DO NO HARM:
CHILDREN AND THE TRANSGENDER MOVEMENT

by Andrew C. Brown, J.D., and Parker Stathatos

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Executive Summary

The latest edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) defines gender dysphoria as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender" (APA, 2013, p. 451). An individual's biological sex determines one's assigned gender. In recent years, an increasing number of children under the age of 18 claimed to experience gender dysphoria or to identify as transgender (Johns et al., 2019; Herman et al., 2017). The number of clinics that provide sex reassignment services has also increased rapidly since Boston Children's Hospital established the first major program in the United States in 2007 (Boston Children's Hospital, n.d.; Human Rights Campaign, n.d.). These services include psychotherapy, puberty blockers, cross-sex hormones, and sex reassignment surgeries.

The proper approach to children and youth who identify as transgender is a subject of continued and heated debate among medical and mental health professionals, lawmakers, parents, and even those who identify as transgender. Professional medical organizations in the United States and Europe have sought to establish uniform criteria for the treatment of children with gender dysphoria. These efforts, however, have only served to further divisions as the medical interventions commonly used to aid minors in transitioning—specifically, the prescription of puberty blockers and cross-sex hormones as well as the performance of sex reassignment surgery—lack sound evidentiary support, remain experimental, and carry the risk of serious short-term and long-term side effects.

Although a wide variety of opinions exist on how to best serve children experiencing gender identity issues and their families, the public policy debate in Texas is primarily divided between those who support the "gender-affirming" approach and those who oppose it. Generally speaking, those within the gender-affirming camp advocate allowing children to freely live out their chosen gender identity with few restrictions. This camp embraces the prescription of puberty blockers and cross-sex hormones to children and adolescents exploring their gender identity, culminating in surgical procedures to confirm it upon reaching the age of majority (Delemarre-van de Waal & Cohen-Kettenis, 2006, pp. 132–134). Among the opposition, a growing debate focuses on how to best protect children from experimental, irreversible, and potentially harmful medical interventions. Proposed solutions range from restricting or prohibiting certain medical and mental health interventions to defining

Key Points

- The performance of sex reassignment procedures and treatments on children, whether through surgery or prescription medications, is harmful to children and should be prohibited by the state of Texas.
- There is a lack of conclusive evidence that puberty blockers and cross-sex hormones help children overcome gender dysphoria or improve their psychological well-being.
- Emerging research documenting risks to the health of children and irreversible side effects associated with these practices has led several European nations to reverse course on providing them to children.
- State action to protect children from experimental and potentially harmful sex reassignment procedures and treatments should be narrowly tailored to focus on prohibiting medical professionals from engaging in these practices.
- Policymakers should acknowledge the pain and confusion children with gender dysphoria and their families experience and avoid punitive approaches toward families that could result in separation or foster care entry.

gender-affirming care as child abuse and leveraging the power of the state to remove children from parents who pursue such treatment modalities.

As the debate over the provision of sex reassignment treatments to children continues, it is incumbent on lawmakers to establish policies that both protect children and show compassion for the genuine pain and confusion experienced by children who struggle with their gender identity and their families. Such policies must be crystal clear that the performance of these treatments on minors under the age of 18, including surgical procedures as well as the prescription of puberty-blocking medications and cross-sex hormones for the purpose of sex reassignment, is harmful to children and should be prohibited. However, policymakers should also resist calls to leverage the power of the child protection system as a means of curtailing these practices. Such an approach is not only ineffective as a means for protecting children, but it also wrongfully expands the reach of Child Protective Services (CPS) into the private realm of the family, subjects already vulnerable children to the additional trauma of entry into foster care, and will likely lead to the further weaponization of CPS as a means of imposing specific views about child-rearing and undermining family autonomy.

Introduction

Following the U.S. Supreme Court's decision affirming the right of same-sex couples to marry in *Obergefell v. Hodges* (2015), the national discussion about sexuality, gender identity, and the role of government has only grown. In recent years, issues related to sex and gender identity have received increasing attention in the public realm, including in the media, pop culture, and public policy discussions.

Although data tracking the number of children identifying as transgender are relatively new, recent studies indicate that the number may be increasing (Strauss, 2019). A 2019 study by the Centers for Disease Control and Prevention (CDC), for example, found that "an average of 1.8% of high school students identify as transgender" (Johns et al., 2019, p. 70). This figure, while relatively small, represents a one-percent increase from a previous estimate conducted by the University of California, Los Angeles (UCLA) utilizing 2014 and 2015 survey data that found 0.7% of youth ages 13 to 17 identified as transgender (Herman et al., 2017). A surge in the number of children and youth referred to pediatric transgender clinics in the United States during the period of time between the UCLA and CDC surveys also suggests that more children are identifying as transgender. One study of referrals of pediatric patients to transgender clinics in Northern California found a marked increase in the number of monthly referrals from 5.1 in 2015 to 25.7 in 2018 (Handler et al., 2019). A pediatric medical center in Boston experienced a fourfold increase in its patient population "following the creation of a formal gender clinic offering treatment of transgender patients" (Spack et al., 2012, p. 422). Similarly, an Indiana pediatric endocrinology clinic received 38 patient referrals for gender dysphoria (GD) from 2002 to 2015, 74% of which were referred since 2012 (Chen et al., 2016, p. 1).

Although many forces are likely at play to explain the increase in the number of children and youth who identify as transgender, research indicates cultural forces play a significant role. A July 2020 study published by the *Journal of the American Medical Association* found a "significant association" between weekly referral rates to pediatric gender clinics in the UK and Australia and the number of "transgender and gender diverse" (TGD) items "appearing within the local media 1 to 2 weeks beforehand" (Pang et al., p. 1). These findings led the authors to conclude that increased visibility of transgender issues in the media is a possible catalyst for children and youth for seeking treatment at gender clinics.

As an increasing number of pediatric patients are being referred to gender clinics for treatment, the incidence of irreversible, body-altering procedures performed on minors continues to rise (Mahfouda et al., 2018, p. 484). While many studies assess the impact of surgical and hormonal interventions in transgender adults, very little research evaluates the risks and benefits of such treatments in transgender youth. However, emerging studies on the impact of medical interventions for transgender children and youth indicate that these interventions carry increased risk of significant short-term and long-term side effects (Mayo Clinic, 2022c, "What are the possible side effects" section; St. Louis Children's Hospital, n.d.; Carmichael et al., 2021, pp. 40–41). These risks will be discussed in greater detail later in this paper.

Due to the increasing visibility and cultural acknowledgment of transgender identification as well as the risks posed by gender-affirming treatment modalities, it is critical for policymakers to understand the political, medical, and mental health contexts in which the current debate is taking place.

Medical and Mental Health Issues

Gender Dysphoria

In 1952, the American Psychiatric Association (APA) released the first edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I), which "was the first official manual of mental disorders to contain a glossary of descriptions of the diagnostic categories" (APA, 1980, p. 1).

Each edition of the DSM incorporates updated knowledge regarding mental disorders and is based on input from the medical community. Since its first edition, the DSM "has become a standard reference for clinical practice in the mental health field … [and] is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders" (APA, 2013, p. xli).

Over time, the DSM has employed different terms to define what is now known as gender dysphoria. The first edition of the DSM was released in 1952, but a term relating to gender dysphoria did not appear in the DSM until the publication of the DSM-III in 1980. The APA used the term "transsexualism" in the DSM-III but replaced it with "gender identity disorder in adults and adolescence" in 1994 with the release of DSM-IV (APA, n.d., "History" section). In 2013, the APA replaced the term with "gender dysphoria" in the DSM-5. According to the APA, "Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender" (APA, 2013, p. 451).

American healthcare providers primarily rely upon the DSM-5 and behavioral health evaluations to diagnose gender dysphoria (Mayo Clinic, 2022b, "Diagnosis" section). Both the DSM-5 and behavioral health evaluations are diagnostic instruments based on mental and psychological wellness indicators, but treatment options for gender dysphoria extend largely beyond the realm of behavioral healthcare. While the DSM-5 provides criteria to differentiate gender dysphoria among different age groups, this paper discusses gender dysphoria as it relates to individuals younger than 18.

Gender Dysphoria in Adolescents

The APA provides eight criteria to diagnose gender dysphoria in children. A child must meet at least six of the criteria, including the first criterion, to be diagnosed with gender dysphoria (APA, 2013, p. 452). The criteria are:

1. *A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).*
2. *In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.*
3. *A strong preference for cross-gender roles in make-believe play or fantasy play.*
4. *A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.*
5. *A strong preference for playmates of the other gender.*
6. *In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (as-signed gender), a strong rejection of typically feminine toys, games, and activities.*
7. *A strong dislike of one's sexual anatomy.*
8. *A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.* (p. 452)

In addition to the criteria above, the DSM-5 specifies, "The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning" (APA, 2013, p. 452).

Treating Gender Dysphoria

Research regarding the long-term effects and efficacy of treatments for gender dysphoria in adolescents remains limited, with existing research focusing largely on the psychological effects of gender dysphoria and how various treatment approaches impact mental health. Furthermore, treatment options vary worldwide and largely depend on a country's healthcare system. Whereas most transgender care in Europe is "centralized at nationally sanctioned and academically oriented gender centers, transgender care in the United States often occurs in a patchwork of community clinics with limited research infrastructure" (Deutsch et al., 2015, p. 606). Despite a lack of consensus among advocates and medical professionals who treat transgender individuals, various medical professional associations, including the Endocrine Society, the American Medical Association, and the World Professional Association for Transgender Health, have sought to establish their own best practices. Even guidelines published by the Endocrine Society acknowledge an insufficient evidence base regarding the treatment of gender dysphoria in prepubertal children (Hembree et al., 2017, p. 3879). These guidelines note that "the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence" (p. 3879). Due to this fact and a lack of clarity around how social transitioning contributes to the persistence of gender dysphoria in adolescence, they conclude that the "persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty" (p. 3879).

According to many professionals, the treatment of gender dysphoria requires a multidisciplinary approach, which may include psychotherapy, hormone or puberty blockers,

cross-sex hormone therapy, and sex reassignment surgery (SRS; Fabris et al., 2015, p. 270). According to the Mayo Clinic (2022), "Treatment can help people who have gender dysphoria to explore their gender identity and find the gender role that feels comfortable for them, easing distress" ("Treatment" section). For example, "Gender-affirming hormone therapy (GHT) is utilized by people who are transgender to align their secondary sex characteristics with their gender identity" (Connelly et al., 2021, p. 223). However, most—if not all—of the gender-affirming drugs given to pediatric patients are prescribed for "off-label" uses.

Off-Label Drug Use

The puberty blockers and cross-sex hormone therapy commonly used when providing care related to gender identity are prescribed off-label. Off-label drug use refers to the legal use of a drug approved by the U.S. Food and Drug Administration (FDA) for an unapproved use, which includes medications that "are legally prescribed for purposes, patient populations, or dosages different from what the FDA originally approved" (Lopez Bauman & Sandefur, 2017, p. I; FDA, 2018). Healthcare providers prescribe drugs for "off-label" uses for a variety of reasons. For example, an FDA-approved drug may not yet exist to treat a certain disease or medical condition. Likewise, off-label use is common when a patient has exhausted all medications that are approved for the treatment of a condition without success. For example, aspirin is often prescribed as a "prophylaxis for coronary disease in diabetic and other high-risk patients, a use for which it is not FDA-approved, making it 'off label'" (Lopez Bauman & Sandefur, 2017, p. I).

According to Lopez Bauman and Sandefur (2017), with the exception of certain controlled substances, "The FDA approves the commercial availability of medications but not the practice of medicine, which falls within the domain of state authority" (p. 4). As such, it is incumbent upon the Texas Legislature and state regulators to understand how commercially available drugs are being utilized by physicians in their state and be prepared to protect minors from potentially harmful off-label uses.

