

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, et al.,

Plaintiffs,

v.

No. 1:19-cv-00272-LCB-LPA

DALE FOLWELL, et al.,

Defendants.

**REPLY IN SUPPORT OF PLAINTIFFS' MOTIONS TO EXCLUDE EXPERT
TESTIMONY OF DR. PETER ROBIE (ECF NO. 202), DR. PAUL W. HRUZ (ECF
NO. 204), DR. PAUL R. MCHUGH (ECF NO. 206), DR. PATRICK W. LAPPERT
(ECF NO. 208), AND DR. STEPHEN B. LEVINE (ECF NO. 212)**

Defendants willfully ignore the Fourth Circuit’s most recent and relevant reaffirmance of “the indispensable nature of district courts’ Rule 702 gatekeeping function in all cases in which expert testimony is challenged.” *Sardis v. Overhead Door Corp.*, 10 F.4th 268, 284 (4th Cir. 2021). The Court should disregard Defendants’ plea for lax gatekeeping and instead should rigorously examine the challenged experts’ qualifications and the relevance and reliability of their testimony.

ARGUMENT

“The proponent of expert testimony has the burden of establishing its admissibility by a preponderance of proof.” *Smith v. Wyeth-Ayerst Lab’ys Co.*, 278 F.Supp.2d 684, 691 (W.D.N.C. 2003). Defendants fail to meet this burden, however, even after specific challenges regarding each experts’ qualifications and opinions. Defendants’ failure to address specific arguments amounts to waiver, which is reason enough to exclude those opinions. *See, e.g., Stenlund v. Marriott Int’l, Inc.*, 172 F.Supp.3d 874, 887 (D. Md. 2016) (“In failing to respond to this argument [in defendant’s motion], Plaintiff concedes the point.”).

I. DEFENDANTS’ EXPERTS ARE NOT QUALIFIED TO OPINE ON THE DIAGNOSIS AND TREATMENT OF GENDER DYSPHORIA.

There is no such thing as a jack-of-all-trades expert. Accordingly, “any expert, including physicians, must have the specialized knowledge or skill *in the specific area in which the testimony is proffered.*” *Smith*, 278 F.Supp.2d at 698 (emphasis added).

“Experience in a particular field is not enough to qualify an expert; *the expert must have experience with the issue before the court.*” *Harvey v. Novartis Pharm. Corp.*, 895

F.Supp.2d 1206, 1209 (N.D. Ala. 2012) (emphasis added); *see also, e.g., Zellers v. NexTech Ne., LLC*, 533 F.App’x 192, 197 (4th Cir. 2013) (neurologist not qualified to testify as an expert about toxicology because “she lacks specific training in th[at] field”); *Hubbard v. Rite Aid Corp.*, 433 F.Supp.2d 1150, 1161 (S.D. Cal. 2006) (dermatologist not qualified as expert in disability). Courts thus routinely recognize that an expert in a particular subspecialty is not *ipso facto* an expert in every other subspecialty within the same field—let alone in an entirely different field. *See, e.g., Elegant Massage, LLC v. State Farm Mut. Auto. Ins. Co.*, 2022 WL 433006, at *9 (E.D. Va. Feb. 11, 2022) (“the Fourth Circuit has recognized that experience and expertise in one area does not automatically qualify someone as an expert in another similar area”); *Maldonado v. Apple, Inc.*, 2021 WL 1947512, at *17 (N.D. Cal. May 14, 2021) (chemical engineer not qualified to opine about “reliability engineering,” because “slapping the label ‘engineering’ on an expert or opinion is insufficient to show expertise across that expansive field”); *Shreve v. Sears, Roebuck & Co.*, 166 F.Supp.2d 378, 392 (D. Md. 2001) (“an expert who is a mechanical engineer is not necessarily qualified to testify as an expert on any issue within the vast field of mechanical engineering”).

Defendants concede—as they must—that their experts cannot qualify based on scientific research and peer-reviewed writing in this area. Instead, Defendants argue that their experts are qualified based on their generalized knowledge, skill, and education in their fields of medicine. That is not enough, however, and Defendants cite no authority for their proposition that any physician may testify about gender dysphoria and its treatment

even if they have no specialized training, research experience, clinical experience, or peer-reviewed publications in the area.

Finally, Defendants conflate and misrepresent Plaintiffs' arguments regarding their experts' "unfamiliarity or disagreement with the ... [WPATH] standards of care." Dkt. 215 at 16. If a challenged expert is unfamiliar with the WPATH Standards of Care, that calls into question both the expert's qualifications *and reliability*. Separately, a challenged expert's disagreement with what is otherwise the recognized medical and scientific consensus calls into question their *reliability* because general acceptance in the relevant scientific community is an important element of reliability. *See Nease v. Ford Motor Co.*, 848 F.3d 219, 229 (4th Cir. 2017).

A. Dr. Robie

Defendants concede that Dr. Robie will not opine regarding "the efficacy of gender dysphoria treatment," Dkt. 215 at 15—not surprising, since Dr. Robie admitted he lacks experience with this area. Dkt. 202 at 8. Instead, Defendants say that Dr. Robie will testify to the medical knowledge he shared with other Board members. Dkt. 215 at 15. But that is a role of a fact witness, not an expert. Moreover, as he stated in his deposition, the knowledge he shared relates to coverage of continuous glucose monitors for diabetic patients, biological agents for cancer treatment, and COVID management, care, and status. Dkt. 203-1 at 23:11–25:12; 31:19–32:14. These issues are irrelevant to this dispute, and there is no need for purported expert testimony on them.

