



LGBTQ Children, Youth, and Families

Practice Guidebook

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Introduction

Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) people live in all countries and cultures, in all urban, suburban, and rural counties, and neighborhoods. Nevertheless, LGBTQ individuals are often invisible to communities and institutions, including the child welfare system. Similar to youth and families everywhere, LGBTQ youth and families have strengths and needs, and like all families with children, some may come into contact with the child welfare system.

Why a practice guide for this population?

All children in foster care have a right to safe and affirming placements and environments. Oklahoma's Department of Human Services (DHS) is committed to improving the quality of life for vulnerable Oklahomans by increasing people's ability to lead safer, healthier, independent, and productive lives. The Practice Standards inform child welfare specialists in their work with vulnerable families and instruct specialists to continuously examine their use of power, examine their personal biases, and seek to learn who families are. While doing the work of assessing child safety and encouraging families in protective and safe behaviors, the Practice Standards clearly guide that this work be done with "respect and honor" toward the families DHS serves. The Quality Standards of safety, integrity, professionalism, and compassion require that specialists reflect the values of the agency in the actions they take as child welfare specialists.

Heterosexism, the assumption that all people are heterosexual and that heterosexuality is the preferred and acceptable sexual orientation, remains prevalent in Oklahoma. This assumption leads to an "invisibility" of the LGBTQ population.

Many LGBTQ youth face discrimination and a lack of understanding not just in their schools and from their peers, but also from social service agencies, medical providers, religious communities and families. Family rejection plays a role in increased risk for youth. According to research published in the journal *Pediatrics* (Ryan et al., 2009), lesbian, gay, and bisexual youth who experienced high rates of rejection from their families based on their sexual orientation or gender identity, when compared with peers from families that reported no or low levels of family rejections, 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.

Child welfare specialists are ethically and professionally responsible for supporting and strengthening all youth and families that they serve, regardless of culture, religion, race, ethnicity, abilities, sexual orientation, or gender identity. As with other cultural groups, social workers and child welfare specialists must develop the competencies, knowledge, and abilities to engage the LGBTQ community from a strengths-based perspective. All individuals and families must be treated respectfully and non-judgmentally, irrespective of personal views of sexual orientation and/or

gender identities. Each child welfare specialist has personal biases and sees the world through a lens, based on family upbringing and cultural expectations, religious and other cultural backgrounds, and life experiences. The child welfare specialist is responsible for managing personal bias when interacting with children, youth, and families.

Chapter 1 – Statistics

The United States (U.S.) Department of Health and Human Services tracks data regarding children in the United States' foster care systems. On September 30, 2015, the Children's Bureau (CB) reported an estimated 427,910 children were in foster care in the U.S. Almost half of those children were in non-relative foster family homes while 30 percent were in the homes of relatives (CB, 2017). The New York Juvenile Justice system reported in 2001 that as many as 78 percent of LGBTQ youth who enter the foster care system also experience further harassment after being placed in out-of-home care (Sullivan, et al., 2001). Finding no safety or well-being within child welfare systems of care, many LGBTQ youth run from their placements, preferring to live on the streets rather than in discriminatory and repressive environments, and rejecting settings where they are in danger of harassment, violence, and possible conversion pressures.

Although there is ample anecdotal evidence that many LGBTQ youth are thrown out of their homes when they disclose self-identification as LGBTQ, it is a minority who enter out-of-home placement as a result of issues related to their gender or sexual orientation. Reasons children, LGBTQ or not, enter the child welfare system include divorce, death, or illness of a parent; family disintegration; physical or sexual abuse or neglect; and substance/alcohol misuse resulting in neglect or physical abuse.

These statistics need to be examined through a trauma lens, as evidence that the risk for LGBTQ children and youth is exacerbated by family rejection and community stigmatization, rather than continuing to blame victims for their self-identity as lesbian, gay, bisexual, transgender, queer or questioning. To accurately assess child safety and protective capacities, the child welfare specialist must examine responses to and feelings about a child or youth's self-identification and coming-out as LGBTQ within the context and culture of that family, educational system, and community.

Risk Factor – Bullying

As a form of youth violence, bullying can lead to physical, emotional, and academic problems (CDC, 2017). The most recent snapshot of Oklahoma's educational climate indicates that bullying continues to be a significant issue for LGBTQ youth. LGBTQ youth experienced bullying in schools, at home, and within every community in Oklahoma (GLSEN, 2017). The U.S. Department of Health (2016) reported that in 2015, 34.2 percent of gay, lesbian, and bisexual American high school students were bullied on school property, compared to 18.8 percent of heterosexual students. Looking closer to home, 93 percent of LGBTQ students in Oklahoma reported having heard verbal

harassment about sexual orientation, while 85 percent reported hearing remarks made about gender expression or identity (GLSEN, 2017). Research indicates negative behavioral health outcomes result when victims are targets for hate crimes based on their sexual orientation or gender non-conformity. Not only is bullying a significant issue for Oklahoma's LGBTQ youth, they are quite likely to experience bullying in their educational environment and communities.

While many states have recognized bullying as a social problem that continues to face the school system today, Oklahoma does not enumerate special categories of protections from harassment and discrimination, such as disabilities, sexual orientation, gender identity, or gender expression (Kull, Kaschw, and Greytak, 2015). Anti-bullying education and prevention programs that include specifically-prescribed language to include LGBTQ have demonstrated the ability to reduce suicide rates and positively impact the safety felt by LGBTQ youth.

Risk Factor – Homelessness

Young people often become homeless in an effort to create safety for themselves when they have been living in violent, abusive, or neglectful homes or institutions. Homelessness has become more of a risk for LGBTQ youth today because the average age youth are coming-out has decreased over time. In the 1970's, people were coming out more commonly at ages 19 to 24 compared to today's average age of 13.4 (Ryan et al., 2009). Coming out at a younger age puts LGBTQ youth at a higher risk of homelessness because they are still living with caregivers, who due to their own anti-LGBTQ bias, may reject, disown, kick out, abuse, or neglect these youth.