Puberty Blockers

Puberty blockers—also known as hormone blockers—are prescription drugs that temporarily suppress puberty. According to the Mayo Clinic (2022c), "The medications mostly commonly used to suppress puberty are known as gonadotropin-releasing hormone (GnRH) analogues" (para. 2). GnRH was discovered in the early 70s and is "the pivotal central regulator of human reproduction" (Marques et al., 2022, "Introduction" section). The FDA has approved GnRH medications for a limited number of uses (FDA, 2017). GnRH medications, such as Trelstar, Synarel, and Eligard, are primarily used to treat the symptoms of advanced prostate cancer, but certain GnRH medications are also approved to treat endometriosis and used as palliative treatment of breast cancer (OptumRx, 2018, p. 1).

Adolescent populations use GnRH agonists as "the standard of care for the treatment of precocious puberty" (Lopez et al., 2018, p. 1432). However, "pediatric patients with normally timed puberty and short stature, children with gender dysphoria, and children with hematologic malignancies" are increasingly being prescribed GnRH agonists for off-label purposes (p. 1432). In children with gender dysphoria, GnRH agonists are used off-label to suppress "the development of secondary sex characteristics of the gender recorded at birth" (Tack et al., 2018, p. 2148). From 2013 to 2016, the "off-label use of GnRH agonists in children increased more than 3-fold with the greatest increases seen in the treatment of short stature and a transgender-related diagnosis" (Lopez et al., 2018, p. 1434).

Despite an increasing number of children being prescribed GnRH treatments, insufficient data exist on the long-term use of such treatments. In 2010, the FDA issued a safety announcement regarding the use of GnRH among men and their " significant increased risks of diabetes and/or cardiovascular events" (para. 2). Although pediatric patients tend to use GnRH agonists for several years, "the side-effect profiles of these therapies among children without precocious puberty have not been thoroughly investigated" (Lopez et al., 2018, p. 1432). In a 2016 update to the safety review of GnRH agonists, the FDA stated, "There are no studies that have evaluated the risk of diabetes and heart disease in children taking GnRH agonists" (FDA, 2016, para. 8). The FDA also cautioned, "For uses other than breast cancer, the recommended length of treatment with GnRH agonists should not exceed one year" (para. 7).

In a subsequent safety update released in 2017, the FDA directed manufacturers of GnRH agonists to add safety information to the drug labels, notably "new information [that] warns about increased risk of diabetes and certain cardiovascular diseases (heart attack, sudden cardiac death, stroke) in men receiving these medications for the treatment of prostate cancer" (FDA, 2017, para. 1).

Emerging research on the use of puberty blockers in children indicates that their use may be associated with a number of long-term effects, including lower bone density, stunted growth, fertility issues, and underdevelopment of genital tissue (Mayo Clinic, 2022c; St. Louis Children's

Hospital, n.d.; Carmichael et al., 2021, p. 40). These side effects, as well as the possibility that there may be other long-term side effects that are not yet known, are acknowledged by clinics and organizations that support providing such treatments to children (St. Louis Children's Hospital, n.d.). In 2020, the Tavistock Gender Identity Development Service (GIDS), which is the only National Health Service gender clinic that specializes in serving children in England, released the results of a study of children prescribed puberty blockers for the purpose of treating gender dysphoria (Barnes & Cohen, 2020; Carmichael et al., 2021). Although the study began in 2011 and lasted for 36 months, Tavistock waited 7 years after its conclusion to release the findings. The Tavistock study followed 44 children between the ages of 12 and 15 for 36 months who presented with "persistent and severe" gender dysphoria (Carmichael et al., 2021, p. 2). These children were provided GnRH pubertal blockers and observed over the course of several years. There was no control group for the study. Of the 44 children who participated in the study, all but one went on to undergo cross-sex hormone treatment, which carries a number of irreversible changes. The study also found that the children experienced side effects that included stunted growth, a decline in bone density, and an increase in weight and body mass index (BMI; p. 40). Notably, the study found little to no change in psychological well-being among the children studied (p. 41). This last finding is especially critical since a key argument made by those in favor of treating gender dysphoria in children with puberty blockers is that this treatment will help improve the overall mental health of these children.

Cross-Sex Hormones

Cross-sex hormones "are gender affirming hormones prescribed for an individual that are consistent with the experienced gender as compared to the assigned gender" (National Health Service [NHS] England, 2016, p. 8). Although certain cross-sex hormones have led to a patient's intended outcomes, studies related to their effect in adults suggest such gender-affirming treatments come with many physical and biochemical side effects, such as altering a patient's brain structure, cognitive processes, and bone density (Mahfouda, 2018, pp. 489–493).

The administration of cross-sex hormones in individuals who transition from female to male (FtM) is based on different forms of testosterone, including intramuscular injections, transdermal preparations, and subcutaneous testosterone implants (Fabris et al., 2015, pp. 271–272). While oral testosterone can be taken in Europe, this option is not provided in the United States due to the risk of oral testosterone causing liver damage. Intramuscular injections are the preferred treatment option for administering testosterone in FtM patients. Transdermal testosterone is applied to the skin in the form of a gel or patches. While "transdermal preparations reproduce normal testosterone levels better than injections" (p. 271), transdermal testosterone in the form of patches can lead to skin irritation. Transdermal testosterone in the form of a gel also "can be transferred by skin contact" (p. 272). Skin transfer of testosterone "may cause penile or clitoral enlargement, premature development, and aggressive behavior" in children exposed to it (p. 272).

Subcutaneous testosterone implants involve the insertion of crystalline testosterone into the subcutaneous tissue. This treatment modality can "maintain adequate serum testosterone levels for up to 6 months," but patients who choose this option are at risk of "pellet extrusion, minor bleeding, and infection" (Fabris et al., 2015, p. 272). If testosterone therapy alone does not stop menstruation, patients transitioning from female to male may also use progestins and testosterone treatments (p. 271). According to Tack et al. (2018), "proandrogenic and antiandrogenic progestins such as lynestrenol (L) or cyproterone acetate (CA)" can suppress "menstruation in girls and erections and hair growth in boys" (p. 2148). However, as of 2018, no data were available on how progestins impact the bone mass or body composition of trans youth (p. 2147).

The use of cross-sex hormones in individuals who transition from male to female (MtF) "is based on the use of estrogens in combination with anti-androgens" (Fabris et al., 2015, p. 272). Medications used for cross-sex hormones in adolescent males seeking to transition from male to female include ethinyl estradiol, spironolactone, and cyproterone acetate and estradiol (Mahfouda, 2018, p. 491). Ethinyl estradiol is an estrogen medication commonly found in contraceptives to prevent pregnancy and ovulation (Mayo Clinic, 2022a), but it has also been administered to adolescent MtF patients to limit growth and induce puberty (Hannema et al., 2017, p. 2359). The medication has been shown to decrease growth velocity and accelerate bone maturation in one patient when administered at a high dose.

One study analyzed the pubertal development of 27 MtF transgender patients who were given various estrogen treatments, including ethinyl estradiol, to induce the development of desired female sex characteristics. Within three months of starting the treatment, 15 out of 18 individuals experienced breast development (Hannema et al., 2017, p. 2358). Within one year, all 27 subjects of the study had experienced breast development. While Hannema et al. found that treatment with ethinyl estradiol was effective

at inducing the development of the patient's desired sex characteristics, they also cautioned that "because of the increased risk of thromboembolic complications, the use of ethinylestradiol is no longer recommended for transgender individuals" (p. 2362). Thromboembolism describes the formation of blood clots in the veins that can cause serious illness, disability, or death (CDC, n.d.).

Many of the changes caused by cross-sex hormone therapy, such as the development of breasts in MtF patients and deepening of the voice in FtM patients, are irreversible (NHS England, 2020b). The long-term use of cross-sex hormones is also associated with temporary and, in some cases, permanent infertility (NHS England, 2016, p. 8).

Sex Reassignment Surgery

Many surgical procedures are conducted to address gender dysphoria, including "feminizing surgery or masculinizing surgery to change the breasts or chest, external genitalia, internal genitalia, facial features, and body contouring" (Mayo Clinic, 2022b, "Medical treatment" section). However, the Endocrine Society recommends that a patient receive the approval of their mental healthcare provider and endocrinologist before pursuing SRS (Hembree et al., 2017, p. 3872). The Endocrine Society also "suggest[s] that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country" (p. 3872).

The U.K.'s National Health Service also does not recommend surgical interventions in youth experiencing gender dysphoria. In fact, most treatments offered to children and young people by the U.K.'s Gender Identity Development Service (GIDS) are psychological and not medical because "in many cases gender variant behavior or feelings disappear as children reach puberty" (NHS England, 2020b, "Treatment for children" section).

Providers of Transgender Medicine Sound the Alarm

Treatment protocols for transgender individuals largely follow the recommendations of the World Professional Association for Transgender Health (WPATH) and the Endocrine Society (NHS England, 2016, p. 2). WPATH is an international nonprofit organization devoted to transgender health and one of the leading advocates for approaches that affirm the patient's perceived gender identity. Its membership consists of individuals from a wide assortment of professions, such as medicine, psychology, law, and family studies (WPATH, n.d.). Since 1979, WPATH has published its *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, which it most recently revised in 2012 and is currently in the process of updating (WPATH, 2012; Ghorayshi, 2022).

The Endocrine Society describes itself as a global community of 18,000 individuals who "unite, lead, and grow the endocrine community to accelerate scientific breakthroughs and improve health worldwide" (Endocrine Society, n.d., para. 3). In 2017, the Endocrine Society published its updated clinical practice guidelines, *Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Pracitce* (Hembree et al., 2017).

Guidelines recommended by WPATH and the Endocrine Society for treating children and youth who identify as transgender are couched in what is known as the "Tanner Stages." The Tanner Stages describe the five stages in which the body develops and experiences puberty, with Stage 1 being the preadolescent stage and Stage 5 being the most developed stage (Vermont Department of Health, n.d.). WPATH (2012) recommends that children with gender dysphoria may begin puberty blockers as soon as the onset of Tanner Stage 2, which can occur in children as young as nine years old. WPATH lists puberty blockers as a "fully reversible intervention" (p. 18) and argues, "their use gives adolescents more time to explore their gender nonconformity and other developmental issues" (p. 19).

Dr. Marci Bowers is a transgender woman who serves on the board of WPATH as president-elect. Dr. Bowers has performed more than 2,000 vaginoplasty operations and is one of the world's most renowned gender surgeons (Shrier, 2021). Although Dr. Bowers previously supported WPATH's position of administering puberty blockers to children during Tanner Stage 2, she expressed different views during an interview with Abigail Schrier in 2021. When discussing children who receive puberty blockers during Tanner Stage 2, Dr. Bowers expressed concern stating, "They're not as functional. I worry about their reproductive rights later. I worry about their sexual health later and ability to find intimacy" (para. 41).

Dr. Bowers also pointed out, "There are definitely people [within WPATH] who are trying to keep out anyone who doesn't absolutely buy the party line that everything should be affirming, and that there's no room for dissent" (Shrier, 2021, para. 12). The accusation that WPATH is unwilling to welcome opposing viewpoints—especially coming from a world-renowned gender surgeon like Dr. Marci Bowers—certainly draws into question the organization's credibility.