B. Dr. Hruz

Defendants argue Dr. Hruz is qualified to testify as an expert in this case because he has purportedly “extensively studied the scientific literature related to the incidence, potential etiology, and treatment of gender dysphoria.” Dkt. 215 at 14; *but see* Dkt. 205 at 20-22 (noting misrepresentations about the nature of his study in the area). However, Dr. Hruz has no clinical, research, or scientific publication experience in this area. And the fact that Dr. Hruz has “read in the area” and “holds an opinion on the topic” “is not enough” to make him an expert on this topic. *United States v. Jacques*, 784 F.Supp.2d 59, 62 (D. Mass. 2011); *see also Zellers*, 533 F.App’x at 197 (neurologist not an expert on toxicology because she reviewed scientific literature on toxicology).

C. Dr. McHugh

In arguing that Dr. McHugh is qualified, Defendants do nothing other than recite his credentials. But “a proffered expert’s professional qualifications are insufficient to support his testimony; he must also have sufficient specialized knowledge to assist the jurors in deciding the particular issues in the case.” *Belk, Inc. v. Meyer Corp., U.S.*, 679 F.3d 146, 162 (4th Cir. 2012) (cleaned up). Here, Dr. McHugh has no clinical, research, or scientific publication experience regarding the diagnosis or treatment of gender dysphoria and is therefore unqualified to testify as to those issues. Dkt. 207 at 5-9.

D. Dr. Lappert

Defendants do not contend that Dr. Lappert is qualified to opine on topics other than plastic surgery (like endocrinology, psychiatry, mental health conditions, and development

of treatment guidelines)—again not surprising, since he conceded he is not an expert in those areas. Dkt. 209 at 9-10, 15-16; *e.g.*, *Scott v. Mid-Atlantic Cable Installation, LLC*, 2006 WL 2079373, at *3 (E.D. Va. July 25, 2006); *Nunez v. Coloplast Corp.*, 2020 WL 2315077, at *5-6 (S.D. Fla. May 11, 2020).

As to surgery, Defendants argue Dr. Lappert is qualified to testify based on his “personal experience with the surgical procedures performed as part of sex reassignment surgery,” although not “for treatment of gender dysphoria.” Dkt. 215 at 14-15. But that is not enough. Defendants do not explain how Dr. Lappert’s experience performing these procedures for *other conditions* qualifies him to opine on the efficacy of these procedures to treat *gender dysphoria*. See *Harvey*, 895 F.Supp.2d at 1210–11; *Thomas v. Novartis Pharms. Corp.*, 443 F.App’x 58, 63 (6th Cir. 2011) (finding experienced maxillofacial surgeon who had treated patients with osteonecrosis of the jaw unqualified to opine on the causation of osteonecrosis of the jaw).

Finally, Defendants fail to respond to Plaintiffs’ argument regarding the Code of Ethics of the American Society of Plastic Surgeons requiring plastic surgeons to have “performed the specific procedure in question within three (3) years of the date of being retained as an expert witness,” which Dr. Lappert has not. Dkt. 209 at 8.

E. Dr. Levine

Plaintiffs have established that Dr. Levine is not qualified to offer opinions about the treatment of prepubescent transgender children. Dkt. 213 at 20-22. In response,

Defendants only recite Dr. Levine’s credentials. But again, credentials alone are “insufficient to support [an expert’s] testimony.” *Belk, Inc.*, 679 F.3d at 162.

II. THE CHALLENGED EXPERTS’ OPINIONS ARE IRRELEVANT AND UNRELIABLE.

“[T]he party seeking the admission of expert testimony must come forward with evidence from which the court can determine that the proffered testimony is ... reliable and relevant.” *In re Smith & Nephew Birmingham Hip Resurfacing (BHR) Hip Implant Prod. Liab. Litig.*, 2021 WL 781682, at *2 (D. Md. Mar. 1, 2021). Defendants fail to meet this burden.

A. Defendants do not refute that many of the challenged experts’ opinions are irrelevant.

Relevancy “is a precondition to admissibility.” *Sardis*, 10 F.4th at 282 (cleaned up). “The test for relevance, or fit, considers whether expert testimony proffered in the case is sufficiently tied to the facts of the case that it will aid the jury in resolving a factual dispute.” *Viva Healthcare Packaging USA Inc. v. CTL Packaging USA Inc.*, 197 F.Supp.3d 837, 846 (W.D.N.C. 2016) (cleaned up).

In asserting their experts’ testimony is relevant, Defendants set up a strawman. Defendants claim that “medical uncertainty” exists around the treatment of gender dysphoria, based on a statement made by Treasurer Folwell. Dkt. 215 at 17-19. They fail to mention, however, that Treasurer Folwell’s belief comes from Dr. Robie, who Defendants concede is not qualified to opine on the treatment of gender dysphoria. Dkt. 180 (Ex. 11 (Folwell Deposition) at 170:8-171:8 (“Q: ... your belief that there was medical

uncertainty of this elective procedure was based on conversation you had with Dr. Robie? A: Generally speaking.”)). The Plan cannot claim “uncertainty” exists and shoehorn expert testimony based on the speculation and conjecture of an individual who is not even qualified to opine on the subject.

Further, Defendants do not rebut Plaintiffs’ challenges to the relevancy of certain opinions by their experts. Accordingly, the Court should exclude opinions related to

1. desistence (Dkt. 205 at 9-10; 207 at 10-11; 209 at 18-19);
2. supposed controversies in other countries (Dkt. 205 at 10-11);
3. hypotheses about the causation of gender dysphoria (Dkt. 205 at 11; 207 at 12; 209 at 18-19);
4. the validity and reliability of the DSM, which does not set forth treatment (Dkt. 207 at 11);
5. Dr. Levine’s opinions about the etiology and immutability of sex (Dkt. 213 at 8-9); and
6. Dr. Robie’s opinions about the supposed need for physicians to know the chromosomal makeup of their patients (Dkt. 203 at 13-14).

