys struggle to represent their clients, often finding themselves putting out fires and preparing for hearings the day before they go to court. From high caseloads to lack of resources to help families and to overcrowded court dockets, many elements of the child welfare system seem out of our control. But what if there was another way, right now, for children’s lawyers to dramatically improve the lives of individual clients and the system as a whole? We believe that there is.

We are four lawyers from three states who share a common belief—that advocacy is the answer to our struggling child welfare system. You may wonder, how can children’s attorneys transform the child welfare system? We believe attorney can do this, but only if there is a culture shift in our profession. We know what we are suggesting may sound unrealistic to some—but stay with us. By the end of this article, we hope you will be ready to join our effort to elevate our profession and take charge of getting our clients home.

The Challenge for Our Profession

While there have been many strides in the area of children’s law, we are still a
Can Children’s Attorneys Transform the Child Welfare System?

relatively young profession compared with other professions that serve children—such as pediatric medicine, which is mentioned in ancient texts from the sixth century BC. We got our start in 1874, when an attorney rescued an orphan, Mary Ellen Wilson, from abusive adoptive parents in Hell’s Kitchen with a writ of habeas corpus. There were no laws protecting children from abuse, so that lawyer, Elbridge Gerry, founded the New York Society for the Prevention of Cruelty to Children. It was the first child protection agency in the United States.

Even though it was a child’s attorney who first took action to systemically protect children in our country, it was not until 100 years later, in 1974, that the federal government would pass the Child Abuse Prevention and Treatment Act (CAPTA). While CAPTA does require some form of representation, it does not do enough to promote quality. The real drivers of effective representation are mainly addressed at the state level: training, caseload size, compensation, and accountability. This has resulted in wide variation among states, with children receiving representation in many different forms and structures.

For 44 years, children’s attorneys have struggled to remove our common roadblocks because we are constantly putting out fires. When we do have time to think globally, we tend to pull in opposite directions. We argue about the nuances of representation that do not affect the majority of children. Some of us take up the banner of due process, believing that every child having some kind of counsel should be the ultimate goal. Others believe that holistic representation is the goal—having enough lawyers and trainings and conferences to address every possible need a child could have. And many, many lawyers are just trying to keep their heads above water, doing the best they can to represent too many children with too little time.

As we speak to children’s lawyers from across the country, we find that the practice looks drastically different from state to state and, in some cases, from county to county. There are, however, some unfortunate constants: high caseloads, low compensation, inadequate training, and lack of supervision. There are other problems, but these are the four constants. At least one and probably some combination of the four are present in your jurisdiction.

How would the practice be different if we were specialized doctors, rather than
specialized lawyers? To return to the pediatric medicine metaphor—we essentially operate as the legal equivalent of pediatric trauma surgeons. We just are not resolving physical problems; we are resolving much more complex emotional, familial, and behavioral problems for our clients. And we must agree as a profession that all of these problems are best resolved in the context of a permanent family. That is our shared role. It starts with recognizing our value as professionals and demanding respect by achieving results for our clients. And it ends with a drastically changed child welfare landscape where the child’s attorney is not an afterthought but is instead the person whose vision guides the child home.

Would pediatric trauma surgeons be asked to work on 150 to 200 children at one time? Would they be asked to do it without nurses or physician’s assistants? Would surgery be scheduled every half hour of the day? Parents would not stand for this. But the children we represent don’t have another option. They get us, in whatever form we take. Our role is critically important to our clients, and we must hold ourselves accountable.

The Solution Is Permanency-Focused Advocacy

So how do we elevate our profession?

There is a way. For over 17 years, the Foster Children’s Project (FCP) has operated in Palm Beach County with a singular purpose—to get kids out of foster care and into permanent homes quickly and safely. The office was founded with the goal of getting children into permanent homes within 12 months. When FCP began taking cases in 2001, the average time to permanency was 36 months. Throughout the life of the program, FCP has averaged 12.5 months to get a child into his or her permanent placement. Some may be concerned that this approach adversely affects parents. But this is not the case. The Chapin Hall study of FCP found substantially higher rates of exits to permanency without any negative impact on rates of reunification.

When FCP was created, it began with the simple premise of measuring the length of time children were in foster care, and it evolved into an approach that has stood the test of time. The primary reason FCP’s work has not been replicated is the assumption that it is too expensive. It operates like a real law firm—with caseload
targets of 50 children per lawyer, social workers, and funds for litigation expenses. This model and approach helped FCP to change the culture of the child welfare system in Palm Beach County. But it is not necessary to have all of the resources in place to take action today.

We are calling this model of representation permanency-focused advocacy and we are proposing a nationwide move in this direction. It means creating a culture in which every case has a sense of urgency—a culture in which we work harder in between hearings than in court. Permanency-focused advocacy is actually very simple. Many of the strategies learned can be applied to any caseload or system. And imagine if we were all able to move children home a bit faster. What could that mean for the child welfare system as a whole? Even one month per child?

There are three key features of permanency-focused advocacy. If every children’s attorney adopted these, we would see the kind of culture shift needed to transform the child welfare system.

**The child’s attorney acts as lead counsel.** As children’s attorneys, we lack clarity that is so common in many other areas of the law. Criminal defense attorneys know they are working for a “not guilty” verdict. A lawyer suing an insurance company on a client’s behalf is looking for a win so the client receives a judgment. The list goes on and on. But for children’s attorneys, there are no wins or losses. We must counsel our clients and seek the best possible outcome, but many times that is a moving target. And we are expected to address the well-being of the child while in the system. This unique role, along with the frequent high caseloads, sets lawyers up for failure. We take the small wins and handle only the most urgent issues between court hearings. This leaves little time for legal strategy and proactive steps to move cases forward.

The only way for children’s lawyers to transform the child welfare system is to step into the role of lead counsel and take responsibility for the direction and pace of the case. After all, the case is styled “in the interest of our client.” That alone should bring us a degree of clarity: We are lead counsel because we represent the most important person, indeed the subject, of the case. Once we realize this, we must then focus on the most important legal problem first.
The child’s attorney focuses on the child’s number one legal problem—being in the custody of the state, instead of a family. Most children in foster care have the same problem that Mary Ellen Wilson had—they need a safe and permanent home. If you are appointed to represent a person who is in state custody, it is safe to conclude that your role is to get your client out of state custody as quickly as possible. Taking that a step further, because your client is a child, it’s safe to assume your client needs to be with a family. By keeping it simple, we believe the mission of the child’s attorney is clear—get the child home. Preferably, with some exceptions, this will mean the birth parent’s home. Sometimes it will mean an adoptive home.

As the child’s attorney, you cannot control what the parents will or will not do on their case plan. You can remove obstacles. You can motivate them with visitation. You can plan concurrently by keeping siblings together and in foster homes that will adopt if need be. And you can do this one case at a time. By developing a strategy for permanency within one year for each of your clients, you can start to move the needle in your jurisdiction, even if it’s just a little.

The child’s attorney enforces permanency time frames as a right of the child. How many cases do not see real movement until right before the hearing? What if we spent more time working between hearings? We must hold the department accountable for referrals and services. We must bring cases back into court when action is not taken.

How do we keep our focus on the time frames? We can start by measuring.

The signal of the importance of something is whether you’re actually measuring it and you’re holding people accountable to improving those numbers.
—Sandra E. Peterson, Group Worldwide Chairman, Johnson & Johnson

While some children’s law offices have databases to track cases, many attorneys operate with a stack of files and an impossible list of things that need to be done. If we are to take charge of our cases and work to improve the
system, we must start by measuring. It is not the lack of laws on the books that prevents children from finding permanency quickly. It is flaws in the system and the court process. These are areas that may seem outside the purview of the role of a children’s attorney, but we submit that they are not. We are, in fact, in the very best position to be the driver of the case.

Once we are in the driver’s seat, it is our role to watch the clock for our client. This means watching more than the goal date of the case plan. It means making sure the parents get engaged in services early, taking the case back into court when it veers too far off the course we have set for it and developing interim goal dates for each task in the case plan. These are all ways you can begin to let your jurisdiction know that you are watching the clock. As you introduce these practices, you’ll start to see a reduction in your client’s length of stay—if you measure your outcomes.

Measuring can also lead to new resources. If the success of FCP can be replicated, we can all make the case for lower caseloads based on the real, measurable impacts we have on individual clients and the system.

Change the Child Welfare System
One Case at a Time

If all of us were pulling together in the direction of permanency-focused advocacy, what would be the cumulative effect on the child welfare system in this country? What if children removed from their homes because the parents smoked marijuana and had a dirty house were returned in 6 months instead of a year? What if children whose parents disappeared from their lives at birth got adopted in 6 months instead of 18 or 24?

What we as children’s attorneys bring to the table our critical thinking skills. We analyze the facts, apply the law to them, and bring about the best outcomes for our clients. Achieving an outcome for your client may involve thinking way outside the box or even changing the practice of the local child welfare agency. By doing this, FCP has impacted its local system of care in the following ways:

**Visitation.** Once you know that visitation is the single biggest predictor of
reunification, you realize once a month is not enough. FCP pushed for three times a week for infants and was told it would break the system. The system did bend, but it did not break. Visitation three times a week is now the rule in Palm Beach County—for every child.

**Concurrent planning.** Once you know that, from the child’s perspective, it makes no sense to spend a year in a foster home only to be moved to an adoptive home if your parents fail, you realize the first placement should be the last placement. So FCP pushed hard for “foster to adopt” homes, so that if parents could not be reunified, the child would undergo only one change in caretakers. FCP was told it could not be done. It would cause too many issues with foster parents who would refuse to let go of children they wished to adopt. Those issues do present themselves from time to time. Separating from a foster child can be heartbreaking. Managing foster parents’ expectations can be time consuming. Litigating against them even more so. However, when balanced against the fact that the majority of Palm Beach County children under age five are in foster homes that will adopt them if the parents are unsuccessful, the struggle has been worth it.

**Material breach of the case plan.** Once you know that the case plan is really just a contract, you realize your client is a party to that contract or, at a minimum, a third-party beneficiary. So FCP borrowed from contract law and argued material breach as a ground to terminate parental rights when parents stopped working their case plans. In these cases, it makes no sense to wait the whole 12 months of the plan. Material breach is now a statutory ground for termination of parental rights in Florida.

**Prescriptive case plans.** Once you know that your client’s parents have trouble getting things accomplished, you know they need to focus only on what needs to get done. They can’t afford distraction. So FCP argued against extraneous tasks in case plans. As it turns out, Chapin Hall found this was one of the critical differences in cases where children were represented by FCP. The case plans contained only relevant tasks—and that helps kids get home quicker.

These are just a few of the ideas that grew organically out of permanency-focused
advocacy. You likely face different issues in your jurisdiction, but the process is the same. Once you change your focus, your practice begins to change. If this seems daunting, keep in mind that not all of the cases we handle as children’s attorneys are difficult. Sadly, parents often make the decision about whether or not our client is going home an easy one. Even ruling out the complex cases, just tackling the cases with an outcome that is not in doubt could have a tremendous effect on child welfare nationally. Some may say that’s not our concern, that it’s the province of state and federal governments to worry about the health of the child welfare systems. We disagree.

We Have the Power to Transform the System

We believe that it is time for us, as children’s attorneys, to take matters into our own hands—just as Elbridge Gerry did when he stepped outside his role as a lawyer and formed the first child protection agency. Let’s all start pulling in the same direction and transform this broken system. Fewer kids in care means a healthier system for our next client to enter. It means case workers with more time. It means less crowded foster homes. It means shorter waiting lists for services. It means all of that—and more.

Together, we can change the system one step at a time. Start small. Pick one. Measure. Use results to show the value of your work and increase resources for high-quality representation.

We hope this conversation continues on many fronts and that you will be a part of it. For our part, we have started the Children’s Law Podcast—the first project of our new organization, True North Child Advocates. You can find us at childrenslaw.org or on iTunes by searching “True North Children’s Law.” Please join the conversation. Your voice is vital.

William Booth, Angela Orkin, Jim Walsh, and John Walsh practice in New York, New York; Atlanta, Georgia; and West Palm Beach, Florida, respectively. Together they formed True North Child Advocates and host the Children’s Law Podcast.

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Can Children’s Attorneys Transform the Child Welfare System?

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Rethinking the child welfare system has become such a prevalent idea that there are blogs, podcast series, and entire non-profits devoted entirely to changing the system. In fact, all of the articles submitted for this winter edition of the Children’s Rights Litigation Committee’s newsletter were (coincidentally) all framed around this concept. Each article took a different approach, but the central focus of all of them was work that individual, front-line lawyers could do to “change the system.” We seem to have reached a broad consensus that and why we need to change our current child welfare system—it does not work for children and families. We are still graduating far too many kids from the system into poor outcomes; it’s estimated that 25 percent of former foster youth experience homelessness within a year and that 25 percent become involved in the criminal justice system within two years of exiting care. Disproportionality is also a significant issue within our system with, for just one example, African American children comprising only 14 percent of the nation’s children and yet representing 23 percent of the national foster care population. Recently a new class action law suit was filed that alleged that foster children in Kansas are moved so often—in one case more than 130 placements in six years—they are effectively rendered “homeless while in state custody.” Indeed U.S. District Judge Janis Graham Jack recently ruled that children in foster care in the state of Texas “almost uniformly leave state custody more damaged when they entered.”
But can individual, front-line lawyers change the system? Though there are large entities representing children like the Children’s Law Center of California and Legal Aid in New York, the majority of lawyers representing children in dependency cases are either solo practitioners or members of small firms. Is it the job of individual lawyers to change the system? Even if it is, do lawyers have that ability?

Thinking about this question reminded me of a conversation I once had with my then high school-aged daughter. She was quiet on the ride home from school, and I asked her if anything was bothering her. It was close to the Martin Luther King, Jr. Day holiday, and her school had talked to the students about how it was their responsibility to change the world. Combined with living in Washington, D.C. where it seems so many people are literally working to do big things and change the world, my daughter felt a little hopeless. “I’m just a kid—just one person. What can I do that is big enough to change the world?” The answer I gave her is, I think, the same answer here. No, one person doesn’t have to do it all, but we must do what we can. And the actions of one individual can make a big difference.

Can one front-line lawyer change the entire system? Perhaps not the entire system, but certainly the actions of one lawyer can change the world for his or her client, literally transforming a child’s future whether because of connections to education or family or perhaps by reversing a decision to remove a child from his or her own home when there was no safety risk. As William Booth, Angela Orkin, James Walsh, and John Walsh note in their article, those individual case actions can lead to systems change, particularly when lawyers begin to pull in the same direction. Lawyers can also call attention to trends in a particular jurisdiction: Does the data in your jurisdiction show there are disparities and disparate outcomes based on race within your child welfare system? Do trends of removal identify sources of problems that the jurisdiction could address to prevent future removals, like the problem of children being removed because they’ve been left alone being addressed with more affordable child care?

Additionally, as the article by Betsy Fordyce points out, lawyers can listen to system-involved youth, support their advocacy, and help to amplify their voices. And as the three articles from Jenny Pokempner outline, lawyers can use the provisions in the Family First Prevention Services Act to advocate for permanency...
and connections for older youth in foster care. That advocacy can push an entire system to change by developing needed placements and services to address the needs of older youth.

Small actions can make big changes, and zealous advocacy on behalf of each client is not only our job but also makes a difference and can push an entire system to do better for all children we serve. The Children’s Rights Litigation Committee is here to help you and is focused on producing content to assist you in working toward change and being the best advocate you can be.

Here are some additional resources from our archives that you might find helpful:

- Five Ways to Address Implicit Bias Within Our Systems
- How Listening to Our Child Clients Can Lead to Big System Changes
- Is a “Least Restrictive” Placement Really the Best We Can Do for Our Clients? (video)

Please let us know if there is other content you would find useful. Together, let’s all do our part to change the child welfare system so it works better for our kids, families, and communities.

*Cathy Krebs* is the director of the Children’s Rights Litigation Committee

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SAFE HAVENS
Closing the Gap Between Recommended Practice and Reality for Transgender and Gender-Expansive Youth in Out-of-Home Care

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TABLE OF CONTENTS

I. Executive Summary ........................................................................................................1

II. Introduction ..................................................................................................................6

III. Existing Law and Policy and Recommendations for Reform ...............................7
    A. Federal Law and Policy ...............................................................................................7
       1. Child Welfare ..........................................................................................................7
       2. Juvenile Justice ........................................................................................................9
       3. Runaway and Homeless Youth ..............................................................................11
    B. State Law and Policy ................................................................................................12
       2. Juvenile Justice ........................................................................................................15
       3. Runaway and Homeless Youth ..............................................................................18
    C. State-Based Licensing, Training and Other Requirements ..................................19

IV. Eliminating Practice Barriers: Lessons from Affirming Programs
    and Positive Experiences of TGNC Youth .................................................................26
    A. Families, Kin, and Guardianship Placements .......................................................26
    B. Congregate Care Settings .......................................................................................29
       1. Child Welfare ..........................................................................................................29
       2. Juvenile Justice ........................................................................................................35
       3. Programs Serving Youth Experiencing Homelessness ........................................37

V. Conclusion ..................................................................................................................39

Endnotes ..........................................................................................................................40

VI. Appendix A: State-by-State Licensing and Other Regulations

VII. Appendix B: Additional Resources
I. EXECUTIVE SUMMARY

Child advocates and experts from a host of disciplines have documented for over a decade the overrepresentation of lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ+) youth in child welfare, juvenile justice and runaway and homeless youth systems (“out-of-home care systems”) compared to the general population. Further, transgender, gender-expansive and gender-nonconforming (TGNC) youth, who may identify across the sexual orientation spectrum, are overrepresented in these systems at even higher rates than youth who identify as LGBQ.

Data are scarce regarding the particular experiences of TGNC youth in out-of-home care. However, extraordinarily high rates of family rejection, societal discrimination and victimization of TGNC people—including staggering rates of violence against transgender women of color—and anecdotal evidence suggest that TGNC youth in out-of-home care are exposed to even harsher and more abusive treatment than LGBQ youth in these systems. Most out-of-home care placements and facilities are sex-specific and many aspects of youths’ supervision and care are governed by regulations that reference a youth’s sex (or gender). This makes it particularly important to insure that out-of-home care practices are accepting and affirming for TGNC young people. For example, placing a young woman who is transgender on the boys’ floor in a child welfare group home, juvenile justice facility or shelter for youth experiencing homelessness can be dangerous, exposing her to bullying, physical assaults and even sexual abuse. At its core, such a placement constitutes a refusal to fully affirm the youth’s identity and may contribute to suicidal ideation and depression and exacerbate gender dysphoria, among other undesirable health outcomes. Lack of affirmation for TGNC youth in care is, too frequently, accompanied by discrimination and mistreatment in school, at work and within their communities. Stigma, conflicts around gender nonconformity and racial identity also contribute to the criminalization of TGNC young people, particularly TGNC youth of color, at higher rates than their cisgender and gender-conforming peers. Without assistance and support from out-of-home care providers, these issues may remain unaddressed, leading to disparately poor life outcomes for these young people.

This report, based on the authors’ research, identifies barriers to affirming treatment for TGNC youth.

GLOSSARY

The authors use the term transgender—a person whose gender identity (i.e., their innate sense of being male, female or something else) differs from the sex they were assigned or presumed to be at birth—to include youth who identify at all points along the gender spectrum, including youth who identify as non-binary or gender fluid. As an example, the authors use the description transgender girl to describe a girl who identifies as female, but was assigned the sex of male at birth.

Gender-expansive is a broad term referring to aspects of gender expression, identity, and interests that go beyond cultural binary prescriptions of behaviors and interests associated primarily with boys or girls. Gender-expansive includes young people who do not identify with the sex they were assigned at birth as well as those who do, but may nonetheless find themselves barraged with questions based on their dress, appearance, or interests, such as, “Are you a boy or a girl?” or “Why do you play with that? It’s a boy/girl toy!” Other words with similar meanings include gender diverse and gender creative. Nat’l Ass’n of School Psychologists & Gender Spectrum, Gender Inclusive Schools: Overview, Gender Basics, and Terminology (2016), https://www.nasponline.org/resources-and-publications/resources/diversity/lgbtq-youth/gender-inclusive-schools-faqs/gender-inclusive-schools-overview-gender-basics-and-terminology.


The authors use the abbreviation TGNC in this report because it appears most frequently in the literature and research. The authors emphasize that every individual is unique and there is no “correct” way to identity or express oneself. Here, the authors use gender-nonconforming to convey that cultural norms around gender still negatively impact youth who express themselves outside of those norms.
youth in out-of-home care and suggests steps to eliminate these barriers. The report provides first-of-their-kind live national maps of specific out-of-home care statutes, policies and licensing regulations related to sexual orientation, gender identity and gender expression, providing a resource to help users understand the explicit protections that exist (or do not exist) in all 50 states and the District of Columbia. Also provided are concrete law and policy reform recommendations and practical tips to better protect and serve TGNC youth involved in intervening public systems. The recommendations were developed with significant input from both TGNC youth who reported affirming experiences during their placement in out-of-home care and providers who have made recommended practices a reality for the youth they serve.

ONLY 5-7% OF YOUTH ARE LGBTQ+
BUT LGBTQ+ YOUTH ARE ALMOST 25% OF THOSE IN FOSTER CARE,
20% OF YOUTH IN THE JUVENILE JUSTICE SYSTEM
AND ALMOST 50% OF YOUTH EXPERIENCING HOMELESSNESS.

"WHILE I WAS IN THE FACILITIES, I WASN’T ABLE TO FOCUS ON MY CLASSES AND WHAT I NEEDED TO LEARN. I WAS ALWAYS MORE FOCUSED ON WHO WAS OUT TO FIGHT ME AND WHO WAS GOING TO JUMP ME TODAY. I WAS SO BUSY PAYING ATTENTION TO MY SURROUNDINGS THAT I COULDN’T PAY ATTENTION TO MY WORK. ONCE I KNEW MY PAROLE OFFICER WAS GOING TO RESPECT ME AND TREAT ME FAIRLY, I WAS ABLE TO FOCUS ON WHAT I NEEDED TO DO AND WORKING ON POSITIVE THINGS."

—LYDIA, transgender youth in care

All photographs are stock images for illustrative purposes only.
THE PROBLEM

Comprehensive data on the number of LGBTQ+ youth in out-of-home care are difficult to find and data specific to transgender and gender-nonconforming youth even more so. Available research using representative samples has shown that while young people who identify as LGBTQ+ comprise about 5-7% of the overall youth population, they make up almost one-fourth of those in the foster care system, one-sixth of those in the juvenile justice system and almost half of young people experiencing homelessness. Moreover, sexual orientation and gender identity are important, but not singular, aspects of a young person’s identity. Data disaggregated by race and ethnicity show that LGBQ and TGNC young people in out-of-home care are disproportionately young people of color, therefore exposed to overlapping inequalities associated with that intersectionality.

For TGNC youth in out-of-home care systems, the combination of societal stigma and discrimination and sex-specific regulations presents a veritable minefield of challenges. While a young person is in out-of-home care, nearly all aspects of the youth’s life—from the doctor they see to the place they sleep, the clothes they wear and who searches their bodies—are controlled by out-of-home care professionals who in most cases lack training and guidance on how to properly serve this population. The report highlights gaps in law and policy that must be filled in order to protect youth from discrimination and seeks to improve practice by sharing insights from the experiences of TGNC youth and from affirming and supportive providers. The authors hope that this information will enable policymakers and practitioners to drive change in the systems where they work, in line with professional commitments and legal obligations that require them to provide for the safety and well-being of all youth.

Out-of-home care systems are often ill-equipped to serve LGBTQ+ youth adequately. Research has shown that once in out-of-home care, LGBTQ+ youth face higher rates of victimization and discrimination and worse life outcomes than their non-LGBTQ+ peers. In New York City, studies show that 78% of LGBTQ+ youth experiencing homelessness were removed or ran away from foster homes because of abuse or discrimination, and 56% chose to live on the street—rather than in a foster care placement—because they felt safer there. Findings show that, when compared to their heterosexual and cisgender peers, LGBTQ+ youth in the juvenile justice system are twice as likely to have experienced child abuse, out-of-home placement or homelessness. The U.S. National Alliance to End Homelessness reports that LGBTQ+ youth experiencing homelessness are roughly 7.4 times more likely to suffer acts of sexual violence than their non-LGBTQ+ peers, and are more than twice as likely to attempt suicide (62%) than their peers (29%). Research specific to TGNC youth has shown that transgender youth in New York City have been found eight times as likely as non-transgender youth to trade sex for a place to stay. This bleak picture is, of course, not inherent to being TGNC, but certainly indicative of intense misunderstanding, stigma and prejudice in general society. These factors fuel horrifyingly high rates of suicide, self-harm and physical and sexual victimization among TGNC youth.

In light of the challenges that TGNC youth face and the weighty obligations of out-of-home care providers, experts have produced a body of professional standards that identify how to serve LGBTQ+ youth appropriately and reduce disparities in outcomes. Some federal and state laws and policies specific to child welfare, juvenile justice and runaway and homeless youth systems of care have likewise evolved and, consistent with youth’s constitutional rights, provide explicit protection from discrimination and harassment on account of sexual orientation, gender identity or gender expression (SOGIE). Flowing from professional standards and law and policy protections, a handful of jurisdictions have provided training for staff working with young people on affirming and supporting LGBTQ+ youth and have developed pilot programs or “best practice” models. At the same time, policies and practices that affirmatively hurt LGBTQ+ children and youth also persist.
OUR FINDINGS:

Our first-of-its-kind 50-state analysis of state statute, regulations and policy found that:

- Despite the fundamental need for protection against discrimination, only 27 states and the District of Columbia explicitly include sexual orientation and gender identity in non-discrimination protections specific to the child welfare system; only 21 states and the District of Columbia do so in their juvenile justice systems; and only 12 states and the District of Columbia do so in their facilities serving runaway and homeless youth.

- Despite the near-ubiquitous use of the term sex (or gender) in regulations governing placement, clothing, searches and other critical aspects of systems of care, only three states in the nation define sex (or gender) to include gender identity, and only one of those does so in a regulation specific to out-of-home care.

- Despite the critical need for placement decisions that respect identity and keep TGNC youth safe, only four states have statutory or regulatory guidance regarding placement of transgender youth in out-of-home care in accordance with their gender identities.

- Even though professional standards dictate that the well-being of TGNC youth requires they be allowed to dress and express themselves in accordance with who they are, 24 states provide no such explicit allowance in statute or regulation in their child welfare systems, 40 states provide no such allowance in their juvenile justice systems and 34 states provide no such allowance in their homeless and runaway youth facilities.
New York and California are the only states to have comprehensive protections in place to protect these young people across all of their out-of-home care systems. Both enacted SOGIE-inclusive anti-discrimination statutes and regulations specific to out-of-home care systems as well as definitions of sex (or gender) that include gender identity. On the other end of the spectrum, the states of Alaska and North Carolina provide no explicit protections for LGBQ or TGNC youth in any of their out-of-home care systems. Most states fall somewhere in between these extremes.

Law and policy protections are essential for ensuring the health and well-being of TGNC youth, but they are not sufficient. Of utmost importance is the responsibility of caregivers to turn recommended practice into reality. Based on concrete tips from providers featured in this report who are bridging that gap, the authors call for solid legal and policy protections that are connected to staff hiring, training and ongoing coaching and development; better support for families of origin and foster and adoptive parents; increased community collaboration; intentional engagement with LGBTQ+ young people to ensure that they are affirmed in care; and a commitment to agency-wide culture change.

Youth with lived experience in out-of-home care systems who contributed to the report had the following recommendations for providers: Provide affirming health care and use qualified and trusted providers; screen existing placements and develop affirming ones; don’t replicate the harm youth experienced at home; respect youth to build trust with them; give non-TGNC youth and adults time to learn about and understand TGNC youth; affirm identity in all aspects and promote well-being; don’t blame youth for being victimized; use resources to help youth and avoid unnecessary grievances; provide safe environments to allow youth to focus on positive development; don’t gender things; if you see bullying, stop it and connect youth to LGBT supports. As this important work progresses, TGNC youth must be engaged to ensure that their voices are part of policy development and that their positive experiences can serve as examples to guide life-changing system improvements.

LGBTQ+ YOUTH EXPERIENCING HOMELESSNESS ARE MORE THAN TWICE AS LIKELY AS THEIR NON-LGBTQ+ PEERS TO ATTEMPT SUICIDE.

“EVEN THOUGH YOUR CLIENTS ARE CHILDREN, THEY STILL NEED TO BE TREATED WITH RESPECT. ESPECIALLY IN THIS SETTING, THE TRANS KIDS YOU WORK WITH ARE THERE FOR A REASON AND IT’S OFTEN BECAUSE THEIR IDENTITIES WERE REJECTED BY THEIR PARENTS. WHEN THE SYSTEM IS SUPPOSED TO BE THERE TO HELP, IT’S CRITICAL THAT IT DOESN’T REPLICATE THE SITUATION THAT [A YOUTH] IS TRYING TO GET AWAY FROM.”

– SAVANNAH, transgender youth in care

Explicit protection from discrimination and training for providers on how best to work with LGBTQ+ youth are critical precursors to safe and supportive participation by youth in system reform efforts. These precursors also allow for safe collection of much-needed SOGIE demographic data on system-involved youth and families in order to inform and improve practice. Unfortunately, the vast majority of states have no statutory or regulatory requirements for LGBTQ+-specific ongoing training and coaching in any of their out-of-home care systems.

The authors hope this report will constitute a call to action for states, agencies, advocates and stakeholders across the country to require their out-of-home care systems to provide affirming treatment for TGNC youth.
II. INTRODUCTION

Could there be any need more fundamental than the need to sleep safely at night? Could anything be more critical to a young person’s development than being accepted where they live? When physical and psychological safety is protected, young people have the freedom to think creatively and optimistically about their futures.

At a minimum, all youth need to be safe, have food and appropriate shelter and be supported and affirmed by others, including their families and communities. For youth in out-of-home care these needs are especially critical and states must ensure that they are met. Many LGBTQ+ youth in out-of-home care systems have been rejected by their families of origin and kicked out of their homes, only to be rejected again based on who they are when placed in other settings. These issues are particularly acute for TGNC youth, because so much of their treatment in out-of-home care systems is governed by the way those systems define and segregate youth on the basis of sex (or gender).34

This report provides concrete recommendations to state policymakers, administrators and providers about comprehensive and affirming policies and practices that can support TGNC youth in their care. The report examines the federal and state laws and policies that enshrine youth’s right to be safe from physical and psychological harm and to be treated equally and fairly while in state custody, and it identifies law and policy gaps and their impacts in the field. Most critically, the report highlights practical tips from providers serving these youth and insights from youth themselves about the positive impact of having their needs met. The authors hope that in response to this call to action, states will adopt comprehensive law and policy for TGNC youth, and that agencies and providers will follow models of appropriate TGNC youth treatment and incorporate constant and meaningful feedback from TGNC youth themselves.

About the Authors

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Christina Wilson Remlin is a Lead Counsel with Children’s Rights, a national non-profit organization that uses the law to bring about meaningful reform in government child welfare agencies that provide foster care, adoptive and child protective services. Since joining Children’s Rights in 2011, Remlin has represented classes of children in foster care in suits challenging violence, inadequate medical care, inappropriate conditions and over-institutionalization. Her clients include those at risk of discrimination associated with their LGBTQ+ identity, gender, race, immigration status and class.

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III. EXISTING LAW AND POLICY AND RECOMMENDATIONS FOR REFORM

The U.S. Constitution requires that youth in state custody be protected from unreasonable risk of harm and provides all youth with freedom of speech and expression as well as protection from unequal treatment under the law. In addition to these fundamental rights, recent advancements in federal law and policy for youth in out-of-home care offer explicit protection from SOGIE-based discrimination. Moreover, courts around the country continue to clarify that discrimination based on sex, a protected class in some federal laws, includes both sex stereotyping and gender identity-based discrimination.

As detailed in Section III (B) below, a growing number of jurisdictions at the state and local level provide explicit protections for youth in their child welfare, juvenile justice or runaway and homeless youth systems of care. Some states offer complete SOGIE-inclusive protection in all three systems, others in only one system and still others only for discrimination on account of sexual orientation. In a few states and localities, protection may be offered under general nondiscrimination laws that are not specific to out-of-home care systems, such as public accommodation or human rights laws. In others, there are no explicit law or policy protections whatsoever against SOGIE-based discrimination.

