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### **Autonomy and accountability: Why informed consent, consumer protection, and defunding may beat conversion therapy bans**

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# AUTONOMY AND ACCOUNTABILITY: WHY INFORMED CONSENT, CONSUMER PROTECTION, AND DEFUNDING MAY BEAT CONVERSION THERAPY BANS

*Melissa Ballengee Alexander\**

## I. INTRODUCTION

After castration, the gay man wrote, “I hate myself; but I can’t help it . . . I have no right to live.” His doctors concluded that his sterilization must have been ill-advised, noting, “mutilation produces a depressing effect, while it does not remove the perverted tendency.”<sup>1</sup>

Historically, sexual orientation change efforts (“SOCE”)<sup>2</sup> by licensed healthcare providers entailed “treatment” that would now be regarded as egregious abuse. While castration is no longer considered acceptable, a small number of healthcare providers continue to advocate forms of talk-based conversion therapy sought primarily by some religious patients.<sup>3</sup>

Controversial and politically charged, sexual orientation change efforts seek to change a person’s sexual orientation or gender identity.<sup>4</sup> Many find

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<sup>1</sup> Havelock Ellis & E.S. Talbot, *Castration* “I think it was that operation . . . that caused my insanity”, J. MENTAL SCI. (1896), reprinted in *GAY AMERICAN HISTORY: LESBIANS AND GAY MEN IN THE U.S.A.*, 140–41, 143 (Johnathan Katz ed., 1976).

<sup>2</sup> Sexual orientation change efforts are also known as “conversion,” “reparative,” “reorientation,” “ex-gay,” or “sexual attraction fluidity exploration” therapy. See, e.g., Christopher Rosik, *Sexual Attraction Fluidity Exploration in Therapy (SAFE-T)*, ALLIANCE FOR THERAPEUTIC CHOICE & SCI. INTEGRITY 1, [http://media.wix.com/ugd/ec16e9\\_1940a968273d47f5be4bdf9614d2dd0c.pdf](http://media.wix.com/ugd/ec16e9_1940a968273d47f5be4bdf9614d2dd0c.pdf) (last visited Apr. 1, 2017).

<sup>3</sup> See, e.g., *NARTH Institute Statement on Sexual Orientation Change*, NARTH INST. (Jan. 25, 2012), <http://www.narth.com/about1> (“[T]he Alliance [for Therapeutic Choice and Scientific Inquiry] remains committed to protecting the rights of clients with unwanted same-sex attractions to pursue change as well as the rights of clinicians to provide such psychological care.”); AM. PSYCHOL. ASS’N, *APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION* 3 (Aug. 2009), <https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf> [hereinafter *APA Report*] (noting that most SOCE research participants are adults “who consider religion to be an extremely important part of their lives and participate in traditional or conservative faiths (i.e. The Church of Latter-Day Saints, evangelical Christianity, and Orthodox Judaism)”).

<sup>4</sup> This Article focuses on sexual orientation change efforts, not reorientation efforts targeting

such efforts offensive because they suggest that there is something wrong with being a sexual minority or having same-sex attractions. Some who have participated in SOCE report that this therapy led to increased depression, anxiety, and stigma.<sup>5</sup> Others, however, claim to have benefited from SOCE and see bans on the practice as curtailing religious freedom.<sup>6</sup>

Recently, legal reforms limiting or deterring conversion therapy in different ways have been rapidly gaining ground. While most reforms focus on legislative bans on state-licensed health professionals providing conversion therapy to minors, several national organizations have also turned to consumer protection litigation to curtail deceptive practices.<sup>7</sup> This Article compares the strengths and weaknesses of both approaches and offers a broader prescriptive remedy.

Scholarship evaluating this developing area of law remains embryonic.<sup>8</sup> This Article seeks to remedy that in three ways.<sup>9</sup> First, this Article

gender identity. Some advocates argue that state conversion therapy bans should specifically include gender identity (and exclude treatment that supports gender transition). See, e.g., *LGBT Policy Spotlight: Conversion Therapy Bans*, MOVEMENT ADVANCEMENT PROJECT, <http://www.lgbtmap.org/policy-spotlight-conversion-therapy-bans> (last updated May 2015). Many points made in this Article, like concern over expressive harm, would seem to apply equally to conversion therapy efforts directed at gender identity. Nonetheless, because the issues and arguments involved with gender identity change efforts are, at least at times, distinct, they are beyond the scope of this Article. See, e.g., Richard Green, *Banning Therapy to Change Sexual Orientation or Gender Identity in Patients Under 18*, 45 J. AM. ACAD. PSYCHIATRY & L. ONLINE 7, 10 (2017) (“[R]ecent legislation with its conflation of sexual orientation and gender identity remains psychiatrically incoherent.”).

<sup>5</sup> *APA Report*, *supra* note 3, at 50.

<sup>6</sup> *APA Report*, *supra* note 3, at 3; see also *Answers to Frequently Asked Questions about the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) and the NARTH Institute and Homosexuality*, NARTH INST., <http://www.narth.com/faq> (last visited July 23, 2016) (“[T]here are many individuals who reported that this type of therapy has provided significant positive benefits in their lives.”).

<sup>7</sup> See *infra* Section II(B).

<sup>8</sup> To date, only three Notes address consumer protection as a strategy to combat SOCE, and they are all very different from this Article. Peter R. Dubrowski, *The Ferguson v. JONAH Verdict and a Path Towards National Cessation of Gay-to-Straight “Conversion Therapy”*, 110 NW. U. L. REV. ONLINE 77, 90–93 (2015) (a practice-oriented article assessing state laws to demonstrate opportunities and obstacles in applying the *JONAH* model); John M. Satira, Note, *Determining the Deception of Sexual Orientation Change Efforts*, 58 WM. & MARY L. REV. 641, 645, 652–55, 657–63, 669–71 (2016) (discussing how consumer protection laws provide opportunity to discredit SOCE, how SOCE practitioners may adapt, and possible roadblocks to widespread consumer protection attacks) (citing Melissa Ballengee Alexander, *Victim to Victor: A Right to Health Perspective on Ferguson v. JONAH*, LGBTQ ISSUES IN PHIL. (Am. Phil. Ass’n, Newark, Del.), Spring 2016, at 2, 4); Jacob M. Victor, Note, *Regulating Sexual Orientation Change Efforts: The California Approach, its Limitations, and Potential Alternatives*, 123 YALE L.J. 1532, 1535–37, 1564–65 (2014) (criticizing bans for essentializing sexual identity and generating political backlash, then arguing in favor of utilizing deceptive-based regulation but doubtful of *JONAH* style consumer litigation). Outside the context of SOCE, there is more scholarship on the value that consumer protection litigation adds to health. See, e.g., Lee Ann Bundren,

documents recent legal reforms limiting conversion therapy, including never-before examined strategies such as defunding. Second, the Article expresses concern regarding two significant unintended consequences of legislative bans: driving SOCE to unmonitored, untrained providers and erosion of the mature minor doctrine.<sup>10</sup> Third, this Article proposes an alternative solution to conversion therapy concerns, focusing on informed consent, consumer protection, and defunding.<sup>11</sup>

Part II of this Article summarizes the empirical evidence on conversion therapy, which lacks compelling proof of efficacy or safety. Then, it describes recent rapid legal reforms relating to conversion therapy, including legislative bans on state-licensed health professionals providing conversion therapy to minors, administrative regulations limiting funding and insurance for conversion therapy, and consumer protection based accountability efforts. Part III argues that the trend of health provider bans on conversion therapy for minors, although well-intentioned and intuitively appealing, poses potentially pernicious consequences both to minors demanding SOCE and to autonomy that outweigh any benefit. Part IV suggests that efforts to limit abuses associated with SOCE should instead focus on improving informed consent, increasing accountability for deceptive practices, and eliminating state funding. Together, these strategies will deter SOCE and change social norms regarding sexual minorities more effectively than health provider bans, without the same risk

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Comment, *State Consumer Fraud Legislation Applied to the Health Care Industry: Are Health Care Professionals Being “Consumed”?*, 16 J. LEGAL MED. 133, 165–66 (1995) (concluding that consumer protection acts should apply to health care professionals); Joan H. Krause, *The Role of the States in Combating Managed Care Fraud and Abuse*, 8 ANNALS HEALTH L. 179, 179 (1999) (recognizing the benefits of state consumer protection laws in combating health fraud).

<sup>9</sup> In contrast, most recent scholarship on conversion therapy has focused on the First Amendment professional speech issue and the tension between parent and state over controversial medical treatment for a child. See, e.g., Marc Jonathan Blitz, *Free Speech, Occupational Speech, and Psychotherapy*, 44 HOFSTRA L. REV. 681, 682–84 (2016) (discussing the disagreement between the Third and Ninth Circuits regarding the First Amendment status of psychotherapy); Janet L. Dolgin, *Physician Speech and State Control: Furthering Partisan Interests at the Expense of Good Health*, 48 NEW ENG. L. REV. 293, 294 (2014) (analyzing SOCE in the context of state control over physician speech); Lynn D. Wardle, *Controversial Medical Treatments for Children: The Roles of Parents and of the State*, 49 FAM. L.Q. 509, 511–12 (2015) (addressing the conflict between the constitutional rights of parents to direct the medical treatment of their children and the state interest in regulating parenting activities in the best interest of minors).

<sup>10</sup> The mature minor doctrine refers to the decision to allow certain minors the authority to make healthcare decisions traditionally reserved for their parents. While the scope and exceptions vary widely, all fifty states recognize some version of the mature minor doctrine. See Ana S. Iltis, *Parents, Adolescents, and Consent for Research Participation*, 38 J. MED. & PHILOS. 332, 334 (2013) (documenting the trend toward expansion of the mature minor doctrine).

