Office of the General Counsel

3211 FOURTH STREET NE • WASHINGTON DC 20017-1194 • 202-541-3300 • FAX 202-541-3337

<u>Submitted Electronically</u>

November 13, 2023

U.S. Department of Health & Human Services
Administration for Children and Families
Mary E. Switzer Building
330 C Street, S.W.
Washington, D.C. 20201

Subj: Safe and Appropriate Foster Care Placement Requirements
RIN 0970-AD03

Dear Sir or Madam:

On behalf of the United States Conference of Catholic Bishops (USCCB), we respectfully submit the following comments on the proposed regulations, published by the Administration for Children and Families (ACF) of the Department of Health and Human Services at 88 Fed. Reg. 66752 (Sept. 28, 2023), on foster care placement requirements.

Some provisions of the proposed regulations establish laudable norms for the placement of children in foster care. The regulations would, for example, require placements that are "safe" and "appropriate," an environment free of "hostility," "mistreatment," and "abuse," and access to services that support the child's "health" and "well-being." One troublesome feature of the proposed regulations, however, is that they make these requirements applicable not to *all* minors, but only to those who present issues with respect to gender identity or sexual orientation (SOGI). In fact, *every* child in the foster care system should be provided with a safe, appropriate placement. *No* child should be subjected to hostility, mistreatment, or abuse of any kind, or be denied services that support his or her health and wellbeing. These norms should apply to *all* minors and should not be limited in their application to some subset of minors or to SOGI-specific cases.

Other provisions of the proposed regulations are problematic because they propose, incorrectly, that gender affirmance is the only and best way to treat gender dysphoria. ACF asserts that gender affirmance is in the "best interests" and meets the "special needs of the child." The regulations would therefore require agencies to ensure that children "who identify as LGBTQI+" have access to "services that are *supportive* of their sexual orientation and gender identity, including clinically appropriate mental and behavioral health supports." At the same time, the regulations would prohibit attempts to "undermine, suppress, or change the sexual orientation or gender identity of a child." These provisions, read together, mean not that children *as persons* must be affirmed and supported, as they should, but that *specific inclinations*

or behaviors with respect to SOGI—and *only* those inclinations and behaviors, no matter how confused, inconsistent, transitory, or ambivalent—must be affirmed. If that is the intent, then the proposed regulations in our view likely violate ACF's statutory duty to provide safe and proper care for children, a duty that can only be carried out faithfully by careful attention *to the whole person* and not just affirmation of one set of behaviors or affective traits in isolation. Only through a whole-person approach are the best interests of the child truly taken into account and the child's special needs met.

These observations ring especially true for gender dysphoria. Experts report that, in the vast majority of cases (roughly nine out of 10), gender dysphoria is resolved in favor of an individual's biological sex. This militates against a gender-affirming approach and in favor of a wait-and-see approach during childhood, accompanied by individual or family psychotherapy and placement in a foster care setting that is unconditionally loving. By requiring a gender-affirming approach to gender dysphoria, the proposed regulations ignore a substantial body of evidence on the health risks associated with that approach and the positive outcomes associated with alternatives.

ACF's proposal to adopt an exclusively orientation-affirming approach to same-sex attractions in minors presents similar problems.

Lastly, while the preamble to the regulations helpfully acknowledges the government's obligation to accommodate the conscience rights of private foster care providers, the regulations themselves are silent on this subject. As to such rights, we believe the regulatory text should mirror the statements in the preamble.

Our more detailed comments, set out below, consist of four parts:

•In Part I, we endorse many of the general requirements described in the proposed regulations, but urge ACF to make these requirements applicable to all minors rather than limit them to a class of minors or to SOGI issues.

•In Part II, we cite evidence adduced by experts that gender dysphoria (GD) in minors is satisfactorily resolved in the vast majority of cases without gender-affirming care. We discuss the demonstrated harm of a gender-affirming treatment, and we discuss the successful outcomes of alternative approaches. We also highlight the personal accounts of individuals who say they were injured by the gender-affirming interventions they received as minors, interventions for which the proposed regulations would lay the groundwork if not facilitate.

•In Part III, we discuss problems with requiring an orientation-affirming approach to same-sex attractions in minors, as these proposed regulations would do.

•In Part IV, we discuss the need to protect the conscience rights of private providers, protection that the preamble acknowledges is necessary and appropriate but that the proposed regulatory text does not address.

