OPEN EXECUTIVE SESSION TO CONSIDER FAVORABLY REPORTING THE NOMINATIONS OF JONATHAN McKERNAN, TO BE UNDER SECRETARY FOR DOMESTIC FINANCE, DEPARTMENT OF THE TREASURY; AND ALEX J. ADAMS, TO BE ASSISTANT SECRETARY FOR FAMILY SUPPORT, ADMINISTRATION FOR CHILDREN AND FAMILIES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

THURSDAY, JULY 31, 2025

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to notice, at 9:55 a.m., in Room SD-215, Dirksen Senate Office Building, Hon. Mike Crapo (chairman of the committee) presiding.

Present: Senators Cornyn, Lankford, Barrasso, Wyden, Cantwell, Whitehouse, and Warnock.

Also present: Republican staff: Courtney Connell, Chief Tax Counsel; Andrew Dell'Orto, Policy Advisor; Kellie McConnell, Health Policy Director; Molly Newell, Chief International Trade Counsel; and Gregg Richard, Staff Director. Democratic staff: Nicole Brussel Faria, Investigator and Health Advisor; Jonathan Goldman, Senior Tax Counsel, International; Joshua

Sheinkman, Staff Director; and Shade Streeter, Investigative Counsel.

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. The committee will come to order. We meet today to consider favorably reporting the nominations of Jonathan McKernan, who is nominated to serve as the Under Secretary for Domestic Finance at the Treasury Department, and Dr. Alex Adams, who is nominated to serve as the Assistant Secretary for Family Support at the Department of Health and Human Services.

The meeting this morning will provide members with the opportunity to offer remarks on the nominees. Following statements, we will recess briefly and then proceed to this morning's nominations hearing.

We will meet at 11 a.m. today off the Senate floor to vote on Mr. McKernan and Dr. Adams at our first vote. During his hearing, Mr. McKernan discussed his plans to use the Office of Domestic Finance's wide-ranging authority to bring back sound and balanced regulation to our financial system.

Properly tailoring regulation to underlying risks rather than intangible policy goals will provide much-needed relief to financial institutions and the individuals they serve. I look forward to working with him, if confirmed, to accomplish this goal.

Dr. Adams spoke strongly about his belief that Federal policy should strengthen rather than supplant parents' capacity to make the best decisions for their children. As the Director of the Idaho Department of Health and Welfare, Dr. Adams knows what policy decisions empower States to provide critical assistance to some of America's most vulnerable populations.

I am confident in his ability to lead the array of programs under the Administration for Children and Families at HHS. I will be voting in favor of both of these nominations, and I encourage all of my colleagues on the committee to do the same.

Before turning to Senator Wyden for his remarks, let me also take a moment to acknowledge the retirement of Bob Becker. Bob has been with the Senate Recording Studio for 34 years and is retiring in August. Today's executive session and hearing are his last, and although he is not actually here in this room, I know he is monitoring what is going on.

We are glad to see you get to end your career with us, the best committee. He is the Recording Studio's go-to hearing director, and has been essential in directing hearing coverage and coverage of the Senate floor, and working in the recording studio in various roles. We wish Bob all the best in his well-earned

retirement and thank him for his many years of service.

I now recognize Senator Wyden.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator Wyden. Thank you very much, Mr. Chairman.

And, Mr. Chairman I join you in giving this special salute to Bob Becker. His excellent work with the Senate Recording Studio is legend here on Capitol Hill, and I have been told that this is his last hearing. Is Bob here? Bob is not here.

Well, we want him to know that we thank him for his extraordinary service. He brings new meaning to the concept of keeping the trains rolling, because he keeps everything rolling, and we wish him all the best in his retirement.

Now, with respect to the nominees that the committee will vote on shortly, first up is Dr. Adams, who is nominated to serve as Assistant Secretary for Family Support at the Department of Health and Human Services. Initially, I thought that Dr. Adams was someone who could make a really big difference, but what I found, both as we looked into his record and some of the questioning at the committee, is he talks an encouraging game with respect to safety and helping families, but a look at his record shows something very different.

He weakened oversight standards for residential treatment facilities, where my own staff have found kids to be at high risk of abuse and neglect. He single-handedly defunded programs in Idaho that supported kids with disabilities and their families. He oversaw the rollback of staffing standards for child-care facilities in Idaho. Simply put, the record shows that a significant number of kids and families were hurt.

Worse still, he appears to be just somebody else who is going to greenlight Donald Trump's dangerous and destructive agenda. During his confirmation hearing, he bobbed and weaved as we asked questions about various issues in areas where the administration is undermining the health of kids and families.

Dr. Adams repeatedly stated that his job is to follow the law. But when asked directly by committee members for a commitment to make sure that congressionally appropriated funds for essential programs like Head Start actually get out the door – and, of course, this is something required by law -- he just did not answer.

His measles response -- and we have been seeing concern about measles all over the country -- is he said he was ready to tackle measles because, on his watch, there had been one case in Idaho. So, if confirmed, I

intend to hold Dr. Adams to his initial commitment to me to work to address abuse and neglect of children, particularly at residential treatment facilities.

To that end, Mr. Chairman, I am making public our latest findings in that investigation that you will remember, as we worked on it together, particularly as it relates to mistreatment of LGBTQ youth, and I would like to make sure that the staff works with yours to have part of made a part of the record.

The Chairman. Absolutely, without objection.

[The report appears at the end of the transcript.]

Senator Wyden. And now let me turn briefly to Jonathan McKernan's nomination to serve as Under Secretary of Domestic Finance at the Treasury.

Earlier this year, Treasury handed DOGE the keys to the kingdom for the Treasury payment system. When I pressed him about this takeover of the Treasury payment system and its implications for taxpayer privacy, Mr. McKernan basically said there's just no "there" there.

If confirmed, he would play a key role in how the Treasury Department handles the most sensitive data of American taxpayers found in that payment system. The American people deserve to know what DOGE is doing with their personal information, and what's being done by the Trump administration to protect the data.

Instead, we have been met consistently by this administration with respect to stonewalling about what is going on in the Fort Knox of people's personal information. Senator Cantwell, my seat-mate up here, has been doing great work on privacy issues for years now. We sure need a lot of it, given what is going on at DOGE.

Mr. McKernan has failed to demonstrate that he will be committed to protecting American taxpayers from the ongoing campaign of destruction at the Treasury Department. With that, I respectfully urge my colleagues to vote "no" on both of these individuals, and I yield back to the chair.

The Chairman. Thank you, Senator Wyden.

Does any other Senator wish to make a remark? Unless there is objection then, the committee will recess briefly and proceed to this morning's nominations hearing. We will notify members of a time later today, which actually has been notified, 11 a.m. at the first vote, for the vote on these nominees.

Senator Wyden. So, Mr. Chairman, I gather that it's been a little hectic. You want to start in a few minutes, and your hope is we will get out by 11 a.m. and be able to vote?

The Chairman. Yes. And if we are not out, then

perhaps you and I can rotate running to votes and coming back, if we need to.

Senator Wyden. That will be fine.

The Chairman. All right. Thank you.

Without objection, it is so ordered, and the committee stands in recess.

[Whereupon, at 10:03 a.m., the meeting was recessed.]

The open executive session was reconvened, pursuant to notice, on Thursday, July 31, 2025, at 11 a.m., in Room S-216, The President's Room, U.S. Capitol, Hon. Mike Crapo (chairman of the committee) presiding.

The Chairman. The committee will come to order.

We now have a quorum. I move that we favorably report the nomination of Jonathan McKernan.

Senator Grassley. Seconded.

The Chairman. The Clerk will call the roll.

The Clerk. Mr. Grassley?

Senator Grassley. Aye.

The Clerk. Mr. Cornyn?

Senator Cornyn. Aye.

The Clerk. Mr. Thune?

Senator Thune. Aye.

The Clerk. Mr. Scott?

Senator Scott. Aye.
The Clerk. Mr. Cassidy?
Senator Cassidy. Aye.
The Clerk. Mr. Lankford?
Senator Lankford. Aye.
The Clerk. Mr. Daines?
Senator Daines. Aye.
The Clerk. Mr. Young?
Senator Young. Aye.
The Clerk. Mr. Barrasso?
Senator Barrasso. Aye.
The Clerk. Mr. Johnson?
Senator Johnson. Aye.
The Clerk. Mr. Tillis?
Senator Tillis. Aye.
The Clerk. Mrs. Blackburn?
Senator Blackburn. Aye.
The Clerk. Mr. Marshall?
Senator Marshall. Aye.
The Clerk. Mr. Wyden?
Senator Wyden. Nay.
The Clerk. Ms. Cantwell?
Senator Cantwell. Nay.
The Clerk. Mr. Bennet?
Senator Bennet. Nay.

The Clerk. Mr. Warner?

Senator Wyden. Nay by proxy.

The Clerk. Mr. Whitehouse?

Senator Whitehouse. Nay.

The Clerk. Ms. Hassan?

Senator Hassan. Nay.

The Clerk. Ms. Cortez Masto?

Senator Cortez Masto. Nay.

The Clerk. Ms. Warren?

Senator Warren. Nay.

The Clerk. Mr. Sanders?

Senator Sanders. Nay.

The Clerk. Ms. Smith?

Senator Smith. Nay.

The Clerk. Mr. Luján?

Senator Wyden. Nay by proxy.

The Clerk. Mr. Warnock?

Senator Warnock. Nay.

The Clerk. Mr. Welch?

Senator Wyden. Nay by proxy.

The Clerk. Mr. Chairman?

The Chairman. Aye.

The Clerk will announce the vote.

The Clerk. Mr. Chairman, the final tally is 14 ayes and 13 nays.

The Chairman. The “ayes” have it. And the nomination is favorably reported.

We’ll now move to favorably report the nomination of Alex Adams.

The Clerk. Mr. Grassley?

Senator Grassley. Aye.

The Clerk. Mr. Cornyn?

Senator Cornyn. Aye.

The Clerk. Mr. Thune?

Senator Thune. Aye.

The Clerk. Mr. Scott?

Senator Scott. Aye.

The Clerk. Mr. Cassidy?

Senator Cassidy. Aye.

The Clerk. Mr. Lankford?

Senator Lankford. Aye.

The Clerk. Mr. Daines?

Senator Daines. Aye.

The Clerk. Mr. Young?

Senator Young. Aye.

The Clerk. Mr. Barrasso?

Senator Barrasso. Aye.

The Clerk. Mr. Johnson?

Senator Johnson. Aye.

The Clerk. Mr. Tillis?

Senator Tillis. Aye.

The Clerk. Mrs. Blackburn?

Senator Blackburn. Aye.

The Clerk. Mr. Marshall?

Senator Marshall. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Nay.

The Clerk. Ms. Cantwell?

Senator Cantwell. Nay.

The Clerk. Mr. Bennet?

Senator Bennet. Nay.

The Clerk. Mr. Warner?

Senator Wyden. Nay by proxy.

The Clerk. Mr. Whitehouse?

Senator Whitehouse. Nay.