<sup>11</sup> When this Article refers to consumer protection accountability, it primarily references and discusses state unfair and deceptive acts and practices (“UDAP”) statutes.

to participants and to the mature minor doctrine. While recommending these strategies in lieu of health provider bans, this section also recognizes that these broader remedial tools could be used to supplement bans.<sup>12</sup>

## II. CONVERSION THERAPY: LACK OF EFFICACY, POSSIBILITY OF HARM, AND EFFORTS TO REFORM

### *A. Insufficient Evidence of Efficacy; Concern Over Risk of Harm*

Sexual orientation change efforts vary widely and may include behavioral, psychoanalytic, medical, or religious interventions.<sup>13</sup> However, most forms of conversion therapy rest on two premises: (1) same-sex attraction is a mental illness or disorder, and (2) same-sex attraction can be changed through therapeutic intervention.<sup>14</sup>

While conversion therapy was once widely accepted, prominent medical organizations have uniformly issued position statements within the last decade advising against the practice and its underlying premises.<sup>15</sup>

<sup>12</sup> This Article proposes a strategy intended to align with the goals (but not the methods) of health provider bans. Even a reader who remains skeptical that health provider bans pose risks will hopefully pursue the recommended informed consent, consumer protection, and defunding strategies. After all, these mechanisms provide means to expand the scope of protection to address SOCE abuses suffered by adults and to combat SOCE abuses committed by more non-healthcare providers. These tools can be used immediately in most states, even if the state has not or will not pass a SOCE ban.

<sup>13</sup> One of the challenges facing empirical evidence relating to conversion therapy is the great breadth of practices falling under that description. Because studies over time have included a wide variety of practices, it is difficult to accurately draw conclusions regarding the efficacy or harm of any particular practice.

<sup>14</sup> Douglas C. Haldeman, *Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy*, 33 PROF. PSYCHOL.: RES. & PRAC., 260, 260 (noting that proponents of SOCE reject the notion that same-sex attraction is a normal variant of human sexuality and portray same-sex attraction as freely chosen and changeable); see also Complaint and Jury Demand at 2, *Ferguson v. JONAH*, 136 A.3d 447 (N.J. Super. Ct. Law Div. 2014) (No. HUDL547312) [hereinafter *Complaint and Jury Demand*] (claiming SOCE provider falsely stated that “gay sexual orientation is a mental disorder” and that sexual orientation is amenable to “treatment”).

<sup>15</sup> *APA Report*, *supra* note 3, at v (“[S]ame-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity . . . .”); Am. Psychiatric Ass’n, Position Statement on Therapies *Focused* on Attempts to Change Sexual Orientation, HUM. RTS. CAMPAIGN (2000), <http://www.hrc.org/resources/policy-and-position-statements-on-conversion-therapy> (opposing treatment “based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation”); Am. Med. Ass’n, *Health Care Needs of the Homosexual Population*, H-160.991, AMA POLICIES ON LGBTQ ISSUES, <https://assets.ama-assn.org/sub/meeting/documents/i16-resolution-804.pdf> 3 (opposing “‘reparative’ or ‘conversion’ therapy for sexual orientation or gender identity” issues) (last updated 2016); Am. Acad. Child & Adolescent Psychiatry, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 968 (2012)

Today, the nation's leading medical associations expressly reject the notion that having same-sex attractions is an illness or disorder.<sup>16</sup> In fact, the American Psychiatric Association removed homosexuality from its Diagnostic and Statistical Manual of Mental Disorders ("DSM") decades ago.<sup>17</sup> Now, national mental health professional organizations like the American Psychological Association ("APA") describe such behavior and attractions as "normal and positive variations of human sexuality."<sup>18</sup>

Similarly, all mainstream medical and mental health organizations agree that there is no competent and reliable scientific evidence supporting the efficacy of conversion therapy.<sup>19</sup> In fact, these organizations warn that such treatment may pose a risk of harm.<sup>20</sup> As the APA concluded in the most comprehensive and definitive review of conversion therapy studies to date, "efforts to change sexual orientation are unlikely to be successful and involve some risk of harm."<sup>21</sup>

Nonetheless, there remains demand for conversion therapy, especially among those with strongly held conservative religious views, and a small but vocal minority of professionals who still endorse the practice.<sup>22</sup>

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("[T]here is no medically valid basis for attempting to prevent homosexuality, which is not an illness."). *But see, e.g., NARTH Institute Statement on Sexual Orientation Change, supra* note 3 ("[T]he Alliance remains committed to protecting the rights of clients with unwanted same-sex attractions to pursue change as well as the rights of clinicians to provide such psychological care.").

<sup>16</sup> Further, the American Medical Association cautions that healthcare providers who begin from the premise that a patient attracted to the same-sex is disordered risk alienating that patient from other needed healthcare. *See* Am. Med. Ass'n, *supra* note 15 at 3 (emphasizing the importance of "nonjudgmental recognition of patient's sexual orientations" to ensure "optimal care" for the specific needs of the LGBTQ population).

<sup>17</sup> *Compare* THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 302.90 (Am. Psychiatric Ass'n ed., 3d ed. rev'd. 1987), *with* THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 302.0, 380 (Am. Psychiatric Ass'n ed., 3d ed. 1980) [hereinafter DSM-III] (listing ego-dystonic homosexuality as a disorder), *and* THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 302.0 (Am. Psychiatric Ass'n ed., 2d ed. 1968) [hereinafter DSM-II] (first listing homosexuality as a disorder, then as a milder "sexual orientation disturbance").

<sup>18</sup> *APA Report, supra* note 3, at v.

<sup>19</sup> *See The Lies and Dangers of Efforts to Change Sexual Orientation or Gender Identity*, HUM. RTS. CAMPAIGN, <http://www.hrc.org/resources/the-lies-and-dangers-of-reparative-therapy> (last visited July 22, 2016) (quoting position statements of fifteen leading professional organizations).

<sup>20</sup> *See id.* Many former participants of SOCE report anxiety, depression, suicidal ideation, self-hatred, social isolation and other negative social and emotional consequences. *See APA Report, supra* note 3, at 41–42. Such reports are further buttressed by clinical observations that unsuccessful efforts can result in considerable psychological distress. *Id.* at 42. *See also* AM. PSYCHOANALYTIC ASS'N, POSITION STATEMENT ON ATTEMPTS TO CHANGE SEXUAL ORIENTATION, GENDER IDENTITY, OR GENDER EXPRESSION, HUM. RTS. CAMPAIGN (2012), <http://www.hrc.org/resources/policy-and-position-statements-on-conversion-therapy> (noting that SOCE "often result[s] in substantial psychological pain by reinforcing damaging internalized attitudes").

<sup>21</sup> *APA Report, supra* note 3, at v.

<sup>22</sup> *See, e.g., NARTH Institute Statement on Sexual Orientation Change, supra* note 3 (remaining

Moreover, while the APA cautions against SOCE<sup>23</sup> due to its potential for harm and the lack of evidence of efficacy, even the APA acknowledges that some SOCE participants “showed lessened physiological arousal to sexual stimuli”<sup>24</sup> and reported “SOCE was helpful.”<sup>25</sup> Even if decreased same-sex sexual behavior as a result of SOCE is “rare,” as the APA report concludes, some individuals may wish to try it with full knowledge that the odds of efficacy are miniscule.<sup>26</sup> Further, while there is reason to be concerned that SOCE may exacerbate internalized sexual stigma or otherwise cause harm to at least some participants,<sup>27</sup> well-conducted empiric studies demonstrating clear harm caused by SOCE remain lacking.<sup>28</sup> As a result, no state currently limits the provision of SOCE to adults.<sup>29</sup>

In contrast, as set forth in Section II (B)(1) *infra*, a growing number of states and cities are adopting bans on state-licensed health workers providing SOCE to minors. This raises the question: is there more conclusive empiric evidence of harm to minors caused by SOCE? The answer appears to be no.<sup>30</sup> As with adults, the overwhelming majority of

“committed to protecting the rights of clients with unwanted same-sex attractions to pursue change as well as the rights of clinicians to provide such psychological care”); *see also APA Report, supra* note 3, at 3–4.

<sup>23</sup> Instead of SOCE, the APA recommends “acceptance, support and understanding,” as well as facilitation of “active coping, social support and identity exploration and development, without imposing a specific sexual orientation identity outcome.” *APA Report, supra* note 3, at v. Arguably, the line between SOCE and providing “active coping” mechanisms for a patient who rejects the same-sex attractions he or she experiences can be thin. The critical distinction, of course, being that the therapist is not neutral regarding the sexual orientation outcome in SOCE.

<sup>24</sup> In contrast, the APA found that “enduring change to an individual’s sexual orientation is uncommon.” *APA Report, supra* note 3, at 3.

<sup>25</sup> *Id.*; *see also Answers to Frequently Asked Questions about the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) and the NARTH Institute and Homosexuality, supra* note 6 (“[T]here are many individuals who have reported that this type of therapy has provided significant positive benefits in their lives.”). Those who reported SOCE was helpful said it enabled them to live in a manner consistent with their faith or provided a sense of community. *See APA Report, supra* note 3, at 3. The APA concluded that these same benefits could be provided without risk of harm within an affirming framework. *Id.*

<sup>26</sup> *APA Report, supra* note 3, at 3.

<sup>27</sup> *Id.* at 2–3.

<sup>28</sup> Certainly, there is ample and concerning anecdotal evidence of harm. Nonetheless, having rejected anecdotal evidence of successful SOCE—in the face of empirical evidence of long-term inefficacy—it would seem hypocritical to credit anecdotal evidence of harm. Moreover, even if such evidence is credited and one assumes that many practices falling within the broad umbrella of SOCE have caused harm to many participants, it is not yet clear whether *all* SOCE efforts cause harm to *all* participants.

<sup>29</sup> *Conversion Therapy Laws, MOVEMENT ADVANCEMENT PROJECT*, [http://www.lgbtmap.org/equality-maps/conversion\\_therapy](http://www.lgbtmap.org/equality-maps/conversion_therapy) (last updated Apr. 7, 2017) (listing California, Illinois, New Jersey, New Mexico, Oregon, Vermont, Nevada, and Connecticut as states that ban conversion therapy for minors).