Advocates and administrators should utilize existing protections to ensure that children and youth are treated fairly while proactively working to develop laws and policies so that protection is explicit and complete. Explicit protection from discrimination is an essential component of appropriate care for system-involved youth and provides clarity for professionals regarding their obligations.

In addition to nondiscrimination laws (whether statutory or regulatory) and policies, a complex array of state-based licensing regulations governs services for children in out-of-home care, covering such areas as placement, clothing and staff training. In some jurisdictions, regulations regarding placement for youth in single-sex homes or facilities, or access to clothing or programming that is sex- or gender-specific, has been perceived as a barrier to affirming gender identity. In the absence of clear definition or guidance, administrators and staff may have assumed that the term sex (or gender) references a youth’s sex assigned at birth and consequently barred them from sex-specific facilities, programming or other practices consistent with that youth’s gender identity. This report offers a compilation of those regulations for out-of-home care systems in all 50 states and the District of Columbia, along with recommendations for regulatory reform. Affirming models are also highlighted.

A. FEDERAL LAW AND POLICY

1. CONSTITUTIONAL LAW

The U.S. Constitution. Youth in child welfare custody have substantive due process rights under the Fourteenth Amendment, including rights to:

- Personal security and reasonably safe living conditions;
- Freedom from psychological harm and from physical and psychological deterioration;
- Adequate care, including the provision of certain services; and
- A reasonably suitable placement.

Additionally, all LGBTQ+ youth, including those in child welfare custody, have the right to be treated equally under the law as compared to their non-LGBTQ+ peers. An Equal Protection claim for a transgender or gender-nonconforming child may be brought where the child has been subjected to discrimination on the basis of their transgender or gender-nonconforming identity because “[t]ransgender people as a class have historically been subject to discrimination or differentiation; . . . they have a defining characteristic that frequently bears no relation to an ability to perform or contribute to society; . . . as a class they exhibit immutable or distinguishing characteristics that define them as a discrete group; and . . . as a class, they are a minority with relatively little political power.” State discrimination against TGNC and LGBQ youth may be subjected to a more rigorous review by the court in an Equal Protection case (enjoying “heightened scrutiny,” making it easier for the plaintiffs to prevail), given the growing number of federal courts recognizing that discrimination on the basis of sexual orientation or gender identity triggers heightened scrutiny. As to these Plaintiffs, gender identity is entirely akin to ‘sex’ as that term has been customarily used in Equal Protection analysis. It is deeply ingrained and inherent in their very beings.” Furthermore, youth have the right to freedom of religion (or freedom not to practice religion) because the Establishment Clause forbids imposition of a
state-sanctioned religion. TGNC youth may have Establishment Clause claims if they are subjected to the imposition of religion in their out-of-home care placement settings.

Youth have the right to freedom of expression, including the right to express one’s identity, which has been interpreted to be “speech” protected by the First Amendment. Many cases affirm constitutional protections of LGBTQ+ speech in schools. Of note, the Fifth Circuit Court of Appeals has also signaled that wearing clothing, even clothing not tied to a particular political message, may constitute protected speech.

Discrimination and mistreatment against LGBTQ+ youth in out-of-home care may violate some or all of these rights.

B. STATUTORY AND REGULATORY LAW

**Titles IV-E and IV-B of the Social Security Act.** The Federal Foster Care Program, authorized by Titles IV-E and IV-B of the Social Security Act, aims to support states in providing safe and stable out-of-home care for children until they are safely returned to their families of origin, placed permanently with adoptive families or guardians or placed in other planned arrangements for permanency. Agencies receiving federal child welfare dollars are required to place children in a “safe setting that is the least restrictive (most family like) and most appropriate setting available and in close proximity to the parents’ home, consistent with the best interest and special needs of the child.” In order for an agency to receive IV-E dollars, its State plan must document how it establishes and maintains standards for foster family homes and child care institutions that are “reasonably in accord with recommended standards of national organizations concerned with [such] standards.” These standards include those related to admission policies, safety and protection of civil rights, among others. In addition, agencies must develop a case that assures the child receives safe and proper care and that services are provided to the parents and child. Thus, agencies are required to ensure safety, permanency and well-being for all children in their care. These fundamental aims are applicable to all children in child welfare custody, including LGBTQ+ children.

**Foster Care Independence Act (John H. Chafee Foster Care Independence Program).** The Chafee program provides services and support to children and youth aging out of foster care to make the transition to self-sufficiency. Agencies receiving funding under this program must ensure that children and youth “have regular, ongoing opportunities to engage in age or developmentally-appropriate activities.” States and tribes must “use objective criteria . . . for ensuring fair and equitable treatment of benefit recipients.” States and tribes are required to use federal training funds “to help foster parents, adoptive parents, workers in group homes and case managers understand and address the issues confronting adolescents preparing for independent living.” These fundamental aims are applicable to all children covered by the Act, including LGBTQ+ children.

**Health and Human Services Grants.** Regulation 45 CFR Part 75, the Department of Health and Human Services (HHS) Grants Rule, provides that “it is a public policy requirement of HHS that no person otherwise eligible will be excluded from participation in, denied the benefits of, or subjected to discrimination in the administration of HHS programs and services based on non-merit factors such as age, disability, sex, race, color, national origin, religion, gender identity, or sexual orientation.” This provision is binding on state child welfare agencies because they receive federal funds through awards from the Administration for Children and Families (ACF), a division of HHS.

**The Affordable Care Act.** Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age or disability in health programs and activities that receive financial assistance from the federal government.
or are administered by an executive agency or any entity established under Title I of the ACA. Many child welfare programs, such as those involving therapeutic foster care or residential treatment, may qualify as health programs under the ACA. In 2016, the HHS Office for Civil Rights issued the final rule implementing Section 1557 of the ACA, the Nondiscrimination in Health Programs and Activities Rule. This rule prohibits discrimination on account of gender identity or sex stereotyping and requires all health programs and activities that receive federal dollars to treat individuals in a manner consistent with their gender identity.

Title IX of the Education Amendments of 1972. Title IX protects people from discrimination based on sex, among other protected classes, in education programs or activities that receive federal financial assistance. Courts have interpreted Title IX’s prohibition on discrimination based on sex to include sex stereotyping, gender identity-based discrimination and nonconformity to gender norms. To the extent that programs serving youth in child welfare systems receive federal funds for educational programs or activities, they are required to follow Title IX requirements.

C. POLICY MEMORANDA AND INFORMATION

Administration for Children and Families Information Memorandum 11-03. On April 6, 2011, Administration on Children, Youth and Families (“ACYF”) Commissioner Bryan Samuels issued an information memorandum to state child welfare agencies regarding LGBTQ+ youth in foster care. Commissioner Samuels’ memorandum “confirms and reiterates [the] fundamental belief that every child and youth who is unable to live with his or her parents is entitled to a safe, loving and affirming foster care placement, irrespective of the young person’s sexual orientation, gender identity or gender expression.” It addresses safety concerns specific to LGBTQ+ youth in foster care and describes steps that states receiving Title IV-E funding should take to protect these young people, including steps regarding workforce development, training, the support of families of origin and of relative legal guardians and recruitment and support for foster and adoptive parents, including LGBTQ+ parents and families.

In addition to the 2011 Memorandum, numerous helpful resources related to recommended practices for appropriately protecting and serving LGBTQ+ youth can be found on ACF’s Children’s Bureau and the Child Welfare Information Gateway websites, including reports and webinars. ACF also funded the RISE (Recognize, Intervene, Support, Empower) Project in Los Angeles and established a Quality Improvement Center focused on developing affirming policies and practice for LGBTQ+ youth in the child welfare system.

2. JUVENILE JUSTICE

A. CONSTITUTIONAL LAW

The U.S. Constitution. In addition to the protections defined in the child welfare description above, LGBTQ+ youth in juvenile justice facilities, like all youth, have the right to a sound classification system that prevents the placement of vulnerable youth in cells or units with aggressive youth who may physically or sexually attack them. All youth, including LGBTQ+ youth, have a right to be free from unreasonably restrictive conditions of confinement, including isolation and segregation, and isolation cannot be used as a punishment for expressing their identity, to protect them from harm or as a response to the unfounded and illogical myth that LGBTQ+ youth pose a danger to other youth.

LGBTQ+ youth in detention and correctional facilities, like all youth, have a right to receive adequate physical and mental health care, including a right to health care that may be of special need to LGBTQ+ youth. For example, even under the more restrictive standard applicable to adult prisoners, courts have held that “transsexualism” constitutes a “serious medical need” and deliberately denying access to transgender-related health care for prisoners amounts to cruel and unusual punishment under the Eighth Amendment of the U.S. Constitution.

Additionally, under the First Amendment, LGBTQ+ youth, like all youth, have the right to religious freedom; to be free from religious indoctrination; not to be forced to hide their identities because of religious objections; and to choose not to participate in religious activities that condemn homosexuality or gender-nonconformity. Nor should facility staff be permitted to intimidate or coerce a young person into adopting any particular religious practices or beliefs.

A Federal District Court has found that LGBTQ+ youth in juvenile detention have the right to be protected from long-term segregation or isolation because it amounts to punishment in violation of their due process rights. The court agreed with an expert that it is “[t]he likely perception by teenagers that isolation if imposed as punishment for being LGBT only compounds the harm.” Though such practices could be excused if they were “an incident of a legitimate non-punitive governmental objective,” the
court held that the practice was, at best, excessive and therefore unconstitutional. The court also held that youth have a due process right to minimally adequate policy, training, staffing, supervision, grievance procedures and a classification system under the Due Process Clause of the Fourteenth Amendment. The court held that the “relentless campaign” of harassment by other youth and staff, of which the juvenile justice detention center supervisors were aware, and the accompanying “failure to take any minimally adequate remedial measures constitute[d] deliberate indifference.” Of note, the court relied on “the totality of the circumstances at [the facility]” in its holding, but specifically noted the failure of the facility to maintain: “(1) policies and training necessary to protect LGBT youth; (2) adequate staffing and supervision; (3) a functioning grievance system; and (4) a classification system to protect vulnerable youth.” Because it found that the plaintiffs were entitled to injunctive relief under their due process claims, the court did not address the Equal Protection claims.

Discrimination and mistreatment against LGBTQ+ youth placed in juvenile justice custody may violate some or all of these rights.

B. STATUTORY AND REGULATORY LAW

Juvenile Justice and Delinquency Prevention Act. The Juvenile Justice and Delinquency Prevention Act (JJDPA)88 established the Office of Juvenile Justice and Delinquency Prevention (OJJDP)89 and established funding for state juvenile justice systems via block and discretionary grants (administered by OJJDP) and other provisions to support local and state efforts to prevent delinquency and improve the juvenile justice system. JJDPA's nondiscrimination provision90 incorporates by reference 42 U.S.C. § 3789d(c)(1), which states: “No person in any State shall on the ground of race, color, religion, national origin, or sex be excluded from participation in, be denied the benefits of, or be subjected to discrimination under or denied employment in connection with any programs or activity funded in whole or in part with funds made available under this chapter.” The JJMDPA should be interpreted in accordance with other federal court decisions finding that sex-based discrimination includes discrimination on account of gender identity and sex stereotyping.

Omnibus Crime Control and Safe Streets Act. The Omnibus Crime Control and Safe Streets Act of 1968 prohibits sex discrimination by federal grant recipients, including police and sheriff departments, prosecutors, courts, juvenile justice facilities and victim assistance programs. As addressed above, since a majority of courts have held discrimination based on transgender or gender-nonconforming identity to be sex discrimination, this prohibition should be interpreted to include discrimination on account of gender identity or sex stereotyping.

Prison Rape Elimination Act. The Prison Rape Elimination Act of 2003 (PREA)94 was passed to address the high rates of sexual victimization and sexual harassment of inmates. It applies to both adult and juvenile facilities. LGBTQ+ people are highlighted as being particularly at risk and entitled to specific protections. In juvenile facilities, PREA standards require:

- an inquiry to ascertain any gender-nonconforming appearance or LGBTQ or intersex (LGBTQI) identity to determine if the juvenile may be at risk of sexual abuse;
- an affirmative opportunity for youth to self-identify as LGBTQI;
- a case-by-case assessment for placement of transgender or intersex youth that seriously considers their gender identity and is not based solely on external anatomy;
- ensuring youth are not segregated or placed in particular housing or bed assignments based solely on being LGBTQI;
C. POLICY MEMORANDA AND INFORMATION

Federal Advisory Committee on Juvenile Justice Recommendations. In 2016, the Department of Justice formed an LGBTQ Subcommittee of the Federal Advisory Committee on Juvenile Justice. In January 2017, the committee adopted the subcommittee recommendations that OJJDP work with state juvenile justice programs to help them establish SOGIE-inclusive nondiscrimination protections, implement training and encourage data collection, among other items.104

Office of Juvenile Justice and Delinquency Prevention LGBTQ Listening Session. In 2014, OJJDP held a listening session entitled “Creating and Sustaining Fair and Beneficial Environments for LGBTQ Youth.”105 At the listening session, experts summarized information and resources about the experiences of LGBTQ+ youth and suggested recommendations for reform. In addition, youth with system involvement discussed their experiences and met with the OJJDP Administrator. A summary of the presentations and recommendations for reform made by the attendees can be found in the listening session report.106

3. SYSTEMS SERVING RUNAWAY AND HOMELESS

A. CONSTITUTIONAL LAW

As described above, under the Constitution, LGBTQ+ youth experiencing homelessness have Equal Protection rights to be treated in the same way as their non-LGBTQ+ peers, First Amendment rights to freedom of speech and expression and the right to be free from religious indoctrination under the Establishment Clause.107

B. STATUTORY AND REGULATORY LAW

The Runaway and Homeless Youth Act. The Runaway and Homeless Youth Act108 authorizes community-based runaway and homeless youth projects to provide temporary shelter and care to runaway or otherwise homeless youth in need of temporary shelter, counseling and aftercare services. The Act, as amended and reauthorized by the Reconnecting Homeless Youth Act of 2008, states that services should be provided “using a positive youth development approach” and should ensure young people have a sense of “safety and structure, belonging and membership, self-worth and social contribution, independence and control over their life, as well as closeness in interpersonal relationships.”109 In 2016, pursuant to the Runaway and Homeless Youth Act, HHS promulgated the Runaway and Homeless Youth Rule, which explicitly prohibits discrimination on account of sexual orientation and gender identity by runaway and homeless youth programs receiving federal funds.110 In addition, the rule requires that providers collect SOGIE demographic information and receive training.111

Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity. The Department of Housing and Urban Development (HUD) Equal Access Rule ensures that its core programs, including runaway and homeless youth shelters, are open to all eligible individuals and families regardless of sexual orientation, gender identity or marital status.112 The rule prohibits discrimination on account of sexual orientation or gender identity in all programs receiving federal assistance through HUD, including all providers who operate shelters for runaway and homeless youth across the country.113

Equal Access in Accordance With an Individual’s Gender Identity in Community Planning and Development Programs. Subsequent to the Equal Access Rule referenced above, HUD issued the Gender Identity Rule to clarify that gender identity should be affirmed in all programs, including housing.114 The Gender Identity Rule also applies to all programs receiving federal financial assistance from HUD.

C. INFORMATION

Information and resources regarding affirming programs and services for LGBTQ+ youth experiencing homelessness may be found on ACF’s and HUD’s websites.115 HUD funded two pilot initiatives to address homelessness among LGBTQ+ youth in Houston (Harris County) and Cincinnati (Hamilton County).116
**Federal Law and Policy Reform Recommendations**

**CHILD WELFARE**
- HHS should issue a nondiscrimination regulation, pursuant to federal child welfare law, clarifying that youth may not be discriminated against on account of SOGIE in federally funded child welfare programs.
- HHS should issue policy guidance interpreting existing federal law as requiring Title IV-E and IV-B agencies to implement SOGIE-inclusive nondiscrimination policies that ensure LGBTQ+ youth are physically and emotionally safe while in care; have equitable access to services and opportunities; and achieve safety, permanency and well-being outcomes. The guidance should also prohibit “conversion” therapy and any similar attempts to change, condemn, suppress or pathologize LGBTQ+ identity.

**JUVENILE JUSTICE**
- Congress should include SOGIE as protected classes in a reauthorization of the JJDPA.
- OJJDP should fully implement the LGBTQ+ recommendations adopted by the Federal Advisory Committee on Juvenile Justice.

**RUNAWAY AND HOMELESS YOUTH**
- Congress should include SOGIE as protected classes in the reauthorization of the Runaway and Homeless Youth and Trafficking Prevention Act.

A wealth of experts have published recommended practices to promote the safety and well-being of LGBTQ+ youth in out-of-home care systems. The authors recommend consulting these professional standards, many of which may be found in Appendix B, for more information. In addition, experts from a wide variety of disciplines have unanimously endorsed explicit protection from discrimination inclusive of SOGIE.

**B. STATE LAW AND POLICY**

Child welfare, juvenile justice and runaway and homeless youth systems of care are administered through a complicated array of state, county and municipal government agencies and their contractors. In addition to the federal protections outlined above, explicit protection from SOGIE-based discrimination may be found in some state statutes and regulations as well as in agency policies specific to these three systems.

State and local public accommodation and human rights laws and ordinances offer additional protections, to the extent that they apply to out-of-home care systems.

This section offers a snapshot of SOGIE nondiscrimination protections found in statutes, regulations and policies specific to out-of-home care systems, in addition to a map of the United States with links to the sources of protection in each state’s child welfare and juvenile justice systems. Due to the scarcity of explicit state-based protections specific to systems serving runaway and homeless youth, a map is not available, but this section does offer a narrative description.

Explicit SOGIE nondiscrimination protections in state law and policy provide youth and professionals with a clear set of expectations and enable systems to conduct training in order to broaden awareness of these obligations. Explicit state-based SOGIE nondiscrimination provisions are essential to the fair and equitable treatment of TGNC youth.

Despite the fundamental importance of these protections, 22 states fail to include both sexual orientation and gender identity in law and policy protections specific to child welfare. In the juvenile justice system, 29 states fail to include both sexual orientation and gender identity as protected classes in law or policy. Only three states have state-based regulatory protections explicitly for runaway and homeless youth systems that are inclusive of sexual orientation and gender identity.
California, New Jersey and New York rank highest among the states in terms of legal protections for TGNC youth, as they provide explicit SOGIE-inclusive protection from discrimination in statute or regulation and additional legal and policy guidance. New Jersey and New York have statewide LGBTQ+-specific policies, and California, as discussed below, requires transgender youth in out-of-home care to be placed in accordance with their gender identity.\(^{123}\) California law also requires providers to receive LGBTQ+ youth-focused training, an essential component of ensuring that protections are implemented. Nevada also ranks highly. In statute, it has sexual orientation and gender identity protections, requires training for system professionals on working with LGBTQ+ youth and mandates that transgender youth be treated in all respects, including placement, in accordance with their gender identity.\(^{124}\) In addition to New Jersey and New York, Connecticut, Illinois, Maryland, Massachusetts, Minnesota, Tennessee and Utah have LGBTQ+-specific agency policy.

The lowest-ranking states—offering no express protection from discrimination on account of sexual orientation, gender identity or sex (or gender) in child welfare-specific law and policy—are Alabama, Alaska, Arizona, Georgia, Kansas, Kentucky, Nebraska, North Carolina and Virginia. Virginia law permits government-funded providers to refuse service to youth if doing so conflicts with “sincerely held religious beliefs.”\(^{125}\)

The following summarizes protections from discrimination, to the extent that they exist, along with their sources:

### Sexual Orientation and Gender Identity as Protected Classes

#### Statute or Regulation

Ten states and the District of Columbia explicitly include sexual orientation and gender identity in statutes or regulations specific to their child welfare systems: California, Florida, Mississippi, Nevada, New Mexico, New Jersey, New York, Ohio (uses sexual identity versus gender identity), Rhode Island and Washington. Florida’s protections cover youth placed in congregate care facilities and are not system-wide.

#### Agency Policy

Additionally, 16 states contain explicit sexual orientation and gender identity protections in agency policy (either Department of Health/ Human or Social Services or the child welfare agency itself): Connecticut (child welfare), Hawai`i (DHS), Idaho (child welfare), Illinois (child welfare), Indiana (child welfare), Iowa (DHS), Maine (child welfare), Maryland (child welfare), Massachusetts (child welfare), Michigan (DHHS),\(^{126}\) Minnesota (child welfare), Oregon (DHS), South Dakota (DSS),\(^{127}\) Tennessee (child welfare), Utah (child welfare) and Vermont (AHS).

#### LGBTQ+-Specific State-Wide Policy

Nine states not only include sexual orientation, gender identity and gender expression in their nondiscrimination protections but also have detailed LGBTQ+-specific policies: Connecticut, Illinois, Maryland, Massachusetts, Minnesota, New Jersey, New York, Tennessee and Utah. California has issued a statewide policy transmittal to county child welfare agencies summarizing their obligations under state nondiscrimination law but does not go into further detail.\(^{128}\)

### Sex and Sexual Orientation as Protected Classes

As noted above, courts have held that discrimination based on sex, a protected class in some federal laws, includes both sex stereotyping and gender identity-based discrimination.\(^{129}\) To the extent the term sex (or gender) appears in state or local anti-discrimination measures, it should be uniformly interpreted.

#### Statute or Regulation

Twelve states include either sex (or gender) and sexual orientation, but not gender identity, as protected classes in nondiscrimination protections in child welfare-specific statute or regulation: Colorado, Delaware, Louisiana, Massachusetts, Minnesota, New Hampshire, North Dakota,\(^{130}\) Pennsylvania, Utah, West Virginia, Wisconsin and Wyoming. Of these states, Colorado, Massachusetts, Minnesota and Utah include gender identity (and some gender expression) in agency policy.

### Sex as a Protected Class

#### Statute or Regulation

Four states include sex (or gender) as a protected class in statute or regulation but do not explicitly include sexual orientation or gender identity: Arkansas, Maine, Oklahoma and South Carolina.
Neither Sexual Orientation, Gender Identity nor Sex as Protected Classes

Ten states have no explicit protection against discrimination on account of sexual orientation, gender identity or sex (or gender) in child welfare-specific statute, regulation or policy: Alabama, Alaska, Arizona, Georgia, Kansas, Kentucky, Nebraska, North Carolina, Texas and Virginia. Virginia has a so-called conscience clause law, which allows providers receiving government funds to refuse to serve persons if doing so conflicts with their “sincerely held religious beliefs.”

Recommended Regulatory Language

Examples of recommended regulatory language may be found in New Mexico’s regulations governing child-placing agencies and Rhode Island regulations governing residential child care:

**New Mexico Child-Placing Agencies:**

Discrimination: Agencies who receive state or federal monies, shall not discriminate against applicants, clients, or employees based on race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity.

**Rhode Island Residential Child Care:**

The Department of Children, Youth, and Families does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap. The prohibition against discriminatory practices extends to the agencies, organizations and institutions the Department licenses.

Recommended TGNC-Affirming Policies

Explicit SOGIE-inclusive nondiscrimination laws are an essential starting point for ensuring safety and well-being for TGNC youth. More detailed policy and training on policy obligations are needed to ensure that youth and system professionals are clear on exactly what it means not to discriminate on account of sexual orientation, gender identity or gender expression. As referenced above, nine states have developed more detailed LGBTQ+-policies and include more specific requirements for working with TGNC youth. A few of the recommended examples below include specifics such as referring to transgender youth by the name and pronouns they use and ensuring that they are allowed to express their gender freely and are provided trans-affirming health and behavioral health care, among other necessities.

The following are examples of recommended policies that provide specific practice obligations to meet the needs of TGNC youth in child welfare systems:

- Maryland Department of Human Resources, Social Services Administration’s Working with Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and Families (2016).
- Minnesota Department of Human Services’ Working with lesbian, gay, bisexual, transgender and questioning/queer youth (2013).
- The most thorough set of guidelines regarding affirming practice for TGNC youth is provided by New York City’s Administration for Children’s Services in their Safe and Respected: Policy, Best Practices, and Guidance for Serving Transgender and Gender Non-Conforming Children and Youth in the Child Welfare, Detention and Juvenile Justice Systems (2014).
The District of Columbia, Louisiana and New York rank highest among state juvenile justice systems by providing not only SOGIE-inclusive non-discrimination protections, but LGBTQ+-specific policy as well. California offers statutory protection but has a county-based system and therefore no statewide LGBTQ+-specific policy. Rhode Island and Texas also provide SOGIE-inclusive regulatory protections. Colorado, Connecticut, Illinois, Massachusetts, New Jersey, Ohio and Tennessee rank high because they, like D.C., New York and Louisiana, have LGBTQ+-specific statewide policies.

The following summarizes express protections from discrimination, to the extent that they exist, along with their sources:

**Sexual Orientation and Gender Identity as Protected Classes**

- **Statute or Regulation**

  Five states and the District of Columbia explicitly include sexual orientation and gender identity in statute or regulation specific to their juvenile justice systems: California, Louisiana, New York, Rhode Island and Texas. Texas’s regulations contain sexual orientation and gender identity as protected classes for youth in the custody of the Texas Juvenile Justice

The lowest-ranking states—offering no protection from discrimination on account of sexual orientation, gender identity or sex (or gender) in juvenile justice-specific law and policy—are Alaska, Maine, Mississippi, Nevada, North Carolina, North Dakota, Oklahoma, South Dakota, Utah and Wisconsin.
Department and for youth placed in non-secure facilities, but not for short-term detention. The District of Columbia’s statutory protections are provided in the District of Columbia’s Human Rights Law, which covers all government agencies.

● **Agency Policy**
  Additionally, 16 states contain explicit sexual orientation and gender identity protections in agency policy (either through a Department of Health/Human Rights or Social Services139 or through a juvenile justice agency or state detention/facility policy): Arizona, Colorado, Connecticut, Georgia, Hawai‘i, Illinois, Iowa (Department of Human Services policy), Kentucky, Massachusetts, Michigan, New Jersey, Ohio, Oregon, Tennessee, Vermont (Administration for Human Services policy) and Washington (Department of Social and Health Services policy). Hawai‘i’s policy is specific to the state’s one detention facility.

● **LGBTQ+-Specific Policy**
  Nine states and D.C. have LGBTQ+-specific policies: Colorado, Connecticut, Illinois, Louisiana, Massachusetts, New Jersey, New York, Ohio and Tennessee. Additionally, the following localities have LGBTQ+-specific policies in part or all of their juvenile justice systems: San Francisco Juvenile Probation Department, Santa Clara County Probation Department, Cook County Juvenile Temporary Detention Center, New Orleans Juvenile Detention Center, New York City Administration for Children’s Services, New York City Probation Department (Adult and Juvenile) and the Philadelphia Juvenile Justice Center.

**Sex and Sexual Orientation as Protected Classes**

● **Statute or Regulation**
  Nine states include either sex (or gender) and sexual orientation, but not gender identity expressly, as protected classes in nondiscrimination protections in juvenile justice-specific statute or regulation: Arizona, Colorado, Florida, Maryland, Minnesota, Montana, New Mexico (transition services only), Pennsylvania (non-secure residential treatment facilities only) and Rhode Island.

● **Agency Policy**
  Five states include either sex (or gender) and sexual orientation, but not gender identity expressly, as protected classes in juvenile justice or detention/facility policy: Delaware, Indiana, Kansas, Missouri (Department of Social Services) and New Hampshire (Department of Health and Human Services).

**Sex as a Protected Class:**

● **Statute or Regulation**
  Seven states include sex (or gender) as a protected class in juvenile justice-specific statute or regulation, but do not include sexual orientation or gender identity: Alabama, Arkansas, Idaho, Kentucky, Nebraska, New Mexico (all services) and Texas (short-term detention).

● **Agency Policy**
  One state, South Carolina, has sex as a protected class in agency policy.

**Neither Sexual Orientation, Gender Identity nor Sex as Protected Classes**

Eleven states have no explicit protections against discrimination on account of sexual orientation, gender identity or sex (or gender) in juvenile justice statute, regulation or agency policy: Alaska, Maine, Mississippi, Nevada, North Carolina, North Dakota, Oklahoma, South Dakota, Utah and Wisconsin.

**Recommended Regulatory Language**

New York provides an example of recommended regulatory language inclusive of sexual orientation, gender identity and gender expression. Notably, it extends protections to preventative services in addition to protecting youth in detention facilities:

> Administration and operation of detention. Staff and volunteers of detention providers shall not engage in discrimination or harassment of families receiving preventative services on the basis of race, creed, color, national origin, age, sex, religion, sexual orientation, gender identity or expression, marital status, or disability. Detention providers shall promote and maintain a safe environment, take reasonable steps to prevent such discrimination or harassment by staff and volunteers, promptly investigate incidents of discrimination and harassment, and take reasonable and appropriate corrective or disciplinary action when such incidents occur.140

California’s regulation directs each county to develop a nondiscrimination policy:

> All facility administrators shall develop, publish, and implement a manual of written policies and procedures that address, at a minimum, all regulations that are applicable to the facility . . . The manual
shall include . . . (h) a non-discrimination provision that provides that all youth within the facility shall have fair and equal access to all available services, placement, care, treatment, and benefits, and provides that no person shall be subject to discrimination or harassment on the basis of actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, gender, sexual orientation, gender identity, gender expression, mental or physical disability, or HIV status, including restrictive housing or classification decisions based solely on any of the above mentioned categories.[141]

**Recommended TGNC-Affirming Policies**

- Massachusetts Department of Youth Services, Policy 03.04.09, *Prohibition of Harassment and Discrimination Against Youth,*[142] is a recommended example of a juvenile justice policy that affirms and supports TGNC (and LGBQ+) youth. Massachusetts’ policy provides comprehensive SOGIE protection, including protection against those perceived to be LGBTQ+ and gender-nonconforming youth, and provides that transgender youth shall be housed consistently with their identity (after consultation with the youth and decision by a team of administrators), referred to by name and pronouns they use and provided with clothing consistent with their identity and expression. Additionally, the policy provides that youth shall have access to qualified medical providers and be provided with recommended care, including hormone therapy.[143]

- Colorado’s Department of Human Services, Division of Juvenile Corrections, *Non-Discriminatory Services to Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) Juvenile,*[144] is also a good example of both providing comprehensive policy protection against discrimination, harassment, violence and disparate treatment and specifically requiring affirmation of youth’s gender identity and expression. It includes sexual orientation, gender identity and gender expression as protected classes, also covers those merely perceived to be LGBTQI and forbids any attempt to change a youth’s identity or expression. In addition, it provides specific guidance regarding housing classifications and clothing provisions based on a youth’s identity and requires that health care be provided by qualified professionals. The policy also dictates that a youth is allowed to choose the sex of a staff member who searches them.[145]

Both of these policies provided an example of how PREA requirements can be incorporated in agency policy.
State-based statutes and regulations and agency policy also offer protection against SOGIE-based discrimination for youth experiencing homelessness and living in government-funded care. These sources may be the same regulations that govern licensing of other types of congregate care facilities, including congregate care facilities that serve youth in child welfare or juvenile justice systems. To the extent these providers and programs receive funding or are otherwise administered through their state’s Department of Health and Human Services or Social Services, they may be covered by nondiscrimination protections in state agency policy. Only California, the District of Columbia and New York have SOGIE-inclusive protection from discrimination in statute or regulation for youth served by runaway and homeless youth programs and shelters.

The following summarizes protections from discrimination, to the extent they exist, and their sources:

**Sexual Orientation and Gender Identity as Protected Classes**

- **Statute or Regulation**
  California, D.C. and New York contain SOGIE-inclusive protection from discrimination
in placements serving youth experiencing homelessness. Regulations in the District of Columbia and New York are specific to programs serving runaway and homeless youth.

**Sex and Sexual Orientation as Protected Classes**

- **Statute or Regulation**
  Six states prohibit discrimination based on sexual orientation and either sex, gender or both sex and gender in regulation: Colorado, Delaware, Louisiana, Massachusetts, Minnesota and Pennsylvania (residential care facilities serving youth experiencing homelessness).

**Sex as a Protected Class**

- **Statute or Regulation**
  Two states, Maine and New Mexico, prohibit discrimination based on sex (or gender) in regulation.

**Neither Sexual Orientation, Gender Identity nor Sex as Protected Classes**

The remaining 48 states provide no explicit protections specific to programs and facilities serving youth experiencing homelessness in statute, regulation or policy.