The Clerk. Ms. Hassan?

Senator Hassan. Nay.

The Clerk. Ms. Cortez Masto?

Senator Cortez Masto. Nay.

The Clerk. Ms. Warren?

Senator Warren. Nay.

The Clerk. Mr. Sanders?

Senator Sanders. Nay.

The Clerk. Ms. Smith?

Senator Smith. Nay.

The Clerk. Mr. Luján?

Senator Wyden. Nay by proxy.

The Clerk. Mr. Warnock?

Senator Warnock. Nay.

The Clerk. Mr. Welch?

Senator Wyden. Nay by proxy.

The Clerk. Mr. Chairman?

The Chairman. Aye.

The Clerk will announce the vote.

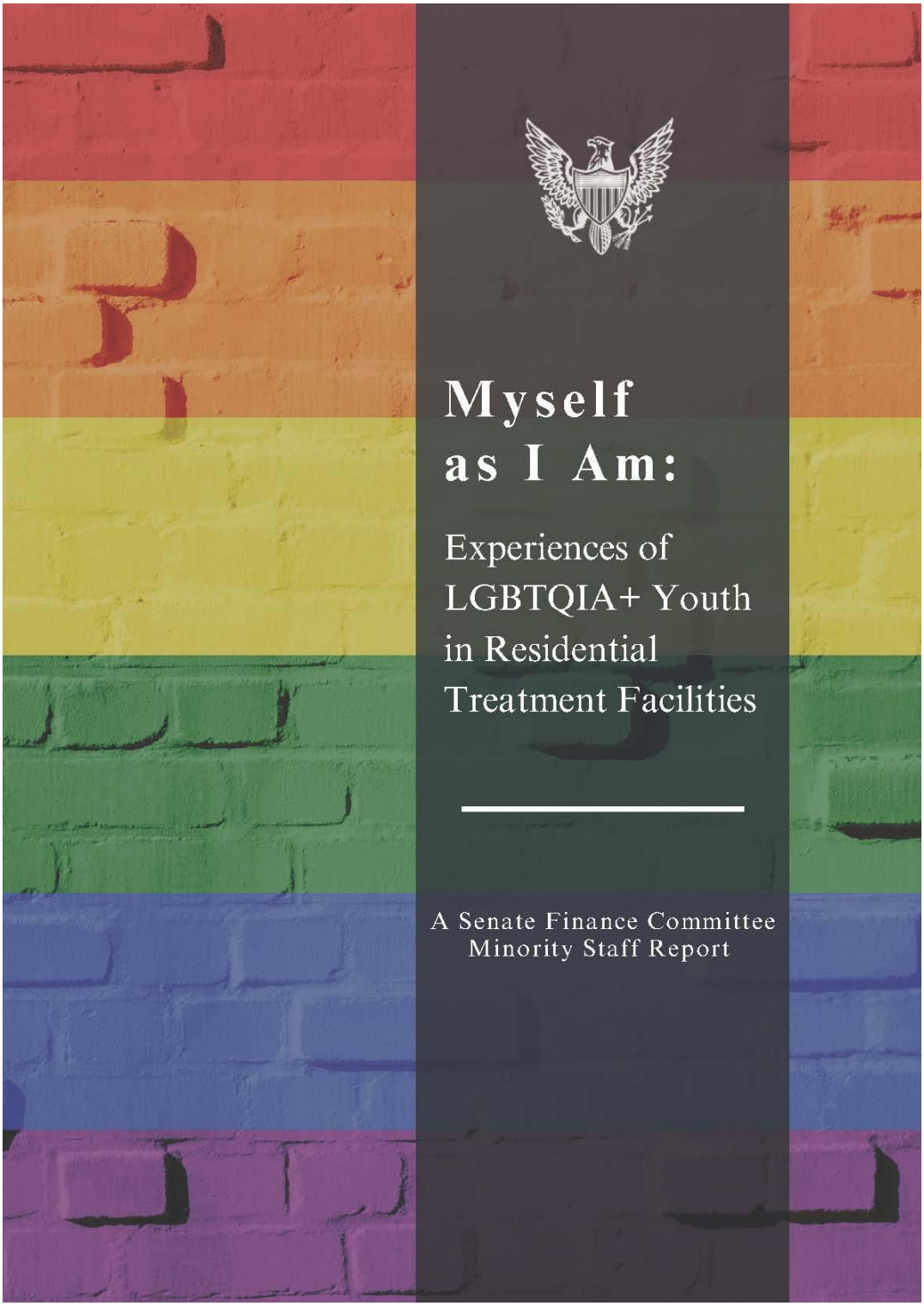
The Clerk. Mr. Chairman, the final tally is 14 ayes and 13 nays.

The Chairman. The “ayes” have it, and the nomination is favorably reported.

I thank my colleagues for their attendance. The committee stands adjourned.

[Whereupon, at 11:41 a.m., the meeting was concluded.]

SUBMITTED BY HON. RON WYDEN



MYSELF AS I AM:
EXPERIENCES OF LGBTQIA+ YOUTH IN RESIDENTIAL TREATMENT FACILITIES

I. Executive Summary

On June 12, 2024 the Senate Committee on Finance (the Committee) released a report entitled *Warehouses of Neglect*: *How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities* (*Warehouses*). This report was the product of a sweeping two-year inquiry by the Democratic Staff into allegations of abuse and neglect at residential treatment facilities (RTFs) operated by four providers: Universal Health Services, Acadia Healthcare, Devereux Advanced Behavioral Health, and Vivant Behavioral Healthcare. Following review of over 25,000 pages of company production, dozens of conversations with behavioral health stakeholders, and in-person, unannounced visits to other residential treatment facilities (RTFs), the Committee found that children suffer routine harms inside RTFs – including sexual, physical, and emotional abuse, unsafe and unsanitary conditions, and inadequate provision of behavioral health treatment – and that this risk of harm to children in RTFs is endemic to the operating model.

This Committee Minority Staff addendum to *Warehouses* focuses exclusively on the harms and discrimination that LGBTQIA+ young people face in RTFs. *This report contains sensitive discussions related to the experiences of LGBTQIA+ individuals in congregate care. It includes extensive discussion of discrimination, verbal abuse, harassment, and other forms of marginalization on the basis of LGBTQIA+ identities. Committee Minority Staff would like to thank the young people who entrusted staff with their reflections, experiences, and stories.*

This addendum takes the findings of *Warehouses* as foundational, and does not re-enumerate the endemic harms that children inside RTFs too often suffer. This follow-on examines the same types of facilities at issue in the initial report: psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities, with a focus on RTFs that provide care to children in the child welfare (also known as foster care) system and those enrolled in Medicaid.

To better understand the scope and prevalence of unique harms experienced by LGBTQIA+ young people in RTFs in foster care and outside of foster care, the Committee reviewed survey responses from over 130 LGBTQIA+ youth. The survey included open-ended prompts that invited respondents to describe their experiences across a range of categories related to time in RTFs as youth. Committee Minority Staff systematically reviewed each response. The testimony from these children as well as the accounts of their treatment from medical professionals, legal

representatives, Protection & Advocacy (P&A) agencies,[1] and child welfare advocates are synthesized into the seven findings below. Unlike *Warehouses*, these findings do not draw on documents supplied by RTF providers. Young people's reflections are presented here in their own words. While the context that brings children into RTFs may differ, their shared stories and experiences show that LGBTQIA+ young people experience harm, regardless of public or private pathways. Their responses reveal a situation that demands attention and contain a number of informed considerations for policymakers.

RTFs are intended to address children and young people's behavioral, emotional, mental health, or substance use disorder needs which cannot be safely and adequately met within the community. The Committee Minority Staff continues to acknowledge that, in limited circumstances, placement in intensive, in-patient treatment that is individualized, high-quality, short term, and always focused on safe return to the community, may be the appropriate care setting for a child. However, in too many instances, RTFs provide a substandard level of behavioral health care and children often face a wide-range of abuse and neglect within these settings. The current operating structure of RTFs can lead to children and young people experiencing harm, including those seeking high acuity behavioral health care, thereby exacerbating the very behavioral health issues they are meant to treat. Further, in violation of settled precedent, in some cases, children and young people are placed in RTFs as an outcome of the child welfare system's incapacity to serve them in less restrictive settings, rather than their needs.

Children and young people in congregate care placements are at-risk of abuse, and those who identify as LGBTQIA+ experience an additional layer of vulnerability. This risk is compounded by the reality that many LGBTQIA+ young people's entrance into the child welfare system is inextricably tied to their identity, often following family rejection. This follow-on investigation finds that, compounded with the risk of abuse, neglect, and indignities that all young people in RTFs face, many LGBTQIA+ young people also experience discrimination on the basis of their identities. These harms cut across a wide spectrum, ranging from identity concealment to feelings of rejection and isolation to bullying and verbal abuse. These experiences deny LGBTQIA+ young people of basic dignity, humanity, and value. In some instances, the abuse escalates to punitive responses to LGBTQIA+ identities, including placing children in solitary confinement, subjecting them to conversion therapy, or withholding gender-affirming clothing or medication. Some youth shared positive reflections related to their experience in RTFs and reported that their identities were respected while in congregate care.

[1] P&As provide nonprofit legal advocacy services for people with disabilities. They have the authority to enter congregate care facilities, like RTFs, for monitoring and abuse and neglect investigation. They may also pursue litigation or other appropriate remedies under federal, state, and local law.

This work makes clear it is imperative to imagine, and help create, a real world with a place for all children, with the support they need to stay in their communities. With this addendum, the Committee Minority Staff continues to witness and attend to the situation and needs of all children to imagine that real world.

II. Background

A. RTF Overview

Concerns about the treatment of children and young people in RTFs are not new. In 1999, the Surgeon General released a special report on best practices in mental health care. It found that "there is only weak evidence for [congregate care's] effectiveness,"[2] and raised concerns related to admission criteria, costliness, and the unrealized potential of community-based treatment as an alternative. That same year, in *Olmstead v. L.C.*, the Supreme Court determined that the segregation of people with disabilities outside the community constituted discrimination under the Americans with Disabilities Act (ADA).[3] Put simply, *Olmstead* requires public entities to administer services to people with disabilities in the most integrated setting appropriate to their needs. In 2021, the National Disability Rights Network published a comprehensive indictment of the RTF industry called *Desperation Without Dignity*, highlighting abuse, neglect, and lack of care.[4] Also in 2021, Think of Us released *Away from Home*,[5] a landmark study that collates reflections from young people in the child welfare system with lived experiences in institutional placements and presents a searing indictment of congregate care. Throughout, there has been a significant outcry from RTF survivors about their treatment and calls for improved oversight of such facilities.

