

ACL 19-27

May 8, 2019

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**EXECUTIVE SUMMARY**

**ALL COUNTY LETTER NO. 19-27**

This All County Letter outlines the provisions of Assembly Bill (AB) 2119 of 2018. This legislation expands the rights of minor and nonminor dependents in foster care to include covered gender affirming physical health care and gender affirming mental health care. Further, a minor/nonminor dependent's involvement in developing their own case plan shall include elements related to placement and gender affirming health care with consideration of their gender identity.



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**DEPARTMENT OF SOCIAL SERVICES**  
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GAVIN NEWSOM  
GOVERNOR

May 8, 2019

ALL COUNTY LETTER (ACL) NO. 19-27

TO: ALL COUNTY CHILD WELFARE DEPARTMENTS  
ALL COUNTY CHILD WELFARE PROGRAM MANAGERS  
ALL CHIEF PROBATION OFFICERS  
ALL FOSTER CARE MANAGERS  
ALL GROUP HOME DIRECTORS  
ALL FOSTER FAMILY AGENCY DIRECTORS  
ALL JUDICIAL COUNCIL STAFF  
ALL TITLE IV-E AGREEMENT TRIBES

SUBJECT: GENDER AFFIRMING CARE FOR MINOR AND NONMINOR  
DEPENDENTS IN FOSTER CARE

REFERENCE: [ASSEMBLY BILL \(AB\) 2119 OF 2018, HEALTH AND SAFETY  
CODE SECTION 1365.5, TITLE 45 CODE OF FEDERAL  
REGULATIONS \(CFR\) SECTION 92.207, WELFARE AND  
INSTITUTIONS CODE \(W&IC\) SECTIONS 11400, 16001.9 and  
16010.2, PROVIDER INFORMATION NOTICE 17-12-CRP,  
DEPARTMENT OF HEALTH CARE SERVICES \(DHCS\) ALL PLAN  
LETTER 16-013, ALL COUNTY INFORMATION NOTICE I-81-10](#)

## PURPOSE

The purpose of this All County Letter (ACL) is to inform county placing agencies, foster family agencies, and administrators of group home and short-term residential therapeutic programs of the passage of [Assembly Bill \(AB\) 2119](#) (Chapter 385, Statutes of 2018), which went into effect on January 1, 2019.

The AB [2119](#) clarifies that minor and nonminor dependents in foster care have the right to receive physical health and mental health care that includes gender affirming medical and mental health care services. This new legislation makes explicit the rights of minor and nonminor dependents in foster care to be involved in the development of case plan

elements related to placement and gender affirming health care, consistent with their gender identity.

Lastly, AB [2119](#) requires the California Department of Social Services (CDSS), in consultation with the Department of Health Care Services (DHCS) and other stakeholders, to develop guidance and describe best practices to identify, coordinate, and support minor and nonminor dependents seeking access to gender affirming physical health care and gender affirming mental health care. For purposes of this ACL, guidance will include information about ensuring access to Medi-Cal covered services for transgender beneficiaries and resources to help identify licensed and qualified providers experienced in providing gender affirming care.

## BACKGROUND

According to a recent federally-funded study of Los Angeles County's foster care system, approximately 5.6 percent of youth in foster care identify as transgender.<sup>1</sup> As defined by the Human Rights Campaign, a transgender person is someone whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth.<sup>2</sup> Transgender and Gender-Nonconforming (TGNC) minor and nonminor dependents in foster care experience unique challenges caused by personal biases and beliefs from their families, caregivers, peers, and professionals.<sup>3</sup> Although this population shares many of the same experiences as their same-aged foster peers, they are at an increased risk of experiencing adverse physical and mental health outcomes due to societal and familial rejection, harassment and stigma.<sup>4</sup> As a result, TGNC minor and nonminor dependents in foster care often encounter multiple placement disruptions including periods of homelessness, high rates of depression, suicidality, and substance abuse.<sup>5</sup> Therefore, it is critical that county social workers (SW), probation officers (PO), caregivers and others working with minor and nonminor dependents in foster care are responsive to the unique needs of TGNC minors, and do not ignore or discredit a minor/nonminor dependent's request or need for gender affirming physical health and mental health care.

