A Public Health Law Response to Gender-Affirming Care Bans

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INTRODUCTION

Anti-LGBTQ+ legislation is surging across the United States, with over 500 bills introduced across 49 states this year targeting healthcare access, school sports, drag, and bathrooms.[1] This uptick reflects resistance to changing societal norms with respect to gender identity, along with scientific disinformation. Many of these bills ban access to gender-affirming care for minors, imposing harsh sanctions on medical professionals who comply with recognized standards of care. In September 2023, the Sixth Circuit Court of Appeals upheld Tennessee and Kentucky bans on gender-affirming care for minors.[2] The Sixth Circuit ruling in particular has created a split in decisions among circuit courts, making a future Supreme Court reckoning on the issue likely.[3] Such bans on gender-affirming care are likely to have disastrous effects on transgender youths' physical and mental health outcomes.[4] Transgender minors in the United States experience significant health disparities and are far more likely than their cis-gender counterparts to experience mental health challenges such as depression, anxiety, self-harm, and suicidality.[5] Gender-affirming care for minors serves as an evidence-based mental health intervention for individuals whose gender does not match their sex-assigned-at-birth.[6] This paper will describe the scope of the issue by drawing on public health disciplines and specifically a social determinants of health approach to exemplify health disparities among transgender adolescents. This paper will then analyze the Sixth Circuit Court of Appeals decision in *L.W. v. Skrmetti*, and frame both the equal protection and due process arguments. The paper will then propose short-term solutions to this public mental health crisis. This analysis will draw on public health principles for those on the ground in states that have upheld gender-

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[1] *Mapping Attacks on LGBTQ Rights in State Legislatures*, ACLU (Mar. 1, 2024), https://www.aclu.org/legislative-attacks-on-lgbtq-rights.

[2] L.W. v. Skrmetti, 83 F.4th 460, 491 (6th Cir. 2023).

[3] Mary Anne Pazanowski, *Gender-Affirming Care Ruling Could Force Supreme Court Reckoning*, BL, (Sept. 29, 2023, 2:54 PM), https://news.bloomberglaw.com/us-law-week/gender-affirming-care-ruling-could-force-supreme-court-reckoning?context=search&index=9.

[4] Susan Jaffe, *More US States Ban Teenagers' Gender-Affirming Care*, 402 LANCET 839 (2023).

[5] Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS 1, 3 (2018) [hereinafter Rafferty].

[6] *Id.* at 4.

affirming care bans and will identify practical tools that could serve as guidance in the wake of a Supreme Court ruling that upholds the Sixth Circuit's decision. In the face of gender-affirming care bans, public health approaches are necessary to (1) reduce harm among the trans minor population in the short term, and (2) implement evidence-based policy for a long-term solution.

I. BACKGROUND

A. *Gender-Affirming Care as an Evidence-Based Intervention for Transgender and Nonbinary Youth*

Transgender and nonbinary children experience significant mental health disparities compared to cisgender children, including increased rates of depression, anxiety, and suicidality.[7] Youths who identify as transgender often also experience gender dysphoria, "a clinical symptom that is characterized by a sense of alienation to some or all of the physical characteristics or social roles of one's assigned gender."[8] Gender dysphoria is a psychiatric diagnosis in the DSM-5, which encompasses "distress that stems from the incongruence between one's expressed or experienced (affirmed) gender and the gender assigned at birth."[9] Such mental health challenges are multifaceted and compounded by other social determinants of health. Social determinants of health are defined by the World Health Organization as "the non-medical factors that influence health outcomes."[10] Transgender children's mental health outcomes are specifically compounded by stigma, discrimination, and social rejection.[11] Furthermore, this population also experiences disproportionately high rates of homelessness, physical violence, and substance use, which can result in a cycle of stigma, discrimination, and mental health inequities.[12]

Gender-affirming care is defined by the World Health Organization as "any single or combination of a number of social, psychological, behavioural or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity."[13] Gender-affirming care includes gonadotropin-releasing hormone analogs ("puberty blockers") and gender-affirming hormone therapy

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[7] Diana M. Tordoff, Jonathon W. Wanta, Arin Collin, Cesalie Stepney, David J. Inwards-Breland, & Kym Ahrens, *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, JAMA NETWORK OPEN, Feb. 25, 2022, at 2 [hereinafter Tordoff].

[8] Rafferty, *supra* note 5, at 2.

[9] *Id.*

[10] *Social Determinants of Health*, WORLD HEALTH ORG., https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (last visited Mar. 6, 2024).

[11] Rafferty, *supra* note 5, at 3.

[12] *Id.*

[13] *Gender Incongruence and Transgender Health in the ICD*, WORLD HEALTH ORG., https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd (last visited Mar. 6, 2024).

(GAHT).[14] Puberty blockers postpone the body's physical changes as a result of puberty, and GAHT is used in order to align physical attributes with gender identity.[15] For transgender adolescents, this gender-affirming care often serves as life-saving mental healthcare. One study of transgender and nonbinary youths aged 13 to 20 years reported a 60% lower odds of depression and a 73% lower odds of suicidal ideation within the first year of receiving gender-affirming care.[16] The research demonstrates that gender-affirming care serves as an evidence-based means of reducing mental health disparities among transgender youth. Furthermore, access to gender-affirming care not only lowers the risk of depression and suicidality among trans adolescents, but drastically improves self-esteem and well-being.[17]

While access to gender-affirming care is correlated with decreased levels of depression and suicidality, the opposite is also true. The restriction of gender-affirming care can lead to worse mental health outcomes not only by limiting access to medication itself, but also by "increasing minority stress through negative public attention and harmful rhetoric debating the rights of transgender and nonbinary youth to live their lives authentically."[18]

The World Professional Association for Transgender Health (WPATH) produces Standards of Care (SOC) for the Health of Transgender and Gender Diverse People.[19] WPATH SOC are based on scientific and professional consensus and are designed to provide recommendations for health professionals in the care of transgender and gender diverse people.[20] The decision to obtain gender-affirming medical treatment is not one made lightly, and involves a variety of considerations. The guidelines note that

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[14] Amy E. Green, Jonah P. DeChants, Myeshia N. Price, & Carrie K. Davis, *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643, 644 (2022) [hereinafter Green].

[15] *Id.*

[16] Tordoff, *supra* note 7, at 7.

