Children and Youth Services Review 91 (2018) 39–46

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

A comparison of LGBTQ youth and heterosexual youth in the child welfare system: Mental health and substance abuse occurrence and outcomes

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ARTICLE INFO

Keywords:
LGBTQ
Child welfare
System of care
Mental health disparities, mental health outcomes

ABSTRACT

Purpose: LGBTQ youth enter the child welfare system often because they are at higher risk of experiencing child maltreatment compared to youth who are heterosexual (Friedman, Marshal, Guadamuz, Wei, Wong, Saewye, & Stall, 2011), and due to family rejection, which places them at higher risk of suicide, higher levels of depression and are more likely to use substances (Ryan, Huebner, Dias & Sanchez, 2009). Using national data from the Substance Abuse and Mental Health Services Administration (SAMHSA), this study had two purposes; first to examine mental health disparities among LGBTQ youth and their heterosexual peers who are involved in the child welfare system, and second to observe the effectiveness of systems of care with youth in child welfare and if any differences exist between LGBTQ youth and heterosexual youth.

Methods: Chi-square and logistic regression were used to analyze differences at intake between youth who identified as LGBT or Q and their heterosexual counterparts. Repeated linear mixed modeling was used to evaluate the outcomes and to compare the groups at fixed time points (intake, 6-months, and 12-months).

Findings: The study found LGBTQ youth had higher levels of suicidal ideation, suicide attempts, depression, and gender identity related problems compared to the heterosexual youth in child welfare. All youth in the study experienced significant improvement, further supporting the effectiveness of system of care approaches. Recommendations are also discussed.

1. Introduction - state of child welfare

The child welfare literature examining strengths and challenges for youth who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ) is an emerging area of scholarship. LGBTQ youth are at higher risk of experiencing child maltreatment compared to youth who are heterosexual (Friedman et al., 2011). Additionally, LGBTQ youth who are rejected by their families are at higher risk of suicide, higher levels of depression and are more likely to use substances (Ryan et al., 2009). Maltreatment and family rejection based on sexual orientation or gender identities/expression are often the reasons LGBTQ youth enter the child welfare system (Mallon, Aledort, & Ferrera, 2002; Ryan, 2009).

Unfortunately, child welfare systems throughout the United States do not record the sexual orientation or gender identities/expression of youth who become involved in child welfare systems; therefore, it is impossible to state with any confidence the percentage of LGBTQ youth in the child welfare system. Study sample estimates have ranged from 11% (Dworsky, 2013) to 20% (Remlin, Cook, & Erney, 2017). For instance, one study reported that LGBTQ youth were overrepresented in foster care in the Los Angeles area, approximately 20% of foster youth identified as LGBTQ (Wilson, Cooper, Kastanis, & Nezhad, 2014). Once in the child welfare system, a number of factors exacerbate the mental health needs of LGBTQ youth. Many LGBTQ youths in the foster care system experience discrimination, violence, and intimidation from the very persons and system that are charged with caring for them (Banghart, 2013; Berberet, 2006; Irvine & Canfield, 2016, McCormick, Schmidt, & Terrazas, 2015; Mallon, 2001; 2002; Sullivan, Sommer, & Moff, 2001). LGBTQ youth also have increased challenges in transitioning from the child welfare system to adult living and have higher rates of health and behavioral risk factors and lower economic outcomes compared to heterosexual youth (Cochran, Stewart, Ginzler, & Cauce, 2002; Dworsky, 2013; Mitchell, Panzarello, Grynkiewicz, & Galupo, 2015).

The Child Welfare League of America (CWLA) has been working since 1991 to provide best practice guidelines for serving LGBTQ children and youth CWLA, 1991; 2006a, 2006b; 2012; but child welfare agencies have fallen short in fully embracing the CWLA

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https://doi.org/10.1016/j.childyouth.2018.05.016
Received 19 January 2018; Received in revised form 10 May 2018; Accepted 11 May 2018

recommendations (Rosenwald, 2009). Some states have adopted policies and practices addressing the needs of LGBTQ children and youth (CWLA, 2012), although only two states have system wide policies or mandatory training designed to prevent discrimination or provide appropriate services to protect LGBTQ youth (Sullivan et al., 2001; Lambda Legal 2001, Remlin et al., 2017). New York and California are the only two states that have comprehensive policies in place to protect youth who are lesbian, gay, bisexual, questioning, transgender or gender expansive (Remlin et al., 2017). Transgender youth, whose circumstances and needs are often misunderstood at a greater rate than other LGBTQ youth, experience poor treatment in the child welfare systems (Drescher & Haller, 2012; Grant et al., 2011). Given the lack of protection afforded LGBTQ youth in the child welfare systems, it is likely that they experience mental health challenges while in care.

The purpose of this study was to evaluate the mental health symptoms, substance use, strengths, and functioning of youth in the child welfare system who received services and supports through the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program, also known as the Children's Mental Health Initiative (CMHI). The study evaluated the mental health outcomes of youth and young adults in the child welfare system who are compared to those who identified as heterosexual. All of the youth in this study were experiencing a serious emotional disturbance (SED), received services and supports through a CMHI system of care community funded in 2009 or 2010, and participated in the national evaluation during the time they were receiving services.

