THE NATIONAL CATHOLIC BIOETHICS CENTER
600 REED ROAD, SUITE 102, BROOMALL, PA 19008 (215) 877-2660 (215) 877-2688 FAX NCBCENTER.ORG

April 6, 2026

Robert F. Kennedy, Jr., Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Subj: *Designated Placement Requirements Under Titles IV-E and IV-B for LGBTQI+ Children; Rescission*; Docket ID ACF-2026-04515; RIN 0970-AD19

Dear Secretary Kennedy:

On behalf of the National Catholic Bioethics Center (NCBC), the National Catholic Partnership on Disability (NCPD), the Catholic Medical Association (CMA), and the National Association of Catholic Nurses, USA (NACN-USA) we respectfully submit the following comments on the proposed regulations, published by the Department of Health and Human Services (HHS: March 6, 2026), on foster care placement requirements: *Designated Placement Requirements Under Titles IV-E and IV-B for LGBTQI+ Children; Rescission* (Proposal).[1] As a foundation to these comments we wish to affirm that we support President Trump's executive order against gender ideology,[2] and the November 2025 HHS Final Report,[3] countering errors of major medical groups' deference to the World Professional Association for Transgender Health (WPATH)[4] in addressing the health care needs of minors with gender identity disorder. Thus, we support this Proposal which seeks to remove the harmful (to children in foster care) requirements issued in the currently vacated Final Rule *Designated Placement Requirements Under Titles IV-E and IV-B for LGBTQI+ Children*.[5]

[1] 91 FR 11017 (March 6, 2026).
[2] President Donald J. Trump, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, Presidential Actions* (The White House: January 20, 2025). https://www.whitehouse.gov/presidential-actions/2025/01/defending-women-from-gender-ideology-extremism-and-restoring-biological-truth-to-the-federal-government/.
[3] U.S. Department of Health and Human Services, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (November 19, 2025). https://opa.hhs.gov/gender-dysphoria-report.
[4] World Professional Association for Transgender Health Archived 2018-10-04 at the Wayback Machine. *Tax Exempt Organization Search*. Internal Revenue Service.
[5] 89 FR 34818 (April 30, 2024).

The National Catholic Bioethics Center (NCBC) is a faith-based organization engaged in bioethics publication, education and consultation to thousands of persons seeking its services. It has a membership of over five hundred members, representing individuals, dioceses, parishes, health care corporations, educational institutions, social services agencies, among many others. Thus, the impact on membership far exceeds the official number of members. Through our consultation services increasingly we are made aware of challenges to families and children, including the value to children of a stable nuclear, and even extended family, in which the complementarity of sexual roles is recognized and modelled. Furthermore, there is a great need for clarity in terms of the legally protected right to religious freedom of individuals and institutions seeking to address the health and social services needs of the very populations served by HHS. These entities often rely on federal grants, partnering with the federal government to meet the needs of residents of the United States, and beyond.

The National Catholic Partnership on Disability (NCPD) works with dioceses, parishes, ministers, and laity to promote the full and meaningful participation of persons with disabilities in the life of the Church. It promotes this ever-evolving mission to renovate and sustain ministry to-and-with all people with disabilities and their families through the following initiatives: leads and participates in trainings, workshops, and regional meetings; collaborates with the U.S. Conference of Catholic Bishops in revising guidelines, resources, and pastoral statements to foster these same ends; provides educational resources using a multitude of accessible media; participates in International Ecclesial Conferences; and advocates for policies that respect the full dignity and inclusion of all persons, especially those with varying abilities. A number of children in foster care experience developmental and cognitive disabilities, and may also suffer from gender identity confusion. In fact it is estimated that 30% of children in foster care experience such confusion.[6] Also, children on the autism spectrum may experience gender identity disorder.[7] These children needing foster care, trusting that their foster care placements will contribute to their human flourishing, not deceptively erode such flourishing by erroneous gender affirming interventions, which in fact are harmful sex-rejecting procedures (SRP).[8] SRPs, promoted by the Final Rule under the past federal administration, actually create disabilities by the very nature of the recommended counseling and chemical and surgical alterations, which themselves are disabling, while not addressing the actual sources of the gender dysphoria. The provisions of the Proposal seek to reverse these government sponsored trends.

The Catholic Medical Association (CMA) has over 3,000 physicians and allied health members nationwide. CMA members seek to uphold the principles of the Catholic faith in the science and practice of medicine—including the belief that every person's physical, psychological, and spiritual integrity, and conscience and religious freedoms, should be protected, especially from the erroneous gender affirming interventions, which in fact are harmful sex-rejecting procedures (SRP). The CMA's mission includes

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[6] Eduardo Gutierrez, "Queer and Vulnerable: Identifying the Challenges of LGBTQ+ Youth in Foster Care," *Congressional Hispanic Caucus Institute Policy Brief: Developing the Next Generation of Latino Leaders* (March 2024). chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://chci.org/wp-content/uploads/2024/04/FINAL.Gutierrez-Eduardo.pdf#:~:text=Executive%20Summary.%20LGBTQ+%20children%20and%20youth%2C%20constituting,negative%20outcomes%20within%20an%20already%20vulnerable%20population.