**Recommended Regulatory Language:**

The District of Columbia provides a good example of regulatory language in the context of programs for runaway and homeless youth: Youth Shelters, Runaway Shelters, Emergency Care Facilities and Youth Group Homes. 6203.1 A resident in a facility not intended exclusively for children who have been abused or neglected has the following rights: (h) In accordance with the District of Columbia Human Rights Act of 1977, as amended, effective December 13, 1977 (D.C. Law 2-38, D.C. Official Code §§ 1-2501 et seq.) not to be discriminated against on the basis of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, familial status, family responsibilities, matriculation, political affiliation, disability, source of income or place of residence or business.148

**State-Based Nondiscrimination Law and Policy Reform Recommendations**

- States should enact laws or promulgate regulations that explicitly prohibit discrimination based on sexual orientation, gender identity and gender expression in out-of-home care systems, including an explicit prohibition against “conversion therapy” and any similar attempt to change, suppress, condemn or pathologize LGBTQ+ youth.
- State and local government agencies and contract providers should include SOGIE-inclusive nondiscrimination protections in their policies, including an explicit prohibition against “conversion therapy” and any similar attempt to change, suppress, condemn or pathologize LGBTQ+ youth.
- State and local government agencies should develop mandatory practice guidelines with detailed expectations for meeting the needs of LGBTQ+ youth generally and TGNC youth specifically.

Additional resources, including publications offering guidance regarding out-of-home care policy development, may be found in Appendix B.

**C. STATE-BASED LICENSING, TRAINING AND OTHER REQUIREMENTS**

State-administered systems of care for youth rely on a variety of regulations to guide everything from living arrangements to clothing provided and training for staff. Through licensing regulations, states have significant opportunities to better support TGNC youth. States can develop inclusive organizational structures that promote the well-being of TGNC youth through regulations that require affirming placement and classification procedures, promote healthy gender identity development and expression, mandate affirming gender-responsive programming and activities while in care and require clear and ongoing training and competency requirements for staff.

The following research149 presents a survey of 50 states and D.C. on current licensing regulations for state child welfare, juvenile justice51 and runaway and homeless systems as they relate to sex (or gender), gender identity and gender expression.152 All regulations referenced here may be found in the full report included as Appendix A. This research is divided into several categories:

1. Definitions of sex (or gender)
2. Admission procedures and facility licensing
3. Sleeping arrangements
4. Clothing
5. Supervision
6. Body searches
7. Training requirements
1. Definitions of sex (or gender)

Professional standards rightly describe gender identity as the defining component of sex, rather than sex simply being based on anatomy or the sex assigned or presumed at birth. To be consistent with professional standards, states should define sex (or gender) in a way that explicitly acknowledges that sex is determined by gender identity. The vast majority of jurisdictions provide no clear definition of sex (or gender), leaving these terms open to interpretation. States should enact statutes or promulgate regulations and issue agency policy clarifying that sex (or gender) is determined by gender identity, based on an accurate understanding of gender identity’s central role.

The definition of sex has a profound impact on systems of out-of-home care. Throughout licensing regulations, states use the terms sex (or gender) when prescribing admissions procedures and in facility licensing, placement determinations, sleeping arrangements, bathroom requirements, clothing distribution, training, supervision and body searches.

While some states may define these terms through agency policy, only three—California, New York and Florida—provide explicit definitions of these terms in statute or regulation that accurately describe gender identity as a defining component of sex (or gender). Of these three states, only Florida explicitly defines gender in the context of out-of-home care licensing regulations. In the absence of explicit definitions in statute, regulation or agency policy, front line workers and administrators are left to interpret the meaning of sex (or gender) on their own. Workers in different systems, such as the child welfare and the juvenile justice system, or in different counties or jurisdictions within the same state, may disagree on the proper interpretation. This may result in discriminatory treatment, specifically a failure to respect a youth’s gender identity and inconsistent treatment and services. In a worst-case scenario, this can mean a youth is housed improperly, refused affirming health care or denied clothing consistent with who they are. These practices are contrary to the child’s safety and well-being and can have long-term detrimental effects on a young person.

Tennessee is the only state that defines sex in a way that explicitly contradicts professional standards and binds sex to an assignment at birth. Tennessee statute says sex is “the designation of an individual person as male or female as indicated on the individual’s birth certificate,” ignoring gender identity entirely. This is problematic in many ways but specifically because it inaccurately assumes that gender is binary and that a person can only be designated as male or female, excluding people who identify elsewhere along the spectrum, including intersex people. Illinois’s definition of sex also contradicts professional standards and fails to affirm TGNC people by excluding non-binary individuals from its definition of sex as the “status of being male or female.”

As an example of the conundrum created for professionals when states do not explicitly define sex (or gender) in statute or regulation, a child welfare administrator may choose to place a transgender girl in an all-female congregate care facility if the administrator correctly interprets “gender-specific” facilities or services to mean facilities or services that correspond to a person’s gender identity, regardless of the youth’s sex assigned at birth. However, if that same young person enters care in a different county or becomes involved in the juvenile justice system, a different administrator may interpret “gender-specific” to mean the provision of facilities and services in accordance with a person’s sex assigned at birth and place that youth in a facility for all males. Placements and provision of services that are inconsistent with a youth’s gender identity can be particularly harmful for that youth, as they can contribute to gender dysphoria, exacerbate other mental health conditions and further complicate an already difficult period of adolescent development.

States should provide clear and concise definitions of sex similar to New York’s definition, found in
how a person identifies. The terms “male,” “female,” or “nonbinary” describe gender that is listed on the person’s birth certificate. Gender identity may or may not correspond to the internal identification or self-image as male or female.

sex facility licensing and admissions procedures, the terms group home or a girl’s shelter). Throughout state young people of a specific sex (or gender) (e.g., a boys’ runaway or homeless youth may be licensed to serve homes, juvenile detention settings and shelters for including congregate care facilities, individual foster homes, juvenile detention facilities’ admissions regulations: (2) “Gender” or “gender identity” means a person’s internal identification or self-image as male or female. Gender identity may or may not correspond to the gender that is listed on the person’s birth certificate. The terms “male,” “female,” or “nonbinary” describe how a person identifies.

California, Colorado, Florida, Hawai’i, Nevada, New Jersey, New York and Tennessee define the terms sexual orientation, gender identity and/or gender expression in statute or regulation. The authors recommend that states define these terms in statute or regulation and agency policy to provide clarity for professionals working with youth in out-of-home care. Defining these terms, however, does not eliminate ambiguity regarding licensing regulations that contain the term sex or gender.

2. Admission procedures and facility licensing
As discussed above, out-of-home care facilities, including congregate care facilities, individual foster homes, juvenile detention settings and shelters for runaway or homeless youth may be licensed to serve young people of a specific sex (or gender) (e.g., a boys’ group home or a girl’s shelter). Throughout state facility licensing and admissions procedures, the terms sex and gender are used interchangeably and, except for as noted above in California and New York statute and Florida regulation, are not defined to include gender identity and expression.

In order to best serve these youth, facilities should also have specific admissions and placement procedures for youth who identify as LGBQ or TGNC, specifying that their placement in a particular facility should be determined in consultation with the youth. Unfortunately, only four states have such procedures in licensing regulations or statute—California’s child welfare placement procedures of transgender youth are specified in statute and Florida regulation provides a protocol for placing transgender youth in accordance with identity. Nevada requires, in statute, that each child who is placed in child welfare and juvenile justice settings be treated in all respects in accordance with their gender identity or expression. The law requires Nevada Department of Children and Family Services (DCFS) to establish factors via regulation for the court to follow to ensure transgender youth are placed appropriately. Significantly, DCFS, in adopting the regulation, must consult with LGBTQ children who are current or former residents of “foster homes, facilities for the detention of children, child care facilities and mental health facilities” and representatives of LGBTQ persons. Florida, Louisiana and Texas have licensing regulations governing the placement of LGBTQ+ youth in juvenile justice systems.

California’s straightforward approach is a recommended example in the child welfare context:

Placement Consistent with Gender Identity. Youth who are placed in settings licensed by Community Care Licensing (foster homes or group homes) are entitled to be placed according to their gender identity, regardless of the gender listed in their court records.

In licensing regulation, Florida provides a protocol for placement of transgender youth that requires consideration of the youth’s safety and well-being, consultation with the youth and recommendations from professionals working with the youth:

(f) For transgender youth, a determination whether the youth should be placed with their gender listed on their birth certificate or their identified gender. Factors to be considered shall include:

1. The physical safety of the transgender youth,
2. The emotional well-being of the transgender youth,
3. The youth’s preference,
4. The recommendation of the youth’s guardian ad litem,
5. The recommendation of the youth’s parent, when parental rights have not been terminated,
6. The recommendation of the youth’s case manager; and,
7. The recommendation of the youth’s therapist, if applicable.

Examples of regulatory language in the juvenile justice context may be found in Louisiana’s juvenile detention facilities’ admissions regulations:

Decisions for housing or programming of youth who are or are perceived to be gay, lesbian, bisexual, or transgender youth on the basis of their actual or perceived sexual orientation shall be made on an individual basis in consultation with the youth and the reason(s) for the particular treatment shall be documented in the youth’s file. The administrator or designee shall review each decision.
In the context of its regulation governing public accommodations, Colorado prohibits discrimination in housing on account of gender identity. Its provisions should be interpreted to cover settings such as group homes or shelters and provide clear direction regarding housing expectations:

(A) Nothing in the Act prohibits segregation of facilities on the basis of gender.

(B) All covered entities shall allow individuals the use of gender-segregated facilities that are consistent with their gender identity. Gender-segregated facilities include, but are not limited to, restrooms, locker rooms, dressing rooms, and dormitories.

(C) In gender-segregated facilities where undressing in the presence of others occurs, covered entities shall make reasonable accommodations to allow access consistent with an individual’s gender identity.169

Overall, only ten states do not mention sex (or gender) in their regulations governing facility licensing and admissions procedures in child welfare, juvenile justice or runaway and homeless systems.

In child welfare admissions procedures and facility licensing, 14 states make no mention of sex (or gender). Thirty-six states and D.C. license child welfare facilities or foster family homes to serve children and youth by sex (or gender) in licensing regulations. As noted above, California, via state statute but not regulation, requires transgender youth in foster care to be placed in accord with their gender identity.170

In juvenile justice licensing regulations, 14 states mention sex (or gender) in their facility licensing and admissions procedures. Of those, nine states license juvenile justice facilities to serve children and youth by sex (or gender), and two states license facilities designated as male or female. Three states—Florida, Louisiana and Texas—have specific juvenile justice placement and admission procedures related to youth who identify as LGBTQ+. Louisiana and Texas require these placement decisions to be made on a case-by-case basis and in consultation with the youth.

In admissions procedures and facility licensing for facilities serving runaway and homeless youth, 20 states license those facilities to serve children and youth by sex (or gender). Thirty states make no mention of sex (or gender) in admission procedures or facility licensing for systems serving runaway and homeless youth.

The importance of ensuring that TGNC youth are placed in facilities in accordance with their gender identity should not be underestimated. In the absence of comprehensive definitions of sex (or gender) that are inclusive of gender identity, states should adopt regulations governing facility licensing and admissions procedures that require placement based on gender identity and require that such decisions be made in ongoing consultation with TGNC youth. Licensing regulations should specify that initial placement determinations are not permanent and that staff should continue to check in with TGNC youth to ensure that they feel safe and affirmed in their current placements.

3. Sleeping Arrangements
In addition to individualized considerations for their placement in a gender-specific facility, best practice literature makes it clear that children should be placed in bedrooms, or other sleeping quarters, according to their gender identity and in consultation with their wishes.171 However, in child welfare licensing regulations, only one state (California) specifically places children in bedrooms in accordance with their gender identity. Thirty-nine states place youth in bedrooms according to their sex (or gender); three use boy/girl or male/female in their placement language; and eight use male/female, boy/girl and gender/sex interchangeably.

In juvenile justice licensing regulations, two states, Florida and Texas, use individualized classification procedures to place children and youth in bedrooms that take into account the youth’s preference. Eight states place youth in bedrooms according to their sex (or gender); nine use boy/girl or male/female in their placement language; and seven use male/female, boy/girl and gender/sex interchangeably.

In states where explicit language was found for bedroom placement procedures in facilities serving runaway and homeless youth, no state specifically places children according to their gender identity. Twenty states place children and youth in bedrooms according to their sex (or gender); three use boy/girl or male/female in their placement language; and four use male/female, boy/girl and gender/sex interchangeably.

Notably, not one state specifically requires placement of children in sleeping arrangements in accordance with their gender identity in all three settings as a matter of explicit statute or regulation.

States should adopt regulatory language governing sleeping arrangements similar to California’s foster family homes:

(B) Nothing in this section shall preclude a caregiver from requesting a Documented Alternative Plan (LIC 973) permitting a “child” to be in a bedroom based on their gender identity.172
4. Clothing

Best practice literature regarding safe and equitable treatment of TGNC youth makes clear that it is essential for well-being that they be allowed to dress and groom themselves in accordance with their gender identity and expression. However, in child welfare licensing regulations, only three states (California, Florida and Ohio) require children and youth to be provided clothing in accordance with their gender identity. Twenty-three states require children to be provided clothing in accordance with their sex (or gender). New York allows for young people to select their own clothing. The remaining twenty-three states do not explicitly mention sex (or gender) in their child welfare licensing regulations for the prescription of clothing.

Ohio regulations governing both family foster care and congregate care facilities require the provision of clothing, toiletry supplies and instruction on habits of personal care and grooming in accordance with gender identity:

Residential Centers, Group Homes, Residential Parenting Facilities

(C) Clothing provided by a residential facility shall be appropriate to the child’s age and gender identity.

(D) A residential facility shall provide each child with adequate personal toiletry supplies. These supplies shall be appropriate to the child’s age, gender identity, race, and cultural background and shall be considered to be the child’s personal property.

(E) A residential facility shall provide instruction on good habits of personal care, hygiene, and grooming. This instruction shall be appropriate to each child’s age, gender identity, race, cultural background, and need for training.

In juvenile justice regulations, one state, Tennessee, requires children and youth in juvenile justice settings to be provided with gender-neutral clothing. Three states, California, Florida and Texas, use male/female language in their requirements and seven states (Colorado, Michigan, Maine, New Jersey, Oregon, Pennsylvania and Wyoming) require children and youth to be provided clothing in accordance with their sex (or gender). New York allows for young people to select their own clothing. The remaining 39 states do not explicitly mention sex (or gender) in their juvenile justice licensing regulations for clothing.

In licensing provisions for systems serving runaway and homeless youth, only 16 states and D.C. explicitly mention sex (or gender) in their regulations on provision of clothing (Arkansas, Colorado, Connecticut, Delaware, D.C., Hawai‘i, Idaho, Indiana, Maryland, Massachusetts, Maine, Michigan, Mississippi, New Jersey, Pennsylvania, Rhode Island and West Virginia). One state, Ohio, requires children and youth to be provided with clothing in accordance with their gender identity. As mentioned above, New York allows for young people to select their own clothing.
In conclusion, no state consistently provides that youth should be allowed to dress in accordance with their gender identity or expression across all three systems, with the exception of New York, which allows young people to select their own clothing unless the facility in which they are placed provides a uniform. Even New York’s regulation fails to require that a youth’s uniform align with their gender identity or expression. In addition, 19 states have no mention of sex or gender in any of their licensing regulations. Thus, no state is fully explicitly protecting TGNC youth with respect to their critical need to wear clothing consistent with their gender identity in the context of statute or regulation. States with LGBTQ+-specific policies may clarify expectations regarding clothing and expression in those policies.

5. Supervision
Many states also use the term sex (or gender) in regulations guiding supervision of youth in general or during showering, using the bathroom or attending to personal hygiene. Twenty-one states in the juvenile justice system, seven states in the child welfare system and five states in systems serving runaway and homeless youth use either term. As with other aspects of programming discussed in this section, lack of clarity regarding the definition of sex (or gender) creates ambiguity and potential harm for TGNC youth. For safe and equitable treatment of TGNC youth, states should adopt definitions of sex and gender as the same concept and determined by gender identity. By doing so, professionals can understand supervision requirements in a manner that affirms youth’s identity and youth may find instructions easier to follow.

6. Body searches
Best practices for ensuring safe and equitable treatment of TGNC youth require that systems that use pat-down searches prohibit cross-gender body pat-downs. Under PREA, such searches are prohibited absent exigent circumstances. However, as mentioned above, ambiguity regarding the definition of sex or gender leads to confusion in this area as well. The PREA Resource Center recommends that in order to remain in compliance with PREA standards, searches of transgender detainees should be conducted by medical professionals, or else transgender youth should be allowed to state a preference of the sex of the staff who conducts a search.

Most states that explicitly mention sex (or gender) in their licensing regulations governing body searches only authorize the use of pat-down or body searches when agency staff have determined a search is necessary to discourage the introduction of contraband. In licensing regulations for child welfare systems and facilities serving runaway and homeless youth, four states (Arizona, Idaho, Montana and Virginia) prohibit cross-gender pat-down or body searches. Three states (Arkansas, Minnesota and New York) prohibit strip searches from being conducted by staff members of a different sex as the youth being searched in their child welfare licensing regulations. One state, Illinois, authorizes the use of body inspections or strip searches in its child welfare licensing regulations only when the agency has decided such a search is necessary to determine if a child or youth is engaging in self-mutilation or self-destructive behavior that may be hidden by their clothing. Illinois requires that such searches be conducted by staff who are the same sex as the youth being searched. One state, Oregon, prohibits cross-gender pat-down searches in its regulations licensing systems serving runaway and homeless youth.

In juvenile justice settings, 13 states (Arizona, California, Idaho, Iowa, Louisiana, Montana, Nebraska, New Jersey, New Mexico, Ohio, Pennsylvania, Tennessee and Texas) prohibit cross-gender body and pat-down searches. Eighteen states prohibit cross-gender strip or body cavity searches. Notably, Idaho’s regulations specifically prohibit the searching of transgender or intersex youths for the purposes of ascertaining their “genital status,” which complies with professional standards and PREA and offer a good example for other states to follow:
h. Prohibition on searches or physical examinations of transgender or intersex residents for the sole purpose of determining genital status. One state, Alaska, permits body searches for the purpose of ascertaining a youth’s “true identity” in its juvenile detention licensing regulations. Although the regulation does not explicitly reference searching to determine genital status, the vagueness of the regulation could allow for such searches in the absence of clear policy to the contrary. The regulation should be amended to avoid such an invasive and psychologically damaging invasion of a young person’s bodily integrity.

States should enact regulations that ensure youth are not searched merely to ascertain their genital status. In addition, states should place PREA standards into regulation and provide that transgender and intersex youth are able to select the sex or gender of the person who searches them.

7. Training requirements
Best practice literature makes clear that staff working with youth should receive initial and ongoing coaching and training regarding healthy sexual and identity development. This should include training about sexual orientation, gender identity and expression and other issues specific to LGBTQ+ youth. The vast majority of states require no training about sexual orientation, gender identity and expression, healthy sexual development or issues specific to LGBTQ+ youth for staff working in child welfare (39 states), juvenile justice (43 states) or runaway and homeless systems (49 states) in statute or regulation. Requirements may appear in policy, however, in states with LGBTQ+-specific policies protecting youth in these systems.

Six states (Massachusetts, Minnesota, New Mexico, Rhode Island, Washington and West Virginia) include training requirements in regulation related to sexual orientation and gender identity for those working with children in the child welfare system. Three states (North Carolina, Ohio and Wisconsin) require workers in child welfare settings to receive training related to human sexuality and sexual development. Nevada, in statute, requires agencies, facility staff and foster parents to receive training on working with LGBTQ+ youth. One state, California, in statute, requires staff working in child welfare systems or facilities serving runaway and homeless youth to receive training on nondiscrimination policies related to sex (or gender), sexual orientation and gender identity.

In juvenile justice settings, three states (Florida, Idaho and Rhode Island) require workers to be trained to provide gender-specific programming. Four states (Louisiana, Minnesota, Nevada and Texas) require workers to receive cultural competency training that includes sexual orientation and gender identity and expression.

Notably, no state requires initial and ongoing coaching and training regarding sexual orientation, gender identity and expression, healthy sexual development and issues specific to LGBTQ+ youth for staff across all three systems. Ensuring that these issues are part of basic competency requirements and providing ongoing support and assistance around these issues for staff working with young people is particularly important to ensure that young people receive consistent, competent treatment while in out-of-home care. States should adopt comprehensive coaching and training requirements regarding healthy sexual and identity development with a particular emphasis on issues particular to TGNC young people.

**State-Based Recommendations for Reform – Licensing, Training and Other Requirements**

- States should, via statute or regulation, expressly define sex (or gender) as inclusive of gender identity and explicitly acknowledge non-binary identity. States should also define sexual orientation, gender identity and gender expression.
- States should, via statute or regulation, require placement in accordance with gender identity after initial and ongoing consultation with the youth.
• States should eliminate sex (or gender) from regulations regarding clothing, grooming and expression in order to avoid unnecessarily stereotyping of young people and harm to TGNC youth.
• States should promulgate regulations that specify that youth are allowed to express themselves regardless of their gender identity or expression.
• States should promulgate regulations that permit transgender youth to select the gender of the person that will perform a search of their person.
• States, via statute or regulation, should require initial and ongoing training for agency staff and all contract providers in their out-of-home care systems regarding the experiences and needs of LGBTQ+ youth, with a special emphasis on TGNC youth.
• Agencies and their contractors should place the recommendations above in agency policy, even if they are not found in statute or regulation.

IV. ELIMINATING PRACTICE BARRIERS: LESSONS FROM AFFIRMING PROGRAMS AND POSITIVE EXPERIENCES OF TGNC YOUTH

Around the country, an increasing number of youth-serving agencies and providers are taking the wealth of guidance available regarding recommended practices for affirming TGNC youth and making them reality.186 TGNC youth187 who have experienced affirmation and support in programs and services have vital insights to share with professionals about how and why their positive experience made a big difference in their lives and how professionals can reform their practice to better support and affirm TGNC youth.

A. Affirmation and Support from Families, Kin and Guardians
Research by the Family Acceptance Project at San Francisco State University confirms that higher rates of family rejection are associated with poorer health outcomes for lesbian, gay and bisexual youth. Lesbian, gay and bisexual 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 use illegal drugs and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection.188 In light of this, the Family Acceptance Project, in collaboration with Child and Adolescent Services at San Francisco General Hospital/University of California, San Francisco and community providers, developed a new model of family-related care to enable families to accept and support their LGBTQ+ children and to prevent health and mental health risks, keep families together and promote well-being for LGBTQ+ children and adolescents.189

The model is of critical importance for youth in out-of-home care, since “conflict related to the adolescent’s sexual and gender identity is a primary cause of ejection or removal from the home.”190 Thus, “[e]arly intervention to help educate families about the impact of rejecting behaviors is important to help maintain these youth in their homes.”191 This new approach helps ethnically and religiously diverse families by decreasing rejection of youth and resulting risks while increasing support to help parents promote their LGBTQ+ children’s well-being. The Family
Acceptance Project provides training and consultation on family support strategies; resources; and an intervention model to providers, families and religious leaders across the United States and in other countries. The Family Acceptance Project also developed a screening tool for use by health, mental health, school-based, social service and other care providers in a wide range of settings to identify those LGBTQ+ youth who are at risk for serious health problems related to family rejection that may also lead to removal or ejection from the home.

Work to assist parents, kin and legal guardians to affirm and accept their LGBTQ+ children takes many forms across the country, ranging from informal referrals to therapists, chapters of Parents and Friends of Lesbians and Gays (PFLAG) and more formal evidence-based interventions such as Multi-Systemic Family Therapy or Functional Family Therapy that incorporate family acceptance work. Family acceptance work is significant given states’ obligation under federal law to make reasonable efforts to prevent removal and to return children home safely, absent extreme circumstances, once they have been removed.192 Featured here is a pilot project that is both a community resource and a source of formal referrals when family rejection emerges as an issue in a child welfare investigation in Wayne County (Detroit), Michigan’s child welfare system.

Overview. For 17 years, the Ruth Ellis Center (REC) has served LGBTQ+ youth in the Detroit area through Second Stories Street Outreach, Ruth’s House residential foster care and a recently added Health and Wellness Center. Historically, social services specific to LGBTQ+ youth have operated as grassroots non-profits. REC was founded in response to a crisis situation: For its first seven years of existence, REC operated primarily as a drop-in center for homeless LGBTQ+ youth.

Eventually, the agency plugged into federal runaway and homeless youth programs, state-funded residential foster care and Medicaid dollars for outpatient community mental health services. Through these more established systems of care, youth and families are now referred to LGBTQ+ specific services with which they would be unlikely to engage otherwise. Additionally, REC is now able to work with clients who are younger than the youth accessing the drop-in center. Working with different systems of care allows REC to provide services to families before youth are kicked out of their homes, saving them from the compounded trauma of family rejection and living on the streets. This represents REC’s primary work to prevent homelessness: engaging families while youth are still in the home, mitigating the harm youth experience from rejection and supporting families in their efforts to stay together, when possible.

Family Preservation Program. In October 2015, REC began a Family Preservation pilot program designed to help LGBTQ+ youth at risk for removal from their families. The key goals of this program are family engagement, preservation and support. The program is a collaboration between REC and Dr. Caitlin Ryan from the Family Acceptance Project. Dr. Ryan is working with REC staff to integrate the Family Acceptance Project’s research-based family intervention strategies into a Family Group Decision Making (FGDM) model. As an established international model, FGDM engages parents, caregivers, youth and others to provide services to keep children safe, preserve families and improve family connections.

REC receives referrals primarily through the county’s Child Protective Services (CPS). Referrals can also come from juvenile justice, foster care, community mental health, runaway and homeless youth providers, primary health care providers or other community-based agencies. REC has trained front line protective service investigators on the core needs and experiences of LGBTQ+ youth. REC has also trained investigators on the Family Acceptance Project’s research, including its findings about the critical role of family support and how to identify abusive and harmful behaviors related to a child’s LGBTQ+ identity.

This approach empowers families to support their LGBTQ+ children in a culturally congruent framework that allows them to address other pressing
needs such as housing stability, food security and health and mental health care. This work aims to reduce the number of LGBTQ+ youth placed in foster care, which can otherwise be a pathway to homelessness or involvement in the juvenile or criminal justice systems. REC has trained almost every CPS caseworker in the county and is working to increase connectedness and support for families and their LGBTQ+ children through this project.

**Initial Recommendations.** Communities and systems can be complex and the FGDM model is not intended to be a one-size-fits-all solution. However, looking at the success of certain steps that REC took could be helpful to other communities seeking to enhance services for LGBTQ+ youth and their families. Agencies should:

1. Take note of all possible systems of care that they are able to contract with through city, county or state. Based on the agency’s relationship with the system, availability of contracts and the contract application or bid process, create a shortlist of systems to approach. REC built relationships with individual child welfare administrators who already had a record of serving LGBTQ+ youth in care. These individuals also understood the available funding structures and were able to make recommendations about where and when an application for a contract would be most likely to succeed.

2. Examine potential referral sources in the system of care that would connect the most vulnerable LGBTQ+ youth and families to agency services. For REC, this was a Family Preservation contract intended to refer families via CPS and/or adoption cases at risk for disruption related to SOGIE rejection. The goal of REC’s awarded contract was to keep children in the home with their families and families were referred to REC as an added element of support.

3. Work with state child welfare systems to learn more about funded models of service. REC worked with the child welfare system at the state level to learn more about models of service within the framework of family preservation. The State of Michigan funded the aforementioned FDGM model, which REC implemented with the help of the Family Acceptance Project. Once the model was chosen, REC set up meetings at the county level to check in with child welfare leaders with the intention of educating them on the benefits the FGDM model could have on their counties.

4. Match the state contract money with a foundation grant, which could make the application for the contract more competitive. The Andrus Family Foundation also funded the REC pilot. This additional funding allowed REC to develop, implement and evaluate training for CPS workers, as well as to work with families referred through systems of care other than CPS. An unanticipated benefit of these trainings was that they led workers to refer more families to REC services. This also encouraged families to continue accessing services, possibly as a means to avoid further system involvement.

REC and the Family Acceptance Project will continue to evaluate the work of the Family Preservation program and share lessons and considerations moving forward. Family preservation to prevent or mitigate LGBTQ+ youth homelessness will look different in every community, but most agencies can engage in this vital piece of system work.

**MOHAMMED,** 19 years old and African American, was assigned female at birth but identifies as male. He was referred to REC through a primary care physician who specializes in transgender health care. Mohammed, who is excellent at advocating for his identity-based needs, contacted the physician because he desperately wanted to begin taking testosterone (T) to help him feel more like...
himself in his body. He felt continuously traumatized by experiencing female puberty and knew T would relieve these symptoms. He believes taking T is necessary to affirm his gender identity.

Mohammed lives with his grandmother, who is his primary caretaker. His mother is his legal parent, but she struggles with addiction. The family loves Mohammed and wants him to be successful, but they have difficulty accepting his gender identity. They use she/her pronouns and the words daughter and granddaughter when referring to him. Mohammed’s mother refuses to consent to Mohammed’s medical transition, including his obtaining a prescription for T, due to her belief that he will “change her mind when she’s older.” Conflating sexual orientation and gender identity, his grandmother shared with a counselor that she believes “Homosexuality is grotesque and against nature. . . My granddaughter drawing thick eyebrows and facial hair on her face is ridiculous and embarrassing.” However, Mohammed’s family does demonstrate some accepting strengths, such as a willingness to provide him with gender-neutral clothing and agreeing to participate in the REC Family Preservation program.

According to REC, Mohammed is at a clear high risk for suicide and additional negative health and safety outcomes. Because a doctor referred the family to the Family Preservation program, the family was more open to the program, and to discussing the prospect of Mohammed medically transitioning, than they would have been if the referral had come from another source. While there are many barriers facing this family, they have attended a family group conference and set goals that aim to minimize their rejecting behaviors. With time, and with the maintenance of a strong support system that includes clergy, community and school, REC is hopeful that Mohammed’s family will come to affirm his identity. Additionally, and critically, the REC intervention has provided Mohammed with the support he needs to continue living at home.

Mohammed has the following recommendation for professionals:

➤ Work with qualified and trusted providers. Mohammed recommends that family preservation programs work closely with clinical practitioners and those to whom families look as trusted sources in their area, including doctors, nurses, teachers, caseworkers and administrators, in order to ensure that referrals to their programming are met with appropriate weight from the family. He also recommends that these programs ensure families are connected with affirming resources in their communities and have access to external social supports.

B. Affirmation and Support in Congregate Care Settings

1. CHILD WELFARE

Around the country, child welfare systems range from being administered primarily at the state level to county-based systems and others that are almost completely privatized via government grants to providers. In all models, state child welfare or county or municipal agencies contract with non-profits to deliver programs and services, including housing. This section features an affirming agency, CHRIS 180, which contracts with the Georgia Department of Children and Family Services (DFCS) to provide a whole host of services to youth, including congregate care.

Following the profile of CHRIS 180, the report details recommendations from three young women, Ashley, Savannah and Jennifer, who are transgender and were or are in child welfare custody. While they all experienced discrimination at points during their time in care, they all had the experience of being affirmed and supported by placement in either an LGBTQ+-specific congregate care facility or a gender-specific congregate care facility in accordance with their gender identity. They share their recommendations for professionals working with TGNC youth in out-of-home care.

CHRIS180

Overview. CHRIS 180 (formerly CHRIS Kids) helps children, adults and families who have experienced trauma change the direction of their lives to become more productive, self-sufficient members of the community. It does this through a combination of mental health counseling, training, self-housing and real world skill building. The CHRIS 180 mission is to heal children, strengthen families and build community. The organization’s name is an acronym reflecting its core values: Creativity, Honor, Respect, Integrity and Safety. With multiple locations across Atlanta, Georgia and surrounding areas, CHRIS 180 provides a holistic bevy of services to children, adults and families. Their website states, “CHRIS 180 saves, serves, and protects children, young adults and families who have experienced trauma to help them change the direction of their lives.”

The organization
focuses on trauma-informed care and recognizes the deep impact that trauma can have on a person’s life, regardless of age.