[17] Jay Lau, *Fighting for Gender-Affirming Care*, HARV. T.H. CHAN SCH. OF PUB. HEALTH (June 28, 2023), https://www.hsph.harvard.edu/news/features/fighting-for-gender-affirming-care/.

[18] Green, *supra* note 14, at 648.

[19] E. Coleman A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tilleman, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus, *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH 1, 3 (2022) [hereinafter E. Coleman].

[20] *Id.* at 5.

adolescents seeking gender-affirming medical treatment benefit from a multi-disciplined team of healthcare providers, including pediatric primary care, endocrinology, psychology, and social work.[21] The guidelines note that healthcare professionals should only recommend gender-affirming medical treatment to those adolescent patients who meet specific criteria, including the diagnostic criteria of gender incongruence that is sustained over time.[22] The adolescent seeking medical gender-affirming care must also demonstrate emotional and cognitive maturity, and must be informed of the potential reproductive health effects.[23] The SOC for gender diverse children are more conservative compared to the SOC for adolescents, as prepubescent gender diverse children are ineligible for medical intervention.[24] Care for children in this context is typically limited to psychosocial support.

B. L.W. v. Skrmetti: *Lower Court Decisions*

1. *Tennessee ban on gender-affirming care*

In March 2023, Tennessee enacted the Prohibition on Medical Procedures Performed on Minors Related to Sexual Identity.[25] The Tennessee law is one of many anti-trans bills introduced by state legislatures targeting healthcare access, and prohibits:

> medical procedures from being administered to or performed on minors when the purpose of the medical procedure is to: (1) Enable a minor to identify with, or live as, a purported identity inconsistent with the minor's sex; or (2) Treat purported discomfort or distress from a discordance between the minor's sex and asserted identity.[26]

In banning gender-affirming care for minors, the law purports that Tennessee:

> [H]as a legitimate, substantial, and compelling interest in protecting minors from physical and emotional harm. This state has a legitimate, substantial, and compelling interest in promoting the dignity of minors. This state has a legitimate, substantial, and compelling interest in encouraging minors to appreciate their sex, particularly as they undergo puberty. This state has a legitimate, substantial, and compelling

[21] *Id.* at 56.
[22] *Id.* at 48 tbl.1, 6.12–6.12.g.
[23] *Id.* at 48 tbl.1, 6.12.c.
[24] *See id.* at 67.
[25] TENN. CODE ANN. § 68-33-101 (West 2023).
[26] *Id.* § 68-33-101(n)(1)–(2).

> interest in protecting the integrity of the medical profession, including by prohibiting medical procedures that are harmful, unethical, immoral, experimental, or unsupported by high-quality or long-term studies, or that might encourage minors to become disdainful of their sex.[27]

The law also creates both a private and state right of action against healthcare providers for violation of the statute:

> The attorney general and reporter may bring an action against a healthcare provider or any person that knowingly violates this chapter, within twenty (20) years of the violation, to enjoin further violations, to disgorge any profits received due to the medical procedure, and to recover a civil penalty of twenty-five thousand dollars ($25,000) per violation.[28]

Like other anti-LGBTQ+ laws across the country, the Tennessee law is rooted in the legislature's role "to protect the health and welfare of minors,"[29] indicating an intention to exert control over children in response to moral panic surrounding gender identity and changing youth norms.[30] Three transgender minors and their parents sued Tennessee to block the ban on gender-affirming care.[31] The District Court for the Middle District of Tennessee granted the plaintiffs' motion for a preliminary injunction, and found a strong likelihood of success on the merits with respect to the plaintiffs' due process and equal protection claims.[32]

2. *Kentucky ban on gender-affirming care*

In March 2023, the Kentucky General Assembly passed "An Act Relating to Children."[33] Like the Tennessee law, the Kentucky statute prohibits healthcare providers from "prescrib[ing] or administer[ing] any drug to delay or stop normal puberty."[34] Although such treatment comports with medical standards of care, if a healthcare provider violates the statute, respective regulatory agencies are directed to revoke that provider's

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[27] *Id.* § 68-33-101(m).
[28] *Id.* at § 68-33-106(b).
[29] *Id.* at § 68-33-101(a).
[30] *See* Chris Pepin-Neff, Opinion, *Anti-Trans Moral Panics Endanger All Young People*, SCI. AMERICAN (May 19, 2023), https://www.scientificamerican.com/article/anti-trans-moral-panics-endanger-all-young-people/.
[31] L.W. v. Skrmetti, 83 F.4th 460, 469 (6th Cir. 2023).
[32] L.W. v. Skrmetti, No. 3:23-CV-00376, 2023 WL 4232308, at *36 (M.D. Tenn. June 28, 2023), *rev'd*, 83 F.4th 460 (6th Cir. 2023).
[33] KY. REV. STAT. ANN. § 311.372 (LexisNexis 2023).
[34] *Id.* § 311.372(2)(a).

license.[35] Several transgender minors and their parents sued Kentucky state officials for the violation of their constitutional rights guaranteed by the Due Process Clause and Equal Protection Clause of the Fourteenth Amendment.[36] In June 2023, the District Court for the Western District of Kentucky granted the plaintiffs' motion for preliminary injunction, finding that "the treatments barred by SB150 are medically appropriate and necessary for some transgender children under the evidence-based standard of care accepted by all major medical organizations in the United States."[37] The district court applied a heightened level of scrutiny to the plaintiffs' equal protection claim, ruling that the discriminatory classifications embodied in the Kentucky law did not serve important government interests and were not substantially related to the government's objectives.[38] The court also found that the plaintiffs had a strong likelihood of success on their due-process claim because the bans likely violated parents' fundamental right to direct the medical care of their children.[39] The plaintiffs in both the Tennessee and Kentucky lawsuits sought preliminary injunctions on equal protection and due process grounds. Specifically, they argued that the laws discriminate on the basis of sex and transgender status in violation of the equal protection clause and deprive parents of their fundamental right to make medical decisions for their children in violation of the due process clause.[40] Following the district court decisions granting preliminary injunctions, Kentucky and Tennessee respectively appealed and moved for stays of the injunctions. The Sixth Circuit stayed the injunctions in both cases pending appeal.[41]

The Sixth Circuit consolidated the two appeals and ultimately reversed both district courts' preliminary injunctions, with a dissenting opinion filed by Judge White.[42] A majority of the appellate panel found no constitutional violation with respect to the plaintiffs' equal protection and due process claims. Instead, the court reasoned that the plaintiffs sought to extend constitutional guarantees to "new territory" that is better left to the discretion of state legislatures.[43] The court did not subject the Kentucky and Tennessee laws to heightened scrutiny, and instead applied rational basis review in upholding them.[44] In doing so, the Sixth Circuit disregarded long standing legal precedent and accepted medical standards of care.