<sup>30</sup> *APA Report, supra* note 3, at 72–73 (“There is a lack of published research on SOCE among

professionals advise against SOCE (with good reason) both because there is scant evidence of efficacy and ample concern such interventions may cause serious harm.<sup>31</sup> They endorse a more neutral and affirming approach to minors struggling with their sexual identity or attractions.<sup>32</sup> Nonetheless, as with adults, the risk of harm associated with SOCE, while troubling, does not currently rest on compelling empiric evidence of causal harm.<sup>33</sup>

## B. Recent Rapid Legal Reforms Limiting Conversion Therapy

### 1. Legislative Bans

While progress on same-sex marriage has enjoyed more coverage in the news, legal reforms limiting conversion therapy have also made overwhelming strides since 2012.<sup>34</sup> In that year, California made national headlines as the first state to ban state-licensed mental health providers from engaging minors in conversion therapy.<sup>35</sup> New Jersey followed suit a year later, and the District of Columbia the year after that.<sup>36</sup>

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children . . . . We found no empirical research on adolescents who request SOCE.”); *see also* Christopher H. Rosik and Michelle A. Cretella, *Psychotherapy for Unwanted Homosexual Attraction Among Youth*, AM. C. PEDIATRICIANS BLOG (Jan. 2016), <https://www.acpedis.org/the-college-speaks/position-statements/sexuality-issues/psychotherapy-for-unwanted-homosexual-attraction-among-youth> (“[T]here is no evidence that psychotherapy for [unwanted same-sex attraction] is any more or less harmful than the use of psychotherapy to treat any other unwanted psychological or behavioral adaption.”).

<sup>31</sup> *See, e.g., APA Report, supra* note, at 3; Am. Acad. Child & Adolescent Psychiatry, *supra* note 15, at 968 (2012) (“Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial, or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated.”); SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. OF THE U.S. DEP’T OF HEALTH AND HUM. SERV. REPORT, ENDING CONVERSION THERAPY: SUPPORTING AND AFFIRMING LGBTQ YOUTH 1 (2015) (SOCE “is not supported by credible evidence” and “may put young people at risk of serious harm”).

<sup>32</sup> *APA Report, supra* note 3, at 5.

<sup>33</sup> Of course, the inherent discrimination against sexual minorities implicit in SOCE is concerning, as is the history of egregious SOCE abuses.

<sup>34</sup> While updated, expanded and re-written, a summary of then-current legal reforms was published in Alexander, *supra* note 8, at 1.

<sup>35</sup> S.B. 1172, 2011–2012, Reg. Sess. (Cal. 2012) (codified at CAL. BUS. & PROF. CODE §§ 865–865.2 (West 2013)) (banning state-licensed mental health providers from sexual orientation change efforts, including gender expression, on persons under eighteen years of age).

<sup>36</sup> Assemb. 3371, 215th Leg., Reg. Sess. (N.J. 2013) (codified at N.J. STAT. ANN. §§ 45:1-54–55 (West 2014)) (banning state-licensed professional counselors, including psychiatrists, from providing sexual orientation change efforts to persons under eighteen years of age); Act. 20-530, 2013–2014, 20th Council Sess. (D.C. 2014) (codified at D.C. CODE § 7-1231.14a (2015)) (banning state-licensed health providers from sexual orientation change efforts, including gender identity or expression, on minors).

Most scholarship to date has focused on the interesting circuit split created by the two decisions considering the constitutionality of these first two state legislative bans. Applying differing legal standards, the Ninth Circuit and Third Circuit United States Courts of Appeal upheld the



In the past two years, legislation curtailing conversion therapy has accelerated rapidly. In May 2015, U.S. Congressman Ted Lieu (D-Los Angeles) introduced the first federal bill seeking to limit conversion therapy nationwide, the Therapeutic Fraud Prevention Act.<sup>37</sup> That same month, Oregon joined California and New Jersey in prohibiting state-licensed health professionals from providing such therapy to minors, and Illinois followed three months later.<sup>38</sup> In December 2015, the city of Cincinnati, Ohio passed the first city ban on conversion therapy.<sup>39</sup> Then, on May 25, 2016, Vermont became the fifth state to implement a legislative ban.<sup>40</sup> Since then, Seattle, Washington; Pittsburgh, Pennsylvania; Miami, Florida; and several other cities have adopted a ban.<sup>41</sup> In the first half of 2017, New

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constitutionality, respectively, of California and New Jersey's statutes limiting conversion therapy. *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014), *cert. denied*, 134 S.Ct. 2871 (2014) (holding that the California statute does not infringe upon providers' First Amendment rights or violate minor client parents' right to make decisions regarding their children); *King v. Governor of New Jersey*, 767 F.3d 216 (3d Cir. 2014) (holding that the N.J. statute does not violate licensed counselors' First Amendment free speech or free exercise of religion rights); *Doe v. Governor of New Jersey*, 783 F.3d 150 (3d Cir. 2015), *cert. denied*, 136 S. Ct. 1155 (2016) (holding that the N.J. statute does not violate minor's First Amendment right to receive information nor parent's due process right to direct upbringing of their child). The Supreme Court declined to grant certiorari, leaving a circuit split regarding two issues. First, are state statutes that prohibit licensed professionals from providing conversion therapy to minors regulating conduct or speech? The Ninth Circuit held the statute regulated conduct, finding no First Amendment protection. *Pickup*, 740 F.3d at 1229. The Third Circuit held the statute regulated speech, finding at least some First Amendment guarantees implicated (but not violated). *King*, 767 F.3d at 229.

Second, to the extent the statutes are properly considered "professional speech" (upon which this Article takes no position), there is an additional circuit split regarding the appropriate standard of review for "professional speech." The Third Circuit recognizes the longstanding tradition of states regulating professionals and then analogizes professional speech to commercial speech, deciding that such speech should be subject to intermediate scrutiny. *Id.* at 233. Under intermediate scrutiny, limits on professional speech are permissible when they "directly advance" a "substantial government interest" and are "not more extensive than [is] necessary to serve that interest." *Id.* at 235 (quotations and citations omitted). Other circuits considering professional speech have applied a lower standard of review: rational basis scrutiny. *See, e.g., Texas Med. Providers Performing Abortion Serv. v. Lakey*, 667 F.3d 570 (5th Cir. 2012). Under this approach, restrictions on professional speech are permissible as long as they are rationally related to a legitimate state interest. *See Connecticut Bar Ass'n v. United States*, 620 F.3d 81 (2d Cir. 2010).

<sup>37</sup> H.R. 2450, 114th Cong. (2015), <http://www.congress.gov/114/bills/hr2450/BILLS-114hr2450ih.pdf>. This bill has not yet passed.

<sup>38</sup> OR. REV. STAT. § 675.850 (2016) (banning state-licensed providers from sexual orientation or gender identity change efforts on persons under eighteen); 405 ILL. COMP. STAT. ANN. 48 / 1-30 (2016) (banning state-licensed providers from sexual orientation change efforts on persons under eighteen).

<sup>39</sup> CINCINNATI, OH., CODE OF ORDINANCES § 769-3 (2016).

<sup>40</sup> S. 132, 2015-2016, Leg. Sess. (Vt. 2016) (codified at VT. STAT. ANN. Tit. 18, §§ 8351-8353 (2016)) (banning state-licensed providers from sexual orientation or gender identity change efforts on persons under eighteen).

<sup>41</sup> MIAMI BEACH, FLA., CODE OF ORDINANCES § 70-406 (2016); BAY HARBOR ISLANDS, FLA., CODE § 23-5.2(b) (2016) ("A person who is licensed by the State of Florida to provide professional counseling, or who performs counseling as part of his or her professional training under Chapters 458,

Mexico, Nevada, and Connecticut enacted bans.<sup>42</sup> Approximately twenty other states are considering similar legislation to restrict health providers from offering conversion therapy to minors.<sup>43</sup>

## 2. Administrative Regulation and Interpretative Guidance

New York has taken a different approach to curb conversion therapy, focusing on administrative regulation and interpretative guidance controlled

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459, 490, or 491 of the Florida Statutes, as such chapters may be amended, including, but not limited to, medical practitioners, osteopathic practitioners, psychologist, psychotherapists, social workers, marriage and family therapists, and licensed counselors, may not engage in conversion or reparative therapy with a minor.”); MIAMI, FLA., CODE § 37-13(b) (2016) (“A person who is licensed by the state to provide professional counseling, or who performs counseling as part of his or her professional training under F.S. ch. 458, 459, 490, or 491, as such chapters may be amended, including, but not limited to, medical practitioners, osteopathic practitioners, psychologist, psychotherapists, social workers, marriage and family therapists, and licensed counselors, may not engage in conversion therapy or reparative therapy with a minor.”); *Official Agenda*, NORTH BAY VILLAGE FLA. (Oct. 25, 2016), [http://www.nbvillage.com/Pages/NorthBayFL\\_Agendas/NorthBayFL\\_CommissionAgendas/2016-10-25%20Village%20Commission%20Meeting%20Agenda.pdf](http://www.nbvillage.com/Pages/NorthBayFL_Agendas/NorthBayFL_CommissionAgendas/2016-10-25%20Village%20Commission%20Meeting%20Agenda.pdf) (“The proposed Resolution expresses support for the movement to prohibit the use of sexual orientation or gender identity change efforts with minors, including reparative and conversion therapy, which have been demonstrated to be harmful to the physical and psychological well-being of lesbian, gay, bisexual, and transgender persons.”); PITTSBURGH, PA., CODE § 628 (2016) (“Ordinance supplementing the Pittsburgh Code, Title VI Conduct, Article 1 Regulated Rights and Actions, to add a new Section 628 Sexual Orientation or Gender Identity or Expression Conversion Efforts prohibiting the practice of conversion therapy for LGBTQIA+ minors within the City of Pittsburgh.”); SEATTLE, WASH., CODE § 14.21.040 (2016) (“It is a violation for any provider to provide conversion therapy or reparative therapy to a minor, regardless of whether the provider receives compensation in exchange for such services.”); WEST PALM BEACH, FLA., ORDINANCE 4666-16 (2016) (“An ordinance of the City Commission of the City of West Palm Beach, Florida, amending Chapter 54 (offenses), Article V (reserved) of the Code of Ordinances of the City of West Palm Beach, Florida, to prohibit the practice of conversion therapy on patients who are minors; providing a codification clause; providing a conflicts and severability clause, providing an effective date; and for other purposes.”); WILTON MANORS, FLA., CODE § 12-12 (2016) (“A person who is licensed by the State of Florida to provide professional counseling, or who performs counseling as part of his or her professional training under F.S. chs. 458, 459, 490, or 491, as such chapters may be amended, including, but not limited to, medical practitioners, osteopathic practitioners, psychologists, psychotherapists, social workers, marriage and family therapists, and licensed counselors, may not engage in conversion or reparative therapy with a minor.”).