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<sup>1</sup> Bianca D.M. Wilson et al., *New Report: Sexual and Gender Minority Youth in Foster Care*, WILLIAMS INST., at 6 (Aug. 2014), [https://williamsinstitute.law.ucla.edu/wp-content/uploads/LAFYS\\_report\\_final-aug-2014.pdf](https://williamsinstitute.law.ucla.edu/wp-content/uploads/LAFYS_report_final-aug-2014.pdf) [hereinafter "*Sexual and Gender Minority Youth*"]; See also LAMBDA LEGAL, CHILDREN'S RIGHTS, & CTR. FOR THE STUDY OF SOC. POLICY, *Safe Havens: Closing the Gap Between Recommended Practice and Reality for Transgender and Gender-Expansive Youth in Out-of-Home Care*, at 2 (Apr. 2017), [https://www.lambdalegal.org/sites/default/files/publications/downloads/tgnc-policy-report\\_2017\\_final-web\\_05-02-17.pdf](https://www.lambdalegal.org/sites/default/files/publications/downloads/tgnc-policy-report_2017_final-web_05-02-17.pdf) [hereinafter "*Safe Havens*"].

<sup>2</sup> The Human Rights Campaign: <https://www.hrc.org/resources/sexual-orientation-and-gender-identity-terminology-and-definitions>

<sup>3</sup> Transgender and Gender Nonconforming Children in California Foster Care <http://www.nclrights.org/wp-content/uploads/2016/02/TGNC-Children-in-CA-Foster-Care-2.24.16.pdf>

<sup>4</sup> *Sexual and Minority Youth*, at 35.

<sup>5</sup> *Id.* at 38; *Safe Havens*, at 26.

## CHANGES TO THE RIGHTS OF MINOR AND NONMINOR DEPENDENTS IN FOSTER CARE

The passage of AB [2119](#) resulted in two changes to the Foster Youth Bill of Rights, defined in Welfare and Institutions Code (W&IC) section 16001.9. First, AB 2119 makes clear the existing right to “receive medical, dental, vision and mental health services”<sup>6</sup> includes the right to access gender affirming physical health care and gender affirming mental health care.<sup>7</sup> The AB 2119 also clarifies the right to receive gender affirming physical health care and gender affirming mental health care is subject to existing laws governing consent to health care for minor and nonminor dependents in foster care and does not add, limit, or otherwise affect applicable laws governing consent to health care. Existing law states minor and nonminor dependents in foster care must be involved with the development of their case plan and plan for permanent placement. The AB 2119 extends this right to include the right to be involved in the development of case plan elements related to placement and gender affirming health care consistent with their gender identity.<sup>8</sup>

### IMPLEMENTATION OF AB 2119

The AB 2119 added W&IC section 16010.2(b)(2) which requires CDSS, *in consultation with DHCS and other stakeholders*, to develop guidance and describe best practices to identify, coordinate, and support minor and nonminor dependents in foster care seeking access to gender affirming physical health care and gender affirming mental health care. Minor and nonminor dependents in foster care are eligible for Medi-Cal services and therefore are able to access gender affirming healthcare services as Medi-Cal beneficiaries. For more information and to read existing guidance related to Medi-Cal services for transgender beneficiaries, please review DHCS’ All Plan Letter (APL) [16-013](#), dated October 6, 2016. This APL confirmed Medi-Cal Managed Health Plans, which serve our California minor and nonminor dependents in foster care, must provide medically necessary covered services to all Medi-Cal beneficiaries, including transgender beneficiaries.

The AB 2119 also defined what constitutes gender affirming physical health care and gender affirming mental health care. These definitions, as stated in W&IC section 16010.2 (b)(3) are:

*(A) “Gender affirming health care” means medically necessary health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to, the following:*

*(i) Interventions to suppress the development of endogenous secondary sex characteristics.*

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<sup>6</sup> W&IC section 16001.9, subd. (a)(4).

<sup>7</sup> W&IC section 16010.2 subd. (b)(1).

<sup>8</sup> W&IC section 16001.9 subd. (a)(19).

(ii) Interventions to align the patient's appearance or physical body with the patient's gender identity.

(iii) Interventions to alleviate symptoms of clinically significant distress resulting from gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.

(B) "Gender affirming mental health care" means mental health care or behavioral health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to, developmentally appropriate exploration and integration of identity, reduction of distress, adaptive coping, and strategies to increase family acceptance.

## **COLLABORATIVE EFFORTS**

The CDSS in collaboration with subject matter experts of the Continuum of Care Reform Sexual Orientation and Gender Identity and Expression (SOGIE) Advisory Group and DHCS developed the following guidance and best practices to assist county SWs, POs, and foster caregivers working with TGNC minor and nonminor dependents in foster care.