CHRIS 180 offers counseling services for children, adults and families, as well as psychiatric support as appropriate. It is committed to keeping youth emotionally, psychologically and physically safe, from birth to young adulthood. Foster youth, particularly those with mental health diagnoses and many of whom are older, have compounded trauma and may be served by JourneyZ group homes. These homes provide safe and supportive housing for youth in the state child welfare system who are considered “highest need” and who cannot thrive in traditional foster homes. In JourneyZ, these youth receive individualized counseling, life skills coaching and safe, secure housing. Youth who have “aged out” of Georgia’s child welfare system and left care can also access supportive housing through CHRIS 180’s Summit Trail Apartment Community. There, youth ages 17-24 who have experienced homelessness, have lived in juvenile justice or mental health care facilities or are parenting can receive support and supervision while learning how to manage the responsibilities of adulthood. CHRIS 180’s Gateway Foster Home program was designed to reunify siblings in foster care who were separated and to prevent their separation when possible, while providing stability in trauma-informed family environments that prepare them for adoption.

Additionally, CHRIS 180 offers community services designed to strengthen families and empower youth. Families are strengthened through the Keeping Families Together Program. Adoption support is provided for families adopting out of Georgia foster care and the CHRIS Clubhouse is a safe place where young adults ages 15-21 with mental health and substance use challenges can go to meet friends and learn important life skills in a fun environment. CHRIS 180 balances its service provisions with extensive community trainings. As with all of its services, CHRIS 180 trainings are based on trauma-informed care, “directed by an understanding of neurological, biological, psychological and social effects of trauma.”195 “They train community partners on issues ranging from child abuse prevention and anti-bullying work to the challenges of working with LGBTQ+ youth, trauma-informed care and workforce development.

CHRIS 180 makes a determined effort to ensure that the entire organization recognizes and embraces the cultural diversity of the youth they serve. Staff participate in a cultural diversity training annually and youth receive and participate in ongoing training as well. The organization fosters special community groups centered around ethnicity, culture and diversity, in addition to religion and spirituality. Youth who choose to practice a religion have the support of the agency and are taken to any religious venue or service they want to attend.

**Affirming LGBTQ+ Youth.** CHRIS 180 has a long history of LGBTQ+-affirming policy and practice dating back to 1988, when it added sexual orientation to its nondiscrimination policy. In 1999, it added gender identity. In 2001, it was the first organization in the Southeast to specifically target LGBTQ+ youth among homeless populations, and in 2015 it was designated as a Leader in Supporting and Serving LGBT Families and Youth by the Human Rights Campaign. This track record emphasizes CHRIS 180’s longstanding commitment to offering effective and affirming services to youth and families across the state of Georgia.

CHRIS 180 has been working for some time to affirm TGNC youth and to place youth in accordance with their gender identity. Cindy Simpson, the organization’s Chief Operating Officer, says, “We have really tried to create a space for them and allow them to articulate the best fit and what they need. We are guided by youth voices. Youth know that the decision they make at intake isn’t necessarily where they have to remain and that they can always look at moving. During the interview process at intake we ask youth, ‘Where will you be most comfortable?’ Some youth are ready to live in a home that corresponds to their gender identity and some aren’t quite ready. We talk about their options and they really get to make the choice.”

**Licensing and Housing.** In years past, CHRIS 180 was met with resistance from the local county agency when seeking to place TGNC youth who were in foster care in housing settings consistent with their gender identity. In 2016, they took the important step of directly and proactively reaching out to the DFCS licensing unit on this matter. Simpson told licensing staff what CHRIS 180 wanted to do and asked if such placements were specifically prohibited. Licensing staff informed Simpson that they had no policy specifically addressing this question and instructed her to “do what [she] think[s] is best.” This outreach opened up

“HOW DO YOU MAKE CHANGE HAPPEN? THE IMPORTANT THING IS HAVING THE COURAGE TO TRY AND TO GIVE STAFF AND YOUTH THE OPPORTUNITY TO GROW AND LEARN.”

– CINDY SIMPSON, CHRIS 180
a dialogue around transgender youth and, as Simpson stated, “got [the licensing unit] to think about this.”

As part of the current intake process, CHRIS 180 personnel have a conversation with youth about whether they would like a single room or prefer to share with another youth. It’s also CHRIS 180 policy that after youth consult with staff and CHRIS 180’s therapist, they may choose to be placed in accordance with their gender identity. After that initial placement, staff repeatedly check in with youth to ensure that they continue to feel safe in their placements and youth know that they may always change their minds.

**Hiring.** In accordance with CHRIS values, CHRIS 180 sets expectations early by alerting job applicants that they will be working with LGBTQ+ youth and using scenarios and asking questions in the hiring process about how applicants would handle situations involving LGBTQ+ youth. Simpson notes that some applicants for positions at CHRIS 180 have left interviews when the agency’s commitment to LGBTQ+ youth was discussed. From her perspective, if an employee cannot support LGBTQ+ youth, then CHRIS 180 is “not the place [they] need to work.” The topic is discussed again during new hire orientation in order to clarify expectations and ensure additional screening. In addition to the interviewing and on-boarding process, CHRIS 180 makes ongoing efforts to hire a diverse staff that represents the population of youth served through their programs. For example, they have a therapist on staff who is transgender.

**Training.** CHRIS 180 provides initial and ongoing training to all staff on working effectively with LGBTQ+ populations. Whenever a transgender youth joins a particular house, additional training is provided to staff before the youth’s arrival. Staff understand that it is up to the youth to share whether they are transgender or not and, if they do, to do so in their own time. Staff are there to offer support and work through any issues with peers. Simpson acknowledges that there are always challenges with direct care staff and that ongoing coaching is critical. Additionally, the youth who come to CHRIS 180 have experienced extensive trauma and discrimination and as a result many face mental health and behavioral issues. At times their behaviors can be challenging, and some of their peers have had issues with TGNC youth. However, by working with TGNC youth on such problems, staff have better understood their own biases and improved their ability to help other staff and young people. Simpson has found that non-LGBTQ+ youth raised by same-sex couples have often been important allies and sources of support for LGBTQ+ youth. Support groups, both general and LGBTQ+-specific, have offered staff and non-LGBTQ+ youth additional opportunities to work through challenges and create a supportive environment. CHRIS 180’s commitment to trauma-informed care, acceptance, respectful behavior and a values-driven culture is behind its success at helping a range of children, adults and families change the direction of their lives toward positive futures and self-sufficiency.

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**ASHLEY**, a 17-year-old girl who is transgender, is in foster care in a southeastern state. Ashley initially experienced rejection from her family because of her identity. In connection with that rejection, Ashley exhibited behavioral problems, used illegal substances and engaged in sex work to obtain money to purchase hormones. She entered care after her parents sought assistance from the local child welfare agency. While in care, Ashley experienced discrimination in multiple ways on account of her identity: Caseworkers and providers failed to respect her as female and she was placed in non-affirming housing and therapeutic services. While there, she was physically and emotionally victimized.

Ultimately, Ashley was placed in a CHRIS 180 group home for girls, which respects her identity, and her situation rapidly improved. While a couple of Ashley’s placements had been affirming, CHRIS 180’s home is the first sustained supportive placement that Ashley has had. She and her parents have also benefitted from affirming family therapy, which has increased her family’s acceptance of her as transgender.

While Ashley has had some ups and downs at CHRIS 180, she is very happy to be in a place that affirms her identity. She says being at CHRIS 180 has caused a “complete turnaround” and describes the people who work at the counseling center as sweet and gender-affirming. At CHRIS 180 she feels “not even different” and “not [like] an outsider.” She says she is doing “everything a girl does.”

Ashley has addressed some issues with staff. At one point, she called a sit-down meeting and gave examples of things staff had said and done that made her feel uncomfortable. These things were hurting

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**“NOW THAT I FEEL SAFER, I DON’T HAVE TO WORRY ABOUT ALL OF THOSE OTHER THINGS. I’M ABLE TO FOCUS ON MY FUTURE AND DOING THE THINGS I NEED TO DO TO BE SUCCESSFUL.”**

— ASHLEY, transgender youth in care
Savannah, an 18-year-old girl who is transgender, is currently a ward of a state child welfare system in the northeastern part of the United States. According to Savannah, her parents do not “agree” with her identity. While living in their home, Savannah experienced emotional distress and exhibited behavior problems, including self-harm and attempted suicide. After entering the child welfare system, the county child welfare agency and its contracted providers rejected her identity. Thus, Savannah was placed in foster homes that were not affirming. The county refused to allow Savannah to use her clothing stipend to buy female clothing, citing “agency policy.” Neither the county nor their contract agencies ensured that she was able to access trans-affirming behavioral health and medical care. While Savannah was still a minor, she was told that she would have to wait until she was 18 to begin hormone therapy. Because her parents were not supportive, Savannah understood that the agency felt its hands were tied and she could not receive trans-affirming health care, even though a qualified psychologist had recommended that she see a doctor at a local children’s hospital to explore hormone therapy.

During the time she was not affirmed, Savannah said she did not even want to talk to other people involved in her case. She had as limited interaction as possible with her foster families because of how they treated her. Lack of support compounded other problems because Savannah did not want to discuss issues with her caseworker that arose due to conflict and lack of support from both her foster family and representatives of the state child welfare system.

One of Savannah’s caseworkers identified a girl’s
independent living program that accepts girls who are transgender. Eventually, Savannah was moved to a new agency and placed in the independent living program. She now has her own apartment with an efficiency kitchen in a large home divided up into individual units. The staff respect her identity and treat her well. Since placement, she describes her mood as being much better and says the supportive environment has made her feel less alone. She hopes her next move can be to her own apartment.

Savannah has the following recommendations for professionals:

**Respect builds trust.** Savannah recommends that caseworkers work to create intentional climates of trust by truly listening to the concerns of young people they work with and then adjust their behavior based on the young people’s feedback. After constant conflict around her gender identity with the county welfare agency and its contract provider during her initial time in care, Savannah felt completely “unmotivated to speak with [her] workers.” She knew that every conversation would end up in conflict, so she wouldn’t speak freely. Savannah reminds caseworkers that they should want to build relationships of trust with clients, so that clients will share with them when important things happen. By contrast, now that her identity is affirmed, the comfort and respect she feels at her current program allows her to open up and be herself and reach out when she needs something.

**Don’t replicate the harm.** Savannah recommends that professionals working with young people make sure their actions do not replicate the harm that initially resulted in a child’s removal from their family of origin, particularly if that involved rejection of a transgender person’s gender identity. Affirmation of gender identity should occur at all points in which young people come into contact with systems of out-of-home care. “Even though your clients are children, they still need to be treated with respect,” she says. “Especially in this setting, the trans kids you work with are there for a reason and it’s often because their identities were rejected by their parents. When the system is supposed to be there to help, it’s critical that it doesn’t replicate the situation that [a youth] is trying to get away from.”

Savannah also has a recommendation for other youth:

**Know your rights.** “Get informed and know what you can do about your situation. If you don’t think you can do anything about it, you won’t.” Savannah says the only people who supported and affirmed her until her recent move to the independent living facility were her attorney and her attorney guardian ad litem. They helped advocate to the judge for a court order requiring her prior agency to allow Savannah to use her clothing stipend to purchase feminine clothing.

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**JENNIFER** is an 18-year-old transgender woman who lives in a southern state.198 During her childhood and adolescence, Jennifer experienced physical and emotional trauma, conflict between her parents and difficulty accepting her transgender identity. These experiences impacted Jennifer’s mental health. After threatening to harm herself, she was admitted to an acute psychiatric facility. After a few weeks, Jennifer was stable enough for discharge from the facility, but her parents refused to take her home. They felt her behavior problems and mental health issues were too extreme for them to handle. The state child welfare agency took custody of Jennifer.

Although the facility had deemed Jennifer ready for discharge and the state was legally required to find a less restrictive placement for her since she no longer needed acute care, she remained there for several months. She understood the delay was because no home or facility across the state would accept her as a transgender girl and affirm her identity. Ultimately, due to lack of affirming placements in her state, the child welfare agency placed Jennifer in a residential treatment facility in a neighboring state. Staff at the facility affirmed her identity in most respects. She was able to wear her own clothes and groom herself in a manner consistent with her identity, staff were generally affirming and she had a supportive therapist. However, due to the facility’s interpretation of licensing regulations requiring that children of a different gender not share rooms, Jennifer was required to share a room with a cisgender male. She felt very uncomfortable with this arrangement, because she and her roommate did not get along and he would sometimes beat her up. The regulation governing out-of-home placement in the state where Jennifer was staying does not define the term gender. According to agency policy, children in child welfare custody in that state are protected from discrimination on account of gender identity, but no statutory, regulatory or policy guidance exists regarding placement of transgender youth in accord with their identity.

While in care, Jennifer experienced additional discrimination due to the fact that her caregivers interpreted gender to mean her sex assigned at birth. Jennifer was unable to use her state clothing stipend for female clothing, because the state’s “policy”199 at the time was that “gender appropriate” clothing meant clothing consistent with a youth’s sex assigned...
called Diversity House, the first of its kind in the specific transitional living facility. The program, experiencing homelessness, opened an LGBTQ+ Oasis, a shelter in Baton Rouge for youth misgender her as a punishment. In addition, when staff at one of the facilities got angry with her, they would intentionally misgender her as a punishment.

While Jennifer was placed out of state, Youth Oasis, a shelter in Baton Rouge for youth experiencing homelessness, opened an LGBTQ+ specific transitional living facility. The program, called Diversity House, the first of its kind in the region, was designed to provide housing and support for LGBTQ+ youth experiencing homelessness, in foster care or transitioning from foster care and in need of supportive housing. Youth Oasis created Diversity House after noting staggering numbers of LGBTQ+ youth experiencing homelessness and seeing transgender youth come to the shelter because there were no affirming placements in the foster care system.

Jennifer was able to transition to Diversity House from her out-of-state placement and in many aspects did well there, but she says she became angry and damaged her apartment. Around the same time, Jennifer turned 18, the age at which foster care ends in her state of origin. Her permanency plan had been to transition to the non-state-funded beds for youth 18 to 22 years old at Diversity House, but due to her behavior she was hospitalized again and could no longer remain there. Upon discharge from the hospital, there was no place for Jennifer to go and she ended up at Covenant House, a homeless shelter in another city. Luckily, Jennifer was connected with a disability rights attorney, and through his advocacy around her diagnoses and needs, Jennifer was eventually able to access services and funding for an apartment of her own.

Jennifer’s recommendations for professionals working with TGNC youth:

1. Develop affirming placements. Jennifer recommends that states ensure they have an adequate number of placements that are affirming of transgender identities so that young people do not have to move out of state or away from their supportive communities to be accepted for who they are. At first Jennifer was excited to go out of state. She thought it would be a “fresh start” and could lead to some new opportunities. She appreciated that staff at the out-of-state facility affirmed her identity, but after a while, Jennifer began to miss her community back home. She had friends there and adults from her church who were supportive, but they were miles away. Also, she just missed the place she grew up and knew well and felt isolated out of state because she knew no one there. The placement out of state had effects on her self-esteem as well. Jennifer says that she knew she was sent away because “no one would accept me because of who I am,” and it made her feel rejected and unwanted. Although she was glad to be transported back home for court appearances in her child welfare case—it was the only time she got to see her supportive attorneys—it was a long and exhausting trip back and forth.

Jennifer was excited to find out about Diversity House when it opened and excited when she was placed there and got to be closer to home. “It felt very good,” she says. “I loved it. People were more respectful in general and they really accepted you for who you are. I could be myself and not have to think ‘Do I need to be this other person today?’” She recalls an instance when staff at Diversity House took her and other residents to a Pride event in Baton Rouge and shielded them from anti-LGBT protesters. Jennifer also felt accepted in terms of her race and religion and had opportunities to participate in community events and to attend church if she wanted. She appreciated having her own place and liked the independent living programming at Diversity House, where she learned how to cook, clean and manage her own money. Covenant House was also affirming of Jennifer’s gender identity and she says she “had a good experience” there. She says it felt great to have the option to “stay on the female floor.” Although she still had some problems in placements that were affirming, Jennifer felt they really made a difference for her, and she was especially glad that Diversity House allowed her to live closer to her community.

Promote well-being by accepting and affirming youth. Jennifer recommends that professionals affirm and support transgender youth because it “really helps their mental health.” She says that when she experienced discrimination from caseworkers, staff at treatment facilities and other professionals in the child welfare system, it “made me feel disrespected and added to my feelings of self-harm and suicidal ideation.” She wasn’t sure “what she was supposed to do” if she could not be herself and that felt “really overwhelming.” She emphasizes that “a lot of trans people aren’t accepted, and it can make them feel bad about themselves.” She says it “felt weird for people who are supposed to be helping [me] to reject [me].” Jennifer believes that affirming treatment is especially important for youth in care, because “not a lot of people accept trans people.” She adds that when youth are affirmed, “they can actually focus on what the problem is . . . They can relate to you better and you are able to relate to them better.” Significantly, given that child welfare agencies are legally obligated to ensure safety, permanency and well-being for youth in their care, Jennifer noted that at Diversity House and Covenant House she felt “emotionally and physically safe and stable.”
Jennifer recommends that states ensure continuity in services by adopting and enforcing affirming policy across all systems of care. When she was settling in to her placement out of state, she says, it “felt good . . . I got to wear female clothing and people were using my name.” She did not, however, like having a cisgender male roommate. It made her “feel uncomfortable and unsafe,” especially because they argue a lot and “he beat me up.” Also, it felt “like they weren’t treating me like a real girl, like all the other girls.” She would have preferred a female roommate and that would have helped make the experience at the facility affirming in all aspects. During her time at the acute psychiatric facility in her out-of-state placement, the state’s refusal to buy Jennifer female clothes impacted her negatively. She felt unsupported and confused, as she was respected in some aspects but not in others and by some of her caseworkers but not others. During her time in care, her state’s administration changed and the “policy” prohibiting the agency from purchasing clothing consistent with gender identity was eliminated. As a result, Jennifer was finally able to use her state-provided stipend to buy clothing that reflected her identity and that made her feel more respected and supported.

Juvenile justice systems across the country operate both long-term secure facilities and short-term detention facilities for youth charged with delinquencies who have met detention criteria such as being a flight risk or a danger to themselves or others. Youth are confined to long-term facilities when a judge has found, after adjudicating a youth as delinquent, that the delinquency is especially severe or that the youth has a long delinquency history. Depending on the type of facility, juvenile detention may be administered by the state, county or city, or by a contract provider. In addition, juvenile justice agencies may administer diversion programs and probation or parole.

Here the report features a short-term juvenile detention facility operated by the City of New York and recommendations from Lydia, a transgender girl who spent time confined in long-term facilities in a southern state and had a very supportive parole officer when she was released. The authors emphasize that most detention facilities pose extreme risk for TGNC youth. Placement in the community is preferred for all youth except when detention is absolutely necessary and strict statutory requirements are met.
in the country, and in 2016 it began work with the Advocates’ Council to update and refine the policy. The policy is detailed and addresses the rights of LGBTQ+ youth in care. A copy of it is presented to all youth, via a “Know Your Rights” palm card. In 2014 ACS issued a best practice guide for working with TGNC youth in care. Later, in 2015, ACS implemented a policy regarding the coverage of transition-related health care not covered by Medicaid for transgender youth in its care. The agency also maintains a resource page for LGBTQ+ youth and an LGBTQ+ support page where users can find agency nondiscrimination policies.

**Affirming Identity in Detention Housing.** Over a year ago, ACS began housing youth in detention in accordance with their gender identity. Jennifer Romelien, Executive Director of Program Services, Division of Youth & Family Justice, Detention Services, in collaboration with others at ACS, helped lead the change in placement policy at detention. She notes that now, “Placing trans youth in accord with their identity is just what we do. It’s normal course of business.” Romelien views the shift as critical for protecting the emotional and physical safety of youth in their care. She emphasizes that “a big part of safety is cooperation and trust—respecting young people for who they are helps foster that relationship.”

“Understanding that identity affirmation is critical to a youth’s well-being and safety while at the facility was crucial to helping staff change the way they had always done business,” she says. Youth sleep in single rooms and Romelien has not encountered any licensing regulation barriers in housing transgender youth in the section of the facility that corresponds to their identity. Agency policy dictates that transgender youth are to be respected in all aspects of their identity, and their efforts to affirm youth go beyond housing.

**Intake.** A social worker on the detention unit administers an intake questionnaire and asks youth how they identify in terms of their sexual orientation and gender identity, in an effort to determine appropriate housing and potential services. Romelien acknowledges that asking SOGIE-related questions at intake was very challenging for staff at first and it took time for them to relax and feel comfortable. Ongoing practice and coaching was critical and helped staff feel more competent at conducting these intakes.

**Culture Change.** Romelien attributes a change in the environment in detention to an overall cultural shift in the way the agency did business. That shift to being transgender-affirming in housing classifications was driven, in large part, by policy change. Romelien advises other administrators that it is helpful to acknowledge that any change is going to be difficult in a structured environment, but it is essential that the message come from the top down and that all share the same philosophy of care.

Romelien has seen some tangible benefits. Creating an environment of respect has allowed staff to get to know and understand transgender youth better. Youth often have very short stays in detention, so it can be challenging to get to know them and build their trust. She says that once staff see that affirmation leads to more trust, less conflict and better peer-to-staff communication, it really helps to foster change. Romelien remembers being particularly proud when she witnessed staff helping a youth prepare for a visit with her parents, who were not accepting of her identity. They worked through how she would feel most comfortable presenting herself and supported her every step of the way.

**Training and Coaching.** Due to the nature of the city hiring process, Romelien does not have much ability to screen potential hires for their attitudes around working with LGBTQ+ youth. ACS does require training on the LGBTQ+ policy and, more generally, on how to work effectively with LGBTQ+ youth. Romelien feels that one key component for providers is to understand that a “one-off” training is not enough and administrators need to commit to ongoing coaching and support. “For some people, it is immediate,” she says, while others need extra support and encouragement to “get them there.”

**Fair Application of the Rules.** Romelien says that one challenge faced by her agency was how exactly to allow transgender youth to express themselves through clothing and grooming in a manner consistent with their gender identity. Staff would bring safety concerns to her, worried for instance that youth were hiding contraband within a weave or a bra. Romelien recommends constant but gentle questioning to address safety risks, always with the mindset that “We can be safe and affirm identity.” She advises administrators, “If there is a perception of a safety issue, talk through how safety can be
achieved and identity and expression affirmed” rather than taking an “it’s-either-this-way-or-that-way approach.”

In sum, Romelien finds it helpful to allow staff to share any frustrations they have and acknowledge how challenging some youth can be, but to always return to the overall goal of meeting the individual needs of the child. She reminds staff, “If anything, [TGNC] youth are the ones who are more vulnerable [in detention settings]. Our work must not be generalized but child-centered and specific to the individualized needs of the child.”

**LYDIA**, a 19-year-old woman who is transgender, lives in a southern state with her mother. Lydia experienced significant trauma while growing up, including physical and sexual abuse. She was special education-certified at a young age and was bullied at school on account of her gender-nonconformity. Lydia entered the juvenile justice system because of escalating behavior problems, which included fire-setting and assaults on a teacher and others. Ultimately, Lydia was sent to long-term secure juvenile justice facilities. While incarcerated, she experienced discrimination by some staff and volunteers (although some were supportive) and was harassed and assaulted by peers. This was often while on a safety plan because she was deemed to be at risk due to her sexual orientation and gender presentation.

Upon release, Lydia had a brief and problematic stint at a halfway house for young men, where she received death threats from peers and was prohibited from expressing herself as female. Ultimately, Lydia was released to her supportive mother’s home and assigned a parole officer. Her experience with her parole officer was very positive. The officer affirmed Lydia’s identity and provided her with helpful tools and resources.

When Lydia first met her parole officer, she was terrified because she thought the officer might judge her and not give her a chance. The officer immediately presented herself as supportive, however, and permitted LGBTQ+-affirming community advocates to join Lydia for their first meeting.

Lydia says her parole officer was enthusiastic but serious, and her main concern “seemed to be making me comfortable with however I identified.” In general, she says, “She gave positive advice about how to turn my negative experiences into positive change.” Lydia successfully completed parole and is no longer under the supervision of the juvenile justice system.

Lydia wishes other professionals could learn from her former parole officer. She loved the way her parole officer asked Lydia what name she wanted to be called and what pronouns she used. “She didn’t skip around it; she didn’t assume anything,” says Lydia. “She asked first.”

Lydia offers the following tips for professionals working with TGNC youth:

- **Don’t blame youth.** Lydia reminds staff working with young people that characteristics inherent to a young person’s identity, including their gender identity and expression, are not the cause of their mistreatment; rather, abuse is caused by the refusal of adults to accept their gender identity and expression. The mistreatment Lydia experienced made her feel “pathetic,” which was especially hard because she was sorting through questions regarding her gender identity. “It made me feel like the mistreatment was my fault,” she says, “and I just wanted to kill myself and leave it at that.”

- **Use resources wisely.** Lydia recommends that professionals focus their attention on providing affirming care rather than policing gender expression. She notes, “We would have saved a lot of trees [if staff] were more supportive and the facilities were safe. I had to write a lot of grievances about my mistreatment.”

- **Allow youth to focus on important things.** Lydia recommends professionals help young people feel safe and affirmed in their surroundings so that they can focus on important things like school work. “While I was in the facilities, I wasn’t able to focus on my classes and what I needed to learn. I was always more focused on who was out to fight me and who was going to jump me today. I was so busy paying attention to my surroundings that I couldn’t pay attention to my work. Once I knew my parole officer was going to respect me and treat me fairly, I was able to focus on what I needed to do and working on positive things.”

*MY PAROLE OFFICER WAS PHENOMENAL. SHE ASKED ME HOW I IDENTIFIED AND WHETHER I WANTED TO DRESS FEMININE OR MASCULINE. I FELT APPRECIATED AND IT MADE ME WANT TO WORK WITH HER.*  

– LYDIA, transgender youth in care
3. Programs for Youth Experiencing Homelessness

Many services for youth experiencing homelessness are provided by non-profit agencies that offer a range of programming, from drop-in centers and meals to storage and shower facilities, short-term housing in shelters and sometimes more long-term independent living arrangements. Many operate on a mixture of federal funding, grant funding and private donations. Featured here is a program in Spokane, Washington that receives funding through HUD in addition to other sources. Barrett, who resides at the shelter, shares his thoughts about being in an affirming place and recommendations for professionals who want to make positive change.

Overview. Crosswalk, part of Volunteers of America of Eastern Washington and Northern Idaho, is a youth serving agency in Spokane, Washington that has provided services to youth experiencing homelessness since 1985. Their website says, “Crosswalk is an emergency shelter, a school dropout prevention program, and a group of lifesaving and life-changing programs dedicated to breaking the cycle of youth homelessness. In an average year, Crosswalk serves more than 1,000 youth. Emergency shelter is available 365 days a year and all services are free and voluntary.”210 Their emergency shelter serves youth between the ages of 13 and 17, while their GED program and drop-in centers serve youth as old as 21. The program offers a plethora of services to address the needs of young people, ranging from the immediate (food to eat and a bed to sleep in) to long-term (independent living training and college scholarships). The compendium of care services offered by Crosswalk is holistic in nature and takes a multifaceted approach to assisting youth in crisis. All of its services are voluntary and free of charge.

Affirmation of LGBTQ+ Youth. Crosswalk seeks to affirm and validate all young people it serves. In the past six years, the program has made a concerted effort to more effectively serve LGBTQ+ youth, whether they arrive at Crosswalk after hearing about it from other youth, through a church referral or targeted by the program’s Street Outreach Team. Each young person coming through the facility doors seeking shelter is asked at intake about their sexual orientation and gender identity, as well as personal pronouns.

In order to provide a safe space for all youth who arrive at Crosswalk, it is essential that staff be safe and affirming. In this aspect, robust nondiscrimination policies and consistent training are the keys to success. Crosswalk also pre-screens its staff for affirming attitudes by asking potential hires in interviews about their experience with and perspectives about issues affecting LGBTQ+ youth. The organization also relies on a strong collaboration with community partners such as the YWCA and juvenile probation. In addition to training their own staff, Crosswalk conducts trainings for partner agencies as well, including the police force.

TGNC Youth Accessing Sex-Specific Facilities Consistent with Identity. The shelter is licensed through the State of Washington, which requires sleeping quarters for different genders to be separated by a visual barrier.211 Crosswalk’s 21 beds are divided between sections for boys and girls, and youth are assigned to the side that matches their gender identity, regardless of whether that aligns with their sex assigned at birth. In the case of a young person who is gender fluid, the place they sleep can vary from night to night. Rather than use separation by sex assigned at birth as a proxy for safety, Crosswalk applies a safety protocol across the facility. For example, youth must be fully clothed when outside of their bedrooms and may not sit or otherwise be on another youth’s bed when that youth is present. Program managers at Crosswalk have a working relationship with their licensing workers who certify that their protocol and sleeping arrangements are in line with the goals of licensing.

The facility’s bathrooms are similarly accessible. There are two of them, both single-user. They originally bore signs designating them as for men or women, but after Crosswalk staff talked with young people at the shelter about what kind of signs they’d prefer to see outside their bathrooms, they made a change. Now instead of gendered signs on the restroom doors, they have a hand-painted dragon above each one, in different colors, painted by young people. Likewise, their two showers, each single stall, are designated with either a sun or a moon.

Culture Change at the Agency. The consistent
and intentional affirming attitudes of Crosswalk have sparked a change in the culture of its service programs. Because they know they’re in a safe space, young people are more likely now to identify themselves as LGBTQ+ at intake. Staff members who identify as LGBTQ+ are more likely to come on board, given that their work environment celebrates diversity. This has the additional positive effect of allowing these adults to serve as role models for the young people in their care. And because Crosswalk has worked so hard to train and collaborate with community partners, the community in general has shifted towards being affirming of people regardless of SOGIE. These changes have the end result of producing a healthier and more nurturing environment for all young people.

**YOUTH AT CROSSWALK ELIMINATED GENDERED SIGNS ON SINGLE-USE RESTROOMS AT THE FACILITY BY PAINTING DIFFERENT COLORED DRAGONS ON THE DOORS. YOUTH MAY USE ANY BATHROOM THEY CHOOSE.**

> **BARRETT**, who was born and raised in the northwest, is 16 years old and identifies as bi-gender (male and demi-girl). 212 He has been a resident at Crosswalk for around 11 months. Prior to coming to Crosswalk, Barrett and his mother were not getting along well and were arguing a lot, in part due to Barrett’s gender identity and expression. At some point, Barrett decided it was not safe for him there. A friend told him that Crosswalk was a good place and he decided to check it out.

Barrett heard from other youth that it was an affirming place for LGBTQ+ youth. When he arrived, he found “posters and signs all over the place” indicating that Crosswalk was a safe space. He says he felt awkward at first adjusting to the new environment but found staff very welcoming. During intake, he was given the option of living in the boys’ or girls’ section of the shelter. Staff affirmed his gender and were interested in communicating and problem solving, he says, making it easier for him to discuss things more openly. Barrett says Crosswalk truly feels like a home environment for him now. He has had one incident with another youth since being there, but staff intervened and helped them work it out peacefully.

For Barrett, having staff at Crosswalk affirm his identity made a big difference. He points out that “When everyone is upset at you for something you don’t have control over, it is really difficult to know how to handle that situation as a young person.”

Barrett is working on his GED with classes at Crosswalk and hopes to get a job through the agency’s employment placement program and to eventually emancipate. He enjoys writing, watching YouTube videos and taking pictures, and hopes to get a job in a creative field.

Barrett offers the following tips for professionals working with TGNC youth:

> **Don’t gender things.** Barrett points out that many things are unnecessarily gendered, including restrooms, bedrooms and clothing options. Barrett has had a lot of anxiety and stress around accessing sex-specific restrooms. He suggests that if restrooms must be gendered for some reason, facilities should also offer a family restroom or some other gender-neutral option.

> **If you see bullying, stop it.** Barrett recommends addressing bullying through restorative justice practices rather than simply punishing those who bully others. Barrett doesn’t want youth or adults who are engaging in bullying to get in trouble or be punished, but he does think it is important for adults to talk with youth who are bullying others and explain why it is harmful. Barrett had in the past been bullied at school and was often blamed for “getting in trouble” when conflicts erupted that were not his fault.