Youth who have experienced the trauma of maltreatment from their birth families often have a more challenging process coming-out in foster care. While in placement, they may face additional rejection, harassment or maltreatment upon coming-out. In some instances, families who have cared for them for long periods of time disown, reject, kick out and/or force them to act "straight" or gender conforming.

Compared to the roughly ten percent of overall youth population who identify as LGBTQ, as many as 43 percent of all homeless youth identify as LGBTQ and the number one reason they are homeless is family rejection ("LGBTQ Homelessness," 2017). Different studies of youth found that 65 percent of homeless LGBTQ youth reported having been in a child welfare placement at some point in their past while half of a sampling of gay and lesbian youth in out-of-home care reported having been homeless at some point in their history (Berberet, 2006; Mallon, G., 1998).

Risk Factor – Trauma

LGBTQ youth are more likely to experience prejudices due to their sexual minority status (Heck, 2015). Experiencing bullying at school or rejection at home are forms of prejudices that can impact behavioral health outcomes for LGBTQ youth (Heck, 2015). According to a survey of homeless service providers administered by the Williams Institute at the

University of California at Los Angeles, 68 percent of the homeless youth they served had a history of family rejection, 65 percent had a history of behavioral health issues, such as depression or anxiety, and 54 percent had a history of family abuse, physical, emotional, or sexual (“LGBTQ Homelessness,” 2017).

Looking closer to home, 55.4 percent of Oklahoma’s LGBTQ students report seriously considering suicide, compared to 11.5 percent of heterosexual students. The same study found that 51.9 percent of Oklahoman LGBTQ students report having made a suicide plan and 26.5 percent had attempted suicide (CDC, 2017). The emotional distress that can lead to suicide, substance abuse, and other problems is caused, in large part, by social isolation and stigma.

Risk Factor – Human Trafficking

A conversation about homeless and traumatized LGBTQ youth must address the very real concern of human trafficking. The US Department of Health and Human Services reports that half of all people trafficked into the U.S. each year are children (Henry et al., 2016) and the National Runaway Hotline found that one in three teens on the street will be lured into prostitution within 48 hours of leaving home (“Why they run,” 2010). The U.S. Department of State's annual report on human trafficking to the United Nations noted “Particularly vulnerable populations in the United States include: Children in the child welfare and juvenile justice systems; runaway and homeless youth, unaccompanied children; American Indians and Alaska Natives; and LGBTQ individuals” (UN Publications, 2017). It has been estimated as many as 86 percent of children involved in human trafficking came directly from child welfare systems of care (UN Publications, 2017).

Chapter 2 – Permanency

For the child welfare specialist experienced in working with family systems, the following situation presents an ideal opportunity for an intervention. A child comes out as LGBTQ to family and a crisis ensues; the family is in turmoil; and everyone is poised for something to happen. Family members love and care for each other, yet find themselves confused, frightened, shame-filled, unprepared, and angry when a child discloses. So many possibilities lie before this family. They can act in a reckless manner, lashing out at the individual who has disclosed, or they might fall into a conspiracy of silence, become completely paralyzed, and numbed by the circumstances. Professionals, who have spent years with families, or even those who have recently entered the field, know that what happens next is not always predictable.

When the situation involves an issue of sexual orientation in the family, one can almost guarantee that there will be a great deal of ambivalence. Coming out in the context of a family system can yield unpredictable outcomes and even accepting parents might experience conflicted feelings about their child’s self-identification or experiences after coming out.

Preserve and Prevent to Promote Permanence

In the best case scenario, placement outside the home can often be prevented through provision of family preservation, family-centered, and supportive services. Research from the Family Acceptance Project showed that many families became less rejecting and more accepting within about two years of learning of their child's LGBTQ identity (Wilbur, Ryan, and Marksamer, 2006).

Best practices demonstrate that the most impact from in-home family prevention services occur when the following elements are present:

- Support, counseling, and guidance in coping with the immediate adjustment to the family's discovery of the youth's sexual orientation or gender identity;
- Information and guidance related to positive adolescent development, human sexuality and gender identity, and the effects on the youth of family acceptance versus rejection;
- Individual and family counseling to support each family member and improve family communication and functioning; and
- Assistance identifying local services and resources to provide ongoing support to the family and youth (Wilbur, Ryan and Marksamer, 2006).

Child welfare best practices support families by acknowledging that it is normal for parents and siblings to struggle when a child "comes out" as LGBTQ. There are many ways to support families in this process:

- Coming to terms with this new knowledge takes time, and parents who realize they need support regarding this issue are to be commended.
- Explore with parents what their main concerns are when their child comes out. Some parents worry that their child will be bullied or become a victim of violence at school or in the community, but all too often their worry is expressed through anger rather than compassion or protectiveness.
- Help youth understand that their family may need time to process this new information about them.

Some parents may have religious or moral objections to issues of sexual orientation and gender identity. Some may even dismiss such topics as "identity politics" rather than genuine concerns for the child, the child's safety and well-being, and family integrity. When possible, linking families who hold religious or moral objections to LGBTQ-supportive resources within their religious faith may help. For many families and adolescents, religion and spirituality are important sources of coping and strength, and providers need to help them understand that loving their child and finding solace in their beliefs are not mutually exclusive (Wilbur, Ryan, and Marksamer, 2006).

In some instances, in particular in families who have religious objections to homosexuality and LGBTQ self-identification, parents may want their child to participate in conversion or reparative therapy, which is intended to change an individual's sexual orientation. Parents should be aware that this kind of therapy has

not been shown effective and may further alienate or harm the child. In addition, the American Psychiatric Association (APA), “Opposes any psychiatric treatment, such as reparative or conversion therapy, which is based upon the assumption that homosexuality per se is a mental disorder, or based upon a prior assumption that the patient should change his/her homosexual orientation” (APA, 2017).

