MARYLAND DEPARTMENT OF HUMAN SERVICES

Office of Licensing and Monitoring

September 27, 2018 – Maryland Department of Transportation (MDOT)
7201 Corporate Center Drive, Hanover, MD 21076

Agenda

Welcome	Darlene Ham
Children's Quality Service Review Initiative (CQSRI)	Deborah Harburger The Institute for Innovation & Implementation University of Maryland School of Social Work
FFPSA Clearance Requirements	SSA/OLM
Placement Resources Discussion	April Edwards
Contracts and Monitoring Update	Tennille Thomas

Questions and Answer Period

THE INSTITUTE FOR
INNOVATION & IMPLEMENTATION
Integrating Systems • Improving Outcomes

Children's Quality Service Reform Initiative (QSRI)

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Background

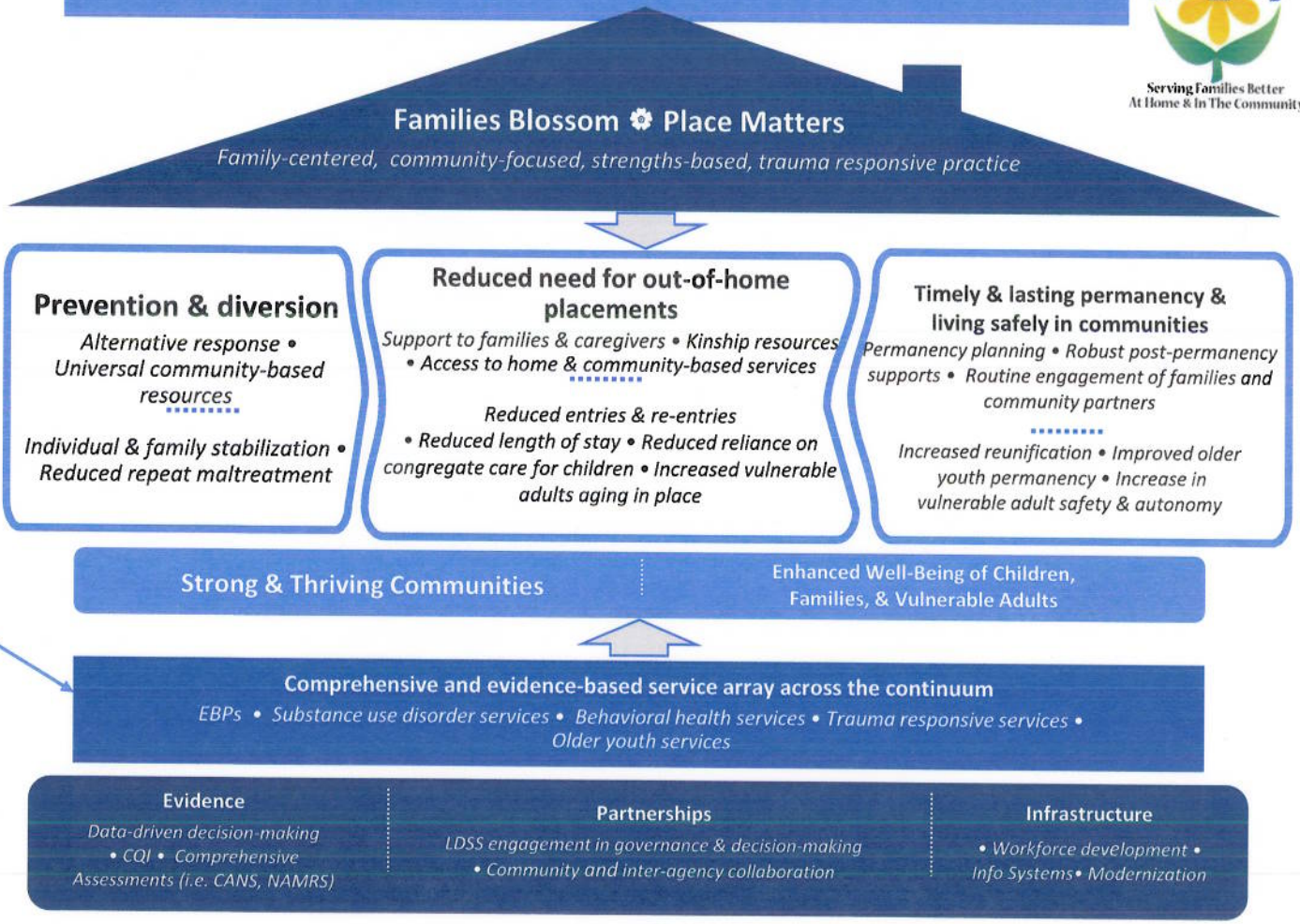
- Across child- and family-serving systems, there is growing emphasis on keeping children at home, and when that is not possible, priority on placing them with relatives or in other family-like settings.
- Recently, the federal Family First and Prevention Services Act was passed, which will let states use some of their funds to support children and families through in-home services in order to prevent out-of-home placement. Federal Title IV-E funds for out-of-home placements in non-family settings will be limited based on the length of stay of the child, the clinical needs of the child, and the specific setting.

Federal changes align with where Maryland was already heading!

- Maryland is interested in placing children in non-family settings *only* when it is in the clinical best interest of the child or when there is a public safety concern. When that happens, the placement should be for the shortest duration that is appropriate.
- Maryland envisions a system where children and youth
  - Are served in their homes and communities whenever possible;
  - Who have been removed from their homes due to child maltreatment should be placed in family homes with kin, guardians, or foster parents or, for older youth, in semi-independent living arrangements, dormitories, or other private, open market housing;
  - Should only be placed in treatment foster care or congregate care settings for a time-limited duration to address a specific behavioral health need and not as a place to house the child/youth; and,
  - Who are involved with the juvenile justice system should be provided with the services and supports they need within community-based settings, consistent with public safety.
- Rates for services should align with the quality and level of clinical care being provided

DHS/SSA Strategic Direction

Families Blossom
Serving Families Better At Home & In The Community



This is where you come in!

Children's Quality Service Reform Initiative (QSRI)

- Maryland's Interagency Rates Committee (IRC) is undertaking a Children's Quality Service Reform Initiative (QSRI).
- The QSRI builds on the work of the 2013 Joint Chairmen's Report and the Rate-Setting activities that have taken place over the past several years.
- The QSRI is led by DHS with the Maryland State Department of Education, Department of Juvenile Services, and Maryland Department of Health, as well as other Cabinet Agencies.
- The Institute for Innovation & Implementation (The Institute) at the University of Maryland School of Social Work is providing project management, technical assistance, and analysis.
- DHS has also contracted with The Hilltop Institute at UMBC to support the development and actuarial soundness of the rates.

What does Maryland hope to accomplish with the QSRI?

- A shared vision for how Maryland serves and supports children, youth, and families who are involved with Maryland's child- and family-serving agencies
- A design for a comprehensive service array of home- and community-based services
- Rates for residential child care providers and child placement agencies and some home- and community-based evidence-based practices that are better aligned with the care being provided to children and their families and rates that better support a continuum of services and supports while maximizing the use of federal dollars.
- A focus on individualized, strengths-based, trauma-responsive, and family-driven care that is measured through a robust continuous quality improvement process that engages families, youth, providers, and agencies in evaluating outcomes and improving services.
- A better approach to align funding so that it supports a highly therapeutic and shorter term program.