I. Safe and Appropriate Care for Minors

The opening paragraph of proposed Section 1355.22(a) states that the title IV-E/IV-B agency "must meet the following requirements for each child in foster care who identifies as lesbian, gay, bisexual, transgender, queer or questioning, or intersex, as well as each child who is non-binary or has non-conforming gender identity or expression (LGBTQI+)." 88 Fed. Reg. at 66768. Thus, judging from the opening paragraph, the requirements set out in Section 1355.22 appear to relate only to a subclass of minors, not all minors.

Immediately following this opening paragraph, and in apparent conflict with the intended limited scope of Section 1355.22 announced in that paragraph, Paragraph (1) states: "The title IV-E/IV-B agency must ensure that a safe and appropriate placement is available for and provided to *all children* in foster care, *including* those who identify as LGBTQI+." 88 Fed. Reg. at 66768 (emphasis added).

Subsequent paragraphs in subsection (a) shift again to a subclass of minors. Those paragraphs state, for example, that for a placement to be considered "safe and appropriate *for an LGBTQI+ child*," the agency must adhere to specified requirements. For example, the agency must "establish an environment free of hostility, mistreatment, or abuse *based on the child's LGBTQI+ status*." 88 Fed. Reg. at 66768 (proposed Section 1355.22(a)(1)(i)) (emphasis added). The agency must facilitate the child's access to services "that support their health and well-being." *Id*. (proposed Section 1355.22(a)(1)(iii)). And the process for reporting concerns about placements "must safeguard the privacy and confidentiality of the child…." *Id*. (proposed Section 1355.22(a)(3)).

It is not clear why the requirement of a safe and appropriate placement, access to services that support the minor's health and well-being, or the protection of his or her privacy, should apply only to a subset of minors, or why the prohibition against hostility, mistreatment, or abuse should be limited to acts or omissions predicated on SOGI. We believe that these requirements—a safe and appropriate placement, access to services that support a minor's health and well-being, and the safeguarding of a child's privacy—should be required for all minors. Likewise, all minors should be free from hostility, mistreatment, or abuse of any kind, whether or not predicated on SOGI.

For these reasons, it would be helpful, in our view, to set out in the regulations the general requirements for foster care placements, and those requirements should apply to all children. Otherwise, it appears that minors presenting SOGI issues are guaranteed rights to care and treatment that are not guaranteed to other minors, and that such protections apply only when a prohibited act or omission is presented in a SOGI context.

II. Gender Identity

The proposed regulations would require agencies to ensure that children "who identify as LGBTQI+," regardless of age or circumstance, have access to "services that are *supportive* of their … gender identity…." 88 Fed. Reg. at 66768 (proposed Section 1355.22(a)(5)) (emphasis added). This is based on the proposition, asserted by ACF, that gender affirmance is in the "best

interests" and meets the "special needs of the child." 88 Fed. Reg. at 66758. The regulations do not specify what services ACF deems "supportive" other than to say that it "includ[es] clinically appropriate mental and behavioral health supports." 88 Fed. Reg. at 66768 (proposed Section 1355.22(a)(5)). The preamble states that these supports include at least "utiliz[ing] the child's identified pronouns, chosen name, and allow[ing] the child to dress in an age-appropriate manner that the child believes reflects their self-identified gender identity and expression." 88 Fed. Reg. at 66757. The regulations do not say whether hormone therapy and puberty blockers are among the "services" or "supports" that should be provided to minors, but neither do they exclude them. In any event, utilizing identified pronouns, chosen name, and cross-dressing would lay the groundwork for other interventions such as hormone therapy, puberty blockers, and even surgery. In addition, the proposed regulations would prohibit "attempts to undermine, suppress, or change the … gender identity of a child." 88 Fed. Reg. at 66768 (proposed Section 1355.22(a)(4)).

Read together, these various provisions require care that "affirms" or "supports" a minor's self-expressed gender identity; every other approach is prohibited. We believe that the requirement of gender-affirming care, and the prohibition of alternative approaches that are effective and less risky than gender-affirming care, violate the ACF's statutory duty to provide for the care and appropriate placement of minors. 42 U.S.C. § 675(1)(B) (stating that children in foster care must receive "safe and proper" care).

The first duty of the health professions is to do no harm. The proposed regulations, in our view, do not pass that fundamental test. "According to the DSM-5, as many as 98% of gender confused boys and 88% of gender confused girls eventually accept their biological sex after naturally passing through puberty." American College of Pediatricians, *Gender Ideology Harms Children* ¶5 (Sept. 2017), https://cplaction.com/wp-content/uploads/Gender-Ideology-Harms-Children.pdf, citing American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013). Clinicians cannot reliably identify the small percentage of children whose gender dysphoria will not naturally resolve from others. Brief of *Amici Curiae* Dr. Paul R. McHugh, M.D., Dr. Paul Hruz, M.D., Ph.D., and Dr. Lawrence S. Mayer, Ph.D. in Support of Petitioner (Jan. 10, 2017), at 13, *Gloucester County Sch. Board v. G.G.*, No. 16-273 (U.S.) ("[T]here is no evidence that any clinician can identify the perhaps one-in-twenty children for whom gender dysphoria will last with anything approaching certainty.").