Preserve and Support Reunification to Promote Permanence

When an LGBTQ youth does require placement out-of-home, a case plan is developed jointly by the youth, parents, and child welfare specialist. This plan includes steps that the youth, parents, foster parents, and child welfare specialist/social service agency must take to address the reasons, behaviors, and family circumstances that led to the placement. It is important to consider steps and/or services that can be used to support a family toward reunification with specific attention paid to the needs of the families of LGBTQ youth. Ideas for possible services and goals to facilitate reunification include:

- Family will participate in family therapy with an LGBTQ-knowledgeable/-affirming therapist. Therapy will focus on increasing the parents’ understanding of their child's LGBTQ-specific needs, repairing the relationship between family members, and assuring safety for all family members.
- Parents will contact the local PFLAG (Parents, Friends, and Families of Lesbian and Gays) chapter to discuss support and resources in the community.
- Youth will participate in individual therapy with an LGBTQ-knowledgeable/-affirming therapist.

Crucial aspects of successful reunification are the child welfare specialist’s roles in preserving and supporting family integrity through frequent, purposeful, and progressive visitation and facilitating family connection with local LGBTQ resources.

Multiple studies have found children placed with relatives during state intervention fare better physically and emotionally, and are more likely to maintain a single, successful placement while in care. In addition, children who are placed with relatives spend less time removed from their parents (91.4 fewer days) and overall felt more connected with parents during the process of child welfare intervention, thus increasing the success of reunification (Flavin, 2017).

An often asked question is how a child welfare specialist knows when it is safe to reunify the child with their parent. This question applies to every placement situation, not just those involving LGBTQ youth. Considerations include not just if the parent complied with and met case plan goals, but more importantly if they can demonstrate necessary behavioral changes that show how they will be able to provide an emotionally and physically safe home for their LGBTQ child. Several questions specific to the needs of LGBTQ youth in care might be:

- Examine parental participation in family counseling focused on repairing the relationship with their LGBTQ youth: What did they learn? What techniques will they use with their child or family? What did they learn that surprised them the most? What might they have done differently now that they know more about their LGBTQ child's needs?
- What is their understanding of their LGBTQ child's unique needs?
- How will they support their LGBTQ child *as they are* in the community? In school?
- What are their attitudes about sexual orientation? About gender identity?
- What are their attitudes about their LGBTQ child?
- How do they describe the impact of their prior rejections, words, and actions toward their child?
- How do they speak to their LGBTQ child? (supportive/affirming and compassionate? Or verbally, spiritually, or physically threatening?)
- How does the LGBTQ youth feel about their safety? How do they view their parents' behavioral and attitude changes toward them since intervention?

These questions should be easily answered for the child welfare specialist who is in regular contact with the parents, youth, foster parents, and service provider(s). When positive behavioral changes have occurred, the family can begin to plan for the youth's return home. Reunification can be stressful on all family members, even when everyone has made progress and worked hard to make positive changes. Successful reunification requires thoughtful planning and consideration of the steps necessary to decrease the possibility of continuing conflict that might result in safety issues.

Reunification plans can include steps, such as:

- Detailed plans for resolution, if arguments or disagreements arise.
- Agreement that all family members will continue therapy until the therapist recommends closing the case due to having completed therapeutic work specific to child welfare needs.
- Agreement that specifically allows the youth to attend local LGBTQ youth groups or school-based Gay-Straight Alliance meetings.
- Agreement that no physical or verbal violence or threats will be used by any household member.
- A list of support people and/or agencies that each family member can contact if additional support is needed.

The child welfare specialist must meet with the family very soon after the reunification to assess how the youth's return home is going. Remember that although a decision was made that a home was safe enough to reunify, the family is going to continue to need ongoing support. Safety should be assessed at every home visit, and the specialist should continue to meet separately with the youth at home, school, or in the community to have the chance to discuss how the transition home has been.

Preserve and Forge New Connections to Promote Permanence

Not every child is able to be successfully reunified with their parents or caregivers. For those children for whom termination of parental rights was a case outcome, preserving and promoting permanence becomes significantly more challenging. Youth who experienced the termination of parental rights often find themselves adrift in the child welfare system, sometimes in a home with a family, but all too often placed in a group home or residential treatment facility. Oklahoma provides a Successful Adulthood program to all children in state custody who are fourteen years or older. Successful Adulthood seeks to provide the scaffolding of life skills, literacy, and functioning necessary to launch children successfully from state care and custody into a sustainable, productive adulthood. One important tenant of success as a young adult is connections and systems that are LGBTQ-informed and affirm the youth's LGBTQ identity and experiences. LGBTQ-knowledgeable/affirming service providers should be located for youth in care and steps taken to ensure that their placement providers also meet the standards of care required for foster and kinship parents of LGBTQ children.

Connections for children who have experienced termination of parental rights should be maintained, whenever possible, with other members of the birth family, such as siblings, grandparents, cousins, and other extended relations. Preserving relationships with members of their family of origin helps children feel connected and increases the pool of people on whom they might rely for support. The child welfare specialist should ensure regular visitation with siblings, grandparents, cousins and other relatives who support, encourage and validate the LGBTQ youth in their journey toward adulthood. Further, the child welfare specialist should encourage the youth to speak openly about the adoptive or permanency situation they prefer and ask questions of potential adoptive or guardianship caregivers specific to the needs of LGBTQ youth.

Protective Communities Promote Safety and Well-being

While Oklahoma has several metro and suburban areas that house a significant number of LGBTQ-specific resources, many areas of the state have limited, if any, LGBTQ-specific resources or LGBTQ-knowledgeable/-affirming therapists. In the absence of such resources, child welfare specialists might take some steps to provide support:

- Provide families with online resource lists, national and local (see Appendix A *Resources*)
- Provide copies of the Family Acceptance Project handbook to the family (Ryan, 2005). Hold discussions specific to the issues raised in the handbook. Process with the family.
- Create and provide a list of books and other media available at your local library.
- Contact your nearest PFLAG chapter to learn about what they offer. Consider hosting a speakers' panel for LGBTQ community support. Ask if PFLAG

- provides training.
- Check with local colleges or universities to see what resources they offer to LGBTQ students. Discuss what services might be available to non-student community members.
 - Connect parents with other community members or foster parents who have struggled with similar issues (following confidentiality protocol).