What is the plan for the next year?

- Development of a vision document that includes performance metrics and specifications
- Crosswalk of existing services to Medicaid billing
- Development of draft rates for services, actuarial review of rates, and piloting of rates (summer 2019)
- Design and implementation of a continuous quality improvement process that includes providers participating in data collection, recalibration of rates as needed, and ongoing assessment of outcomes
- Technical assistance to providers to become Medicaid providers (as appropriate) and accredited (as appropriate).
- Lots of engagement with providers, families, youth and young adults, community partners, child- and family-serving agencies!

What else should we know?

- Providers impacted: All Residential Child Care Providers & Child Placement Agencies (Treatment Foster Care & Independent Living) as well as some community-based evidence-based practices.
- QSRI is not a cost-reduction strategy. The goal is to improve outcomes and quality by maximizing flexibility and breaking the link between placement and services.
- We will be seeking ongoing input from a broad range of stakeholders and your voice is welcome and encouraged!
- We understand that rapid reform could be financially disruptive and we are committed to being as transparent, communicative, and responsive as possible throughout this process.
- Bottom line: Maryland wants to retain quality service providers and we need you to be our partner in this work!

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AND IMPLEMENTATION

Questions?

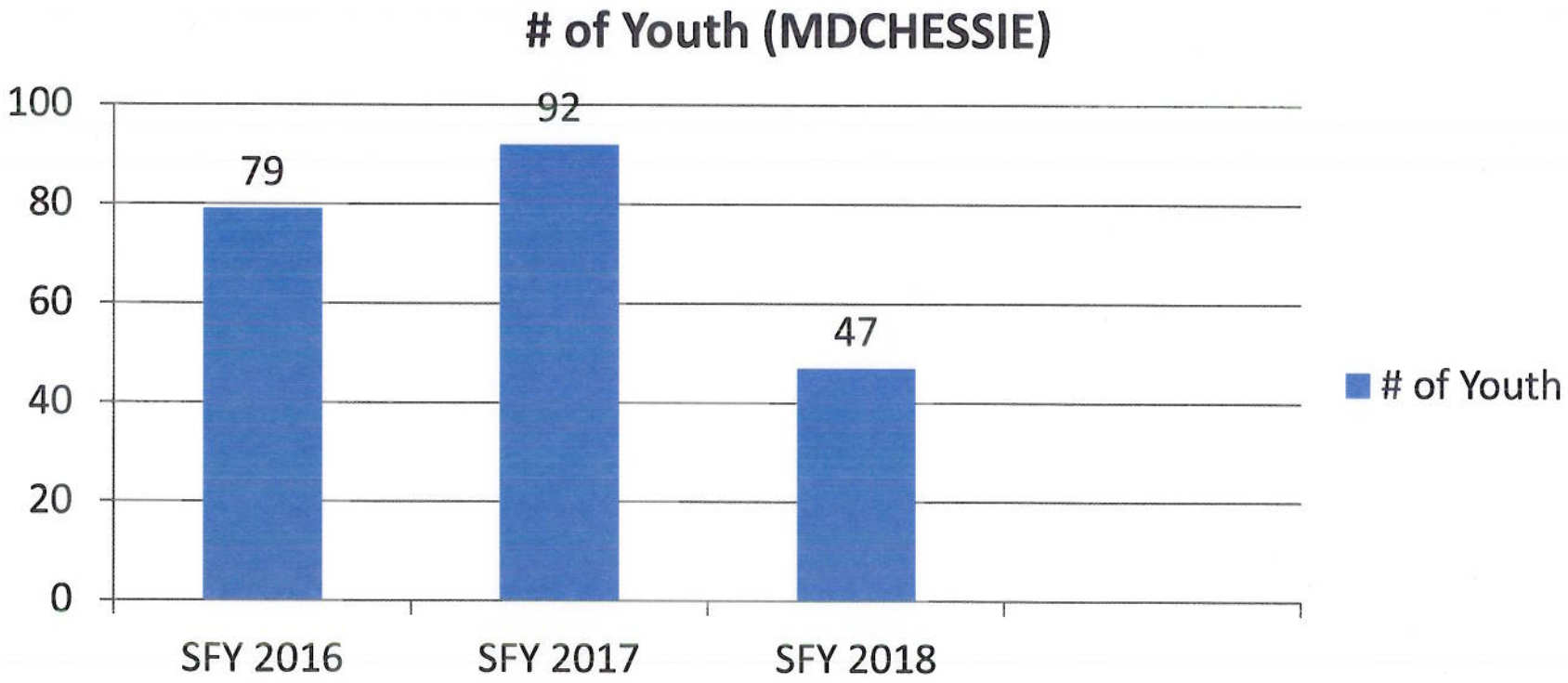
MARYLAND DEPARTMENT OF
HUMAN SERVICES

MARYLAND DEPARTMENT OF HUMAN SERVICES

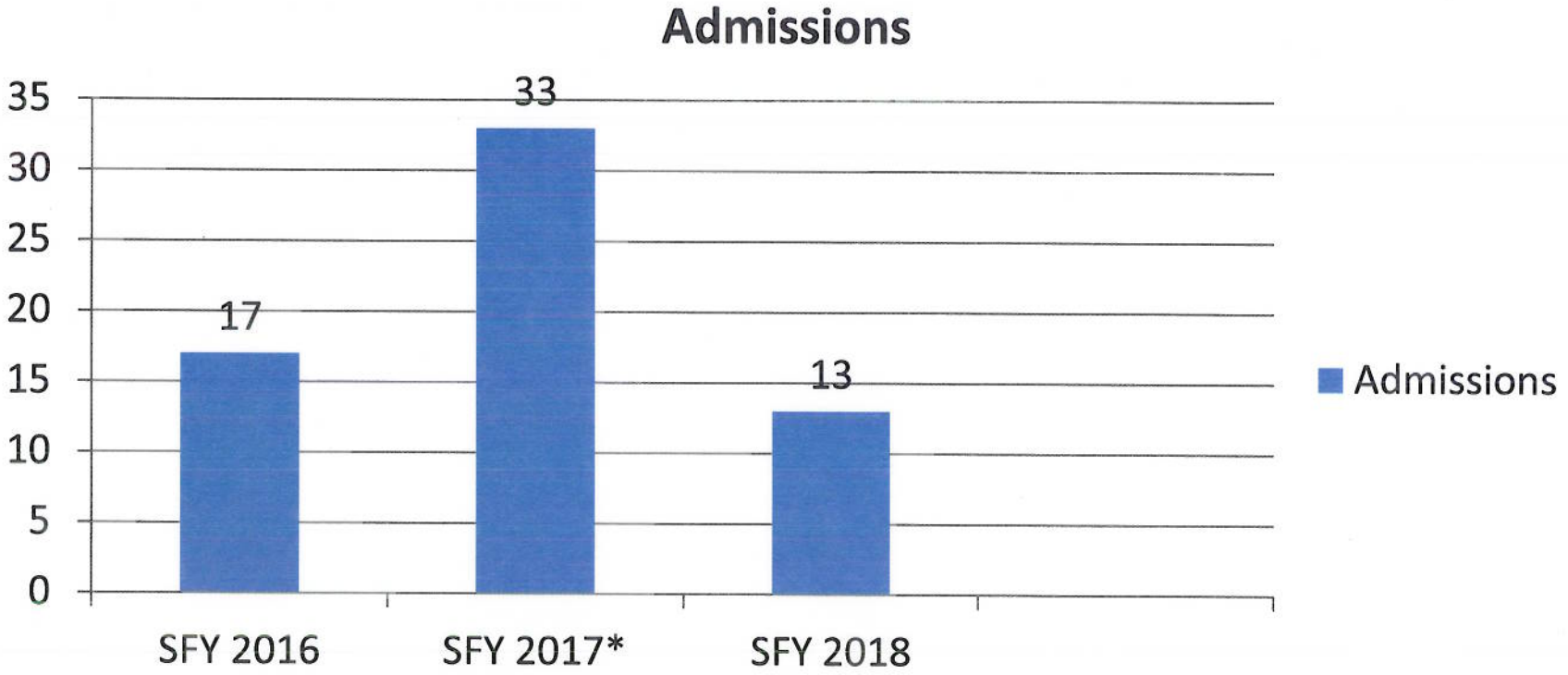
Maryland State Department of Human Services