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[35] *Id.* § 311.372(4).

[36] *L.W.*, 83 F.4th at 470.

[37] Doe v. Thornbury, No. 3:23-CV-230-DJH, 2023 WL 4230481, at *2 (W.D. Ky. June 28, 2023), *abrogated by* L.W. v. Skrmetti, 83 F.4th 460 (6th Cir. 2023).

[38] *Id.* at *5.

[39] *Id.* at *6.

[40] *L.W.*, 83 F.4th at 497 (White, J., dissenting).

[41] *Sixth Circuit Allows Tennessee's Ban on Care for Transgender Youth to Take Effect*, ACLU (July 8, 2023), https://www.aclu.org/press-releases/sixth-circuit-allows-tennessees-ban-on-care-for-transgender-youth-to-take-effect.

[42] *L.W.*, 83 F.4th at 470, 491.

[43] *Id.* at 471–72.

[44] *Id.* at 489 (holding that "[p]lenty of rational bases exist for these laws, with or without evidence").

II. EVALUATION OF THE SIXTH CIRCUIT'S DUE PROCESS AND EQUAL PROTECTION ANALYSIS

A. *Due Process*

The Due Process Clause of the Fourteenth Amendment provides that "No State shall . . . deprive any person of life, liberty, or property, without due process of law."[45] The Due Process Clause extends heightened constitutional protection "against government interference with certain fundamental rights and liberty interests."[46] Such fundamental rights include those that are "deeply rooted in this Nation's history and tradition" and "implicit in the concept of ordered liberty."[47] The Supreme Court has long recognized a "private realm of family life which the State cannot enter."[48] Such parental autonomy is sacred in this nation's history, and is reflected in its jurisprudence.[49] The Supreme Court has included parents' rights "concerning the care, custody, and control of their children" among such fundamental rights requiring heightened protection from governmental interference.[50]

The Supreme Court in *Parham v. J.R.* held that "[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments."[51] The *Parham* Court recognized that parents are best equipped to recognize what is best for their children, noting that "[o]ur jurisprudence historically has reflected Western civilization concept of the family as a unit with broad parental authority over minor children."[52]

While courts have extended this fundamental right of parents to direct the upbringing of their children to the medical context[53] the Sixth Circuit holds that there is no deeply rooted tradition of "preventing governments from regulating the medical profession in general or certain treatments in

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[45] U.S. CONST. amend. XIV, § 1.

[46] Washington v. Glucksberg, 521 U.S. 702, 720 (1997).

[47] *Id.* at 721 (quoting Palko v. Connecticut, 302 U.S. 319 (1969)).

[48] Moore v. City of E. Cleveland, 431 U.S. 494, 499 (1977) (holding that there is a right to a zone of privacy and autonomy in family matters under the due process clause, requiring heightened scrutiny for government infringement).

[49] *See* Pierce v. Soc'y of Sisters, 268 U.S. 510 (1925) (holding that an Oregon law mandating every child to attend public school infringed on parental choice to make decisions regarding their children's education); *see also* Meyer v. Nebraska, 262 U.S. 390 (1923) (noting that a Nebraska law prohibiting the teaching of foreign languages to children before eighth grade implicated parental rights to control their children's education).

[50] Troxel v. Granville, 530 U.S. 57, 66 (2000).

[51] Parham v. J.R., 442 U.S. 584, 603 (1979).

[52] *Id.* at 602.

[53] *See id.* at 603 ("The same characterizations can be made for a tonsillectomy, appendectomy, or other medical procedure."); *see also* Kanuszewski v. Michigan Dep't of Health & Hum. Servs., 927 F.3d 396, 418 (6th Cir. 2019) (holding that the defendant's storage of children's blood without parental consent following disease screening violated parental fundamental rights, and that "[p]arents possess a fundamental right to make decisions concerning the medical care of their children.").

particular, whether for adults or their children."[54] In focusing the inquiry on states' rights to regulate medicine, the court justifies application of rational basis review. Yet the issue with these bans, which override parents' decisions about consenting for their children to healthcare that the medical profession supports, is more accurately a question of a parent's fundamental right to direct the upbringing of their children as opposed to the government's role in regulating medical treatments. When framed as the former, the analysis requires strict scrutiny. While the majority recognizes the essential role of parents in directing the upbringing of their children, the court nonetheless partakes in parental rights cherry-picking, asserting that the claimants "overstate the parental right by climbing up the ladder of generality to a perch—in which parents control all drug and other medical treatments for their children."[55]

To be sure, parental autonomy is not absolute and cannot prevail in all contexts. As the Supreme Court noted in *Prince v. Massachusetts*, parental rights are not beyond regulation in the name of public interest, and the state has a duty to protect minor children under the doctrine of parens patriae.[56] In certain circumstances, the doctrine allows the state to intervene and undertake parental responsibilities to promote the child's wellbeing, but there must be a compelling reason for such intervention.[57] If the state does not provide such a showing, then governmental interference constitutes a parental due process violation under the Fourteenth Amendment.[58] In other words, the right to parental autonomy can be infringed only when a more important state interest is being protected.[59] Typically, such state interventions into the parent-child relationship are reserved only for cases involving child neglect or abuse.[60]

Particularly in the context of medical decision making, "[t]he statist notion that governmental power should supersede parental authority in *all* cases because *some* parents abuse and neglect children is repugnant to American tradition."[61] The greater the infringement on parental autonomy, the greater the state justification needs to be. To pass constitutional muster, the law must be narrowly tailored to achieve a compelling government interest, and the government has the burden to prove this means-end fit.[62] The Tennessee and Kentucky laws do not comport with Supreme Court

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[54] L.W. v. Skrmetti, 83 F.4th 460, 473 (6th Cir. 2023).

[55] *Id.* at 475.

[56] Prince v. Massachusetts, 321 U.S. 158, 166 (1944) (holding that Prince, a Jehovah's Witness, violated state child labor laws in allowing a child in her custody to pass out religious literature into the evening).

[57] Elchanan G. Stern, *Parens Patriae and Parental Rights: When Should the State Override Parental Medical Decisions?*, 33 J. L. & HEALTH 79, 91 (2019).

[58] *Id.* at 92.