B. The challenged experts’ opinions are unreliable.

Expert testimony should only be admitted if it is reliable and “proffered evidence that has a greater potential to mislead than to enlighten should be excluded.” *In re Lipitor (Atorvastatin Calcium) Mktg., Sales Pracs. & Prods. Liab. Litig. (No II) MDL 2502*, 892 F.3d 624, 632 (4th Cir. 2018) (cleaned up). Moreover, “where a party seeks to qualify a

witness as an expert based upon experience, the district court must require the experiential witness to explain how his experience leads to the conclusion reached, why his experience is a sufficient basis for the opinion, and how his experience is reliably applied to the facts.” *Jackson v. United States*, 2010 WL 2228378, at *6 (D.S.C. May 28, 2010) (cleaned up).

Here, again, Defendants fail to meet their burden and have not contended with many of Plaintiffs’ arguments regarding reliability. Where Defendants do not address a particular argument, they should be deemed to have conceded the point.

1. Dr. Robie

Defendants now contend Dr. Robie’s opinions are limited to (1) medical knowledge he shared with other Board members;¹ (2) the diagnostic process primary care physicians follow; and (3) the importance of accurate information about a patient’s chromosomal sex during that process. Dkt. 215 at 34-35; Dkt. 215-5.²

But Dr. Robie does not inquire about his patients’ chromosomal makeup normally, Dkt. 203 at 13-14, and therefore cannot explain how such knowledge is important to the diagnostic process. Moreover, he only formed this opinion in 2019 in connection with this litigation. Accordingly, his opinion on this should be excluded as unreliable. *See Kiessling v. Kiawah Island Inn Co. LLC*, 2019 WL 331176, at *8 (D.S.C. Jan. 25, 2019).

¹ As noted above, to the extent Defendants say that Dr. Robie will testify to the medical knowledge he shared with other Board members, that is the role of a *fact* witness, not an expert.

² The Court should exclude any other expert opinions by Dr. Robie beyond these three, including those regarding costs (*see* Dkt. 203 at 15-17).

2. Dr. Hruz

Defendants do not refute that all of Dr. Hruz's opinions are based on hypotheses and not *facts*. Dkt. 205 at 11-13. "Speculation, guesswork and conjecture are not acceptable substitutes for facts and data, and an opinion based on speculation is not founded on reliable methodology." *Samuel v. Ford Motor Co.*, 112 F.Supp.2d 460, 470 n.11 (D. Md. 2000). And because "[a]n expert's opinion should be excluded when it is based on assumptions which are speculative and are not supported by the record," *Tyger Const. Co. Inc. v. Pensacola Const. Co.*, 29 F.3d 137, 142 (4th Cir. 1994), all of Dr. Hruz's opinions should be excluded.

Defendants also fail to rebut Plaintiffs' arguments about the misleading nature of some of Dr. Hruz's opinions. Dkt. 205 at 13-17. Defendants portray these arguments as mere disagreements, but there are no "alternative facts" in court. *See Old White Charities, Inc. v. Bankers Ins., LLC*, 2018 WL 8622359, at *6 n.10 (S.D.W. Va. Aug. 28, 2018). "Facts must be facts and truth must be truth." *Id.* at *6. Dr. Hruz is untruthful when he says gender-affirming care has not been accepted by relevant scientific communities, or when he says no medical care is provided to adolescents and adults with gender dysphoria under the "watchful waiting" model. Dkt. 205 at 13-14, 15. His opinions are more likely to mislead than to enlighten.

In addition, Dr. Hruz has conducted no scientific research or study with regards to gender dysphoria, rather he has read some articles and talked with other professionals. *Id.* at 6-7. But not only does he misrepresent the nature of his conversations, *see id.* at 20-22,

conversations with others health care professionals do not make him an expert. *See Jackson*, 2010 WL 2228378, at *7.

Finally, Defendants do not address Plaintiffs' argument that Dr. Hruz's testimony is unreliable because it is permeated by unscientific views and bias. Dkt. 205 at 19-23.

3. Dr. McHugh

Defendants' assertion that Plaintiffs' challenge opinions by Dr. McHugh not in his report strains credulity. The desistence opinions that Dr. McHugh offered at his deposition are rooted in his report. *See* Dkt. 207-4 at 14. Likewise, Dr. McHugh's opinions about reparative therapy are connected to his opinions that gender-affirming care is harmful and/or experimental. His belief in reparative therapy (widely considered harmful and unethical) as the proper mode of treatment for gender dysphoria underscores the unreliability of his opinions. Defendants also do not refute that the foundation of Dr. McHugh's opinions is that transgender people are supposedly "disordered" because they suffer from a "disorder of assumption" or "overvalued idea." Dkt. 207 at 13-14.

Defendants argue that Plaintiffs deem Dr. McHugh's views unreliable solely because he disagrees with the WPATH Standards of Care. Not true. Dr. McHugh's opinions conflict with those of *every* major medical or health organization in the United States. *Id.* at 14-17. This includes the U.S. Department of Health and Human Services ("HHS"), which just last week, proclaimed that, "[HHS] and all leading national medical and pediatric associations confirm that providing gender-affirming medical care is in the best interest of children and youth who need it." Ex. A.

Defendants also do not refute that Dr. McHugh's opinions are based on speculation and untested theories, Dkt. 207 at 17-18, and thus should be excluded because "speculation is unreliable evidence and is inadmissible." *Dunn v. Sandoz Pharms. Corp.*, 275 F.Supp.2d 672, 684 (M.D.N.C. 2003). Nor do Defendants refute that Dr. McHugh's opinions about the provision of care in other countries are both unreliable and misleading. Dkt. 207 at 18.