<sup>42</sup> S.B. 121, 2016-2017, Reg. Sess. (N.M. 2017) (banning certain health professionals from providing conversion therapy to persons under age 18); S.B. 201, 79th Sess. (Nev. 2017) (“A psychotherapist shall not provide any conversion therapy to a person who is under 18 years of age regardless of the willingness of the person or his or her parent or legal guardian to authorize such therapy.” But not prohibiting “licensed health care professionals from engaging in expressive speech or religious counseling . . . .”); 2017 Conn. Acts 17-5, §§ 2-3 (Reg. Sess) (“No health care provider shall engage in conversion therapy . . . . It shall be unlawful for any person who practices or administers conversion therapy to practice or administer such therapy while in the conduct of trade or commerce.”).

<sup>43</sup> See *Active Laws & Legislation: The Details*, NAT’L CTR. LESBIAN RTS. (last visited June 22, 2017), <http://www.nclrights.org/bornperfect-laws-legislation-by-state/>.

by the executive branch.<sup>44</sup> New York's approach has three primary components. First, in February 2016, the New York State Department of Health issued a "Policy & Billing Guidance" in its *Medicaid Update* clarifying that Medicaid does not cover conversion therapy under fee-for-service or managed care Medicaid.<sup>45</sup> The Guidance expressly provides that conversion therapy is not covered because "homosexuality is not considered a medical condition that requires treatment."<sup>46</sup> Interestingly, unlike the legislative bans, New York's refusal to cover conversion therapy applies regardless of age and is not limited to minors.<sup>47</sup> Second, in April 2016, the New York State Office of Mental Health amended its mental health regulations to prohibit state facilities from providing services to minors that are intended to change the minor's sexual orientation.<sup>48</sup> Third, later in 2016, the New York State Department of Financial Services adopted a new insurance regulation that prohibits insurance coverage for conversion therapy to minors by mental health professionals.<sup>49</sup> Through these administrative changes, New York effectively prohibits public insurance from funding conversion therapy for anyone, bars state facilities from being used for conversion therapy on minors, and bans private insurance coverage of conversion therapy for minors.<sup>50</sup>

### 3. Judicial Remedy: Consumer Protection Litigation

Meanwhile, consumers and their advocates have launched another front against sexual orientation change efforts, focusing on consumer protection-oriented attacks.<sup>51</sup> One day before the landmark United States Supreme

<sup>44</sup> New York does not currently ban state-licensed professionals from providing conversion therapy, although such legislation has been proposed in the past. *See id.*

<sup>45</sup> *New York Medicaid Does Not Cover "Conversion Therapy"*, MEDICAID UPDATE (N.Y. St. Dep't. of Health, Albany, N.Y.), Feb. 2016, at 1, 10 [hereinafter N.Y. St. Dep't. of Health].

<sup>46</sup> *Id.* at 10.

<sup>47</sup> Laila Kearney, *New York Bans Insurance Coverage of LGBT 'Conversion Therapy'*, REUTERS (Feb. 6, 2016, 1:52 PM), <http://www.reuters.com/article/new-york-lgbt-idUSL2N15LOHW>.

<sup>48</sup> N.Y. COMP. CODES R. & REGS. tit. 14, § 527.8(d) (2016) ("Notwithstanding the provisions of this section, no facility shall provide services to minor patients that are intended to change such minor's sexual orientation or gender identity . . .").

<sup>49</sup> N.Y. COMP. CODES R. & REGS. tit. 11, § 52.16(n)(2) (2016) ("No policy or certificate shall provide coverage for conversion therapy rendered by a mental health professional to an individual under the age of 18 years.").

<sup>50</sup> *Id.*; N.Y. COMP. CODES R. & REGS. tit. 14 § 527.8(d); Kearney, *supra* note 47. Connecticut's legislative ban adopts a similar strategy, prohibiting public funds from being expended to practice, to provide a referral, or to provide benefits for conversion therapy on minors. 2017 Conn. Acts 17-5, § 4 (Reg. Sess.).

<sup>51</sup> Consumer protection attacks generally argue that SOCE practices are deceptive either because (1) same

Court decision recognizing a constitutional right to same-sex marriage, *Obergefell v. Hodges*, on June 25, 2015, a New Jersey jury vindicated another important right for sexual minorities.<sup>52</sup> In *Ferguson v. JONAH*, a jury returned a verdict finding that a faith-based organization advertising and selling conversion therapy services violated New Jersey's consumer fraud act.<sup>53</sup> The jury concluded that the faith-based organization, JONAH, and other defendants acting therewith "made misrepresentations in connection with the advertisement, sale or subsequent performance of the JONAH program and engaged in unconscionable commercial practices."<sup>54</sup>

The *JONAH* case appears to have precipitated a trend toward more consumer protection-oriented attacks on sexual orientation change efforts at the state and federal levels. Shortly after the *JONAH* verdict, in August 2015, Illinois became the fourth state to restrict conversion therapy and the first state to expressly provide a private right of action for consumer fraud based on the so-called therapy.<sup>55</sup> Then, on February 10, 2016, four members of Congress asked the Chairman of the Federal Trade Commission ("FTC") to regulate conversion therapy as part of the FTC's mandate to restrict "unfair or deceptive acts or practices in or affecting commerce."<sup>56</sup> Later that same month, three human rights organizations jointly filed a Complaint with the FTC asking the Commission to investigate and take enforcement action to stop an organization, People Can Change, Inc., from advertising and providing conversion therapy services.<sup>57</sup>

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sex attraction is not a medical disorder, or (2) because there is no evidence that SOCE can change a participant's sexual orientation.

<sup>52</sup> See Order Granting Permanent Injunctive Relief and Awarding Attorneys Fees at 2, *Ferguson v. JONAH*, 136 A.3d 447 (N.J. Super. Ct. Law Div. Dec. 18, 2015) (No. HUDL547312) [hereinafter *Order*]. See also *Jury in Groundbreaking SPLC Suit Finds Gay 'Conversion' Program is Unconscionable and Fraudulent*, S. POVERTY L. CTR. (June 24, 2015), <https://www.splcenter.org/news/2015/06/25/jury-groundbreaking-splc-suit-finds-gay-'conversion'-program-unconscionable-and-fraudulent>.

<sup>53</sup> *Jury in Groundbreaking SPLC Suit Finds Gay 'Conversion' Program is Unconscionable and Fraudulent*, *supra* note 52.

<sup>54</sup> *Order*, *supra* note 52, at 2.

<sup>55</sup> 405 ILL. COMP. STAT. ANN. 48 / 25 (West 2016) ("No person or entity may . . . use or employ any deception . . . offering conversion therapy services in a manner that represents homosexuality as a mental disease . . . . A violation of this Section constitutes an unlawful practice under the Consumer Fraud and Deceptive Business Practices Act.").

<sup>56</sup> Letter from Patty Murray et al., to Edith Ramirez, Chairwoman, FTC (Feb. 10, 2016), [http://www.huffingtonpost.com/entry/congress-ftc-gay-conversion-therapy\\_us\\_56bb6402e4b0c3c5504f9574](http://www.huffingtonpost.com/entry/congress-ftc-gay-conversion-therapy_us_56bb6402e4b0c3c5504f9574); Mollie Reilly, *Members of Congress Urge Ban on Gay Conversion Therapy*, HUFFINGTON POST (Feb. 10, 2016, 12:20 PM), [http://www.huffingtonpost.com/entry/congress-ftc-gay-conversion-therapy\\_us\\_56bb6402e4b0c3c5504f9574](http://www.huffingtonpost.com/entry/congress-ftc-gay-conversion-therapy_us_56bb6402e4b0c3c5504f9574) (internal quotations omitted).

<sup>57</sup> Complaint for Action to Stop False, Deceptive Advertising and Other Business Practices at 1, *Human Rights Campaign v. People Can Change, Inc.* (Feb. 2016), <http://hrc-assets.s3-website-us-east-1.amazonaws.com/files/assets/resources/FTC-ConversionTherapy-Complaint-Final.pdf> [hereinafter *FTC Complaint*].

The FTC Complaint alleged that the organization's advertisements constituted unfair, deceptive and fraudulent business practices.<sup>58</sup> Most recently, Connecticut made it a violation of that state's unfair or deceptive trade practices act to provide conversion therapy to a minor in the conduct of trade or commerce.<sup>59</sup>

Recognizing the three different approaches to address conversion therapy (legislative, executive, and judicial), as well as the many permutations within each, this Article begins to make recommendations on a comprehensive strategy. The first step in this regard, however, is to identify concerns with existing legislative bans on state-licensed healthcare workers providing conversion therapy to minors.