Chapter 3 – Confidentiality

Confidentiality can be difficult to navigate when a child’s safety is involved. How do you advocate for protection without outing a youth who would rather not be open about their sexual orientation or gender identity? LaRue Oberloh, program manager with the Sioux Falls Area Casa Program of South Dakota offers this advice, “I think that foremost is to respect the confidentiality of the youth. If safety is an issue, the key is to leave it to the youth to decide whether to disclose their sexual orientation or gender identity expression. A trusted adult can tell the youth, ‘We have these resources, and I can help you with this issue’ and let them have control. The youth may say, ‘Okay, fine, let’s do this.’ We’re better off including them and developing a plan to ensure their safety. But once it’s documented that a youth has come out, that will follow wherever he or she goes, and that’s not always a good thing” (CASA, 2009).

Many LGBTQ youth choose not to come out until they can be assured that the person with whom they share this part of their identity will be accepting and supportive. The decision to hide one’s LGBTQ identity is reinforced by social images and expectations, and a culture in which negative and biased (homophobic and transphobic) attitudes are still common and openly expressed. Many experts suggest that it is not typically appropriate to ask a young person directly if they identify as LGBTQ. Specialists should expect youth at first to be reluctant to discuss their sexual orientation or gender identity expression. In order to encourage youth to be open about these issues, child welfare specialists should adopt an approach that helps youth feel safe enough to disclose information about themselves – at their own pace and on their own terms (Wilbur, Ryan, and Marksamer, 2006). In his book *Lesbian, Gay, Bisexual, Transgender, and Questioning – LGBTQ Youth Issues: A Practical Guide for Youth Workers*, Gerald P. Mallon offers ideas to assist child welfare specialists in engaging LGBTQ youth in the coming out process. Some of his suggestions are summarized below (2010).

Prior to Coming Out

Child welfare specialists may be wondering, “What can child welfare specialists do to assist LGBTQ youth with the coming out process?” The only sure way of identifying an LGBTQ youth is when he or she self-discloses his or her orientation to you – in other words, when a youth comes out to you. Remember, the goal of

working with a possible LGBTQ youth is not to get them to come out to you, but to facilitate the experience of coming out, if and when a young person decides it is safe to do so. Facilitating the experience means that child welfare specialists need to do the following:

- Use the words “gay,” “lesbian,” “transgender,” “questioning,” and “queer” in your conversations. The child welfare specialist’s ability to say and use these words with ease suggests that they are comfortable with these issues and are a safe person with whom to talk about these issues.
- Be open to the terms a youth may use to identify their sexual orientation or gender identity. Engage youth in conversations that allow space for their language on their terms to develop at the pace they set.
- Ensure your workplace demonstrates acceptance of the LGBTQ population through visual means, such as posters, books, flyers
- Challenge inappropriate jokes or humor based on race, culture, gender, age, ability, religion, sexual orientation, national origin or gender identity. Be clear about why the humor is offensive. Demonstrate quality standards of professionalism, respect, integrity, and compassion by supporting LGBTQ individuals.
- Provide all youth with opportunities to talk about gender and sexuality in a healthy way. Draw LGBTQ youth into the conversation without calling out their sexual orientation or gender identity.
- Encourage training, organizational reform, and review of policies that might discriminate against LGBTQ youth, families, service providers, or co-workers.
- Understand that people who self-identify as LGBTQ are more than their sexual orientation or gender identity; they are whole people with interests, likes, dislikes, joys and fears, just like everyone else. Engage other parts of their experiences unrelated to their LGBTQ identity.

During the Disclosure/Coming Out Process

When a youth has trusted the child welfare specialist enough to share their self-identity as gay, lesbian, bisexual, transgender, questioning or queer, it is important that the child welfare specialist allow the youth to take the lead in this conversation. The youth will use words to describe their sexual orientation or gender identity that they have found to describe themselves and their feelings. Using the youth’s words in the conversation reflects, supports, validates, and affirms their choices and decisions in self-description and self-identity. The child welfare specialist should anticipate that the youth will have concerns for confidentiality and explain the level of privacy required for child welfare specialists. It is crucial to the coming out process that the specialist give the message that they are willing to talk about any issue that concerns the youth. The child welfare specialist should be prepared to validate and accept a youth’s expression of same-gender attraction, desires, and behaviors, as well as gender

variance and self-identification. Most youth have spent time figuring out what words best describe themselves before sharing this identity with others.

When a youth comes out, they are disclosing very personal information about themselves that could potentially lead to negative outcomes in their life. Violence and isolation are very real fears for LGBTQ persons. Child welfare specialists should ask youth about their fears and concerns specific to coming out, being LGBTQ, and familial response to their coming out. Discuss their anticipated consequences and outcomes. Guide the youth through an examination of who they want to tell, when, and what the possible outcomes might be with each person they tell. The specialist needs to remember to start where the youth is and proceed with gentleness and patience. Assist the youth in safely exploring and understanding their feelings, thoughts, and behaviors related to sexuality and gender identity (Elze and McHaelen, 2009).

It is important to remember that sexual orientation and gender identity are different constructs. Transgender youth may self-identify as gay, lesbian, bisexual, heterosexual, or questioning their sexual orientation, or they may not label themselves in that way. Child welfare specialists should focus on validating the youth's disclosure as it unfolds. Transgender youth may need additional help in differentiating between their gender identity and sexual orientation.

Be aware that a youth who is disclosing is highly vulnerable. A child welfare specialist has the power to tell others and to influence the outcome of the youth's decision to come out. The youth may be afraid that you will not protect their secret or their identity. Know that not all LGBTQ youth will be clear or comfortable about their emerging identity or sexual orientation when they first come out. Some youth may be distressed and others may be confused about their feelings. Let young people who are confused know it is normal to be confused and explore their confusion with them. Child welfare specialists should be prepared to be affirming, supportive, and able to assess the youth's level of information. The child welfare specialist should provide accurate information and correct myths and stereotypes as they come up, being careful to avoid pushing youth toward any particular resolution of their self-identity, gender identity, or sexual orientation.

The child welfare specialist must recognize that many youth, regardless of sexual orientation, act provocatively and use a variety of means to express their self-identity and/or independence. LGBTQ youth who are "out and proud" and share this information with many people may be at even greater risk of harassment or violence. While "out and proud" youth may feel strong in their self-identity, they will also require support and validation in their coming out process.