Social Services Administration
Placement and Permanency Program
Placement Overview

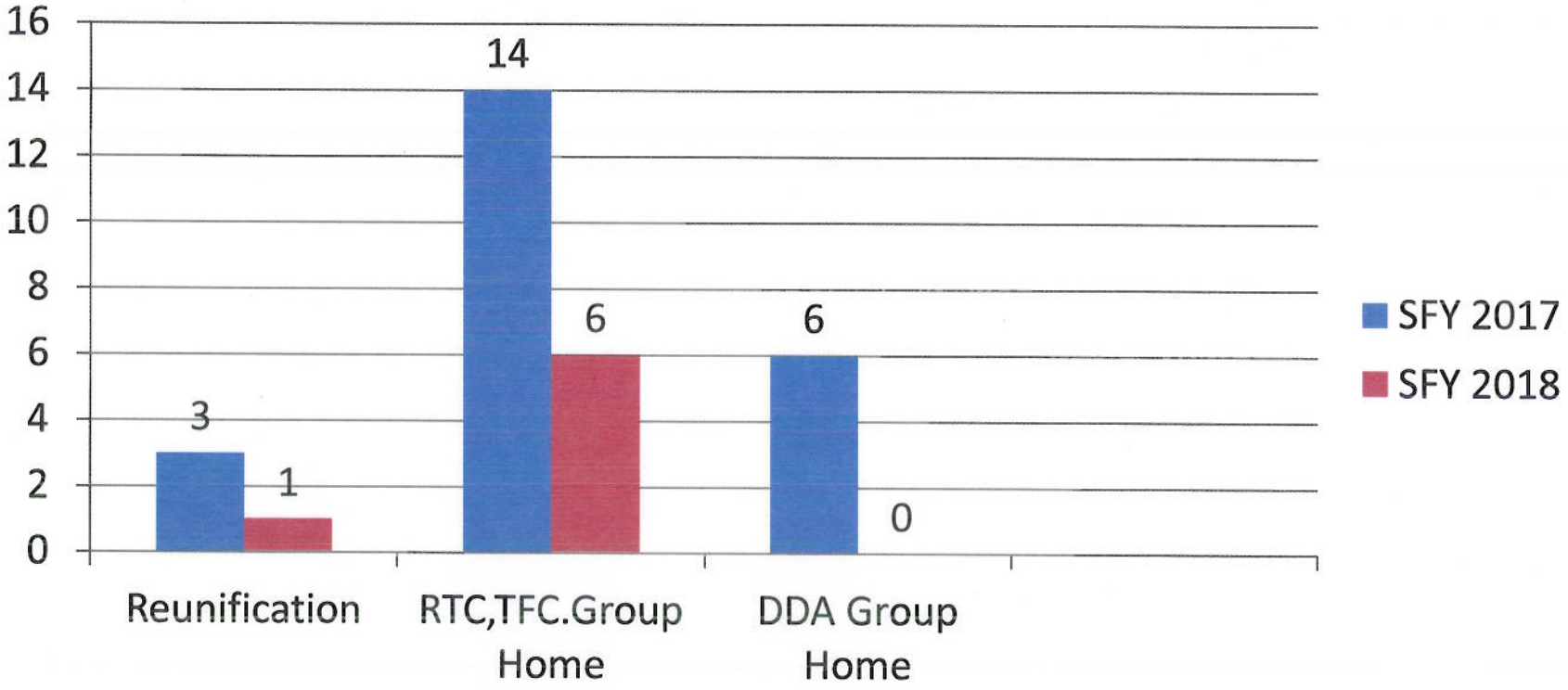
HOW FAR WE'VE COME - TOTAL # OF YOUTH



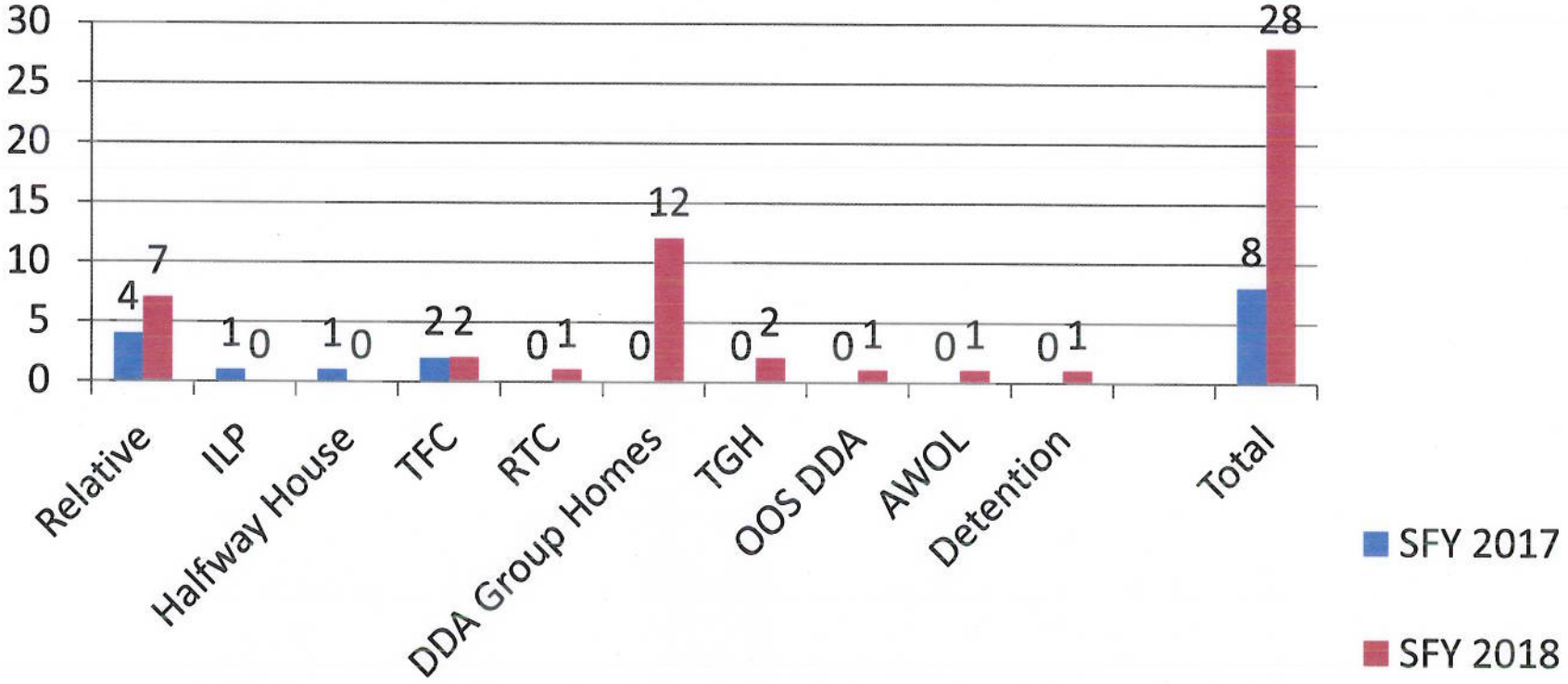
NEWLY PLACED OOS



KIDS DIVERTED FROM OOS PLACEMENT



OUTCOMES FOR YOUTH DISCHARGED FROM OOS PLACEMENTS



HOW CAN THE PRIVATE PROVIDER COMMUNITY HELP?