> **Connect youth to LGBTQ supports.** Barrett recommends that professionals working with young people take the time to familiarize themselves with LGBTQ+ supports and services, including LGBTQ+-affirming providers, social groups and networks, so that they can connect youth to these supports and services. Before living at Crosswalk, Barrett went to Odyssey, a drop-in center for LGBTQ+ youth nearby.213 Barrett found lots of support and met people he liked. He said it was hard for him when he first came to Crosswalk, and having somewhere consistent where he felt connected and supported was really important.

> **IF YOU DON’T GET THE SUPPORT THAT YOU NEED, IT CAN LEAD TO SELF-HARM AND IT IS REALLY IMPORTANT TO BE THERE FOR YOUTH.”**

– Barrett, bi-gender youth in care
V. CONCLUSION

The needs of TGNC youth in out-of-home care are straightforward and similar to those of their cisgender and gender-conforming peers: They need to be affirmed, protected and accepted for who they are, especially where they live. Out-of-home care systems exist to serve the most vulnerable of our society and are obligated to proactively and comprehensively serve the needs of the youth who access their services. As this report has detailed, despite the solid constitutional basis for TGNC youth to be protected from harm and treated fairly and despite increasingly explicit protections under federal law, comprehensive and explicit protections for TGNC youth in state statutes, regulations and policy are rare. And yet examples of model protections exist in a variety of places, and excellent work is being done by providers who have proactively pursued appropriate TGNC youth treatment through policy, practice, training and continuous quality improvement.

States should adopt comprehensive and explicit statutory, regulatory and policy protections for TGNC youth. The authors also recommend that agencies and providers follow models of appropriate TGNC youth treatment, including requiring affirming placement and classification procedures, promoting healthy gender identity development and expression, mandating affirming gender-responsive programming and activities while in care and providing clear and ongoing training and competency requirements for staff. Finally, the authors urge everyone reading this report to heed the voices of TGNC youth, those featured in this report and those they encounter in their work, because they are the most qualified to say what they need and because their courage and wisdom are beacons of hope for us all.
2. The authors use the terms runaway and homeless youth and runaway and homeless youth systems because the terms flow from federal statute and regulation and corresponding names of federal agencies. Where possible, the authors describe youth as experiencing homelessness or accessing programs and services, including shelters, for youth. The authors encourage professionals working with young people to emphasize this distinction in their practice, as young people are not defined by their housing status or a period of housing instability.


4. The authors use the term transgender—a person whose gender identity (i.e., their innate sense of being male, female or something else) differs from the sex they were assigned or presumed to be at birth—to include youth who identify at all points along the gender spectrum, including youth who identify as non-binary or gender fluid. As an example, the authors use the term transgender girl to describe a girl who identifies as female, but was assigned the sex of male at birth.

5. “Gender-expansive is a broad term referring to aspects of gender expression, identity and interests that go beyond cultural binary prescriptions of behaviors and interests associated primarily with boys or girls. Gender-expansive includes young people who do not identify with the sex they were assigned at birth as well as those who do, but may nonetheless find themselves barraged with questions based on their dress, appearance, or interests, such as, ‘Are you a boy or a girl?’ or ‘Why do you play with that? It’s a boy/girl toy!’ Other words with similar meetings include gender diverse and gender creative.” Nat’l Ass’n of School Psychologists & Gender Spectrum, Gender Inclusive Schools: Overview, Gender Basics, and Terminology (2016), https://www.nasponline.org/resources-and-publications/resources/diversity/lgbtq-youth/gender-inclusive-schools-faq/gender-inclusive-schools-overview-gender-basics-and-terminology.


7. The authors use the abbreviation TGNC in this report because it appears most frequently in the literature and research. The authors emphasize that every individual is unique and there is no “correct” way to identify or express oneself. Here, the authors use gender-nonconforming to convey that cultural norms around gender still negatively impact youth who express themselves outside of those norms.

8. Sexual orientation, gender identity and gender expression are distinct concepts. A person who is transgender or gender-nonconforming may describe their sexual orientation as heterosexual, gay, lesbian, bisexual, or in other ways.


12. In 2015, the National Coalition of Anti-Violence Programs (NCAPV) received reports of 24 homicides classified as hate crimes against LGBTQ people and people living with HIV, a 20% increase from the previous year. Of these, 62% were people of color and 67% were TGNC people. In total, 13 of the homicide victims (54%) were transgender women of color. 79% of victims
were age 35 or younger. Nat’l Coal. of Anti-Violence Programs, Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence in 2015 (2016), at 9, 18, http://www.avp.org/storage/documents/ncavp_hvreport_2015_final.pdf. That same year, NCAPV received reports of 17 intimate partner-related homicides of LGBTQ people and people living with HIV. 46% of victims were transgender women, all of whom were women of color. Nat’l Coal. of Anti-Violence Programs, Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Intimate Partner Violence in 2015 (2016), at 8-9, http://www.avp.org/storage/documents/2015_ncavp_lgbtqipvreport.pdf. These figures do not reflect the total number of hate-related homicides or intimate partner-related homicides perpetrated against these populations across the U.S.

13. Congregate care, including group homes in the child welfare system, non-secure and secure facilities in the juvenile justice system, and shelters for youth experiencing homelessness, is often sex-specific or divided between “male” and “female” units or sections. As explained in more detail below, regulations governing out-of-home care systems use the terms sex and gender frequently.

14. “Gender dysphoria refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term gender identity disorder and focuses on dysphoria as the clinical problem; not identity per se.” Am. Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders 451 (5th ed. 2015).


16. Cisgender, or cis, describes a person whose gender identity corresponds with the sex they were assigned or presumed at birth.

17. Ctr. for Am. Progress, et al., Unjust: How the Broken Juvenile and Criminal Justice Systems Fail LGBTQ Youth (2016), at 1 (LGBTQ youth represent 7-9% of the youth population nationally, but 20% of the population of juvenile justice facilities, and 40% of the population of girls’ facilities), http://www.lgbtmap.org/file/ltgb-criminal-justice-youth.pdf; BreakOUT! & Nat’l Council on Crime & Delinquency, We Deserve Better: A Report on Policing in New Orleans by and for Queer and Trans Youth of Color (2014), at 17-18. (Transgender respondents were more likely than cisgender respondents to report being approached by police (87% vs. 66%), being called homophobic or transphobic slurs by police (50% vs. 22%), feeling targeted by police because of their SOGIE (84% vs. 45%), being asked for a sexual favor by police (59% vs. 12%), and being presumed by police to be a sex worker (64% vs. 26%). LGBTQ respondents of color reported higher rates of negative interactions with police than white LGBTQ respondents, including the finding that 42% of respondents of color reporting that they have called police for help in the past and been arrested themselves, compared to 0% of white respondents;), https://www.scribd.com/document/334018552/We-Deserve-Better-Report; Angela Irvine, Shannan Wilber & Aisha Canfield, Lesbian, Gay, Bisexual, Questioning, and/or Gender Nonconforming and Transgender Girls and Boys in the California Juvenile Justice System: A Practice Guide (2017), at 3 (19% of detained youth surveyed in California facilities identified as LGTB or TGNC, and 90% identified as youth of color). See Angela Irvine, Shannan Wilber & Aisha Canfield, Lesbian, Gay, Bisexual, Questioning, and/or Gender Nonconforming and Transgender Girls and Boys in the California Juvenile Justice System: A Practice Guide (2017), at 10-13, http://impactjustice.org/wp-content/uploads/2017/02/CPOC-Practice-Guide_Final.pdf. The authors also recommend collecting information regarding the sexual orientation of youth, aged fourteen and older, and foster and adoptive parents as part of demographic data sent to HHS. In addition, agencies must capture whether family conflict related to the child’s sexual orientation, gender identity, or gender expression (“SOGIE”) was a “child and family circumstance at removal.” Adoption and Foster Care Analysis and Reporting System, 81 Fed. Reg. 90524 (Dec. 14, 2016) (to be codified at 45 CFR 1355), https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29366.pdf. The authors also recommend collecting information regarding gender identity even though the federal government does not require its collection. However, SOGIE-inclusive nondiscrimination policies, training on safely and respectfully gathering SOGIE-related data, and confidentiality protocols for managing and storing such data are critical prequisites before beginning collection. See Angela Irvine, Shannan Wilber & Aisha Canfield, Lesbian, Gay, Bisexual, Questioning, and/or Gender Nonconforming and Transgender Girls and Boys in the California Juvenile Justice System: A Practice Guide (2017), at 10-13, http://impactjustice.org/wp-content/uploads/2017/02/CPOC-Practice-Guide_Final.pdf, see also Family Builders, Legal Servs. for Children, Nat’l Ctr. for Lesbian Rights & Ctr. for the Study of Social Policy, Guidelines for Managing Information Related to the Sexual Orientation & Gender Identity and Expression of Children in Child Welfare Systems (2013), available at http://cssr.berkeley.edu/cwscmsreports/documents/Information%20Guidelines%20P4.pdf.


23. Id.

24. Id.


26. Wilber, et al. (2006), at 5-6. Note that the New York City study was conducted before New York City’s Administration for Children’s Services developed its comprehensive LGBTQ+-affirming policy in the city’s child welfare system and
its corresponding training and implementation. It is expected that new studies, currently under way, will reveal an improvement in the experiences of LGBTQ+ youth as a result of these improvements in policy and practice.


32. Authentic youth engagement requires intentional decision-making by adults and professionals working with youth. Necessary elements of authentic youth engagement models must include: (1) co-design with young people in the planning, development, implementation and assessment of initiatives; (2) a plan for sustained engagement with young people throughout the project and a system of support in place for when the project is completed; (3) a plan for commensurate compensation for young people as well as intentional scheduling, child care, transportation compensation and communication considerations to fit young people’s schedules and lives; (4) a plan for how adults will ensure young people are prepared and empowered to make informed decisions throughout the project and are able to share as much or as little of their experiences as they feel comfortable; and (5) measures for ensuring confidentiality of identifying information.

33. See note 17 and accompanying text.

34. The authors use the terms sex and gender interchangeably. In addition, the authors recommend, as discussed at length in this report, that sex and gender be defined as the same concept and determined by gender identity.

35. See infra notes 39-43 and accompanying text.

36. See infra notes 62-74, 104 and 108-114 and accompanying text.

37. See infra note 69 and accompanying text.

38. While the authors are focused here on explicit SOGIE protections found within statutory and regulatory schemes specific to child welfare, juvenile justice, and runaway and homeless youth systems of care, the authors also attempt to highlight places where protections may exist more generally, such as in states’ and localities’ public accommodation or human rights laws.

39. See Hernandez ex rel. Hernandez v. Tex. Dept of Protective & Regul. Servs., 380 F.3d 872, 880 (5th Cir. 2004) (holding that foster children enjoy a substantive due process right “to personal security and reasonably safe living conditions”); Doe ex rel. Magee v. Covington Cty. Sch. Dist. ex rel. Keys, 675 F.3d 849, 849 (“In the circumstances of . . . foster care, the state has . . . rendered the person in its care completely unable to provide for his or her basic needs and it assumes a duty to provide for these needs”); Doe v. Taylor Indep. Sch. Dist., 975 F.2d 137, 146 (5th Cir. 1992) (“By removing the child from his home . . . the state thereby obligates itself to shoulder the burden of protecting the child from foreseeable trauma”); M.D. v. Abbott, 152 F. Supp. 3d 684, 696 (S.D. Tex. 2015) (“under the Fourteenth Amendment, the State owes its foster children ‘personal security and reasonably safe living conditions’”).

40. See K.H. through Murphy v. Morgan, 914 F.2d 846, 848 (7th Cir. 1990) (“The extension to the case in which the plaintiff’s mental health is seriously impaired by deliberate and unjustified state action is straightforward”); Mariol A. by Forbes v. Giuliani, 929 F. Supp. 662 (S.D.N.Y. 1996) aff’d sub nom. Mariol A. v. Giuliani, 126 F.3d 372 (2d Cir.1997) (children in foster care have a “substantive due process right to be free from unreasonable and unnecessary intrusions into their emotional well-being”); M.D., 152 F. Supp. 3d at 696 (foster children have the right to protection from psychological abuse); R.G. v. Röller, 415 F. Supp. 2d 1129, 1156 (D. Haw. 2006) (due process rights for juveniles in detention “encompass[] a right to protection from psychological as well as physical abuse”); Aristotle P. v. Johnson, 721 F. Supp. 1002, 1010 (N.D. Ill. 1989) (“The fact that the plaintiffs’ injuries are psychological rather than physical is of no moment”).

41. See K.H., 914 F.2d at 852; M.D., 152 F. Supp. 3d at 696 (foster children have the right to be free from “unreasonable and unnecessary intrusions into their emotional well-being”); and Mariol A., 929 F. Supp. at 674.

42. See Youngberg v. Romeo, 457 U.S. 307, 315, 317 (1982); Wyatt v. Aderholt, 503 F.2d 1305, 1309 (5th Cir. 1974) (holding that state mental institution’s failure to employ “qualified staff” in numbers sufficient to administer adequate treatment” violated the rights of class members); M.D., 152 F. Supp. 3d at 696-8 (holding foster care children have right to minimally adequate care, treatment, and services such that it prevents unreasonable risk of harm).

43. See Johnson v. Collins, 58 F. Supp. 2d 890, 904 (N.D. Ill. 1999) (recognizing “a clearly established substantive due process right to suitable foster care placement, which includes the right to adequate supervision and physical safety”), vacated on other grounds, 5 F. App’x 479 (7th Cir. 2001); Camp v. Gregory, 67 F.3d 1286, 1294-95 (7th Cir. 1995) (concluding that plaintiff stated claim for substantive due process violation where plaintiff asserted that caseworker returned foster child “to an environment he allegedly knew to be inadequate”).

44. See, e.g., Lawrence v. Texas, 539 U.S. 558, 582 (2003) (O’Connor, J., concurring) (“[W]e have never held that moral disapproval, without any other asserted state interest, is a sufficient rationale
under the Equal Protection Clause to justify a law that discriminates among groups of persons”); Suidan v. City of Houston, 31 F. App’x 154, at *2 (5th Cir. 2001) (“Plaintiff alleges that it was the police department's policy to afford less protection to a victim of domestic violence in a homosexual relationship; that animus was at least a motivating factor for the department's disparate treatment; and that [the plaintiff] was injured by this conduct. That is sufficient to state an equal protection claim”); Nabozny v. Polkany 92 F.3d 446, 457 (7th Cir. 1996) (evidence indicated that Nabozny was treated differently and that administrators' statements regarding his sexual orientation (i.e., that he should expect such harassment) were sufficient to allow a jury to find that “discriminatory treatment was motivated by the defendants' disapproval of Nabozny's sexual orientation”); Flores v. Morgan Hill Unified Sch. Dist., 324 F.3d 1130, 1136 (9th Cir. 2003) (holding that plaintiffs had proffered sufficient evidence to show that “defendants failed to adequately train teachers, students and campus monitors about the District's policies prohibiting harassment on the basis of sexual orientation,” that trainings that did occur did not focus on issues concerning sexual orientation, and that “discrimination the plaintiffs faced was a highly predictable consequence of the defendants not providing that training”); Gill v. Devlin, 867 F. Supp. 2d 849, 856 (N.D. Tex. 2012) (citing Supreme Court precedent in Romer and Lawrence for proposition that “arbitrary discrimination on the basis of sexual orientation violates the Equal Protection Clause”).


46. See, e.g., SmithKline Beecham Corp. v. Abbott Labs., 740 F.3d 471, 481-84 (9th Cir. 2014) (holding heightened scrutiny should apply to government classifications based on sexual orientation); Baskin v. Bogan, 766 F.3d 648 (7th Cir. 2014) (holding heightened scrutiny should apply to government classifications on the basis of sexual orientation); Windsor v. United States, 699 F.3d 169 (2d Cir. 2012) (holding heightened scrutiny should apply to government classifications on the basis of sexual orientation), aff’d, 133 S. Ct. 2675 (2013); Glenn v. Brunswy, 663 F.3d 1312, 1316 (11th Cir. 2011) (holding that “discriminatio[n] against someone on the basis of his or her gender non-conformity constitutes sex-based discrimination under the Equal Protection Clause”); Smith v. City of Salem, 378 F.3d 566, 572 (6th Cir. 2004) (finding that transgender firefighter stated sex discrimination claim under equal protection clause for “discrimination he experienced was based on his failure to conform to sex stereotypes by expressing less masculine, and more feminine manners and appearance”); Norsworthy v. Beard, 74 F. Supp. 3d 1100, 1114 (N.D. Cal. 2014), opinion amended and superseded, 87 F. Supp. 3d 1104 (N.D. Cal. 2015) (“[T]he Court concludes that discrimination based on transgender status independently qualifies as a suspect classification under the Equal Protection Clause because transgender persons meet the indicia of a ‘suspect’ or ‘quasi-suspect classification’ identified by the Supreme Court”).


48. Though no federal cases have yet applied these principles to LGBTQ+ youth in out-of-home care, these rights exist in case law for youth in child welfare custody in general. See, e.g., Teen Ranch, Inc. v. Udov, 479 F.3d 403 (6th Cir. 2006) (Sixth Circuit affirmed a district court finding that state placement of children in a residential facility that incorporated religious beliefs into its treatment program raised Establishment Clause concerns).

49. See, e.g., R.G. v. Koller, 415 F. Supp. 2d at 1151 (noting that youth have the right to be free from state imposed religion in suit challenging treatment in facility where staff promoted certain religious ideas by allowing no personal items in cells apart from the Bible and discussing religion including that the “Bible says that being gay is ‘not of God.’”).

50. See Hurley v. Irish-American Gay, Lesbian & Bisexual Grp. of Boston, 515 U.S. 557, 570 (1995) (finding that the group's participation in a parade “to celebrate its members' identity as openly gay, lesbian, and bisexual descendants of the Irish immigrants” was protected speech); McMillen v. Iatwanha Cty. Sch. Dist., 702 F. Supp. 2d 699, 703 (N.D. Miss. 2010) (“Expression of one's identity and affiliation to unique social groups' may constitute 'speech' as envisioned by the First Amendment” (citation omitted)); see also Tester v. City of N.Y., No. 95 Civ. 7972 (LMM), 1997 WL 81662, at *4 (S.D.N.Y. Feb. 25, 1997) (noting that “[t]he expression of a person's sexual orientation may, in certain circumstances, constitute protected speech,” but finding that plaintiff failed to allege any affirmative expression of his sexual orientation).

51. See, e.g., McMillen, 702 F. Supp. at 705 (school's conduct violated student's First Amendment rights, reasoning that “Constance has been openly gay since eighth grade and she intended to communicate a message by wearing a tuxedo and to express her identity through attending prom with a same-sex date”); Henkle v. Gregory, 150 F. Supp. 2d 1067 (D. Nev. 2001) (denying defendants' motion to dismiss the claims of a gay high school student for suppression of protected speech and retaliation).

52. Canady v. Bousier Parish Sch. Bd., 240 F.3d 437, 441 (5th Cir. 2001) (“While the message students intend to communicate about their identity and interests may be of little value to some adults, it has a considerable effect, whether positive or negative, on a young person's social development. Although this sort of expression may not convey a particularized message to warrant First Amendment protection in every instance, we cannot declare that expression of one's identity and affiliation to unique social groups through choice of clothing will never amount to protected speech.”). See Doe ex rel. Doe v. Yunios, No. 001060A, 2000 WL 33162199 (Mass. Super. Oct. 11, 2000), aff’d sub nom. Doe v. Brockton Sch. Comm., No. 2000-J-638, 2000 WL 33342399 (Mass. App. Ct. Nov. 30, 2000) (holding that a transgender student had free expression right to wear clothing consistent with his gender identity).


55. Id.

56. 45 CFR § 1355.34(b)(1)(ii); 45 CFR § 1355.34(b)(1)(i).


58. See § 477 of the Act.

59. See § Id. at (a)(8).

60. See § Id. at (b)(2)(E).

61. See § Id. at (b)(3)(D).


63. Section 1557 of the Patient Protection and Affordable Care Act, 81 F.R. 31375 (May 18, 2016) (to be codified at 45 C.F.R. 92).

I City of Salem, 378 F.3d 566, 572-73 (6th Cir. 2004) (holding of Cincinnati Smith v. Barnes v. City described as being on the basis of sex or gender.

her gender-nonconformity is sex discrimination, whether it's

At the time of writing, HHS, Office of Civil Rights has the


Id. At the time of writing, HHS, Office of Civil Rights has the following notice on their website: “On December 31, 2016, the U.S. District Court for the Northern District of Texas issued an opinion in Franciscan Alliance, Inc. et al v. Burwell, [Franciscan All., Inc. v. Burwell, No. 7:16-CV-00108-O, 2016 WI 7638311 (N.D. Tex. Dec. 31, 2016)] enjoining the Section 1557 regulation's prohibitions against discrimination on the basis of gender identity and termination of pregnancy on a nationwide basis. Accordingly, HHS’ Office for Civil Rights (HHS OCR) may not enforce these two provisions of the regulation implementing these same provisions, while the injunction remains in place. Consistent with the court's order, HHS OCR will continue to enforce important protections against discrimination on the basis of race, color, national origin, age, or disability, as well as other sex discrimination provisions that are not impacted by the court's order.” https://www.hhs.gov/civil-rights/for-individuals/section-15571557faqs/.


70. Doe v. Mercy Catholic Med. Ctr., No. 16-12487, 2017 WL 894455 (3d Cir. Mar. 7, 2017) (holding that education programs or activities covered by Title IX’s nondiscrimination provision include federally funded programs whose mission is, at least in part, educational).


72. Id.


75. Alexander S. By &Through Bowers v. Boyd, 876 F. Supp. 773 (D.S.C. 1995), as modified on denial of relg (Feb. 17, 1995), at 797-798 (facilities must have a system for screening and separating
aggressive juveniles from vulnerable juveniles); R.G. v. Koller, 415 F. Supp. 2d at 1145, 1158 (same).

76. See, e.g., Alexander S., 876 F. Supp. at 798. See also H.C. ex rel. Hewett v. Jarrard, 786 F.2d 1080 (11th Cir. 1986) (juvenile isolated for seven days was entitled to damages for violation of Fourteenth Amendment); Milonas v. Williams, 691 F.2d 931 at 941-42 (use of isolation rooms for periods less than 24 hours violated the Fourteenth Amendment); Morales v. Tiernan, 364 F. Supp. 166 (E.D. Tex. 1973) (solitary confinement of young adults held unconstitutional); Inmates of Boys' Training Sch. v. Affleck, 346 F. Supp. 1354 (D.R.I. 1972).


78. See, e.g., Allard v. Gomez, 9 Fed. Appx's. 793 (9th Cir. 2001); Meriwether v. Faulkner, 821 F.2d 408, 413 (7th Cir. 1987) (holding that “[t]here is no reason to treat transsexualism differently from any other psychiatric disorder”); Kioslek v. Malone, 221 F. Supp. 2d 156 (Mass. Dist. Ct. 2001); Wolfe v. Horse, 130 F. Supp. 2d 648 (E.D. Pa. 2001); Phillips v. Michigan Dep't of Corr., 731 F. Supp. 792 (W.D. Mich. 1990). In 2013, gender dysphoria replaced the diagnosis of gender identity disorder (GID) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the American Psychiatric Association (APA) manual used by clinicians and researchers to diagnose and classify mental conditions. The APA explained, “Replacing ‘disorder’ with ‘dysphoria’ in the diagnostic label is not only more appropriate and consistent with familiar clinical sexology terminology, it also removes the connotation that the patient is ‘disordered.’” The APA said it was concerned that completely “removing the condition as a psychiatric diagnosis—as some had suggested—would jeopardize access to care . . . Many of the treatment options for this condition include counseling, cross-sex hormones, gender reassignment surgery, and social and legal transition to the desired gender. To get insurance coverage for the medical treatments, individuals need a diagnosis.” See also note 14 and accompanying text.

79. See Castell v. Lightner, 143 F.3d 1210, 1214 (9th Cir. 1998) (holding that a practice of condoning or failing to prevent known proselytizing or religious indoctrination by prison staff would violate the Establishment Clause if plaintiff could make requisite factual showing); Bellmore v. United Methodist Children's Home and Dep't of Human Res. of Ga., settlement terms available at www.lambdalegal.org. See also R.G. v. Koller, 415 F. Supp. 2d at 1160-1161 (“[T]he court is concerned by the evidence that members of the HYC staff have promoted certain religious teachings to the plaintiffs”).

80. Id.


82. Id.

83. Id. at 1155-56 (internal citation omitted).

84. Id. at 1156.

85. Id.

86. Id. at 1157.

87. Id. at 1159.


90. Administrative authority. 42 U.S.C.A. § 5672(b) incorporating by reference prohibition of federal control over state and local criminal justice agencies; prohibition of discrimination, 42 U.S.C.A. § 3789d(c)(1).

91. Id. (emphasis added).

92. 42 U.S.C. ch. 46 § 3701.

93. See supra note 69 and accompanying text.


96. A variety of conditions that lead to atypical development of physical sex characteristics are collectively referred to as intersex conditions. These conditions can involve abnormalities of the external genitals, internal reproductive organs, sex chromosomes, or sex-related hormones.” Am. Psychological Ass'n, Answers to Your Questions About Individuals with Intersex Conditions (2006), available at http://www.apa.org/topics/lgbt/intersex.pdf.


99. Id. at §§ 115.342(d), (f) (2012).

100. Id. at § 115.342(c) (2012).

101. Id.

102. Id. at § 115.342(g) (2012).

103. Id. at § 115.315 (2012).


106. Id.

107. See supra notes 46-50 and accompanying text.


117. Id.


119. Id.

120. Id.


124. See Section VII, Appendix B: Additional Resources for a list of additional research, recommended practice and curricula for professionals and additional sample policy, statute and regulation.


126. Some state and local human rights and public accommodation laws and ordinances are broad enough to cover out-of-home care systems. These laws and ordinances offer critical protection in jurisdictions where SOGIE-inclusive protections specific to the child welfare, juvenile justice and runaway and homeless youth systems do not exist.


128. Due to the large number of counties and municipalities in the United States, the report does not attempt to collect and analyze all policies at the county and municipal level. Content accessible via the linkable maps includes local policies of which the authors are aware.


133. M.C.L.A. 722.124(e); See also text accompanying note 125.

134. S.B. 149 (S.D. 2017) (not yet codified); See also text accompanying note 125.


136. See supra note 69 and accompanying text describing how courts have held that discrimination based on sex, a protected class in some federal laws, includes both sex stereotyping and gender identity-based discrimination.

137. Sex is a protected class in North Dakota policy, but not in state regulation. See also text accompanying note 125.

138. In the context of independent living services, Arizona policy requires “every effort [be made] to ensure a diverse array of services and resources are identified to assist teens to address their needs, including any special needs or concerns related to their sexual orientation and/or gender identity,” Ariz. Dep’t of Child Safety, Policy & Procedure Manual, ch. 5, sec. 35, “Independent Living Services and Supports,” https://extranet.azdes.gov/dcyfpolicy/ (Choose Chapter 5, Section 35 from the drop-down menu).

139. See note 125.


144. Available at https://edocs.dhs.state.mn.us/lfs/docs/Policy/DHS-6500-ENG.


146. In some states, some or all juvenile justice services are located under the state Department of Health and Human Services, In
others, they are standalone agencies or under the state Department of Corrections or another agency.

140. N.Y. Comp. Codes R. & Regs. tit. 9, § 180.5(a)(6) (emphasis added).


143. Id.


145. Id. Colorado’s policy provides that a youth who has already been provided hormones shall, in consultation with a qualified provider, continue to receive those hormones. The policy does not explicitly state that a youth may begin hormone therapy while in custody, but does state youth shall meet with qualified providers. Any interpretation of this policy as one that only allows youth who have begun hormones to have access to them (if recommended by a physician) is not recommended policy.


148. D.C. Mun. Regs. tit. 29, § 6203, Note that gender identity is not listed as a protected class in the regulation, but is in the District of Columbia Human Rights Act (‘It is the intent of the Council of the District of Columbia, in enacting this chapter, to secure an end in the District of Columbia to discrimination for any reason other than that of individual merit, including, but not limited to, discrimination by reason of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an intrafamily offense and place of residence or business.”), D.C. Code Ann. § 2-1401.01 (formerly cited as D.C. Code Ann. 1981 § 1-2501).

149. Opportunities to further this research may investigate local- and county-level practices and policies, state administrative policies and the work of nongovernmental organizations that have proven promising in improving outcomes for transgender and gender-nonconforming youth involved in intervening public systems.

150. As of June 2016.

151. Many states’ juvenile justice systems are accredited by the American Correctional Association and participate in the Office of Juvenile Justice and Delinquency Prevention Performance-Based Standards (PbS). The research presented here highlights where states have expanded upon PbS in state regulation.

152. This research is limited in scope in that it was conducted as a single point-in-time survey that reflects only codified state regulations and is not a complete survey of state-, county- and local-level practice or statements of administrative policy. Additionally, many states rely on local or county-administered systems that may or may not build upon existing state regulatory frameworks.


161. E.g., Nevada defines gender identity or expression, in the context of its statute requiring foster youth to be treated in accordance with their gender identity, regardless of the gender or sex listed in their court or child welfare records in its Illinois Foster Child and Youth Bill of Rights policy, available at https://www.illinois.gov/dcfs/aboutus/notices/Documents/CFS_496-1_Illinois_Foster_Child_and_Youth_Bill_of_Rights.pdf.


163. ‘The Illinois Department of Children and Family Services provides the right “[t]o be placed in out-of-home care according to their gender identity, regardless of the gender or sex listed in their court or child welfare records” in its Illinois Foster Child and Youth Bill of Rights policy, available at https://www.illinois.gov/dcfs/aboutus/notices/Documents/CFS_496-1_Illinois_Foster_Child_and_Youth_Bill_of_Rights.pdf.

164. A.B. 99 (Nov. 2017) (not yet codified), https://www.leg.state.nv.us/Session/79th2017/Bills/AB/AB99_EN.pdf. DCFS must also consult with representatives of child welfare agencies, detention facilities and juvenile and family courts; attorneys and advocates for children; and other persons deemed appropriate by the DCFS.


166. S.B. 731 (Ca. 2015), Cal. Welf. & Inst. Code § 16006. California Department of Social Services issued an implementation plan
pending development of implementing regulations. See www.cddl.ca.gov/res/pdf/16APX-18.pdf at 14, 15. Interim regulations have been proposed and are pending. See http://www.dss.cahealthnet.gov/ord/PG5060.htm.


169. 3 Colo. Code Regs. § 708-1:81.9.


177. Minn. R. 2960.0150.


180. Idaho Admin. Code r. 05.01.02.227.

181. 7 Alaska Admin. Code 52.405(b).


183. In Rhode Island, “sexual orientation and expression” is included in a list of potential training subjects to fulfill eight of the minimum sixteen required continuing education hours for direct care staff working in residential child care facilities (R.I. Code R. 14-3-101:3(B)(G)(H)).

184. Washington requires foster parents to connect a child with resources that meet their needs regarding sexual orientation and gender identity, including cultural, educational and spiritual activities in their home or community, and provides assistance through their licensor, the child’s social worker or case manager to connect foster families with those resources (Wash. Admin. Code 388-148-1520(7)-(8)).


186. By including providers in this report, the authors do not represent that their existing service delivery is perfect or that their work on improving services for TGNC youth is complete, but that the featured providers have taken significant steps to provide affirming programs and services to LGBTQ+ youth and are committed to continuous learning and improvement in this area.

187. Interviews conducted for this report were for the sole purpose of agency improvement and public policy reform and are not held as a representative study or research. Interviews from youth are provided with their consent and where necessary, specific identifying information has been removed to protect their confidentiality. Some youth profiled here are clients of Lambda Legal and some youth were contacted through the agencies profiled in this section. Youth contributors were either compensated for their time and expertise or are current pro bono clients of Lambda Legal. Of the six youth profiled in or contributing to this report, one identifies as White, three as African-American, one as White and Pacific Islander, and one as White and Asian Pacific Islander. The authors have decoupled racial identity from each youth’s contribution to further ensure anonymity, but include information here given the over-representation of youth of color in out-of-home care systems compared to their representation in society as a whole and because youth face discrimination or mistreatment on account of multiple aspects of their identity in care and in society. As an example, in New York, while 51% of the child population are children of color, children of color comprise 73.8% of young people in juvenile detention, residential and/or correctional facilities, and 72% of children in foster care. Annie E. Casey Foundation, Kids Count Data Center (2017), http://datacenter.kidscount.org/.