The high-resolution rate, and the inability to identify with any degree of confidence those whose gender dysphoria will not resolve, have important consequences for treatment. "Because such a large majority of these children will surely naturally resolve their confusion, proper medical practice calls for a cautious, wait-and-see, approach for all gender dysphoric children." *Id*. "This sensible approach can be and often is rightly supplemented in many cases by family or individual psychotherapy to identify and treat the underlying problems which present as the belief that one belongs to the opposite sex." *Id*. at 13-14.

Appropriate therapy should not accept at face value incorrect or distorted thinking about one's own body. On this point, the Catholic Medical Association draws a helpful analogy:

> Health care professionals must not affirm what is not true. Cognitive Based

> Therapy (CBT) has been shown to be useful in treating other body dysphoria disorders associated with increased risk of death, such as anorexia nervosa. Persons with GD would benefit from such treatment of depression and anxiety along with aggressive counseling and medications directed to those conditions.[1]

Treatment of children who suffer from gender dysphoria should always be accompanied by unconditional love for the child:

> Parents and guardians [or, in the present regulatory context, foster parents] must show unconditional love if confronted with a child who professes to be transgender and demands affirmation which denies the reality of biological sex. Parents and guardians must be free to determine how best to address lovingly this challenge through informed consent that is not obstructed by policies that deny that right. It is best to enter into dialogue and allow the child to tell his or her story. At the same time, the parents should gently inform the child of the correct scientific data.[2]

Experts in this field have suggested that a gender-affirming approach, far from being helpful, may be harmful for minors because it "interfere[s] with the natural progress of psycho-sexual development." Brief of *Amici Curiae* Dr. Paul R. McHugh *et al*., *supra* at 14; *see also* Brief of *Amicus Curiae* Christian Medical and Dental Association, *Tingley v. Ferguson*, at 8, No. 22-942 (U.S.) ("Because the rate of desistance is so high, … GTPs [gender-transition procedures] will necessarily cause serious and irreversible harm to many children and adolescents who would naturally outgrow the condition if not 'affirmed.' Moreover, evidence suggests that minors who are pushed further into their gender confusion by trusted adults (such as parents and medical professionals) will continue down that path."), and studies cited therein.

Experts also point to the lack of reliable evidence supporting a gender-affirming approach generally. "Importantly, there are no long-term, longitudinal, control studies that support the use of gender-affirming policies and treatments for gender dysphoria." Brief of Amici Curiae Dr. Paul R. McHugh *et al*., *supra* at 14. Affirming a child's gender identity at a social level (such a by change of pronouns and dress) lays the groundwork for, and indeed is often accompanied by, hormonal and other interventions, either during minority or adulthood, that carry still more health risks:

> Cross-sex hormones as associated with dangerous health risks. Estrogen administration to boys will place them at risk of developing thromboembolism, elevated lipids, hypertension, decreased glucose tolerance, cardiovascular disease, obesity, and breast cancer. Girls provided with high-dose testosterone will be at risk of developing elevated lipids, insulin resistance, cardiovascular disease, obesity, polycythemia, and unknown effects on breast, endometrial, and ovarian tissues. Children who receive puberty blocking hormones followed by cross-sex hormones

[1] Catholic Medical Association, *The Ideology of Gender Harms Children* (Sept. 8, 2023), at https://www.cathmed.org/resources/the-ideology-of-gender-harms-children/.

[2] *Id*.

prior to completion of gonadal maturation risk permanent sterilization.[3]

Gender-affirming interventions are also linked to adverse mental health outcomes. "New research from the United Kingdom is showing that over a third of children placed on puberty blockers and hormone drugs suffered severe mental health deterioration afterward." S.A. McCarthy, *UK Report: Over One-Third of Children on Puberty Blockers Experienced Worsened Mental Health*, THE DAILY SIGNAL (Sept. 25, 2023), at https://www.dailysignal.com/2023/09/25/uk-report-over-one-third-of-children-on-puberty-blockers-experienced-worsened-mental-health. Suicide rates are elevated to an extraordinary degree:

> Rates of suicide are nearly twenty times greater among adults who use cross-sex hormones and undergo sex reassignment surgery, even in Sweden which is among the most LGBTQ-affirming countries.[4]