[59] *Prince*, 321 U.S. at 165 ("To make accommodation between these freedoms and an exercise of state authority always is delicate.").

[60] Parham v. J.R., 442 U.S. 584, 604 (1979) (noting that parents retain a traditional interest and responsibility in the upbringing of their children "absent a finding of neglect or abuse").

[61] *Id.* at 603.

[62] Washington v. Glucksberg, 521 U.S. 702, 721 (1997).

precedent on parental rights since they unreasonably allow state intervention into an unauthorized realm of parental decision making. The *L.W.* majority contends that while parents have a fundamental right to direct the upbringing of their children, "becoming a parent does not create a right to reject democratically enacted laws."[63] However, when such laws infringe on parental autonomy without a compelling government interest, parental rights should prevail.

It is important to note that in some situations, parental control of a child or adolescent's decision-making is not always in alignment with the minor's wishes or in the best interest of the minor. The *Parham* case illustrates this idea, as the plaintiffs were children voluntarily committed to a Georgia state mental hospital.[64] The commitment proceedings were initiated by the children's parents, and the children claimed that such procedures violated their due process rights.[65] In recognizing parental authority to make such decisions, the *Parham* Court stated: "Simply because the decision of a parent is not agreeable to a child or because it involves risk does not automatically transfer the power to make that decision from the parents to some . . . officer of the state."[66] In the context of voluntary commitments, the Court concluded that parents retain "a substantial, if not the dominant, role in the decision."[67]

The *Parham* decision illuminates the double-edged sword of near-absolute parental control over minor children. While parental rights may serve as one key constitutional basis for a minor's access to gender-affirming care, this same parental control can in other contexts dampen children's expressive freedom or limit exposure to ideas.[68] The *Parham* case operated under the idyllic presumption that parents always act in the best interest of their children.[69] Advocating for strong parental rights, particularly in the context of LGBTQ+ rights, is a somewhat fraught task. Gender-affirming care is unique in that parental consent is the only means for minors to receive the care they need. Frequently, however, LGBTQ+ minors face a lack of parental support, which can lead to high rates of homelessness and other negative health outcomes.[70]

Furthermore, judicial restraint in the area of parental decision-making and deference to parental rights can hinder other public health and health policy goals. This idea was reiterated during the Covid-19 pandemic,

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[63] L.W. v. Skrmetti, 83 F.4th 460, 475 (6th Cir. 2023).
[64] *Parham*, 442 U.S. at 587.
[65] *Id.* at 588.
[66] *Id.* at 603.
[67] *Id.* at 604.
[68] Anne C. Dailey, *In Loco Reipublicae*, 133 YALE L.J. 419, 442 (2023).
[69] *Id.* at 438 ("The most important constitutional doctrine affecting children is not children's right to liberty or procedural justice or any other right held by children themselves; the most important constitutional doctrine affecting children is the Constitution's broad protection for the rights of their *parents*.").
[70] *Homelessness and Housing Instability Among LGBTQ Youth*, THE TREVOR PROJECT, https://www.thetrevorproject.org/wp-content/uploads/2022/02/Trevor-Project-Homelessness-Report.pdf.

particularly with respect to mask mandates and vaccines. In this context, parental rights became a weapon to combat policies aimed at protecting the public's health. Such rhetoric is rampant: following a September 2023 Maryland elementary school mask mandate, Senator Ted Cruz tweeted, "[i]f you want to voluntarily wear a mask, fine, but leave our kids the hell alone."[71] This same pretext also exists in education, as House Republicans recently passed the "Parents Bill of Rights Act," which would give parents the right to inspect their children's school curricula, school budgets, and library books.[72] Importantly, the bill would also require elementary schools to obtain parental consent before altering any student's pronouns or preferred name.[73] In the context of gender-affirming care, this protection of parental rights falls away, making room for the furtherance of anti-LGBTQ+ legislation. While these bans are part of a culture-war directed at transgender youth, they are also about a larger-scale preservation of social norms, along with the exertion of power and control over children as a whole.[74]

While this paper argues against state bans on gender-affirming care, this is not to say there is no place for state experimentation in the area of parental rights and family law. The states' power to regulate in the areas of public health, education, and family law have long been respected.[75] There can (and should) be a place for this experimentation on the local level, as "state sovereignty over family law serves to diffuse governmental power over the formation of individual values and moral aspirations," protecting diversity among our citizenry.[76] But state legislatures cannot have unchecked discretion to violate constitutional principles with the purpose of undermining such expressions of individuality.

As Judge White reiterates in her *L.W.* dissent, the right of parents to control their children's medical choices is a right deeply rooted in our nation's history.[77] The purported rationales of the Tennessee and Kentucky laws, including the "compelling interest in encouraging minors to appreciate their sex, particularly as they undergo puberty,"[78] fly in the face of longstanding precedent that the state cannot standardize its children.[79] This ideal extends to education, religion, and the very most sacred and private aspects of family life. The court's willing departure from this principle is representative of rampant moral panic aimed at youth control under the guise of protection. The decision to undergo gender-affirming medical treatment

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[71] Hannah Natanson, Fenit Nirappil, & Maegan Vazquez, *A Few Schools Mandated Masks. Conservatives Hit Back Hard.*, WASH. POST https://www.washingtonpost.com/education/2023/09/06/school-mask-mandate-politics/ (last updated Sept. 7, 2023).

[72] Parents Bill of Rights Act, H.R. 5, 118th Cong. (2023).

[73] *Id.*

[74] Pepin-Neff, *supra* note 30.

[75] Anne C. Dailey, *Federalism and Families*, 143 U. PA. L. REV. 1787, 1791 (1995).

[76] *Id.* at 1872.

[77] L.W. v. Skrmetti, 83 F.4th 460 (6th Cir. 2023) (White, J., dissenting).

[78] TENN. CODE ANN. § 68-33-101(m) (West 2023).

[79] Pierce v. Soc'y of Sisters, 268 U.S. 510 (1925).

should be encompassed in this realm of family autonomy. The majority claims that upholding the district court's decision would result in numerous line-drawing exercises that are better suited for the legislature. However, the court partakes in its own line-drawing exercise, trampling on established family and constitutional law doctrines requiring heightened scrutiny for infringement on parental autonomy.