188. Caitlin Ryan, et al., Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults, 123 Pediatrics 346 (2009), available at http://pediatrics.aappublications.org/content/123/1/346.


191. Id.


193. Mohammed is a pseudonym. Mohammed’s circumstances were described by REC based on its work with him and his family. Due to the confidentiality of his child welfare case, the authors did not speak with Mohammed directly. REC provided the description of Mohammed’s circumstances here, and the information shared is provided with the consent of Mohammed and his family members.


196. Lambda Legal represents Ashley. The information provided from Ashley was obtained through interviews with her and is included with her consent. Ashley’s parents have reviewed and consented to inclusion of her contribution and recommendations.

197. Lambda Legal represents Savannah. Her contribution and recommendations are provided through interviews with Savannah and with her consent.

198. Jennifer’s contributions are based on interviews with Jennifer and contact with professionals who were involved in her child welfare case. The authors also had contact with staff at Youth Oasis during and after the creation and implementation of Diversity House. Jennifer was provided with a stipend for her time contributing to this report.

199. The authors use the term “policy” here to refer to uncodified statements of agency policy that interpret and implement state statute and regulations.


VI. APPENDIX A:
STATE-BY-STATE LICENSING AND OTHER REGULATIONS


VII. APPENDIX B:
ADDITIONAL RESOURCES

RESEARCH AND REPORTS


Angela Irvine & Aisha Canfield, The Overrepresentation of Lesbian, Gay, Bisexual, Questioning, Gender


Hannah Hussey, Ctr. for Am. Progress, Beyond 4 Walls and a Roof: Addressing Homelessness Among Transgender Youth (2015), https://www.americanprogress.org/issues/lgbt/reports/2015/02/02/105754/beyond-4-walls-and-a-roof/


BEST PRACTICE GUIDELINES AND CURRICULA


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I. INTRODUCTION

1. In September of 2018, the media reported the alleged rape of a thirteen-year-old girl sleeping in a child welfare agency office in Johnson County, Kansas. The story of this child – staying overnight in an office because Kansas’ broken system lacked any housing for her – exemplified a long known danger. Kansas’ child welfare system is, and has been for at least a decade, systematically failing to protect the safety and well-being of vulnerable children and youth.
in foster care in the custody of the Kansas Department for Children and Families (DCF). This action addresses two fundamental systemic failures creating this danger.

2. **First**, Defendants – state officials responsible for the operation of the statewide foster care system in Kansas – maintain the dangerous practice of subjecting children in foster care to extreme housing disruption, also known as churning. Children in DCF custody needlessly move from placement to placement more than fifteen or twenty times, and some children even move more than fifty or one hundred times. Alarmingly, DCF frequently subjects children to “night-to-night” or short-term placements. In a repetitive, destabilizing cycle, children are regularly forced to sleep for a night or several nights anywhere a bed, couch, office conference room, shelter or hospital can be found. For days, weeks, or even months at time, they spend their nights in these short-term placements and their days in agency offices waiting to find out where they will sleep next, only to repeat the same cycle again. DCF’s practice of extreme housing disruption inherently deprives children of basic shelter and effectively renders them homeless while in state custody.

3. According to DCF data, as of June 2018, there were 7,687 children in DCF custody. Between April and September of 2018 alone, 1,459 of the children in care were forced to sleep in one-night placements. This figure, while alarming, fails to fully capture the scope of the harm children in DCF custody face. It reflects neither children churning through multiple night-to-night placements nor those housed in short-term transient placements for up to a week or a month at a time.

4. The Named Plaintiff children in this action have been moved anywhere from ten to over one hundred times while in DCF custody. Much of that churning has occurred in just the past one to two years. Given the fluid nature of the foster care population, Defendants constantly expose
different children to extreme housing disruption, as a child with just one or two placements today can become the child with ten, twenty, or more placements in the near future.

5. The practice of churning in Kansas causes and presents a risk of emotional, psychological, developmental and neurological harm. Research literature and studies show that churning causes and worsens both attachment and behavioral disorders. Research literature and studies also demonstrate that churning causes direct physical harm to children’s normal brain development; a child’s brain, central nervous system, and endocrine system are directly harmed by the practice.

6. Second, Defendants fail to provide children in DCF custody with mental health and behavioral health screening, diagnostic services, and treatment, including trauma-related screening and diagnostic services. The failure to provide mental health services mandated by the federal Medicaid statute causes, and risks causing, profound emotional and psychological harm to children in foster care. All children entering foster care in Kansas have suffered the known trauma of removal from their homes, and thousands of children in DCF custody have identified mental health needs and disorders at any given time. Yet, known shortages, delays, and waitlists for mental health services and treatment, including administrative barriers to prompt and sustained service delivery, continue to result in children being deprived of the mental health care they require.

7. The fundamental problems of churning and mental health service delivery failures are deeply interconnected. In Kansas, churning often delays or disrupts mental health screens, diagnostic services, and treatment, and the trauma of churning itself causes harm and makes the need for prompt mental health services even more urgent. This in turn contributes to more instability because foster families are frequently unable and unprepared to meet children’s unidentified and/or untreated mental health needs. For instance, while in foster care, ten-year-old
Named Plaintiff C.A. has been moved among foster homes, group homes, and agency offices more than seventy times. In 2018, he endured a three-month string of continuous night-to-night placements. Treatment for C.A.’s attention deficit disorder (ADD) and post-traumatic stress disorder (PTSD), both diagnosed while C.A. has been in DCF custody, has been disrupted in significant part because he has been moved around so often. Similarly, seventeen-year-old Named Plaintiff M.L. was diagnosed with a mood disorder after being moved over forty times while in DCF custody, bouncing among homes, facilities, offices and other night-to-night placements. Yet she has received inconsistent or negligible mental health treatment, in significant part because she has been moved so frequently.

8. Named Plaintiffs and their Next Friends bring this federal civil rights class action pursuant to Fed. R. Civ. P. 23(a) and (b)(2), as well as 42 U.S.C. § 1983, on behalf of themselves and a statewide general class of children who are or will be placed in foster care in the protective custody of DCF, and a subclass of children who have identified mental health treatment needs.

9. Defendants include Kansas Governor Jeff Colyer, Kansas DCF Secretary Gina Meier-Hummel, Kansas Department of Health and Environment (“KDHE”) Secretary Jeff Andersen, and Kansas Department for Aging and Disability Services (“KDADS”) Secretary Tim Keck, all sued in their official capacities.

10. Plaintiffs seek solely declarative and injunctive relief compelling Defendants to remedy known dangerous practices and specific structural deficiencies in the Kansas foster care system. Plaintiffs further seek to end violations of their federal rights under the Fourteenth Amendment to the U.S. Constitution, and under the Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) provisions of the federal Medicaid Act, and the resulting harms, and risks of harm, to foster children in DCF custody.
II. JURISDICTION & VENUE

11. This class action for declaratory and injunctive relief is brought pursuant to 42 U.S.C. § 1983 to redress the ongoing deprivation of rights guaranteed by the United States Constitution and federal statutory law.


13. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events and omissions giving rise to the claims herein occurred in this district and because Defendants maintain offices in this district.

III. PARTIES

A. THE NAMED PLAINTIFFS AND NEXT FRIENDS

M.B. and S.E.

14. M.B. and S.E. are brothers, aged seven and eight, respectively, who are currently in foster care in DCF custody. M.B. and S.E. have both been in DCF custody for almost eight months. Pursuant to Fed. R. Civ. P. 17(c)(2), M.B. and S.E.’s case is brought by their adult Next Friend, Katharyn McIntyre, who resides in Leavenworth County, Kansas. Ms. McIntyre is sufficiently familiar with the facts of M.B. and S.E.’s situation and is dedicated to fairly and adequately representing M.B. and S.E.’s interests in this litigation.

15. M.B. and S.E. first entered DCF custody together in Doniphan County in March 2018, when they were six and seven years old, respectively.

16. Prior to entering DCF custody, S.E. was diagnosed with attention deficit hyperactivity disorder (ADHD), and received medication for this condition.
17. Upon entering DCF custody, M.B. and S.E. were immediately separated from their older sister. Defendants subjected M.B. and S.E. to extreme housing disruption, including night-to-night placements for nearly a week.

18. M.B. and S.E. did not receive any diagnostic services to assess the trauma they suffered in connection with their removal.

19. For a period of approximately four months in 2018, DCF placed M.B. and S.E. together in Ms. McIntyre’s home. While in this home, M.B. began exhibiting behavioral health issues. Ms. McIntyre requested mental health assessment and treatment for M.B. multiple times. Despite these requests, DCF failed to provide either M.B. or S.E. with the mental health treatment they required. M.B.’s mental health continued to deteriorate, and he required hospitalization twice during this four-month period.

20. Despite their clear need for mental and behavioral health services, DCF continued to fail to provide adequate mental health services for M.B. and S.E. Without these necessary supports, that foster home was unable to continue caring for them. DCF then separated M.B. and S.E. from each other, again subjecting them to a period of extreme housing disruption, including night-to-night placements. After leaving Ms. McIntyre’s home, S.E.’s mental health deteriorated and he required hospitalization.

21. Upon information and belief, DCF is still separating M.B. and S.E. from each other, and their mental health treatment has been inconsistent, disrupted and inadequate. DCF has moved both M.B. and S.E. at least fifteen times.

22. Defendants’ actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate M.B. and S.E.’s substantive due process and federal statutory rights. Defendants have failed to protect M.B. and S.E. from harm and risk of harm by subjecting
them to extreme housing disruption, including repeated night-to-night placements, and by failing to provide for their mental health screening, diagnostic, and/or treatment needs. M.B. and S.E. continue to be at risk of harm as a result of Defendants’ actions and inactions, policies, patterns, customs, and/or practices.

V.A.

23. V.A. is a fifteen-year-old boy currently in foster care in DCF custody. V.A. has been in DCF custody for approximately seven months. Pursuant to Fed. R. Civ. P. 17(c)(2), V.A.’s case is brought by his adult Next Friend, Kathryn Ashburn, who resides in Franklin County, Kansas. Ms. Ashburn is sufficiently familiar with the facts of V.A.’s situation and is dedicated to fairly and adequately representing V.A.’s interests in this litigation.

24. Upon information and belief, V.A. first entered DCF custody in April 2018 in Franklin County.

25. DCF has already subjected V.A. to extreme housing disruption and has moved him among different placements over ten times in the seven months that V.A. has been in custody. His placements have included over a week of night-to-night placements, two group homes, and a foster home. Although V.A. is originally from Franklin County, DCF has already moved him to Paola County, Sedgwick County, and Wyandotte County. He is presently in a foster home in Shawnee County.

26. Upon information and belief, V.A. still does not have a stable placement. Since entering DCF custody, V.A. has not received any diagnostic services to assess the trauma he suffered in connection with his removal. Additionally, V.A. has not received any mental health or behavioral health screening, diagnostic services, or treatment.
27. Defendants’ actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate V.A.’s substantive due process and federal statutory rights. Defendants have failed to protect V.A. from harm and risk of harm by subjecting him to extreme housing disruption, including repeated night-to-night placements, and by failing to provide for his mental health screening, diagnostic and/or treatment needs. V.A. continues to be at risk of harm as a result of Defendants’ actions and inactions, policies, patterns, customs, and/or practices.

J.M.

28. J.M. is a sixteen-year-old boy currently in DCF custody in foster care. J.M. has been in DCF custody since March 2018. Pursuant to Fed. R. Civ. P. 17(c)(2), J.M.’s case is brought by his adult Next Friend, Ed Bigus, who resides in Miami County, Kansas. Mr. Bigus is sufficiently familiar with the facts of J.M.’s situation and is dedicated to fairly and adequately representing J.M.’s interests in this litigation.

29. J.M. first entered DCF custody in Johnson County, Kansas. J.M. has a history of physical abuse, acting out, and depression. J.M. has been assessed with having disruptive mood dysregulation disorder and other specific episodic mood disorders, for which he requires counseling and/or psychotherapy. Despite his mental health needs, DCF did not even conduct an intake mental health assessment until he had been in custody for more than three months. On July 30, 2018, J.M. was found to be suffering from traumatic stress.

30. DCF has subjected J.M. to extreme housing disruption and has moved him among different placements more than twenty-five times in the few months he has been in DCF custody. J.M. has experienced weeks of short-term and night-to-night placements, spending his days at KVC offices. He has also spent the night at the KVC office.
31. Despite his clear need for stability and consistent mental health services, DCF has continued to subject J.M. to extreme housing disruption, worsening J.M’s mental and emotional health.

32. J.M. still does not have a stable placement. He also has not been provided with consistent mental health services to meet his identified mental health treatment needs. The mental health treatment he has received has been repeatedly disrupted and inadequate.

33. J.M. has run away from his placements on multiple occasions.

34. Defendants’ actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate J.M.’s substantive due process and federal statutory rights. Defendants have failed to protect J.M. from harm and risk of harm by subjecting him to extreme housing disruption, including repeated night-to-night placements, and by failing to provide for his mental health screening, diagnostic, and/or treatment needs. J.M. continues to be at risk of harm as a result of Defendants’ actions and inactions, policies, patterns, customs, and/or practices.

**M.J.**

35. M.J. is a seventeen-year-old boy currently in DCF custody in foster care. M.J. has been in DCF custody for nine years. Pursuant to Fed. R. Civ. P. 17(c)(2), M.J.’s case is brought by his adult Next Friend, Ed Bigus, who resides in Miami County, Kansas. Mr. Bigus is sufficiently familiar with the facts of M.J.’s situation and is dedicated to fairly and adequately representing M.J.’s interests in this litigation.

36. M.J. first entered DCF custody nine years ago in Johnson County, Kansas, when he was eight years old.

37. M.J. has intense mental health needs, for which he has been prescribed medications. He is currently housed at a youth residential facility.
38. DCF has subjected M.J. to extreme housing disruption and has moved him more than eighty times among different placements, including group homes, shelters, psychiatric residential treatment facilities ("PRTFs"), and multiple night-to-night placements. For the past five years, M.J. has been repeatedly housed in night-to-night placements, sometimes for weeks at a time. When subjected to night-to-night placements, J.M. would be forced to stay in KVC offices during the day.

39. Despite his clear need for stability and consistent mental health services, DCF has continued to subject M.J. to extreme housing disruption, worsening M.J.’s mental and emotional health.

40. DCF has also failed to provide M.J. with mental health services for prolonged periods of time, especially after he has been discharged from residential facilities or moved to different parts of the state. Any mental health services he has received have been inconsistent, disrupted, and inadequate.

41. The churning DCF has imposed on M.J. has disrupted his access to education. During his numerous night-to-night placements, J.M. was not attending school at all.

42. Defendants’ actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate M.J.’s substantive due process and federal statutory rights. Defendants have failed to protect M.J. from harm and risk of harm by subjecting him to extreme housing disruption, including repeated night-to-night placements, and by failing to provide for his mental health screening, diagnostic, and/or treatment and service needs. M.J. continues to be at risk of harm as a result of Defendants’ actions and inactions, policies, patterns, customs, and/or practices.
R.M.

43. R.M. is a thirteen-year-old boy currently in DCF custody in foster care. R.M. has been in DCF custody for six years. Pursuant to Fed. R. Civ. P. 17(c)(2), R.M.’s case is brought by his adult Next Friend, Allan Hazlett, who resides in Shawnee County, Kansas. Mr. Hazlett is sufficiently familiar with the facts of R.M.’s situation and is dedicated to fairly and adequately representing R.M.’s interests in this litigation.

44. R.M. first entered DCF custody in 2012 in Shawnee County, Kansas, when he was seven years old. He remained in foster care for three years until 2015 when he became eligible for adoption.

45. R.M. was moved out of state for a possible adoption with a relative in Iowa. However, DCF failed to take the necessary steps to finalize the adoption. As a result, the placement disrupted and R.M. returned to Kansas.

46. When he returned to DCF custody, R.M was placed in a PRTF. In or around 2016, R.M. was diagnosed with attention deficit disorder (ADD), oppositional defiance disorder (ODD), post-traumatic stress disorder (PTSD), and a mood disorder, for which he was prescribed psychotropic medications and requires counseling and/or psychotherapy.

47. DCF has subjected R.M. to extreme housing disruption and has moved him among different placements over 130 times since he has been in DCF custody. R.M.’s placements have included foster homes, group homes, and other facilities, as well as multiple night-to-night and short-term placements. While in DCF custody, R.M. has received inconsistent mental health services. In 2016, at eleven years old, R.M. was so desperate for a stable loving home that he ran away from his DCF placement for several days.
Despite his clear need for stability and consistent mental health services, DCF has continued to subject R.M. to extreme housing disruption, worsening R.M.’s mental and emotional health. Since 2016, R.M. has been hospitalized for mental health related issues on three separate occasions.

The churning DCF has imposed on R.M. has caused him to frequently change schools. During some of his night-to-night and short-term placements, he has not attended school at all. Despite being a competent student, the constant disruption has caused R.M. to fall behind in his education.

R.M. still does not have a stable placement. He also is not receiving mental health services, including counseling and/or psychotherapy, to meet his identified mental health treatment needs. Any mental health services he has received have been inconsistent, disrupted and inadequate.

Defendants’ actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate R.M.’s substantive due process and federal statutory rights. Defendants have failed to protect R.M. from harm and risk of harm by subjecting him to extreme housing disruption, including repeated night-to-night and short-term placements, and by failing to provide for his mental health screening, diagnostic, and/or treatment needs. R.M. continues to be at risk of harm as a result of Defendants’ actions and inactions, policies, patterns, customs, and/or practices.

C.A.

C.A. is a ten-year-old boy currently in DCF custody in foster care. C.A. has been in DCF custody for six years. Pursuant to Fed. R. Civ. P. 17(c)(2), C.A.’s case is brought by his adult Next Friend, Allan Hazlett, who resides in Shawnee County, Kansas. Mr. Hazlett is 

sufficiently familiar with the facts of C.A.’s situation and is dedicated to fairly and adequately representing C.A.’s interests in this litigation.

53. C.A. first entered DCF custody in 2012 in Shawnee County, Kansas, when he was four years old. C.A. entered DCF custody with his sister. However, C.A. was soon separated from his sister when she was placed with her biological father.

54. DCF has subjected C.A. to extreme housing disruption and has moved C.A. among different placements over seventy times since he has been in DCF custody. C.A.’s placements have included foster homes and group homes, as well as multiple night-to-night and short-term placements. DCF has forced C.A. to sleep overnight at child welfare offices on multiple occasions. From approximately March through May of 2018, DCF subjected C.A. to a near continuous three-month string of night-to-night placements in different settings. During this time, ten-year-old C.A. never knew where he would sleep each night.

55. While in DCF custody, C.A. has been diagnosed with ADD and PTSD. He has been prescribed psychotropic medications for ADD and requires counseling and/or psychotherapy. He has an individual education plan (IEP) at school for behavioral health issues relating to his mental health conditions. The churning DCF has imposed on C.A. has caused him to frequently change schools, and during some of his night-to-night and short-term placements he has not attended school at all.

56. C.A. still does not have a stable placement. He is also not receiving mental health services, including counseling and/or psychotherapy, to meet his identified mental health treatment needs. Any services he has received have been inconsistent, disrupted and inadequate.

57. Defendants’ actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate C.A.’s substantive due process and federal statutory rights.
Defendants have failed to protect C.A. from harm and risk of harm by subjecting him to extreme housing disruption, including repeated night-to-night and short-term placements, and by failing to provide for his mental health screening, diagnostic, and/or treatment needs. C.A. continues to be at risk of harm as a result of Defendants’ actions and inactions, policies, patterns, customs, and/or practices.

Z.Z.

58. Z.Z. is an eleven-year-old girl currently in DCF custody in foster care. Z.Z. has been in DCF custody for six years. Pursuant to Fed. R. Civ. P. 17(c)(2), Z.Z.’s case is brought by her adult Next Friend, Ashley Thorne, who resides in Sedgwick County, Kansas. Ms. Thorne is sufficiently familiar with the facts of Z.Z.’s situation and is dedicated to fairly and adequately representing Z.Z.’s interests in this litigation.

59. Z.Z. first entered DCF custody in 2012 in Butler County, Kansas, when she was five years old. Z.Z. was initially placed with an elderly foster mother. Due to the foster mother’s health, she was unable to adequately care for Z.Z., and Z.Z. was moved from this home.

60. After her initial placement disrupted, Z.Z. started to exhibit behavioral health problems. DCF placed Z.Z. in a PRTF in Topeka, across the state from her home community.

61. While Z.Z. was living in the PRTF for several months, her mental health began to improve, but, upon information and belief, her treatment was artificially cut short. Despite Z.Z.’s continued need for mental health treatment, she left the PRTF prematurely and without access to any “step down” placements to meet her ongoing treatment needs. Instead, Z.Z. was moved from the PRTF to a string of night-to-night and short-term placements, including being forced to sleep overnight in child welfare offices.
62. DCF has subjected Z.Z. to extreme housing disruption and has moved Z.Z. among different foster homes, group homes, and other facilities over twenty-five times since she has been in DCF custody. Z.Z.’s placements have included multiple night-to-night and short-term placements.

63. After a desperate and tragic episode where she placed her own life and her foster mother’s life at risk, Z.Z. languished for months on a waiting list for a second PRTF placement. She did not receive a diagnostic brain scan or alternative treatment despite an identified need and requests for this treatment.

64. Even while Z.Z. was on the PRTF waiting list due to her identified need for mental health services, DCF continued to subject her to continued extreme housing disruption. Z.Z. was moved among ten different placements between May 2017 and June 2018.

65. Z.Z. still does not have a stable placement. She has not received mental health services, including counseling and/or psychotherapy, that are necessary to meet her identified mental health treatment needs. Any services she has received have been inconsistent, disrupted and inadequate.

66. Defendants’ actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate Z.Z.’s substantive due process and federal statutory rights. Defendants have failed to protect Z.Z. from harm and risk of harm by subjecting her to extreme housing disruption, including repeated night-to-night placements, and by failing to provide for her mental health screening, diagnostic, and/or treatment needs. Z.Z. continues to be at risk of harm as a result of Defendants’ actions and inactions, policies, patterns, customs, and/or practices.
B.B.

67. B.B. is a sixteen-year-old girl currently in DCF custody in foster care. B.B. has been in DCF custody for six years. Pursuant to Fed. R. Civ. P. 17(c)(2), B.B.’s case is brought by her adult Next Friend, Ashley Thorne, who resides in Sedgwick County, Kansas. Ms. Thorne is sufficiently familiar with the facts of B.B.’s situation and is dedicated to fairly and adequately representing B.B.’s interests in this litigation.

68. B.B. first entered DCF custody in 2012 in Butler County. B.B. was adopted shortly after she entered DCF custody, but the adoption disrupted and she returned to DCF custody. B.B.’s mental health and behavior deteriorated after the adoption disrupted.

69. DCF has subjected B.B. to extreme housing disruption and has moved B.B. among different placements numerous times since she has been in DCF custody. B.B.’s placements have included foster homes, group homes, and other facilities, as well as multiple night-to-night and short-term placements. B.B. has been placed in a PRTF several times. She has also been placed in juvenile justice facilities.

70. B.B. still does not have a stable placement. She also is not receiving mental health services, including counseling and/or psychotherapy, to meet her identified mental health treatment needs. Any services she has received have been inconsistent, disrupted and inadequate. Upon information and belief, for the last several months DCF has subjected B.B. to a string of night-to-night and short-term placements, and B.B. has run away from them on multiple occasions.

71. Defendants’ actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate B.B.’s substantive due process and federal statutory rights. Defendants have failed to protect B.B. from harm and risk of harm by subjecting her to extreme housing disruption, including repeated night-to-night placements and by failing to provide for her
mental health screening, diagnostic, and/or treatment needs. B.B. continues to be at risk of harm as a result of Defendants’ actions and inactions, policies, patterns, customs, and/or practices.

**M.L.**

72. M.L. is a seventeen-year-old girl currently in DCF custody in foster care. Pursuant to Fed. R. Civ. P. 17(c)(2), M.L.’s case is brought by her adult Next Friend, Ashley Thorne, who resides in Sedgwick County, Kansas. Ms. Thorne is sufficiently familiar with the facts of M.L.’s situation, and she is dedicated to fairly and adequately representing M.L.’s interests in this litigation.

73. M.L. first entered DCF custody in 2007, in Sedgwick County, when she was approximately six years old. She entered care with two biological siblings, her then approximately seven-year-old sister and her infant brother.

74. After the three siblings’ adoption in 2010, their adoptive father and adoptive brother repeatedly sexually assaulted and sodomized M.L. and her sister. Upon information and belief, the sisters remained in this home for three years despite multiple calls to Child Protective Services reporting the abuse.

75. In 2013, DCF finally removed M.L. and her siblings from their adoptive father’s home and they reentered foster care. M.L. was immediately separated from both of her biological siblings.

76. Since M.L. returned to DCF custody in 2013, DCF has subjected her to extreme housing disruption and has moved her among different placements more than forty-two times. M.L.’s placements have included foster homes, group homes, PRTFs, and other facilities, as well as multiple night-to-night and short-term placements. In one of her placements, M.L. was sexually exploited and a victim of sex trafficking. On several occasions, DCF cycled M.L. through night-
to-night placements for weeks at a time. At other times, DCF forced M.L. to sleep overnight in child welfare agency offices – once for an entire week. During one of M.L.’s overnight office stays, a DCF contract agency staff member physically assaulted M.L. Despite this assault, DCF continued to house M.L. in the agency office.

77. Following years of trauma and extreme housing disruption in DCF custody, M.L. developed a mood disorder. In 2017, she was diagnosed with PTSD and bipolar disorder. She was also prescribed psychotropic medications. Since her diagnosis, however, she has not received consistent medically necessary mental health treatment. Instead, her frequent placement changes and changes in service providers have repeatedly disrupted and delayed treatment.

78. Beginning in 2017, DCF placed M.L. in a PRTF for more than twelve months. M.L.’s documented mental health needs did not require restrictive residential treatment, but no less restrictive placement existed to meet her needs.

79. On at least two occasions in 2018, M.L. has run away from DCF care in an effort to escape the churning and further abuse. M.L. still does not have a stable placement. She is also not receiving mental health services to meet her identified mental health treatment needs. Any services she has received have been inconsistent, disrupted, and inadequate. During periods when DCF housed M.L. in night-to-night and short-term placements, she often did not attend school.

80. Defendants’ actions and inactions, policies, patterns, customs, and/or practices have violated and continue to violate M.L.’s substantive due process and federal statutory rights. Defendants have failed to protect M.L. from harm and risk of harm by subjecting her to extreme housing disruption, including repeated night-to-night placements, and by failing to provide for her mental health screening, diagnostic, and/or treatment needs. M.L. continues to be at risk of harm as a result of Defendants’ actions and inactions, policies, patterns, customs, and/or practices.
B. DEFENDANTS

81. Jeff Colyer, Governor of Kansas, is sued in his official capacity. Under Article I, Section 3 of the Kansas Constitution, the governor holds supreme executive power and is responsible for the enforcement of the laws of the state. He is therefore responsible for ensuring all Kansas executive agencies comply with all applicable laws. Governor Colyer has the authority to issue executive reorganization orders “transferring, abolishing, consolidating or coordinating the whole or any part of any [executive] state agency, or the functions thereof” and to significantly reshape the functions and coordination of defendant agencies DCF, KDHE, and KDADS. Governor Colyer is also responsible for appointing, and has the power to remove, the Secretaries of DCF, KDHE, and KDADS. The governor has used his executive authority to manage the work of defendant agencies DCF, KDHE, and KDADS, including child welfare and Medicaid. Governor Colyer’s office is located in this District.

82. Gina Meier-Hummel, Secretary of DCF, is sued in her official capacity. DCF serves as the executive agency responsible for the safety and well-being of children in need of care. DCF is the agency with overall direct non-delegable custodial responsibility for investigating allegations of abuse and neglect, placing children in foster care in placements that meet their needs, ensuring children’s safety and well-being, and ensuring that children in foster care receive appropriate mental health screening and treatment. Secretary Meier-Hummel has “the power and duty to determine the general policies relating to all forms of social welfare which are administered or supervised by the secretary and to adopt the rules and regulations therefor.” Secretary Meier-Hummel is responsible for developing and administering or supervising program activities including the care and protection of children in need of care. Secretary Meier-Hummel is ultimately responsible for ensuring that DCF finds suitable homes for children in need of care and
supervises those children in such homes. Secretary Meier-Hummel maintains her principal office in this District.

83. Jeff Andersen, Secretary of KDHE, is sued in his official capacity. KDHE is the single state Medicaid agency pursuant to 42 U.S.C. § 1396a(a)(5). KDHE is the executive agency responsible for financial management and contract oversight of Kansas’ Medicaid program, KanCare. Secretary Andersen is responsible for ensuring that Kansas’ Medicaid and mental health services are administered in a manner consistent with federal and state law. Secretary Andersen maintains his principal office in this District.

84. Tim Keck, Secretary of KDADS, is sued in his official capacity. KDADS is the executive agency responsible for operating hospitals and institutions in Kansas and for administering Medicaid waiver programs for disability services, mental health, and substance abuse. KDADS is also responsible by statute and holds the authority and responsibility to coordinate and provide mental health services in Kansas. KDADS also oversees the Home and Community Based Services (HCBS) program in Kansas. Secretary Keck is responsible for ensuring that Kansas’ Medicaid and mental health services are administered in a manner consistent with federal and state law. Secretary Keck maintains his principal office in this District.

IV. CLASS ACTION ALLEGATIONS

General Class

86. All Plaintiffs seek to represent a statewide General Class defined as all children who are now, or in the future will be, in the protective custody of DCF pursuant to KAN. STAT. ANN. § 38-2242(c)(1).

87. The General Class is sufficiently numerous to make joinder of all members impracticable. According to DCF data, as of September 2018, there were 7,530 children in DCF’s protective custody in foster care. Upon information and belief, a similar number of children are currently in DCF’s protective custody in foster care.

88. The questions of fact and law raised by the Named Plaintiffs’ claims are common to and typical of members of the General Class whom they seek to represent. Each Named Plaintiff and putative General Class member relies on Defendants for their safety and well-being, and has been subjected to significant harms, and/or risks of harm, as a result of the known dangers and structural deficiencies alleged in this Complaint.

89. Defendants have acted or failed to act on grounds generally applicable to all members of the General Class, necessitating class-wide declaratory and injunctive relief. Plaintiffs’ counsel know of no conflicts between or among members of the General Class.

90. The common questions of fact shared by the Named Plaintiffs and the members of the General Class they seek to represent include: (1) whether Defendants have a pattern, custom, policy, and/or practice of extreme housing disruption, exposing the General Class to psychological, emotional, and physical harm and/or an ongoing immediate risk of such harm; and (2) whether Defendants have a pattern, custom, policy, and/or practice of failing to provide children in foster care with required screening and diagnostic services, including trauma-related screening and diagnostic services.
91. The common questions of law shared by the Named Plaintiffs and members of the General Class they seek to represent include: (1) whether Defendants’ pattern, custom, policy, and/or practice of extreme housing disruption, and the structural deficiencies contributing to that known danger, subject the General Class to continuing risk of deprivation of their substantive due process rights conferred by the Fourteenth Amendment to the United States Constitution; and (2) whether Defendants’ pattern, custom, policy and/or practice of failing to provide the General Class with screening and diagnostic services, including trauma-related screening and diagnostic services, violates their rights under the EPSDT provisions of the Medicaid Act.

92. The Named Plaintiffs will fairly and adequately represent the interests of the General Class they seek to represent.

93. Defendants’ patterns, customs, policies and/or practices harm and/or present an ongoing imminent risk of harm to all members of the General Class. Accordingly, final injunctive and declaratory relief is appropriate for the class as a whole.

**Mental Health Treatment Subclass**

94. Plaintiffs M.B., S.E., J.M., M.J., R.M., C.A., Z.Z., B.B., and M.L. seek to represent a Mental Health Treatment Subclass of all children in the General Class who have or will have an identified mental health or behavioral health treatment need pursuant to the EPSDT provisions of the Medicaid Act, 42 U.S.C. §§ 1396a(a)(10)(A)(i)(I), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r). Children with identified mental health or behavioral health treatment needs include: children eligible for the Serious Emotional Disturbance (“SED”) Waiver Program; children prescribed psychotropic medications; and/or children who have received a DSM-III, DSM-IV, or DSM-5 diagnosis.
95. The Mental Health Treatment Subclass is sufficiently numerous to make joinder impracticable. According to Kansas data reported to the federal government in 2016, there were over 3,000 children identified as emotionally disturbed in out of home care at any point during federal fiscal year 2016. Upon information and belief, a similar number of children in foster care in DCF protective custody are currently identified as having a serious emotional disturbance.