The harms associated with gender-affirming care,[5] and the absence of credible evidence of long-term benefits from such care,[6] have led to changes in the treatment of gender dysphoria in Europe. At least five European nations—Great Britain, Sweden, Finland, France and Denmark—have "restricted the use of puberty blocking drugs in children with GD. Researchers in these countries posed the question that the treatment protocol could be ideology driven and not evidence based."[7] Dr. Riittakerttu Kaltiala, one of the first physicians in the world to head a clinic devoted to the treatment of young people diagnosed with gender dysphoria, states: "My country [Finland], and others, found there is no solid evidence supporting the medical transitioning of young people. Why aren't American clinicians paying attention?" Dr. Riittakerttu Kaltiala, *Gender-Affirming Care is Dangerous. I Know Because I Helped Pioneer It*, THE FREE PRESS (Oct. 30, 2023), at https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor. Along similar lines, Jathon Sapsford and Stephanie Armour caution that the medical community in the United States is becoming increasingly isolated in its views

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[3] Catholic Medical Association, *supra* (citation omitted). *See also* American College of Pediatricians, *Gender Ideology Harms Children*, *supra* at ¶6 ("Pre-pubertal children diagnosed with gender dysphoria may be given puberty blockers as young as eleven, and will require cross-sex hormones in later adolescence to continue impersonating the opposite sex. These children will never be able to conceive any genetically related children even via artificial reproductive technology. In addition, cross-sex hormones (testosterone and estrogen) are associated with dangerous health risks including but not limited to cardiac disease, high blood pressure, blood clots, stroke, diabetes, and cancer."); Brief of *Amius Curiae* Christian and Dental Association, *supra* at 9-12 (providing a long list of health risks and citing studies).

[4] American College of Pediatricians, *Gender Ideology Harms Children*, *supra* at ¶7.

[5] The risks of hormone therapy and puberty blockers are so great that at least 21 states have barred the practice for minors. *L.W. v. Skrmetti*, 83 F.4th 460, 471 (6th Cir. 2023) (listing 19 states in addition to Tennessee and Kentucky).

[6] See Paul Dirks, *Transition as Treatment: The Best Studies Show the Worst Outcomes*, THE PUBLIC DISCOURSE (Feb. 16, 2020) ("The mainstream narrative often says that medical transition is well-studied, and that there is academic consensus on its effectiveness. In reality, the literature is fraught with study design problems, including convenience sampling, lack of controls, cross-sectional design, small sample sizes, short study lengths, and enormously high drop-out rates among participants."), at https://www.thepublicdiscourse.com/2020/02/60143/.

[7] Catholic Medical Association, *The Ideology of Gender Harms Children*, *supra* (citations omitted).

on treatment for gender dysphoria:

> The U.S. is becoming an outlier among many Western nations in the way its national medical institutions treat children suffering from distress over gender identity.
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> For years, the American healthcare industry has staunchly defended medical interventions for transgender minors, including puberty blockers, which suppress the physical changes of adolescence as a treatment for those distressed over their gender.
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> The European medical community, by contrast, is expressing doubts about that approach. Having allowed these treatments for years, five countries—the U.K., Sweden, Finland, Norway and France—now urge caution in their use for minors, stressing a lack of evidence that the benefits outweigh the risks. This month, the U.K.'s publicly funded National Health Service for England limited the use of puberty blockers to clinical trials, putting the drugs beyond the reach of most children.
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> "These countries have done systematic reviews of evidence," said Leor Sapir, a fellow who studies transgender care at the conservative-leaning Manhattan Institute think tank. "They've found that the studies cited to support these medical interventions are too unreliable, and the risks are too serious."[8]

Such reports suggest a need for caution.

Personal accounts of persons who have undergone gender transition procedures and are now seeking damages for what they claim are the resulting injuries serve as a further cautionary tale.

Take the case of Chloe Brockman.

Earlier this year, Chloe sued her doctors and health care providers for injuries she alleges resulted from the defendants' gender-affirming approach. *Brockman v. Kaiser Foundation Hospitals*, No. STK-CV-UMM-2023-0001612 (Cal. Super. Ct., County of San Joaquin, Stockton Branch) (filed Feb. 22, 2023). Her court-filed complaint states:

> ¶1. This case is about a team of doctors (i.e., the Defendants) who decided to perform a mutilating, mimicry sex change experiment on Chloe, then a thirteen-year-old vulnerable girl struggling with complex mental health co-morbidities, who needed love, care, attention, and regular weekly psychotherapy, not cross-sex

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[8] Jathon Sapsford and Stephanie Armour, *U.S. Becomes Transgender-Care Outlier as More in Europe Urge Caution* WALL STREET JOURNAL (June 19, 2023), at https://www.wsj.com/articles/u-s-becomes-transgender-care-outlier-as-more-in-europe-urge-caution-6c70b5e0. *See also L.W. v. Skrmetti*, 83 F.4th at 477 (noting that "some of the same European countries that pioneered these treatments [of puberty blockers and hormone therapies for gender dysphoria] now express caution about them and have pulled back on their use.").

hormones and mutilating surgery.