Dr. Erica Anderson works at the University of California San Francisco's Child and Adolescent Gender Clinic as a clinical psychologist and, like Dr. Bowers, serves on the

board of WPATH. Anderson submitted an op-ed to the *New York Times* in which she and a co-author expressed concerns that transgender children were receiving reckless healthcare. Similar to the disposition of WPATH, the *New York Times* declined to publish Anderson's op-ed and told Anderson that her piece was "outside [the *Times*'] coverage priorities right now" (Shrier, 2021, para. 6). Anderson expressed worry about WPATH's recommendation to start puberty blockers at early stages of puberty and her belief that many providers of transgender care are "rushing people through the medicalization … [while failing] to evaluate the mental health of someone historically in current time, and to prepare them for making such a life-changing decision" (para. 50).

The concerns expressed by Drs. Bowers and Anderson, along with emerging research detailing the potentially harmful outcomes associated with gender-affirming care and recent changes made by several European nations in their approach to treating children with gender dysphoria, should inform how policymakers respond to this critical public health issue. This emerging research and treatment course correction are discussed in the following section.

The Global Politics of Gender Identity

As the field of transgender medicine developed throughout the 20th century, so too did government regulation of the field. Over time, these regulations have evolved and vacillated based both on medical research and the political ideology of the governing authorities. This section provides a brief history of this development in Europe, the United Kingdom, and the United States.

The Dutch Protocol

The use of puberty blockers and cross-sex hormones in treating children experiencing gender dysphoria was pioneered in the Netherlands in the mid-1990s and popularized by psychologists Peggy Cohen-Kettenis and Stephanie van Goozen. Their 1998 article, "Pubertal Delay as an Aid in Diagnosis and Treatment of a Transsexual Adolescent," detailed one of the earliest known cases of a transgender adolescent being treated with puberty blockers and, later, hormonal treatment and SRS (Cohen-Kettenis & van Goozen, 1998, p. 248). The treatment protocol Cohen-Kettenis and van Goozen describe became the foundation of what would later become known as the "Dutch Protocol."

Under the Dutch Protocol, a pediatric patient progresses through a series of steps over the course of several years that may culminate in the performance of SRS (Delemarre-van de Waal & Cohen-Kettenis, 2006, p. S131). The protocol begins with a diagnostic procedure in which "it is investigated whether an applicant fulfills Diagnostic and Statistical Manual of Mental Disorders-IV-RT criteria for gender identity disorder (GID)" (p. 132). Since 2015, the *Diagnostic Statistical Manual of Mental Disorders-5* has been used (Arnoldussen et al., 2020, p. 806). In addition to meeting this diagnostic requirement, the patient must also be found to "have suffered from lifelong extreme gender dysphoria," be "psychologically stable," and have a safe, supportive home environment (p. 131). Once these criteria are met, the patient may then progress to a period of time living in their desired gender role, known as a "real-life experience" or "RLE" (p. 132). During this RLE period, the patient may begin taking puberty-suppressing drugs. Under the Dutch Protocol, puberty suppressants are prescribed as early as 12 and continue until the child reaches 16 (p. 133). Once the child reaches age 16, if they wish to continue with the treatment, cross-sex hormones are added to puberty suppressants. In the final phase, the patient is eligible for SRS once they reach 18 (p. 134).

The general process outlined above quickly became the predominant course of treatment for children experiencing gender dysphoria and was adopted by gender clinics worldwide. It is only within the last decade that clinicians have begun questioning its efficacy (Ghorayshi, 2022; Doubts Are Growing, 2021; Shrier, 2021).

Gender Identity Development Service (United Kingdom)

In 1989, England's NHS commissioned GIDS to provide children and adolescents under the age of 18 with highly specialized services relating to gender identity development (GIDS, n.d.; NHS England, 2020a, p. 1). Housed at the Tavistock and Portman NHS Foundation Trust, GIDS is England's only gender identity clinic for children and adolescents. The services commissioned by NHS England adhere to best practices and standards of care provided by WPATH and the Endocrine Society, which are largely rooted in the Dutch Protocol (NHS England, 2020a, p. 2).

In July 2012, NHS Scotland published its *Gender Reassignment Protocol*, which outlines detailed procedures for gender reassignment based on WPATH recommendations (NHS Scotland, 2012, p. 7). In October 2013, NHS England adopted the NHS Scotland protocol as an interim step toward the development of "a definitive English policy and services specification" (NHS England, 2013, p. 5). Subsequent to the adoption of the interim protocol, NHS England developed "service specifications" detailing how care is provided to individuals experiencing gender dysphoria (NHS England, 2020b, "NHS guidelines for gender dysphoria" section). Service specifications for providing gender identity development services to children and adolescents were first published by NHS England in December 2020, and later amended in October 2021 (NHS England, 2020a).

Like the interim guidelines adapted from the Scottish protocol, these new guidelines for serving children and adolescents follow guidelines published by WPATH and the Endocrine Society (p. 2).

Just like for similar services in the United States, demand for the services provided by GIDS has surged over the last decade. While GIDS received only 77 referrals from 2009 to 2010, the service received more than 2,700 referrals from 2019 to 2020, with a waitlist of more than 4,600 adolescents (Dyer, 2021, p. 1).

Bell v. Tavistock

In October 2019, a lawsuit was filed against the Tavistock and Portman NHS Foundation Trust in connection with its operation of GIDS and its clinical practices related to the prescription of puberty blockers and cross-sex hormone treatment (Holt, 2021; Hurst, 2019). The suit, known as *Bell v. Tavistock*, was filed in the High Court of Justice of England and Wales by Keira Bell, a 24-year-old woman who was assessed at the Tavistock clinic and started on puberty blockers beginning at age 16 before later detransitioning back to female (Holt, 2021). Bell was joined by the mother of a child who was referred to Tavistock but had not yet undergone treatment in arguing that children under the age of 18 are incapable of providing informed consent to the treatment of gender dysphoria with puberty blockers and sought a requirement for court approval before puberty blockers are prescribed to any individual under the age of 18 (*Bell v. Tavistock*, 2021, p. 3).

In the hearing before the High Court, Dr. Annelou de Vries, a founding board member of the European Professional Association for Transgender Health (EPATH) and a member of WPATH, provided the High Court with evidence based on her experience using puberty blockers to treat gender dysphoria in children in Amsterdam (*Bell v. Tavistock*, 2020, p. 15). According to the High Court, Dr. de Vries "sa[id] that of the adolescents who started puberty suppression, only 1.9 per cent stopped the treatment and did not proceed to CSH [cross-sex hormones]" (p. 15). Whereas Tavistock argued that the prescription of puberty blockers is completely separate from the treatment of gender dysphoria with cross-sex hormones, the High Court found that the two medical interventions comprise "two stages of one clinical pathway" (p. 35). The court ruled, "once on that pathway it is extremely rare for a child to get off it" (p. 35). According to the High Court, for a child or adolescent to achieve the competence necessary to consent to treatment they "would have to understand not simply the implications of taking PBs [puberty blockers] but those of progressing to cross-sex hormones," including the risks and life-altering consequences associated with the treatments as well as the limited evidence supporting the efficacy of the treatment (p. 35).

The court went on to detail the various implications as well as side effects associated with the course of treatment, including the progression from puberty blockers to cross-sex hormones to surgery, the likelihood of loss of fertility as a result of taking cross-sex hormones, the impact of the treatment on sexual function, the "unknown physical consequences" associated with taking puberty blockers, and "the fact that the evidence base for this treatment is as yet highly uncertain" (p. 35). Ultimately, in December 2020, the High Court ruled that children younger than 16 likely cannot provide informed consent to receive treatment from puberty blockers[1] (NHS England, n.d.).

In September 2021, however, the Court of Appeal overturned the ruling of the High Court (NHS England, n.d.). The Court of Appeal reiterated its role as a judicial actor in the case of *Bell v. Tavistock* (2021) and stated:

> *Medical opinion is far from unanimous about the wisdom of embarking on treatment before adulthood. The question raises not only clinical medical issues but also moral and ethical issues, all of which are the subject of intense professional and public debate…Such policy decisions are for the National Health Service, the medical profession and its regulators and Government and Parliament.* (p. 3)

The Court of Appeal determined that the High Court erred in providing guidance relating to informed consent, as the High Court misapplied the contextual application of informed consent and disregarded the role of clinicians (*Bell v. Tavistock*, 2021, p. 24). According to the Court of Appeal, "clinicians must satisfy themselves that the child and parents appreciate the short and long-term implications of the treatment upon which the child is embarking" (p. 25). Therefore, the Court of Appeal ruled that children, in consultation with their parents and physicians, can provide informed consent to the treatment of gender dysphoria with puberty blockers without a court's approval. Notably, though, the Court of Appeal did not explicitly reject the High Court's finding regarding the uncertainty and controversy surrounding the evidence supporting the use of puberty blockers in treating children with gender dysphoria.

1 Under English law, when a youth turns 16, they are able to exercise certain additional rights independent of parental control. These rights include the ability to leave home without parental consent, enter into a housing contract, work a full-time job, leave school, and consent to medical treatment (Lawble, 2021).

Changing Course

In recent years, the United Kingdom and many European nations have begun slowly changing course on the Dutch Protocol and the course of treatment currently catching on in the United States. Finland made international news in June 2020 when it tightened its guidelines to prefer psychological counseling to the prescription of medication in treating those with gender dysphoria (Council for Choices in Health Care in Finland, 2020; Doubts Are Growing, 2021; The Controversy Over Trans Teens, 2021). Later that same year, the Tavistock Gender Identity Development Service in England released the results of its study of children prescribed puberty blockers for the purpose of treating gender dysphoria (Barnes & Cohen, 2020; Carmichael et al., 2021). As discussed above, the study found little to no change in psychological well-being among the children studied and documented numerous side effects, including stunted growth, a decline in bone density, and an increase in weight and BMI (Barnes & Cohen, 2020; Carmichael et al., 2021, pp. 40–41). Following the release of the Tavistock study, in March 2021, the National Institute for Health and Care Excellence (NICE) released a study commissioned by England's NHS examining the "effectiveness, safety, and cost-effectiveness" of the use of puberty blockers to treat children and adolescents with gender dysphoria (NICE, 2021). In its review of existing studies promoting the use of these drugs, NICE found the evidence to be of poor quality, "subject to bias and confounding," and suggestive that the use of puberty blockers in children has little impact on "critical outcomes of gender dysphoria and mental health" (NICE, 2021, pp. 13, 44). Finally, in April 2021, the Karolinska Institute, one of Sweden's premier medical universities, announced that its hospitals would cease providing puberty blockers and cross-sex hormones to minors (Doubts Are Growing, 2021). The Karolinska Institute's announcement was followed by the Swedish National Board of Health and Welfare updating its "recommendations for hormone therapy for gender dysphoria in young people" in February 2022. Citing "uncertain science and new knowledge," the board "now recommends restraint when it comes to hormone treatment" for minors presenting with gender dysphoria (National Board of Health and Welfare, 2022). The updated recommendations came after the board conducted a literature review of existing studies that found "that it is not yet possible to draw any definite conclusions about the effect and safety of the treatments based on scientific evidence." Other concerns cited by the board included a dramatic and unexplainable increase in the number of children, particularly females, seeking care for gender dysphoria between 2008 and 2018, documented cases of patients regretting their decision and choosing to detransition, and the risk of "poorer health and quality of life" resulting from the treatment, especially among those who later choose to detransition. As a result of this emerging information, the board ultimately concluded that "the risks of anti-puberty and sex-confirming hormone treatment for those under 18 currently outweigh the possible benefits for the group as a whole."

The Politics of Gender Identity in the United States

National Coverage Determinations

The U.S. Department of Health and Human Services (HHS) makes rules to enforce the provisions of the Social Security Act, which are published in the Federal Register upon approval. Some of these rules—called national coverage determinations (NCDs)—state whether certain medical treatments and procedures are eligible for Medicare coverage. According to the Centers for Medicare & Medicaid Services (CMS, n.d.), "National coverage determinations (NCDs) are made through an evidence-based process, with opportunities for public participation" (para. 1).