- Collaboration with the Local Departments of Social Services regarding the needs of youth.
- Request additional behavioral supports such as 1:1 services.
- Ensure treatment planning meetings are held.
- Ensure discharge recommendations are given timely.
- Provide notice of 72 hour discharge timely stating the reason for the discharge.

SSA Policy/COMAR Clarification

- **SSA Policy Directive #18-13**
  - Providers must have a LGBTQ Policy Guideline approved by OLM prior to accepting a placement.

- **SSA Policy Directive #18-15**
  - 2017 Legislation Passage
  - increased from 2 to 3 foster siblings being placed together without an exception request.
  - 3 foster youth may be placed in a treatment home if at least two of the youth are siblings.

- **Difficulty of Care Rate for Treatment Providers**

Per COMAR 07.02.11.32 State Standard Rates for Purchased Out of Home Placement Services

Section B. Private Child Placement Agency Treatment Foster Care Rate.

(1) This rate, paid according to the negotiated rate issued by the State Department of Education and the terms of the contract with the Department, provides for the care of a child who requires treatment foster care as defined in Regulation .03B of this chapter.

(2) In recognition of the severe nature of the problems of children cared for in treatment foster homes, a supplemental difficulty of care stipend is paid to these foster parents. The Department shall set the amount of the stipend to be included in the contract with the private provider agency.

DEPARTMENT OF HUMAN SERVICES
SOCIAL SERVICES ADMINISTRATION
311 WEST SARATOGA STREET
BALTIMORE, MARYLAND 21201

DATE:	March 1, 2018
POLICY #:	SSA-CW #18-15
TO:	Directors, Local Departments of Social Services Assistant Directors, Local Departments of Social Services Foster Care Supervisors, Local Departments of Social Services
FROM:	Rebecca Jones Gaston Executive Director Social Services Administration
RE:	Local Department Referrals to Private Treatment Foster Care Programs
PROGRAMS AFFECTED:	Out-of-Home Placement Services
ORIGINATING OFFICE:	Office of Child Welfare Practice and Policy
BACKGROUND:	Original Policy
ACTION REQUIRED OF:	All Local Departments
ACTION DUE DATE:	Immediately
CONTACT PERSON:	Shirley Brown, Policy Analyst Social Services Administration 410-767-7152 shirley.brown@maryland.gov April Edwards, Program Manager Resource Homes/Adoption Placement Support Services 410-767-7195 april.edwards@maryland.gov

Purpose

The purpose of this Policy Directive is to standardize policy and procedures governing Local Department of Social Services referrals to Private Treatment Foster Care programs. Private Treatment Foster Care programs are treatment programs that are operated and administered by private child placement agencies that contract with the state of Maryland to deliver services for the placement of children in foster care, treatment foster care, adoption, and independent living programs.

Background

Private Treatment Foster Care is a 24-hour substitute care program, operated by a licensed private child placement agency, designed to provide a high level of treatment services in a family setting for children with serious emotional, behavioral, medical or psychological conditions. Treatment is defined as the coordinated provision of services and use of procedures designed to produce a planned outcome in an individual's behavior, attitude, or general condition based on a thorough assessment of possible contributing factors. Treatment services are provided according to a written treatment plan.

An emotional, behavioral, medical or psychological condition alone does not warrant treatment foster care. The emotional, behavioral, medical or psychological condition must be "serious". A serious emotional, behavioral, medical or psychological condition is evidenced by the limitation of an individual's capacity, which adversely affects the individual's ability to perform:

- Daily living skills;
- Community living skills;
- Interpersonal relationships; and
- Appropriate educational activities.

Treatment foster care should not be a continuous program. Only on rare occasions should a child's specific condition and care warrant extended continuity of the program. It is not simply more intense foster care. Treatment foster care placement is a more restrictive placement and so must be justified in the case record with an eligibility determination and a justification for payment different from the regular board rate. The need for treatment must be clearly documented in the case record and reviewed periodically. Because of the complexity of the Treatment Foster Care program, a child should not be determined to be eligible simply because he/she may need therapy or be on a medicinal regime. A gradual discharge plan or "step-down" plan must be developed for all children who are placed in a treatment foster care home when treatment is needed for emotional, behavioral and/or psychological conditions.

Eligibility

According to COMAR 07.02.21.06A, a child is eligible for treatment foster care if the local department determines that the child:

1. Is committed to the LDSS or qualifies for foster care under COMAR 07.02.11.04 and has one or more of the following conditions:
2. A serious medical condition including, but not limited to:
   (i) HIV positive and symptomatic or has AIDS,
   (ii) Multiple handicaps, or
   (iii) A symptomatic drug-exposed newborn; or
3. A serious emotional, behavioral, or psychological condition including:
   (i) Psychiatric diagnosis by appropriate qualified professionals, or
   (ii) History of an ongoing substance abuse problem; or
   (iii) Developmental disability; or
4. Is in need of a high level of treatment in a family setting.

A serious medical condition includes the medically fragile child. Medically Fragile for the purposes of Treatment Foster Care is defined in COMAR 07.02.12.02(B)(22). Medically Fragile refers to a child or children:

1. Dependent at least in part of each day on mechanical ventilation;
2. Requiring prolonged intravenous administration of nutritional substances or drugs;
3. With daily dependence on other device-based respiratory or nutritional support, including tracheotomy tube care, suctioning, oxygen support, or tube feeding on a daily basis; or
4. With prolonged dependence on other medical devices that compensate for vital body functions and who require daily or near daily nursing care, including;

   a) Infants requiring apnea or cardio-respiratory monitors,
   b) Children requiring renal dialysis as a consequence of chronic kidney failure, and
   c) Children requiring other mechanical devices such as catheters or colostomy bags, as well as substantial nursing care in connection with the disabilities; or

5. With an unstable medical condition that requires ongoing, close medical monitoring and supervision.

Referral Process

A. The local department shall:

   1. Determine that a child is eligible for treatment foster care; and
   2. Send each potential provider agency, which has contracted with the Department of Human Services and with which the local department seeks to place a child, the following:

      a) A referral for purchase of care;
      b) A current case plan drafted within 180 calendar days before the date of referral;
      c) Relevant medical records within 1 year before the date of referral to the provider agency; and

d) The psychological or psychiatric evaluations performed within 1 year before the date of referral to the provider agency if eligibility is based on a serious emotional, behavioral, or psychological condition.