Children and young people may be placed in RTFs through a number of channels, including through the juvenile justice system, school districts, medical providers, family or guardians, and the child welfare system. When the placement of a child reflects a behavioral health need, health insurance is generally the primary payer for an RTF.[6] When foster youth are warehoused in RTFs as a reflection of insufficient capacity in family-like settings, child welfare programs pay.[7] Finally, in some cases, families pursue private RTF placements and pay for these services out-of-

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[2] U.S. Dept. of Health and Human Servs. Nat. Inst. of Mental Health, *Mental Health: A Report of the Surgeon General* (1999), https://profiles.nlm.nih.gov/spotlight/nn/catalog/nlm:nlmuid-101584932X120-doc.
[3] Olmstead v. L.C., 527 U.S. 581 (1999).
[4] National Disability Rights Network, *Desperation Without Dignity* (Oct. 14, 2021), https://www.ndrn.org/wp-content/uploads/2021/10/NDRN_Desperation_without_Dignity_Final.pdf.
[5] Think of Us, *Away From Home: Youth Experiences of Institutional Placements in Foster Care* (June 17, 2021), https://www.thinkofus.org/case-studies/away-from-home.
[6] Title IV-E covers the placement of children in Qualified Residential Treatment Programs, sex trafficking facilities, and RTFs for expectant and parenting youth as well as the two weeks a child spends in any facility.
[7] This contravenes *Olmstead* and is in violation of child welfare best practices.

pocket. The Office of Refugee Resettlement (ORR) may also place children in RTFs and, in these cases, is the payer.

Many RTF placements implicate payment mechanisms within the Committee's jurisdiction. The Committee has jurisdiction over the Social Security Act; through the Medicaid program (Title XIX) and federal child welfare provisions (Title IV-B, Title IV-E, and the Social Services Block Grant), programs in the Committee's jurisdiction pay for a significant portion of youth behavioral health services, including RTF placements. The Committee also has jurisdiction over elements of ORR. Unaccompanied immigrant children are placed in ORR custody when they enter the country for temporary care and housing and eventual placement with sponsors. ORR acts as a child welfare agency within the U.S. Department of Health and Human Services (HHS) through its care and custody of unaccompanied children, separate from immigration enforcement agencies under the Department of Homeland Security (DHS).

Within the child welfare system, children may be placed in RTFs for treatment of behavioral health needs. Nearly all children in foster care are eligible for Medicaid, so it is the payer for such services. When the foster care system lacks adequate family-like placement capacity, children may also be warehoused in congregate care settings without a diagnosis that would justify RTF care. As of 2022, an estimated 34,000 foster youth were living in RTFs,[8] and a 2013 assessment by the Administration for Children and Families (ACF) found that 28.8 percent of children in congregate care had "No Clinical Indicators."[9] These RTF placements reflect capacity restraints, rather than a child's individual needs or best interest.

B. Addendum Methodology

In late 2024, two child welfare organizations with strong connections to young people with lived experience in congregate care issued a nationwide questionnaire which surveyed LGBTQIA+ people on their experiences in RTFs as youth. Examples of survey questions include: '*Did you feel safe sharing your identity with some or all of the staff? If so, why?*'; '*Were you treated differently from your peers because of your sexual orientation or gender identity?*'; and '*What would it have meant to you to receive services that affirmed your sexual orientation or gender identity? If you did receive affirming services, what did it mean?*'[10] Respondents were given the opportunity to skip any questions they did not feel comfortable answering. The 130+ respondents gave consent to have their answers shared with child welfare advocates and policymakers, and the organizers submitted the full set of responses to the Committee Minority Staff. Throughout

[8] U.S. Gov't. Accountability Off., *Child Welfare: Abuse of Youth Placed in Residential Facilities* (June 12, 2024), GAO-24-107625 https://www.gao.gov/products/gao-24-107625.
[9] U.S. Dept. of Health and Human Servs. Admin. for Children and Families, *A National Look at the Use of Congregate Care in Child Welfare* (May 13, 2015), at p. II https://www.acf.hhs.gov/sites/default/files/documents/cb/cbcongregatecare_brief.pdf.
[10] A complete list of survey questions is included in Appendix I.

the addendum, whenever a quote is included in quotation marks without a citation, it comes from this survey.

In addition to the survey responses, the report draws on materials submitted by medical professionals, legal representatives, P&As agencies, and child welfare advocates. Some of the materials collected from these stakeholders were submitted over a year ago as part of the broader *Warehouses* effort.

LGBTQIA+ is a loosely-defined term that encompasses people who identify with some type of gender or sexual diversity, including people who are lesbian, gay, bisexual, transgender, queer, intersex, asexual and beyond, as captured by the "+." The survey was targeted at people who identified as LGBTQI+. Additionally, some participants specifically identified as asexual in their responses. To align with the survey responses and validate the preferences of young people, the Committee Minority Staff uses LGBTQIA+ as its base descriptor throughout this addendum.

C. LGBTQIA+ Youth in RTFs

Public reporting has long highlighted concerns about the specific mistreatment of LGBTQIA+ children in RTFs. In one instance, a recently-out 16-year-old was allegedly attacked by two other children at an RTF in Florida.[11] According to the police report, the child was attacked and told by his attacker that he "didn't want a f****t in the pod."[12] Just this month, there was a report of a transgender teen's jaw being broken at a juvenile facility when she was placed in a program that did not align with her gender identity.[13] Put simply, as one pediatrician described, "for LGBTQIA+ youth, the harm [in RTFs] is even more profound, as they face not only the trauma of being removed from their families [and placed in an RTF] but also rejection and invalidation in the very settings designed to care for them."

The Minority Stress Model (MSM) is a psychological framework that explains how individuals from marginalized groups, like LGBTQIA+ people, experience chronic stress due to social stigma, discrimination, and lack of acceptance. According to the MSM, marginalized groups experience external stressors (like discrimination, rejection from family, and abuse) and internal stressors (like internalized stigma, concealment, and fear of rejection).[14] The cumulative effect of these external and internal stressors contributes to anxiety, depression, and suicidality, and

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[11] Erik Avanier, *Deputies: Youth Academy inmate attacked because he's gay*, News4Jax (Sept. 10, 2018), https://www.news4jax.com/news/2018/09/11/deputies-youth-academy-inmate-attacked-because-hes-gay/.
[12] *Id.*
[13] Joe Kottke, *Trans girl housed in male unit has jaw broken at D.C. juvenile detention center*, NBC News (July 15, 2025) https://www.nbcnews.com/nbc-out/out-news/trans-girl-housed-male-unit-jaw-broken-dc-juvenile-detention-center-rcna218960.
[14] David M. Frost and Ilan H Meyer, *Minority stress theory: Application, critique, and continued relevance*, Current Opinion in Psychology (June 2023) 51:101579. doi: 10.1016/j.copsyc.2023.101579. https://pmc.ncbi.nlm.nih.gov/articles/PMC10712335/.

increased risk of substance use or self-harm. Finally, the MSM highlights that there are protective factors that can reduce harm, such as social support and affirming environments.

Applying the MSM to RTFs is instructive in unpacking one contributor for why LGBTQIA+ youth are overrepresented in these facilities, why they experience acute harms in these spaces, and what a vision for more effective care might look like. The cumulative effect of external and internal stressors may account, in part, for the overrepresentation of LGBTQIA+ young people in RTFs. Then, while in RTFs, LGBTQIA+ young people continue to experience the compounding harms of both internal and external stressors, as captured by the dozens of quotes from young people included in this addendum. Further, LGBTQIA+ young people face additional harms when they are not afforded access to protective factors, such as supportive peers and affirming staff. In survey responses, LGBTQIA+ youth describe the additional external and internal stressors they experience when deprived of access to such factors. In spaces meant to provide treatment, like RTFs, protective factors are foundational to effective treatment and care. Young people capture the importance of protective factors in their survey responses, making clear that social support and affirming care environments can make a substantial difference in a person's effective mental health treatment.

LGBTQIA+ youth in the child welfare system experience similar challenges. Children enter the child welfare system for many reasons, including facing abuse and neglect, and this holds true for LGBTQIA+ children. However, in many cases, LGBTQIA+ young people's involvement in the child welfare system is inextricably tied to their identity, with entrance following family rejection. As a result, LGBTQIA+ children are overrepresented in the child welfare system, with one in three young people in foster care identifying as LGBTQIA+ compared to one in ten young people in the general population.[15] A significant portion of young people in the child welfare system – nearly 38 percent – report poor treatment related to their status as a sexual or gender minority.[16] LGBTQIA+ young people are also more likely to end up in congregate care settings compared to their peers, according to the Government Accountability Office (GAO).[17] This is likely at least in part due to LGBTQIA+ youth being rejected by multiple placements, and the

[15] Human Rights Campaign, *LGBTQ+ Youth in the Foster Care System* https://www.thehrcfoundation.org/professional-resources/lgbtq-youth-in-the-foster-care-system; Theo G. M. Sandfort, New York City Admin. for Children's Servs., *Experiences and Well-Being of Sexual and Gender Diverse Youth in Foster Care in New York City* (July 7, 2020), https://www.nyc.gov/assets/acs/pdf/about/2020/WellBeingStudyLGBTQ.pdf.

[16] Jessica N. Fish et al., *Are sexual minority youth overrepresented in foster care, child welfare, and out-of-home placement? Findings from nationally representative data*, (2019) Vol. 89 Child Abuse & Neglect 203-211, ISSN 0145-2134, https://doi.org/10.1016/j.chiabu.2019.01.005; Bianca D.M. Wilson et al., The Williams Institute – UCLA School of Law, *Sexual and Gender Minority Youth in Foster Care: Assessing Disproportionality and Disparities in Los Angeles* (Aug. 2014), https://williamsinstitute.law.ucla.edu/wp-content/uploads/SGM-Youth-in-Foster-Care-Aug-2014.pdf.

[17] U.S. Gov't. Accountability Off., *Foster Care: Further Assistance from HHS Would be Helpful in Supporting Youth's LGBTQ+ Identities and Religious Beliefs*, GAO-22-104688 (Apr. 20, 2022), https://www.gao.gov/products/gao-22-104688.

instability that stems from that, which puts LGBTQIA+ young people at greater risk for behavioral health needs. According to a separate survey, almost one-third of LGBTQIA+ young people in the child welfare system had been placed in RTFs.[18] In addition to high rates of RTF placement, LGBTQIA+ young people also have longer lengths of stay in RTFs.[19] Together, these facts paint a dark picture about the child welfare system's capacity to care for LGBTQIA+ young people in the least restrictive setting possible, as required by law.

In ORR custody, LGBTQIA+ young people are particularly vulnerable to harm.[20] While the number of children in ORR custody who identify as LGBTQIA+ has not been estimated, many such children entering ORR custody have arrived in the United States after fleeing trafficking, physical abuse, and sexual abuse in their home countries. In all cases, they are separated from parents and loved ones. These experiences compound the risks these children face in ORR-contracted RTFs. These facilities are governed by a patchwork of legal standards, policies, and federal regulations expressed in ORR contracts, the ORR Policy Guide, the Unaccompanied Children Program Foundational Rule, the terms of the *Flores v. Reno* settlement agreement and relevant case law, the terms of the *Lucas R.* psychotropic medication and disability rights settlement agreements, and state and federal child welfare laws.[21]

In 2024, in an effort to better meet the needs of LGBTQIA+ young people and adopt protections long-championed by legal advocates, child welfare experts, and the medical community, HHS finalized the *Designated Placement Requirements Under Titles IV-E and IV-B for LGBTQI+ Children* rule. The rule sought to ensure that LGBTQIA+ children would be accorded safe and appropriate care and placements in the child welfare system that take into account their

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[18] Theo G. M. Sandfort, New York City Admin. for Children's Servs., *Experiences and Well-Being of Sexual and Gender Diverse Youth in Foster Care in New York City* (July 7, 2020), https://www.nyc.gov/assets/acs/pdf/about/2020/WellBeingStudyLGBTQ.pdf.