In 1965, the U.S. Congress amended the Social Security Act and prohibited certain medical treatments and procedures from Medicare coverage (Social Security Amendments, 1965). As a result, most payments that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (p. 325) are ineligible for Medicare coverage.

In 1989, HHS published an NCD to prohibit the coverage of SRS under Medicare. The rule stated:

> *Transsexual surgery for sex reassignment of transsexuals is controversial. Because of the lack of well controlled, long-term studies of the safety and effectiveness of the surgical procedures and attendant therapies for transsexualism, the treatment is considered experimental. Moreover, there is a high rate of serious complications of these surgical procedures. For these reasons, transsexual surgery is not covered.* (Medicare Program; National Coverage Decisions, 1989, p. 34572)

2014 Decision

In 2014, the Departmental Appeals Board within HHS rescinded the 1989 NCD (HHS, 2014). The board received expert testimony from healthcare workers, including surgeons and mental health professionals, who explained why the 1989 NCD was no longer valid. One witness, Katherine Hsiao, M.D., is a surgeon who had performed hysterectomies in FtM SRS for a decade. Dr. Hsiao testified, "gender affirming surgeries for transgender men are extremely safe and have very low rates of serious complications" (p. 11).

Another witness, Randi Ettner, Ph.D., is a clinical psychologist who had treated individuals with gender dysphoria. According to Dr. Ettner, "decades of extensive scientific and clinical research" justify the efficacy and safety of SRS (p. 15). Multiple doctors also disputed the claim that SRS remains experimental (pp. 21–22). The board stated, "the bases stated in the NCD and the NCD record for denying coverage, even assuming they were reasonable when the NCD was issued, are no longer reasonable" (p. 8). The board's decision for rescinding the NCD was based on the declination of CMS to defend the NCD as reasonable and new medical evidence that has been published since 1981. The medical evidence, which the board claims is proof that "transsexual surgery is safe" (p. 11), however, remains disputed in the medical community.

The expert testimonies largely focused on transgender adults and failed to explain how medical research from the past 30 years applied to transgender adolescents. According to one study used by the board to make its decision, "Adolescents with a lifelong GID [gender identity disorder], who have no psychiatric comorbidity and are socially functioning well and supported, who underwent SRS, are satisfied and functioning well" (Gijs & Brewaeys, 2012, p. 216). Yet, Gijs and Brewaeys acknowledged, "GID at prepubertal ages decreases or even disappears in a considerable percentage of children after they have reached puberty" (p. 213), and "we recognize that replications by other treatment centers and longer follow-up periods are necessary" (p. 216). Despite the increased medical knowledge and research on SRS for transgender adults, much more research is needed relating to how SRS may impact adolescents.

On August 30, 2016, CMS declined to issue an NCD. CMS determined, "In the absence of a NCD, coverage determinations for gender reassignment surgery … will continue to be made by the local MACs [Medicare Administrative Contractors] on a case-by-case basis" (Jensen et al., 2016, "Decision" section). The decision not to issue an NCD also cited "evidence gaps" and referenced the need for more clinical studies relating to SRS. The memorandum further states, "the result of this decision is not national non-coverage rather it is that no national policy will be put in place for the Medicare program" ("Decision" section).

Implementing Section 1557: The 2016 Rule

On May 18, 2016, HHS—at the time under the Obama administration—published the finalized "2016 Rule" (Nondiscrimination in Health Programs and Activities, 2016), which implemented Section 1557 of the Patient Protection and Affordable Care Act (ACA; 42 U.S.C. 18116(a)). The rule specifically prohibits discrimination in any program or activity that receives federal funding under applicable state laws and the following federal legislation:

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.)
- Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.)
- Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.)
- Section 504 of the Rehabilitation Act of 1973 (Section 794 of title 29)

The 2016 rule prohibited any healthcare provider or insurer from discriminating against an individual because of a person's gender identity or sex (Nondiscrimination in Health Programs and Activities, 2016, p. 31467). Section 92.206 of the rule requires a federally funded healthcare provider to provide a transgender person with health services that are available to the sex that matches their gender identity, whether or not the person's gender identity matches the person's biological sex (p. 31471). Section 92.207 of the rule requires federally funded health insurance providers to provide coverage to health services, including gender transition procedures, to transgender persons consistent with their gender identity, whether or not the person's gender identity matches the person's biological sex (p. 31472).

The 2016 rule provides definitions for both "gender identity" and "sex," which healthcare service and coverage providers are required to follow as it relates to nondiscrimination. The rule states:

> Gender identity *means an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth. The way an individual expresses gender identity is frequently called 'gender expression,' and may or may not conform to social stereotypes associated with a particular gender. A transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth.*
>
> On the basis of sex *includes, but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.* (p. 31467)

Through a bureaucratic rulemaking process, the Obama administration sought to build upon existing civil rights

legislation and impose regulatory mandates on nearly every healthcare provider and insurer in the nation. Section 1557 did not create any new protected class but simply prohibited discrimination against protected classes under existing law. However, the Obama administration sought to create a new protected class that includes gender identity through its implementation of Section 1557. If a healthcare provider or insurer did not comply with the 2016 rule, the service provider could be prohibited from receiving any federal funding (Archer, 2017, p. 24). The loss of federal funding could create a major negative financial impact for a healthcare provider, as the federal government heavily subsidizes healthcare costs. The Congressional Budget Office (CBO, 2020) projected that U.S. net federal subsidies toward Medicaid and CHIP programs would total approximately $366 billion in 2020 (p. 17). CBO also projected this figure to total $118 billion toward Medicare programs and $58 billion toward marketplace-related coverage and the basic health program. The 2016 rule requires physicians to provide gender transition procedures and treatments to their patients without allowing any form of religious or other exemption for physicians who do not wish to do so (Archer, 2017, p. 23). For example, as a result of the 2016 rule, a religious hospital may be forced to allow procedures with which it fundamentally disagrees or risk a financial disaster and the loss of its ability to care for its other patients.

Franciscan Alliance, Inc. v. Burwell

On October 21, 2016, three private healthcare providers—dubbed the Franciscan Alliance, Inc.—and a group of eight states[2] sued HHS and its secretary, Sylvia Burwell, in the U.S. District Court for the Northern District of Texas over the 2016 rule, arguing that it will require them and other similar private healthcare providers to "perform and provide insurance coverage for gender transitions and abortions, regardless of their contrary religious beliefs or medical judgment" (*Franciscan Alliance, Inc. v. Burwell*, 2016, p. 670). The plaintiffs further alleged that by redefining "sex" and what constitutes prohibited sex discrimination, HHS under the Obama administration violated the Administrative Procedures Act because its new definition is "contrary to law and arbitrary and capricious" (p. 676).

On December 31, 2016, the court ruled in favor of the plaintiffs and enjoined the 2016 rule from taking effect (*Franciscan Alliance, Inc. v. Burwell*, 2016, p. 669). The court found that Section 1557 of the ACA "clearly adopted Title IX's existing legal structure for prohibited sex discrimination," which "unambiguously refers to 'the biological and anatomical differences between male and female students as determined at their birth'" (p. 687). According to the court, when Title IX was passed, "Congress intended to prohibit sex discrimination on the basis of the biological differences between males and females" (p. 687). As such, the court ruled that the 2016 rule violated the Administrative Procedure Act and was likely also in violation of the Religious Freedom Restoration Act (p. 670).

Implementing Section 1557: The 2020 Rule

On June 19, 2020, HHS—at the time under the Trump administration—published its final rule, commonly known as the "2020 Rule," relating to the enforcement of Section 1557 of the ACA (Nondiscrimination in Health and Health Education Programs, 2020). The final rule sought to conform the implementation of Section 1557 more closely to existing federal law and act as a cost-savings, deregulatory measure (p. 37162).

Among many changes from the 2016 rule, the revised 2020 regulation included the repeal of "Overbroad Provisions Related to Sex and Gender Identity" and "Unnecessary Regulatory Burdens" (Nondiscrimination in Health and Health Education Programs, 2020, pp. 37161–37162). According to the 2020 rule, the Obama administration's provision of "gender identity" was a legislative action that HHS did not have the authority to make (pp. 37161–37162). As a result, the 2020 rule "does not provide a new definition of sex discrimination" (Office for Civil Rights, 2020, p. 3), nor does it include gender identity in the definition of "discrimination on the basis of sex." The 2020 rule also eliminated unnecessary or duplicative language to reduce confusion and inconsistency as it relates to civil rights enforcement (Nondiscrimination in Health and Health Education Programs, 2020, p. 37163). The final rule took effect on August 18, 2020.

Bostock v. Clayton County

As the Trump administration was finalizing its changes to rules enforcing Section 1557 during the summer of 2020, the U.S. Supreme Court issued a key ruling in a case known as *Bostock v. Clayton County* that would further complicate the issue. Gerald Bostock was an employee of Clayton County, Georgia, who was fired "for conduct 'unbecoming' a county employee shortly after he began participating in a gay recreational softball league" (*Bostock v. Clayton County*, 2020, p. 1). Bostock sued the county and alleged it had committed unlawful discrimination under Title VII of the Civil Rights Act of 1964 ("Title VII") based on sex. Title VII prohibits employers from discriminating against an employee on the basis of an "individual's race, color, religion, sex, or national origin" (42 U.S.C. §2000e–2(a)(1)).

2 Texas, Wisconsin, Nebraska, Kansas, Louisiana, Arizona, Kentucky, and Mississippi

The Eleventh Circuit ruled that employer discrimination against homosexuality is not prohibited under Title VII (*Bostock v. Clayton County*, 2018, p. 2). Bostock appealed to the Supreme Court.

Justice Gorsuch delivered the majority opinion of the Supreme Court and held, "When an employer fires an employee for being homosexual or transgender, it necessarily and intentionally discriminates against that individual in part because of sex" (*Bostock v. Clayton County*, 2020, p. 18). Justice Gorsuch reasoned that the Title VII prohibition against sex discrimination in the workplace might include discrimination related to an individual being homosexual or transgender. According to Justice Gorsuch, "homosexuality and transgender status are inextricably bound up with sex … to discriminate on these grounds requires an employer to intentionally treat individual employees differently because of their sex" (p. 14).

The majority found that an employer violates Title VII if it fires an employee—even in part—for being homosexual or transgender (*Bostock v. Clayton County*, 2020, p. 11). According to the Court's reasoning, "In Title VII, Congress adopted broad language making it illegal for an employer to rely on an employee's sex when deciding to fire that employee. … An employer who fires an individual merely for being gay or transgender defies the law" (p. 33). Thus, the court found that Clayton County discriminated against Gerald Bostock when they fired Bostock for being gay.

Executive Order 13988

Seizing on Justice Gorsuch's majority opinion in *Bostock*, the Biden administration sought to return to the 2016 rule's definition of "sex" and what constitutes sex discrimination. On January 20, 2021, President Biden signed an executive order titled "Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation" (Exec. Order No. 13988, 2021). The order required each impacted federal agency to "review all existing orders, regulations, guidance documents, policies, programs, or other agency actions" (p. 7023) related to the agency's implementation of Title VII. Each agency was also ordered to "consider whether to revise, suspend, or rescind such agency actions, or promulgate new agency actions" (p. 7024) that would prohibit discrimination based on an individual's gender identity or sexual orientation. Executive Order 13988 states:

> *Under Bostock's reasoning, laws that prohibit sex discrimination—including Title IX of the Education Amendments of 1972, as amended (20 U.S.C. 1681 et seq.), the Fair Housing Act, as amended (42 U.S.C. 3601 et seq.), and section 412 of the Immigration and Nationality Act, as amended (8 U.S.C. 1522), along with their respective implementing regulations—prohibit discrimination on the basis of gender identity or sexual orientation.* (p. 7023)

Whereas Title VII of the Civil Rights Act of 1964 prohibits certain types of discrimination against employees in the workplace (p. 253), Title IX—amended to the Civil Rights Act in 1972—prohibits discrimination in educational institutions that receive federal funding (p. 326). Following the issuance of Executive Order 13988, the Civil Rights Division of the U.S. Department of Justice provided guidance to federal agency officials regarding the application of *Bostock v. Clayton County* to Title IX (Memo from Principal Deputy Asst. AG Karlan, 2021). The guidance—provided in the form of a memo—held that the Supreme Court's rationale in *Bostock v. Clayton County* applies to Title IX. According to the Civil Rights Division, "the best reading of Title IX's prohibition on discrimination 'on the basis of sex' is that it includes discrimination on the basis of gender identity and sexual orientation" (p. 2).