## **GUIDANCE AND BEST PRACTICES IN SERVING TGNC MINOR AND NONMINOR DEPENDENTS IN FOSTER CARE**

The following guidance includes seven separate sections: (1) Definitions of Commonly Used Terms; (2) Gender Affirming Physical Health Care and Gender Affirming Mental Health Care Services; (3) Covered Gender Affirming Services for Minor and Nonminor Dependents in Foster Care; (4) Consent Laws for Gender Affirming Care for Minor and Nonminor Dependents in Foster Care; (5) Required Responsibilities for County Case Management Workers; (6) Working with TGNC Minor and Nonminor Dependents in Foster Care; and (7) Identifying Qualified and Licensed Gender Affirming Providers.

### I. Definitions of Commonly Used Terms

**Gender identity** refers to a person's internal sense of being either male, female, both, or neither. It is a deeply felt, core component of a person's identity connected with a variety of social, psychological, and/or emotional traits. Every person has a gender identity. Gender identity is not necessarily the same as assigned or presumed sex at birth. Individuals whose gender identity matches their sex assumed or assigned at birth are "cisgender."

**Transgender** describes people whose gender identity does not match the sex assigned to them at birth. For example, a transgender boy is a child who was assigned female at birth, but who identifies as a boy. Likewise, a transgender girl is a child who was

assigned male at birth, but who identifies as a girl. Transgender identity is a part of natural human diversity and should not be viewed or treated as negative or pathological. Transgender persons may also include “non-binary” people who do not identify as either male or female.

**Gender nonconforming** describes people whose gender expression differs from the cultural norms prescribed for their assigned sex and/or gender identity. Terms such as “gender expansive,” “gender diverse,” and “gender variant” are used to describe gender nonconforming individuals. As with transgender individuals, gender nonconforming people may also identify as non-binary.<sup>9</sup>

**Gender dysphoria** is defined by the World Professional Association of Transgender Health as discomfort or distress that is caused by a disparity between one’s gender identity and their sex assigned at birth. According to the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition (DSM-5) the “clinically significant distress” a person experiences associated with their sex and gender assigned at birth is the critical element of gender dysphoria. Symptoms and signs of gender dysphoria can include any of the following: disgust of one’s own genitalia, social isolation from peers, anxiety, loneliness, depression, and suicidal ideations or attempts. Depending on the person, gender dysphoria can range from manageable to debilitating especially as puberty begins, which can cause problems with school performance and social interactions.<sup>10</sup>

It is important for county case management workers and foster caregivers to respect and affirm the minor/nonminor dependent’s preferred term, as experienced and defined by the minor/nonminor dependent and welcome any opportunity to learn from them what their needs may be as it relates to service delivery, service planning, and/or placement.

For further definitions and terminology related to sexual orientation and gender identity, please refer to All County Letter [18-133](#).

## II. Gender Affirming Physical Health Care and Gender Affirming Mental Health Care Services

Gender affirming care involves an individualized approach that allows TGNC individuals to explore and understand their gender identity at their own pace. For individuals experiencing gender dysphoria, treatment focuses on alleviating distress by taking

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<sup>9</sup> See GET R.E.A.L. CALIFORNIA, FAMILY BUILDERS, CTR. FOR THE STUDY OF SOC. POL’Y, & NAT’L CTR. FOR LESBIAN RIGHTS, *Transgender and Gender Nonconforming Children in California Foster Care*, <http://www.cclid.ca.gov/res/pdf/TGNCCChildrenCAFosterCare.pdf>  
[LAMBDA LEGAL, Glossary, Glossary | Lambda Legal](#)

<sup>10</sup> HUMAN RIGHTS CAMPAIGN, AM. COLLEGE OF OSTEOPATHIC PEDIATRICIANS, & AM. ACAD. OF PEDIATRICS, *SUPPORTING & CARING FOR TRANSGENDER CHILDREN* (2016), [https://assets2.hrc.org/files/documents/SupportingCaringforTransChildren.pdf?\\_ga=2.89992479.568513386.1541786151-1555657000.1519230320](https://assets2.hrc.org/files/documents/SupportingCaringforTransChildren.pdf?_ga=2.89992479.568513386.1541786151-1555657000.1519230320).

steps, known as “gender transition,” to affirm the gender that is authentic to the individual. Gender transition often assists a person in aligning their appearance more closely with their gender identity and expression. Transition is an individual process, which is different for every person. Not all transgender people can or undergo medical forms of transition. Transgender people may transition as children, teenagers, or adults. The transition process is unique for each individual and may include:

- **Social transition:** living in alignment with one’s gender identity, which may include changing one’s name, hairstyle, clothing, identity documents, and the pronouns used to describe oneself. Social transition may also include participation in sports and other activities, or accessing restrooms and changing rooms, consistent with one’s gender identity.
- **Puberty suppression:** temporarily and reversibly suppressing puberty by using gonadotropin-releasing hormone analogs or “hormone blockers.” Delaying puberty prevents the increased dysphoria frequently associated with puberty and avoids the development of permanent secondary-sex characteristics. Pausing puberty allows TGNC children additional time to work with health and behavioral health providers to determine the next steps in their transition, if any.
- **Cross sex hormone therapy (aka Hormone Replacement Therapy):** using cross-sex hormones (testosterone or estrogen) to induce masculinizing or feminizing physical changes consistent with one’s gender identity.
- **Gender confirmation surgery or reconstructive surgery:** undergoing surgical procedures that change the appearance and/or function of one’s physical body to align with one’s gender identity.