Defendants argue the Court should permit Dr. McHugh's opinions about the DSM, but aside from being irrelevant, those opinions are highly misleading, and Dr. McHugh's proposed alternative to the DSM "has been able to attract only minimal support within the community." Dkt. 207 at 19-20.

Finally, Defendants do not even attempt to negate that Dr. McHugh's opinions are so tainted by bias and prejudice that they are unreliable. *Id.* at 22-24.

4. Dr. Lappert

Ignoring their burden, Defendants do not respond to Plaintiffs' arguments that Dr. Lappert's non-surgery-related opinions are unreliable. Dkt. 207 at 9-10, 15-20. Whatever the reason for Defendants' failure to respond, they have not carried their burden to demonstrate that these opinions satisfy Rule 702.

Dr. Lappert's opinions on risks of surgical procedures are also unreliable. In particular, he opines about the supposed risks of these procedures when used to treat gender dysphoria. But that is a specific application of these procedures to a particular population with which Dr. Lappert admittedly has no first-hand experience whatsoever, and for which

he therefore has no basis to offer expert testimony. *See, e.g., SDM Software, Inc. v. EMove, Inc.*, 945 F.Supp.2d 628, 639 (E.D.N.C. 2013).

5. Dr. Levine

Defendants summarize some of what Dr. Levine will say but do not explain “how his experience leads to the conclusion reached” or “how his experience is reliably applied to the facts.” *Jackson*, 2010 WL 2228378, at *6 (cleaned up). Dr. Levine’s opinions are not relevant and reliable just because Defendants deem it so. Defendants cannot explain how Dr. Levine’s testimony will enlighten the factfinder, because it will not. And here, where Dr. Levine testified that he follows and applies the WPATH Standards of Care in his own practice, Dkt. 213 at 6-8, 12-13, his testimony against coverage of this care has a greater potential to mislead than to enlighten.

Ultimately, Defendants argue that Dr. Levine’s testimony about a purported lack of studies is based on his review of scientific literature and provides a basis for a factfinder to conclude the Exclusion is justified. But what Dr. Levine and Defendants fail to do explain how the alleged lack of long-term studies somehow proves that gender-affirming treatment is not medically necessary and effective, particularly given the multitude of cross-sectional, observational, and longitudinal studies demonstrating the efficacy of such treatment.³

³ The Court should disregard Defendants’ arguments about what certain studies show. Not only do Defendants misrepresent those studies (*e.g.*, Dkt. 207 at 18 n.5; 213 at 13-14), but legal argument from Defendants’ counsel is not expert testimony.

CONCLUSION

It is Defendants' burden to prove that the challenged experts are qualified and that their opinions are relevant and reliable; they have failed to do so. Defendants do not explain how their experts' experience leads to their conclusions, why their experience is a sufficient basis for their opinions, and how their experience is reliably applied to the facts of this case. To the contrary, the challenged experts' opinions are based on conjecture.

The Court should grant Plaintiffs' motions to exclude expert testimony.

Dated: March 9, 2022

Respectfully submitted,

/s/ Amy Richardson

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* Appearing by special appearance pursuant to L.R. 83.1(d).

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief is in compliance with Local Rule 7.3(d)(1) because the body of this brief, including headings and footnotes, does not exceed 3,125 words as indicated by Microsoft Word, the program used to prepare this document.

Dated: March 9, 2022

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CERTIFICATE OF SERVICE

I certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system which will send notification of such filing to all registered users.

Dated: March 9, 2022

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**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, in his official capacity as
State Treasurer of North Carolina, *et al.*,

Defendants.

Case No. 1:19-cv-00272-LCB-LPA

SUPPLEMENTAL DECLARATION OF OMAR GONZALEZ-PAGAN

Pursuant to 28 U.S.C. § 1746, I, Omar Gonzalez-Pagan, do hereby declare as follows:

1. I am over 18 years of age.
2. I am Counsel at Lambda Legal Defense and Education Fund, Inc. and serve as counsel of record for the plaintiffs in the above-captioned matter.
3. I have personal knowledge of the stated herein, except those stated on information and belief, and if called upon, could and would testify competently to them.
4. I submit this declaration in support of Plaintiffs' Reply in support of Plaintiffs' Motions to Exclude Expert Testimony of Dr. Peter Robie (ECF No. 202), Dr. Paul W. Hruz (ECF No. 204), Dr. Paul R. McHugh (ECF No. 206), Dr. Patrick W. Lappert (ECF No. 208), and Dr. Stephen B. Levine (ECF No. 212).

5. Attached as **Exhibit A** is a true and correct copy of Information Memorandum Log No. ACYF-CB-IM-22-01 issued by the Administration of Children, Youth and Families of the U.S. Department of Health and Human Services on March 2, 2022.

I declare under the penalty of perjury that the foregoing is true and correct.

Dated this 9th day of March, 2022.

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan

Exhibit A

Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA (M.D.N.C.)
Reply in Support of Plaintiffs' Motions to Exclude Experts

ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration on Children, Youth and Families	
	1. Log No: ACYF-CB-IM-22-01	2. Issuance Date: 03-02-2022
	3. Originating Office: Children's Bureau	
	4. Key Words: Title IV-E and Title IV-B; LGBTQI+; John H. Chafee Foster Care Program for Successful Transition to Adulthood; Training; Foster Care	

INFORMATION MEMORANDUM

TO: State, Tribal, and Territorial Agencies Administering or Supervising the Administration of Titles IV-E and IV-B of the Social Security Act (the Act); Indian Tribes and Indian Tribal Organizations

SUBJECT: Titles IV-B and IV-E of the Act program requirements that state, county, and tribal child welfare agencies and their federally funded contractors (collectively, title IV-B and IV-E agencies, unless otherwise noted) can use to guide their work when determining how best to serve lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI+¹) children and youth, including those with non-conforming gender identity or expression who are involved with the child welfare system.