Executive Order 14035

On June 25, 2021, President Biden signed an executive order titled "Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce" (Exec. Order No. 14035, 2021). President Biden ordered:

> *The head of each agency shall, in coordination with the Director of OPM, ensure that existing employee support services equitably serve LGBTQ+ employees, including, as appropriate, through the provision of supportive services for transgender and gender non-conforming and non-binary employees who wish to legally, medically, or socially transition.* (p. 34600)

In the executive order, the director of the Office of Personnel Management (OPM) and the secretary of defense were also ordered to "take actions to promote equitable healthcare and health insurance coverage" for LGBTQ+ employees, their beneficiaries, and their eligible dependents (p. 34600).

President Biden's executive order had a similar effect to the 2016 rule (Nondiscrimination in Health Programs and Activities, 2016), implementing Section 1557 of the ACA. Both the 2016 rule and President Biden's executive order would require that healthcare insurance providers cover sex reassignment treatments and procedures for federal employees, their beneficiaries, and their dependents.

State Legislative and Regulatory Activity

Beyond the activity occurring at the federal level, state legislatures and executive agencies have also weighed in

on transgender-related policies, especially in the context of children and youth. This section focuses primarily on actions taken in the state of Texas, but it should be noted that this debate is occurring in multiple states.

Legislative Actions

According to the National Conference of State Legislatures, "From 2013 to 2016, at least 24 states considered 'bathroom bills,' or legislation that would restrict access to multiuser restrooms, locker rooms, and other sex-segregated facilities on the basis of a definition of sex or gender consistent with sex assigned at birth or 'biological sex'" (Kralik, 2019, "Overview of state legislation" section). In 2017, the Texas Legislature considered legislation that sought to designate multi-occupancy bathrooms and changing facilities for use only by individuals of the indicated biological sex (SB 6, 2017). Texas' "bathroom bill," Senate Bill 6, passed the Texas Senate along a strict party-line vote but was not considered before a committee in the Texas House.

As of May 2021, state lawmakers in 31 states had introduced legislation relating to the participation of transgender athletes on sports teams (Rivera, 2021). During a special legislative session in October 2021, the Texas Legislature passed a bill (HB 25, 2021) that prohibits schools from "allowing a student to compete in a competition designated for the biological sex opposite to the student's as correctly stated on the student's official birth certificate" (HB 25 Bill Analysis, 2021, p. 3). Texas Gov. Abbott signed HB 25 into law on October 25, 2021. As of December 2021, nine states (Arkansas, Alabama, Florida, Idaho, Mississippi, Montana, Tennessee, Texas, and West Virginia) have enacted restrictions on the participation of transgender youth in interscholastic athletics (Rezal, 2021). South Dakota implemented a similar regulation via executive order and subsequently as a legislative act (SB 46, 2022).

Prior to 2021, no state had successfully enacted legislation directly related to the performance of sex reassignment treatments and procedures on children. All that changed in April 2021 when the Arkansas General Assembly passed the Save Adolescents from Experimentation (SAFE) Act (HB 1570, 2021) by overriding a veto of the legislation by Gov. Asa Hutchinson. The passage of the SAFE Act made Arkansas the first state to prohibit gender-affirming treatments and surgical procedures for transgender youth (Bryan, 2021a). Gov. Hutchinson vetoed the bill, stating that the legislation was too broad and did not include a grandfather clause for transgender youth already undergoing medical interventions (Hutchinson, 2021, 07:25; Bryan, 2021b). On April 16, 2021, the Arkansas Legislature voted to override Gov. Hutchinson's veto.

The SAFE Act prohibits any healthcare provider from providing gender-affirming procedures on minors for the purpose of gender reassignment (HB 1570, 2021, p. 8), which includes a prohibition on puberty blockers, cross-sex hormones, and surgical procedures (p. 6). The act also barred public funds from being used for gender transition procedures for minors under the age of 18 (p. 9), including public funds in Arkansas' Medicaid program, and prohibits health insurers from providing coverage to minors for the purpose of gender transition procedures (p. 10). Lastly, the SAFE Act entitles individuals to "compensatory damages, injunctive relief, declaratory relief, or any other appropriate relief" (p. 9), which may include disciplinary actions imposed on a physician by a "licensing entity or disciplinary review board" (p. 9).

On the heels of Arkansas' enactment of the SAFE Act, Tennessee Gov. Bill Lee signed Senate Bill 126 (2021) into law on May 18, 2021. The law, which is much more limited in scope than the SAFE Act, prohibits healthcare providers from prescribing hormone treatment to children who have not yet reached puberty for the purpose of treating gender dysphoria or gender incongruity. In 2021, 21 states introduced legislation similar to measures enacted by Arkansas and Tennessee that would place restrictions on the provision of gender-affirming care to minors (Conron et al., 2021, para. 1).

During the regular session of the 87th Texas Legislature, two bills were introduced that took a similar approach to the Arkansas and Tennessee laws. House Bill 1399 (2021) and Senate Bill 1311 (2021) both defined the prescription of puberty-blocking drugs and cross-sex hormones as well as certain surgical procedures intended to aid in reassigning a child's gender as prohibited medical practices under Chapter 161 of the Health and Safety Code and Chapter 164 of the Occupations Code (HB 1399, 2021, pp. 1–2; SB 1311, 2021, pp. 1–2). Under the proposed legislation, medical providers who engage in prohibited practices would be subject to disciplinary action, including the revocation of their license to practice medicine in Texas (HB 1399, 2021, p. 7; SB 1311, 2021, p. 3). Both bills also prohibited insurance companies from providing professional liability coverage for "damages assessed against the physician or health care provider" who engages in prohibited conduct (HB 1399, 2021, p. 3; SB 1311, 2021, p. 3). Neither bill passed the full Legislature before sine die.

Executive Actions

On August 6, 2021, Texas Gov. Greg Abbott (Letter from Gov. Abbott to Commissioner Masters, 2021) directed Texas Department of Family and Protective Services (DFPS) Commissioner Jaime Masters to "issue a

determination of whether genital mutilation of a child for purposes of gender transitioning through reassignment surgery constitutes child abuse" (p. 1) and noted that Texas Family Code, Section 167.001, already prohibits genital mutilation for females under the age of 18 years old. In the letter, Gov. Abbott directed DFPS to "consider making explicit what is already implicit in the statute: that the genital mutilation of a child through reassignment surgery is child abuse" and recommended exceptions for "medically necessary procedures" for children with certain conditions or injuries (Letter from Gov. Abbott to Commissioner Masters, 2021, p. 1).

DFPS Commissioner Jaime Masters responded to Gov. Abbott on August 11, 2021 (Letter from DFPS Commissioner Jaime Masters to Gov. Greg Abbott, 2021), affirming that genital mutilation of a child for the purposes of gender reassignment surgery constitutes child abuse as it would create "a genuine threat of substantial harm from physical injury to the child" (Texas Family Code, Section 261.001(1)(c)) and "physically alter a child's genitalia for non-medical purposes" (Letter from DFPS Commissioner Jaime Masters to Gov. Greg Abbott, 2021, p. 1). Commissioner Masters also explained the limited exceptions during which a surgical procedure of this type would not be considered child abuse, which typically occurs when a child's body parts have been affected by a birth defect, illness, or trauma.

Six months after this exchange, on February 18, 2022, Texas Attorney General Ken Paxton issued a nonbinding opinion finding that certain "'sex change' procedures and treatments … can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code" (Texas Attorney General Opinion No. KP-0401, 2022, p. 2). Four days later, Gov. Greg Abbott sent a follow-up letter to DFPS Commissioner Jaime Masters directing the agency to "follow the law as explained in OAG Opinion No. KP-0401" and investigate reported instances of children being subjected to sex-reassignment procedures or treatments (Letter from Gov. Abbott to Commissioner Masters, 2022, p. 1).

On April 20, 2022, the Florida Department of Health weighed into the debate by releasing guidance addressing the treatment of gender dysphoria in minors by healthcare providers in that state (Florida Department of Health, 2022). Citing the "lack of conclusive evidence" supporting the provision of so-called gender-affirming care to minors and "the potential for long-term, irreversible effects," the guidelines advise against prescribing puberty blockers or cross-sex hormones to children as well as performing gender reassignment surgery on children or adolescents. It notably makes exceptions for procedures intended to treat "children or adolescents born with a genetically or biochemically verifiable disorder of sex development (DSD)." Based on available information at the time of writing, it is unclear if or how Florida will enforce these guidelines.

Defining Abuse and the Impact of Foster Care

DFPS uses the definition of abuse located within the Texas Family Code, Section 261.001(1), when investigating reports of child abuse or neglect. The Texas Senate passed SB 1646 (2021c) during the 87th Legislature, seeking to redefine abuse to include instances in which a person provides a child with or allows a child to receive services related to sex reassignment, including hormone blockers, cross-sex hormones, and surgical procedures (p. 3). As introduced, SB 1646 (2021a) would have made this conduct a state jail felony under Texas Penal Code, Section 22.041. These criminal offenses were removed from the bill before it was passed out of the Senate Committee on State Affairs (SB 1646, 2021b). Senate Bill 1646 was referred to the House Committee on Public Health but failed to make it out of committee before the regular session ended.

Given the irreversible, lifelong harm to children caused by these procedures, it is natural to call for the state to intervene and protect children from this harm by defining the practice as child abuse under Texas law. However, we must recognize that the term "abuse" has a specific legal meaning and carries serious consequences for children that can subject them to additional harm at the hands of the state. Consequently, amending the definition of abuse in code is unworkable for the purposes of protecting children from being subjected to sex reassignment treatments and procedures. Defining these procedures as abuse and leveraging Child Protective Services (CPS) as the means of enforcement improperly expands the reach of CPS into the private realm of the family and could lead to the further weaponization of CPS as a tool for advancing particular ideological beliefs regarding child-rearing and family autonomy. Of course, advancing specific beliefs concerning what is good for individuals, families, and society as a whole is one of the chief goals of policymaking. In achieving those goals, however, policymakers should take care when selecting the right tool for the job and seek to implement policy in the most narrowly tailored, least disruptive way possible. As this paper has demonstrated, protecting children from the risks associated with sex reassignment medications and procedures is a legitimate exercise of state authority. However, policymakers should be wary of the collateral consequences associated with utilizing Child Protective Services as the means of advancing this goal.

Enforcement of such a provision would require an investigation of DFPS that likely would result in the

removal of the alleged child victim into foster care and could culminate in the legal termination of the parent-child relationship. Under Texas Family Code, Section 263.401, once a child is placed in DFPS custody, the family has one year to satisfy the court that they have addressed the risk factors that led to the child entering care and are able to care for the child. At the conclusion of the one-year time limit, the court must either return the child to the family or permanently sever the legal relationship between the parent and child. The average length of time a child will spend in the Texas foster care system currently stands at 20.6 months (DFPS, n.d.). Those who are eventually reunited with their families will spend a shorter period of time in care, but still average more than a year—13.9 months—in state custody (DFPS, n.d.). Only one third of children who enter the Texas foster care system are ever reunited with their families (DFPS, n.d.). Given the life-altering consequences and well-documented harms associated with foster care for both the child and the child's family, intervention by the child welfare system must always be a last resort.