Young people who have been sexually abused may require even more time to work out their sexual identity. Sometimes, experiencing sexual abuse can cause confusion about sexual orientation.

After Disclosure/Coming Out

Coming out is a different process than being found out, yet both require confidentiality be maintained. No one, including child welfare specialists, should ever take it upon themselves to “out” another person. As with other case sensitive information, without the client’s permission, the specialist should keep the information confidential. In most cases, the child welfare specialist should not share this information with coworkers. Each specialist must determine whether the culture and climate of their office is supportive and validating of a youth who has come out as LGBTQ prior to discussing issues related to LGBTQ youth, families, resources, and service providers. There are cases where youth should be encouraged to disclose to others when they feel safe and comfortable doing so. No one should ever disclose someone’s sexual orientation or gender identity without their specific permission. Disclosure is a very personal choice.

Some specialists may wonder whether they should document that a youth has come out. There is no Oklahoma DHS policy that requires a child welfare specialist document and record that a youth has come out as LGBTQ *unless such information is crucial to understanding and assessing child safety*. Each child welfare specialist must determine the degree to which issues related to coming out, gender identity, and sexual orientation are crucial to understanding the youth’s safety, well-being, and permanence in their current living situation. Information specific to youth self-identification as LGBTQ might be documented in the Assessment of Child Safety, as well as the youth’s Individual Service Plan, as indicated by safety, well-being, and permanence strengths and needs.

For those LGBTQ youth who are currently in state custody and out-of-home placement, certain basic civil rights apply (DHS, 2016). Ensuring that youth in out-of-home care are supported and validated during their coming out process requires that child welfare specialists have conversations with foster and kinship parents specific to the needs of LGBTQ youth. The very same questions used to determine safety for children who live with biological parents need to be answered for foster and kinship caregivers. It is crucial that the child welfare specialist understand how foster and/or kinship caregivers define supportive, affirming, and validating language and behaviors toward youth who come out as LGBTQ. The specialist should observe the foster or kinship parents demonstrate ways that they will be able to provide an emotionally and physically safe home for an LGBTQ child.

Ideas for supporting youth in their coming out process include:

- Promote pride. Recognize and affirm the youth’s positive attributes and strengths. Promote these strengths as sources of pride.
- Be aware of local resources and services for LGBTQ youth. Link youth with local resources and services that are LGBTQ-knowledgeable, -affirming, and -supportive.
- Be aware of and support local public and private school Gay/Straight Alliances (GSA’s) or similar programs where youth may find support.

- Educate parents (biological, kinship and foster) on LGBTQ issues and terminology.
- Facilitate conversations about possible situations where the youth is “found out” before they have come out. Discuss possible outcomes and consequences, as well as how the youth will manage such situations.
- Discuss possible concerns, fears, or issues in the school and community.
- Facilitate conversations about plans to manage conflict, harassment and possible violence in school or public places (Ragg and Patrick, 2008).

Chapter 4 – Oklahoma Foster Youth

Please see Appendix B: Rights of Oklahoma Foster Youth.

Once an LGBTQ youth enters the foster care system, their child welfare specialist is an important link to support and safety. It is critical that a child’s specialist has the capacity, understanding, and willingness to support the youth’s social and emotional development while in state care and custody. The specialist is responsible for assessing and serving the needs of each child without bias and to ensure the safety of all children in foster and out-of-home care (DHHS, 2011). Policies should be in writing and located in an easily accessible place that makes very clear what steps an LGBTQ youth in care can take if they experience harassment or discrimination in their foster home. No child should be told or expected not to talk about their sexual orientation or gender identity and any safety issues, such as threats of harm or actual maltreatment, must be addressed immediately. If it becomes clear that a foster or adoptive home cannot be supportive and accepting of the youth, unfortunately a placement change may be necessary. However, in many cases, with skilled mediation or problem-solving resources, difficulties can be worked out in order to maintain stability for the youth.

The right to a safe and stable home includes autonomous rights to personal bodily integrity – the right to privacy of person and sleeping arrangements, the right to clean and appropriate clothing that fits and corresponds to gender identity, the right to free hygiene, to dress and groom according to culture and identity. The physical and emotional well-being of LGBTQ youth is at risk if the young person is harassed or mistreated based upon their actual or perceived sexual orientation or gender identity expression. In situations where LGBTQ youth in foster care or other placements are mistreated and their physical or emotional well-being is harmed, the caretakers, as well as the professionals responsible for making the placement decision and providing on-going monitoring of the placement, are responsible for rectifying the situation.

The right to safety also includes the right to receive services to prevent physical or psychological harm or deterioration while in foster care. Child welfare professionals must be vigilant to avoid contracting for services that use inappropriate or unethical practices when dealing with LGBTQ youth, such as

“conversion” or “reparative” therapy or other controversial practices intended to involuntarily change a youth’s sexual orientation or gender identity expression.

The duty to protect young people in the child welfare system imposes a corresponding duty on the professionals involved to maintain regular contact with them in order to insure their continued safety. LGBTQ young people in state custody are vulnerable to mistreatment and harm from a variety of sources, both inside and outside their placements. By maintaining regular contact with a child, the lines of communication are more likely to be open, and the child welfare specialist is more likely to learn of harassment and abuse and be better prepared to take all the necessary steps to stop it (Estrada and Marksamer, 2006).

While working toward developing a positive, respectful relationship with an LGBTQ youth, it is vital that CW specialists ensure that any placement youth have to enter is safe and supportive. LGBTQ youth are particularly vulnerable to “failed” placements, multiple rejections, and frequent transitions (Wilbur, Ryan and Marksamer, 2006).

Foster parents’ attitudes toward LGBTQ youth warrant consideration. Agencies must be particularly attuned to placing young people who identify as LGBTQ with foster families who are committed to providing a safe, supporting, and affirming environment for a child while in care. While agencies should recruit, train, and provide ongoing support to families who are able to provide a safe, loving placement for youth who are LGBTQ and involved with the child welfare system, child welfare is responsible to ensure foster parents have been educated on LGBTQ issues (DHHS, 2011).