LEGAL AND RELATED REFERENCES: Titles IV-B and IV-E of the Act

PURPOSE: Research and best child welfare practices clearly demonstrate that every child and youth in foster care should be affirmed and supported, including children and youth who are LGBTQI+ or who have a non-conforming gender identity or expression. Supporting and affirming LGBTQI+ children and youth in foster care is an overarching equity issue for each title IV-B and IV-E agency and for the Children's Bureau, and we encourage each agency to approach serving these children and youth through both a programmatic and an equity lens.

¹ Throughout the Information Memorandum, we use the term "LGBTQI+" as inclusive of individuals who have non-conforming gender identity or expression.

This Information Memorandum (IM) offers guidance to title IV-B and IV-E agencies when serving LGBTQI+ children and youth who are involved with the child welfare system. It also encourages agencies to consider the many provisions in titles IV-B and IV-E of the Act that agencies can use to help guide their work with families at risk, and when creating case plans for LGBTQI+ children and youth in foster care.

SUMMARY: Children and youth who are LGBTQI+ and are involved with the child welfare system historically and currently are particularly vulnerable and often are underserved. Many are at high risk for varying degrees of family rejection, neglect, exploitation, and hostility. Many other children and youth, especially transgender youth, are unable to access necessary and affirming medical care for a variety of reasons, including as a result of intentionally erected systemic barriers. These include policies that discourage, penalize, or otherwise impede providing such care and policies that falsely seek to characterize gender-affirming care, both of which present a severe risk of creating further barriers to access to such care. The Department of Health and Human Services and all leading national medical and pediatric associations confirm that providing gender-affirming medical care is in the best interest of children and youth who need it. Such children, youth, and their families can require specific support in order to ensure that a child or youth can remain at home in an emotionally and physically safe environment. As such, each title IV-B and IV-E agency should consider how best to provide services and supports to each LGBTQI+ child and youth who is at risk of entering or is in foster care. These services and supports should be tailored to their individual needs, including those related to their sexual orientation, gender identity, or gender expression.

Entities that accept title IV-B and IV-E federal funding must comply with the title IV-B and IV-E plan requirements associated with the funding, as well as with all other applicable federal laws. Title IV-B and IV-E agencies and their federally funded grantees and contractors are encouraged to apply the title IV-B and IV-E requirements in ways that are intentional, creative, and responsive to the needs of each LGBTQI+ child and youth who is involved with the child welfare system.

For example, title IV-B and IV-E agencies must consider and address the needs of children and youth in their care as part of their case plan. This includes placing them in safe, permanent placements that support the whole of each child and youth's well-being. This also should include addressing needs that a child or youth may have as a result of their sexual orientation, gender identity, or gender expression. Agencies also must consult with youth age 14 and older on various aspects of their case plans and provide services that are appropriate for older youth and young adults. Such services should address LGBTQI+ issues as needed. See generally section 475(1) of the Act. This IM delineates the title IV-B and IV-E program provisions that each agency should consider when serving LGBTQI+ children and youth who are in care or whose families are at risk of a child or youth entering foster care.

I. Background Research: LGBTQI+ Children and Youth

Studies demonstrate that children and youth who are LGBTQI+ are over-represented in the child welfare system. The Williams Institute published “Sexual and Gender Minority Youth in Foster Care,” which was the result of a multi-year study that examined the experiences of sexual and gender-minority youth in the Los Angeles, California foster care system (the LAFYS Study). The LAFYS Study found that LGBTQI+ youth are 1.5 to 2 times more likely than their peers to be living in foster care.² They also experienced increased rates of physical violence and emotional harm both prior to being involved with, and while in, the child welfare system.³ The LAFYS Study also found that 12.9% of LGBTQI+ children and youth reported poor treatment by the foster care system, compared to 5.8% of non-LGBTQI+ children and youth in foster care.⁴ LGBTQI+ children and youth were found to be more than 2.5 times more likely than their non-LGBTQI+ counterparts to be placed in congregate care placements, such as group homes.⁵ There is consensus across multiple stakeholders that most children and youth are best served in a family setting. Stays in congregate care should be based on a child or youth’s specialized behavioral and mental health needs or clinical disabilities,⁶ not on a child or youth’s sexual orientation or gender identity.

Additionally, many LGBTQI+ children and youth enter foster care as a result of familial conflict, neglect, exploitation, or hostility about their sexual orientation, gender identity, or gender expression.⁷ These youth also experience homelessness at disproportionately high rates, sometimes before entering foster care. These traumatic experiences correlate with increased rates of suicide and depression.⁸ This underscores the need for child welfare agencies to work with families of LGBTQI+ children and youth to address family conflict related to sexual orientation and gender identity prior to a crisis that necessitates the need for the child or youth to be removed from the home.

Every child and youth who is unable to live with their parents should be provided a safe, loving, and affirming foster care placement, regardless of the young person’s sexual orientation, gender

² Cooper, K., Katsinas, A., Nezhad, S., & Wilson, B. (2014, August). *Sexual and gender minority youth in foster care: Assessing disproportionality and disparities in Los Angeles*, p. 37. Retrieved from <http://williamsinstitute.law.ucla.edu/research/safe-schools-and-youth/lafys-aug-2014/>

³ *Id.* at 11.

⁴ *Id.* at 40.

⁵ *Id.* at 7.