[7] Aimilia Kallitsounaki and David M Williams, "Autism Spectrum Disorder and Gender Dysphoria/Incongruence. A systematic Literature Review and Meta-Analysis," *J Autism Dev Disord*. (2022 May 20;53(8)):3103–3117. doi: 10.1007/s10803-022-05517-y.

[8] Robert F. Kennedy Jr., Secretary of U.S. Department of Health and Human Services, "Declaration of the Secretary of the Department of Health and Human Services RE: Safety, Effectiveness, and Professional Standards of Care for Sex Rejecting Procedures on Children and Adolescents" (December 18, 2025). chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.hhs.gov/sites/default/files/declaration-pediatric-sex-rejecting-procedures.pdf.

defending its members' rights to provide care to address the best interest of their patients, and in so doing follow their consciences and Catholic teaching within the physician/professional-patient relationship. Members engage in this ministry of health within numerous secular as well as faith-based organizations sponsored by the Catholic Church, the largest provider of non-profit, non-governmental health care and social services in the United States. There are numerous examples of CMA members and Catholic sponsored ministries partnering with the federal government to meet critical health and social service needs of society, including health care of vulnerable children in foster care, regardless of the setting.

The National Association of Catholic Nurses, USA (NACN-USA) is a non-profit organization of nurses from different backgrounds and specialties. NACN-USA shares the ministry of Catholic Nursing which advocates for human rights of vulnerable populations, and the rights of health care professionals to protect those persons, as well as the rights of those professionals to have their own deeply held moral and religious beliefs protected. Through prayer, leadership, fellowship, education, and the formation of conscience, we strive to imitate Jesus Christ and His teachings. Our members endorse the dignity and sanctity of all human life from conception to natural death, and the innate integrity written within human sexuality. As professionals directly involved with patients and their family members, including foster children, we are seeing firsthand the harm done by a gender ideology that is not addressing the foundational needs of the persons they serve.

NCBC, NCPD, CMA, and NACN-USA, support this Proposal which would remove the requirements issued in the currently vacated Final Rule *Designated Placement Requirements Under Titles IV-E and IV-B for LGBTQI+ Children*.[9] The Final Rule required agencies administering or supervising the administration of title IV-E and IV-B of the *Social Security Act*, under the Administration for Children and Families (ACF) to ensure safe and appropriate placements of children in need of foster care who self-identify with an alternative sexual orientation or self-identify as something other than their sex.[10] While laudable, one of the troublesome features of the provisions of the Final Rule is that they make these requirements applicable not to all minors, but only to those who present with sexual orientation or gender identity (SOGI) differences (as relate to biological sex). 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 focused on their application to some subset of minors or to SOGI specific cases.

Other provisions of the Final Rule also are problematic because they propose, incorrectly, that gender affirmance is the only and best way to treat gender dysphoria. The Final Rule would therefore require agencies to ensure that children "who identify as LGBTQI+"[11] have access to services that are supportive of their sexual orientation and gender identity, including questionable "clinically appropriate mental and behavioral health care supportive of their sexual orientation and gender identity and expression, as needed."[12] At the same time, the regulations would prohibit attempts to undermine, suppress, or change the sexual orientation or gender identity of a child.[13] These provisions, read together, would require that specific inclinations or behaviors with respect to SOGI—and only those inclinations

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[9] Supra note, 5.

[10] *Id*., 89 FR 34819.

[11] Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex, et al. See: Kevin Le, PharmD, BCPS, BCPPS, "What Does LGBTQIA+ Stand For?" *GoodRx* (May 16, 2024). https://www.goodrx.com/health-topic/lgbtq/meaning-of-lgbtqia.

[12] Supra note 5, "Overview of Final Rule," 89 FR 34819.

[13] "Designated Placement requirements under titles IV-E and IV-B for LGBTQI+ children" 89 FR 34818 (April 30, 2024), § 1355.22.

and behaviors, no matter how confused, inconsistent, transitory, or ambivalent—must be affirmed. However, only through a whole-person approach are the best interests of the child truly taken into account and the child's special needs met.