[19] Jessica N. Fish et al., *Are sexual minority youth overrepresented in foster care, child welfare, and out-of-home placement? Findings from nationally representative data*, (2019) Vol. 89 Child Abuse & Neglect 203-211, ISSN 0145-2134, https://doi.org/10.1016/j.chiabu.2019.01.005; Bianca D.M. Wilson et al., The Williams Institute – UCLA School of Law, *Sexual and Gender Minority Youth in Foster Care: Assessing Disproportionality and Disparities in Los Angeles* (Aug. 2014), https://williamsinstitute.law.ucla.edu/wp-content/uploads/SGM-Youth-in-Foster-Care-Aug-2014.pdf.

[20] Sharita Gruberg and Hannah Hussey, *Fostering Safety: How the U.S. Government Can Protect LGBT Immigrant Children*, Center for American Progress (Sept. 30, 2014), https://www.americanprogress.org/article/fostering-safety/.

[21] *Id.*, Office of Refugee Resettlement, ORR Unaccompanied Alien Children Bureau Policy Guide, https://acf.gov/orr/policy-guidance/unaccompanied-children-bureau-policy-guide;Lucas R. v. Alex Azar, 2:18-cv-05741, (C.D. Cal.), *see* National Center for Youth Law, Lucas R. v. Azar, https://youthlaw.org/cases/lucas-r-v-azar; 89 FR 34384, https://www.federalregister.gov/documents/2024/04/30/2024-08329/unaccompanied-children-program-foundational-rule; Stipulated Settlement Agreement, Flores v. Reno, No. CV 85-4544-RJK(Px) (C.D. Cal. Jan. 17, 1997), *see* National Center for Youth Law, Flores v. Reno, https://youthlaw.org/cases/flores-v-reno.

identities.[22] In particular, it emphasized the importance of staff and caregivers who understand and affirm the LGBTQIA+ identities of children in their care. In 2023, 19 Senators sent a comment letter in support of the proposed rule.[23] The principles set out in this rule continue to guide thinking about how to safely and effectively serve LGBTQIA+ youth.

D. Current Attacks on the LGBTQIA+ Community

There is a nationwide, anti-LGBTQIA+ agenda that is playing out at the federal, state, and local levels. The result is a government-wide campaign to roll back protections for LGBTQIA+ people, eliminate their access to government services, and functionally erase their existence.[24] At the federal level, President Trump has issued a number of Executive Orders that target the LGBTQIA+ community, including one that directs agencies to eliminate "gender ideology"[25] from all materials and one that defines gender as a strict binary, a definition at odds with medical consensus and lived reality.[26] More recently, in July, the Trump Administration eliminated federal funding for a suicide and crisis hotline that offered individualized, affirming support to LGBTQIA+ youth in crisis, despite very high suicide rates among this population. This hotline has served more than 1.3 million young people since its creation in 2022.[27] Alongside these federal actions, states are pursuing similar anti-LGBTQIA+ policies, like restrictive bathroom laws and sports laws.

Similarly, there has been an aggressive effort to eliminate access to medically-necessary, gender-affirming care.[28] In April, contrary to the best available scientific evidence and longstanding medical consensus,[29] the Centers for Medicare & Medicaid Services (CMS) wrote to State

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[22] 88 FR 66752 Vol. 88, Iss. 187, *Safe and Appropriate Foster Care Placement Requirements for Titles IV-E and IV-B* (Sept. 28, 2023), https://www.federalregister.gov/documents/2023/09/28/2023-21274/safe-and-appropriate-foster-care-placement-requirements-for-titles-iv-e-and-iv-b.

[23] Letter from Sen. Wyden et al. to Secretary Xavier Beccerra, *Re: Notice for Public Comment, Safe and Appropriate Foster Care Placement Requirements for Titles IV-E and IV-B, Document Number: 88 FR 66752* (Dec. 8, 2023), https://www.finance.senate.gov/imo/media/doc/safe_and_appropriate_placement_comment_letter_12823final.pdf.

[24] This is in no way an exhaustive list of the myriad anti-LGBTQIA+ efforts the Trump Administration has taken since assuming office.

[25] *Id.*; Exec. Order No. 14190, *Ending Radical Indoctrination in K-12 Schooling* (Jan. 29, 2025), https://www.whitehouse.gov/presidential-actions/2025/01/ending-radical-indoctrination-in-k-12-schooling/.

[26] Exec. Order No. 14168, 90 F.R. 8615, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government* (Jan. 20, 2025), https://www.whitehouse.gov/presidential-actions/2025/01/defending-women-from-gender-ideology-extremism-and-restoring-biological-truth-to-the-federal-government/.

[27] The Trevor Project, *Trump Administration Orders Termination of National LGBTQ+ Youth Suicide Lifeline, Effective July 17th* (Jun. 18, 2025), https://www.thetrevorproject.org/blog/trump-administration-orders-termination-of-national-lgbtq-youth-suicide-lifeline-effective-july-17th/.

[28] Gender-affirming care describes a broad spectrum of services a person may receive for treatment of gender dysphoria, including social affirmation and specialized behavioral health care.

[29] Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence – Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, The American Academy of Pediatrics, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* (Oct. 2018,

Medicaid Directors stating that gender-affirming care for transgender minors "lack[s] reliable evidence…[and such] interventions are now known to cause long-term and irreparable harm."[30] Building on this same body of disinformation, HHS published a May report claiming that there is weak evidence to support gender-affirming care, highlighting purported risks of this care, and endorsing "gender exploratory therapy," a rebranding of long-discredited conversion therapy.[31] Alongside these efforts, Congressional Republicans sought to include a gender-affirming care ban for all transgender adult and minor Medicaid beneficiaries in the Republican reconciliation bill. This provision was struck after the Senate Parliamentarian advised it was an impermissible attempt to enact sweeping policy within a budget bill.[32] There are concurrent attacks on gender-affirming care access at the state-level.[33] These aggressive federal actions have already eroded access to medically-necessary, gender-affirming care nationwide, even though these prohibitions violate the best available scientific evidence and longstanding medical consensus. Many hospitals have shuttered their gender-affirming care services or stopped accepting new patients, leaving LGBTQIA+ youth without access to such care.[34]

Reaff. Aug. 4, 2023) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820437; Board of Trustees, American Medical Association, *Clarification of Evidence-Based Gender-Affirming Care H-185.927*, (Mod. and Reaff. 2024), https://policysearch.ama-assn.org/policyfinder/detail/%22Clarification%20of%20Evidence-Based%20Gender-Affirming%20Care%22?uri=%2FAMADoc%2FHOD-185.927.xml; Committee on Gynecologic Practice and Committee on Health Care for Underserved Women, The American College of Obstetricians and Gynecologists, *Health Care for Transgender and Gender Diverse Individuals*, Comm. Op. No. 823 (Mar. 2021, Reaff. 2024), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals; APA Council of Representatives, American Psychological Association, *APA Policy Statement on Affirming Evidence-Based Inclusive Care for Transgender, Gender Diverse, and Nonbinary Individuals, Addressing Misinformation, and the Role of Psychological Practice and Science* (Feb. 2024), https://www.apa.org/about/policy/transgender-nonbinary-inclusive-care; Congress of Delegates, The American Academy of Family Physicians, *Care for Transgender and Gender Nonbinary Patient* (Sept. 2024), https://www.aafp.org/about/policies/all/transgender-nonbinary.html. *See* GLAAD, "Medical Association Statements in Support of Health Care for Transgender People and Youth" (June 26, 2024), https://glaad.org/medical-association-statements-supporting-trans-youth-healthcare-and-against-discriminatory/ for collated statements from over 30 medical associations and world health authorities in support of gender-affirming care access for transgender people and youth.

[30] Letter from Drew Snyder, Deputy Administrator and Director, Center for Medicaid & CHIP Services, *RE: Puberty blockers, cross-sex hormones, and surgery related to gender dysphoria* (Apr. 11, 2025), https://www.cms.gov/files/document/letter-stm.pdf.

[31] Dept. of Health and Human Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (May 1, 2025) at 387 https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf.

[32] Ranking Member Jeff Merkley, *Byrd Rule Violations Continue to Mount on the Republicans' "One Big, Beautiful Bill*, U.S. Sen. Comm. on the Budget (June 25, 2025) https://www.budget.senate.gov/ranking-member/newsroom/press/byrd-rule-violations-continue-to-mount-on-the-republicans-one-big-beautiful-bill.

[33] United States v. Skrmetti, 605 U.S. __ (2025).

[34] Meredith Willse, *Penn State Health joins growing list of hospital systems banning some forms of gender-affirming care*, York Dispatch (Apr. 24, 2025). https://www.yorkdispatch.com/story/news/education/2025/04/24/penn-state-health-joins-growing-list-of-hospital-systems-banning-some-forms-of-gender-affirming-care/83232869007/; Jenna Portnoy, Kyle Swenson, and Karina Elwood, *Children's National Hospital to end gender-transition care*, The Washington Post (July 18, 2025), https://www.washingtonpost.com/dc-md-va/2025/07/18/children-national-ends-gender-transition-care/.

The incessant attacks on LGBTQIA+ people in the media has a serious effect on the mental health and wellbeing of all LGBTQIA+ people, especially children. Taken together, these attacks have resulted in myriad barriers to care for LGBTQIA+ young people that compound the harms explored in this report.

Gender-affirming care is an umbrella term that describes a wide range of support and services to validate and affirm a person's gender identity, including behavioral health care (such as group, individual, or family therapy), social transition support (such as name and pronoun changes), access to inclusive spaces (such as schools with affirmative policies), affirming personal expression (such as clothing, make-up, or wigs), and validating identity through community (such as peer support or media representation).[35] These forms of care can be just as life-changing and protective for the mental health of LGBTQIA+ people as medical interventions.[36] In limited instances, transgender young people may seek medical interventions as part of their gender-affirming care services. Such care may include individualized, evidence-based, medically-necessary puberty-pausing medications and/or hormone therapy and, in very rare circumstances for older adolescents, surgical care.[37] In the limited instances when medical interventions are pursued, this care is evaluated and prescribed by trained medical professionals in consultation with the patient and their guardians and within substantial guardrails.[38]

The elimination of access to gender-affirming care conflicts with the broad consensus across the world's leading medical and psychiatric organizations about the value of such care for people suffering from gender dysphoria.[39] Current best practice guidance emphasizes individualized care, rigorous psychological assessment, and affirming medical interventions only when

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[35] Ha Le, MD, *Further Defining Gender-Affirming Care*, American Academy of Pediatrics (Dec. 22, 2023), https://publications.aap.org/journal-blogs/blog/27752/Further-Defining-Gender-Affirming-Care?autologincheck=redirected.