B. A provider agency shall:

(a) Have a written admission policy which includes the acceptance criteria; and
(b) Respond in writing to the referring agency within 14 working days, accepting or denying admission of a child and giving the reason for a denied admission.

A child placement agency may not accept for placement youth parents with infants or children, including pregnant youth, unless the agency is licensed to provide parent-child foster care.

Post–Acceptance Responsibilities

A. The Local Department shall:

(1) Within 30 calendar days of the child's acceptance by the provider agency, develop a permanency plan in conjunction with the provider agency;

(2) Inform the foster care review board and the court of a child's placement with the provider agency and the name of the child's case manager;

(3) Review quarterly, with the child's provider agency case manager, the written progress report on the treatment plan;

(4) Meet with the child and the child's biological family every six months in consultation with the child's provider agency case manager to update the plan; and

(5) Attend foster care review board hearings and court hearings.

B. The provider agency shall:

(1) Within 30 calendar days of a child's acceptance into the program, develop a treatment plan in conjunction with the local department;

(2) Convene a team, including but not limited to the local department of social services, treatment parents, and therapist to evaluate each child's treatment plan at intervals not to exceed 3 months;

(3) Visit the treatment foster parents at least twice a month;

(4) Provide a child access to medical care;

(5) Have face-to-face contact with a child at a minimum of twice a month;

(6) Provide services to the biological family of a treatment foster care child as required in the permanency and treatment plans;

(7) Attend foster care review board hearings and court hearings;

(8) Provide advance information to the local department on changes affecting services to a child which could result in revisions to the treatment plan, such as changes in placement, placement location, or visitation plans;

(9) Provide the local department with a written progress report on the treatment plan every three months;

(10) Provide the treatment foster parents all medical and psychological information necessary for the care of a child;

(11) Provide treatment foster parents access to both planned and crisis respite care of their treatment foster children; and

(12) Maintain a written pre-service and in-service training curriculum specific to the population serviced.

Treatment Foster Care Bed Capacity Exceptions

COMAR 07.02.21.09 sets a limit of two foster children to be placed in a treatment foster care home. The Social Services Administration may grant an exception to the treatment foster care limitation of two foster children and allow the placement of only one additional child. The Social Services Administration may also grant an exception for the placement of a minor mother and her infant child in a treatment foster home if the home is not part of a Minor Mother Program. A granted exception is specific to the treatment foster home and children as listed on the exception request form. Any change to the make-up of the treatment foster home renders the exception invalid.

Legislation passed in 2017 raised the limit to three foster children who may be placed together without the requirement of an exception when placing siblings together. Accordingly, a local department may place up to three children who require treatment in an eligible treatment foster care home if at least two of the children are siblings and it is in the best interests of the siblings to be placed together.

The treatment foster placement agency and the local department must jointly prepare the Exception Request Packet (DHR/SSA Form 1310). Either the treatment foster placement agency or the local department may submit the completed Packet to the appropriate OLM Licensing Coordinator. The submitting party is responsible for gathering all information and documentation, including written acknowledgement from all local departments having children

placed in the home in question. The form must be completed electronically. The submitted packet must include DHR/SSA Forms 1310-A, B, C, and D to be considered complete. Incomplete packets will be returned without consideration.

Valid documentation of a determination on each treatment child in the home and the child for which an exception is requested is stated in COMAR 07.02.21.06 as:

- Documented serious medical condition;
- Documented serious emotional, behavioral or psychological condition (documentation must include psychiatric diagnosis by appropriate qualified professionals);
- Documentation of need of a high level of treatment in a family setting;
- Written policy for planned discharge of child from treatment program (documentation that discharge plan revisited on regular basis).

Factors considered by the Social Services Administration in the approval or disapproval of an exception include but are not limited to the following:

- Sibling placements;
- Child's eligibility for Treatment Foster Care services;
- Treatment needs of child and other children in home;
- Skills and abilities of Treatment Foster Parent;
- Previous exception requests for child/siblings;
- Services needed and offered for Treatment children and family;
- Changes in Treatment foster parent responsibility.

Exceptions are granted only with Supervisory approval at the local level. Exceptions are for non-related children only. No more than a total of two non-related treatment foster children with special needs or three treatment level siblings may reside in a home at the same time. TFC families with two or more children are not to be used as respite families for an additional child.

Treatment Plan

The treatment plan and the treatment team are essential to treatment accountability regarding the individual treatment foster child. The Treatment Plan is a written description of the objectives, goals, and services to address the needs of a child, including the child's projected length of stay in the program. The treatment plan provides the measurable time limited goals and written procedures for the child's treatment. The treatment team assesses the progress or lack of progress in achieving the outcome goals set forth in the plan.

A written treatment plan is required for each child in treatment foster care. In order to define the role of the treatment foster parent in the child's treatment regime, the treatment plan shall include:

A. Child's diagnosis and treatment;

B. Role of the treatment foster parent;

C. Role of the provider;

D. Specific tasks to be carried out by treatment parents during placement;

E. Long-term goals of treatment, including criteria for discharge, projected length of stay in the program, projected post-treatment, aftercare services; and

F. Identification of treatment team members who will assist in the provision of planned care.

Treatment Team Meetings

Part of the duties of the treatment foster care placement provider indicated in COMAR 07.02.21.08A is to convene a team to evaluate the child's treatment plan at intervals not to exceed three months. The quarterly team meeting should include a review of the child's treatment plan. This review should examine the continued appropriateness of the plan based on the child's needs, progress made, and any additional activities that should be added to the plan. The team meeting should result in a confirmation of the treatment plan being continued as is, amended, or revised. The team meetings provide the forum for all those involved in the child's treatment to discuss the treatment and the child's progress or changing needs. The team should, at least every six months, determine and document the continued need for treatment foster care or if the child is ready for step-down or in need of step-up.

Treatment Team Members

The Treatment Team includes but is not limited to the child's TFC case manager, local department of social services case worker, treatment foster parents, therapists, and any other professional involved in the child's treatment. Each member of the treatment team has specific and general responsibilities in the treatment program of the particular child. The general role is to participate in treatment team meetings and contribute input regarding the child's needs and reactions to treatment and progress. The specific responsibilities are determined by the role of the team member. All members of the Treatment Team must be notified and invited. The child's record shall include documentation that team members were invited to the meeting and that they were notified of the opportunity to share information regarding the child by other means, such as a letter, email, fax, or phone call in lieu of their attendance.

TFC Program Aftercare

There are two instances where a child is considered to be in TFC aftercare. This does not equate to the level of aftercare services for foster care. If a child is "stepped" up into a more intensive living arrangement (i.e. therapeutic group home, RTC) or "stepped" down into regular foster care, the treatment program should hold that child in treatment aftercare status for up to 3 months. This is to aid in the transition of services, whether the services are more or less intense or down to regular foster care. The responsibilities of the treatment case manager would be limited to maintaining visitation levels and assisting the new caseworker in assuming responsibility for case management for the aftercare period to ensure that the child transitions successfully.

Retention of Jurisdiction

The LDSS shall retain responsibility for the permanency plan and sufficient involvement with the child to determine all matters relating to custody, supervision, care, treatment and disposition of the child's care. This responsibility will be retained until the child is returned home, placed with relatives, adopted, reaches majority age, becomes self-supporting, discharged with the concurrence of the appropriate authority (if placement from another state) or the case is rescinded by court order.