Furthermore, experts report that, in the vast majority of cases (roughly nine out of ten), gender dysphoria is resolved in favor of an individual's biological sex.[14] By requiring the erroneous gender affirming approach to gender identity disorders and gender dysphoria, consistent with SRPs, the Final Rule ignored a substantial body of evidence on the health risks associated with that approach and the positive outcomes associated with alternatives.[15]

It should be noted, that while the Final Rule acknowledges the government's obligation to accommodate the religious freedom rights of foster care providers, it states that no faith-based entity has an obligation to apply to be a provider. Thus, those with religious objections could be excluded from participation in this critical service to vulnerable children needing foster care. Furthermore, while accommodations can be sought by such providers, the criteria are unclear, and the accommodations are not assured but provided on a case-by-case basis, consistent with applicable department-wide regulations.[16] This could lead to the denial of valuable foster care services to thousands of vulnerable children awaiting such critical placements.

I. This Proposal Confirms the Appropriateness of the Vacating of the Final Rule which Does Not Provide Safe and Appropriate Care for Minors Suffering from Sexual Orientation and Gender Identity (SOGI) Disorders

The Final Rule, which claimed to provide safe and appropriate placement of minors with SOGI, not only is harmful but also is discriminatory. The requirement of a safe and appropriate foster care placement, access to services that support the minor's health and well-being, including the prohibition against hostility, mistreatment, or abuse not limited to acts or omissions, and the protection of his or her privacy, should not apply only to a subset of minors, predicated on sexual orientation and gender identity (SOGI), but should be assured for all minors. Thus, these aforementioned requirements included in the Final Rule are discriminatory. However, the Final Rule, as will be demonstrated here, provided for unsafe and inappropriate provisions for the care of children in foster care, and this Proposal will remedy those harmful provisions, as addressed below. Thankfully, the court has vacated those provisions.[17] However, there is a need to rectify the promulgation that led to the Final Rule. Promulgating this Proposal will accomplish that.

With the fact that the Final Rule has been vacated, the recession provisions of the Proposal will eliminate uncertainty and provide clarity for public and regulated entities engaged in this most important service of caring for all children in foster care, who by their very need for placement are in vulnerable situations. In *Texas v. U.S. Department of Health & Human Services*, the court ruled the Final Rule violates

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[14] Society for Evidenced Based Gender Care, "Early Social Gender Transition in Children is Associated with High Rates of Transgender Identity in Early Adolescence" (May 6, 2022). https://segm.org/early-social-gender-transition-persistence#:~:text=Historically%2C%2061%25%2D98%25%20of,%2Dcalled%20%E2%80%9Cdesisters%E2%80%9D).

[15] Dr. Hilary Cass, "Cass Review: Independent Review of Gender Identity Services for Children and Young People," NHS England (Primary source). Archived from the original on 9 April 2024. https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143933/https://cass.independent-review.uk/home/publications/final-report/.

[16] 89 FR 34841; also 45 CFR 87.3(b).

[17] Vacated: *Texas v. U.S. Dep't of Health & Hum. Servs.,* Case No. 6:24-cv-348-JDK (E.D. Tex.), Doc. 37 (filed June 13, 2025).

the *Administrative Procedure Act*[18] (APA) in two ways: "(1) HHS lacked rulemaking authority to issue the Final Rule and (2) the Final Rule conflicts with the text of Title IV-E."[19] Furthermore, the *Social Security Act* gives HHS only limited administrative review of States' foster-care systems—not the authority to create a new category of foster children and require new and untested methods in fostering them.[20] Thus, there is no legal foundation or historical precedent for HHS for these requirements which single out a subset of foster children for special rules, which, as we will demonstrate, below are the antithesis of providing "safe and appropriate" placements for these vulnerable children.

II. The Final Rule Would Require Health Care Professionals, and Others Caring for Foster Children, to Violate the Best Interest of Foster Children as Well as the Hippocratic Principle, "To Do No Harm."

The Proposal would codify the vacating of the provisions of the Final Rule, which would have required foster care providers to ensure that children who identify as LGBTQI+, regardless of age or circumstance, have access to harmful conditions that are supportive of their erroneous gender identity. Such supports could include use of preferred pronouns and names, and dressing in a manner that the child believes reflect their self-identified gender identity and expression.[21] Utilizing identified pronouns, chosen names, and cross-dressing would lay the groundwork for other sex-rejecting procedures (SRPs) such as hormone therapy, puberty blockers, and even surgery. In addition, the Final Rule would prohibit "Attempts to undermine, suppress, change, or stigmatize a child's sexual orientation or gender identity or expression through 'conversion therapy.'"[22] While no child should be stigmatized for the gender identity disorder they are experiencing, "gender affirming" approaches increasingly have been shown to be not only without sound scientific support, but harmful to the developing youth.[23]

Modern healthcare is grounded in a longstanding ethical tradition of the Hippocratic Oath, originating in the Hippocratic corpus, which identifies nonmaleficence - the obligation to refrain from inflicting harm - as the physician's primary moral commitment.[24] Because the oath is a promise, this foundational principle establishes a normative relationship between physician and patient, giving rise to specific moral duties and responsibilities on the part of medical professionals.[25] Thus, healthcare professionals are not merely for-profit businesses or service vendors, but professionals and institutions that are entrusted with the health of their patients and the protection of the most vulnerable.