⁶ The Children’s Bureau. (2015, May 13). *A national look at the use of congregate care in child welfare*. Retrieved from <http://www.acf.hhs.gov/cb/resource/congregate-care-brief>

⁷ Cooper, K., Kastanis, A., Nezhad, S., & Wilson, B. (2014, August). *Sexual and gender minority youth in foster care: Assessing disproportionality and disparities in Los Angeles*, p. 40. Retrieved from <http://williamsinstitute.law.ucla.edu/research/safe-schools-and-youth/lafys-aug-2014/>

⁸ *Id.*

identity, or gender expression.⁹ Evidence is clear that LGBTQI+ children and youth in foster care are most likely to thrive in safe, affirming environments without risk of physical or emotional harm on the basis of their sexual orientation or gender identity, and regardless of the type of placement in which the child lives.

II. Titles IV-B and IV-E: Provisions that Support LGBTQI+ Children and Youth

ACF recognizes that several existing federal laws, including title IV-B, title IV-E and their implementing regulations are intended to ensure the safety and well-being of children and youth in foster care, including the LGBTQI+ children and youth that child welfare agencies serve. These laws also provide funds for agencies to provide prevention and support services to families who are struggling to accept that the child or youth is LGBTQI+ or otherwise are not providing a safe environment for the child or youth. Similarly, title IV-E provides agencies with training funds to assist foster parents, kinship caregivers, and agency staff understand issues related to LGBTQI+ identities that are particularly relevant to children and youth in foster care.

This IM describes provisions in title IV-B and IV-E that child welfare agencies can use to support, encourage, and care for LGBTQI+ children and youth across the child welfare continuum. Similarly, this IM describes provisions that agencies can use to educate families, foster caregivers, and caseworkers.

A. Title IV-B Prevention and Family Preservation Services

Title IV-B of the Act provides funding to states and eligible tribes to provide “family preservation services,” which are defined as “services for children and families designed to help families (including adoptive and extended families) at risk or in crisis.” These services include preventive services, such as intensive family preservation programs that are designed to help children at risk of foster care placement remain safely with their families. Title IV-B funding also can be used to help parents identify where they need to develop or learn additional parenting skills, and to help parents build capacity to effectively parent an LGBTQI+ child or youth. See generally section 431(a)(1) of the Act.

⁹ See ACYF-CB-IM-11-03. Retrieved from <http://www.acf.hhs.gov/cb/resource/im1103>

Research is clear that children and youth who are LGBTQI+ enter foster care at disproportionate rates.¹⁰ Agencies should consider how to use family preservation funds and services to support families who are grappling with how to embrace an LGBTQI+ child or youth. For example, an agency could focus on parent education and building skills that will help the parent understand how best to support and parent the child in a safe and affirming manner that does not threaten the child's safety or well-being.

B. Title IV-B Adoption and Post-Adoption Support Services

Additionally, title IV-B provides funding to states and eligible tribes for “adoption promotion and support services.” Section 431(a)(8) of the Act defines “adoption promotion and support services” as those services “designed to encourage more adoptions out of the foster care system when adoptions promote the best interests of children, including such activities as pre and post adoptive services and activities designed to expedite the adoption process and support adoptive families.” Accordingly, title IV-B and IV-E agencies should consider what types of practices and services would best support families who have adopted LGBTQI+ children. These services can and should be intentional and highly personalized to address the needs of each family, child, and youth and can serve to support adoptive families whose adoptions may be at risk of disrupting because a child or youth is LGBTQI+. For example, an agency may assist a family in accessing gender affirming health care for their child or youth; connect the family with local supportive services; or update legal documents to reflect the child or youth's gender identity.

C. Title IV-E Reasonable Efforts to Prevent Removal

When determining whether a child should be removed from home, the title IV-E agency must ensure that it has made reasonable efforts to prevent the need for a child to be removed from home prior to being placed in foster care. Similarly, it must make reasonable efforts to reunify families when a child has been removed. See section 471(a)(15)(B) of the Act. Finally, once a child has been in foster care for 12 months, and every 12 months thereafter while in foster care, the agency must obtain court validation that it has made reasonable efforts to finalize the child's permanency plan. It also must ensure that when it makes reasonable efforts to prevent removal, reunify a family, or finalize the permanency plan, “the child's health and safety shall be the paramount concern.” See 45 C.F.R. § 1356.21; section 471(a)(15)(A) of the Act.

¹⁰ Cooper, K., Katsinas, A., Nezhad, S., & Wilson, B. (2014, August). *Sexual and gender minority youth in foster care: Assessing disproportionality and disparities in Los Angeles*, p. 37. Retrieved from <http://williamsinstitute.law.ucla.edu/research/safe-schools-and-youth/lafys-aug-2014/>.

Reasonable efforts are specific to each family's circumstances and needs. In the case of a family who is at risk or whose child or youth has been removed from home as a result of conflicts related to the child or youth being LGBTQI+, these efforts might include, but are not limited to working with a family to provide family preservation services around the issues with which the family is struggling. It might include parent outreach or education. It might include working closely with kinship supports to determine whether a kinship placement might be the most supportive and affirming for the child or youth. Similarly, reasonable efforts to finalize the permanency plan might include the agency's efforts to assist a parent complete longer term or ongoing parent education on parenting a child or youth who is LGBTQI+.

D. Title IV-E Case Review System

Each title IV-B and IV-E agency must have a case review system, which is a procedure for assuring various protections for each child and youth in foster care, including a case plan for each child and youth. The case plan must be individualized and designed to achieve placement in a "safe setting that is the least restrictive (most family like) and most appropriate setting available and in close proximity to the parents' home, consistent with the best interest and special needs of the child" or youth. See section 475(5)(A) of the Act. In addition, the case plan must address a variety of issues, including the child or youth's safety, services that facilitate reunification, and services that support the child or youth's needs while in foster care. See section 475(1)(A) and (B) of the Act. When developing and implementing the child's case plan, states and tribes must consider all of a child or youth's needs, including those related to their sexual orientation and gender identity. See sections 471(a)(16) and 475(1) of the Act.