Record Documentation

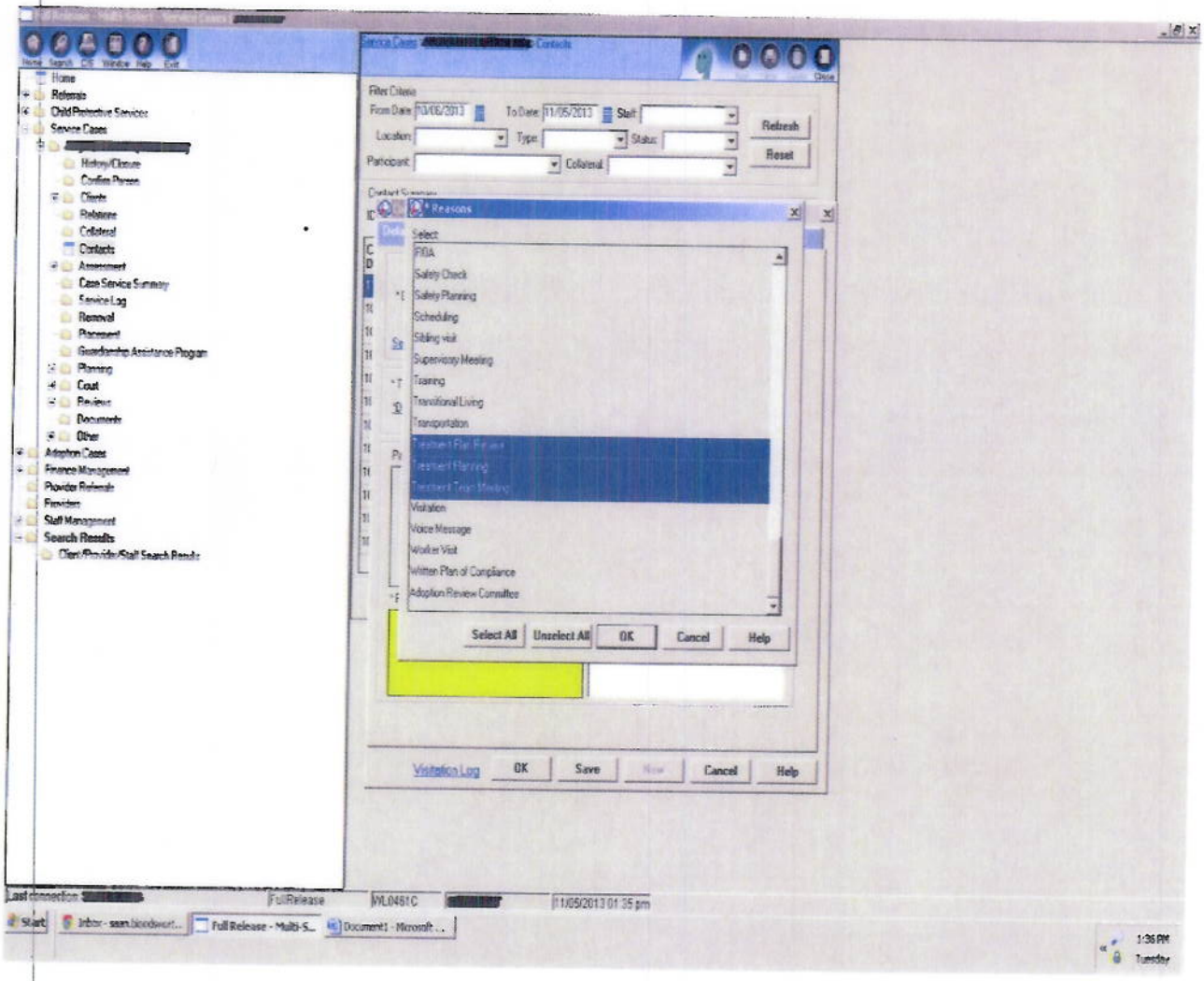
The record must contain a treatment plan for the child that is current within the last 6 months. Treatment team meetings, attendance and membership are also to be documented in the case record. While each person involved with the treatment of the child may not be able to attend the meeting, the record should reflect that each team member was notified of the meeting. Documentation from team meetings must include indications of treatment plan review (confirmation the current plan continues, revised treatment plan or amended treatment plan) and it should include minutes or notes.

The child's record must contain all record documentation requirements of COMAR 07.02.11. Additionally, the record must contain written documentation of eligibility for the private treatment program and documentation of a periodic review/assessment of continued eligibility for treatment foster care.

Treatment team meeting results may be filed in Section 9 (Case conference summaries). The treatment plan and eligibility determination may be filed in Section 12 Health or with the current case plan in Section 1.

MD CHESSIE

Documentation of all Treatment Team Meetings and Treatment Plan Reviews shall be recorded in MD CHESSIE. The documentation of Contacts shall include all members of the team that participated in the meeting and outline the results of the meeting. A copy of the treatment plan shall be scanned into the file cabinet in MD CHESSIE . The paper copy of the treatment plan shall be placed in the paper record.



DEPARTMENT OF HUMAN SERVICES
SOCIAL SERVICES ADMINISTRATION
311 W. SARATOGA STREET
BALTIMORE, MARYLAND 21201

DATE:	March 1, 2018
POLICY #:	SSA-CW #18-13 (revised) This policy supersedes SSA policy directive #17-08
TO:	Directors, Local Departments of Social Services Assistant Directors, Services
FROM:	Rebecca Jones Gaston, MSW Executive Director Social Services Administration
RE:	Working with Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth and Families
PROGRAMS AFFECTED:	Out-of Home Placement Services
ORIGINATING OFFICE:	Out-of-Home Placement Services
ACTION REQUIRED OF:	All Local Departments
REQUIRED ACTION:	Implementation of Policy
ACTION DUE DATE:	March 1, 2018
CONTACT PERSON:	April Edwards, Placement and Permanency Supervisor Social Services Administration (410) 767-7195 April.edwards@maryland.gov

PURPOSE:

The Department of Human Services (DHS) is committed to ensuring the safety and well being of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth in out-of-home placement. All child welfare staff shall provide affirming care to LGBTQ youth and families involved with DHS.

BACKGROUND:

There are increasing numbers of youth who openly identify as LGBTQ, and they are coming out at earlier ages.[1] While no tracking mechanism exists to document the number of LGBTQ youth in the out-of-home placement, numerous studies indicate that LGBTQ youth, particularly LGBTQ youth of color, are disproportionately represented within foster care. LGBTQ youth in care report experience significant discrimination related to their sexual orientation, gender identity and/or gender presentation.

All youth have the right to affirming placements, that actively promote their well-being, respect their identities, and are sensitive to their individual needs. LGBTQ youth in foster care are a particularly vulnerable population, who often times do not feel safe within the foster care system due to significant societal, familial and institutional barriers. Research on LGBTQ youth in care reveals several troubling themes, including high risk of familial rejection, bullying and housing instability.

In September 2014, Congress passed the "Preventing Sex Trafficking and Strengthening Families" Act, Pubic Law (P.L.113-183). In addition to other provisions, the Act establishes the "reasonable and prudent parent" standard for decision making. This standard is characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a youth while at the same time encouraging the emotional and developmental growth of the youth. It is the responsbilility of the local department to ensure resource parents are knowledgeable about and have the skills to make "reasonable and prudent parent" decisions regarding their foster youth.