[36] Rosemary Claire Roden, MD; Marley Billman, BS; Angelea Francesco, BS; Robert Mullin, DO; Christelle Tassi, BS; Boni Wozolek, PhD; Brandyn Heppard, PhD; Jamal Essayli, PhD; Heather Stuckey-Peyrot, DEd, *Treatment Goals of Adolescents and Young Adults for Gender Dysphoria*, 153 Pediatrics 1 (Jan. 2024), https://publications.aap.org/pediatrics/article/153/1/e2023062202/196235/Treatment-Goals-of-Adolescents-and-Young-Adults, Dannie Dai et al., *Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US.*, JAMA Netw Open. (Jun. 27, 2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820437.

[37] Patrick Boyle, *What is Gender Affirming Care? Your Questions Answered*, AAMC (Apr. 12, 2022), https://www.aamc.org/news/what-gender-affirming-care-your-questions-answered.

[38] Rosemary Claire Roden, MD, *et al.*, *Treatment Goals of Adolescents and Young Adults for Gender Dysphoria*, 153 Pediatrics 1 (Jan. 2024), https://publications.aap.org/pediatrics/article/153/1/e2023062202/196235/Treatment-Goals-of-Adolescents-and-Young-Adults, Dannie Dai et al., *Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US.*, JAMA Netw Open. (Jun. 27, 2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820437.

[39] Gender dysphoria describes the distress a person experiences when their gender identity differs from their sex assigned at birth.

appropriate. The American Academy of Pediatrics,[40] the American Medical Association,[41] the American College of Obstetricians and Gynecologists,[42] the American Psychological Association,[43] and American Academy of Family Physicians[44] agree that access to gender-affirming care for transgender people is safe, evidence-based, and in the best interest of the young person.

III. Investigative Findings

Finding 1: Many LGBTQIA+ young people at RTFs choose to conceal their identities out of fear for their own safety.

"I felt pressure to hide who I was to avoid conflict, which impacted my mental health and sense of self-worth."

LGBTQIA+ individuals often choose to conceal their identities out of fear for their own safety. A recent meta-analysis of 210 studies on sexual orientation concealment and its impact on mental health found that identity concealment is associated with increased mental health problems like depression, anxiety, distress, and disordered eating.[45] Further, identity concealment deprives LGBTQIA+ individuals of social support and community, which may be a protective factor against behavioral health impacts, including trauma. In the context of RTFs, which purport to treat behavioral health needs, the ability for young people to show up and present as their full selves is even more necessary.

The ability to present as one's full and authentic self – including safely disclosing LGBTQIA+ status – is an essential aspect of care for young people. Young people should be placed in care

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[40] Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence – Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, The American Academy of Pediatrics, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* (Oct. 2018, Reaff. Aug. 4, 2023) https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820437.

[41] Board of Trustees, American Medical Association, *Clarification of Evidence-Based Gender-Affirming Care H-185.927* (Mod. and Reaff. 2024), https://policysearch.ama-assn.org/policyfinder/detail/%22Clarification%20of%20Evidence-Based%20Gender-Affirming%20Care%22?uri=%2FAMADoc%2FHOD-185.927.xml.

[42] Committee on Gynecologic Practice and Committee on Health Care for Underserved Women, The American College of Obstetricians and Gynecologists, *Health Care for Transgender and Gender Diverse Individuals*, Comm. Op. No. 823 (Mar. 2021, Reaff. 2024), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals.

[43] APA Council of Representatives, American Psychological Association, *APA Policy Statement on Affirming Evidence-Based Inclusive Care for Transgender, Gender Diverse, and Nonbinary Individuals, Addressing Misinformation, and the Role of Psychological Practice and Science* (Feb. 2024), https://www.apa.org/about/policy/transgender-nonbinary-inclusive-care.

[44] Congress of Delegates, The American Academy of Family Physicians, *Care for Transgender and Gender Nonbinary Patient*, (Sept. 2024) https://www.aafp.org/about/policies/all/transgender-nonbinary.html.

[45] John Pachankis et. al., *Sexual orientation concealment and mental health: A conceptual and meta-analytic review*, Psychological Bulletin (Oct. 2020), 146(10):831-871. doi: 10.1037/bul0000271.

settings where they feel comfortable disclosing and embracing their LGBTQIA+ identities Unfortunately, many LGBTQIA+ young people described feeling afraid to share their LGBTQIA+ identities with staff and peers at RTFs. In many cases, this concealment was predicated on witnessing abuse or mistreatment of other LGBTQIA+ children. Children reported that this concealment was psychologically damaging and led to feelings of isolation.

Testimony reviewed by the Committee Minority Staff reflects that many LGBTQIA+ youth were afraid to come out at RTFs because they witnessed other LGBTQIA+ youth discriminated against on the basis of their identity. Two young people shared that they did not feel safe disclosing their LGBTQIA+ status because they had "seen instances where others were treated differently after coming out" or were "excluded." One young person described how they "saw very clearly when the young men who were a little bit more feminine, [they] would be screamed at and berated and shamed, and get in trouble for just being who they were…[and so] I never felt safe being anything other than what they wanted me to be." Another child noted, "I wasn't out to anyone at 13. My boarding school mate was abused for being gay." One young person observed that they "saw how other lgbtqi+ individuals were treated and excluded and [they] feared the same would happen to [them] if [they] disclosed." One stated simply: "...I didn't feel safe because I have seen the hate some persons have with people with identity like mine."

Testimony reviewed by the Committee Minority Staff reflects that many LGBTQIA+ youth were afraid to come out at RTFs because staff had negative feelings towards LGBTQIA+ identities. Put simply, one youth said "I never disclosed out of fear," and another explained, "I did not feel safe sharing my identity with some or all of the staff." Echoing this same sentiment, one young person explained they did not share their identity with staff because they were "afraid of being rejected or discriminated against," while another said they were afraid staff "might have bias or misunderstand my identity," and a third young person stated that "fear of judgment" kept them from sharing their LGBTQIA+ identity. One young person said they "fear that some [staff] may not be accepting [and…they] want to protect [themselves] from potential judgment or discrimination that could arise from revealing" their full self. One young person said they saw "staff treating queer/trans kids poorly," which convinced them not to come out.

In testimony reviewed by the Committee Minority Staff, a number of LGBTQIA+ youth described feeling isolated, uneasy, or unsafe due to identity concealment while at RTFs. Many young people described not feeling comfortable fully expressing themselves or sharing their LGBTQIA+ identities. Numerous young people reported feeling "uneasy," "on edge," "isolated within the system," "lonely," "isolated from others," lacking "a sense of belonging," or only understood at a "superficial" level. Put simply, one young person reported that, because staff were not supportive of the LGBTQIA+ community, it "made it harder to feel safe." One

young person reported that, "I feel I need to hide my true identity to avoid unnecessary conflicts or misunderstandings, which makes me feel depressed."

Finding 2: Young people described RTFs as hostile environments for LGBTQIA+ people.

"I've felt that my sexual orientation made me a target for discrimination among my peers, which affected my sense of belonging."

The surveyed LGBTQIA+ young people in RTFs frequently reported enduring verbal abuse, discrimination, and hostile environments created by both peers and staff. These environmental factors contribute to feelings of isolation and present a barrier to treatment. Studies have found that youth build resilience through social connection and through an understanding that they are seen and respected by those around them.[46] LGBTQIA+ youth in care settings may experience more complex barriers to social connection due to histories of discrimination as well as discrimination experienced in the RTF by staff and peers.[47] Hostile environments are antithetical to effective treatment.

Patterns of verbal and psychological abuse were noted by many respondents to this survey and, for many young people, defined their entire experience in care. These experiences have long-term implications for mental health, trust in care providers, and ability to establish social connections inside and outside of the RTF setting.

Testimony reviewed by the Committee Minority Staff reflects that LGBTQIA+ youth felt their identities were not respected at RTFs. Overall, many LGBTQIA+ youth felt that their identity was offered "very little" or no respect. Young people described having their LGBTQIA+ identity "made fun of" and "laughed" about and, overall, peers being "mean." In one instance, a young person shared that their "sexual orientation was always at [sic] target and [this person] was always being harassed" because of it. One young person reported that they "avoid the topic of LGBTQ" because they still feel judged on the basis of who they are. Another young person said that these experiences made it "difficult expressing" that they were part of the LGBTQIA+ community.

Testimony reviewed by the Committee Minority Staff details that LGBTQIA+ young people often felt excluded and diminished inside RTFs on the basis of their identities. These experiences highlighted the barriers to care young people face when their identities are not respected, leading to social exclusion and feelings of profound loneliness. One young person described that their "peers would exclude [them] based on assumptions about [their] identity,

[46] Mónica López López et al., *"They told me that you can be with whomever you want, be who you are": Perceptions of LGBTQ+ youth in residential care regarding the social support provided by child welfare professionals*, 159 Children and Youth Services Review (Apr. 2024), https://www.sciencedirect.com/science/article/pii/S0190740924000707.
[47] *Id.*

leading to feelings of isolation." In another case, a young person said, "[t]here were instances where I felt isolated from other residents due to my identity, which created a sense of loneliness during my placement." Another young person noted that their "experiences related to LGBTQ issues were dismissed or minimized in group discussions." One young person relayed that they "often feel treated differently from [their] peers, such as being excluded or ignored in group activities because of [their] different sexual orientation." These experiences of isolation extended to relationships with RTF staff, too. One young person shared that "[s]ome staff members were indifferent when [they] expressed [their] emotions, or even laughed at [their] feelings, which made [them] feel very lonely and helpless."

Testimony reviewed by the Committee Minority Staff suggests that LGBTQIA+ youth who experienced discrimination on the basis of their identity may be afraid to report it. Fear of retaliation or disbelief prevented some young people from seeking help. According to one young person, they "did not report it [because they] felt like it wouldn't change anything, and [they were] concerned about potential retaliation." Another felt that reporting harassment "would make matters worse." Some young people noted that their concerns were minimized when they did report discrimination. One person said: "I felt my concerns were dismissed and not taken seriously," and another shared that they "receive[d] support, but also encountered some suspicion and misunderstanding."

Testimony reviewed by the Committee Minority Staff details that LGBTQIA+ young people felt that the lack of understanding of their identities led to feelings of isolation. One person explained that the lack of understanding about their LGBTQIA+ identity "made it difficult to build trust with" staff members and providers. Another said their treatment led to "[i]dentity crises and depression cus [sic] of how misunderstood and ill treated" they were. Youth described that a lack of acceptance led to feelings of isolation: "My experience in congregate care made me acutely aware of how important acceptance is for mental wellbeing. Being in an environment where I felt marginalized due to my identity made me struggle with feelings of isolation and low self-worth." Another described feeling lonely because other people there "may not understand [their] gender identity or sexual orientation." The effects of this isolation can be long-lasting and adverse to the goals of care. As one youth described, "[w]hile in group care, I felt a sense of isolation and pressure to not be accepted, especially when expressing my gender identity and sexual orientation. This made me more aware of social biases against LGBTQI+ youth, which led to insecurity in relationships after I left."