The Children's Bureau recognizes that a safe and appropriate placement setting is one in which a child or youth's LGBTQI+ identity is supported and affirmed, and their individualized needs are considered and addressed, including those related to being LGBTQI+. Moreover, Children's Bureau acknowledges that a placement in which so called "conversion therapy," or any other attempt to undermine, suppress, or change the sexual orientation or gender identity of a child or youth in foster care is utilized, is neither safe nor appropriate. As such, there are no circumstances under which an LGBTQI+ child or youth should be subjected to so called "conversion therapy," including a child or youth in foster care. This practice has been widely discredited as both ineffective and harmful by the mental health, psychological, and medical fields. In fact, in 2015, the United States Substance Abuse and Mental Health Services Administration (SAMHSA) published a report that outlined research, clinical expertise, and expert consensus on therapeutic practices related to children's and adolescent's sexual

orientation and gender identity that made clear that so-called “conversion therapy” should not be used among this population.¹¹

Additionally, when considering a prospective foster care placement, including one for an LGBTQI+ child or youth, the title IV-E agency must consider whether the prospective environment will be physically and emotionally safe. This includes that the child or youth’s whole development will be supported and affirmed in the placement that the agency determines is most appropriate for the child or youth. Similarly, as part of the child or youth’s case plan, the title IV-E agency must provide services to facilitate a child or youth’s reunification with their parents, if that is the plan for the family. Specifically, the case plan must include how the agency is working to improve the conditions in the family such as any underlying issues or conflicts with the child or the youth’s parents that impede reunification, including those that relate to the child or youth’s sexual orientation or gender identity/expression.

E. Developmentally Appropriate Activities for Children and Youth in Foster Care

A title IV-E agency must ensure that children and youth in its care have caregivers who are trained in understanding developmentally appropriate activities for such children and youth, including the reasonable and prudent parenting standard. The reasonable and prudent parenting standard is the standard characterized by “careful and sensible parental decisions that maintain the health, safety and best interests of a child, while at the same time encouraging the emotional and developmental growth of the child...when determining whether to allow a child in foster care under the responsibility of the State to participate in extracurricular, enrichment, cultural, and social activities.” See sections 471(a)(10)(A) and 475(10) of the Act.

For example, as part of its title IV-E plan licensing requirements, the agency must ensure that each child-care institution has an onsite authority who is trained and authorized to apply the reasonable and prudent parenting standard for children and youth who are placed in the child-care institution. See section 471(a)(10) of the Act. Similarly, before placing a child or youth in a foster family home, a title IV-E agency must ensure that the foster parents have been prepared adequately to provide for the child or youth, including appropriate activities, knowledge, and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of the child or youth. See section 471(a)(24) of the Act.

¹¹ Substance Abuse and Mental Health Services Administration. (2015, November). *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*. Also accessible at: <http://store.samhsa.gov/shin/content//SMA15-4928/SMA15-4928.pdf>

This means, among other things, that an agency should consider a child or youth's sexual orientation and gender identity when determining how to facilitate their "extracurricular, enrichment, cultural, and social activities." See section 471(a)(24) of the Act. In order to ensure that children and youth have the opportunity to engage in age or developmentally appropriate activities, the title IV-E agency must consider the circumstances of each child and youth, which should include their sexual orientation and gender identity or expression. See section 475(11) of the Act. For example, participating in a school-based club could be a "developmentally appropriate" activity.

Each agency should also ensure that it does not prohibit LGBTQI+ children or youth from participating in such activities solely on the basis of the child or youth's sexual orientation or gender identity. Additionally, as appropriate or requested, agencies should help to provide LGBTQI+ children or youth with opportunities to participate in activities such as mentoring programs, peer support groups, or other community activities that affirm and support their identities in an age-appropriate manner. See sections 471(a)(10) and (24) of the Act; see also sections 475(5)(B) and (11)(A) of the Act. For example, if a youth in foster care wanted to participate in a Gender and Sexualities Alliance club within their high school, or attend faith-based youth groups, the title IV-E agency should not deny them the opportunity to do so solely because of their perceived or expressed sexual orientation and gender identity. Similarly, the title IV-E agency should provide individualized, intentional services to assist LGBTQI+ older youth and young adults transition to adulthood, including those related to their sexual orientation or gender identity, and including those related to their religious or spiritual beliefs and faith life.

Each agency should familiarize itself and partner with community and local LGBTQI+ affirming entities that parents, kinship providers, prospective parents, and child-care institution authorities can access to assist them to support and care for an LGBTQI+ child or youth. We also encourage each title IV-E agency to consider how it can ensure that each LGBTQI+ child and youth has the ability to participate in a wide variety of activities, including those that may affirm or support their identity.

F. John H. Chafee Foster Care Program for Successful Transition to Adulthood (Chafee Program)

The Chafee program provides funding for services and support to children and youth who have experienced foster care at age 14 or older to transition to self-sufficiency. See section 477 of the Act. These funds are used to assist youth to engage in age or developmentally appropriate activities; positive youth development; and experiential learning that reflects what their peers in intact families experience. See section 477(a)(3) of the Act. It also provides funding for a variety of services and supports to former foster care recipients who are between 18 and 21 years of

age (or 23 years of age, at state option). These services and supports should complement the youth/young adult's own efforts to achieve self-sufficiency and assist young adults to accept responsibility for transitioning from adolescence to adulthood. See section 477(a)(4) of the Act. States and eligible tribes that receive Chafee funds must use objective criteria for determining eligibility for benefits and services under the programs, and for ensuring that Chafee recipients, including those who are LGBTQI+, receive fair and equitable treatment. See section 477(b)(2)(E) of the Act.