Children are foremost among the most vulnerable. Because of their age and maturity level, minors naturally lack the full capabilities for making informed decisions about healthcare procedures, especially surgeries that will fundamentally alter their bodies. Furthermore, even if minors did have the capabilities to make informed decisions about such significant medical procedures, meaningful informed consent is a necessary, but not sufficient condition for justifying SRPs. Healthcare professionals and institutions must also justify any healthcare procedure that they provide by considering their fundamental duties and responsibilities towards their patients - duties and responsibilities that flow from the first principle of the Hippocratic oath.

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[18] Administrative Procedure Act (APA) of 1946 (5 U.S.C. §§ 551–559).
[19] Supra note, 17.
[20] Sec. 471. **[**42 U.S.C. 671**].**
[21] Supra note, 5: 89 FR 34822 and 34823.
[22] Supra note, 5: 89 FR 34860.
[23] Supra note, 15.
[24] William Stigall, "The Hippocratic Oath," *The Linacre Quarterly* Volume 89 (3) (2022) Pages 275-286.
[25] *Id.*

Health care professionals, those providing social services, and advocates for ethical care for all, including those in foster care and those with disabilities, must not affirm what is not true. Since the first duty of the health professions is to do no harm, the Final Rule did 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."[26] However, erroneously the current so called "treatment" for gender dysphoria in the U.S. includes affirmation of the child's confusion, chemically blocking puberty, lifelong cross-sex hormones (testosterone for girls and estrogen for boys), and mutilating surgeries. These SRPs present substantial risks of adverse outcomes, and the long-term effects of these interventions are either severely deleterious or insufficiently supported by scientific evidence.

Many SRPs are shown to carry irreversible consequences for fertility, sexual functions, and physical development. Prepubertal children who receive puberty blocking hormones followed by cross-sex hormones risk permanent sterilization.[27] Data support that puberty blocking hormones "arrest bone growth, decrease bone density, prevent the sex steroid dependent organization and maturation of the adolescent brain, and inhibit fertility."[28] Recently the U.S. Food and Drug Administration (FDA) placed a warning on the use of hormone puberty blockers because of several cases of pseudotumor cerebri.[29] The pathological effects of puberty blockers are not easily reversed. The noxious psychological effect of not growing into adolescence together with one's peers is not reversible. Cross-sex hormones are 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 place them at risk of developing elevated lipids, insulin resistance, cardiovascular disease, obesity, polycythemia, and unknown effects on breast, endometrial, and ovarian tissues.[30]

Furthermore, having allowed these treatments for years, five countries—the United Kingdom (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.[31] "These countries have done systematic reviews of evidence," said Leor Sapir as cited in the June 19, 2023 article in the *Wall Street Journal* (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

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[26] American College of Pediatricians, "Gender Ideology Harms Children" (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).

[27] Executive Committee of the Catholic Medical Association, *The Ideology of Gender Harms Children* (October 16, 2023). https://www.cathmed.org/resources/the-ideology-of-gender-harms-children/.

[28] American College of Pediatricians, "Gender Dysphoria in Children" (2018). https://acpeds.org/position-statements/gender-dysphoria-in-children.

[29] U.S. Food and Drug Administration (FDA), "Risk of Pseudotumor Cerebri Added to Labeling for Gonadotropin-Releasing Hormone Agonists" (2022). https://www.fda.gov/media/159663/download.

[30] Supra note, 28.

[31] Jill Lawless, "England's Health Service Says It Won't Give Puberty Blockers to Children at Gender Clinics." *Associated Press* (June 11,2023). https://apnews.com/article/uk-transgender-puberty-blockers-abd9145484006fea23de6b4656c937da. Lisa Nainggolan, "Hormonal Tx of Youth with Gender Dysphoria Stops in Sweden." *Medscape* (May 12, 2021). https://www.medscape.com/viewarticle/950964. Wesley J. Smith, "Finns Turn against Puberty Blockers for Gender Dysphoria." *National Review* (July 25, 2021). https://www.nationalreview.com/corner/fins-turn-against-puberty-blockers-for-gender-dysphoria/. Wesley J. Smith, "France's Academy of Medicine Urges 'Great Medical Caution' in Blocking Puberty," National Review (April 26, 2022). https://www.nationalreview.com/corner/frances-academy-of-medicine-urges-great-medical-caution-in-blocking-puberty/.