Youth in foster care who self-identify as LGBTQ may be less likely to find a permanent home than other children whether through means of reunification, adoption or transfer of permanent legal and physical custody. Where reunification is part of the child’s case plan, agencies should support the families to ensure the parents or guardians develop the capacity to address the child’s needs in a healthy, understanding manner when the family is reunified. One of the issues that affects youth in the system who are sexual or gender minorities is not enough focus on permanency.

Prevent and Preserve while in Placement

During the application and home study process, child welfare specialists must address cultural competency, as well as cultural, religious, and ethnic differences. Such cultural discussions and education must include information specific to LGBTQ issues and having children in their care that may currently self-identify as LGBTQ or may “come out” as LGBTQ while in their home. All families should be encouraged to process their feelings about issues related to sexual orientation and gender identity expression. Families that are uncomfortable caring for LGBTQ youth in an unbiased way should not have these youth placed in their

care. Some families may express hesitation during an initial home study, but with deeper discussion of some of their concerns and issues, and given education, training, and support opportunities, these families may become appropriate and support placement options for LGBTQ children.

Foster parent orientation training must include information on cultural issues. The training should include information specific to LGBTQ issues and LGBTQ youth needs. All foster and adoptive families need and deserve support, regardless of the sexual orientation of the child or youth placed in their home and care. When LGBTQ youth are placed in a foster or adoptive home, however, these families may need some specialist supports. Foster parents may be interested in more details and specific information about normal developmental issues of LGBTQ youth, including a greater understanding of the “coming out” process and how this may impact the youth and family. Foster parents should be assured it is normal to feel nervous or unsure about how best to meet the needs of LGBTQ youth, and that it is okay for them to ask questions or be uncertain during the process of guiding a youth into young adulthood.

Child welfare can also take steps to help ensure LGBTQ youth will be safe in out-of-home care by actively recruiting a wide variety of loving and supportive foster families who can be affirming to youth that identify with the LGBTQ populations. As is true for straight or heterosexual individuals, not all LGBTQ people should be foster or adoptive parents. The question is not whether LGBTQ applicants should be approved, but whether they will be offered the same fair process and open opportunity to become foster or adoptive parents as non-LGBTQ people who seek to adopt or foster. Home study forms and processes should be inclusive and directly address LGBTQ issues in the application and approval process. Inclusive forms are gender neutral (“Applicant 1,” “Applicant 2,” rather than “Mother” and “Father”) and do not presume that the applicants are heterosexual.

Crucial Considerations for Out-of-Home Caregivers

Foster and adoptive parents need to:

- Acknowledge that foster children in their care may be LGBTQ. Do not assume all children are heterosexual and it would “never happen” in their home.
- Examine their beliefs and attitudes that might impact their ability to support LGBTQ youth in their care. Regardless of personal beliefs, it is a foster parent’s responsibility to provide a safe, nurturing and nonjudgmental environment to all youth in their care.
- Be prepared for the fact that their own family, friends and community supports may or may not be accepting and supportive to the LGBTQ foster children in their home.
- Educate themselves on LGBTQ issues through reading books, watching films, conducting research, attending workshops and trainings.

- Understand that being LGBTQ is not a “choice” or something a person can change. The leading mental health and child welfare associations have long recognized that lesbian, gay or bisexual sexual orientation is a normal variation on human sexuality and no more susceptible to change than is a heterosexual orientation. A foster child in care should never be subjected to “conversion” or reparative” therapies for the purposes of changing their sexual orientation, gender identity, or gender expression.
- Know that your acceptance or rejection affects the health, well-being, and permanency of any LGBTQ child in your care.
- Respect the privacy and confidentiality of LGBTQ youth, including their self-identification as LGBTQ.
- Apply the same standards to LGBTQ youth that they apply to other youth for age-appropriate adolescent behaviors, including romantic, sports, and other teen behaviors.
- Provide safety in all settings for LGBTQ youth.
- Be an advocate for LGBTQ youth, particularly in the school and community settings.
- Acknowledge that there is more to an individual than their sexual orientation or gender identity and expression. Avoid making assumptions about a young person based entirely on these characteristics. In particular, beware assuming that every struggle faced by an LGBTQ child is the result of being lesbian, gay, bisexual, transgender, questioning or queer. Many of their struggles are the same as other children’s – a result of the lack of support received from caregivers and peers.
- Take advantage of community resources for you and your LGBTQ foster or adoptive child.

Chapter 5 – Placement Safety

Safety is a paramount issue for LGBTQ youth. LGBTQ youth are at higher risk for physical violence and verbal harassment in their homes, schools and communities. In the United States, the Adoption and Safe Families Act of 1997 declares that a state’s child welfare system has a mandate to ensure a child’s safety in foster care (ASFA, 1997).

Sometimes LGBTQ children are placed in residential facilities, when a family foster home is not appropriate or not available. In some cases, LGBTQ youth are neglected and/or discriminated against by facility staff and peers, and confront inadequate policies, protections, support services, and insensitivity. Some LGBTQ youth experience verbal harassment or physical or sexual abuse because of their sexual orientation or gender identity. This abuse can be perpetrated not only by peers, but

also by facility staff, child welfare specialists, and medical care providers. When the abuse is between peers, it is sometimes condoned by facility staff or goes unchallenged (Feinstein et al., 2001). An LGBTQ youth who experiences disrespect or bias from facility staff, or agency child welfare specialists is at greater risk of being bullied, harassed, isolated, depressed, and/or suicidal.

When LGBTQ youth experience harassment and discrimination, out-of-home placement providers sometimes respond by moving the LGBTQ child to another – often more restrictive – facility or isolating the child rather than addressing the underlying homophobia, transphobia, and/or bullying behaviors (DeSetta, 2003). LGBTQ children are sometimes segregated or put in isolation based on a myth that LGBTQ youth will “prey” upon other youth. This segregation not only reinforces the notion that LGBTQ youth are bad or to blame for harassment directed at them, but can also result in further denial of access to resources and support for children. Facilities sometimes discipline LGBTQ children for engaging in age-appropriate conduct that would not be punishable if between two children of different genders.