B. *Equal Protection*

The Equal Protection Clause of the Fourteenth Amendment prohibits any state from denying "any person within its jurisdiction the equal protection of the laws."[80] A court's equal protection analysis is dependent on the type of classification at issue. Suspect classifications including race, religion, and national origin require the most stringent review.[81] In such cases a court would apply strict scrutiny, requiring that the law be narrowly tailored to achieve a compelling government interest.[82] For quasi-suspect classifications such as sex and gender, courts apply an intermediate scrutiny, requiring the law to be substantially related to an important government interest.[83] When there is no suspect or quasi-suspect classification at issue, a court applies rational basis review. This standard of review is extremely deferential to the legislature, requiring that the law only be rationally related to a legitimate government interest.[84]

The Sixth Circuit should have applied heightened scrutiny to the Tennessee and Kentucky laws since they discriminate on the basis of sex and gender. Laws that facially classify on the basis of sex or gender are subject to heightened scrutiny under the Equal Protection Clause.[85] The Tennessee and Kentucky laws at issue "reference a minor's sex and gender conformity . . . and use these factors to determine the legality of the procedures."[86] Since the laws facially classify on the basis of sex, the test then becomes a means-end fit as to whether the law is substantially related to an important government interest. While the majority recognizes that laws based on sex typically receive heightened review, the court nonetheless applies rational basis to its equal protection analysis.[87] In doing so, the court argues that since the laws limit access to gender-affirming care treatments for all minors, there are no "traditional equal-protection concerns."[88]

However, the court rejects the principle that all sex-based classifications warrant heightened scrutiny, even when applied to both sexes

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[80] U.S. CONST. amend. XIV, § 1.
[81] Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432, 440 (1985).
[82] *Id.*
[83] Miss. Univ. for Women v. Hogan, 458 U.S. 718, 723–24 (1982).
[84] Plyler v. Doe, 457 U.S. 202, 216 (1982).
[85] Reed v. Reed, 404 U.S. 71, 75 (1971).
[86] L.W. v. Skrmetti, 83 F.4th 460, 502 (6th Cir. 2023).
[87] *Id.* at 480 (stating that "[sex] classification, it is true, receives heightened scrutiny.").
[88] *Id.*

evenhandedly.[89] In arguing that the law applies equally to minors of both biological sexes, the court does not even attempt a means-end analysis. By the court's reasoning, the laws treat all minors alike, so there is "no reason to apply skeptical, rigorous, or any other form of heightened review to these laws."[90] This is the same reasoning that failed in *Loving v. Virginia*. Simply because the anti-miscegenation laws at issue in *Loving* applied equally to both Black and white individuals, equal application is not "enough to remove the classifications from the Fourteenth Amendment's proscription of all invidious racial discriminations."[91] The same reasoning applies in this case, as the court attempts to circumvent a heightened equal protection standard by putting on blinders. Heightened equal protection analysis exists for the purpose of applying a rigorous review to laws that classify based on sex, gender, or race—particularly those laws that bury invidious discrimination beneath a guise of equal application.

While the Tennessee and Kentucky laws do not "prefer one sex over the other"[92] on their face, they formulate an exclusion from gender-affirming care based on transgender status. In this sense the classes at issue are not male versus female, but transgender versus cis-gender. Simply because the discrimination applies equally to transgender-girls and transgender-boys does not negate the discrimination felt by the transgender class as a whole.

The level of scrutiny applied to LGBTQ+ classifications varies between federal circuit courts, and the Supreme Court has provided little guidance on the issue.[93] While the Court in *Bostock v. Clayton County* applied heightened scrutiny to transgender status in the Title VII context, circuits are divided as to whether this extends to other areas, particularly equal protection claims.[94] However, the Sixth Circuit disregards the *Bostock* Court's assertion that "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex."[95] This reasoning reaches beyond Title VII. The court should have applied *Bostock's* heightened scrutiny analysis to the equal protection context, since discrimination based on transgender status invariably turns on that individual's sex.[96]

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[89] *See id.* (White, J., dissenting) (noting that since sex and gender play an "unmistakable . . . role" with respect to the bans' applications, "these statutes should raise an open-and-shut case of facial classifications subject to intermediate scrutiny.").

[90] *Id.* at 481.

[91] Loving v. Virginia, 388 U.S. 1, 8 (1967).

[92] L.W. v. Skrmetti, 83 F.4th 460, 480 (6th Cir. 2023).

[93] Kaleb Byars, *Bostock: An Inevitable Guarantee of Heightened Scrutiny for Sexual Orientation and Transgender Classifications*, 89 TENN. L. REV. 483, 491 (2022).

[94] Grimm v. Gloucester Cnty. Sch. Bd., 972 F.3d 586, 613 (4th Cir. 2020) (extending *Bostock* to the equal protection context and held that a school board's restroom policy "constitute[d] sex-based discrimination and, independently, that transgender persons constitute a quasi-suspect class.").

[95] Bostock v. Clayton Cnty., 140 S. Ct. 1731, 1741 (2020).

[96] Byars, *supra* note 93, at 513.

C. *Poor Means-End Fit*

While the court should have applied heightened scrutiny to the Tennessee and Kentucky laws, it does not even attempt a means-end analysis. The court instead notes that gender-affirming care treatments are "experimental in nature," and it is "difficult to gauge the risks to children."[97] The Tennessee law seeks to "[protect] minors from physical and emotional harm," claiming (with little scientific evidence) that gender-affirming treatments can cause sterility and an increased risk of disease and illness, including "adverse and sometimes fatal psychological consequences."[98] While the purported rationales of the Tennessee and Kentucky legislatures are rooted in the protection of minors from physical and psychological harms, the court neglects to meaningfully connect gender-affirming care bans to this end. Although rational basis review is an extremely low bar, it still "requires a legitimate government interest . . . Courts must investigate alleged government justifications to avoid rubber-stamping restrictions that do nothing but harm groups that already suffer disproportionately."[99] Public health and health policy decision-making must be rooted in sound data as opposed to politics and culture wars. It is nonetheless a court's job to provide a nonpartisan lens in evaluating the state's interest in advancing certain policies, and the means used to do so. Had the Sixth Circuit panel engaged in the correct due process and equal protection analyses, it would have found that the Tennessee and Kentucky laws could not stand.