serious."[32] Most notably the United Kingdom's Cass Review—a 4-year independent evaluation of pediatric gender medicine that was published in April 2024,[33] led to the closure of the United Kingdom's Gender Identity Development Service (GIDS), which had been given a rating of "inadequate" by the Care Quality Commission in 2021).[34] Similarly, in the United States, twenty-seven states prohibit such interventions on minors.[35]

The November 2025 HHS Final Report countered errors of major medical groups' deference to the World Professional Association for Transgender Health (WPATH).[36] As explained in Chapter 9 of the HHS Final Report, the guidelines issued by WPATH "have been rated among the lowest in quality and have not been recommended for implementation by systematic reviews (SRs) of guidelines."[37] Since that time there has been a growing awareness of this erroneous deference. For example, the American Society of Plastic Surgeons (ASPS) has issued a statement, citing that "ASPS currently understands that there is considerable uncertainty as to the long-term efficacy for the use of chest and genital surgical interventions for the treatment of adolescents with gender dysphoria, and the existing evidence base is viewed as low quality/low certainty."[38] They caution that: "As members of the multidisciplinary care team, plastic surgeons have a responsibility to provide comprehensive patient education and maintain a robust and evidence-based informed consent process, so patients and their families can set realistic expectations in the shared decision-making context."[39] This is consistent with reports from European medical professional groups, as cited earlier.[40] In February 2026, the American Medical Association (AMA) indicated it had modified its position on what they term "gender-affirming care" for minors, and it was assumed AMA was aligning with more recent medical professionals' recommendations that surgical interventions should generally be deferred until adulthood. However, they have since indicated that their position had not changed: "The AMA supports gender-affirming care as medically necessary per our policy."[41] However, legal challenges, as well as science documenting the unsound nature of these SRPs are increasing. It is not only that the ASAP has issued cautions related to these procedures on minors, but the Catholic Medical Association also "calls on the medical organizations that promote the practice of sex reassignment of children with GD [gender dysphoria] to reverse their decision. These organizations should consider the profoundly harmful long-term physical and psychological damage that awaits these children as they grow into adulthood."[42] This CMA document, *The Ideology of Gender Harms Children*, has

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[32] 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-asmore-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.").

[33] Supra note, 15.

[34] Brooks, Libby (20 January 2021). "Gender identity development service for children rated inadequate". *The Guardian*. Archived from the original on 20 January 2021.

[35] Annette Choi, "27 states have passed laws restricting gender-affirming care for trans youth," *CNN* (April 30, 2025) https://www.cnn.com/politics/state-ban-gender-affirming-care-transgender-dg/index.html.

[36] Supra note, 4.

[37] Supra note, 3.

[38] ASPS "Statement Regarding Gender Surgery for Adolescents" (Wednesday, August 14, 2024) https://www.plasticsurgery.org/reconstructive-procedures/asps-statement-regarding-gender-surgery-for-adolescents.

[39] *Id.*

[40] Supra note, 31.

[41] AMA Board of Directors, "AMA Board Newsletter" (March 2026). https://cloud.e.ama-assn.org/newsletter.

[42] Executive Committee of the Catholic Medical Association, *The Ideology of Gender Harms Children* (October 16, 2023). https://www.cathmed.org/resources/the-ideology-of-gender-harms-children/.

identified the harms that have been done to children, consistent with those identified in the Proposal. The science is continuing to document that such interventions are scientifically unsound.

The evidence of risk and harm is beginning to surface: "more than a quarter of the [minor] patients" who have undergone gender transition subsequently regret it.[43] Evidence of the lack of meaningful informed consent of minors abound. These individuals claim they were coerced into undergoing surgical and medical interventions rejecting, and thus harming, their innate human sexuality when most vulnerable and immature, and when uninformed of consequences. Some are initiating lawsuits against medical practitioners and medical organizations who provided such interventions.[44] Minors, who are now adults, are seeking damages for the harm done to them. Chloe Cole sued her doctors and health care providers for injuries she alleges resulted from the defendants' so called gender-affirming approach.[45] Luka Hein sued her health care providers and physicians for injuries she alleges resulted from so called gender-affirming care.[46] The lack of meaningful informed consent of the minors subjected to these sex-rejecting procedures is no more evident by a landmark 2026 court decision in a malpractice verdict regarding a teenager who regretted her sex-rejecting surgery. In *Fox Varian v. Kenneth Einhorn, PhD, et al.* a jury awarded the woman $2 million in damages after her mother having been pressured into consenting to the teenager's double mastectomy. The jury found that the doctors and psychologists ignored the applicable procedures and standards of care when the then-teenager was consulting them and failed to obtain meaningful informed consent.[47]