1.1. About the Children's Mental Health Initiative

Since 1993, the Child, Adolescent and Family Branch in the SAMHSA has provided funding through cooperative agreements to states, counties, municipalities, tribal governments, and territories (CMHS, 2015). The mission of CMHI is to improve the behavioral health outcomes for children and adolescents experiencing SED and their families through providing services that are evidence-based, comprehensive, and coordinated across all child-serving entities. In order to be eligible to receive services through CMHI, the youth need to meet three eligibility requirements: have a diagnosable emotional, socio-emotional, behavioral, or mental disorder; unable to functional at home, in the community and/or in school or requires intervention from two or more community service agencies (ex. mental health, child welfare, juvenile justice, substance abuse); the disability must have been present for one year or longer and expected to last more than one year (SAMHSA, 2017).

CMHI is based on the values and principals espoused in the “system of care” framework, which include being strength based, culturally and linguistically competent, family driven and youth guided. Following the system of care framework, CMHI services are individualized based on the strength and needs of the youth, while reflecting the cultural, racial, ethnic, and linguistic differences in the community (Stroul & Blau, 2008). These same principals were highlighted in the landmark publication, LGBTQ Youth in Child Welfare (2006) as essential competencies for practices and strategies to meet the needs of LGBTQ youth in the child welfare system. Studies have found that children, youth, and young adults who receive system of care community services experience decreased mental health symptoms, suicide ideation and attempts, contacts with law enforcement, and use of inpatient services, along with improvements in school attendance and grades (CMHS, 2015; Haber, Cook, Kilmer, & Hemphill, 2010; Hemphill, Cook, & Kilmer, 2010; Manteuffel, Stephens, Brashears, & Krivelyova, 2008; Stroul, Goldman, Pires, & Manteuffel, 2012). As part of the national evaluation of CMHI, youth receiving services through a system of care community were asked to self-identify their sexual orientation and gender identity, which child welfare data systems do not have the ability to capture at this time.

Given the lack of accurate and comprehensive data on the percentage of LGBTQ youth in the child welfare system who are experiencing mental health and substance abuse challenges, we need to look at the literature on mental health disparities for LGBTQ youth not involved with child welfare systems to get some understanding about the extent of mental health problems.

1.2. Mental health disparities among LGBTQ youth (notes: Variations of LG/LGB/LGBT/LGBQ used in accordance with each study's participants)

In the United States alone, there are an estimated 1.3 million lesbian, gay, bisexual, and questioning (LGBQ) high school-aged young adults (Zaza, Kann, & Barrios, 2016). A growing body of literature reveals the disparities in mental health-related outcomes between LGBTQ and their heterosexual peers (Meyer, 2003; Zaza et al., 2016). Specifically, depressive symptoms, suicidality, victimization, and substance abuse rise as critical factors to healthy development (IOM, 2011; Lewis, 2009; Shearer et al., 2016; Zaza et al., 2016).

Of critical importance is the elevated prevalence of suicidality among LGBTQ youth. LGBQ individuals face significant risks for suicidality (suicidal ideation, making a suicide plan, suicide attempts, and attempts requiring medical intervention) (Fergusson, Horwood, & Beautrais, 1999; IOM, 2011; Zaza et al., 2016), particularly young gay and bisexual men (Lewis, 2009). While gender or gender expansive expression did not significantly predict suicidality, impulsivity, a past history of suicide attempts, LGBT-specific victimization, and weak social supports did (Liu & Mustanski, 2012). In particular, those with past suicide attempts were 2.5 times as likely to harm themselves after experiencing LGBT-specific victimization (Liu & Mustanski, 2012). Moreover, Marshal et al.'s (2011) meta-analysis of 19 suicidality studies found that LGB females and males were more likely to have a history of suicidality than their heterosexual peers. At greatest risks were bisexual participants who reported an approximate five-fold increase in suicidality. Marshal et al. (2011) also identified differences in the severity of suicidal experiences. As the severity of suicidality increased across the entire sample (for example 28% of LGB reported a history of suicidality as compared to 12% of heterosexual), LGB youth had greater rates of suicidality than heterosexuals.

Compounding disparities in mental health is the greater likelihood of increased substance use among LGBTQ youth. LGBT youth were at increased risks for substance use than heterosexual youth (IOM, 2011; Reisner, Greytak, Parson, & Ybarra, 2014). Nicotine dependence was 5 times as likely to occur and other substance abuse was almost 2 times as likely among LGB youth. A meta-analysis examining mental health issues with sexual minorities also supported elevated rates of substance abuse among LGB youth (Lewis, 2009). More recently, Zaza et al. (2016) not only found LGB youth were at greater risks for cigarette, alcohol, and marijuana use, but also a pervasive use of hallucinogens, heroin, methamphetamines, and prescription drug abuse (Zaza et al., 2016). Given these findings, the current study provides an important first step in understanding the needs of LGBTQ youth in the child welfare system.

This study is significant in that it evaluates functional outcomes for young people identified as LGBTQ based on a specialized service framework (i.e., system of care approach).

It builds on existing research by answering the following research questions:

1) How did the LGBTQ identifying youth and young adults compare at intake into CMHI SOC services with their non-LGBTQ counterparts on history of suicidal ideation and suicide attempts, being bullied or cyber-bullied, being a victim of a sexual or physical assault, and history of physical illness?
2) How did the LGBTQ identifying youth and young adults compare at intake into CMHI SOC services with their non-LGBTQ counterparts on levels of depression, anxiety, substance use/abuse, functioning and strengths?