III. INVOKING A PUBLIC HEALTH LAW RESPONSE

Given the available empirical evidence, there is no legitimate government interest being advanced by gender-affirming care bans. In actuality, these bans will harm the same children that the state is allegedly seeking to protect, deepening both physical and mental health inequities among the transgender minor population. While all major medical associations support gender-affirming care, including the American Academy of Pediatrics, the American Psychological Association, and the American Academy of Child and Adolescent Psychiatry, some courts disturbingly rely on scientific disinformation.[100] Scientific disinformation is separate from scientific misinformation, as it is "used by those who know, or have the resources to know, that [the information] is false or misleading."[101] Such scientific disinformation and scientific denialism are being used to perpetuate gender-affirming care bans nation-wide.

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[97] L.W. v. Skrmetti, 83 F.4th 460, 468, 477 (6th Cir. 2023).

[98] TENN. CODE ANN. § 68-33-101(b) (West 2023).

[99] Michael R. Ulrich, *303 Creative, Transgender Rights, and the Ongoing Culture Wars*, BILL OF HEALTH (July 27, 2023), https://blog.petrieflom.law.harvard.edu/2023/07/27/303-creative-transgender-rights-and-the-ongoing-culture-wars/.

[100] Meredithe McNamara, Hussein Abdul-Latif, Susan D. Boulware, Rebecca Kamody, Laura E. Kuper, Christy L. Olezeski, Nathalie Szilagyi, & Anne Alstott, *Combating Scientific Disinformation on Gender-Affirming Care*, 152 PEDIATRICS 1, 1 (2023).

[101] *Id.* at 2.

Gender-affirming care bans encompass four "themes" of scientific denialism, including "repudiation of the medical condition that is the target of treatment, misrepresentation of the standard of care, false claims about risks associated with treatment, and misuse of existing research."[102] It is critical to note, confront, and combat the use of these four themes within Kentucky and Tennessee's gender-affirming care bans.

Among the above reasons cited by the legislature for implementing gender-affirming care bans is the notion that transgender minors will come to regret their transition.[103] The Tennessee bill states that "minors lack the maturity to fully understand and appreciate the life-altering consequences of such procedures and that many individuals have expressed regret for medical procedures that were performed on or administered to them for such purposes when they were minors."[104] This paternalistic rhetoric is not only extremely harmful to the transgender population as a whole, but it is based in scientific disinformation and denialism. Drawing on the above themes, the Tennessee legislature made a false claim concerning the risks associated with gender-affirming care and misused existing research. In a systematic review of 27 studies that pooled 7,928 transgender patients who underwent gender-affirming surgery, the regret rate was only 1%.[105] Additionally, such regret is often not medical regret, but underpinned by outside psychosocial circumstances including community or social stigma and discrimination.[106]

The Tennessee Legislature also posits that such treatments can lead to harmful (and sometimes fatal) psychological outcomes for transgender minors.[107] In making this claim, the Legislature dismisses the gender dysphoria experienced by minors seeking gender-affirming care; it also perpetuates a logical fallacy. While 35% of transgender and nonbinary youth have reported attempting suicide, gender-affirming care has been shown to improve mental health outcomes and reduce rates of suicidality.[108] Transgender minors often undergo gender-affirming care to *treat* the negative mental health effects of their gender dysphoria. Furthermore, gender-affirming care treatment does not occur in a vacuum, and transgender minors' mental health can also be impacted by social stigma and discrimination.

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[102] Meredithe McNamara, Christina Lepore, & Anne Alstott, *Protecting Transgender Health and Challenging Science Denialism in Policy*, 387 NEW ENG. J. MED. 1919, 1919 (Nov. 2022).

[103] TENN. CODE ANN. § 68-33-101(h) (West 2023).

[104] *Id.*

[105] Valeria P. Bustos, Samyd S. Bustos, Andres Mascaro, Gabriel Del Corral, Antonio J. Forte, Pedro Ciudad, Esther A. Kim, Howard N. Langstein, & Oscar J. Manrique, *Regret After Gender-Affirming Surgery: A Systematic Review and Meta-Analysis of Prevalence*, PLASTIC RECONSTRUCTION SURGERY GLOB. OPEN (Mar. 2021).

[106] *New Study Shows Discrimination, Stigma, and Family Pressure Drive "Detransition" Among Transgender People*, FENWAY HEALTH (Apr. 7, 2021), https://fenwayhealth.org/new-study-shows-discrimination-stigma-and-family-pressure-drive-detransition-among-transgender-people/.

[107] TENN. CODE ANN. § 68-33-101(b) (2023).

[108] Christina Lepore, Anne Alstott, & Meredithe McNamara, *Scientific Misinformation is Criminalizing the Standard of Care for Transgender Youth*, 176 JAMA PEDIATRICS 965 (2022).

In the midst of legal analysis and political debates surrounding growing numbers of gender-affirming care bans, there are real and tangible repercussions affecting transgender youths, their families, and their providers. While medical gender-affirming care bans have harmful effects on youth, the extent of these harms also implicates the minor's family unit. In a qualitative study of parents' perspectives on laws banning gender-affirming care, researchers discovered common themes including fear of losing their child, fear of losing access to care, and fear of discrimination.[109] One mother reflected:

> [Proposed laws] mean I have to start fearing, again, that my son will try to take his life because his dysphoria is so bad, and he does not have his blocker to stop his body from betraying him. I asked him the other night how he thinks his life would look without them. Without needing to think about it, he said, 'I'd probably be dead.' He's 14.[110]

With respect to government intrusion on parental rights, another parent responded that "[t]he very existence of these laws, regardless that they are in other states, renders my child less safe. They encourage and legitimize hate. The idea that the government can raise children better than the parents is absurd."[111]

Nearly all the survey participants reported concern that the proposed legislation in their state would lead to worsening mental health outcomes for their children.[112] The survey also demonstrates how the law itself can negatively impact the mental health of transgender minors. Another parent stated, "[e]ven if [the laws] do not pass, just the news cycle letting him know that people hate him, despise him, and have no larger concerns than to dispose of his very existence is a very trying experience."[113] This data reflects the stark reality of anguish felt by transgender children and their families in the wake of gender-affirming care bans.

When safe and necessary medical care is withheld from an individual, that individual will do everything in their power to obtain that care. Public health is harmed when (in the best case) individuals obtain healthcare out of state, disrupting their work or schooling, or (in the worst case) individuals turn to illegal or backdoor ways to receive such care. The means do not fit the claimed ends of protecting children when the result in any case is harm to the child.