¶3. … Chloe developed the erroneous idea that she was a boy…. Defendants immediately affirmed Chloe in her self-diagnosed gender dysphoria. They did not question, elicit, or attempt to understand the psychological events that led her to this belief, nor did they seek to evaluate or appreciate her multi-faceted presentation of co-morbid symptoms…. Defendants assumed that Chloe, a thirteen-year-old emotionally troubled girl, knew best what she needed to improve her mental health and handed her the prescription pad. They quickly put her on the puberty blockers and hormones "conveyer belt" of mimicry sex change. There is no other area of medicine where doctors will surgically remove a perfectly healthy body part and intentionally induce a diseased state of pituitary gland function based simply on the patient's wishes. Thus, they abetted her erroneous notion that she could change her sex.

¶4. Under Defendants' "care," between ages 13-17 years, Chloe underwent harmful transgender transition, specifically, off-label puberty blockers and cross-sex hormone "treatment," and a radical double mastectomy of her healthy breasts. There is at least one high quality, large scale, 30-year, population-based study that demonstrated that transgender individuals who chemically/surgically "transition" have poor mental health outcomes. This includes increased psychological morbidity, increased suicidal ideation and attempt, and a *19-fold increased rate of suicide as compared with the general population*. The studies that purportedly support positive outcomes for this "gender affirmation" treatment are "low to very low-quality studies," meaning they present a significant risk of containing erroneous conclusions and present a significant risk that patients will not attain the purported desired outcomes of treatment. In contrast, multiple reliable studies consistently indicate that *between 80% and 90% of minors that present with gender dysphoria accept their biological sex by late adolescence*. These risks all materialized in Chloe's case. She did not experience any long-term relief from her gender dysphoria treatment. Rather, her mental health ideation condition declined as she proceeded through this treatment, and she eventually developed suicidal ideation after her radical double mastectomy, which symptoms she never experienced prior to this so-called "gender affirmation treatment."

¶7. … [A]s a result of the so-called transgender "treatment" that Defendants performed on Chloe, she now has deep physical and emotional wounds, severe regrets, and distrust of the medical system. Chloe has suffered physically, socially, neurologically, and psychologically. Among other harms, she has suffered mutilation to her body and lost social and physical development along with her peers, and at key developmental milestones that can never be regained.

¶8. Chloe was the victim of Defendants who did not have any interest in taking the time necessary to sit with her and perform the regular, weekly psychotherapy that Chloe needed. Defendants grossly breached the standard of care by pushing Chloe into this harmful experimental treatment regimen without a proper period of

psychological evaluation, without evaluating and treating her serious co-morbidities, without providing informed consent, and while actively utilizing emotionally super-charged and false information to derail the rational decision-making process of Chloe and her parents. Defendants were not "caring" for Chloe, they were experimenting on her, and doing so all to their own great financial benefit.

Or take the case of Luka Hein.

On September 13 of this year, Luka sued her health care providers and physicians for injuries she alleges resulted from gender-affirming care. *Hein v. UNMC Physicians*, No. D01C1230007381 (Neb. Dt. Ct. Douglas County) (filed Sept. 13, 2023). Her complaint states:

> ¶1. When Luka was just 16-years-old, her breasts were surgically amputated as the first step in her "gender affirming care" with the Defendants.
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> ¶20. The [defendant] clinic earned the Top Performer badge [from the Human Rights Campaign] because UNMC faculty operate on the "gender affirming" model. This means that UNMC staff do not question a patient's self-diagnosis of transgender identification, no matter their age or the root issues from which they suffer. Rather, UNMC faculty "affirm" the chosen gender identity of the patient and then undertake pharmacological and surgical interventions based on what is known as the "Dutch Protocol."
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> ¶21. The Dutch protocol was based on a poorly designed study of transgender patients who received puberty blockers, cross-sex hormones and/or surgery in the early 2000's. The first obvious weakness of the study is that there was no control group. The second flaw was the "cherry picking" of subjects: beginning with 111 adolescents, researchers excluded those whose treatment with puberty-blockers "did not progress well." Thus, the data set excluded precisely those patients who were harmed by or dissatisfied with their treatment. Thirdly, due to poor follow-up the study ended with an even smaller sample of 55 patients. Of these, only forty completed the study.
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> ¶31. Rather than treating gender dysphoria, the affirming model conditions children toward transgender identification by encouraging social transition, chest binding, opposite sex pronouns, cross-sex hormones and surgery.
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> ¶33. By immediately affirming Luka, Defendants developed a type of transgender tunnel vision that blocked out the other factors that were or may have been the cause or causes of Luka's dysphoria.
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> ¶35. Defendants … were negligent in failing to question Luka's self-diagnosis, instead "affirming" her toward irreversible chemical and surgical solutions.
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> ¶36. … Defendants negligently "affirmed" Luka's new gender identity during a time in her life when she was going through profound personal upheaval, trauma,