The child welfare system exists "to protect children who are in imminent danger of harm and to help their families rehabilitate, promote safe environments, and increase familial strength and stability" (Pressley, 2020, p. 1). Children who enter foster care will endure a number of traumatic incidents including the initial maltreatment, the trauma of removal from their home and family, and various traumatic experiences that occur while they are in care (Brown & Huntzinger, 2019, p. 2).

Numerous studies have documented the complex trauma and lifelong negative outcomes experienced by children who spend even a short time in foster care. One such study that documented the experiences of over 650 adults who had previously spent one year of their childhood in foster care found that "about one-third of alumni reported some maltreatment while in care" (Pecora et al., 2006, p. 1470). Another study conducted by the U.S. HHS Administration on Children, Youth and Families estimated that between 50% and 90% of child trafficking victims had previously been involved with child protective services (Child Welfare Information Gateway, 2017, p. 4). The treatment of children in the Texas foster care system has historically been so bad that a federal judge in 2015 ruled that children "almost uniformly leave State custody more damaged than when they entered" (*M.D. v. Abbott*, 2015, p. 828).

Beyond these immediate risks to their health and safety, children who spend time in foster care are also at heightened risk of severe life-long negative impacts, including developmental delay, chronic mental and physical health issues, drug abuse, suicide attempts, and incarceration (Conn et al., 2013; Dworsky et al., 2011; Vaughn et al., 2007). Foster care alumni also struggle to provide for themselves upon leaving care. According to Pecora et al. (2006, pp. 1471–1472), over 20% of foster care alumni studied experienced homelessness within the first year after exiting care, and the poverty rate among foster care alumni is more than three times larger than the national poverty rate.

A further complication associated with leveraging CPS to protect children from the risks associated with sex reassignment procedures relates to the enforcement of the abuse definition. The current child welfare system is reactive by nature (Milner & Kelly, 2021). Due to both the practical and constitutional constraints placed upon it, the child welfare system generally does not become involved with a family until after abuse or neglect occurs (Logan, 2018, p. 2; Welch & Haskins, 2020). This reactionary stance is even seen in the definitions of "abuse" and "neglect" codified in the Texas Family Code, Section 261.001(1) & (4), which require the state to prove that either an act or omission of a parent has resulted in harm to a child or placed a child at an immediate or substantial risk of harm. Practically speaking, then, protecting a child from the risks associated with sex reassignment procedures via the child welfare system would require either an affirmative step toward or the actual performance of a prohibited medical procedure on a child. Given this reactionary framework, the effectiveness of amending the definition of abuse to include sex reassignment procedures relies, at least in part, on the definition creating a deterrent effect on families seeking these procedures for their children. This, in turn, requires enforcement of the definition by CPS caseworkers, local district and county attorneys charged with prosecuting abuse cases, and judges who preside over child protection courts—something that recent history shows is far from guaranteed.

In the days following the release of AG Paxton's opinion and Gov. Abbott's directive classifying the provision of medical procedures related to sex reassignment as child abuse, at least five district attorneys representing some of the largest Texas counties publicly stated they would refuse to prosecute abuse allegations brought in connection with the opinion (Aguilar, 2022; Thornton, 2022). Prior to the directive, the stated policy of the Department of Family and Protective Services, the agency charged with investigating abuse allegations, was to affirm children receiving its services who identified as transgender (DFPS, 2019). In its 2021 Title IV-B progress report, the department highlighted its work "providing CPS staff with the tools they need to support youth who identify as lesbian, gay, bisexual, transgender, or questioning" as well as its partnership with Lambda Legal, a national civil rights organization focused on LGBTQ+ issues, to require all CPS caseworkers

to receive training on issues impacting LGBTQ+ youth as a condition of certification (DFPS, 2021, pp. 276, 366–367). Moreover, the National Association of Social Workers, the world's largest professional organization for social workers, issued a statement opposing Gov. Abbot's and AG Paxton's directives (NASW, 2022). While not predictive, these developments indicate a strong opposition to the policy among those who are charged with enforcing it and cast further doubt on whether the approach will be effective as a means of preventing children from being subjected to these procedures.

A Third Way

Given the well-documented risks associated with the performance of sex reassignment procedures on children and the harm caused by family separation and entry into foster care, lawmakers should explore more limited and effective means of protecting children from the risks of the former without subjecting them to the harms of the latter. The simplest and most effective solution is for states to exercise their authority to regulate the practice of medicine and prohibit the performance of sex reassignment procedures on minors under the age of 18, including both the surgical altering of genitalia and the prescription of puberty-blocking medications and cross-sex hormones.

In the United States, the regulation of the practice of medicine is delegated to the states in accordance with the 10th Amendment to the Constitution (Roy, 2021, p. 165). Prior to the 19th century, however, "the states largely opted to not robustly exercise this power" (p. 165). A major shift came with the United States Supreme Court's landmark decision in *Dent v. West Virginia* (1889) upholding a West Virginia statute that set some of the most stringent licensing requirements at the time governing the practice of medicine in the state. Ruling in favor of West Virginia, the Court found that the statute was a legitimate exercise of "the power of the State to provide for the general welfare of its people" (*Dent v. West Virginia*, 1889, p. 122). The *Dent* decision made clear that states were free to enact laws regulating the practice of medicine within their borders and is foundational to the modern medical regulatory framework.

Central to both the Court's reasoning in *Dent* and the modern regulation of the practice of medicine is the state's interest in protecting its citizens from harm (p. 123). Given the documented risks of significant physical, emotional, and psychological harm associated with the performance of sex reassignment procedures on children, prohibiting medical professionals from engaging in these practices is a legitimate exercise of the state's constitutional authority. Moreover, this authority can be exercised in several ways that do not unnecessarily expose children to unintended harm. Texas House Bill 1399 (2021) and Senate Bill 1311 (2021), both filed during the regular session of the 87th Texas Legislature, are well-crafted examples of this approach. Under these pieces of legislation, the performance of sex reassignment procedures, including the prescription of certain medications intended to facilitate sex reassignment, would be defined as prohibited practices for minors under the Health and Safety Code. Medical professionals who perform these procedures in violation of the law would be subject to disciplinary action by the State Medical Board, including the revocation of their license or authorization to practice medicine in the state. The legislation also would have prohibited insurance providers from providing coverage for legal damages awarded against a healthcare provider found to have provided sex reassignment procedures or medications to a minor in violation of the law. Both HB 1399 and SB 1311 contained exceptions for treatment for medically verifiable conditions like genetic sex development disorders or regulation of early-onset (or "precocious") puberty, ensuring that children in need of care for these conditions could still receive it.

House Bill 1399 and Senate Bill 1311 represent narrowly tailored and easily enforceable approaches to preventing children from being subjected to sex reassignment procedures. By targeting specific medical practices and holding healthcare professionals accountable, the regulatory framework established by these bills protects children from both the dangers associated with sex reassignment procedures as well as the unintended consequences and well-documented harms associated with child welfare system involvement.

Conclusion and Recommendations

Recent increases in the number of children experiencing gender dysphoria and the growing visibility of transgender identity and issues in the media have ignited a national conversation around how states should address this complex and polarizing phenomenon. Guided largely by interest groups like WPATH and the Endocrine Society, treatment for these children in the United Kingdom, Europe, and, increasingly, the United States has followed a "gender affirming" approach that includes the off-label prescription of puberty suppressing medication and cross-sex hormones. In recent years, however, the United Kingdom and nations in Europe, which have largely been ahead of the United States in their embrace of gender-affirming care for children, have altered course on medical interventions as research has called into question their efficacy and highlighted significant short-term and lifelong health risks associated with their use. Additionally, leading gender medicine practitioners have expressed concerns with the trajectory

of their field and warned against the rapid move toward medical and surgical interventions for minors.

The rapid proliferation and controversy surrounding gender affirming treatment for children have been met in the United States with a wave of policymaking, primarily at the state level. Although states have enacted a variety of legislation related to transgender youth, including bills requiring individuals to use public restrooms that correspond to their biological sex and regulating the participation of transgender students in school athletics, only two states—Arkansas and Tennessee—have enacted legislation expressly prohibiting doctors from performing sex reassignment procedures on children.

Some states, including Texas, have proposed protecting children from sex reassignment procedures by defining the practice as abuse and leveraging CPS to investigate and respond to alleged cases. As demonstrated in this paper, this approach, while well-intentioned, is ineffective as a means for protecting children from these medical procedures and carries significant risk of subjecting children to additional harms resulting from their entry into the foster care system. In addition, it improperly expands the reach of CPS and could lead to its further weaponization as a means of imposing specific policy preferences. By contrast, the approach taken by Arkansas and Tennessee—and proposed during the regular session of the 87th Texas Legislature via HB 1399 and SB 1311—restricting the procedures themselves and subjecting healthcare providers who perform them to liability represents an effective, narrowly tailored approach that avoids causing unnecessary harm to children and families.

Due to the lack of sound medical research supporting the efficacy of gender affirming medical procedures and emerging evidence that many of the interventions carry significant risk of irreversible harm, the Texas Legislature should prohibit the performance of sex reassignment procedures, including the prescription of puberty blockers and cross-sex hormones as well as the surgical altering of genitalia, on minors under the age of 18. In doing so, however, the Legislature should also recognize the vulnerable position children experiencing gender dysphoria and their families are in and take care to ensure that actions intended to protect children from sex reassignment procedures are narrowly tailored and do not expose these children to additional harm from involvement with the child welfare system. This strategy represents a compassionate, effective approach that is rooted in sound medical science and limits government overreach.

References

Aguilar, J. (2022, February 24). *Local district and county attorneys push back against Texas directive on transgender medical care*. KERA. https://www.keranews.org/texas-news/2022-02-24/local-district-and-county-attorneys-push-back-against-texas-directive-on-transgender-medical-care

American Psychiatric Association. (n.d.). *Gender dysphoria diagnosis*. Retrieved February 11, 2022, from https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). American Psychiatric Association.