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[109] Kacie M. Kidd, Gina M. Sequeira, Taylor Paglisotti, Sabra L. Katz-Wise, Traci M. Kazmerski, Amy Hillier, Elizabeth Miller, & Nadie Downshen, *"This Could Mean Death for My Child": Parent Perspectives on Laws Banning Gender-Affirming Care for Transgender Adolescents*, 68 J. ADOLESCENT HEALTH 1082, 1082 (2021).

[110] *Id.* at 1084.

[111] *Id.* at 1085.

[112] *Id.* at 1084.

[113] *Id.* at 1085.

Both the Tennessee and Kentucky laws contain a private right of action and impose harsh penalties against healthcare providers in violation of the laws. In Tennessee, this includes a $25,000 civil penalty for each violation.[114] In Kentucky, this also encompasses loss of medical licensure for violations.[115] The pediatric health workforce in states with gender-affirming care bans face extreme risk in implementing their field's standards of care. Such bans force providers to violate key tenets of biomedical ethics, including their duties of beneficence and justice.[116] Furthermore, there is an existing limited workforce of pediatric endocrinologists.[117] As with abortion providers, competent pediatric providers may choose to practice out of state for fear of losing their license for following their ethical duties as healthcare providers. This fear will result in a loss of healthcare workforce in an area that needs it most, resulting in potential care deserts.

In a qualitative study of doctors, nurse practitioners, and physician assistants providing gender-affirming care to transgender minors, there was overwhelming opposition to gender-affirming care bans.[118] Their responses exemplified themes including politicization of care, worsening mental health outcomes for their patients, and adverse impacts on providers.[119] A Montana provider stated, "I have considered leaving my state to practice in a more tolerant area."[120] Other providers expressed concern for the safety of themselves and their families, citing increases in protesting, hate mail, and harassment.[121] The experiences of transgender minors, their parents, and providers reflect the consequences of gender-affirming care bans, along with the broader consequences of legislatures and courts relying on scientific disinformation.

A. *Short-Term Public Health Solutions*

On November 6, 2023, the appellees in the *L.W.* case petitioned for a writ of certiorari to review the Sixth Circuit's opinion. While it is unclear whether the Supreme Court will take on this issue in the near future, the impacts of the Tennessee and Kentucky bans are already being felt among transgender minors, their families, and their providers. As transgender minors across the country watch as their existence is "left to the legislature" for debate, mental health outcomes are likely to worsen, and minors are

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[114] TENN. CODE ANN. § 68-33-106(b) (2023).

[115] KY. REV. STAT. ANN. § 311.372(4) (LexisNexis 2023).

[116] Brief for Biomedical Ethics and Public Health Scholars as Amici Curiae Supporting Plaintiffs-Appellees at 2, L.W. v. Skrmetti, 83 F.4th 460 (6th Cir. 2023) (No. 23-5600).

[117] Pranav Gupta, Ellis Barrera, Elizabeth R. Boskey, Jessica Kremen, & Stephanie A. Roberts, *Exploring the Impact of Legislation Aiming to Ban Gender-Affirming Care on Pediatric Endocrine Providers: A Mixed-Methods Analysis*, 7 J. ENDOCRINE SOC'Y 1, 5 (2023).

[118] Landon D. Hughes, Kacie M. Kidd, Kristi E. Gamarel, Don Operario, & Nadia Dowshen, *"These Laws Will be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents*, 69 J. ADOLESCENT HEALTH 976 (2021).

[119] *Id.* at 978–80.

[120] *Id.* at 980.

[121] *Id.*

likely to be at a higher risk of harm without access to gender-affirming care. Provisional, short-term public health solutions can reduce harm among the transgender minor population during a period of uncertainty in the legal landscape. This paper recognizes that gender-affirming care is medically necessary for those transgender minors experiencing gender dysphoria—nothing can replace this standard of care. However, amid rising anti-trans legislation, public health methods can be employed to mitigate further negative mental health outcomes among transgender minors.

1. *Medical-legal partnerships*

Medical-legal partnerships (MLPs) integrate legal services into healthcare settings to effectively address social determinants of health.[122] This holistic approach recognizes the influence of structural factors on health outcomes, and are essential in the face of gender-affirming care bans. In an ever-changing legal landscape, many providers are unsure of the status or extent of their state's gender-affirming care ban. Many providers are also wary of the legal risk associated with including medical gender-affirming care within their practices, and this combination of fear and misinformation has led many providers to halt care preemptively.[123] A MLP model among states with gender-affirming care bans would alleviate the burden felt by providers to continuously interpret vague laws in a shifting legal landscape. Lawyers in particular should translate these laws and encourage providers to know their legal risk. Importantly, providers should be encouraged and empowered to not completely halt care until legally required to do so. These partnerships would allow providers to more easily determine what care is and is not allowed, and to implement that care more quickly and effectively. By combining the expertise of lawyers and healthcare providers, the care authorized in states with bans can be stretched up to the legal boundary.

2. *Training in WPATH guidelines for pediatric providers*

In states that have upheld bans, minors will not have access to gender-affirming care until the age of eighteen. The pediatric and mental health workforce in these states should undergo extensive training in the WPATH guidelines, particularly the guidelines on social transition. Social transition "refers to a process by which a child is acknowledged by others and has the opportunity to live publicly . . . in the gender identity they affirm."[124] Such actions may include name changes, pronoun changes, changes in sex and/or gender markers such as identification documents, along with personal

[122] *Medical Legal Partnerships*, THE SOLOMON CENTER, https://law.yale.edu/solomon-center/projects-publications/medical-legal-partnerships (last visited Mar. 4, 2024).

[123] Jim Salter & Geoff Mulvihill, *Some Providers are Halting Gender-Affirming Care for Minors, Even Where it Remains Legal*, PBS NEWSHOUR (Sept. 22, 2023, 12:34 PM), https://www.pbs.org/newshour/nation/some-providers-are-halting-gender-affirming-care-for-minors-even-where-it-remains-legal.

[124] E. Coleman, *supra* note 19, at 75.

expression.[125] For prepubescent children in particular, social transition facilitates gender congruence, reduces gender dysphoria, and enhances psychosocial adjustment and wellbeing.[126] Research has also shown that social transition can improve the mental health of transgender individuals. Healthcare providers in particular can help children navigate the potential advantages and challenges of social transition.[127]

3. *Intersectional approaches*

It is important to note that access to gender-affirming care is inequitable, and individuals face many barriers to care apart from gender-affirming care bans. These barriers and inequities exist throughout the healthcare system, and such bans will likely widen these disparities. Access to gender-affirming care is also often dependent on financial resources, as many individuals cite financial and insurance issues as barriers to care.[128] In a study examining healthcare equity among transgender youth, researchers found that 28% of the participants were uninsured compared to the 5% national average for children under eighteen.[129] Furthermore, individuals and families with the most resources will likely be able to afford travel and other expenses associated with out-of-state treatment in places without gender-affirming care bans.