Child welfare specialists must have conversations with facility caregivers to ensure that supportive and evidence-based therapies are being utilized for children in care. As mentioned above, “conversion” or “reparative” therapies are harmful and should not be the basis of any treatment plan for an LGBTQ child. Prior to placing any child in a residential care and treatment facility, a child welfare specialist must determine if the facility has a welcoming and supportive environment for that specific child. In particular, when placing an LGBTQ child, child welfare specialists should consider:

- What signs or posters in the lobby or intake area indicate that LGBTQ people are supported and respected? Examples might include rainbow, pink triangle, “LGBTQ Allies,” “Safe Zone,” or “Hate-Free Zone” signs, posters or stickers.
- How prominent are anti-discriminatory policy signs? What do they include? How specific are they to LGBTQ issues?
- What training does the facility provide to staff, child welfare specialists, residents and administration specific to LGBTQ issues, concerns, risks, needs, resources (local, online, other), and support systems? What does their training say about gender identity and gender expression? What does their training say about sexual orientation and the coming out process? What curricula do they use?
- How comfortable and knowledgeable is the residential, administrative, and therapeutic staff when talking about LGBTQ-related topics? What is their knowledge of local and community resources that are LGBTQ-supportive or LGBTQ-affirming?
- Are facility forms gender-neutral? How welcoming and LGBTQ-supportive are statements of welcome and orientation by the facility?
- What is the facility policy addressing confidentiality specific to LGBTQ issues, such as coming out, gender identity, gender expression, or sexual orientation?
- What is the level of LGBTQ community involvement with this facility? Have

(or would) they participated in community review for LGBTQ-welcoming and friendliness?

Preserve and Protect to Promote Well-being and Safety

All staff within residential facilities should be ready to talk with all incoming youth about their privacy and safety considerations. Youth who self-identify as LGBTQ have a heightened desire for privacy and safety, making these conversations even more crucial to their well-being. The conversations should be open and honest and include the following topics:

- preferred name and pronouns;
- housing and sleeping preferences/arrangements;
- privacy in showers and bathrooms;
- safety concerns; and
- confidentiality.

Child welfare specialists should ensure that these confidentiality measures are in place and being utilized when referring a child to a facility. Confidentiality is important and even more critical to stress with youth who self-identify as LGBTQ. These children may or may not be “out” at all or only to certain people and it is up to the youth to determine to whom and how they come out about their sexual orientation or gender identity. Child welfare specialists should stress to the residential facility that honoring and respecting confidentiality in the way the LGBTQ youth has requested is critical.

Sleeping arrangements for LGBTQ youth may be a complicating factor for facilities. Youth who self-identify as gay, lesbian, bisexual, transgender, questioning, or queer should not be treated differently in terms of sleeping arrangements or housing placements. If a youth reports being treated differently in terms of sleeping arrangements at the facility where they are placed, then the child welfare specialist should contact the facility director to discuss the situation and ensure that the child will be treated equally in this regard.

Some residential care facilities worry that allowing a gay or lesbian child to be placed in the same bedroom with other children of the same sex will lead to sexually inappropriate behaviors. LGBTQ youth are no more likely to engage in inappropriate sexual behavior than non-LGBTQ children. A policy that addresses sexual activity, violence, and sexual violence would prohibit all such activities and situations, regardless of the participants’ genders or sexual orientation.

Chapter 6 – Transgender Considerations

In order to be considerate of transgender children and people, it is important to have an understanding of what gender identity is. All people have a gender identity. The term “gender identity expression” refers to a person’s internal sense of being male, female, or something else. For most people, their gender identity

expression matches the gender they were assigned at birth. As an example, a person declared to be female at birth identifies as a girl in her youth and later as a woman in her adulthood. She is comfortable with and feels described by the terms “she,” “her,” and “hers.” For transgender people, the sex/gender assigned at birth does not “feel” right, and is not a comfortable description of how they feel.

Individuals who have a different gender identity expression than their biological sex or birth-assigned sex are often referred to or refer to themselves as “transgender.” An example would be a person who was assigned female at birth by medical personnel, who as a child felt like a boy, was uncomfortable being called a girl, and as they grew up felt like a male/man whose body did not match their internal sense of self. They are more comfortable with pronouns such as “he,” “his,” and “him.” This person would be considered transgender female to male person (FTM). Similarly, a person assigned male at birth who feels female would be a transgender male to female person (MTF).

Many people are confused about the difference between sexual orientation and gender identity or gender expression. Some people believe that all gay, lesbian, and bisexual people are transgender or that all transgender people are gay or lesbian. This distinction is important: transgender female youth see themselves as females, not gay males, and transgender male youth see themselves as male, not lesbian females. Sexual orientation and gender identity are two separate things. (See Appendix C: Glossary)

Often residential facilities choose to place transgender children in the sleeping areas of youth of their biological sex, as opposed to the current gender identity of the transgender youth. These concerns seem to be related to safety. Specifically, program administrators may be fearful that a transgender girl may sexually or physically assault another resident. These types of attacks are extremely rare and any policy generally prohibiting sexual behaviors and violence would address the situation. An LGBTQ-supportive residential facility will ask a child during the intake process where they are most comfortable sleeping and bathing. The child can then determine if they are most comfortable in gendered areas or an individual space. Some facilities may have a private room available. Before a single, isolated option is given, facility staff should consider that this may not be a helpful action as other youth who occupy shared spaces may get jealous, angry, or resentful and then take their frustrations out on the child who does get a private space.

This discussion needs to take place prior to placement in single-sex facilities. If the residential facilities are separated by sex/gender, discussions with the child can help determine which residential treatment/care facility is most appropriate.

Bathroom arrangements are also presented as concerns for many residential facilities, in particular for transgender youth. Ideally, bathroom and shower facilities for all youth offer privacy, including single stalls with locking doors. It

is uncomfortable for anyone to be naked and not have a choice about whether others see them that way or not. If a facility cannot accommodate individual restrooms for each resident, it is best practice to have at least one single-stall restroom with a door that locks. Such a restroom should be gender-neutral, available for all youth to use regardless of gender identity. An alternative for facilities that do not have a single restroom is to allow for a youth to use the group facilities privately. These options can also provide privacy for youth with medical issues or any youth who feels uncomfortable bathing and using the bathroom in the presence of others.