### III. HEALTH PROVIDER BANS ON SOCE FOR MINORS ARE BAD HEALTH POLICY

After a history of *de jure* and *de facto* discrimination against sexual minorities and of stomach-turning abuses associated with some conversion therapy efforts, at first blush, passage of legislative bans on state-licensed healthcare workers providing SOCE to minors may seem like cause for celebration.<sup>60</sup> Such legislation appears to recognize that attempting to change sexual orientation to conform to hetero-normative ideals is not in the best interest of minors. Expressively, SOCE bans arguably counter historic stigma by declaring that same-sex attraction is not a disease or disorder meriting medical treatment. Similarly, such legislation counters the notion that same-sex attraction is a choice that therapeutic efforts can alter.<sup>61</sup> Closer analysis, however, raises concerns with this well-intentioned approach.

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<sup>58</sup> *Id.*

<sup>59</sup> 2017 Conn. Acts 17-5, § 3 (Reg. Sess.) ("It shall be unlawful for any person who practices or administers conversion therapy [to minors] to practice or administer such therapy while in the conduct of trade or commerce...[to do so] shall be considered an unfair or deceptive trade practice . . .").

<sup>60</sup> In fact, when I first wrote on the promise of consumer protection based strategies to combat the abuses of SOCE, I saw such litigation as complimenting legislative bans rather than in lieu thereof. *See* Alexander, *supra* note 8, at 3. It was only after further study and thought that I became troubled that health provider bans do more harm than good.

<sup>61</sup> Most individuals experience little or no sense of choice over sexual orientation. *See* AM. PSYCHOL. ASS'N, ANSWERS TO YOUR QUESTIONS: FOR A BETTER UNDERSTANDING OF SEXUAL ORIENTATION AND HOMOSEXUALITY 2 (2008) [hereinafter "APA Q&A"]. As a result, many refer to sexual orientation as "immutable." Even among those who oppose SOCE, however, some contest immutability, arguing that for some individuals, attractions are more fluid and change naturally over time.

*A. The Narrow Scope of Bans Makes Them Ineffective and Possibly Harmful*

Bans are grossly under-inclusive if the goal is to combat any abuses associated with SOCE. All legislative bans on SOCE to date are limited to minors.<sup>62</sup> They do not apply in any way to the overwhelming majority of people who might seek SOCE.<sup>63</sup> Instead, bans only curtail the provision of services to those under the age of eighteen.<sup>64</sup> This relatively young age parameter means that legislative bans are wholly irrelevant to most potential SOCE participants.

Moreover, the selected age, eighteen, is too young to enable bans to effectively provide many of the desired benefits.<sup>65</sup> Identity exploration typically continues for several more years.<sup>66</sup> So, bans are not well targeted if their goal is to prohibit SOCE until individuals have a more stable sense of identity. Likewise, to the extent bans hope to avoid parental coercion to participate, they have a timing problem. At age eighteen, most adolescents are still living at home, financially and emotionally dependent on their parents, and have not yet graduated from high school.<sup>67</sup> Bans no longer apply before the most significant threat of parental coercion ends.<sup>68</sup>

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<sup>62</sup> CAL. BUS. & PROF. CODE §§ 865–865.2 (West 2013); D.C. CODE § 7-1231.14a (2015); 405 ILL. COMP. STAT. ANN. 48 / 1–30 (2016); N.J. STAT. ANN. §§ 45:1-54, 55 (West 2014); OR. REV. STAT. § 675.850 (2016); VT. STAT. ANN. tit. 18, §§ 8351–8353 (2016); S.B. 121, 2016–2017, Reg. Sess. (N.M. 2017); S.B. 201, 79th Sess. (Nev. 2017); 2017 Conn. Acts 17-5 (Reg. Sess.).

<sup>63</sup> See *APA Report*, *supra* note 3, at 3 (most SOCE research participants are adults).

<sup>64</sup> States likely adopted the age eighteen because they have a more compelling state interest in protecting the health and welfare of minors than adults. So, bans are more likely to survive constitutional scrutiny when limited to minors. While such constitutional analysis is beyond the scope of this Article, it is worth noting that there is at least some question of whether bans, without any possibility of judicial by-pass or mature minor consent, violate substantive due process. See *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) (holding that blanket parental consent requirement for minor’s abortion, without possibility of judicial by-pass or mature minor consent, is unconstitutional); see also Jessie Hill, *Constituting Children’s Bodily Integrity*, 64 *Duke L.J.* 1295 (2015) (arguing in favor of recognizing a child’s constitutional right to bodily integrity which includes the right to autonomy in medical decision-making and the right to protection against bodily harm). *But see Doe v. Governor of New Jersey*, 783 F.3d 150 (3d Cir. 2015), *cert. denied*, 136 S. Ct. 1155 (2016) (upholding constitutionality of New Jersey ban).

<sup>65</sup> See Sanam Assil, Note, *Can You Work It? Or Flip It and Reverse It?: Protecting LGBT Youth from Sexual Orientation Change Efforts*, 21 *CARDOZO J.L. & GENDER* 551 (2015) (arguing that SOCE bans should extend to twenty-one years old to enable potential participants to reach greater emotional maturity).

<sup>66</sup> *APA Report*, *supra* note 3, at 77 (“[Minors] are in the midst of developmental processes in which the ultimate outcome is unknown.”).

<sup>67</sup> *Id.* (“[Minors are] emotionally and financially dependent on adults.”).

<sup>68</sup> Concerns about potential parental coercion, while troubling, are better addressed through requiring robust minor assent and mature minor consent or even judicial by-pass rather than through

Even for those under eighteen, health provider bans are inadequate because of their narrow scope and the resulting unintended, negative incentive structure. Such bans do not stop *anyone* from participating in SOCE or from being coerced to participate in SOCE. Instead, they merely drive minor SOCE participants to unlicensed, non-healthcare providers who are not restricted in any way.<sup>69</sup> The failure to limit non-licensed providers makes bans, at best, ineffective and at worst, harmful.<sup>70</sup> After all, many abuses reported in relation to SOCE today are associated with organizations that utilize “religious,” non-healthcare providers.<sup>71</sup> Health provider bans do nothing to address the egregious, exploitative, and unprofessional

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blanket legislative bans which fail to account for individual needs, as discussed in Section III (D) *infra*.

<sup>69</sup> Most bans only restrict state-licensed healthcare providers. See CAL. BUS. & PROF. CODE §§ 865–865.2 (West 2013); D.C. CODE § 7-1231.14a (2015); 405 ILL. COMP. STAT. ANN. 48 / 1–30 (2016); N.J. STAT. ANN. §§ 45:1-54, 55 (West 2014); OR. REV. STAT. § 675.850 (2016); VT. STAT. ANN. tit. 18, §§ 8351 – 8353 (2016); S.B. 121, 2016-2017, Reg. Sess. (N.M. 2017); S.B. 201, 79<sup>th</sup> Sess. (Nev. 2017). *But see* 2017 Conn. Acts 17-5, §§ 2–3 (Reg. Sess.) (also banning provision of SOCE to minors by any provider “while in the conduct of trade or commerce.”). Of course, health provider bans may effectively deter or delay some participants. However, those who are not deterred or delayed will seek SOCE from untrained, unmonitored, non-healthcare providers at increased risk of harm. See Section II(C) *infra* for a more detailed discussion.

<sup>70</sup> States likely limited bans to state-licensed health providers at least in part because many non-healthcare providers of SOCE are religiously affiliated. Religious freedom is constitutionally protected by the First Amendment, as well as by federal and state laws. The need to respect religious freedom makes it considerably more challenging for states to regulate non-healthcare SOCE providers. However, the failure to regulate all providers dramatically changes the practical effect of health provider bans.

The Supreme Court appears likely to offer new guidance on the balance between free speech and free exercise rights, on one hand, and state’s desire to protect equal rights, on the other, during its next term in *Masterpiece Cake, Ltd. v. Colorado Civil Rights Commission*. No. 16-11 (2017). This precedent may eventually enable states to craft broader legislative bans on SOCE without fear of constitutional challenge.

<sup>71</sup> For example, unlicensed, “religious,” non-healthcare providers staffed the “sadistic Christian bootcamps” reported in Alabama that ultimately led to three child abuse convictions. Art Levine, *The Harrowing Story of Life Inside Alabama’s Most Sadistic Christian Bootcamp*, NEWSWEEK (March 2, 2017), <http://www.newsweek.com/2017/03/10/saving-youth-foundation-alabama-christian-school-beatings-nudity-562257.html>; Pete Madden, Brian Epstein, and Brian Ross, *Alabama Legislation Stops Short of Banning Sexual Orientation ‘Conversion Therapy’*, ABC NEWS (June 15, 2017), <http://abcnews.go.com/Politics/alabama-legislation-stops-short-banning-sexual-orientation-conversion/story?id=47984624>; Brian Epstein and Brian Ross, *Alabama State Lawmaker Seeks Crackdown on Troubled Youth Programs After ABC News Report*, ABC NEWS (March 17, 2017), <http://abcnews.go.com/US/alabama-state-lawmaker-seeks-crackdown-troubled-youth-programs/story?id=46181915>. Moreover, JONAH (before the lawsuit effectively dismantled it) and People Can Change (now known as Brothers Road) are alleged to have engaged in deceptive practices and to utilize some unlicensed, “religious,” non-healthcare providers. See *FTC Complaint, supra* note 57, at 2. *But see* NAT’L TASK FORCE FOR THERAPY EQUALITY, REPORT TO F.T.C., IN THEIR OWN WORDS: LIES DECEPTION AND FRAUD (2017), <https://www.voiceofthevoiceless.info/wp-content/uploads/2017/05/In-Their-Own-Words-Lies-Deception-and-Fraud-National-Task-Force-Complaint-to-the-Federal-Trade-Commission.pdf>.

practices—like requiring participants to undress and touch their genitals in front of a mirror while a “counselor” watches—reported in the *JONAH* case.<sup>72</sup>

As a potential solution, health provider bans are woefully deficient. Only under the narrowest of circumstances and in the smallest of ways do they decrease access to SOCE, as bans provide no limit to any participant age eighteen or older or to many providers regardless of participant age.<sup>73</sup> Nonetheless, even a small step forward can be important. So, the question becomes whether bans present an actual step forward. One way in which they might is through making important expressive statements that could decrease the stigma of same-sex attraction or provide broader deterrence than the actual scope of the bans.<sup>74</sup>

### *B. Limiting Bans to Minors Undercuts Any Potential Expressive Benefits*

There are several possible expressive benefits to legislative bans on SOCE.