Young people detailed that staff had little understanding of their LGBTQIA+ identities which made it difficult to foster deep relationships. One young person described the providers' knowledge of LGBTQIA+ identities as "superficial." Two others detailed that "employees didn't fully understand" LGBTQIA+ identities and "lack knowledge about LGBTQI+ issues." As a result of this, young people felt it was "hard to connect on a deeper

level" and "difficult to build trust with them." In one case, a young person said that they did not "feel safe or supported" because of staff's disposition towards LGBTQIA+ issues.

Young people detailed that they were not able to thrive in treatment when care did not take their LGBTQIA+ identities into account. While youth in RTFs often experience care that is not personalized to meet their treatment plans, the issue may be even more acute in the case of LGBTQIA+ young people, whose challenges and needs may not be represented in a one-size-fits-all approach. Numerous young people highlighted the shortcomings in LGBTQIA+-informed behavioral health care.

One young person noted that behavioral health services were not "tailored to [their] experiences as an LGBTQ individual. [They] often felt that the counselors did not fully understand the unique challenges [they] faced, which made it difficult for [them] to open up and feel supported." Another young person explained that they "sometimes needed additional support to discuss issues related to [their] identity, but most of the time could only rely on peer support." A third young person shared that, "[o]ther services, such as support groups or educational programs focused on LGBTQ issues, were virtually nonexistent. This lack of resources left [them] feeling isolated and unsupported in [their] identity." Another young person "felt [their] needs were partially met, but sometimes lacked sensitivity to LGBTQI+ youth. While counselling services were available, there was little support specifically for gender identity or sexual orientation issues."

Finding 3: Many LBGTQIA+ young people at RTFs described experiencing punitive treatment on the basis of their identities.

"[W]hen I was caught holding hands I was sent to … an isolation room for hours. I was cavity searched several times."

Numerous young people reported being punished for their LGBTQIA+ identities. In one case, a young person reported that "many people in my program were explicitly punished for their queerness." A second young person reported that revealing LGBTQIA+ identity "can lead to retaliation or punishment." Another reported that: "[o]n one occasion, I was isolated in the institution because I discussed our sexual orientation with other teenagers, which made me feel punished and isolated." Similarly, one young person said that they "have experienced unreasonable restrictions, such as being banned from certain activities because of [their] gender identity, which made [them] feel a loss of freedom and dignity." One young person reported: "I was told I waived my right to be strip search[ed] by a member of the same sex because I was bisexual."

Testimony reviewed by the Committee Minority Staff reflects that some RTFs embraced discriminatory and highly-dangerous theories that view LGBTQIA+ identities as a disease. Multiple children detailed that LGBTQIA+ identities were treated as "a disease" or "a plague" which young people could be accused of "spreading" to one another. Similarly, one young person said staff in their RTF described LGBTQIA+ identities as "contagious."

Testimony reviewed by the Committee Minority Staff reflects that some RTFs embraced discriminatory and highly-dangerous theories that view LGBTQIA+ identities as a phase or a reflection of limited life experiences. One young person recounted that facility staff said they were "following trends and trying to infect my leers [sic] with my ideologies." Another young person said that their LGBTQIA+ identity was referred to by staff as "a phase and a [t]rend." When one person shared that "she was lesbian and the staff said it's because she never tried d**k before." Another LGBTQIA+ young person "was told [they were] confused" and that this person was "too pretty to involve [themselves] in that [LGBTQIA+] lifestyle because [they would] be putting [themselves] in harm's way." These types of comments invalidate LGBTQIA+ people, dismiss their lived experience, and undermine self-discovery and self-acceptance.

Testimony reviewed by the Committee Minority Staff reflects that some RTFs embraced discriminatory and highly-dangerous theories that view LGBTQIA+ identities as sinful. In many of these cases, LGBTQIA+ children were subjected to religious teachings, including punishments. Some young people were told "being gay was sinful." In one case, the RTF "tried to get [them] to go to church" in response to their LGBTQIA+ identity. Another young person said "homosexuality was a sin and punishable" in their RTF while another said that LGBTQIA+ young people were "punished and treated as a deeply wrong Mormon religious taboo." One example of a religiously-rooted punishment for LGBTQIA+ identity was when a child was "made to write thousands of lines of scripture over and over again…[and] targeted and humiliated during chapel sessions." In two cases, young people said that their LGBTQIA+ identities were treated as demonic – in the first instance, children were "all accused of being possessed by a homosexual demon" and, in the second, they "assumed [LGBTQIA+ children] were demon possessed." Similarly, a young person said that peers tried to "exorcise" their LGBTQIA+ identity.

A pediatrician told the Committee Minority Staff about a young patient who was criminalized on the basis of his LGBTQIA+ identity. In one instance, a LGBTQIA+ young person was separated from his twin brother and placed in an RTF. The child was bisexual and, while in congregate care, he began "exploring his sexual identity in a developmentally normal way," according to his pediatrician.[48] The RTF staff, however, labeled him as a "sex offender" and insisted on specialized therapy to purportedly treat the young person's bisexuality.

[48] Testimony submitted by Health Care Providers (Jan. 10, 2025), on file with the Committee.

Finding 4: Anecdotes shared by legal service providers detail how RTF providers abused children on the basis of their LGBTQIA+ identity.

LGBTQIA+ unaccompanied children in ORR custody are among the most vulnerable in the entire country. Outside of the foster care system, unaccompanied immigrant children may be placed in RTFs through ORR, the child welfare agency responsible for their care before they are unified with sponsors. Children in ORR custody may also be placed in transitional foster care, group homes, or staff-secure facilities. These children are separated from family and community, and are likely to have fled violent or otherwise unsafe conditions in their home countries. This background leaves them particularly vulnerable to deficiencies of care inside RTFs. Because unaccompanied children placed in RTFs are in the custody of ORR, the federal government is directly responsible for their wellbeing. These children often do not have access to parents or family members to monitor their treatment. In the instances these children are afforded legal representation, their lawyers provide critical insight into facility conditions and quality of care. The following stories were shared by such lawyers, highlighting both the unique harms LGBTQIA+ children in ORR custody may face and the vital role lawyers play in telling their stories.

One ORR provider placed a transgender child in solitary confinement on the basis of their LGBTQIA+ identity.[49] In one instance, a transgender child was deprived of clothing that aligned with her gender identity. After the child's lawyer advocated on her behalf and secured her the appropriate clothing, RTF staff placed her in solitary confinement for eight days "for [her] protection."[50] During this time the child was not allowed to leave, attend school, or speak to her lawyer. After her release from solitary confinement, staff continued to discriminate against, bully, and deadname[51] this child. Additionally, this child later shared with her lawyer that another transgender child was likewise placed in solitary confinement because of her gender identity.

Two ORR providers deprived LGBTQIA+ children of access to socially-affirming items, including clothing, make-up, and wigs.[52] In one instance, a transgender child was deprived of clothing that aligned with her gender identity and affirming make-up and wigs as a form of punishment. Staff at this same facility reportedly threatened transgender children with restrictive placement as a form of punishment. In another instance, a transgender child reported that she was "not allowed to have female clothing."[53]

[49] Testimony submitted by Legal Services Provider (Mar. 26, 2025), on file with the Committee.
[50] *Id.*
[51] Deadnaming refers to the practice of calling a person by their birth name, rather than their chosen name.
[52] Letter from Legal Service Provider (Apr. 25, 2024), on file with the Committee.
[53] Letter from Legal Service Provider (Mar. 26, 2025), on file with the Committee.

In a few cases, ORR providers discriminated against and harassed LGBTQIA+ unaccompanied children. An unaccompanied youth was bullied for his sexual orientation.[54] The discrimination was so severe that it caused the child to develop panic attacks, depression, and have vivid nightmares. Rather than address the underlying homophobia by staff, the child was sent to a psychiatrist who prescribed him medication that made him fall asleep in class. The legal service provider stated that the staff "made no meaningful efforts to protect him from the tremendous harassment and abuse that he faced on a daily basis." A separate legal service provider reported that RTF staff made "discriminatory comments about transgender people, including [calling them] derogatory names."[55] Additionally, this legal service provider reported issues with staff misgendering transgender children.[56]

The Trump Administration's attempts to terminate the legal services contract for unaccompanied children in ORR custody leaves children at heightened risk of abuse and neglect by service providers. With the disruption of this program, all unaccompanied children will suffer.

The unaccompanied children in ORR custody are not guaranteed legal representation in court or counsel as they prepare their case. However, the government is required to make the greatest practicable effort to provide direct legal representation to unaccompanied children in ORR custody as they proceed through the immigration system, as required by the Trafficking Victims Protection Reauthorization Act (TVPRA), the HHS Foundational Rule, and the *Flores* Settlement Agreement. On March 21, 2025, the Trump Administration terminated its $200 million legal services contract without warning and, seemingly, without cause.[57] Through this contract, a national nonprofit administered legal representation and court services through a network of legal service providers under the Unaccompanied Children Program (UCP).[58]

After a months-long legal process, during which time the Trump Administration refused to obey court orders demanding the resumption of the UCP, the Administration has executed a renewed contract with the national nonprofit administering the program through September 2025. Though these services have, in theory, resumed, their protracted, sudden termination and the uncertainty of their future funding has already caused irreparable harm. Unaccompanied children, as young as infants and toddlers, have already been forced to face the immigration system and appear unrepresented and alone before judges in court. With no certainty that representation will

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[54] Testimony submitted by Legal Services Provider (Mar. 26, 2025), on file with the Committee.
[55] Testimony submitted by Legal Services Provider (Apr. 25, 2024), on file with the Committee.
[56] Letter from Legal Service Provider (Apr. 25, 2024), on file with the Committee.
[57] Miriam Jordan, *Trump Administration Halts Funding for Legal Representation of Migrant Children*, New York Times (Mar. 21, 2025), https://www.nytimes.com/2025/03/21/us/migrant-children-legal-representation-funding.html.
[58] Janie Har, *Legal services for unaccompanied migrant children still uncertain after judge orders reinstatement*, Associated Press (Apr. 2, 2025), https://apnews.com/article/trump-migrant-children-lawyers-4304ba9d06a48f808df8650ff25e4a6e.

continue past this contract term, more unaccompanied children are likely to be subjected to a complicated, adversarial system with little oversight or intervention on their behalf. Already, children have been exposed to risk of abuse and trafficking, as well as removal, while the termination of services was in place.

Beyond the acute harms unaccompanied children will face, this contract termination had the secondary but profound impact of weakening the infrastructure that provides insight into the conditions of unaccompanied children and helps keep them safe from abuse and neglect inside RTFs. Legal service providers are an on-the-ground resource to children in ORR custody who advocate in their best interest. They also serve as a trusted confidant to whom children can report abuse and neglect. Where such harms occur, legal service providers can help ensure that proper reporting and recourse takes place.