Gender affirming mental health care requires providers to be experienced in working with TGNC children, youth, young adults, and their families. Experienced mental health service providers are vital resources as they help parents/caregivers understand gender-expansive behavior and gender dysphoria and are able to share strategies to help support the TGNC child, youth, or young adult. Gender affirmative approaches follow the young person’s lead and promote developmentally appropriate exploration and integration of one’s identity, including strategies and skills to reduce distress while encouraging resilience to support one’s overall health and well-being.

All TGNC minors and nonminor dependents in foster care need accurate and timely information related to gender identity and expression including access to gender affirming health and mental health care. It is the role of the child welfare agency and foster caregiver to support a minor/nonminor dependent’s ability to access gender affirming physical health care and gender affirming mental health care while recognizing that community support is an important aspect of affirming an individual’s transition, and

ultimately their overall wellness.<sup>11</sup> The required responsibilities of county case management workers is discussed later in Section V of this letter.

### III. Covered Gender Affirming Services for Minor and Nonminor Dependents in Foster Care

According to the DHCS APL [16-013](#), dated October 6, 2016, Medi-Cal Managed Care Health Plans are to provide all Medi-Cal beneficiaries, including transgender beneficiaries, with medically necessary covered services including (but not limited to) services that meet the definition of reconstructive surgery.

Medically necessary covered services are those services “*which are reasonable and necessary to protect life, to prevent significant illness or disability, and to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury*” (Title 22 California Code of Regulations section 51303).

Reconstructive surgery is “*surgery performed to correct or repair abnormal structures of the body . . . to create a normal appearance to the extent possible*” (Health and Safety Code section 1367.63(c)(1)(B)).

The determination of whether a medical service requested by a transgender beneficiary is medically necessary must be made by a licensed and qualified mental health professional and/or the treating surgeon, in collaboration with the beneficiary’s primary care provider. As long as a service is deemed medically necessary by the minor or nonminor dependent’s respective medical professionals, any of the aforementioned medical services that a TGNC minor may require, including puberty suppression, cross sex hormone therapy or hormone replacement therapy and gender confirmation surgery or reconstructive surgery are covered services under Medi-Cal Managed Care Health Plans.

### IV. Consent Laws for Gender Affirming Care for Minor and Nonminor Dependents in Foster Care

Gender affirming physical care and gender affirming mental health care are subject to the same rules governing consent for other medical or behavior health care services for minor and nonminor dependents in foster care. Minor and nonminor dependents in foster care who are age 12 years or older may privately seek and consent to certain services, including outpatient behavioral health counseling and treatment, which includes gender affirming mental health care.<sup>12</sup>

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<sup>11</sup> See Russell et al., *Chosen Name Use is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth*, J. ADOLESCENT HEALTH (2018) (online publication ahead of print), <https://www.ncbi.nlm.nih.gov/pubmed/29609917>.

<sup>12</sup> Health and Safety Code section 124260



If a minor in foster care is under age 12 and seeking behavioral health treatment or is under age 18 and seeking surgical or medical treatment, a parent or legal guardian of said minor generally must provide consent, unless the juvenile court has limited the parents' medical rights. After due notice, if no parent or guardian is capable of authorizing or willing to authorize medical, surgical, or other remedial care or treatment for the minor in foster care, the juvenile court may authorize a SW, PO, or person standing in loco parentis, if any, to consent to medical, surgical, or other remedial gender affirming care upon the recommendation of the attending physician and surgeon.<sup>13</sup> If the court has limited the parent's rights to make medical decisions on behalf of the minor, then a court order must be granted for a minor under 12 to receive mental health treatment and for a minor under 18 to receive medical treatment (to include medications or surgery).

Nonminor dependents in foster care have reached the age of majority and therefore may legally consent to their own medical and mental health care.