G. Title IV-E Administrative and Training Funds

In accordance with an approved cost allocation plan, a title IV-E agency may use and claim title IV-E training and administrative funds to train agency staff and foster and adoptive parents in competencies related to bolstering protective factors and parenting LGBTQI+ children and youth. The types of training courses that may be allowable include, but are not limited to: courses that address the particular health care needs of LGBTQI+ children and youth; particular child development issues that are common to LGBTQI+ children and youth, such as emotional support or support for trauma related to violence that a child or youth has experienced that is related to sexual orientation or gender identity/expression; resources that are available to support such children within an under-served community; trainings related to uncovering or addressing bias against LGBTQI+ individuals and other such issues.

In addition, an agency may claim title IV-E training funds to support prospective adoptive or foster parents' attendance at conferences that have training components or that include discussions of significant issues covering the needs of LGBTQI+ children and youth in foster care or who have been adopted. See generally section 474(a) of the Act; 45 C.F.R. § 1356.60; Child Welfare Policy Manual (CWPM) at § 8.1H, including Question and Answer (QA) #21. We strongly encourage each title IV-E agency to consider how to use title IV-E administrative and training funds to bolster its capacity and skill to train its foster and adoptive parents and care for LGBTQI+ children and youth.

III. Enforcement

A. Fair Hearings

Federal regulations require the agency responsible for the title IV-E and title IV-B programs to provide an opportunity for a fair hearing to any individual whose claim for benefits or services is denied or is not acted upon with reasonable promptness. See section 471(a)(12) of the Act; 45 C.F.R. § 205.10 (through cross reference at 45 C.F.R. § 1355.30). This includes an opportunity

for complainants to have access to the fair hearing process for LGBTQI+ related service disputes, including not providing age or developmentally appropriate services or services identified in the case plan to the youth on the basis of sexual orientation or gender identity. See CWPM §8.4G, QA #1.

Each state or tribal title IV-E agency's fair hearing process differs slightly. However, the hearing process always requires, among other things, that applicants and recipients be advised of their right to a hearing, that they may be represented by an authorized representative, and that there be a timely notice of the date and place of the hearing. See 45 C.F.R. § 1355.30 (p) and § 205.10. To the extent that a state or tribe's fair hearing process does not include appeals for service-related issues for LGBTQI+ children and youth, we strongly encourage the agency to consider ensuring that its fair hearing process can address such issues as needed.

B. Partial Reviews

The regulations at 45 C.F.R. § 1355.32(d) regarding partial reviews of title IV-E or IV-B plans allow ACF to conduct a partial review appropriate to the nature of the concern if ACF becomes aware of a title IV-B or IV-E compliance issue outside the scope of the Child and Family Services Review (CFSR). As part of the partial review, ACF will conduct an inquiry and require the title IV-E agency to submit additional data as may be necessary. If the inquiry demonstrates that the agency is not in compliance with its title IV-B or IV-E plan, the agency must enter into a program improvement plan (PIP) that is designed to bring the agency into compliance with its plan and relevant requirements. If, after the PIP process, the agency still fails to comply with the applicable requirements, the agency will be subject to a penalty related to the extent of the noncompliance. See 45 C.F.R. § 1355.32(d)(4). The partial review process applies to title IV-B and IV-E plan compliance issues that involve children and youth who are LGBTQI+.

Conclusion

The Children's Bureau stands solidly in support of LGBTQI+ children and youth who are involved with the child welfare system. Each agency should be intentional about assessing each LGBTQI+ child and youth's individualized needs, including those related to the child or youth being LGBTQI+. LGBTQI+ children and youth experience higher rates of violence prior to and while in foster care than their non-LGBTQI+ peers. Too often, systemic barriers and practices are created to deny such children and youth gender affirming medical care, especially to transgender and gender nonconforming children and youth. The Children's Bureau does not support these barriers and practices, and we are unequivocal that they are counter to children and youth's best interests. As such, each title IV-E agency should be particularly vigilant about placing LGBTQI+ children and youth in homes and child-care institutions where they are supported, safe, and can develop as a whole person. But the agency's responsibility does not stop there: each agency

also should provide LGBTQI+ children and youth with opportunities to participate in activities that further support their identity, resilience, and development, including activities related to being LGBTQI+.

Additionally, we strongly encourage agencies to take advantage of opportunities to work internally to develop the capacity to identify, understand, and address some of the issues that often confront LGBTQI+ children and youth at different points in the child welfare continuum. An agency also should consider whether its data can inform appropriate services to LGBTQI+ children, youth, and families, including when a family is at risk of a child or youth entering foster care, once a child is in foster care, or after the child has been adopted. The agency must be prepared and competent to address trauma-related issues that have occurred as a result of the child or youth facing rejection, discrimination, or harassment because they are LGBTQI+, especially in their family of origin. Children's Bureau also strongly encourages agencies to focus attention on ensuring that each LGBTQI+ child has access to affirming medical care. This includes working with and providing services and training opportunities to parents who are struggling to accept that their child or youth is LGBTQI+ or has a non-conforming gender identity, especially when that is either the cause of the child or youth being removed or a barrier to a safe, healthy reunification.

Finally, the Children's Bureau has resources to help each agency develop the capacity to serve LGBTQI+ children and youth, as well as their foster parents, adoptive parents, and kinship caregivers. Consider partnering with community organizations that can provide additional or specialized support to LGBTQI+ children, youth, and families who are involved with your agency. We also encourage each agency to take advantage of the wide variety of resources accessible on the [Child Welfare Information Gateway](#). The [Children's Bureau's Regional Program Managers](#) also stand ready to assist each agency to support, affirm, encourage, and lift up the voices and experiences of each LGBTQI+ child and youth in its care.

INQUIRIES TO:

[Children's Bureau Regional Program Managers](#)