#### 1. Bans as Warnings

First, by banning SOCE, states go from neutrality to a statement that SOCE is unnecessary, ineffective, and potentially harmful. Bans warn potential participants that SOCE is a bad choice, different from other healthcare alternatives.<sup>75</sup> This legislative expression seems likely to deter some potential participants from selecting SOCE (even if allowed to choose).<sup>76</sup>

<sup>72</sup> *Complaint and Jury Demand*, *supra* note 14, at 46.

<sup>73</sup> *See, e.g.*, *Pickup v. Brown*, 740 F.3d. 1208, 1232 n.8 (9th Cir. 2013).

<sup>74</sup> *See, e.g.*, Cass R. Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021, 2021 (1996) (analyzing the expressive function of law and arguing that law can play a positive role changing social norms so long as the consequence of the law is also positive); *see also* Cynthia Lee & Peter Kwan, *The Trans Panic Defense: Masculinity, Heteronormativity, and the Murder of Transgender Women*, 66 HASTINGS L.J. 77, 120 (2014) (arguing a ban on the trans panic defense would serve an important expressive function, sending “a loud and clear message that our society abhors this kind of violence”); Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 NOTRE DAME J.L. ETHICS & PUB. POL’Y (2000) (finding law may serve as a consensus statement of socially agreed upon, but not unanimous, values).

<sup>75</sup> *See* Sunstein, *supra* note 74, at 2034–35 (recognizing potential value in laws as expressive tools that help to change social norms, like not smoking, and thereby improve health through “information-induced norm cascades”).

<sup>76</sup> While the expressive statement of laws can be important, it should also be acknowledged that laws only change social norms or deter people to the extent that people are aware of the content of the laws.



## 2. Bans as Distancing State Sponsorship

Second, bans may also serve another important expressive purpose by distancing state sponsorship from SOCE practices. Many states have a history of *de jure* discrimination against sexual minorities and same-sex sexual conduct.<sup>77</sup> Legislative bans that limit “state-licensed” providers arguably distance state sponsorship from SOCE practices that many view as reinforcing discriminatory stigmas against sexual minorities. In this way, bans can be seen as an attempt to limit further state complicity in discrimination. Bans may be seen as an important step towards addressing lingering structural violence, stemming at least in part from past *de jure* discrimination.<sup>78</sup>

Limiting state-licensed health providers may also be viewed as an attempt to remove the cloak of authority from SOCE providers. By restricting state-licensed healthcare workers from providing SOCE, the state is refusing to allow the legitimacy it confers through state licensing to be used for practices it deems pernicious. Even without a history of state sponsored discrimination, this sort of distancing arguably serves a valuable purpose.

## 3. Bans as De-Medicalization

Third, because most bans only apply to licensed health providers, bans also arguably express the view that being a sexual minority or having same-sex attractions is not a medical condition.<sup>79</sup> Again, this distancing attempts to break a historically created stigma, since mainstream medical organizations once characterized same-sex attraction as disordered.<sup>80</sup> By

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<sup>77</sup> Before the 1960’s, consensual sodomy was a felony in every state. See Margot Canaday, *We Colonials: Sodomy Laws in America*, THE NATION (Sept. 3, 2008), <https://www.thenation.com/article/we-colonials-sodomy-laws-america/>.

<sup>78</sup> See Alberto B. Lopez, *Forty Yeas and Five Nays – The Nays Have It: Morrison’s Blurred Political Accountability and the Defeat of the Civil Rights Provision of the Violence Against Women Act*, 69 GEO. WASH. L. REV. 251, 291 (2001) (noting the important “symbolic value of the law” to distance the state from past discrimination).

<sup>79</sup> See CAL. BUS. & PROF. CODE §§ 865–865.2 (West 2013); D.C. CODE § 7-1231.14a (2015); 405 ILL. COMP. STAT. ANN. 48 / 1–30 (2016); N.J. STAT. ANN. §§ 45:1-54, 55 (West 2014); OR. REV. STAT. § 675.850 (2016); VT. STAT. ANN. tit. 18, §§ 8351–8353 (2016). In contrast, clergy and other non-medical providers remain free to offer SOCE.

<sup>80</sup> See DSM-III *supra* note 17 (listing ego-dystonic homosexuality as a disorder); DSM-II *supra* note 17 (first listing homosexuality as a “disorder” then as a milder “sexual orientation disturbance”); see also Nancy J. Knauer, *LGBT Elder Law: Toward Equity in Aging*, 32 HARV. J. L. & GENDER 1, 21–22 (2009) (discussing how stigma shapes self-image and relationship with the medical profession when

prohibiting licensed health providers from offering SOCE to minors, states limit the “same-sex attraction disorder” diagnosis and treatment that devalues sexual minorities.<sup>81</sup> In this way, bans reinforce the dignity of all sexual minorities, even those who never consider SOCE.<sup>82</sup>

#### 4. Not a Matter of Maturity: Limiting Bans to Minors Undoes Most, If Not All, Expressive Benefit

Unfortunately, any potential expressive benefit from current legislative bans on SOCE is greatly undercut, if not altogether eliminated, by the fact that such bans only limit the provision of SOCE to minors under the age of eighteen.<sup>83</sup> Sadly, this limitation suggests that SOCE is appropriate for those old enough to handle it. This age-limitation also implies that providing SOCE is (still) medically appropriate, even for state-licensed health providers. Because the age-limitation eviscerates most, if not all, of the potential expressive benefit of legislative bans, the question becomes: what other consequences may result from bans?

#### C. Health Provider Bans Drive SOCE to Untrained, Unmonitored, Less Accountable Providers

One troubling unintended consequence is that bans are likely to drive SOCE participants to unsafe providers.<sup>84</sup> While bans may deter or delay some minors from seeking SOCE, those who continue to demand conversion therapy will be forced to seek services from people who are not

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homosexuality is classified as a mental disorder); Edward Stein, *Mutability and Innateness Arguments about Lesbian, Gay, and Bisexual Rights*, 89 CHI.-KENT L. REV. 597, 625 (2014) (describing how de-medicalization of homosexuality has decreased stigma).

<sup>81</sup> This pernicious diagnosis undermines the dignity of sexual minorities and perpetuates and reinforces stigma and discrimination against them. Even well-intended medically-based sexual orientation change efforts may be seen as in tension with non-discrimination principles, at least to the extent they rest on the insidious premise that having same-sex attractions is medically disordered.

<sup>82</sup> While health provider bans are not as explicit as New York’s Guidance, they arguably serve the same purpose. See N.Y. St. Dep’t. of Health, *supra* note 45, at 1, 10 (“[H]omosexuality is not considered a medical condition that requires treatment.”).

<sup>83</sup> The positive expressive message of a blanket ban on SOCE for all would be compelling. However, for the reasons set forth in Section III *infra*, health provider bans, are bad health policy. Additionally, states have other more targeted ways to provide a beneficial expressive message, without undermining autonomy and driving SOCE participants to higher risk providers.

<sup>84</sup> Bans also seem likely to drive SOCE participants to other states without bans and without a commitment to sexual minority rights. Already in Alabama’s case, there is evidence of conservative religious parents sending their children across state lines to seek unlicensed, “religious” residential therapy. See, e.g., Levine, *supra* note 71; Madden, *supra* note 71; Epstein, *supra* note 71. Minors are particularly vulnerable when isolated in rural areas of states that largely oppose sexual minority rights.

licensed health providers.<sup>85</sup> Because bans limit access to professional health providers but do little to decrease demand, they effectively drive SOCE to untrained, unmonitored, and less accountable providers.<sup>86</sup> Given the importance of accountability, education, and ethics, prohibitions on allowing licensed healthcare workers to provide SOCE will almost certainly result in those minors participating in SOCE facing a greater risk of harm.<sup>87</sup>

After all, states monitor licensed health providers.<sup>88</sup> States do not have an equivalent monitoring system for unlicensed SOCE providers.<sup>89</sup> In fact, many abuses reported in relation to SOCE today are associated with organizations that utilize unlicensed providers.<sup>90</sup> Most current SOCE bans do nothing to address reported exploitative practices of certain unlicensed providers, whose practices are outside even a minority standard of care for any medical professional.<sup>91</sup> Without state monitoring systems that provide some accountability for state-licensed healthcare workers, abusive SOCE practices are less likely to be identified and stopped.<sup>92</sup>

State licensing also creates leverage for accountability. It creates an incentive for better self-regulation. If state-licensed healthcare workers value their license, they will be hesitant to deviate too far from the standard

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<sup>85</sup> See CAL. BUS. & PROF. CODE §§ 865–865.2 (West 2013); D.C. CODE § 7-1231.14a (2015); 405 ILL. COMP. STAT. ANN. 48 / 1–30 (2016); N.J. STAT. ANN. §§ 45:1-54, 55 (West 2014); OR. REV. STAT. § 675.850 (2016); VT. STAT. ANN. tit. 18, §§ 8351–8353 (2016); 2017 N.M. Laws 132. Connecticut’s ban goes beyond licensed health providers and restricts the provision of conversion therapy to minors by any person in the conduct of “trade or commerce,” but even this ban would allow minors to immediately seek conversion therapy from non-paid providers. 2017 Conn. Acts 17-5, (Reg. Sess.).