and distress – and was simply too young to understand the irreversible implications of the transgender "treatment" recommended, prescribed, and carried out by Defendants.

¶37. In marketing their services, Defendants use pleasant sounding descriptions such as "masculinizing hormone therapy," "gender affirming hormones," and "gender affirming surgery for chest."

¶38. The use of "therapy" for these services is deceptive. The plain meaning of "therapy" is "medicinal or curative." The procedures marketed by Defendants are neither. In fact, they are the opposite. Rather than healing, these procedures inflict harm that causes malfunctioning and malformation of the teenage body and brain.

¶40. Defendants deceive gender-distressed patients by leading them to believe that chemical and surgical procedures will medically "transition" them from male to female and vice versa. This is not reality. In fact, it is not medically or biologically possible. Leading patients toward a false horizon is not compassionate or "affirming"; it is deceptive….

¶125. By using deceptive descriptions and making misleading claims about the nature of their "gender affirming" therapies, Defendants conditioned Luka to accept their recommendations of transgender intervention.

¶130. As a proximate result of the actions of the Defendants, … Luka's breasts were surgically amputated, leaving her physically and psychologically scarred. If she has not also suffered the loss of her fertility, Luka has lost her ability to breastfeed thereby depriving her of the maternal benefits of nursing. Luka's future children will be deprived of the natural bonding effects and nutritional benefits of breastfeeding.

¶131. As a proximate result of the actions of the Defendants …, Luka was placed on testosterone for 4 years which caused the disruption of her endocrine system, heart damage, deepening of her voice, pain in her vocal cords, joints, lumbar spine, hands, wrists, elbows and pelvic area, as well as permanent dysregulation of her reproductive organs.

These reports by individuals who underwent gender-affirming interventions are strong cautions against ACF's proposal to require gender-affirming care and to rule out alternatives. The American Academy of Pediatrics' endorsement of a gender-affirming approach to gender dysphoria, by contrast, has come under sharp criticism:

Although almost all clinics and professional associations in the world use what's called the *watchful waiting* approach to helping transgender and gender diverse (GD) children, the AAP statement rejected that consensus, endorsing only *gender affirmation*. That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition. With AAP taking such a

> dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy, however, I was pretty surprised—rather alarmed, actually: These documents simply did not say what AAP claimed they did. In fact, the references that AAP cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing *watchful waiting*.
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> The AAP statement was also remarkable in what it left out—namely, the actual outcomes research on GD children. In total, there have been 11 follow-up studies of GD children, of which AAP cited one (Wallien & Cohen-Kettenis, 2008), doing so without actually mentioning the outcome data it contained. The literature on outcomes was neither reviewed, summarized, nor subjected to meta-analysis.… As they make clear, *every* follow-up study of GD children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition. AAP is, of course, free to establish whatever policy it likes on whatever basis it likes. But any assertion that their policy is based on evidence is demonstrably false….

James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. OF SEX AND MARITAL THERAPY at 1-2 (Dec. 14, 2019).[9] Last month the AAP was named as a defendant in a lawsuit brought by Isabelle Ayala, who alleges that the Academy and other defendants engaged in a civil conspiracy to "fraudulently and misleadingly misrepresent[] the evidence" in support of gender-affirming care with the effect of "mislead[ing] or deceiv[ing] members of the public." *Ayala v. American Academy of Pediatrics*, No. PC-2023-05428 (R.I. Super. Ct., Providence/Bristol County), Complaint ¶ 96 (filed Oct. 23, 2023), at https://dw-wp-production.imgix.net/2023/10/Ayala-v-AAP-Complaint_stamped.pdf. Ayala alleges that the defendants have continued to advocate for gender-affirming care "despite (1) immediate criticism that its stated evidence base was misleadingly presented and/or failed to actually support any of its recommendations, conclusions, or proposed treatments, and (2) a growing international skepticism for the evidence base for the recommended interventions and concerns about their harms." Complaint, ¶ 1.