Archer, D. L. (2017). Will Catholic hospitals survive without government reimbursements? *The Linacre Quarterly*, *84*(1), 23–28. https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC5375649&blobtype=pdf

Arnoldussen, M., Steensma, T. D., Popma, A., van der Miesen, A. I. R., Twisk, J. W. R., & de Vries, A. L. C. (2020). Re-evaluation of the Dutch approach: Are recently referred transgender youth different compared to earlier referrals? *European Child & Adolescent Psychiatry*, *29*, 246–248. https://doi.org/10.1007/s00787-019-01394-6

Barnes, H., & Cohen, D. (2020, December 11). *Tavistock puberty blocker study published after nine years*. BBC News. https://www.bbc.com/news/uk-55282113

Bell v. Tavistock, EWHC Admin. 3274 (2020). https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf

Bell v. Tavistock, EWCA Civ. 1363 (2021). https://www.judiciary.uk/wp-content/uploads/2021/09/Bell-v-Tavistock-judgment-170921.pdf

Bostock v. Clayton County, 723 Fed. Appx. 964 (2018). https://mwhlawgroup.com/wp-content/uploads/Bostock-v.-Clayton-Cty.-Bd.-of-Comm_rs_-723-Fed.-Appx.pdf

Bostock v. Clayton County, 590 U.S. __ (2020). https://supreme.justia.com/cases/federal/us/590/17-1618/#tab-opinion-4261584

Boston Children's Hospital. (n.d.). *Gender multispecialty service (GeMS)*. Retrieved February 16, 2022, from https://www.childrenshospital.org/centers-and-services/programs/f-_-n/gender-multispecialty-service

Brown, A., & Huntzinger, C. (2019) *Let my people go home: Reducing foster care trauma by prioritizing the use of monitored return*. Texas Public Policy Foundation. https://www.texaspolicy.com/wp-content/uploads/2019/04/Brown-Huntzinger-Monitored-Return.pdf

Bryan, M. (2021a, April 6). Arkansas lawmakers ban youth transgender treatment and surgeries, overriding governor's veto. *USA Today*. https://www.usatoday.com/story/news/nation/2021/04/06/arkansas-transgender-surgeries-bill-legislature-overrides-gov-asa-hutchinson/7112107002/

Bryan, M. (2021b, April 6). Hutchinson vetoes bill banning youth gender reassignment, calling it 'overbroad, extreme.' *USA Today*. https://www.usatoday.com/story/news/2021/04/05/arkansas-governor-hutchinson-vetoes-transgender-bill-hb-1570/4844228001/

Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLOS One*, *16*(2), 1–26. https://pubmed.ncbi.nlm.nih.gov/33529227/

Centers for Disease Control and Prevention. (n.d.). *What is venous thromboembolism?* Retrieved January 10, 2022, from https://www.cdc.gov/ncbddd/dvt/facts.html

Centers for Medicare & Medicaid Services. (n.d.). *Medicare coverage determination process*. U.S. Department of Health & Human Services. Retrieved October 27, 2021, from https://www.cms.gov/Medicare/Coverage/DeterminationProcess

Chen, M., Fuqua, J., & Eugster, E. A. (2016). Characteristics of referrals for gender dysphoria over a 13-year period. *Journal of Adolescent Health*, *58*(3), 369–371. https://doi.org/10.1016/j.jadohealth.2015.11.010

Child Welfare Information Gateway. (2017). *Human trafficking and child welfare: A guide for child welfare agencies*. U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/trafficking_agencies.pdf

Cohen-Kettenis, P. T. & van Goozen, S. H. M. (1998). Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. *European Child & Adolescent Psychiatry*, *7*, 246–248. https://doi.org/10.1007/s007870050073

Congressional Budget Office. (2020). *Federal subsidies for health insurance coverage for people under 65: 2020 to 2030*. https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf

Conn, A. M, Calais, C., Szilagyi, M., Baldwin, C., & Jee, S. H. (2013). Youth in out-of-home care: Relation of engagement in structured group activities with social and mental health measures. *Children and Youth Services Review*, *36*, 201–205. https://www.researchgate.net/publication/259120346_Youth_in_Out-of-Home_Care_Relation_of_Engagement_in_Structured_Group_Activities_with_Social_and_Mental_Health_Measures

Connelly, P. J., Clark, A., Touyz, R. M., & Delles, C. (2021). Transgender adults, gender-affirming hormone therapy and blood pressure: A systematic review. *Journal of Hypertension*, *39*(2), 223–230. https://doi.org/10.1097/HJH.0000000000002632

Conron, K. J., O'Neil, K. K., & Vasquez, L. A. (2021). *Prohibiting gender-affirming medical care for youth* [Brief]. The Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/publications/bans-trans-youth-health-care/

Council for Choices in Health Care in Finland. (2020, June 16). *Medical treatments for gender dysphoria that reduces functional capacity in transgender people—recommendation*. https://palveluvalikoima.fi/documents/1237350/22895838/Summary+transgender.pdf/2cc3f053-2e34-39ce-4e21-becd685b3044/Summary+transgender.pdf

Delemarre-van de Waal, H. A., & Cohen-Kettnis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Society of Endocrinology, 155*(1), S131–S137. https://doi.org/10.1530/eje.1.02231

Deutsch, M. B., Bhakri, V., & Kubicek, K. (2015). Effects of cross-sex hormone treatment on transgender women and men. *Obstetrics & Gynecology*, *125*(3), 605–610. https://doi.org/10.1097/AOG.0000000000000692

Doubts are growing about therapy for gender-dysphoric children. (2021, May 13). *The Economist*. https://www.economist.com/science-and-technology/2021/05/13/doubts-are-growing-about-therapy-for-gender-dysphoric-children

Dworsky, A., Courtney, M. E., Hook, J., Brown, A., Cary, C., Love, K., Vorhies, V., Lee, J. S., Raap, M., Cusick, G. R., Keller, T., Havlicek, J., Perez, A., Terao, S., & Bost, N. (2011). *Midwest evaluation of the adult functioning of former foster youth*. Chapin Hall at the University of Chicago. https://www.chapinhall.org/research/midwest-evaluation-of-the-adult-functioning-of-former-foster-youth/

Dyer, C. (2021). Gender dysphoria service rated inadequate after waiting list of 4600 raises concerns. *BMJ*, *372*(205). https://doi.org/10.1136/bmj.n205

Endocrine Society. (n.d.). *About us*. Retrieved January 10, 2022, from https://www.endocrine.org/about-us

Exec. Order No. 13988, 86 Fed. Reg. 7,023 (Jan. 20, 2021). https://www.federalregister.gov/documents/2021/01/25/2021-01761/preventing-and-combating-discrimination-on-the-basis-of-gender-identity-or-sexual-orientation

Exec. Order No. 14035, 86 Fed. Reg. 34,593 (June 25, 2021). https://www.federalregister.gov/documents/2021/06/30/2021-14127/diversity-equity-inclusion-and-accessibility-in-the-federal-workforce

Fabris, B., Bernardi, S., & Trombetta, C. (2015). Cross-sex hormone therapy for gender dysphoria. *Journal of Endocrinological Investigation*, *38*(3), 269–282. https://doi.org/10.1007/s40618-014-0186-2

Florida Department of Health (2022, April 20). *Treatment of gender dysphoria for children and adolescents*. https://www.floridahealth.gov/_documents/newsroom/press-releases/2022/04/20220420-gender-dysphoria-guidance.pdf

Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660 (N.D. Tex. 2016). https://scholar.google.com/scholar_case?case=14386575405068683828&hl=en&as_sdt=6,44

Gender Identity Development Service. (n.d.). *About us*. Retrieved October 25, 2021, from https://gids.nhs.uk/about-us

Ghorayshi, A. (2022, January 13). Doctors debate whether trans teens need therapy before hormones. *New York Times*. https://www.nytimes.com/2022/01/13/health/transgender-teens-hormones.html

Gijs, L., & Brewaeys, A. (2012). Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness, and challenges. *Annual Review of Sex Research*, *18*(1), 178–224. https://www.tandfonline.com/doi/abs/10.1080/10532528.2007.10559851

Handler, T., Hojilla, J. C., Varghese, R., Wellenstein, W., Satre, D. D., & Zaritsky, E. (2019). Trends in referrals to a pediatric transgender clinic. *Pediatrics*, *144*(5), 1–7. https://doi.org/10.1542/peds.2019-1368

Hannema, S. E., Schagen, S. E. E., Cohen-Kettenis, P. T., & Delemarre-van de Waal, H. A. (2017). Efficacy and safety of pubertal induction using 17β-estradiol in transgirls. *The Journal of Clinical Endocrinology & Metabolism*, *102*(7), 2356–2363. https://doi.org/10.1210/jc.2017-00373

HB 25. Enrolled. 87th Texas Legislature. Third Called Session. (2021). https://capitol.texas.gov/tlodocs/873/billtext/pdf/HB00025F.pdf

HB 25 Bill Analysis. House Research Organization. 87th Texas Legislature. Third Called Session. (2021, October). https://hro.house.texas.gov/pdf/ba873/hb0025.pdf

HB 1399. House Committee Report. 87th Texas Legislature. Regular. (2021). https://capitol.texas.gov/tlodocs/87R/billtext/pdf/HB01399H.pdf

HB 1399 Witness List. Public Health Committee. 87th Texas Legislature. Regular. (2021, April). https://capitol.texas.gov/tlodocs/87R/witlistbill/pdf/HB01399H.pdf

HB 1570. Enrolled. 93rd Arkansas General Assembly. Regular. (2021). https://www.arkleg.state.ar.us/Acts/FTPDocument?path=%2FACTS%2F2021R%2FPublic%2F&file=626.pdf&ddBienniumSession=2021%2F2021R

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine treatment of gender-dsyphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, *11*(1), 3869–3903. https://doi.org/10.1210/jc.2017-01658

Herman, J. L., Flores, A. R., Brown, T. N. T., Wilson, B. D. M., & Conron, K. J. (2017). *Age of individuals who identify as transgender in the United States*. The Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/publications/age-trans-individuals-us/

Holt, A. (2021, June 23). *Keira Bell: Puberty blockers give children options, Trust says*. BBC News. https://www.bbc.com/news/health-57573428

Human Rights Campaign. (n.d.). *Interactive map: Clinical care programs for gender-expansive children and adolescents*. Retrieved February 16, 2022, from https://www.hrc.org/resources/interactive-map-clinical-care-programs-for-gender-nonconforming-childr

Hurst, G. (2019, October 12). Mother sues Tavistock child gender clinic over treatments. *The Times*. https://www.thetimes.co.uk/article/mother-sues-tavistock-child-gender-clinic-over-treatments-r9df8m987

Hutchinson, A. (2021, April 5). *LIVE: Governor Asa Hutchinson holds pen and pad session with local media* [Speech video recording]. YouTube. https://www.youtube.com/watch?v=9Jt7PxWkVbE&t=445s

Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L., Demissie, Z., McManus, T., Rasberry, C., Robin, L., & Underwood, J. M. (2019). Transgender identity and experience of violent victimization, substance use, suicide risk, and sexual behaviors among high school students—19 states and large urban school districts, 2017." *Morbidity and Mortality Weekly Report*, *68*(3), 67–71. https://www.doi.org/10.15585/mmwr.mm6803a3

Kralik, J. (2019, October 24). *"Bathroom bill" legislative tracking*. National Conference of State Legislatures. https://www.ncsl.org/research/education/-bathroom-bill-legislative-tracking635951130.aspx#3

Lawble. (2021). *16 year old rights against parents*. https://www.lawble.co.uk/16-year-old-rights-against-parents/

Letter from DFPS Commissioner Jaime Masters to Gov. Greg Abbott (2021, August 11). https://gov.texas.gov/uploads/files/press/Response_to_August_6_2021_OOG_Letter_08.11.2021.pdf

Letter from Gov. Greg Abbott to DFPS Commissioner Jaime Masters (2021, August 6). https://gov.texas.gov/uploads/files/press/O-MastersJaime202108060890.pdf

Letter from Gov. Greg Abbott to DFPS Commissioner Jamie Masters (2022, February 22). https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf

Logan, B. (2018). *Family privacy and parental rights as the best interests of children*. Texas Public Policy Foundation. https://www.texaspolicy.com/family-privacy-and-parental-rights-as-the-best-interests-of-children/

Lopez, C. M., Solomon, D., Boulware, S. D., & Christison-Lagay, E. (2018). Trends in the "off-label" use of GnRH agonists among pediatric patients in the United States. *Clinical Pediatrics*, *57*(12), 1432–1435. http://doi.org/10.1177/0009922818787260

Lopez Bauman, N., & Sandefur, C. (2017) *Restoring free speech in medicine: How state lawmakers can overcome FDA regulations that keep doctors and payers in the dark* [Policy brief]. Goldwater Institute. https://goldwaterinstitute.org/wp-content/uploads/2017/06/Restoring-Free-Speech-in-Medicine-Policy-Paper.pdf