<sup>86</sup> While bans may cause some minors (or their parents) to reassess SOCE and to instead seek recommended sexual orientation outcome-neutral therapeutic approaches or to wait until age eighteen, some minors desiring SOCE, who would have sought SOCE from a medical professional, will now do so from someone without the same education, training, and experience (and likely with different goals).

<sup>87</sup> It should be conceded, however, that there is currently no empirical evidence quantifying (or even validating) this increased risk.

<sup>88</sup> See Victor, *supra* note 8, at 1554 (describing state monitoring of licensed providers and arguing in favor of relying on censure of SOCE therapists for making deceptive promises in advertising and for making unrealistic guarantees to their patients).

<sup>89</sup> See, e.g., *Pickup v. Brown*, 740 F.3d. 1208, 1215 (9th Cir. 2013).

<sup>90</sup> See, e.g., Levine, *supra* note 71 (describing a “Christian” residential camp providing SOCE that utilized isolation, shackles, and beating on minors); Madden, *supra* note 71; Epstein, *supra* note 71; *FTC Complaint*, *supra* note 57, at 2; *Order*, *supra* note 52, at ¶¶ 45–46.

<sup>91</sup> See CAL. BUS. & PROF. CODE §§ 865–865.2 (West 2013); D.C. CODE § 7-1231.14a (2015); 405 ILL. COMP. STAT. ANN. 48 / 1–30 (2016); N.J. STAT. ANN. §§ 45:1-54, 55 (West 2014); OR. REV. STAT. § 675.850 (2016); VT. STAT. ANN. tit. 18, §§ 8351–8353 (2016).

<sup>92</sup> See June Carbone & Paige Gottheim, *Markets, Subsidies, Regulation, and Trust: Building Ethical Understandings into the Market for Fertility Services*, 9 J. GENDER RACE & JUST. 509, 518 (2006) (One risk of prohibition is that a state “loses control of the activity altogether. If the demand remains sufficiently high, black markets develop, within or without the jurisdiction, that evade effective state regulation.”).

of care in the provision of services to avoid losing their license or facing other discipline. In this way, licensing deters the provision of harmful or abusive practices.

Moreover, if monitoring and deterring fail on the front end, state licensing systems also offer an additional mechanism of redress against unscrupulous SOCE practitioners.<sup>93</sup> Anyone concerned with the care provided by a state-licensed health worker has the additional (and often more efficient and less costly) alternative of pursuing state administrative sanction against the provider, as well as any civil litigation remedies.<sup>94</sup> When SOCE providers are unlicensed, participants lose this potential avenue of redress and providers are less accountable.

Further, if demand for SOCE remains and begins to be met solely by unlicensed, non-healthcare providers, SOCE participants will almost certainly face a greater risk of harm. Unlicensed, non-healthcare providers typically lack the medical education and training licensed providers receive.<sup>95</sup> Without adequate education and training, even well intentioned SOCE providers are less likely to help and more likely to harm participants. They simply lack relevant knowledge, training, and experience.

Unlicensed providers may also have different goals for treatment. Doctors and many other mental health professionals take an oath to work to the best of their ability to heal their patients.<sup>96</sup> Non-healthcare providers do not and may be more likely to be motivated primarily by reinforcing heteronormative moral ideologies than by healing.<sup>97</sup> Because monitoring, accountability, education, and ethics are critical to quality healthcare, as long as demand for SOCE persists, bans are more likely to imperil minors seeking SOCE than to protect them.<sup>98</sup>

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<sup>93</sup> See Victor, *supra* note 8, at 1535; see also, e.g., David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 ALB. L. REV. 583, 592 (1994) (noting how state licensing boards hold members accountable for violations of medical ethics).

<sup>94</sup> Victor, *supra* note 8, at 1574.

<sup>95</sup> *Credentialing, Licensing, and Education*, NCCIH (Oct. 2015), <https://nccih.nih.gov/health/decisions/credentialing.htm>.

<sup>96</sup> Even without an oath, professional health providers have professional ethical obligations that encourage them to focus on healing. In contrast, “religious” providers offering SOCE may be focused on preserving moral ideals, without regard to the health consequences for an individual patient.

<sup>97</sup> See *APA Report*, *supra* note 3, at 12.

<sup>98</sup> The history of restrictions on abortion teaches that restricting access to a healthcare service, without curtailing demand, drives desperate seekers to less safe and less accountable providers with detrimental health outcomes.

### *D. Bans Undermine Autonomy, Endangering Health*

Health provider bans are also bad health policy because they create a restriction on access to desired care available to adults. In doing so, they strip choice from the traditional decision-makers (doctors and patients) without regard to individualized circumstance and endanger the mature minor doctrine.

#### 1. Bans Usurp Professional Self-Regulation

SOCE bans deviate, without adequate justification, from the traditional deference accorded to the medical profession for self-regulation.<sup>99</sup> Generally, medical professionals largely self-regulate what manner of health care to offer patients.<sup>100</sup> They do so primarily through setting standards of care, issuing position statements, and (in conjunction with the state) controlling licensing and policing of the professional practice.<sup>101</sup> While imperfect, this system of deference makes sense, as medical professionals have substantially more healthcare education and experience than state legislators.<sup>102</sup> In all but rare instances, medical professionals are better situated than state legislatures to serve as decision makers regarding the type of care that is appropriate to offer patients.<sup>103</sup>

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<sup>99</sup> There may seem to be a tension between acknowledging that having same-sex attractions is not a medical condition meriting treatment and categorizing SOCE as healthcare. However, many individuals experiencing internal dissonance over same-sex attractions desire assistance from a mental health professional. Moreover, even the medical organizations that counsel against SOCE consider it appropriate for a therapist to provide “active coping” mechanisms and to facilitate “identity exploration.” See *APA Report*, *supra* note 3, at v (recommending “active coping” and “identity exploration”). The controversy over SOCE is that the therapist is not neutral regarding the sexual orientation outcome. All mainstream professional organizations continue to see a role for medical professionals to play in sexual orientation identity exploration, simply in a neutral and affirming capacity.

<sup>100</sup> See, e.g., Joshua E. Perry, *Physician-Owned Specialty Hospitals and the Patient Protection and Affordable Care Act: Health Care Reform at the Intersection of Law and Ethics*, 49 AM. BUS. L.J. 369, 416 (2012) (“[T]he medical profession has historically been self-regulated by codes of ethics and commitments to professionalism.”). Self-regulation has limits, of course. It is well established that legislatures retain the power to regulate licensed healthcare professionals when necessary for the benefit of the public’s health, safety, and welfare. See, e.g., *Dent v. West Virginia*, 129 U.S. 114, 122–23 (1889).

<sup>101</sup> They are then accountable through professional malpractice liability or discipline.

<sup>102</sup> Certainly, history is replete with examples, like castration for conversion therapy, where the medical professionals got it wrong. However, history is similarly replete with legislative actions, like forced sterilization, that were wrong. Absent conflict of interest, there is no reason to believe that legislatures will do better than trained and experienced health professionals.

<sup>103</sup> See, e.g., Andrew Fichter, *The Law of Doctoring: A Study of the Codification of Medical*

## 2. Bans Usurp Patient Autonomy, Harming Overall Health

Bans also deviate, without adequate justification, from traditional deference to patient decision-making. Experts widely endorse autonomy in medical decision-making because healthcare decisions primarily impact the patient and do not harm others and because patients express wide variation in preferences for care.<sup>104</sup> Care, such as gender confirming surgery, demonstrates the broad range of needs, values, and experiences individuals have in realizing health. Sometimes, a small minority of patients benefit from care that would be contrary to the best interest of most patients. Consequently, it is important not to strip decision-making authority from competent, informed individuals and their health providers without overwhelming evidence that the care would be harmful to *all* those demanding it.

Variation in patient preference seems likely to be especially pronounced in the context of SOCE, which is often closely tied to religious or moral beliefs.<sup>105</sup> In fact, it is indisputable that some individuals value access to SOCE, even if SOCE cannot change sexual orientation.<sup>106</sup> There are several potentially valid reasons for the seeming disjunction between efficacy and demand.<sup>107</sup> Some may view SOCE as part of their personal

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*Professionalism*, 19 HEALTH MATRIX 317, 341 (2009) (“Because the medical profession is functionally specific, and because its subject matter is abstruse and requires extensive training . . . , the medical profession is entitled to, and in fact must regulate itself.”); Bratislav Stankovic, “*It’s a Designer Baby!*”: *Opinions on Regulation of Preimplantation Genetic Diagnosis*, 2005 UCLA J.L. & TECH. 3, 55 (2005) (“The medical profession is far better situated to self-regulate health practices, including morally debatable ones.”).

<sup>104</sup> See, e.g., TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (7th ed. 2013) (arguing that dilemmas in bioethics should be resolved by applying the principles of autonomy, non-maleficence, beneficence, and justice). Over time, experts have come to accept that different patients define beneficence very differently. The individualized nature of defining beneficence makes autonomy critical. See Benjamin Moulton and Jaime S. King, *Aligning Ethics with Medical Decision Making: The Quest for Informed Patient Choice*, 38 J.L. MED. & ETHICS 85, 89–90 (2012) (demonstrating how studies show wide variation in patient preferences, tipping the balance in favor of autonomy for healthcare decision-making).

<sup>105</sup> *APA Report*, *supra* note 3 (noting that most SOCE research participants are well-educated, adult, white males, “who consider religion to be an extremely important part of their lives and participate in traditional or conservative faiths (i.e. The Church of Latter-Day Saints, evangelical Christianity, and Orthodox Judaism).”).

<sup>106</sup> *Id.*

<sup>107</sup> There are potentially troubling reasons for this disjunction as well, such as internalized stigma and inadequate informed consent. This Article suggests that states should address informed consent directly, rather than through bans, and combat stigma, at least indirectly, through consumer protection-based accountability and defunding SOCE. See *infra* Section IV. Demand driven by internalized social stigma is virtually impossible to address directly without abandoning all semblance of respect for autonomy. There simply is no way to effectively differentiate corrupting societal influence from

road to self-acceptance.<sup>108</sup> Others may want to participate—even absent any coercive influence—to assuage their parents or other family members.<sup>109</sup> Still more may hope to temporarily buy time with decreased frequency or intensity of same-sex attractions (even if unlikely), until they can graduate, move out of their parents' house, move to a more tolerant city, or find another job.