Critics state that the endorsement of a gender-affirming approach has been driven by politicization of this field, a rush to judgment, and a failure to submit to careful scientific scrutiny, all to the detriment of patients:

> [T]he field [of youth gender transition] has a penchant for exaggerating what is known about the benefits of the practice, while downplaying the serious health risks and uncertainties. As a result, a false narrative has taken root. It is that "gender-affirming" medical and surgical interventions for youth are as benign as aspirin, as well-studied as penicillin and statins, and as essential to survival as insulin for

[9] *See also* Aaron Sibarium, *The Hijacking of Pediatric Medicine*, THE FREE PRESS (Dec. 7, 2022) (stating that AAP statement "was an extraordinary departure from the international medical consensus. Most European countries do not encourage social or physical transition until a child's gender dysphoria has persisted for quite some time—an approach known as 'watchful waiting'—in part because the dysphoria desists on its own in the majority of cases, particularly once puberty hits."), at https://www.thefp.com/p/the-hijacking-of-pediatric-medicine.

> childhood diabetes—and that the vigorous scientific debate currently underway is merely "science denialism" motivated by ignorance, religious zeal, and transphobia. This highly politicized and fallacious narrative, crafted and promoted by clinician-advocates, has failed to withstand scientific scrutiny internationally, with public health authorities in Sweden, Finland, and most recently England doing a U-turn on pediatric gender transitions in the last 24 months. In the U.S., however, medical organizations so far have chosen to use their eminence to shield the practice of pediatric "gender affirmation" from scrutiny. In response to mounting legal challenges, these organizations have been exerting their considerable influence to insist the science is settled. We argued [in a previous paper] that this stance stifles scientific debate, threatens the integrity and validity of the informed consent process—and ultimately, hurts the very patients it aims to protect.

E. Abbruzzese, Stephen B. Levine, and Julia W. Mason, *The Myth of "Reliable Research" in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—And Research That Has Followed*, 49 J. OF SEX & MARITAL THERAPY 673, 673-74 (2023) (citations omitted), at https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2150346.

The same authors note that "more than a quarter of the patients" who have undergone gender transition subsequently regret it. *Id*. at 691. By their own account, so do Chloe Brockman, Luka Hein, and Isabelle Ayala. As their cases illustrate, it is a mistake to take a child's self-expressed gender identity at face value and to exclude all other factors. Children themselves may be ambivalent or conflicted as to their gender identity. Brockman's, Hein's, and Ayala's court filings suggest that a single-minded focus on affirming a child's self-perceived gender identity—however confused, transitory, or ambivalent—to the exclusion of all else, is associated with harmful outcomes. What is needed is affirmation of the child *as a whole person*. Such whole-person affirmation does the most to ensure that the best interests of the child will truly be taken into account and that his or her special needs will be met. *See*, *e.g*., Archdiocese of Portland in Oregon, *A Catholic Response to Gender Identity Theory* (Jan. 25, 2023) (recommending whole-person affirmation, rather than confirmation of gender identity, as an appropriate response to gender dysphoria), at https://archdpdx.org/gender.

Our principal point is that the proposed requirement of a gender-affirming approach is not in the best interests of children. From the argument and evidence we have offered in support of that point, it also follows that a prospective foster parent should not be excluded from the foster care program on the ground that he or she does not agree with or implement a gender-affirming approach to gender dysphoria, and this is true whether or not the foster parent's views on this point are based on religious or secular grounds (or both).

III. Sexual Orientation

The proposed regulations would require agencies to ensure that children "who identify as LGBTQI+" have access to "services that are *supportive* of their sexual orientation…." 88 Fed. Reg. at 66768 (proposed Section 1355.22(a)(5)) (emphasis added). The regulations do not specify what services it deems "supportive" of sexual orientation other than to say that it "includ[es] clinically appropriate mental and behavioral health supports." *Id*. The proposed

regulations would prohibit "attempts to undermine, suppress, or change the sexual orientation … of a child…." 88 Fed. Reg. at 66768 (proposed Section 1355.22(a)(4)).

Read together, these provisions require care that "affirms" or "supports" a minor's self-expressed sexual orientation and forbid other approaches with positive outcomes. We believe this requirement and prohibition violate ACF's statutory duty to provide for the appropriate care and placement of minors. 42 U.S.C. § 675(1)(B) (children in foster care must receive "safe and proper" care).