The various aforementioned provisions in the Final Rule require interventions that "affirm" or "support" a minor's self-expressed gender identity; every other approach is prohibited. Our principal point is that the Final Rule requirements are not in the best interests of children. Because of the absence of conclusive medical evidence demonstrating the alleged benefits of SRPs, these interventions more closely resemble experimental practices than established medical procedures supported by robust scientific evidence.[48] In fact, there is growing evidence of the harms they cause. Promoting gender affirmance, as the Final Rule would mandate foster parents, foster care agencies/professionals, including their healthcare and social service professionals who are engaged in implementing *Designated Placement Requirements Under Titles IV-E and IV-B*, to ensure that foster children who identify as LGBTQI+ have access to services that are supportive of their gender identity confusion: "clinically appropriate mental and behavioral health care supportive of their sexual orientation and gender identity and expression, as needed."[49] At the same time, the Final Rule would prohibit attempts to address the underlying gender identity disorder.[50] Such mandates clearly violate the best interests of children in foster as well as the

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[43] 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: 691), at https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2150346.

[44] Independent Women's Forum, ND. "Identity Crisis: Stories the transgender movement doesn't want you to hear." https://www.iwf.org/identity-crisis/. Accessed August 13, 2023.

[45] *Brockman v. Kaiser Foundation Hospitals*, No. STK-CV-UMM-2023-0001612 (Cal. Super. Ct., County of San Joaquin, Stockton Branch) (filed Feb. 22, 2023).

[46] *Hein v. UNMC Physicians*, No. D01C1230007381 (Neb. Dt. Ct. Douglas County) (filed Sept. 13, 2023).

[47] *Varian v. Einhorn et al*. (61150/2023). Westchester County Supreme Court. See https://www.ncregister.com/cna/new-york-jury-awards-2-million-to-teen-girl-who-formerly-identified-as-male-in-malpractice-case.

[48] M.J. Defant, "Reevaluating gender-affirming care: biological foundations, ethical dilemmas, and the complexities of gender dysphoria," *Journal of sex & marital therapy*, 51:2 (2025) 200–210. https://doi.org/10.1080/0092623X.2025.2456066

[49] Supra note, 12.

[50] Supra note, 13.

Hippocratic Principle, "To Do No Harm." Science is continuing to document that such approaches to gender identity disorder are scientifically unsound.[51]

It also follows that a prospective foster parent or foster care agencies should not be excluded from the foster care program on the grounds they do 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). We believe that the requirement of gender-affirming approach, and the prohibition of alternative approaches that are effective and less risky than gender-affirming interventions, violate the ACF's statutory duty to provide for the care and appropriate placement of minors, under 42 U.S.C. § 675(1)(B) (stating that children in foster care must receive "safe and proper" care), and thus, the Final Rule should be withdrawn as indicated in this Proposal.

III. Psychotherapy is the Effective Healthcare Option

While evidence of the benefits of medical and surgical interventions to improve mental health or reduce symptoms of gender dysphoria is questionable, psychotherapy is an effective intervention for many of the neurodevelopmental disorders and mental health conditions that are highly prevalent in children and adolescents, including those frequently co-occurring in patients diagnosed with gender dysphoria. There is a need to address the real psycho-social sources of gender dysphoria and include psychotherapeutic interventions to remedy the causes and treat their effects. In fact, other countries are realizing the benefit of psychotherapy, making psychosocial treatments and/or exploratory psychotherapy a first line of treatment for gender related distress in young patients.[52]

There is significant evidence of contagion of "rapid onset gender dysphoria"[53] especially among adolescent girls, from a society, including the government, endorsing the falsehood that mutilating one's human sexuality will remedy the underlying psychological foundations for the dysphoria. There are probably many paths that could lead to gender dysphoria. Particularly vulnerable are persons on the autism spectrum, and those suffering from mental health comorbidities who need to be protected from false remedies to the struggles they already are facing.[54] Also, children in need of foster care are vulnerable to a host of comorbidities, regardless of their gender identity. Foster care children face significantly higher rates of comorbidities compared to the general population, with 42.7% to 61% having mental health issues and high rates of chronic physical problems. Common comorbidities include behavioral disorders, Attention Deficit Hyperactive Disorder, depression, anxiety, Post Traumatic Stress Disorder, asthma, obesity, and developmental delays stemming from trauma.[55] Up to 30% of youth

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[51] Supra note, 15.

[52] Joanne Sinai and Peter Sim, "Psychodynamic psychotherapy for gender dysphoria is not conversion therapy," *J Can Acad Child Adolesc Psychiatry* 33:2 (2024 Jul 1) 45–153. Federal Register: Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children.

[53] L. Littman, "Rapid onset of gender dysphoria in adolescents and young adults: A descriptive study." Abstract, Journal of Adolescent Health (February 2017, 60:2, Supplement 1) S95-S96. https://doi.org/10.1016/j.jadohealth.2016.10.369.