DEFINITIONS/COMMONLY USED TERMS:

- Gender expression: a person's expression of gender identity (see below), including characteristics and behaviors such as appearance, dress, mannerisms, speech patterns, and social interactions.

- Gender identity: a person's internal, deeply felt sense of being male, female, something other, or in-between. Everyone has a gender identity. Note: sexual orientation and gender identity are separate and distinct aspects of a person's identity.

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[1] Kennedy, N. & Hellen M. (2010). Transgender Children: More Than a Theoretical Challenge. *Graduate Student Journal of Social Science,* 7(2), 25 – 43.

- Gender Non-Conforming: Describes a person whose behaviors or gender expression fall outside what is generally considered typical for their sex assigned at birth.

- LGBTQ: a common acronym for Lesbian, Gay, Bisexual, Transgender, and Questioning.

- Sexual orientation: a person's romantic or sexual attraction to people of a specific gender or genders. "Lesbian," "gay," "bisexual" and "straight" are examples of sexual orientations. Everyone has a sexual orientation. Note: sexual orientation and gender identity are separate and distinct aspects of a person's identity.

- Transgender: A term that describes people whose gender identity is different from their sex assigned at birth.

ACTION:

Caseworkers' Responsibilities

Being in foster care can be difficult, and caseworkers shall do everything they can to make sure children and youth feel safe and respected. For lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, life may be even more complex. DHS/SSA is committed to all youth in care residing with a provider where they can be open and honest about their identities.

- Caseworkers shall evaluate every youth's overall safety as it relates to their sexual orientation, gender identity and gender presentation in terms of placement, emotional, and physical wellbeing.

- Caseworkers will not disclose a youth's sexual orientation, gender identity, or gender expression to other individuals or agencies, without the youth's permission.

- Caseworkers shall connect youth and families with local LGBTQ resources.

- Caseworkers, when requested by youth or caregiver, shall meet with school officials to discuss steps the school needs to take to ensure safety for an LGBTQ youth at school.

- Caseworkers are encouraged to consult with their supervisors with any questions or concerns when they are unsure about steps to take about the well-being and safety of LGBTQ youth.

Placements

LGBTQ youth in out-of-home placement may not be placed in housing situations where their identities are not respected. In some cases, this happens because staff and/or resource

families are unaware about the specific needs of LGBTQ youth. In other cases, it is because there is active hostility towards youth who identify as LGBTQ, or who are perceived to violate traditional gender roles. In either situation, this creates an emotionally and physically unsafe living space environment and directly increases negative outcomes for LGBTQ youth in care. LGBTQ youth shall be consulted actively involved in the placement process during the placement process to ensure that the team can work cohesively to identify a safe and affirming placement that will achieve permanency. When making the decision to place a youth in any placement, the caseworker should first look into relatives when determining placement. When making a placement decision, the caseworker should ensure that there are no relative resources available for placement.

Additional guidance for the LGBTQ youth includes:

- Placements should be discussed with LGBTQ youth before initiating placement to assess their feelings of safeness and to address concerns. Caseworkers must include completion of SAFE-C OHP throughout youth's continuum in out-of-home placement and Safe-C for a trial home visit.

- Caseworkers shall ask all resource providers about their levels of acceptance for LGBTQ individuals and community members, and specifically discuss scenarios around gender presentation, gender identity, sexual orientation, attendance of cultural events, dating, etc.

- If a youth grants permission to a worker to disclose information, workers may use it to inform decision making regarding placement, service provision, treatment plans, etc.

- Caseworkers shall check in with youth at appropriate intervals to review placement and ensure that it is LGBTQ affirming, and take steps to report any mistreatment, including verbal harassment and bullying, and report/address any concerns to supervisory staff and, in the case of private agencies, the Office of Licensing and Monitoring.

- For placement of transgender and gender non-conforming youth in congregate care facilities, assignment to a facility for male or female residents and other housing and programming assignments shall be made based on consideration, on a case-by-case basis, of what placement would best ensure the youth's health and safety, and whether a placement would present management or security problems. A transgender or gender non-conforming own views with respect the kind of placement that would best serve his or her own emotional and physical safety shall be given serious consideration in the assignment decision. The assignment decision shall not be based on the youth's sex assigned at birth or on the youth's external genital anatomy. Every effort will be made to place youth in facilities with individual sleeping quarters (1 person bedrooms) to allow for privacy. Transgender and gender non-conforming

youth shall be allowed to shower and use bathrooms privately. Staff may utilize LGBTQ subject matter experts when determining placements for gender non-conforming and transgender youth.

- The local department placement unit and/or caseworker must ensure that the proposed placement provider has a policy guideline approved by the Office of Licensing and Monitoring before a placement can occur. (See Attachment)

Personal Grooming, Clothing & Use of Names

In order to express a gender identity, and/or gender presentation that is consistent with their identity, LGBTQ youth should be permitted to select and wear clothing that is consistent with their gender expression. As long as a youth is dressed appropriately, they can wear the clothing, accessories, and/or hairstyle that suit their gender identity (i.e. someone born male has a right to wear a dress, someone born female has a right to wear men's clothing). This may include removal of facial or body hair, make-up, jewelry, etc. and modifications of hairstyles (e.g. weaves/extensions, buzz cuts, etc.). Youth should also be called by their preferred names and pronouns. Failure to respect the youth's personal grooming, clothing and preferred name and pronoun can deny LGBTQ youth their ability to express their identity, and can endanger their physical and emotional well-being.

Confidentiality & Disclosure

Disclosing a young person's identity can be a potentially traumatic experience, and may place that young person at risk for greater harm and/or abuse. These guidelines review steps caseworkers shall take to ensure that young people are engaged throughout the disclosure process as necessary, and that their confidentiality is protected.

- All staff are required to protect the confidentiality of the families they serve. Staff will keep in mind that when a youth discloses their sexual orientation, gender identity, or gender expression, it will be considered sensitive information and be kept confidential, given that such disclosure could pose great risk to the youth.

- Staff will not disclose a youth's sexual orientation, gender identity, or gender expression to other individuals or agencies, without the youth's permission. If a youth grants permission to share information on their sexual orientation, gender identity, or gender expression, this information may also prove relevant to decisions regarding safety in a youth's placement.

- Staff are prohibited from attempting to convince or coerce an LGBTQ youth to disclose or reveal their identity or to change their gender identity or sexual orientation.

- At no time may any staff member label a young person as LGBTQ without the youth explicitly acknowledging that identity.

LGBTQ Affirming Services

Once an LGBTQ youth enters the out-of-home placement, the caseworker is an important link to support and safety. It is critical that a child's caseworker has the capacity, understanding and willingness to support their social and emotional development while in out-of-home placement. It is the caseworker's responsibility to assess and serve the needs of child without bias, and to ensure the safety of all youth in out-of-home placement.

- Social Services Administration will ensure that LGBTQ-affirming training is included as part of competency training and testing for all new staff as well as mandated for all caseworkers and their supervisors.

- Local departments shall have a familiarity with community resources and services available for LGBTQ youth in their respective jurisdictions. Local departments should assess the needs of their communities to develop targeted outreach to LGBTQ community agencies.