Children, as noted earlier, are best supported in a loving environment that treats and affirms them as whole persons. A tunnel-vision approach that requires confirmation of one set of affective traits or behaviors to the exclusion of all other factors does them a disservice. Children and adolescents with same-sex attraction, in particular, can be at serious risk for personal difficulties, including suicidal ideation and attempts. *See* USCCB, *Ministry to Persons with a Homosexual Inclination*, at 22-23 (2006), at https://www.usccb.org/issues-and-action/human-life-and-dignity/homosexuality/upload/minstry-persons-homosexual-inclination-2006.pdf. They should have access to age-appropriate counseling services, and such services should retain the latitude to address the needs of each child. In its *Ministry to Persons with a Homosexual Orientation*, the USCCB affirms that "[e]very effort should be made to ensure that adolescents have access to age-appropriate professional counseling services that respect Church teaching in matters of human sexuality." *Id*. at 23. Adolescents raised as Catholic and foster parents who practice that faith should not be walled off from receiving or procuring such services.

We believe that the proposed regulations, by mandating the affirmation of same-sex attraction and forbidding all other approaches, fail to adequately protect the best interests of all children and violate ACF's statutory duty to ensure a foster care environment that is safe and appropriate. It also follows that a prospective foster parent should not be excluded from the foster care program on the ground that he or she does not agree with or implement an orientation-affirming approach, whether or not the parent's views on this point are based on religious or secular grounds (or both).

IV. <u>Religious Liberty</u>

The preamble to the proposed regulations includes many laudable statements about religious liberty and other freedoms. 88 Fed. Reg. at 66761-62.

For example, ACF notes the importance of "ensuring that religious organizations are eligible on the same basis as any other organization to participate in child welfare programs administered with title IV-E and IV-B funds." *Id*. at 66761. ACF states that it "takes seriously its obligations to comply with the Constitution and Federal laws that support and protect religious exercise and freedom of conscience," including the First Amendment and RFRA. *Id*. ACF states that it "will continue to operate the title IV-E and IV-B programs in compliance with these legal requirements." *Id.*

ACF states that it intends to give states and tribes "the flexibility to implement" the rules "without imposing any substantial burden on providers' religious exercise…." *Id*. "Most

importantly, nearly all of the requirements in this proposed rule would be imposed directly on state and tribal IV-E/IV-B agencies, as opposed to on any private foster care agency, foster parent, kinship caregiver or other provider." *Id*. Citing *Fulton v. City of Philadelphia*, 141 S. Ct. 1868 (2021), ACF states that "the proposed rule, if adopted, would not require any faith-based provider to seek designation as a safe and appropriate provider for LGBTQI+ children as described in this proposed rule if the provider had sincerely held religious objections to doing so." 88 Fed. Reg. at 66761. ACF "recommend[s]" that states and tribes "not adopt selection criteria that adversely disadvantages any faith-based organizations that express religious objections to providing safe and appropriate placements for LGBTQI+ children." *Id*. at 66762. Other court decisions are to the same effect. *E.g*., *Marouf v. Azar*, No. 18-cv-00378, slip op. at 11-12 (D. D.C. July 7, 2023) (stating, in a case involving foster care services for unaccompanied refugee minors, that "this court cannot imagine that the Supreme Court would sanction what Plaintiffs propose here as a remedy: ordering the federal government to make as a condition of a religious organization's participation in a federal program that it violate its sincerely held religious beliefs on same-sex marriage.").

To be sure, these and similar statements in the preamble are helpful, but they are relegated to the preamble and not actually replicated in the text of the proposed regulations. Because statements in a regulatory preamble are not themselves legally enforceable, functioning much like legislative history in relation to statutory text, *see*, *e.g*., *Wyeth v. Levine*, 555 U.S. 555, 577 (2009) (declining to defer to agency views set out in the preamble to a regulation as opposed to the regulation itself), we believe the regulations should incorporate these assertions so that they are legally binding on the federal government, states, and tribes. The requirements to respect religious liberty and not to disadvantage faith-based organizations with respect to their religious objections should not be tucked away in the preamble or expressed merely as "recommend[ations]" (88 Fed. Reg. at 66762), but set out as requirements in the regulations themselves.

Conclusion

We endorse many of the general requirements described in the proposed regulations, but we encourage ACF to make these requirements applicable to all minors rather than limit them to a class of minors or to SOGI issues. We urge ACF to reconsider its requirement that minors be provided with an approach that affirms gender-identity and sexual orientation and excludes all other approaches. We applaud ACF for its recognition of the free exercise rights of religious organizations, and we encourage the incorporation of those requirements into the text of the regulations.

Respectfully submitted,

William J. Quinn
General Counsel
Michael F. Moses
Director, Legal Affairs
Daniel E. Balserak
Assistant General Counsel and
Director, Religious Liberty