[54] Supra Note, 7. Also, Society for Evidenced Based Gender Medicine, "The Gender Dysphoria Diagnosis in Young People Has a 'Low Diagnostic Stability,' Finds a New German Study" (July 19, 2024). https://segm.org/gender-dysphoria-diagnosis-desistance-germany#:~:text=Youth%20diagnosed%20with%20gender%20dysphoria,has%20significant%20implications%20for%20treatment.

[55] Stine Lehmann, *et al.,* "Mental disorders in foster children: a study of prevalence, comorbidity and risk factors," *Child Adolesc Psychiatry Ment Health* 7:39 (2013 Nov 21) 7-39. doi: 10.1186/1753-2000.

in foster care identify as LGBTQ+, with a high prevalence of gender dysphoria and a significant overrepresentation of transgender and non-binary youth.[56]

However, there is no single-family dynamic or social situation that appears to be causative of gender confusion. There may be an association with adverse events in childhood. The traditional understanding of childhood gender dysphoria had been that it reflected confused thinking on the part of the child. The standard approach was watchful waiting by the parents with the advice of a mental health specialist. The goals of therapy were to address family pathology when present, treat any psychosocial co-morbidities in the child, and aid the child in aligning gender identity with biological sex.[57] Misguided trends, increasingly coming under scrutiny, have reversed that approach.

Sexually confused children frequently show psychiatric co-morbidities.[58] While "gender affirming" interventions should not be provided, treatment of the underlying psychological or behavioral conditions should be. Gender dysphoria and gender identity disorder should be differentiated from the underlying psychological or behavioral conditions. The incidence of suicidality in this group corresponds to the psychiatric co-morbidities these children show. Scientific evidence suggests that the transgender interventions do not reduce the risk of suicide. In fact, puberty blockers are associated with depression and other emotional disturbances related to suicide. Furthermore, data support that in the long run transitioning may even exacerbate the psychological distress that could lead to suicide.[59] The claim that children with sexual confusion will commit suicide if they are not quickly affirmed and set on the path toward sex-rejecting procedures is not scientifically supported.

Other effective and less harmful interventions exist. 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.[60] Persons with gender dysphoria would benefit from such treatment of depression and anxiety along with aggressive counseling and medications directed to those conditions.[61] The harms associated with a gender-affirming approach,[62] and the absence of credible evidence of long-term benefits from such care,[63] have led to changes in the treatment of gender dysphoria in Europe.

Those experiencing gender dysphoria, and most importantly those who have experienced the trauma of surgical or hormonal SRPs have great need for authentic care. The attempt to address surgically

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[56] Andrea G. Fogelsinger, "LGBTQ+ youth in foster care: Struggles, misconceptions, and how the legal community can do better," *Michigan Bar Journal* (June 2025). https://www.michbar.org/journal/Details/LGBTQ-youth-in-foster-care-Struggles-misconceptions-and-how-the-legal-community-can-do-better?ArticleID=5121#:~:text=LGBTQ+%20youth%20are%20greatly%20overrepresented,the%20author%20for%20more%20information..

[57] Supra note, 28.

[58] Joseph Elkadi, *et al.,* "Developmental Pathway Choices of Young People Presenting to a Gender Service with Gender Distress: A Prospective Follow-Up Study," *Children Basel* 10:2 (2023 Feb 7), 314. doi: 10.3390/children10020314.

[59] J.W. Robbins Broyles, V. R., "The Myth about Suicide and Gender Dysphoric Children, Child and Parental Rights," Online resource (ND) *American College of Pediatricians*.

[60] Alexandra F. Muratore, PhD and Evelyn Attia, MD, "Current Therapeutic Approaches to Anorexia Nervosa: State of the Art," *Clinical Therapeutics Volume* 43, Issue 1 (January 2021) Pages 85-94. https://www.sciencedirect.com/science/article/abs/pii/S0149291820305166.

[61] Supra note, 27.

[62] Supra notes, 26, 27, 35.

[63] 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 dropout rates among participants."), at https://www.thepublicdiscourse.com/2020/02/60143/.

and hormonally, what should be treated psychiatrically with counselling, is not authentic health care. Society should never affirm what is not true. Children 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. This is especially true if the focus of a foster care placement is on human sexuality, not the whole person. Furthermore, since LGBTQI+ identity is centered around an individual's gender identity with implications concerning sexuality, the ACF ought to consider setting behavioral standards to avoid minors engaging in sexual activity before the age of consent. There is a need for the federal government to address the root psycho-social causes of gender dysphoria, not perpetuate the harm done to children, especially for children in the foster care system, for whom the government has a grave responsibility.