Mahfouda, S., Moore, J. K., Siafarikas, A., Hewitt, T., Ganti, U., Lin, A., & Zepf, F. D. (2018). Gender-affirming hormones and surgery in transgender children and adolescents. *Lancet Diabetes Endocrinol*, *7*(6), 484–498. https://doi.org/10.1016/S2213-8587(18)30305-X

Marques, P., Skorupskaite, K., George, J. T., & Anderson, R. A. (Updated 2022, January 5). Physiology of GNRH and gonadotropin secretion. *National Center for Biotechnology Information*. https://www.ncbi.nlm.nih.gov/books/NBK279070/

Mayo Clinic. (2022a, February 1). *Ethinyl estradiol and norgestimate (oral route)*. Retrieved January 10, 2022, from https://www.mayoclinic.org/drugs-supplements/ethinyl-estradiol-and-norgestimate-oral-route/description/drg-20061380

Mayo Clinic. (2022b, February 26). *Gender dysphoria: Diagnosis*. Retrieved March 22, 2022, from https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/diagnosis-treatment/drc-20475262

Mayo Clinic. (2022c, February 19). *Pubertal blockers for transgender and gender-diverse youth*. Retrieved March 22, 2022, from https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075

M.D. v. Abbott, 152 F.Supp. 3d 684 (S.D. Tex. 2015). https://casetext.com/case/md-v-abbott

Medicare Program; National Coverage Decisions, 54 Fed. Reg. 34555 (August 21, 1989). https://www.govinfo.gov/content/pkg/FR-1989-08-21/pdf/FR-1989-08-21.pdf

Memo from Principal Deputy Assistant Attorney General Pamela S. Karlan to Federal Agency Civil Rights Directors and General Counsels. (2021, March 26). https://www.justice.gov/crt/page/file/1383026/download

Milner, J., & Kelly, D. (2021). The need for justice in child welfare. *Child Welfare Journal*, *99*(3). https://www.cwla.org/the-need-for-justice-in-child-welfare/

National Association of Social Workers. (2022, February 25). *NASW condemns efforts to redefine child abuse to include gender-affirming care*. https://www.socialworkers.org/News/News-Releases/ID/2406/NASW-Condemns-Efforts-to-Redefine-Child-Abuse-to-Include-Gender-Affirming-Care

National Board of Health and Welfare. (2022, February 2). *Updated recommendations for hormone therapy for gender dysphoria in young people* (Google Translate, Trans.). https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdaterade-rekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/

National Health Service England. (n.d.). *Update following recent court rulings on hormone blockers*. Retrieved January 10, 2022, from https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/update-following-recent-court-rulings-on-hormone-blockers/

National Health Service England. (2013). *Interim gender dysphoria protocol and service guideline 2013/14*. https://webarchive.nationalarchives.gov.uk/ukgwa/20180501162646mp_/https://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf

National Health Service England. (2016). *Clinical commissioning policy: Prescribing of cross-sex hormones as part of the Gender Identity Development Service for children and adolescents*. https://www.england.nhs.uk/wp-content/uploads/2018/07/Prescribing-of-cross-sex-hormones-as-part-of-the-gender-identity-development-service-for-children-and-adolesce.pdf

National Health Service England. (2020a). *Gender identity development service for children and adolescent service specification*. https://www.england.nhs.uk/publication/gender-identity-development-service-for-children-and-adolescent-service-specification/

National Health Service England. (2020b). *Gender dysphoria: treatment*. https://www.nhs.uk/conditions/gender-dysphoria/treatment/

National Health Service Scotland. (2012). *Gender reassignment protocol*. https://www.sehd.scot.nhs.uk/mels/CEL2012_26.pdf

National Institute for Health and Care Excellence. (2021). *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria*. National Institute for Health and Care Excellence, NHS England, NHS Improvement. https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3ffrom%3d2020-01-01%26q%3dgender%2bdysphoria%26sp%3don%26to%3d2021-03-31

Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375 (May 18, 2016). https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities

Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020). https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority

Obergefell v. Hodges, 576 U.S. 644 (2015). https://www.supremecourt.gov/opinions/14pdf/14-556_3204.pdf

Office for Civil Rights. (2020, June 12). *Fact sheet: HHS finalizes ACA Section 1557 Rule*. U.S. Department of Health and Human Services. https://www.hhs.gov/sites/default/files/1557-final-rule-factsheet.pdf

OptumRx. (2018, February 28). *Therapeutic class overview: Gonadotropin-releasing hormone (GnRH) agonists/ luteinzing hormone-releasing hormone (LHRH) agonists*. https://www.medicaid.nv.gov/Downloads/provider/GnRH_LHRH_Agonists_2018_0312.pdf

Pang, K. C., de Graaf, N. M., Chew, D., Hoq, M., Keith, D. R., Carmichael, P., & Steensma, T. D. (2020). Association of media coverage of transgender and gender diverse issues with rates of referral of transgender children and adolescents to specialist gender clinics in the UK and Australia. *JAMA Network Open*, *3*(7). https://doi.org/10.1001/jamanetworkopen.2020.11161

Pecora, P. J., Kessler, R. C., O'Brien, K., Roller White, C., Williams, J., Hiripi, E., English, D., White, J., & Anne Herrick, M. (2006). Educational and employment outcomes of adults formerly placed in foster care: Results from the Northwest Foster Care Alumni Study. *Child and Youth Services Review*, *28*(12), 1459–1481. https://doi.org/10.1016/j.childyouth.2006.04.003

Pressley, N. (2020, September 9). *Second chance parenting: Restoring parental rights*. Texas Public Policy Foundation. https://www.texaspolicy.com/second-chance-parenting-restoring-parental-rights/

Rezal, A. (2021, December 1). States restricting how transgender students play sports. *U.S. News & World Report*. https://www.usnews.com/news/best-states/articles/2021-12-01/these-states-restrict-how-transgender-students-participate-in-school-sports

Rivera, A. (2021, May 11). *A look at shifting trends in transgender athlete policies*. National Conference of State Legislatures. https://www.ncsl.org/research/education/a-look-at-shifting-trends-in-transgender-athlete-policies-magazine2021.aspx

Roy, C. G. (2021). Patient safety functions of state medical boards in the United States. *The Yale Journal of Biology and Medicine, 94*(1), 165–73. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7995940/

SB 6. Engrossed. 85th Texas Legislature. Regular. (2017). https://capitol.texas.gov/BillLookup/History.aspx?LegSess=85R&Bill=SB6

SB 46. Enrolled. 97th South Dakota Legislature. Regular. (2022). https://mylrc.sdlegislature.gov/api/Documents/231879.pdf

SB 1311. Engrossed. 87th Texas Legislature Regular. (2021). https://capitol.texas.gov/tlodocs/87R/billtext/html/SB01311E.htm

SB 1646. Engrossed. 87th Texas Legislature. Regular. (2021c). https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB01646E.pdf

SB 1646. Introduced. 87th Texas Legislature. Regular. (2021a). https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB01646I.pdf

SB 1646. Senate Committee Report. 87th Texas Legislature. Regular. (2021b). https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB01646S.pdf

Shrier, A. (2021, October 4). Top trans doctors blow the whistle on 'sloppy' care. *Common Sense* on Substack. https://bariweiss.substack.com/p/top-trans-doctors-blow-the-whistle

Social Security Amendments of 1965, Pub. L. No. 89–97, 79 Stat. 286 (1965). https://www.govinfo.gov/content/pkg/STATUTE-79/pdf/STATUTE-79-Pg286.pdf

Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*, *129*(3), 418–425. https://doi.org/10.1542/peds.2011-0907

St. Louis Children's Hospital. (n.d.). *Puberty blockers*. Retrieved January 10, 2022, from https://www.stlouischildrens.org/conditions-treatments/transgender-center/puberty-blockers

Strauss, V. (2019, January 24). CDC: Nearly 2 percent of high school students identify as transgender—and more than one-third of them attempt suicide. *Washington Post*. https://www.washingtonpost.com/education/2019/01/24/cdc-nearly-percent-high-school-students-identify-transgender-more-than-one-third-them-attempt-suicide/

Tack, L. J. W., Craen, M., Lapauw, B., Goemaere, S., Toye, K., Kaufman, J., Vandewalle, S., T'Sjoen, G., & Zmierczak, H. (2018). Proandrogenic and antiandrogenic progestins in transgender youth: Differential effects on body composition and bone metabolism. *The Journal of Clinical Endocrinology & Metabolism*, *103*(6), 2147–2156. https://doi.org/10.1210/jc.2017-02316

Texas Attorney General Opinion No. KP-0401. (2022, February 18). https://texasattorneygeneral.gov/sites/default/files/global/KP-0401.pdf

Texas Department of Family and Protective Services. (n.d.). *Child Protective Services (CPS): Children exiting DFPS legal custody*. Retrieved February 21, 2022, from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Exits.asp

Texas Department of Family and Protective Services. (2019). *Prevention and early intervention: progress report on implementation of five-year strategic plan fiscal year 2019*. https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/PEI/documents/2019/2019-09-01_PEI_Strategic_Plan.pdf

Texas Department of Family and Protective Services. (2021). *The state of Texas Title IV-B child and family services plan 2021 annual progress & services report*. https://www.dfps.state.tx.us/About_DFPS/Title_IV-B_State_Plan/documents/2021_Progress_Report/APSR.pdf

The controversy over trans teens. (2021, October 24). *The Week*. https://theweek.com/life/1006253/the-controversy-over-trans-teens

Thornton, C. (2022, February 24). *5 Texas DAs defy Gov. Greg Abbott, won't treat gender affirming care for trans youth as 'child abuse.'* USA Today. https://www.usatoday.com/story/news/nation/2022/02/24/texas-order-trans-youth/6926395001/

U.S. Department of Health and Human Services. (2014, May 30). *NCD 140.3, Transsexual surgery* [Docket No. A-13-87; Decision No. 2576]. Departmental Appeals Board, Appellate Division. https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf

U.S. Food and Drug Administration. (2010, May 3). *GnRH agonists: Safety review of drug class used to treat prostate cancer*. Retrieved February 23, 2022, from the Wayback Machine, Internet Archive at http://wayback.archive-it.org/7993/20170112165411/http:/www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm210576.htm

U.S. Food and Drug Administration. (2016, March 8). *FDA drug safety communication: Ongoing safety review of GnRH agonists and possible increased risk of diabetes and certain cardiovascular diseases*. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/fda-drug-safety-communication-ongoing-safety-review-gnrh-agonists-and-possible-increased-risk

U.S. Food and Drug Administration. (2017, December 13). *FDA drug safety communication: Ongoing safety review of GnRH agonists and possible increased risk of diabetes and certain cardiovascular diseases*. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-update-ongoing-safety-review-gnrh-agonists-and-notification

U.S. Food and Drug Administration. (2018, February 5). *Understanding unapproved use of approved drugs "off label."* https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label

Vaughn, M. G., Ollie, M. T., McMillen, J. C., Scott Jr., L., Munson, M. (2006). Substance use and abuse among older youth in foster care. *Addictive Behaviors*, *32*(9), 1929–1935. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2633867/

Vermont Department of Health. (n.d.). *The tanner stages*. Retrieved January 10, 2022, from https://www.medschool.lsuhsc.edu/medical_education/undergraduate/spm/SPM_100/documents/tannerstagescard.pdf

Welch, M., & Haskins, R. (2020, April 30). *What COVID-19 means for America's child welfare system*. Brookings. https://www.brookings.edu/research/what-covid-19-means-for-americas-child-welfare-system/

World Professional Association for Transgender Health. (n.d.). *Mission and vision*. Retrieved January 10, 2022, from https://www.wpath.org/about/mission-and-vision

World Professional Association for Transgender Health. (2012). *Standards of care for the health of transsexual, transgender, and gender nonconforming people* [7th Version]. https://www.wpath.org/publications/soc

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