Through the UCP's funding and access authority, legal providers may have access to facilities where children in ORR custody are being housed for the purposes of legal proceedings, client visits, or to administer know-your-rights presentations. Visits to these facilities allow legal service providers to observe conditions unmediated and speak directly with children. The American Bar Association found that:

> A child's immigration attorney may be the only trusted adult in their life. Attorneys trained to work with children can develop rapport and earn their trust over time. While immigration judges are required by the TVPRA to look for indicia of trafficking, there are many limitations for a judge to ascertain this information from the bench and to develop the necessary trust with child respondents. Because of their ongoing relationship, a child's attorney is likely in the best position to learn information needed to protect a child from unsafe conditions. Without legal services, unaccompanied children become more vulnerable to trafficking, exploitation, and other forms of abuse.[59]

The anecdotes in this report were provided by legal service providers. In addition to serving as counsel to unaccompanied child clients, legal service providers advocate on these children's behalf – and on behalf of all children in ORR custody – by compiling their stories. Without essential legal services providers, these stories are unlikely to come to light.

[59] American Bar Association Children Law Academy and Commission on Immigration, *Unaccompanied Minors in Immigration Court: The Critical Role of Legal Representation* (Apr. 10, 2025), https://cilacademy.org/wp-content/uploads/2025/04/2025-04-10-uc-immigration-court-explainer.pdf.

Finding 5: Numerous young people described experiencing punitive treatment tied to their transgender identities while in RTFs.

"[M]ental health cannot be gained by denying your identity. You will not end up with fewer trans kids, just fewer alive ones. Being in supportive loving environments and being accepted is so important. I no longer self-harm and it's been a decade since my last suicide attempt and it would not be possible without loving myself as I am."

Gender dysphoria describes the distress a person experiences when their gender identity differs from their sex assigned at birth. This difference between one's physical body and identity can lead to severe psychological distress. Access to gender-affirming care for transgender people has been found to reduce mental health challenges, including suicidality, depression, and anxiety, and improve wellbeing.[60] There is a broad spectrum of services that fall within the umbrella of gender-affirming care, including non-medical social affirmation such as gender-affirming clothing and preferred pronoun and name usage. Research has shown that when transgender individuals are able to access gender-affirming care, including non-medical items like clothing, wigs, and makeup, they report significantly lower rates of depression and higher self-esteem.

Conversion therapy describes the widely discredited, non-evidence-based, and dangerous practice of attempting to eliminate an LGBTQIA+ person's sexual orientation or gender identity to make them conform with cisgender and heteronormative standards. At its core, conversion therapy promotes the false and harmful idea that being LGBTQIA+ is wrong. Because sexual orientation and gender identity are not mental illnesses, they cannot be changed through "therapy," and attempting to "treat" such identities pathologizes – and stigmatizes – LGBTQIA+ people.

The scientific basis for conversion therapy is non-existent, with a recent literature review commissioned by the Substance Abuse and Mental Health Services Administration finding no scientific evidence supporting the effectiveness of conversion therapy.[61] Further, substantial research links conversion therapy with severe psychological harm. Individuals exposed to conversion therapy are significantly more likely to experience depression, substance abuse, suicidal ideation, and attempt suicide.[62]

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[60] *See. e.g.*, Annelou et al., Pediatrics, *Young adult psychological outcome after puberty suppression and gender reassignment* (2014), 134(4), 696-704; Luke R. Allen et al., Clinical Practice in Pediatric Psychology, *Well-being and suicidality among transgender youth after gender-affirming hormones* (Sept. 1, 2019) 7(3), 302; Christal Achille et al., International Journal of Pediatric Endocrinology, *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results* (Apr. 30, 2020) Vol. 1, 1-5.

[61] Substance Abuse and Mental Health Services Administration, *Moving Beyond Change Efforts: Evidence and Action to Support and Affirm LGBTQIA+ Youth* (2023), https://omh.ny.gov/omhweb/resources/publications/samhsa-lgbtqia-youth-report.pdf.

[62] Minn. Dept. of Health, *Summary of Findings: A review of Scientific Evidence of Conversion Therapy* (Apr. 11, 2022), https://www.health.state.mn.us/people/conversiontherapy.pdf.

In one case, a young person reported that transgender identity was treated as the pretense for placement in an RTF. A young person reported being sent to an RTF because of his transgender identity. In his medical notes, a provider had written, "[s]he considers herself a male." This reflects a pathologization of transgender identity.

Testimony reviewed by the Committee Minority Staff shows that multiple people experienced conversion therapy at RTFs. Five young people surveyed attested to their treatment in RTF being "conversion therapy," and one person elaborated that the care at the RTF was about "fixing us. Making us straight." In numerous instances, young people described going along with the conversion therapy for safety and rejecting their true LGBTQIA+ identities. One young person said, "I converted myself," whereas another said that "[e]ven though I knew I was not a straight cis girl, I had to act like and was treated like one." Another person described "becoming brainwashed" in order to survive at the RTFs.

Testimony reviewed by the Committee Minority Staff reflects that three young people felt that their LGBTQIA+ identities served as the basis for punishment in RTFs. A young person explained that they did not come out while in the RTF because they saw that "[i]t can lead to retaliation or punishment." Two young people were specific about the type of punishment LGBTQIA+ people faced in their respective RTFs: solitary confinement. In one instance, a child described that being LGBTQIA+ was "[f]orbidden and [p]unished cruelly, including [with] solitary confinement." A second youth reported that LGBTQIA+ people were similarly criminalized at their RTF with any activity related to being LGBTQIA+ resulting in "severe punishments like solitary confinement."

Testimony from youth shows that transgender identities were often not viewed as valid expressions of self at RTFs and were instead met with scrutiny, suppression, and hostility. As one transgender individual put it, the staff "didn't like me because I was transitioning and they felt it was a bad example for other youth." Another transgender young person shared that "[t]he staff were very disrespectful towards me and my transitioning. I felt very unsafe." In another case, a transgender young person was deprived of access to health care. They were interested in starting "testosterone and to get a gender therapist for me to get a consultation on top surgery," but they were not offered access to any health care providers who could help them navigate such services. This deprivation of care was life-altering. In one case, a young person did "not fully transition till [leaving the RTF]" because of the abuse they faced at the RTF on the basis of their transgender identity.

Testimony from three young people describes RTF staff positing previous trauma as the root cause of the young person's LGBTQIA+ identities. One young person was told that they were "confused, [and] only thought I was trans because I was raped, only thought I was trans

because I was autistic, etc." Another participant shared that they were "put through conversion therapy [where] I was told I was inherently disordered and brought my CSA [childhood sexual abuse] up on myself by being queer." In the same vein, a young person recalled being told by RTF staff that "my abuse was because I attracted it to me by being bi and queer." Weaponizing a young person's trauma against them is abusive and demonstrates a fundamental misunderstanding of LGBTQIA+ identities.

Finding 6: In numerous instances, RTFs were not accommodating of LGBTQIA+ young people's preferred names or pronouns and staff withheld gender-affirming items from young people.

"I would get deadnamed and misgendered, I was kept from swimming activities and wearing anything that resembled men's clothing, they took my deodorant because it was for men, they made me grow out my hair and refused to let me get it cut."

Testimony reviewed by the Committee Minority Staff reflects that many LGBTQIA+ youth did not have their preferred names respected at RTFs. One young person reported a staff member plainly refusing to refer to another client by their chosen name, saying "I'm not going to call you that" and, instead, proceeding to deadname that young person. Another young person reported that their preferred name "wasn't always respected" by staff. This mirrors the experiences of another young person who said they "would get deadnamed and misgendered" regularly.

Testimony reviewed by the Committee Minority Staff reflects that many LGBTQIA+ youth did not have their preferred pronouns respected at RTFs. A number of young people reported that their pronouns were "often overlooked" or "not well used," and that staff were largely "very neglectful" towards pronouns. Two young people reported that their pronouns were repeatedly joked about. Another young person reported that "just one staff made [LGBTQIA+ young people] feel safe and respected [their] pronouns." In one instance, a young person was told that their preferred pronouns would only be used in the RTF after they turned 18. At some RTFs, hostility toward proper pronoun usage was encouraged by the institution, with a young person reportedly being "told off if I tried correcting someone" who used incorrect pronouns and, in a separate instance, a young person reporting that "students who used the correct [preferred] name or pronouns would be reprimanded."

Youth testimony and reports from pediatricians show that incorrect pronoun usage has material, negative impacts on LGBTQIA+ young people's mental health and wellbeing, in line with

research on this issue.[63] In one instance, a young person told their pediatrician they felt "invisible" because staff at the RTF refused to use their preferred pronouns. Other young people described similar emotional impacts from their preferred names being disregarded, stating that it was "frustrating and disheartening" and "exhausting and disheartening." A pediatrician reported that a young person began self-harming shortly after being placed in an RTF because they felt that their identity was "invalidated" at every turn, including their preferred name and pronouns being disregarded. Their provider observed that this "despair was a direct response to the hostile environment they endured daily."

In many cases, LGBTQIA+ young people reported being denied the ability to present or dress in a manner that reflected their gender identity or preferred dress. Youth reported "[b]arriers to accessing gender-affirming clothing," with clothing options being limited and self-expression controlled and/or discouraged. Another young person "wasn't allowed to wear [their] hair short at some placements [and] had to wear very feminine clothing," even though that was not their preference. Many young people reported few clothing options that aligned with their style. One young person explained that, "[c]lothing options were limited and often did not reflect my personal style," while another described the clothing as "[i]ll-fitted clothing and [having] limited control over choice." A third young person described the clothing offerings as "limited" and explained that they do "not express my personality." Put simply, a young person recalled having "no autonomy over my appearance…[and being] forced to dress a certain way."

In multiple cases, gender-affirming materials were explicitly withheld from transgender young people by RTF providers. According to a pediatrician, a transgender child in an RTF had her wigs and clothing discarded by the RTF. When she met with her health care provider she appeared "shrouded in shame, desperately trying to hide…her embarrassment palpable." The pediatrician described how this young person's mental health deteriorated significantly following this abuse and relayed that the young person described herself as "stripped of her identity" without these gender-affirming items. Similarly, an RTF psychiatrist discontinued a young person's hormone therapy and withheld their affirming prosthesis and chest binding materials. A legal service provider suggested that this was "a consequence of undesirable behavior."[64] A pediatrician detailed how one of their young transgender clients had their wigs and clothing discarded by RTF staff.[65] She "began acting out" and staff complained to the provider about her behavior. The provider suggested that affirming her identity would likely improve her emotional wellbeing and, consequently, make her behavior more manageable for staff. The RTF staff refused to follow this recommendation.

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[63] Stephen T. Russell et al., Journal of Adolescent Health, *Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth* (Vol. 63, Iss. 4, 503 - 505) doi: 10.1016/j.jadohealth.2018.02.003.
[64] Email from P&A to staff (Jan. 8, 2025), on file with the Committee.
[65] Testimony submitted by Health Care Providers (Jan. 10, 2025), on file with the Committee.