A good practice for residential facilities is to create and enforce gender neutral dress codes when they feel the need to have a dress code in place. For example, a policy might require that everyone wear clothing that covers certain parts of their body. The child welfare specialist's responsibility is to ensure that any residential treatment facility into which they place a child has reasonable guidelines, dress codes, sleeping arrangements, and bathing accommodations for that specific child. LGBTQ children should never be penalized by a dress code or bathing accommodations that are based solely on biological sex expectations. For example, if a transgender male to female youth is wearing traditionally "female" clothing that is within the guidelines of the dress code (i.e. – skirts, dresses), then they should be allowed to do so. Concerns specific to clothing that violates gender-neutral dress codes should be addressed by staff regardless of the child's sexual orientation or gender identity. As an example, the dress code may state that clothing that reveals bathing suit areas is inappropriate, regardless of the youth's gender, sexual orientation, or gender expression, e.g. – males may go shirtless while females are required to wear shirts or cover their breasts at all times.

Unique Barriers for Transgender People

Some of the barriers that transgender people face are similar to gay, lesbian, or bisexual people, but they face even more difficult barriers when it comes to obtaining proper identification, employment and health care. Many studies have shown that transgender people face higher rates of harassment and are more vulnerable to violence than non-transgender people. Specific barriers experienced by transgender people include:

- Difficulty obtaining a social security card, state ID, or driver's license.
- Lack of family support.
- Lack of education due to harassment in school/educational setting (GLSEN, 2014, 2017).
- Discrimination by health care providers leading to less or no health care services.
- Inability to pay for transgender-related healthcare, such as hormone treatments, counseling, and gender reassignment procedures. Almost no transgender-related health care is covered by U.S. insurance providers.

- Higher risk for substance misuse and addiction.
- Discrimination by housing providers and landlords, social service agencies and/or employers.
- Increased vulnerability to street crimes.
- Being prohibited from making decisions for themselves due to their age, such as how they dress or who they date.
- Higher risk for depression, suicide, self-harm, and homelessness (CDC, 2017).

Similar to gay, lesbian, and bisexual children, transgender children face a high risk of being harassed, abused, disowned, and/or kicked out by their biological or foster families. There is a high level of intolerance of transgender people which leads many parents to try to force their children to conform to gender norms associated with their assigned sex. This can be devastating for the child and cause them to become isolated, depressed, and/or suicidal. It can also cause them to run away from their home and face a life on the streets. Due to the high rates of non-acceptance by biological and/or foster parents of transgender children and the high rates in which these youth either run away or are kicked out of their homes, there is a large disparity of the number of transgender youth who experience homelessness (Henry et al., 2016).

Best practices for transgender youth do not differ greatly from best practices for all children. Transgender children have the same rights as all youth. They should not be held to stricter standards due to their gender identity expression. As with all children, ask what they prefer to be called and then *call the child by their preferred name*. Be certain to use pronouns the youth prefers. Other best practices include:

- Whenever possible, use forms that allow the youth to disclose their own gender rather than a form with checkboxes for “male” and “female.”
- Ask about relationships in ways that avoid assumptions (ask about “someone special” or “dating” versus “do you have a boy/girlfriend”).
- Be familiar with local area LGBTQ support groups, counseling, and other services specific to transgender youth.
- Provide information about youth LGBTQ support groups and trans-specific services.
- Ensure potential foster parents will be supportive of the child’s gender identity and expression.
- Ensure potential residential facilities are safe and respectful for transgender youth.
- Ask about school, harassment and bullying. Address any harassment or bullying with appropriate authorities.
- Send the child to transgender-friendly clinics and service providers.
- Ensure that youth are able to receive all transition-related treatment required or recommended by the youth’s health care provider.
- Ensure that the youth has access to safe sex messages inclusive of all

sexual orientations and gender identities.

- Connect youth with local resources that can help assist transgender youth with legal issues, such as getting their name changed or identity documents (ID, driver's license, birth certificate) (Wilbur, Ryan, and Marksamer, 2006; Mottet and Ohle , 2003).

Transgender Health Care Considerations

For child welfare specialists who are working with transgender youth, it is good to have some basic knowledge of health care needs. The summary below provides an overview, but it is important that you speak with a qualified medical professional familiar with specific details for any child you with whom you are working.

Sometimes transgender people may choose to make changes to physical appearance, through surgery or hormones, while others may not feel safe making visible changes due to concerns for violence, harassment, or attacks. Surgeries are very expensive and rarely covered by insurance. While hormone treatments are less expensive than surgeries, their cost is still prohibitive to many transgender people.

Sometimes transgender people do not have the resources or legal authority (due to age) to pursue medical transition therapies, such as hormone therapy or gender reassignment surgeries. Transgender people may or may not seek out hormone treatments, surgery, or other transition-related medical care. These are deeply personal decisions. Parental consent is required for children under the age of 18 to have any surgery, including gender reassignment surgery.

People who are in the process of transitioning from female to male often take testosterone which increases muscle mass, causes facial and body hair to grow, lowers the pitch of one's voice, and changes body fat distribution to a male pattern. People who are transitioning from male to female take estrogen along with testosterone blockers which cause development of breast tissue, softened skin, and redistribution of body fat in a female pattern.

Ideally, hormone treatments are prescribed by medical professionals and their effects are monitored with regular check-ups and blood work. However, because many people cannot afford to get hormones through the medical system, some people may purchase hormones through an underground market. Hormones purchased illegally come with risk. For example, the dosage of hormones may not be at the correct level for that person. Without regular medical check-ups, the hormones may cause or exacerbate other health problems that could go undetected and untreated. Bear in mind that if transgender people are using non-prescription hormones, silicone injections, or other risky practices to make their physical appearance more congruent with their gender identity, they are doing so out of real needs that are related to mental health and physical safety. While safer

transition alternatives should be found as quickly as possible, transgender people should not be shamed or scolded for changing their bodies in these ways.

Be aware that:

- Disruption in hormone treatment may have mental and physical effects
- Transgender people may possess syringes for hormone treatment therapies
- Hormones purchased on the street come with risk and if needles are shared there is a risk for HIV or other disease transmission.

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