96. The questions of fact and law raised by the Named Plaintiffs’ claims are common to and typical of members of the Mental Health Treatment Subclass they seek to represent. Each Named Plaintiff and putative Mental Health Treatment Subclass member relies on Defendants for his or her safety and well-being, and has been subjected to known harms, and risks of harm, as a result of the known patterns, customs, policies, practices, and structural deficiencies alleged in this Complaint.

97. Defendants have acted or refused to act on grounds generally applicable to all members of the Mental Health Treatment Subclass, necessitating class-wide declaratory and injunctive relief. Plaintiffs’ counsel know of no conflicts between or among members of the Mental Health Treatment Subclass.

98. The common question of fact shared by the Named Plaintiffs and the members of the Mental Health Treatment Subclass they seek to represent is whether Defendants have a pattern, custom, policy and/or practice of failing to provide children in DCF foster care custody with access to timely medically necessary mental and behavioral health treatment, as required by law.

99. The common question of law shared by the Named Plaintiffs and the members of the Mental Health Treatment Subclass they seek to represent is whether Defendants’ patterns, customs, policies and/or practices, noted above, violate the rights of children in the Mental Health Treatment Subclass under the EPSDT provisions of the Medicaid Act.
100. The Named Plaintiffs will fairly and adequately protect the interests of the Mental Health Treatment Subclass they seek to represent.

101. Defendants’ patterns, customs, policies and/or practices harm and/or present an ongoing imminent risk of harm to all members of the Mental Health Treatment Subclass. Accordingly, final injunctive and declaratory relief is appropriate for the subclass as a whole.

**Next Friends**

102. Each Named Plaintiff appears by a Next Friend. Each Next Friend has sufficient familiarity with the facts of the respective Named Plaintiff and is dedicated to fairly and adequately representing that Named Plaintiff’s interests in this litigation. Each Next Friend is also dedicated to representing the best interests of the putative General Class and/or Mental Health Treatment Subclass they seek to represent.

**Plaintiffs’ Representatives**

103. Plaintiffs, the General Class, and the Mental Health Treatment Subclass are represented by:

   a. Attorneys from Kansas Appleseed Center for Law & Justice, Inc., a nonprofit, nonpartisan advocacy organization dedicated to vulnerable and excluded Kansans, who investigate social, economic, and political injustice in Kansas and work toward systemic solutions, and who serve as a voice for the public at large and for individuals and groups who are without effective legal representation;

   b. Loretta Burns-Bucklew, J.D., Child Welfare Law Specialist, an attorney in Kansas City, Missouri, who has experience in complex federal child welfare class actions and impact litigation, the individual representation of children in child welfare proceedings, and the child welfare service delivery structure in Missouri and Kansas;
c. Attorneys from the National Center for Youth Law, a national nonprofit organization specializing in representing children and adolescents in child welfare, mental health, education, and juvenile justice reform class actions and impact litigation; and 

d. Attorneys from Children’s Rights, a national nonprofit organization, who have experience in complex federal class actions in child welfare, mental health, education, and juvenile justice.

104. These attorneys and organizations have investigated all claims in this action and committed sufficient resources to represent the General Class and the Mental Health Treatment Subclass.

105. Plaintiffs’ counsel are well-suited to fairly and adequately represent the interests of the General Class and the Mental Health Treatment Subclass.

V. FACTUAL ALLEGATIONS

A. Foster Care Housing and Mental Health Delivery and Oversight Structure in Kansas

**Kansas’ Foster Care Delivery and Oversight Structure**

106. Kansas began the process of privatizing its child welfare system in 1996. Kansas DCF continued to investigate allegations of abuse and neglect, but awarded contracts to three nonprofits covering five regions of the state to assist in the provision of foster care services, including placements and the delivery of mental health and behavioral health services.

107. Kansas’ most recent foster care contracts started on July 1, 2013. Currently, Kansas contracts with two lead agencies, KVC Behavioral HealthCare Kansas (“KVC”) and St. Francis Community Services (“SFCS”), to provide family preservation, foster care, adoptive, and reintegration services throughout the state. KVC provides services to children in the East and Kansas City regions and SFCS provides services to children in the West and Wichita regions.
These two lead agencies subcontract with a variety of other placement and service providers and agencies.

108. When children enter foster care, they are placed in DCF’s protective custody pursuant to KAN. STAT. ANN. § 38-2242(c)(1). DCF engages contractors and subcontractors to perform some functions, but it always retains the direct legal duty and responsibility for the safety and well-being of children in foster care. As stated in a July 2016 audit, DCF “has a primary role in recommending whether a child should be removed from their home,” remains responsible for placement, and has the authority to place children. Additionally, DCF is responsible for licensing foster homes.

**Kansas’ Children’s Mental Health Delivery and Oversight Structure**

109. Medicaid is a cooperative federal and state funded program authorized and regulated pursuant to Title XIX of the Social Security Act, providing for medically necessary health and mental health care for low-income children and families, among others. State participation is voluntary, but states including Kansas that choose to accept federal funding and participate in Medicaid must adhere to its statutory and regulatory requirements. 42 U.S.C. § 1396 et seq. States receive federal matching funds for their own programs in the form of reimbursements by the federal government for a portion of the cost of providing Medicaid benefits.

110. As a participant in the Medicaid program, Kansas must provide all Medicaid-eligible children and youth under the age of twenty-one with EPSDT screenings that include “a comprehensive health and developmental history (including assessment of both physical and mental health development).” 42 U.S.C. § 1396d(r)(1)(B). Periodic screening must occur at regular age intervals as laid out on a periodicity schedule. 42 U.S.C. § 1396d(r)(1)(A)(i). Kansas adopted
the Bright Futures periodicity schedule, which requires a psychosocial/behavioral health assessment at every periodic screening.

111. In addition, Kansas must provide EPSDT screening at other intervals indicated as medically necessary to determine the existence of certain physical or mental illnesses or conditions. 42 U.S.C. § 1396d(r)(1)(A)(ii). For children entering foster care, all of whom have known exposure to trauma, such medically necessary screening includes screening to assess their trauma-related needs.

112. Kansas must also provide and arrange for such other health care, diagnostic services, treatment, and other measures necessary to correct or ameliorate a psychiatric, behavioral, or emotional condition discovered by the screening services. 42 U.S.C. § 1396d(r)(5). For children entering foster care, such diagnostic and treatment services must address their known trauma history and any trauma-related treatment needs. Among the intensive home and community-based treatment services that Kansas is obligated to provide are: home health care services, 42 U.S.C. § 1396d(a)(7), recommended medical and remedial services, 42 U.S.C. § 1396d(a)(13), case management services, 42 U.S.C. §§ 1396d(a)(19), 1396n(g), and personal care services, 42 U.S.C. § 1396d(a)(24).

113. All children in DCF protective custody in foster care are entitled to Medicaid services, including these mandated EPDST screenings, diagnostic services and treatment. Such medical assistance, including EPSDT services, must be provided with reasonable promptness. 42 U.S.C. §§ 1396a(a)(8), 1396d(a)(4)(B).

114. States, including Kansas, may adopt managed care models for required services, contract with other entities concerning the delivery of services, and arrange services through provider networks. Nonetheless, all the states, including Kansas, remain responsible for ensuring
compliance with all relevant Medicaid requirements, including the mandates of the EPSDT program. 42 U.S.C. §§ 1396a(a)(5), 1396a(a)(43), 1396u-2. States, including Kansas, must ensure that the managed care entity has the capacity to offer the full range of necessary and appropriate preventative and primary services for all enrolled beneficiaries. 42 U.S.C. § 1396u-2(b)(5).

115. All Defendants share responsibility for delivering mental health and behavioral health services to children in foster care in Kansas. KDHE and KDADS jointly administer KanCare, which is the program through which Kansas has administered Medicaid since 2013. KDHE maintains financial management and contract oversight of the KanCare program, while KDADS administers Medicaid waiver programs for disability services, mental health, and substance abuse, while also operating state hospitals and institutions. KanCare provides services to consumers through three health plans, Sunflower Health Plan, United Healthcare Community Plan of Kansas, and Amerigroup Kansas (to be replaced by Aetna Better Health of Kansas effective in January 2019). Each of these entities is responsible for coordinating all care, including preventive services, screenings, diagnostic services, and ongoing treatment, for its members. DCF, as the agency charged with the protection of children in need of care (including all foster children in DCF custody), has a legal responsibility to protect children’s well-being by ensuring that they have access to and are provided with the mental and behavioral health services they need, and that these services are provided with reasonable promptness.

B. **Defendants’ Known Practice of Extreme Placement Instability, Including “Night-to-Night” Placements, Harms Children and Imposes an Unreasonable Risk of Harm.**

116. Defendants have a known dangerous policy, custom, pattern or practice of subjecting children in foster care to extreme housing disruption, also known as churning. It is not uncommon for children in DCF custody to move between placements more than fifteen or twenty
times, and even more than thirty, forty, or fifty times. This practice also includes a “high frequency of one-night placements,” also known as short-term and “night-to-night” placements, in which children are forced to sleep for a night or a short-term period anywhere a bed, couch, office conference room, shelter or hospital bed can be found. The next morning, children are collected at an agency office to wait for their next placement, in a loop that can repeat for days, weeks or even months at a time. For example, when Named Plaintiff M.L. has been subjected to night-to-night and short-term placements, DCF and/or a placement or service provider under contract with DCF drop her off at a foster home in the late afternoon or early evening with barely more than the clothes on her back. After a one-night, or perhaps several-night stay, she is picked up again, restarting the cycle. On several occasions, DCF has subjected M.L. to night-to-night placements for weeks at a time. More than once, DCF has forced M.L. to sleep overnight in a child welfare agency office.

**The Practice of Placement Instability Has Steadily Worsened to its Current Crisis.**

117. The known practice of churning in the Kansas foster care system dates back almost twenty years. Since 2001, the Federal Children’s Bureau, part of the Administration of Children Youth and Families in the Department of Health and Human Services, has reviewed state child and family services programs through the Child and Family Services Reviews (“CFSR”). These reviews determine whether such programs are in substantial conformity with federal requirements for federal funding purposes.

118. Kansas has significantly failed to meet the National Standard for “stability of foster care placements” in all three rounds of the CFSR, going back to 2001. In the first round of the CFSR in 2001, the national standard for “stability of foster care placements” was established at 86.7% or more of “children who entered foster care during a twelve-month-period that had two or
fewer placements,” but Kansas’ percentage was only 64.2%. In the second round of the CFSR in 2007, the national standard for placement stability was a composite score of three measures together totaling 101.5 or higher, but Kansas’ composite score was only 77.5. In the third round of the CFSR in 2015, the measure was a maximum of 4.12 moves per 1,000 days in foster care for all children who enter care in a twelve-month period, but Kansas’ performance was 5.28 moves.

119. Housing instability for Kansas children in foster care has continued to escalate after the third round of the CFSR. In State Fiscal Year (“SFY”) 2016, Kansas’ Observed Performance for placement instability increased to 6.6 moves per 1,000 days in foster care, and in SFY 2017 it climbed to 7.1. Even worse, data for SFY 2018 was reported at 8.6 moves per 1000 days, more than double the federal CFSR standard and a thirty percent increase in instability from 2016. Kansas’ most recent data report to the federal government on the actual frequency and number of moves of foster children, completed in 2016, reveals that 696 children had experienced more than ten placements; of those, 247 children experienced more than twenty placements, and 105 children experienced more than thirty placements. This 2016 data does not account for the thirty percent increase in the average number of moves experienced by children entering DCF foster care from 2016 to 2018. Accordingly, upon information and belief, the current number of moves actually experienced by large numbers of foster children is significantly higher.

120. The current housing disruption crisis in Kansas’ foster care system is reflected in the experiences of the Named Plaintiffs. DCF has moved each of these children anywhere from ten to over one hundred times while in DCF custody, with much of that extreme movement occurring in the last one to two years. For example, Named Plaintiffs V.A. and J.M. both entered DCF custody in 2018 and have already been moved more than ten and twenty times, respectively. DCF has moved Plaintiff R.M. between different placements over 130 times.
The Current Crisis of “Night-to-Night” Placements in Kansas

121. A Report of the Child Welfare System Task Force to the State Legislature in January 2018, identified “increasing numbers of children and youth who are forced to sleep overnight in child placement agency offices because there is nowhere else for them to go after being removed from their homes.” The Task Force specifically referred to both “one-night placements” and “overnight stays in contractor offices.” Such placements may be literally for one night or may occur for several nights at a time. Whether the overnight setting is an office, foster home, or facility, it is part of the same ongoing dangerous practice and cycle. Instead of providing optimal or even appropriately matched housing to meet children’s needs, Defendants often have nowhere to house a foster child in DCF custody. As a result, children spend their days at contractor agency offices, and then are either forced to sleep in the office or dropped off in the evening at any foster home or facility willing to provide a bed just for the night. The same process then repeats over and over again.

122. Kansas’ Child Welfare System Task Force received testimony in April 2018 that many foster children “without permanent placement do not know from night-to-night where they will be staying. They are literally packing a suitcase and moving every morning,” and “they frequently have no idea where they will be sleeping that night.” This practice amounts to an inherent deprivation of shelter and is de facto homelessness.

123. According to testimony by Defendant Meier-Hummel to the Child Welfare System Task Force, SFCS, one of the two DCF lead contractor agencies in Kansas, subjected 764 children to one-night placements from April to September of 2018. In the same testimony, Defendant Meier-Hummel stated that during that same period, KVC, the other lead DCF contractor agency, subjected 695 children to one-night placements. Thus, combined, according to DCF data, 1,459
children were forced to sleep in one-night placements just from April to September of 2018. This data does not identify children who were subjected to multiple night-to-night placements or include all children sent to “short-term” transient placements where they stayed more than one night.

124. The “night-to-night” practice is not limited to children just removed from their homes or older teens; the practice also affects children who have already been in DCF custody for months or years, and children of varying ages. For example, eleven-year-old Named Plaintiff Z.Z., who first entered DCF custody in 2012, was moved ten times in 2017 and 2018 alone.

125. Additionally, the “night-to-night” practice is not limited to a day or even a few days; it is sometimes forced on children for weeks or even months at a time, resulting in an almost incomprehensible level of chaos and instability and literally dozens of placement moves in a short period of time. For example, ten-year-old Named Plaintiff C.A. was subjected to three months of near continuous night-to-night placements in 2018.

126. The “night-to-night” crisis has even expanded to state-sanctioned “couch surfing,” whereby DCF contractors pay a foster parent additional funds to house a child for one night on their couch or to add a child to an already full bedroom. Inadequate sleeping space for children in foster care in DCF custody was noted in a January 2016 audit report, which found that “during a 15-month period, DCF granted 98% of the approximately 1,100 requests by child placing agencies to waive the capacity or sleeping space requirements.” The report “saw no evidence of DCF scrutiny or review of the requests that were approved.” Further, the report noted that “[f]our of the 12 foster homes in our targeted review did not have sufficient sleeping space.” In one example, one home had ten children (regulations allowed for six), including seven foster children, and “five of the foster children shared a room with only 25 square feet per child—well below the state’s minimum requirement.”
127. Additionally, upon information and belief, since 2017, DCF has no longer required provider agencies to even request an exception to placement regulations when a foster home is at full capacity, as long as the child does not return to the home multiple times in a seven-day period. Accordingly, for this category of transient placements, DCF fails to consider or track any capacity conditions. For example, in information provided to the Child Welfare Task Force, KVC stated that it “did not request or require any exceptions for one-night placements during FY17.” Similarly, SFCS indicated only one capacity exception in FY 2017.

128. Additionally, upon information and belief, DCF’s private contractors pay a premium to homes that will take a “night-to-night” drop-off at late hours of the night, such as after 9:00 PM.

129. Whether or not they actually sleep there, children may also stay in contractor offices for extended periods without DCF oversight. DCF’s contracts with its private providers do not stipulate how long children can be in contractors’ offices. According to a May 2017 news article, a DCF official stated that DCF “doesn’t require private contractors to report [] data” on “overnight [or] long-term stays at [contractor] facilities.” Reflecting how routine the pattern of office stays has become, the DCF official stated: “[c]hildren . . . waiting to be placed with a foster family . . . spend most of their time in rooms equipped with couches, televisions, toys and games.”

**Extreme Housing Disruption in Kansas Harms Children and Places Children at Risk of Emotional, Psychological and Physical Harm.**

130. According to a February 2018 Task Force update, one of the two lead contractor agencies, KVC, explained that “if [a] youth is in a short-term placement overnight, the youth is in the office with staff during the day. We have anywhere from 30-50 kids in our offices daily, which makes it difficult for workers to complete their daily tasks, and has caused several severely unsafe scenarios.” Also in February of 2018, according to a news article, Defendant DCF Secretary Meier-
Hummel stated that the use of “night-to-night” placements in agency offices is “not an acceptable practice.”

131. However, the “severely unsafe scenarios” referenced in the DCF report in February of 2018 were not corrected. In September of 2018, the media reported that authorities charged an older youth with raping a thirteen-year old girl in foster care in DCF custody at an Olathe child welfare office where they were both forced to sleep overnight. According to a news report, the sexual assault was reported in May of 2018. The news report quoted the Johnson County District Attorney as stating: “This is not an isolated incident involving criminal conduct at the KVC offices involving children.”

132. The risk that children subjected to extreme housing disruption will be harmed in their placements is not limited to children housed in agency offices. The chaos of an ever-changing transient population moving among different placements, overcrowded homes beyond their capacity, and the lack of monitoring and oversight by DCF exposes children to a risk of harm in their placements. As set forth in Section V.D. of this Complaint, DCF maintains the practice of subjecting caseworkers to excessive caseloads and turnover, resulting in the failure of caseworkers to visit children in DCF custody as required. Caseworkers simply cannot identify dangers to children’s safety or well-being in placements they do not visit. This danger is greatly heightened when children are exposed to churning.

133. Kansas’ churning crisis also disrupts children’s educational stability and contributes to poor educational outcomes. A 2016 audit found that the majority of Kansas foster children in out of home placements – over 85% – do not attend their school of origin, violating a federal standard.
134. When youth bounce from placement to placement, they often bounce from school to school, too. DCF is aware of the problems associated with frequent school changes. For instance, it reported in 2015 that former Kansas foster youth complain of “the difficulty in keeping up with school when placement changes occur.” More recently, in 2018, a Kansas educator testified to the Child Welfare System Task Force that the “growing segment of [] children in the custody of DCF and/or their contractors . . . that have no permanent placement . . . frequently have no idea where they will be sleeping that night, only that it will likely be in a different and more distant town from where they are asked to attend school.” Further, “due to frequent placement changes, these children do not have the educational stability required for successful learning,” and “are not ready to learn at the level of performance expected of them and their typically-developing peers.” As a result, they are “much more likely to receive special education services,” and are “significantly behind academically and exhibit high social, emotional, and behavioral needs that require extensive interventions.”

135. The churning crisis in Kansas not only disrupts children’s education but also precludes access to education itself. Kansas foster children do not consistently attend school while subjected to churning. Children shuffled among numerous placements are often picked up by caseworkers in the morning and dropped off at an office, rather than being dropped off at school. Inexplicably, school-age children often sit around an office during the day instead of sitting in a classroom. According to testimony to the Child Welfare Task Force in 2018, “[i]n some circumstances, DCF and/or their contractors who have physical custody of these children, wait days or weeks before enrolling them in school.” For instance, “a student had been spending their days at the contractor’s office for two weeks, and was only enrolled after [an educator] sought them out and alerted the county truancy officer.” A KVC official stated in a 2017 news article that
“[i]f you have a child that’s grade school aged, they should be in school [] during the day and not in the office,” yet she acknowledged that children may remain in offices for more than twenty-four-hour periods. The article reported that “according to a Facebook forum devoted to foster and adoptive parents, it isn’t uncommon for children, especially those who frequently ‘bounce’ in and out of homes, to miss days or weeks of school.” For example, Named Plaintiffs M.J., R.M., C.A., and M.L. all missed school during periods of night-to-night placements.

136. The educational instability tied to churning contributes to poor educational outcomes for Kansas foster youth. DCF self-reported in 2016 that 58.2% of Kansas youth in out-of-home placements for at least a year do not progress to the next grade level, which violates a federal standard.

137. Faced with churning, some Kansas foster youth turn to escaping the system itself in the hopes of a better life: they run away. For instance, Named Plaintiff M.L. has been so desperate for a stable, permanent, safe placement that she has run away several times. Named Plaintiff R.M., who has been moved more than 130 times since he entered DCF custody in 2012, also tried to run away, at the age of eleven in 2016.

138. According to DCF data, as of June 2017, seventy-eight foster youth were runaways. As of February 2018, DCF data showed an average of eighty-five foster children on “runaway” status each month since July 2017. As of August 31, 2018, DCF reported that there were sixty-three missing or runaway youth, and in October 2018, DCF reported that “the number of youth who have run away from placement continues to fluctuate daily.” Additionally, DCF’s oversight and tracking of youth is inadequate, such that when foster youth do run away, DCF sometimes fails to even notice.
139. Additionally, the risk of children becoming victims of sex trafficking is prevalent among vulnerable foster youth generally, and is a known risk for foster youth subjected to churning in Kansas. A February 2018 news article referred to Kansas as a “known . . . crossroads for human trafficking.” Dr. Karen Countryman-Roswurm, Executive Director of the Center for Combating Human Trafficking at Wichita State University, explained in a February 2018 news article that the Kansas foster care to human trafficking pipeline is well-known. She noted that foster youth experience trauma that places them at a greater risk of trafficking; and “the [foster] system [] exacerbates a disconnect between children and a community, putting them further in jeopardy.” Dr. Countryman-Roswurm further stated that the risk of trafficking is “of particular concern when there were 71 foster care children in Kansas who have run away[.]”

140. According to a 2018 news article, DCF reported that it conducted 285 assessments on possible survivors of trafficking since 2014. But, as the Kansas Attorney General’s Office stated in the same article, concrete data on trafficking “is elusive” because of the crime’s underground nature. Named Plaintiff M.L. has been victimized multiple times by trafficking while in DCF custody.

141. Kansas’ extreme housing disruption crisis further threatens children’s health by systematically denying them access to mental health care. For example, the very nature of churning creates barriers to actually receiving mental health treatment. Many of the Named Plaintiffs experienced delay or disruption in their mental health treatment, including counseling and/or psychotherapy, as a result of the extreme housing disruption that they suffered in DCF custody. The short-term nature of placements makes it difficult for a child’s temporary placement even to obtain and schedule an appointment with a mental health care provider for the child. The frequency of placement changes makes it difficult for children to attend appointments and receive consistent
care. According to an April 2017 audit of DCF, eight of eleven children’s files in a random sampling indicated “mental health services . . . were delayed or infrequent,” and tellingly, one child with “extreme, trauma-related emotional and behavioral issues” was denied treatment because Defendants’ frequent placement moves caused her providers to “doubt[] that she would be able to make progress before [she] moved again [emphasis added].”

142. In addition to the above dangers created by extreme housing disruption, churning itself is widely recognized as inherently detrimental to children in the child welfare system. As Lori Ross, President and CEO of Kansas City’s FosterAdopt Connect, explained in a May 2017 news article, removal from one’s home is traumatic for any child, especially for those who have been repeatedly removed from homes, and long-term use of temporary placements simply adds to the burden. She stated that “[w]hat this does is create more trauma for the child,” whereby “each time they need to move, they hear in their head, ‘You’re not part of this family, you’re not valuable, you’re being moved like an animal, not a human.’”

143. On the issue of whether frequent moves cause trauma for children, Defendant Meier-Hummel stated in a media interview on October 31, 2018: “absolutely trauma [is] associated with that. I mean you know if [] you are unsure about where you are sleeping, if you are unsure about what where you’re going to go to school, if you’re concerned about having to move the next day, I mean all of those things create uncertainty and, and then ultimately lead to, you know, mental health issues and perhaps bad outcomes for kids. So we certainly yeah have to do better than that[.]”

144. It is widely recognized that churning causes both immediate and long-term emotional, psychological, physical developmental and neurological harm.¹ Studies show that

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¹ Rae R. Newton et al., *Children and Youth in Foster Care: Disentangling the Relationship Between Problem Behaviors and Number of Placements*, 24 CHILD ABUSE & NEGLECT 1363, 1363-4, 1371-3 (2000).
extreme housing disruption negatively affects a child’s ability to form secure attachments, or enduring emotional bonds, with caregivers. These attachment disorders are connected to behavioral and mental health problems and contribute to foster children’s disproportionately high risk for poor developmental, social, emotional, behavioral, cognitive, and mental health outcomes.

145. Specifically, children who experience extreme housing disruption are at an increased risk of mood disorders, such as depression, anxiety disorders, and behavior problems, such as substance use and disruptive behavior disorders. Studies show that children with multiple placements experience a sixty-three percent increase in behavior problems compared to children who achieved any stability in foster care. Churning may also compound other problems, including aggression, low self-image, and academic under-achievement.

146. In addition to causing emotional and psychological harm, extreme housing disruption causes physical harm to children’s normal brain development as well as their central nervous and endocrine systems. It is a well-accepted principle that childhood experiences can affect brain development. For children in foster care, multiple moves and a “lack of predictability” are “chronic adverse experiences” early in life. These experiences can “fundamentally and permanently alter the functioning of key neural systems involved in learning, memory, and self-regulation and the complex networks of neuronal connectivity among these systems.”

2 Sonya J. Leathers, Foster Children’s Behavioral Disturbances and Detachment from Caregivers and Community Institutions, 24 CHILDREN AND YOUTH SERVICES REVIEW 239, 259 (2002); Yvonne A. Unrau et al., Former Foster Youth Remember Multiple Placement Moves: A Journey of Loss and Hope, 30 CHILDREN AND YOUTH SERVICES REVIEW 1256, 1261 (2008).


5 Rubin, supra note 4, at 337, 341.

6 Harden, supra note 3, at 38-39; Newton, supra note 1.

especially true for young children whose brains are at an intense stage of development.\(^8\) For these children, extreme housing disruption has been associated with executive functioning deficits,\(^9\) which are connected to serious conditions including: Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, disruptive behavior disorders, and substance abuse.\(^10\)

147. Extreme housing disruption has also been associated with harm to children’s central stress response system, the hypothalamic-pituitary-adrenal (HPA) axis, which involves both the central nervous system and the endocrine system.\(^11\) The HPA axis plays a major role in regulating an individual’s response to stressful events.\(^12\) Disruption of HPA axis activity has been linked to anxiety disorders, affective disorders, and disruptive behavior disorders.\(^13\)

148. Published national practice standards also acknowledge the extreme trauma imposed by instability in foster care. The Child Welfare League of America, Standards of Excellence provide that “[p]roactive efforts should continually promote stability and avoid disruptions in foster care, recognizing that a disruption can be another loss, rejection, and possible trauma for the child.” Consistently, the Council on Accreditation’s Standards for Public Agencies notes that “[s]ignificant research has demonstrated the correlation between placement instability and negative child outcomes including poor academic performance and social and emotional difficulties. Regardless of a child’s prior history of maltreatment or behavioral challenges, these negative outcomes increase following placement disruptions.”

\(^8\) Id.
\(^10\) Fisher, supra note 7, at 9, 7.
\(^12\) Id.
\(^13\) Id. at 540.
C. **Defendants’ Failure to Provide Mandated Mental Health Screenings, Diagnostic Services, and Treatment Harms Children and Imposes an Unreasonable Risk of Harm.**

149. Under federal law, Defendants must provide regular health screenings for foster children in DCF protective custody, including a “comprehensive” assessment of each child’s mental health development as required under the EPSDT provisions of the Medicaid Act. *See* 42 U.S.C. § 1396d(r)(1)(A)-(B). Kansas has adopted the Bright Futures periodicity schedule as its standard for pediatric preventive services. This periodicity schedule, developed by the American Academy of Pediatrics, calls for a psychosocial/behavioral assessment at every screening interval from infancy through to age twenty-one, and an annual screening for depression beginning at age twelve.

150. In addition to these periodic screenings, Defendants must provide screenings at other intervals indicated as medically necessary to determine the existence of certain physical and mental illnesses and conditions. *See* 42 U.S.C. § 1396d(r)(1)(A)-(B). Categorically, all children entering foster care are exposed to multiple forms of trauma stemming from their removal from their homes and the abuse, neglect, or abandonment that precipitated their removal. Accordingly, upon entry to the foster care system, they are entitled to screening and diagnostic services that assess their known trauma-related histories and needs. Trauma-related screening must also be repeated periodically thereafter.

151. The state must also provide “other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services . . . .” 42 U.S.C. § 1396d(r)(5).

152. The state is responsible for providing or arranging for medical assistance, including screening, diagnostic services, and treatment, in a reasonably prompt manner. *See* 42 U.S.C. § 1396a(a)(8), (10), (43)(B), (C); 42 U.S.C. § 1396d(a)(4)(B); 42 C.F.R. § 435.930(a).
153. DCF is responsible for the well-being of all children in foster care, and therefore for providing timely screening, diagnostic services, and treatment for their mental health and behavioral health needs. KDHE is the designated single state Medicaid agency pursuant to 42 U.S.C. § 1396a(a)(5), and is therefore responsible for the financial management and contract oversight of Kansas’ Medicaid program, KanCare. KDADS has responsibility for operating hospitals and institutions and administers Medicaid waiver programs for disability services, mental health, and substance abuse in Kansas. Together, Defendants all share the legal responsibility for ensuring that Kansas complies with the EPSDT requirements of the Medicaid Act.

154. Despite these legal obligations, Defendants maintain a known dangerous pattern, policy, custom, or practice of failing to provide these mental health screenings, diagnostic services, and treatment to children in foster care in Kansas. Defendants’ failure to implement a system that appropriately screens, diagnoses, and treats children in foster care with mental health needs, including mental health needs related to trauma, causes deterioration of their physical, mental, and behavioral health and compromises children’s health, safety, and well-being. In exposing children to these risks, Defendants abdicate their responsibility to serve children in foster care.

Defendants Fail to Provide Required Initial and Periodic Screening and Trauma-Informed Diagnostic Services.

155. Although children in foster care in Kansas are entitled to periodic screening for their mental and behavioral health needs, including trauma-related needs, no comprehensive or coordinated system exists to ensure that these screens happen in practice. Indeed, while KanCare’s EPSDT form requires providers to complete a developmental screening tool, and refers providers to relevant resources, there is no similar prompt with respect to mental health screening. Instead, the form simply calls for the screener’s “emotional observations.” There is no reference to trauma-related screening. With no structure in place to ensure that necessary screening takes place,
Defendants frequently fail to promptly and appropriately screen children for mental and behavioral health needs.

156. Specifically, Defendants fail to evaluate children’s trauma-related needs upon their entry into DCF custody. All children entering Kansas’ foster care system have necessarily experienced traumatic events, in that they were removed from their home and family, and that they were placed in state custody due to the state’s own finding of abuse, neglect, or abandonment. The research literature and national standards establish the undisputable known trauma of removal and of abuse or neglect.\textsuperscript{14} Indeed, the literature describes “common features” of children in foster care as including “the psychological and neurobiological effects associated with disrupted attachment to biological parents; the specific traumatic experiences (e.g., neglect and/or abuse) that necessitated placement; the emotional disruption of the placement; [and] the need to adjust to a foster care environment.”\textsuperscript{15}

157. Additionally, medical research conclusively establishes that trauma, including the trauma that all children in DCF custody have experienced due to removal and from child abuse or neglect, carries a high risk of physical, developmental, and emotional harm, including by causing


\textsuperscript{15} Racusin, \textit{supra} note 14, at 200.
or exacerbating mental and behavioral health problems and disorders.16 Up to eighty percent of children in foster care enter with significant mental health needs.17

158. Because every child entering DCF custody has experienced known trauma, and that trauma is known to carry an extremely high risk of needing mental health treatment, all children entering DCF custody require trauma-related screening and diagnostic services upon entry to the foster care system, in addition to their ongoing periodic trauma-informed screenings.18 These trauma-informed screening and diagnostic services are essential to effectively identify children in need of trauma-related treatment and to provide that treatment promptly.