IV. Religious Liberty

The Final Rule includes many laudable statements about religious liberty and other freedoms, citing existing legal provisions. However, despite citing the religious freedom of foster care providers addressed in *Fulton* v. *City of Philadelphia*,[64] the Final Rule contains two categories of providers: the "designated provider,"[65] who is identified as "safe and appropriate," for LGBTQ+ children, and the remainder of providers, inferring that they are not "safe and appropriate."[66] Foster care providers, have a choice to participate or not participating in *Under Titles IV-E and IV-B for LGBTQI+ Children*, and those with religious objections to so called gender affirming interventions may be "accommodated"[67] on a "case-by-case basis."[68] If denied, will that mean that the provider will not be considered a "designated provider," or, if designated a "safe and appropriate" provider, will the provider be forced to obtain hormone replacement therapy, double mastectomies, genital mutilations, and other such "services" for the children they are supposed to protect in foster care?

Thus, the conscience protections for persons and agencies/institutions that have a religious character/belief could effectively be threatened by parts of the Final Rule. Such persons and entities should be expressly safeguarded for their deeply held moral and religious beliefs protected by the U.S. Constitution's First Amendment[69] and the *Religious Freedom Restoration Act* (RFRA). RFRA was enacted specifically to protect against government actions that substantially burden religious liberty.[70] An integral aspect of the RFRA is the belief that individuals and institutions should not be forced to choose between their own religious beliefs and participation in public life. Furthermore, federal law (Church Amendments) dictates that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."[71] Government programs should not place religious individuals and institutions in an impossible position of either materially participating in what they view as grave evils or withdrawing from participating in public

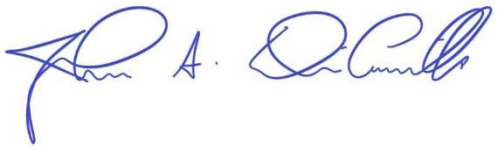
[64] 593 U.S. 522 (2021).
[65] Supra note, 5, 89 FR 34819.
[66] *Id*.
[67] Supra note, 5, 89 FR 34834.
[68] Supra note, 16.
[69] U.S. Const. amend. I.
[70] 42 U.S.C. § 2000bb (3).
[71] 42 U.S.C. § 300a-7 (d)

programs that help to serve their community. This Proposal, when finalized, would reverse the fear and doubts that had been created by the Final Rule.

V. In summary:

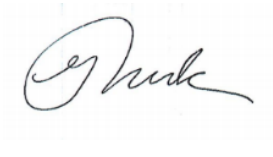
We believe that by mandating the affirmation of LGBTQI+ identity and forbidding all other approaches, government fails to adequately protect the best interests of all children, violates the Hippocratic tradition of professionals committed to their care, and discriminates against objecting foster care providers by challenging their status as "safe and appropriate" providers. There is an underlying erroneous assumption that affirmation is the only appropriate response and faith-based providers are not appropriate placements for LGBTQI+ youth. Medical science is indicating otherwise. Cognitive-based therapy is successfully being used to address gender confusion and resulting dysphoria. Thus, such mandates violate ACF's statutory duty to ensure a foster care environment that is safe and appropriate regardless of the gender identity of those entrusted to its care. Furthermore, the resulting discrimination against conscience and religious-based objectors not only violates the statutory protections existing in federal law, but also the recently adjudicated decision by the U.S. Supreme Court in the decision of *Chiles v. Salazar.*[72] Thus, the Final Rule should be rescinded as indicated in this Proposal.

Sincerely yours,



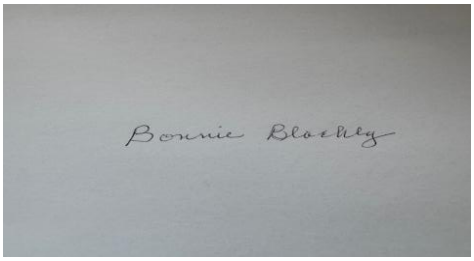
John A. Di Camillo, PhD, BeL
President
The National Catholic Bioethics Center
600 Reed Road, Suite 102
Broomall, PA 19008

215-877-2660



Greg F. Burke, MD
Vice-President
The Catholic Medical Association
550 Pinetown Road, Suite 205
Fort Washington, PA 19034
484-270-8002

Mary O'Callaghan, Ph.D
Board Liaison
Ethics and Public Policy Committee
National Catholic Partnership on Disability
415 Michigan Avenue, N.E, Suite 95
Washington, D.C. 20017
771-203-4477



Bonnie Blachly, MN, RN
The National Association of Catholic Nurses, USA
450 State Road 13 North, Suite 106-Box124
St. Johns, Florida 32259

[72] *Chiles v. Salazar*, U.S. Supreme Court (March 31, 2026). https://www.denvercatholic.org/u-s-supreme-court-strikes-down-colorado-ban-on-gender-dysphoria-care-for-minors-citing-first-amend.