#### V. Required Responsibilities for County Case Management Workers

Under AB 2119, the SW or PO is responsible for ensuring a TGNC minor/nonminor dependent in foster care has access to gender affirming care provided by qualified and licensed clinicians experienced in working with TGNC children and youth. The CDSS along with members of the SOGIE Advisory Group have developed some resources to assist county case management workers. A screening tool with specific questions to ask medical and mental health providers has been developed. Additionally, a list of competent providers of gender affirming mental health care and gender affirming medical care by region is included with the screening tool. If a provider serving a minor is not included on the developed list, then it is recommended the case management worker use the screening tool to ensure the provider is qualified to assist the minor. It is not the responsibility of the SW or PO to determine the appropriate treatment protocols for the TGNC minor or nonminor dependent in foster care. The CDSS recommends SWs and POs simply ensure a qualified provider is serving the minor/nonminor dependent, and the doctor or professional or team of professionals will determine the best course of treatment.

Further, when working with minor/nonminor dependents in the development of their case plan and plan for permanent placement, the SW or PO must ensure case plan elements related to placement and gender affirming health care consider the young person's gender identity. The inclusion of specified case plan elements were added to the Foster Youth Bill of Rights defined in W&IC section 16001.9 (a). While a person's gender identity may affect certain case plan elements for a minor, it is not necessary to share private, personal information about a minor's gender identity in the case plan. For example, a TGNC minor may be receiving weekly therapy from a qualified gender affirming therapist. The fact the minor identifies as TGNC and the therapist is gender

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<sup>13</sup> W&IC section 369 subd. (c)

affirming does not need to be specified in the case plan. This element in the case plan can be kept general so it would simply say “weekly therapy” and not state the specific reason or that therapy is provided by a specialized provider.

#### VI. Working with TGNC Minor and Nonminor Dependents in Foster Care

Because transitioning is such an individual process, and there is no single way to “be” transgender, different indicators (including disclosure by the young person) may or may not be present. Additionally, the young person may or may not feel supported and affirmed in their identity and therefore may not readily disclose this information. Lastly, not all young persons can or do come out; therefore, we cannot assume any one young person is or is not TGNC unless that young person has disclosed this information.

Some of the ways a young person may display or verbally express signs of distress about their gender may include:

- The young person exhibits elevated or severe discomfort related to their sex assigned at birth and/or prescribed gender identity.
- The young person expresses disgust about their body, especially their genitals/secondary sex characteristics, and may even harm their body parts.
- The distress gets worse as the young person gets older, particularly as puberty approaches or begins.
- The young person asserts they are a different gender that does not align with the sex assigned to them at birth consistently, persistently and with little or no ambivalence.
- The young person repeatedly voices or expresses they want to know more about gender identity, gender expression, or other gender-related topics.

It is essential SWs, POs, and foster care providers nurture open and honest relationships with minor and nonminor dependents in foster care they serve not only to assist them in receiving their physical health and mental health care services, but also to demonstrate to the young person they are affirmed, valued, and respected without judgement or criticism. Additionally, it is important caregivers contact the minor’s SW or PO when the minor/nonminor dependent’s needs are identified, or if the caregiver is having trouble locating a gender affirming provider or any barriers in receiving gender affirming services have been identified.

#### VII. Identifying Qualified and Licensed Gender Affirming Providers

All SWs and POs are encouraged to ask questions when seeking out a gender affirming medical or mental health provider to ensure the provider is both competent and affirming. Below are some examples of topics that should be considered:

- The expertise of the provider working with TGNC young persons in a specified age group.

- The provider's familiarity with relevant standards of care, particularly for treatment of gender dysphoria.
- The provider's treatment approach working with TGNC young persons.
- Other professionals with whom the provider may consult or collaborate when working with a TGNC young person.

The CDSS along with workgroup members of the SOGIE Advisory Group have developed some resources to assist SWs and POs with finding appropriate providers for TGNC youth. Please review the screening tool, which will assist case managers with some suggested questions to ask a potential provider to determine if they are qualified and affirming. Additionally, a list of qualified mental health and health care providers who are gender affirming has been developed, organized by region.

This screening tool and list of providers may be viewed here:

<http://www.cdss.ca.gov/Portals/9/Screening%20Tool%202.19.19.pdf?ver=2019-02-19-161842-863>.

## **CONCLUSION**

The CDSS has issued this letter with the intent to provide counties with assistance in the implementation of AB 2119 and to provide guidance in best serving TGNC minor and nonminor dependents in foster care.

If you have any questions or need additional guidance regarding the information in this letter, please contact the Permanency Policy Bureau at (916) 657-1858 or via email at [SexualDevWorkgroup@dss.ca.gov](mailto:SexualDevWorkgroup@dss.ca.gov).

Sincerely,

### **Original Document Signed By:**

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