Written Testimony Presented to the
New York City Administration for Children's Services

On Close to Home: Draft Plan for Non-Secure Placement

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My comments are very much in support of ACS's Close To Home initiative but I am making some suggestions to strengthen it. I am a physician that is Executive Director of the HEAT Program (www.heatprogram.org), caring for HIV positive and high risk LGBTQ youth, ages 13-24 years in Brooklyn. My comments are largely focused on issues surrounding the medical care of transgender youth in ACS and OCFS custody, and are based on a significant wealth of experience treating transgender youth in ACS and OCFS custody.

In response to the ACS document "Guidelines for Promoting a Safe and Respectable Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved with DYFJ," I submit the following suggestions:

1) This document is far reaching and provides significant guidance to ACS staff in the provision of services to transgender youth, specifically. Although the document demonstrates an enlightened policy on ACS's behalf, implementation and day to day execution of it are two separate situations. Transgender health issues are relatively new to many (or most) youth medical and social service providers as well as juvenile justice administrators and facility staff. Although a policy can be enlightened, implementation of such a policy requires that providers and staff working with become not only "culturally sensitive" to the needs of transgender youth, but more importantly, "culturally competent". Cultural competency of persons working with this population need to better understand the implications of access to **appropriate** medical care and treatment.

   In my recent experience, I have come across a case where ACS was in favor of providing hormonal treatment to an 18 year old in ACS custody, but continues to ask questions as to the protocols for treatment, the specific hormonal regimen and other issues surrounding treatment that have led to the delay of approving the treatment's payment so as to initiate treatment. While this has led to an unfair and largely inexcusable delay in initiating treatment for this young person, it is also entirely conceivable that the same ACS officials responsible for this approval may be unfamiliar with what the proper and necessary hormonal treatment that the ACS policy is in favor of providing. For ACS to properly enact its own policy in this area, significant training as per treatment protocols and hormonal regimens should be provided to ACS personnel responsible for approval of such treatment.

   These issues are highlighted in the Teen SENSE Model Standards and Policies released earlier this year by The Center for HIV Law & Policy. *Model Policy: Training for Youth Facility Staff: Ensuring Competence that Includes the Rights and Needs of LGBTQ Youth* outlines the basic requirements for staff training on these issues. I strongly endorse the testimony submitted by The Center for HIV Law & Policy that underscores the need for very specific written standards on LGBTQ and HIV-related competence. The Center's *Model Staff Training Standards Focusing on the Needs of LGBTQ Youth in State Custody* is a fine example of written standards that help youth facility staff understand and protect the health and well-being of all young people, including LGBTQ youth and youth living with or at significant risk of HIV. The HEAT Program endorses these Model Standards and Policy, as well as The Center's *Model Sexual Health Care Standards for Youth in State Custody* and *Model Sexual Health Education Standards for Youth in State Custody.*

2) ACS would be advised to make two minor amendments to its policy above on page 5 of the "LGBTQ Guidelines". First, the guidelines (see page 5, second paragraph from the bottom of the page) refer to "accepted standards of care (see WPATH Standards of Care for GID)". GID is outdated terminology that refers to "gender identity disorder", a term that stigmatizes and pathologizes a person's gender identity. It has been largely dropped from use by the medical and psychiatric community and is considered by transgender individuals to be offensive. The actual title of the WPATH Standards of Care does not use the term GID, but the most current version of them (7th version) is properly titled "Standards of Care for the Health of Transsexual Transgender, and Gender Nonconforming People" (available at: http://www.wpath.org/publications_standards.cfm). Amending the LGBTQ guidelines to correct this minor error would demonstrate ACS's commitment to providing these young people with the most up to date care in a respectful manner.

   The second amendment I would strongly recommend is, in addition to citing the WPATH Standard of Care as part of its commitment to the care of these young people, ACS should also endorse and cite as a reference the Endocrine Society's Clinical Guidelines on the Endocrine Treatment of Transsexual Persons (2009) (available at: (http://www.endo-society.org/guidelines/final/upload/endocrine-treatment-of-transsexual-persons.pdf). This document has become the standard of treatment for most medical providers who care for transgender patients on hormonal therapy. ACS would be well served to endorse these clinical guidelines and familiarize its staff with their major points related to treatment so as to best avoid the types of delays in treatment as cited above. It will only be through familiarity with the best recommended medical practice in transgender hormonal treatment that ACS can provide access to this treatment in a timely fashion. Such delays are unwarranted, unfair to the youth involved and only cause further distress in their lives. That is clearly not ACS's intention with such an enlightened policy.

3) Finally, I would recommend consultation with Dr. Michael Cohen, the Medical Director of OCFS in Albany. Dr. Cohen has been highly successful in implementation of OCFS policies to provide access to transgender treatment to youth in OCFS custody at state facilities with medical providers around New York State. If this can be implemented for youth in detention facilities statewide, where medical providers may be far from the facilities, it should be much easier to implement more locally in New York City where a number of medical providers who provide transgender treatment to adolescents can be found in much closer proximity.