According to health care professionals, withholding gender-affirming items from young people is not only dehumanizing — it is psychologically harmful and dangerous. Clothing is a tool for self-expression and confidence building, especially during adolescence. Allowing young people to wear clothing that reflects their personal preferences and supports identity development is a sound mental health practice.[66] Further, access to gender-affirming clothing is even more critical for transgender or nonbinary young people. For them, clothing can be a vehicle for social affirmation. One study of over 500 transgender women found that social gender affirmation, including access to gender-affirming clothing, was directly linked to improved psychological wellbeing.[67] Finally, with respect to chest binding, withholding adequate supplies places people at risk of injury.[68]

Finding 7: LGBTQIA+ youth expressed feeling safer when RTF staff engaged in affirming and safe practices related to their identities.

"They gained my trust—it took about a year and a half—but I trusted them, and we still talk to this day ... they're like sisters to me."

Though the majority of survey responses identified harms that LGBTQIA+ youth experienced on the basis of their LGBTQIA+ status, some young people acknowledged the efforts of staff to engage in best practices. The presence of well-informed, inclusive, and empathetic staff can dramatically shift a young person's experience in care. On the whole, these instances highlight that having staff who are supportive of LGBTQIA+ communities is essential, especially in RTFs that house LGBTQIA+ children and youth. As one survey respondent put simply, "...I felt accepted by sharing my identity because staff showed support and inclusion for the LGBTQIA+

[66] Connor Whiteley, Strands of Transgender Identity: A literature review on sense of belonging through gender-affirming clothing, https://sentiojournal.uk/wp-content/uploads/2024/10/I6_Connor_Whiteley.pdf; Menkin, Dane, and Dalmacio Dennis Flores. "Transgender Students: Advocacy, Care, and Support Opportunities for School Nurses." NASN school nurse (Print) vol. 34,3 (2019): 173-177. doi:10.1177/1942602X18801938; Rine, Christine M. "The Significance of Clothing in Gender Affirmation: Considerations for Social Work." Health & social work vol. 47,4 (2022): 237-239. doi:10.1093/hsw/hlac029; Teti, Michelle, Kristen Morris, L. A. Bauerband, Abigial Rolbiecki, and Cole Young. 2019. "An Exploration of Apparel and Well-Being among Transmasculine Young Adults." Journal of LGBT Youth 17 (1): 53–69. doi:10.1080/19361653.2019.1611519.; Durwood, Lily et al. "A Study of Parent-Reported Internalizing Symptoms in Transgender Youth Before and After Childhood Social Transitions." Clinical psychological science : a journal of the Association for Psychological Science vol. 12,5 (2024): 984-996. doi:10.1177/21677026231208086; Plume Clinic, Beyond Healthcare: Clothing as a Gender-Affirming Tool (Dec. 16, 2024), https://getplume.co/blog/beyond-healthcare-clothing-as-a-gender-affirming-tool/.

[67] Glynn, Tiffany R., Kristi E. Gamarel, Christopher W. Kahler, Mariko Iwamoto, Don Operario, and Tooru Nemoto. *The Role of Gender Affirmation in Psychological Well-Being Among Transgender Women*, *Psychology of Sexual Orientation and Gender Diversity*, Vol. 3, No. 3, September 2016, pp. 336–344, https://pmc.ncbi.nlm.nih.gov/articles/PMC5061456/#R10.

[68] Peitzmeier, Sarah et al. "Health impact of chest binding among transgender adults: a community-engaged, cross-sectional study." Culture, health & sexuality vol. 19,1 (2017): 64-75. doi:10.1080/13691058.2016.1191675; Julian, Jamie M et al. "The Impact of Chest Binding in Transgender and Gender Diverse Youth and Young Adults." The Journal of adolescent health : official publication of the Society for Adolescent Medicine vol. 68,6 (2021): 1129-1134. doi:10.1016/j.jadohealth.2020.09.029.

community." These reported positive experiences in RTFs make clear that it is possible for LGBTQIA+ youth to receive effective and affirming care. Though the vast majority of respondents experienced ineffective or even harmful conditions in congregate care, this need not be the norm.

Youth reported that they felt safer when staff were supportive and understanding. One young person reported that they felt safe especially when staff expressed support and understanding of LGBTQ+ issues. Others reported that generally staff called them by the correct name and allowed them to display their chosen name on their bedroom door. One youth reported that, "I would feel safe sharing my identity with some of the staff because I have noticed that a few of them have shown understanding and support towards LGBTQ issues in the past. Their openness makes me feel more comfortable being myself around them." Such understanding appeared to be essential to building effective, trusting relationships between staff and young people. As one youth stated, "[t]hey respected my sexual orientation and gender identity. Staff did their best to use the correct pronouns, and always used the correct name." Some youth described their placements as spaces where they not only felt supported by staff, but also by peers, stating, "I feel supported by both staff and peers – my sexual orientation and gender identity are respected in my current placement."

While these affirming experiences were meaningful for LGBTQIA+ young people, they were contrasted with inconsistencies in staff training and policy. As one young person noted, "[w]hile some [staff] were supportive and understanding, others seemed disconnected from the unique challenges I faced as an LGBTQ individual." Another youth added that, "I would feel safe sharing my identity with all the staff if there were clear policies in place that promote inclusivity and respect for LGBTQ individuals. Knowing that the environment is supportive would encourage me to be open." Another young person highlighted the necessity of training for staff: "I sometimes felt like I had to educate the employees about LGBTQ issues, which was frustrating. I wished they had more training on how to support youth like me."

IV. Conclusion

Reporting and research studies have detailed the unique challenges LGBTQIA+ young people face in accessing appropriate and affirming care, services and social integration within RTFs. This report builds on the findings of *Warehouses*, which explores the risks and harm to all young people placed in RTFs, with a closer look at a population of children who are especially vulnerable to the deficiencies of this system. It seeks to illustrate the experiences of LGBTQIA+ young people in congregate care in their own words.

Youth testimony illustrates a system that tends to lead to the marginalization and suppression of LGBTQIA+ young people. Many LGBTQIA+ youth were denied the ability to express their identities, subjected to harmful and punitive practices like conversion therapy, or demeaned on

the basis of their identities. Other young people reported being misgendered, isolated, and/or forced to educate staff about their proper treatment. These harms are driven by systemic factors reviewed in *Warehouses*, such as inadequate oversight, lack of staff training, and placement decisions driven by system constraints. In limited instances, young people reported support and affirmation by staff and peers inside RTFs. However, in this review, there were far fewer positive reflections than negative ones from LGBTQIA+ youth about their experiences in RTFs.

Throughout testimony reviewed by the Committee Minority Staff, LGBTQIA+ youth were clear that they felt safe when they were respected, affirmed, and supported by knowledgeable staff and inclusive policies. These accounts point toward what is possible when care environments are built with LGBTQIA+ youth in mind – possibilities that improve treatment and outcomes for all children. The stories reviewed by the Committee Minority Staff reflect an urgent need for change. Safe and affirming placements must be the rule, not the exception.

In their own words, LGBTQIA+ young people shared their considerations for policymakers:

- "Advocates should understand that **trauma from mistreatment or neglect during care has long-term effects** on our ability to trust and form healthy relationships"
- "Being in congregate care made me feel isolated from my community, which amplified my struggles with identity and acceptance. I wish advocates understood **how important it is to create safe and supportive environments** for LGBTQ youth in these settings"
- "It's not just about providing services; it's about **creating [an] environment where every individual feels valued, safe, and affirmed for who they are**. Policies should prioritize individualized care, cultural competency, and resources that address the unique challenges faced by LBTQ+ youth and other marginalized groups."
- "It would be nice to have **more activities that foster inclusivity** and allow me to meet others like me"
- "I feel more comfortable sharing my thoughts and feelings with **adults who respect my experiences and validate my identity**"
- "I sometimes felt like I had to educate the employees about LGBTQ issues, which was frustrating. I **wished they had more training on how to support youth like me**."
- "The instability of congregate care placements made it difficult to form lasting connections, which is especially challenging for LGBTQ youth seeking community and support. Advocates must recognize **the need for consistent and caring relationships** in these environments."
- "**The lack of representation and understanding of LGBTQ issues among staff** in congregate care facilities often left me feeling misunderstood and invalidated. It's crucial for policymakers to ensure that caregivers receive training on LGBTQ inclusivity."

V. Appendix I: Survey Questions

Below is the complete list of survey questions that child welfare stakeholders used to solicit reflections from LGBTQAI+ people regarding their experiences in congregate care as youth.

- How old were you when you were sent to the institutional placement(s)?
- Did you feel safe during your time in congregate care?
- Were your sexual orientation and gender identity (including pronouns) respected?
- Did any aspects of the environment make you feel unsafe or uncomfortable? If so, could you share more about what they were?
- Were you housed in a way that matched your gender identity?
- Did any aspects of the environment [make] you feel safe and affirmed? If so, what were they?
- How would you describe your living conditions? If you feel comfortable, you can share about the quality of food, clothing, or overall care.
- How would you describe your relationships with staff?
- Did you feel safe sharing your identity with some or all of the staff? If so, why?
- How would you describe your relationship with caring and supportive adults and family outside of the congregate care placement?
- Was the treatment you received different because of your identity?
- How would you describe your relationships with other young people in the congregate care placement?
- Did you feel safe sharing your identity with some or all of the young people at the congregate care placement? If so, why?
- If you shared your LGBTQI+ identity while in care, how was it received? You can share whether you were treated differently, felt supported, or experienced abuse or mistreatment related to sharing your identity.
- How do you think that being placed in an [sic] congregate care placement impacted your ability to build relationships and connections with others?
- What impact did being placed in a congregate care placement have on the development of your LGBTQI+ identity?
- Were you treated differently from your peers because of your sexual orientation or gender identity?
- Did you experience any mistreatment, unfair treatment, or abuse from staff (including unreasonable restraint, seclusion, or search)? Feel free to share as much or as little as you're comfortable with.
- Did you experience any mistreatment, unfair treatment, or abuse from peers? Feel free to share as much or as little as you're comfortable with.
- If you experienced abuse or mistreatment, did you report it? If so, what was the response?
- Describe your access to health care, mental health support, and other services you needed while in congregate care. Did you feel your needs were met?

- Did you receive any services or support to meet your needs related to your sexual orientation or gender identity? If so, what support and services did you receive? Did those services meet your needs? If not, what did you need?
- Were the service providers that you received support from affirming of your sexual orientation or gender identity?
- What would it have meant to you to receive services that affirmed your sexual orientation or gender identity?
- If you did receive affirming services, what did it mean?
- How have your experiences in congregate care affected your life and well-being, both during your time there and after leaving? Please share any ways these experiences have influenced you.
- If there was a service that you received that was beneficial for you, what was that? What made it so valuable?
- What other information would you want advocates and policymakers to understand about your experience and the impact that had on you?