- SSA shall designate one or more out-of-home placement staff members who are knowledgeable about issues relevant to LGBTQ youth and families to be available to staff statewide. Local departments are encouraged to designate a child welfare staff member to be accessible as a local information and referral resource for LGBTQ youth, their families, and other staff members.

- Staff shall identify affirming resources and referrals, including those for physical and mental health, for LGBTQ youth and make them available as needed. Transgender and gender non-conforming youth have the right to transition related care. For specific questions regarding health care needs and rights of transgender youth, staff should contact SSA Out-of-Home Placement staff.

- Staff are to make sure that the youth is referred to appropriate services. Foster parents must support youth in accessing appropriate and preferred services.

OFFICE OF LICENSING AND MONITORING

DATE: January 9, 2018

TO: Child Placement Agencies and Residential Child Care Programs

FROM: Darlene Ham, Executive Director, Office of Licensing and Monitoring

RE: Guidelines for Placement of Transgender or Non-Conforming Youth

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In recent months several private agencies have inquired about guidelines for placing transgender youth. The term transgender describes people whose gender identity is different from their sex assigned at birth (See attached DHS Social Services Administration policy directive: Working with Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth and Families). The Office of Licensing and Monitoring (OLM) requires agencies to have a comprehensive policy that ensures the safety and wellbeing of transgender youth in out of home placement. As explained below a safety plan for transgender youth involves special consideration. Prior to admission of a transgender youth the agency must submit a placement of transgender youth policy to the Office of Licensing and Monitoring for approval. Once OLM approves the policy the agency may begin admitting transgender youth.

All agencies that are considering providing services to transgender youth must include in their written policy a safety plan that addresses:

Education:

- Employees and foster parents should be educated to understanding the unique challenges and resiliencies of transgender youth. Training should include but not be limited to the following:
  - The difference between "normal" and developmentally inappropriate behaviors.
  - Possible responses and reactions if a child is gender non-conforming.
  - Awareness and Sensitivity to the unique needs of the transgender population
  - Confidentiality prohibition on disclosure of youth's sexual orientation, gender id, or gender expression even to other youth in the program
  - Need to treat youth as being of the gender with which they identify
  - Definition of key terms, .i.e. Assigned sex, Cisgender, Gender identity etc.

Safety Plan:

- Need for heightened supervision to protect transgender youth from victimization and abuse.
- Agency ability to meet transgender youth's health care needs
- Not use isolation as a form of protection
- Implementation of LGBTQ inclusive polices
- Policy need to address sleeping and bathing accommodation
  - Ability to provide single person bedroom

- Transgender and non-conforming youth using shower and bathrooms privately.

Confidentiality

- All employees and foster parents, who care for transgender youth, must sign a confidentiality statement that specifies that confidentiality requirements apply to the disclosure of a youth's transgender or non-conformity orientation.

Agencies should include policies that:

- Agency should outline best practices in their policy
  - Address youth using their preferred gender pronouns or where youth do not identify with transgender use non-gendered language
  - Require use of non-gendered language
  - Honor the rights of Transgender youth
  - Require the display of visible symbols of diversity around the office e.g. rainbows etc.
  - Be an advocate for protection of youth in schools, doctor's offices and other forums.
  - Tuning into self: To evaluate possible bias of this population. (What are your values and triggers?)
  - Help youth family members understand their roles in supporting youth's gender identity
  - Have support groups for LGBTQ youth and foster parents with youth
  - Identify and make use of LGBTQ resources within the region
  - Promote the recruitment of employees and foster parents that are accepting of LGBTQ youth

Thank you for your cooperation in protecting our most vulnerable citizens, our children and youth. If you have any questions, please do not hesitate to contact your Licensing Coordinator.

LGBTQ Glossary of Terms

1. **Ally** - A person who is not LGBTQ but shows support for LGBTQ people and promotes equality in a variety of ways.
2. **Androgynous** - Identifying and/or presenting as neither distinguishably masculine nor feminine.
3. **Asexual** - The lack of a sexual attraction or desire for other people.
4. **Assigned Sex** – The gender we are given at birth based on our external reproductive anatomy.
5. **Biphobia** - Prejudice, fear or hatred directed toward bisexual people.
6. **Bisexual** - A person emotionally, romantically or sexually attracted to more than one sex, gender or gender identity though not necessarily simultaneously, in the same way or to the same degree.
7. **Cisgender** - A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.
8. **Closeted** - Describes an LGBTQ person who has not disclosed their sexual orientation or gender identity.
9. **Coming out** - The process in which a person first acknowledges, accepts and appreciates his or her sexual orientation or gender identity and begins to share that with others.
10. **Gay** - A person who is emotionally, romantically or sexually attracted to members of the same gender.
11. **Gender dysphoria** - Clinically significant distress caused when a person's assigned birth gender is not the same as the one with which they identify. According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), the term - which replaces Gender Identity Disorder - "is intended to better characterize the experiences of affected children, adolescents, and adults."
12. **Gender-expansive** - Conveys a wider, more flexible range of gender identity and/or expression than typically associated with the binary gender system.
13. **Gender expression** - External appearance of one's gender identity, usually expressed through behavior, clothing, haircut or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.
14. **Gender-fluid** - According to the Oxford English Dictionary, a person who does not identify with a single fixed gender; of or relating to a person having or expressing a fluid or unfixed gender identity.
15. **Gender identity** - One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.
16. **Gender non-conforming** - A broad term referring to people who do not behave in a way that conforms to the traditional expectations of their gender, or whose gender expression does not fit neatly into a category.
17. **Genderqueer** - Genderqueer people typically reject notions of static categories of gender and embrace a fluidity of gender identity and often, though not always, sexual orientation. People who identify as "genderqueer" may see themselves as being both male and female, neither male nor female or as falling completely outside these categories.
18. **Gender transition** - The process by which some people strive to more closely align their internal knowledge of gender with its outward appearance. Some people socially transition, whereby they might begin dressing, using names and pronouns and/or be socially recognized as another gender. Others undergo physical transitions in which they modify their bodies through medical interventions.
19. **Homophobia** - The fear and hatred of or discomfort with people who are attracted to members of the same sex.

20. **Identity Attribution** – How society perceives one's gender identity and sexual orientation based on a variety of assumptions.
21. **Lesbian** - A woman who is emotionally, romantically or sexually attracted to other women.
22. **LGBTQ** - An acronym for "lesbian, gay, bisexual, transgender and questioning."
23. **Living openly** - A state in which LGBTQ people are comfortably out about their sexual orientation or gender identity – where and when it feels appropriate to them.
24. **Outing** - Exposing someone's lesbian, gay, bisexual or transgender identity to others without their permission. Outing someone can have serious repercussions on employment, economic stability, personal safety or religious or family situations.
25. **Queer** - A term people often use to express fluid identities and orientations. Often used interchangeably with "LGBTQ."
26. **Questioning** - A term used to describe people who are in the process of exploring their sexual orientation or gender identity.
27. **Same-gender loving** - A term some prefer to use instead of lesbian, gay or bisexual to express attraction to and love of people of the same gender.
28. **Sexual Orientation** – A person's romantic or sexual attraction to people of a specific gender or gender or genders. "Lesbian," "gay," "bisexual" and "straight" are examples of sexual orientations. Everyone has a sexual orientation. **Note**: sexual orientation and gender identity are separate and distinct aspects of a person's identity.
29. **Transgender** - An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.
30. **Transphobia** - The fear and hatred of, or discomfort with, transgender people.