159. However, upon information and belief, Defendants fail to categorically provide all children in DCF custody either (1) an initial trauma screen and diagnostic services upon entry into DCF custody or (2) regular, ongoing, trauma-informed mental and behavioral health screenings while in DCF custody. A report of the Mental Health Task Force to the State Legislature in January 2018 confirmed that mental health care in Kansas is not consistently trauma-informed, and recommended that the state “promote the education of trauma-informed practices” and “develop trauma-based behavioral health services for parents whose children are in the custody of [DCF] or at risk of entering custody.”


160. Without these required screens and diagnostic services, Defendants have no way to timely identify youth with mental and behavioral health needs, and consequently no way to ensure that such children receive prompt treatment.

161. When Defendants do provide mental and behavioral health screenings, these services often come too late. Notwithstanding Defendants’ legal obligation to promptly provide required screening and diagnostic services, in Kansas, screening and diagnostic services are routinely delayed until a child receives a stable or permanent placement. This means that children who are held in temporary placements, sometimes for weeks or months, are denied access to the mental health screening and diagnostic services – and, consequently, the mental health treatment – they desperately need. Defendants’ churning practice creates an impenetrable barrier to promptly accessing services mandated under the Medicaid Act.

162. Underscoring Defendants’ systemic failure to meet their obligations under the Medicaid Act, according to the April 2017 state audit, DCF has not even developed the processes or maintained the data necessary to track whether children have or have not received their mandated screens and diagnostic services.

**Defendants Fail to Provide Required Mental Health and Behavioral Health Treatment.**

163. When foster children are identified as having mental and behavioral health needs, they often do not receive medically necessary mental and behavioral health treatment. And, as indicated in an April 2017 audit, when mental and behavioral health services are provided, they are often “delayed or infrequent.” These systemic failures are due to several factors: a shortage of mental health services, the churning problem, and/or administrative barriers.

164. The Mental Health Task Force recognized in a January 2018 report that “providing crisis intervention and prevention services to children in a natural setting such as school, home, or
community is necessary to effectively treat children and promote healthy development.” Yet that same report found “the range of [community-based] options available was limited, restricting the continuum of care.”

165. Additionally, a DCF audit in April 2017 found an insufficient range of services as well as inadequate coordination and communication between case managers, support staff, and foster parents blocking access to these community-based mental health services. Transportation issues, for instance, impede the delivery of mental health services. The January 2018 Kansas Child Welfare System Task Force Report explained that “[w]hile DCF and the contractors are to be credited for being aware of the services that are available, caseload, funding, and transportation issues are keeping the full amount of services needed from being delivered.”

166. In addition, there is often insufficient system capacity to meet the mental health needs of children in foster care. This lack of capacity results in long wait times for services. A representative of DCF contractor SFCS noted in 2015 that it “experienced longer waiting time to engage services in the communities for behavioral health needs,” particularly for youth with intellectual and developmental disabilities and/or serious emotional disturbance, “leaving children, youth and families to struggle keeping all parties safe.”

167. A representative of DCF contractor SFCS further stated in October of 2017 that the lack of a standardized protocol governing “the undefined term ‘medical necessity’ sometimes results in denying mental health treatment to a child.”

168. For children with more acute mental health needs, Defendants often fail to maintain an adequate number of available beds in Psychiatric Residential Treatment Facilities (“PRTFs”). In fact, Defendants decreased their capacity of PRTF beds by 65% between 2011 and the end of 2017; as a result, children wait weeks or months for a needed placement and medically necessary
inpatient mental health treatment. As of February 1, 2018, for example, SFCS and KVC together had a total of twenty-four children who had met the criteria for a PRTF but were placed on a waitlist. The Children’s Continuum of Care (“CCC”) Task Force acknowledged in December 2017 that there should be an “[i]ncrease in PRTF bed capacity,” with waitlists “shorten[ed] or eradicate[d],” and recommended that “KDADS conduct data and trend analysis on PRTF bed utilization and waiting lists to determine the need” and plan “[t]he number of additional beds.”

Describing the challenges it faced in 2015, a SFCS representative stated that “[i]t is extremely unfortunate to be in a position to not have access to the services needed for the children and youth we serve.” Without an increase in capacity, challenges in accessing higher levels of care will continue.

169. As the CCC Task Force recognized in 2017, while awaiting PRTF placement, children often bounced from one foster care provider to another, including through night-to-night placements. The Task Force further noted that, while they are waiting, untreated and without a stable placement, children’s symptoms can escalate, progressing from non-emergent to acute and requiring hospitalization. Additionally, according to the same CCC Task Force report, when a PRTF or hospital bed cannot be accessed, a child may even be kept in a juvenile justice facility for delinquent youth.

170. At the same time, as noted in the minutes of a Mental Health Medication Advisory Committee meeting in August of 2017, Defendants fail to provide appropriate alternative options to PRTFs, particularly for children with serious emotional, developmental, and/or intellectual needs. In some cases, as stated in an October 2017 report, PRTFs reject children whose behavioral issues they deem too severe. Upon information and belief, no other placements exist to meet the needs of these children in DCF custody.
171. In other cases, upon information and belief, children whose needs could be met in a therapeutic foster home or other foster home with readily available mental health service supports are sometimes placed or kept in PRTFs because no such housing exists. This results both in the inappropriate placement in PRTFs of youth whose needs could be met in a less restrictive setting and in additional strain on PRTF capacity. For example, beginning in 2017, DCF placed Named Plaintiff M.L. in a PRTF for over twelve months even though her documented mental health needs did not require a restrictive residential treatment, because no less restrictive placement and service environment existed to meet her needs.

172. As acknowledged in a January 2018 Mental Health Task Force report and the CCC Task Force report of December 2017, when youth are placed in PRTFs, some are pushed out too soon, having received incomplete or inadequate treatment and without appropriate step-down services to support them in their transition. For example, Named Plaintiff Z.Z. was placed in a PRTF but her stay was artificially cut short, and without any appropriate step-down placements, Z.Z. was subjected to a string of night-night placements upon her discharge from the PRTF.

173. Further, as noted in the January 2018 Mental Health Task Force Report, very few PRTF locations offer case management, therapy, family education and support, and other aftercare services in the immediate community. The failure to properly support youth transitioning from PRTFs compromises their mental health and creates a cycle that sends children into temporary, unstable placements when foster parents are unwilling or unable to care for children with unmet mental health needs, or back to a PRTF, impeding the individual children’s treatment and exacerbating the systemic shortage of beds.

174. Even youth with less intensive mental health needs experience systemic barriers to accessing the mental and behavioral health treatment they need. Upon information and belief,
children in foster care in Kansas often must wait to begin treatment until they are in a stable or non-temporary placement, meaning that their access to care is often denied when they need it the most – shortly after they are separated from their families, or when they are experiencing a period of extended disruption and instability through multiple short-term placements and night-to-night stays.

175. For example, a legislative audit described a child “with extreme, trauma-related emotional and behavioral issues [who] inconsistently received the therapy she needed because her issues caused her to move to new foster homes frequently.” According to contractor staff, “community mental health providers declined to provide her therapy during her short-term placements because they doubted she would be able to make progress before the child moved again. Additionally, she experienced gaps in treatment during each transition between placements, as it took time for providers to send referrals for her, transfer her records, and get her intake sessions scheduled.”

176. In addition, upon information and belief, Defendants’ practice of repeatedly moving children among placements across the state often disrupts any mental health care that has begun, and interferes with children’s ongoing relationships with their mental health care providers. DCF has acknowledged that “[w]ith placement and school instability, the challenge for case managers is referring to, securing and implementing wrap-around treatment services in a timely manner. For instance, a placement move to a new CMHC catchment area will mean starting the referral process for mental health services over again.” Even if individual children are able to continue relationships with their mental health care providers, due to unmanageable caseloads, often no one is available to transport a child to an appointment; this creates yet another barrier between children and the mental health treatment that they need.
177. For instance, ten-year-old Named Plaintiff C.A. was diagnosed with PTSD and ADD while in DCF custody, yet C.A. has been moved more than seventy times, significantly disrupting necessary mental health treatment. Named Plaintiff M.L., who has a mood disorder, has been moved over forty times while in DCF custody, and has received inconsistent or negligible mental health treatment throughout this churning.

178. Additionally, instead of ensuring necessary and legally mandated appropriate treatment of foster children’s mental and behavioral health needs, Kansas often relies on the overuse of psychotropic medications. These medications are powerful drugs such as antipsychotics and antidepressants that act on the central nervous system and can affect cognition, emotions, and behavior. Although the use of psychotropic medications should always be paired with evidence-based and systemically monitored psychosocial interventions, children in foster care in Kansas are routinely prescribed psychotropic medications by non-specialists in order to manage behavior.

179. Not only does churning disrupt mental health treatment, but the failure to provide necessary mental health treatment to children in foster care exacerbates Kansas’ pervasive problems with extreme housing disruption, because untreated mental health needs may lead to additional placement disruptions.\(^{19}\) DCF describes “the challenge with caring for the children on the wait list [for services], first and foremost, [as] stability in placement.” Foster parents may not be equipped to respond to a child’s untreated mental health needs, and may feel that they cannot keep the child and others safe with the behaviors they are displaying. As a result, the child’s

placement may change, often repeatedly. In a recurring cycle, this in turn can lead to further mental health challenges including mood difficulties, aggression, low self-image, and attachment issues.\footnote{David M. Rubin, Amanda O’Reilly, R., Xianqun Luan, & A. Russel Localio, \textit{The Impact of Placement Stability on Behavioral Well-Being for Children in Foster Care}, 119 \textit{PEDIATRICS} 336, 336, 341-43 (2007); Rae R. Newton, Alan J. Litrownik & John A. Landsverk, \textit{Children and Youth in Foster Care: Disentangling the Relationship Between Problem Behaviors and Number of Placements}, 24 \textit{CHILD ABUSE AND NEGLECT} 1363, at 1363-64, 1371-73 (2000); Joseph P. Ryan & Mark F. Testa, \textit{Child Maltreatment and Juvenile Delinquency: Investigating the Role of Placement and Placement Instability}, 27 \textit{CHILDREN AND YOUTH SERVICES REVIEW} 227, 230, 244-45 (2005).}

180. Research also shows that untreated mental health conditions can cause children to run away from their foster care placements, leaving them vulnerable to homelessness, trafficking, and involvement in the juvenile justice system.\footnote{Theodore P. Cross, et al., \textit{Why Do Children Experience Multiple Placement Changes in Foster Care? Content Analysis on Reasons for Instability}, 7 \textit{JOURNAL OF PUBLIC CHILD WELFARE} 39, 48, 53 (2013).}

181. Defendants are aware that they are failing to meet the mental health needs of children in foster care in Kansas. For example, Kansas’ own Mental Health and Continuum of Care Task Forces have explicitly identified problems including the need for trauma-informed care, limited array of available services, inadequate PRTF capacity, and unacceptably long waitlists. Meanwhile, DCF’s foster care contractors report that service interventions are needed in the area of mental health, noting, for example, particular challenges with accessing higher levels of care when children need them, excessive wait times to receive services, and high usage of medication for foster youth.

182. As a KVC representative stated in October of 2017, “[t]he greatest area for improvement in the foster care system is that more effective interventions are needed in the mental health area.”

183. Despite such information and notice and despite the relevant legal mandates, Defendants have failed to take adequate actions to correct these broad failings and to provide or arrange for the screenings, diagnostic services, and treatment that children in foster care in Kansas
need. These failures are harming the children in their care and imposing an unreasonable risk of ongoing harm.

D. Three Additional Structural Failures Cross Over, Contribute To, and Exacerbate the Churning and Mental Health Services Failures.

184. Three additional structural failures cross over the two fundamental problems addressed in this Complaint, and contribute to and exacerbate the harms and dangers of extreme housing deprivation and the denial of mental health screenings, diagnostic services, and treatment: (1) excessive workloads, turnover and inadequate monitoring of children and their caregivers by frontline case workers; (2) the failure to directly oversee private providers; and (3) the failure to track and maintain accurate and timely data.

Defendants’ Practice of Excessive Caseworker Caseloads, Turnover and Inadequate Monitoring

185. DCF maintains a known policy, custom, pattern or practice of excessive workloads of its frontline case manager workforce, which impedes caseworkers’ ability to monitor the safety and well-being of the foster children assigned to them, and their ability to provide basic support to foster parents. The excessive workloads and high turnover of caseworkers significantly contribute to and exacerbate the harms and risks of harm to children alleged in this Complaint.

186. Defendant Meier-Hummel agrees that Kansas caseworkers’ ability to accomplish their jobs when forced to juggle so many cases is “an issue for sure.” She stated on October 31, 2018, that “[i]f we don’t have an adequate workforce and they’re asked to do too much, [that] is when children’s safety is compromised.”

187. Once in foster care in DCF’s protective custody, by definition, children are highly vulnerable and without adequate family protection. Once they enter the State’s custody, caseworkers (provided under contract with the two lead provider agencies, KVC and SFCS), are
responsible for ensuring their safety and well-being. As noted in the April 2017 Performance Audit Report, “case management staff develop and oversee children’s case plans, refer children for physical and mental health services, supervise visits between parents and children, write court reports and testify in court proceedings.” Consistently, caseworkers are required to complete initial and ongoing assessments of children and their families; develop and implement case plans; facilitate and coordinate visits with children and their caregivers; prepare children for placement moves; provide intervention in crisis situations; support resource families to maintain placements; assess ongoing case plan goals and permanency options; and maintain written documentation in the child’s and family’s case record.

188. To perform these essential functions, as noted in a state audit report in April 2017, “[i]t is important [that] case management staff have reasonable caseloads, so they can provide each child the quality of services and individual attention they need.” Professional standards, as promulgated by the Child Welfare League of America, recommend that foster care caseworkers have workloads that range from twelve to fifteen children per caseworker in order to fulfill their responsibilities. Standards of the Council on Accreditation recommend that caseworkers have workloads between eight and fifteen children, depending on the level of need of the children.

189. An April 2017 state audit report found that, in Kansas, “[c]ase managers’ maximum caseloads frequently exceeded 30 cases during fiscal years 2014-2016.” Subsequent reports reveal that workloads have continued to increase. A media report in November 2017 found that caseworkers responsible for as many as forty-three and fifty-seven children found it impossible to complete each monthly visit as well as case plans, court hearings and meetings with families. That same month, a local magistrate judge explained to the Child Welfare System Task Force that “[c]aseworkers are carrying enormous caseloads that prevent the attention these kids require.” In
February 2018, a news report found that “[c]aseworkers who have quit the agency and its subcontractor KVC have complained of caseloads of up to seventy at a time.”

190. Numerous press articles describe caseworker turnover, low morale, and all the harm caused to children in DCF care. A March 2017 news article reported that “DCF has cut its social worker positions by 20 percent, despite an additional 33 percent increase in children entering the system during the past five years. Experienced social workers have left in droves.” A July 2018 news article reported that DCF still had seventy-six vacant child protection positions in June of 2018.

191. Additionally, the data likely under-reports the actual caseloads of foster care caseworkers assigned to children. For example, according to the April 2017 state audit, caseworker supervisors, against practice standards, often carry caseloads of children on top of their own supervisory workloads, skewing caseload data.

192. With frequently excessive workloads, the caseworkers often do not have time to perform essential tasks to protect children’s safety and well-being, such as visit with children in their placements, ensure children are adjusting in new placements, ensure children are attending mental health appointments, facilitate follow-up behavioral health services, coordinate visits between children and their parents and siblings, and attend to other issues that may threaten the well-being of a child. As the January 2018 Report of the Child Welfare System taskforce found, “[e]xcessive caseloads and limited funding affect timely response for needed services.” Similarly, that same report notes that “mental health services are especially needed” and that “caseload[] issues . . . are keeping the full amount of services needed from being delivered.”

193. Excessive workloads also prevent caseworkers from providing basic support to foster parents. For example, a July 2016 legislative audit report showed that only thirteen percent
of a sample of Kansas foster families had confirmed and completed documented visits from the caseworker assigned to support the foster family. In another example, as noted in the April 2017 legislative audit report, “DCF’s case review for the federal CFSR, our targeted file review, and our stakeholder survey all indicated poor communication and coordination between licensed case managers, support staff, and foster parents sometimes prevented children from receiving services they needed.” Similarly, in a 2018 Report to the Child Welfare Task Force, “[t]he working group heard and received testimony on lags in communication or misinformation between DCF and stakeholders that negatively affected persons and service providers such as foster parents, grandparents, attorneys and clinicians, to name a few.”

194. According to DCF data, in 2016, 26% of the children who were in foster care for all 12 months had three or more case managers. Upon information and belief, children continue to experience turnover among assigned caseworkers today. Frequent changes in caseworkers, combined with their high workloads, further inhibit caseworkers’ ability to do their job monitoring the safety and well-being of foster children and to support foster parents.

195. Given the critical role caseworkers play in ensuring the safety and well-being of foster children in DCF’s protective custody – including visiting children, maximizing placement stability, supporting foster parents, and coordinating the delivery of mental health services – the high caseloads and turnover of caseworkers significantly contribute to and worsen the practice of extreme housing disruption and the denial of mental health screens, diagnostic services, and treatment.

**Defendants Fail to Adequately Oversee Private Contract Providers.**

196. As an April 2017 state audit report stated, DCF is “ultimately responsible for the state’s foster care system” even though Kansas has privatized most of the day-to-day operations.
“The foster care contracts and state law specify the department has ultimate responsibility for the well-being of children, the quality of the services, and the overall success of the foster care system.” DCF’s lead contractors, KVC and SFCS, provide case management, placement and service coordination for Kansas foster children statewide.

197. DCF contracts with KVC and SFCS to provide case management services, which include the obligation to “develop and oversee progress on case plans for children in foster care and their families.” KVC and SFCS subcontract with child placing agencies to provide placements for foster children in DCF custody. “Child placing agencies recruit and sponsor foster homes. They help the case management contractors find a placement for children placed in DCF custody. Child placing agencies also assist homes with licensing and are charged with regularly visiting foster families.” KVC and SFCS monitor children in those placements, and are responsible for “directing clients to appropriate services (such as family preservation and mental health services).”

198. In fiscal year 2016, “about $154 million was paid [by DCF] to foster care contractors to provide placement (reintegration, foster care, and adoption) and case management services.”

199. DCF’s contracts with KVC for “Reintegration/Foster Care/Adoption Services” provide for a “monthly prospective base rate for term July 1, 2017 through June 30, 2018 [of] $810,000.00 per month” for the Kansas City Region and “$920,500.00 per month” for the East Region. The contracts further provide for a “monthly prospective case rate [of] $1,342.00 per out of home placement per month” for the Kansas City Region and “$1,558.00 per out of home placement per month” for the East Region. DCF’s current contract with KVC extends through June 2019.
200. DCF’s contracts with SFCS for “Reintegration/Foster Care/Adoption Services” provide for a “monthly prospective base rate for term July 1, 2017 through June 30, 2018 [of] $898,860.00 per month” for the West Region and “[of] $725,000.00 per month” for the Wichita Region. The contracts further provide for a “monthly prospective case rate [of] $1,726.00 per out of home placement per month” for the West Region and “$1,666.00 per out of home placement per month” for the Wichita Region. DCF’s current contract with SFCS extends through June 2019.

201. As an April 2017 state audit makes clear, DCF “must actively oversee the contractors and evaluate their performance. That oversight includes ensuring children are placed in appropriate settings, children’s physical and mental health needs are addressed, and permanency is secured for them in a timely manner.”

202. DCF maintains a structural deficiency of a known, dangerous policy, custom, pattern or practice of failing to oversee private contract providers adequately, which significantly contributes to and exacerbates the dangers of churning and failing to ensure children receive mental health screening, diagnostic services, and treatment alleged in this Complaint.

203. An April 2017 state audit report found that “DCF did not collect and maintain the data it needed to effectively oversee the case management contractors.” For example, DCF requires contractors to “place each child in the foster home nearest his or her removal home that provided the best fit, as well as to ensure each child received the physical and mental health screenings, assessments, and referrals he or she needed. However, DCF did not develop the processes or maintain the data necessary to ensure these things happened for all children.”

204. DCF’s contracts with KVC and SFCS provide that, if KVC or SFCS “fails to provide all of the goods and services under [the contract] as amended, then DCF may proceed to
institute such corrective action as it deems reasonably appropriate to ensure the requirements of the contract are met.”

205. The contracts further state that if KVC or SFCS fails to provide the required goods and services, “DCF may assess a penalty based on DCF internal audit recommendations, in addition to any damages it may incur as a result of . . . non-performance, including the need to obtain such goods and services for children and families outside the scope of the contract.”

206. The contracts also require that, subsequent to the close of the fiscal year, KVC and SFCS “shall provide to DCF any and all documentation requested by DCF” for the purposes of conducting an annual audit. Under the contracts, “audits performed by DCF may include audits of contract performance, i.e., compliance with terms and conditions of the contract with DCF including accomplishment of federal and state outcomes related to children and families.”

207. Additionally, “[t]he foster care contracts allow DCF to request and approve a performance improvement plan when a contractor does not meet federal outcome requirements or when [DCF] identifies problems through any of its oversight processes.” DCF “may assess financial penalties if a contractor fails to meet its goals for two consecutive quarters, and may terminate the contract if the contractor fails to meet them by the end of the state fiscal year in which the plan was implemented.”

208. According to the April 2017 state audit report, “DCF has not been aggressive in addressing the problems it identified with its contractors.” The report further noted that “DCF has only required two performance improvement plans since 1997 . . . despite the fact the contractors did not meet federal outcome benchmarks in several years,” including federal requirements related to timeliness and stability and including known failures to ensure the provision of mental and behavioral health services.
209. DCF has directly failed to monitor and oversee its contractors in order to remedy the known problems of churning and the failure to provide mental health screening, diagnostic services, and treatment to Plaintiffs and members of the General Class and Mental Health Subclass.

210. DCF has failed to pursue effective remedies from its contractors, including specific corrective actions, financial penalties resulting in measurable improvement, or contract termination in response to these known dangers. DCF has effectively ignored these specific foster care system dangers.

211. In the wake of the alleged rape of a thirteen-year-old girl at KVC’s Olathe office, where she was forced to sleep in a conference room overnight in May 2018, a September 19, 2018 news article reported that since Kansas privatized its child welfare system in the mid-1990s, DCF has only penalized a contractor financially once.

212. DCF has failed and continues to fail to directly monitor and oversee the financial and programmatic operations and outcomes of KVC, SFCS, and the other private organizations that contract to provide housing and other services to children in DCF’s care. This failure significantly contributes to and exacerbates the harms and risks of harm to children alleged in this Complaint.

**Defendants’ Failure to Accurately Track, Monitor, and Share Data**

213. Defendants’ known failure to accurately track, monitor, and share current data is a structural deficiency that cuts across the systemic problems with placement stability; mental health care; workloads, monitoring, and visits; and contract oversight. As result, data failures significantly contribute to and exacerbate the harms and risks of harm to children alleged in this Complaint. As DCF stated in an October 2018 update to the Child Welfare System Task Force, “[o]ur current system was built 30 years ago, prior to the internet, and it [is] on a mainframe
Current IT staff are unable to fix issues that arise within our system because it is so outdated. The current system is a barrier to our staff, and ultimately, puts children in danger.”

214. Data failures contribute to churning. As identified in the Report of the Child Welfare System Task Force to the 2018 Kansas Legislature in January 2018, “[a]n antiquated set of various computer systems within the DCF prevents communication between computers within DCF, as well as between DCF and the two child welfare system contractors[,]” KVC and SFCS. As found in the Legislative Post Audit Performance Audit Report in April 2017, “DCF could not monitor if children were placed in appropriate homes, in part because it did not collect integrated information about foster homes.” Moreover, “[t]he case management contractors [KVC and SFCS] may not have information about all potential foster homes when making placement decisions.”

215. Additionally, “DCF did not have a complete dataset it could easily access to show where all children in their custody had been placed.” Moreover, “DCF’s data on licensed foster homes was outdated and missing important information about the number of open beds” available to place children.

216. Data failures also contribute to problems of ensuring mental health and behavioral health screenings, diagnostic services, and treatment. For example, an April 2017 audit found that case management contractors failed to consistently document children’s mental health needs and services in their files and instead relied heavily on verbal communication.

217. In addition, data failures also contribute to problems of monitoring monthly visits. As a July 2016 Audit Report found: “For 114 cases (59%), because of poor documentation, [auditors of DCF from the Legislative Division of Post Audit] could not tell whether some monthly visits happened or [they] questioned the quality of the visit.” The Report further stated: “Poor documentation makes it difficult for DCF and case management contractors to monitor child
placing agencies and ensure the safety of the children in foster care.” It explained that “case management staff may not always be completing or documenting required monthly visits, which puts children at risk of harm while in DCF care.”

218. Finally, data failures contribute to inadequate contract monitoring. As the April 2017 Audit Report found, “DCF’s monitoring processes did not capture important management-level information.” The Report “showed the department [DCF] expected the contractors to ensure children were placed in appropriate homes and their well-being, but did not maintain data to monitor whether this occurred.” Additionally, “DCF could not monitor if children were placed in appropriate homes, in part because it did not collect integrated information [or data] about foster homes.”

VI. CAUSES OF ACTION

FIRST CAUSE OF ACTION

Substantive Due Process Under the Fourteenth Amendment
[Brought by All Named Plaintiffs and the General Class Against Governor Colyer and DCF Secretary Meier-Hummel]

219. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as if fully set forth herein.

220. The state assumes an affirmative duty under the Fourteenth Amendment to the United States Constitution to protect a child from harm and to keep a child reasonably free from harm and risks of harm when it takes that child into foster care custody.

221. The foregoing actions and inactions of Defendants Colyer and Meier-Hummel, in their official capacities, who directly and indirectly control and are responsible for the policies of DCF, constitute a failure to meet their affirmative duty to protect from harm and keep reasonably free from harm and risk of harm all Named Plaintiffs and General Class members. These failures
are a substantial factor leading to, and proximate cause of, the violation of the constitutionally-protected liberty interests of the Plaintiffs.

222. The foregoing actions and inactions of Defendants Colyer and Meier-Hummel, in their official capacities, constitute a pattern, custom, policy and/or practice that are contrary to law and any reasonable professional standards, are substantial departures from accepted professional judgment, and are in deliberate indifference to known harms and imminent risk of known harms and to Plaintiffs’ and the General Class’s constitutionally protected rights and liberty interests, such that Defendants were plainly placed on notice and chose to ignore the dangers in a manner that shocks the conscience.

223. As a result of Defendants Colyer and Meier-Hummel’s actions and inactions, Plaintiffs have been harmed or are at continuing and imminent risk of harm and have been deprived of their substantive due process rights guaranteed by the Fourteenth Amendment, including but not limited to the right to be reasonably free from harm while in state custody.

SECOND CAUSE OF ACTION
Medicaid Act
[Brought by All Named Plaintiffs and the General Class Against All Defendants]

224. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as if fully set forth herein.

225. Defendants have failed to promptly provide or otherwise arrange for Plaintiffs and the members of the General Class to receive, upon entry to foster care, early and periodic screening and diagnostic services that would determine the existence of trauma-related physical or mental illnesses or conditions, in violation of 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(10)(A), 1396a(a)(43)(B), 1396d(a)(4)(B), 1396d(a)(13), 1396d(r)(1), and 1396d(r)(5).
226. The foregoing actions and inactions of Defendants, in their official capacity, constitute a pattern, custom, policy and/or practice that deprives Named Plaintiffs and the General Class of the enforceable rights conferred on them by the EPSDT provisions of the federal Medicaid Act to promptly receive trauma-related early and periodic screening and diagnostic services upon entry to foster care.

THIRD CAUSE OF ACTION

Medicaid Act
[Brought by All Named Plaintiffs and the General Class Against All Defendants]

227. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as if fully set forth herein.

228. Defendants have failed to promptly provide or otherwise arrange for Plaintiffs and the members of the General Class to receive early and periodic mental and behavioral health screening that would determine the existence of physical or mental illnesses or conditions, including trauma-related illnesses or conditions, in violation of 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(10)(A), 1396a(a)(43)(B), 1396d(a)(4)(B), and 1396d(r)(1).

229. The foregoing actions and inactions of Defendants, in their official capacity, constitute a pattern, custom, policy and/or practice that deprives Named Plaintiffs and the General Class of the enforceable rights conferred on them by the EPSDT provisions of the federal Medicaid Act to promptly receive ongoing early and periodic mental and behavioral health screening, including trauma-related screening.
FOURTH CAUSE OF ACTION
Medicaid Act

230. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as if fully set forth herein.

231. Defendants have failed to provide or otherwise arrange for Plaintiffs and the members of the Mental Health Treatment Subclass to promptly receive medically necessary behavioral and mental health services, including intensive, community, and home-based mental health services, that would correct or ameliorate their mental health illnesses or conditions, in violation of 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5).


VII. PRAYER FOR RELIEF

233. WHEREFORE, Plaintiffs respectfully request that the Court:
   a. Assert jurisdiction over this action;
   b. Order that Plaintiffs may maintain this action as a class action pursuant to Rule 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure;
   c. Declare unconstitutional and unlawful pursuant to Rule 57 of the Federal Rules of Civil Procedure:
i. Defendants Colyer and Meier-Hummel’s violation of Named Plaintiffs’ and the General Class’s substantive due process rights to be free from harm and unreasonable risk of harm under the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution;

ii. Defendants’ violation of Named Plaintiffs’ and the General Class’s rights under 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(10)(A), 1396a(a)(43)(B), 1396d(a)(4)(B), 1396d(a)(13), 1396d(r)(1), and 1396d(r)(5);

iii. Defendants’ violation of Named Plaintiffs’ and the Mental Health Treatment Subclass’s rights under 42 U.S.C. §§ 1396a(a)8, 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5).

d. Permanently enjoin Defendants from subjecting Plaintiffs to practices that violate their rights and order appropriately tailored remedies directed at Defendants to ensure Defendants’ future compliance with their obligations to Plaintiffs, including, but not limited to, the following:

RELIEF REQUESTED FOR GENERAL CLASS:

i. Enter a permanent injunction requiring that Defendants (1) end the practice of subjecting children to extreme housing disruption, including short-term and night-to-night placements, (2) conduct an expert workload study to determine the workload(s) necessary to conduct required visits and monitoring of foster children, coordinate mental health services for children, and support foster parents; (3) implement staff hiring and retention strategies to maintain the workload(s) identified by the workload study; (4) design and implement a plan to
provide direct oversight over the contracts with DCF’s private providers concerning placement stability and delivery of mental health services; (5) create a single, cross-system, web-based, integrated case management and data reporting system which can be used by DCF, KDHE and KDADS to efficiently and effectively collect and share information concerning children and their placement and treatment needs, placement availability and matching, and mental health service needs and providers; (6) provide, upon entry to foster care, initial trauma-related screening and diagnostic services to all children in foster care in DCF custody; and (7) provide early and periodic mental and behavioral health screening, including periodic trauma-related screening, to all children in foster care in DCF custody.

RELIEF REQUESTED FOR MENTAL HEALTH TREATMENT SUBCLASS:

   ii. Enter a permanent injunction requiring that Defendants establish and implement trauma-informed practices to ensure that all members of the Mental Health Treatment Subclass receive access to the medically necessary mental health treatment services to which they are entitled under the EPSDT provisions of the federal Medicaid Act by taking steps including, but not limited to: (1) conducting a current network adequacy study to identify specific shortages in the number and array of mental health treatment services for children in DCF custody, including providers of such treatment services and facilities such as PRTFs; and (2) filling any identified gaps in the network adequacy study.
FURTHER RELIEF REQUESTED:

iii. The provisions of the Court order entered pursuant to Federal Rule of Civil Procedure 65(d) shall be monitored by a neutral expert monitor appointed by the Court. In addition, the Court shall have continuing jurisdiction to oversee compliance with that Order;

e. Award to Plaintiffs the reasonable costs and expenses incurred in the prosecution of this action, including reasonable attorneys’ fees and costs, pursuant to 28 U.S.C. § 1920 and 42 U.S.C. § 1988, and Federal Rules of Civil Procedure 23(e) and (h); and

f. Grant such other equitable relief as the Court deems just, necessary, and proper to protect Plaintiffs from further harm while in Defendants’ custody and care.

DATED: November 16, 2018

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