Public health strategies must be cognizant of inequities and barriers to gender-affirming care. Black, Latinx, and Indigenous minors are less likely to receive gender-affirming care than their white counterparts.[130] The pediatric and mental health workforce should also be aware of these inequities and provide care that takes into account experiences of racism, misogyny, and transphobia. Advocacy for systems-level change in conjunction with other initiatives is necessary to prevent worsening disparities.

4. *Mental Health Initiatives*

The consensus among experts remains that bans on gender-affirming care will worsen transgender youths' mental health outcomes. While these predictions are disheartening, there are available options for improving mental health outcomes among this population. Adolescent medical providers should involve mental health providers and social workers in the

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[125] *Id.* at 76.

[126] *Id.* at 77.

[127] *Id.*

[128] Jae A. Puckett, Peter Cleary, Kinton Rossman, Michael E. Newcomb, & Brian Mustanski, *Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals*, 15 SEXUALITY RSCH. & SOC. POL'Y 48, 52–53 (2018).

[129] Jillian McKoy, *Gender Identity, Race Intersections "Really Matter for Access to Healthcare,"* B.U. SCH. OF PUB. HEALTH (June 2, 2023), https://www.bu.edu/sph/news/articles/2023/gender-identity-race-intersections-really-matter-for-access-to-healthcare.

[130] Meredithe McNamara, Gina M. Sequeira, Landon Hughes, Angela Kade Goepferd, & Kacie Kidd, *Bans on Gender-Affirming Healthcare: The Adolescent Medicine Provider's Dilemma*, 73 J. ADOLESCENT HEALTH 406, 407 (2023).

care of transgender and nonbinary youth from an early stage.[131] Since areas with bans in place will likely see a shortage of healthcare providers, existing facilities should train all providers on suicide risk assessment and mental health first aid. Such task-shifting will make optimum use of resources, and flag higher-risk individuals for further intervention. This same paradigm should be utilized in states without bans, as these clinics will likely see an influx of out-of-state patients.[132] These clinics should prepare for such an increase and prioritize treatment of individuals who are low on medication or are presenting with distress.[133] Additional mental health screening tools should be implemented in both school settings and pediatric primary care providers' offices to target those individuals who may not be receiving specialized care.

Increasing protective factors and mitigating risk factors can also serve as a valuable public mental health strategy. School belonging, family support, and peer support are all protective factors that promote interpersonal belonging and reduce suicide risk among transgender youth.[134] Importantly, transgender youth who reported feelings of school belonging were half as likely to have attempted suicide.[135] Increasing inclusive school policies and social support programs in the face of gender-affirming care bans may help mitigate negative mental health outcomes.

B. *A Call for Long-Term Solutions*

Increasing reliance on "band-aid" solutions in states with gender-affirming care bans reflects the failure of some state legislatures and courts to provide upstream protections for transgender youth, placing the burden on likely exhausted providers and families. While these short-term solutions can reduce harm among trans minors during a period of legal uncertainty, they are not the ideal. Longer-term solutions are required to allow minors equitable access to gender-affirming care in accordance with medical standards of care. Should the Supreme Court take on the *L.W.* case, it should comport with long-standing due process jurisprudence and reverse the Sixth Circuit's holding. Furthermore, in the drafting of health policies, both federal and state legislatures should defer to accepted medical standards of care. The federal government should continue denouncing restrictive state bans on gender-affirming care and implement policies that expand healthcare access for LGBTQ+ individuals.[136] Such policies should also

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[131] *Id.*

[132] *Id.* at 408.

[133] *Id.*

[134] Ashley Austin, Shelley L. Craig, Sandra D'Souza, & Lauren B. McInroy, *Suicidality Among Transgender Youth: Elucidating the Role of Interpersonal Risk Factors*, 37 J. INTERPERS. VIOLENCE 2696, 2696 (2022).

[135] *Id.* at 2710.

[136] Lindsey Dawson, Jennifer Kates & MaryBeth Musumeci, *Youth Access to Gender Affirming Care: The Federal and State Policy Landscape*, KFF (June 1, 2022), https://www.kff.org/other/issue-brief/youth-access-to-gender-affirming-care-the-federal-and-state-policy-landscape/.

target social determinants of health including insurance coverage, housing, stigma, and transphobia in the healthcare setting. While there have been efforts to recognize the federal government's duty to codify transgender people's rights, including Senator Edward J. Markey and Representative Pramila Jayapal's recent "Transgender Bill of Rights,"[137] such efforts are largely symbolic.[138] Transgender and nonbinary individuals require actual governmental protection when it comes to necessary healthcare, particularly in the face of rampant anti-LGBTQ+ legislation at the state level.

CONCLUSION

Legislation targeting transgender individuals continues to grow, and is increasingly infringing on medical decision-making, parental rights, and recognized standards of care. The Sixth Circuit Court of Appeals decision in *L.W. v. Skrmetti* exemplifies this trend, along with the limited constitutional protections afforded to transgender minors, their parents, and medical providers. The *L.W.* decision in particular sets aside long-standing due process jurisprudence and perpetuates scientific denialism, furthering the Kentucky and Tennessee legislatures' political goal of tethering shifting societal norms. The result in states with harsh bans is a public health crisis. Transgender minors disproportionately experience negative mental health outcomes, and the medical community expects these outcomes to worsen without access to medically necessary treatment. If the *L.W.* decision is at all predictive of the future of transgender rights to healthcare, we must be prepared to implement public health strategies to reduce harm among this population in conjunction with advocacy for long-term and systemic changes.

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[137] *Sen. Markey and Rep. Jayapal Introduce the Trans Bill of Rights Ahead of International Transgender Day of Visibility*, ED MARKEY (Mar. 30, 2023), https://www.markey.senate.gov/news/press-releases/sen-markey-and-rep-jayapal-introduce-the-trans-bill-of-rights-ahead-of-international-transgender-day-of-visibility.

[138] Samantha Riedel, *Democrats Reintroduce a "Trans Bill of Rights" in Congress*, THEM (Mar. 31, 2023), https://www.them.us/story/trans-bill-of-rights-congress.