Of course, the real question is not so much whether SOCE could ever be beneficial to anyone, but who gets to decide whether or not state-licensed health providers may offer it as an alternative. Generally, healthcare providers determine what services to offer, and competent adults select among care options in consultation with the provider. This deference to doctor-patient decision-making extends to practices that have no medical benefit and entail some risk of serious harm, like elective cosmetic surgery.<sup>110</sup> SOCE arguably falls within such category of practices, and no state has restricted the provision of SOCE to adults.<sup>111</sup>

The default preference for autonomy in medical decision-making recognizes that doctors have the best expertise regarding what healthcare alternatives should be offered, and that patients have the best knowledge regarding how their values weigh potential risks and benefits of available alternatives. Legislators lack the doctor's expertise and the patient's personal knowledge. So, it is rare for them to play a desirable role in healthcare decision-making.

The same reasoning also applies to minors' healthcare decision making. Generally, experts consider autonomy to be a fundamental tenet of just and appropriate health policy and practice, even for minors.<sup>112</sup> However,

differences in preferences and values.

<sup>108</sup> Even if it does not “work,” it may help some individuals to be able to tell themselves that they tried everything before accepting their same-sex attractions.

<sup>109</sup> In this way, SOCE could conceivably help to avoid early familial rejection, with its deleterious consequences.

<sup>110</sup> S.R. Mousavi, *The Ethics of Aesthetic Surgery*, 3 J. CUTANEOUS & AESTHETIC SURGERY 38, 38 (2010) (“In general, competent adults have the right to decide whether they wish to undergo a surgical procedure or not . . . [even] where patients are not suffering from any ‘illness’ . . . [and surgery] may lead to long-term adverse effects on body function and health.”).

<sup>111</sup> *Conversion Therapy Laws*, *supra* note 29.

<sup>112</sup> See, e.g., *Chapter 2: Opinions on Consent, Communication & Decision Making*, AM. MED. ASS'N 7 (2016), <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-2.pdf> (“Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child’s abilities.”); Jessie Hill, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 J. HEALTH CARE L. & POL’Y 37, 39 (2012) (arguing that developing a doctrine surrounding minors’ rights to bodily integrity “would be highly desirable and beneficial to both health care providers and to minors”); Aviva L. Katz & Sally A. Webb, *Informed Consent in Decision-Making Pediatric Practice*, 138 PEDIATRICS 1, 5 (2016) (“Physicians should involve pediatric

minors may exercise healthcare decision-making autonomy differently than adults. Minors typically consent to medical care in one of three ways: (1) directly, (2) through parental consent,<sup>113</sup> or (3) through judicial by-pass.<sup>114</sup> Utilizing these consent mechanisms, minors enjoy virtually the same array of healthcare choices as adults.

As compared to the legislature, the case for patient autonomy in healthcare decision-making remains strong even when applied to minors, although perhaps not as strong as in the case of adults.<sup>115</sup> Because minors' preferences and values are still developing, states often assert a heightened state interest in protecting them.<sup>116</sup> This state interest usually lies dormant, however, because states recognize that parents generally provide the best surrogate decision maker for their minor children.<sup>117</sup> In fact, outside the "mature minor" doctrine,<sup>118</sup> parents are the default healthcare decision-makers for their children, and states usually only interfere with parental decision-making authority when a child's life, welfare, or "best interests" are threatened.<sup>119</sup>

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patients in their health care decision-making by providing information on their illness and options for diagnosis and treatment in a developmentally appropriate manner and seeking assent to medical care whenever appropriate.”).

<sup>113</sup> Parental consent is often coupled with minor assent.

<sup>114</sup> Judicial by-pass is a relatively rare consent mechanism whereby courts provide consent to care for minors by making an individualized finding that such care is in the minor's "best interests." Judicial by-pass arises as a procedural safeguard when parents select certain controversial treatments for a minor, when parents refuse to consent to care in the minor's best interest (and the minor lacks the right or refuses to consent directly), or when other conflict arises. For example, some states require parents to seek judicial approval before sterilizing a minor. *See, e.g.*, COLO. REV. STAT. § 25.5-10-231. One benefit of judicial by-pass is that it entails an individualized determination of what is in the minor's best interests.

<sup>115</sup> Molly J. Walker Wilson, *Legal and Psychological Considerations in Adolescents' End-of-Life Choices*, 110 NW. U. L. REV. ONLINE 33, 42 (2015) ("Although adolescents vary in terms of their cognitive maturity, there are important reasons to give adolescents a broader voice in their healthcare decision making, including recognition of the adolescent's personal autonomy, freedom, and dignity.").

<sup>116</sup> *Carey v. Population*, 431 U.S. 678, 693, 702 (1977) (striking down a statute prohibiting distribution of contraception to minors, while recognizing a "significant state interest" in protecting minors); *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944) (holding that states have authority to override parental decision-making when a child's life, welfare, or "best interests" are threatened).

<sup>117</sup> *See Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Pierce v. Soc'y of Sisters of the Holy Names of Jesus and Mary*, 268 U.S. 510 (1925).

<sup>118</sup> This Article uses the term "mature minor doctrine" to refer generally to laws that allow adolescents under the age of 18 to consent to medical care, whether or not such laws are limited in scope and whether or not the laws require a finding of maturity. Experts use the term "mature minor doctrine" in myriad different ways, sometimes as a legal term and other times as an ethical term. Some experts consider the "special spheres" consent discussed *infra* to be distinct from the mature minor doctrine; others describe special spheres as a limited application of the mature minor doctrine. This Article treats special sphere as a sub-set of the mature minor doctrine. Using this definition, while the scope and exceptions vary widely, all fifty states recognize some version of the mature minor doctrine. *See* Iltis, *supra* note 10 (documenting the trend toward expansion of the mature minor doctrine).

<sup>119</sup> Iltis, *supra* note 10, at 333. States also interfere if they determine that a parent is unfit.



While minors may still be developing, their healthcare preferences are already entitled to weight.<sup>120</sup> Like adults, minors face the consequences of their healthcare decisions, and research suggests some adolescents are capable of making healthcare decisions comparable to adults.<sup>121</sup> Particularly in the context of sexual and mental health, experts recognize the importance of granting decision-making authority to “mature minors,” as any other consent requirement poses a detrimental barrier to care.<sup>122</sup> So, although respect for individual preferences and values is complicated by the still-developing nature of minors and the state’s heightened interest in protecting them, autonomy (at least *vis a vis* the legislature) remains the default for healthcare decision making for minors.<sup>123</sup>

In a significant deviation from this norm, legislative bans on SOCE strip minors of the ability to consent to care directly, through their parents, or even through judicial bypass. This absolute restriction on access to professional care available to adults is virtually unprecedented.<sup>124</sup> It is also

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<sup>120</sup> See, e.g., *Chapter 2: Opinions on Consent, Communication & Decision Making*, *supra* note 112 (“Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child’s abilities.”); see also *APA Report*, *supra* note 3, at 74 (“It is now recognized that adolescents are cognitively able to participate in some health care treatment decisions, and such participation is helpful . . .”).

<sup>121</sup> Iltis, *supra* note 10, at 333, 334 (noting that “some psychological research suggests that adolescents have the cognitive capacities to make decisions comparable to those adults make” and, after documenting the expansion and basis for the mature minor doctrine, arguing that “regardless of its application to clinical health care decisions, [the mature minor doctrine] ought to be set aside in the research setting in favor of greater parental involvement”); see also Jennifer Rosato, *What are the Implications of Roper’s Dilemma for Adolescent Health Law?*, 20 J.L. & POL’Y 167, 189 (2011) (arguing that mature minors should be given greater autonomy in healthcare decision-making because adolescents are capable of making these type of unhurried, logical decisions).

<sup>122</sup> See, e.g., Soc’y. Adolescent Med., *Access to Healthcare for Adolescents and Young Adults*, 35 J. ADOLESCENT HEALTH 342, 343 (2004) (“Adolescents should be able to receive confidential services based on their own consent whenever limitations to confidentiality would serve as an obstacle impeding their access to care . . . Efforts to repeal minor consent laws or to place limits on the confidentiality of services for adolescents who are minors could undermine their access to essential services and should be opposed.”); Rosato, *supra* note 121, at 170, 171 (“[The mature minor doctrine] may affect adolescents’ ability to participate in decisions as important as whether they should be able to get the Human Papillomavirus (“HPV”) vaccine; decline genetic testing for late-onset diseases; obtain treatment for mental health problems; consent to participation in research trials; or elect treatment to change gender identity.”); Iltis, *supra* note 10, at 333, 334.

<sup>123</sup> This Article focuses in particular on damage health provider bans may do to the mature minor doctrine. For an article criticizing the damage bans may do to parental rights, see, e.g., Wardle, *supra* note 9 (suggesting that anti-SOCE laws may only be successfully upheld by ignoring and brushing aside the Supreme Court’s support of “thick” parental rights).

<sup>124</sup> Outside the context of healthcare, it is more common and more widely accepted for state legislatures to restrict the rights of minors, without regard to their parents’ preferences or a court’s judgment. For example, states limit when minors can purchase tobacco or alcohol without regard to

unjustified.<sup>125</sup> No state has yet banned state licensed providers from providing SOCE to adults.<sup>126</sup> In virtually every other context, minors have access to the medical services offered to adults by virtue of parental consent, mature minor consent, or judicial bypass consent. Moreover, it is not at all clear why a legislature would be more capable of determining minors' "best interests" regarding SOCE than parents, doctors, the minors themselves, or courts, who can take into account a particular minor's needs and preferences in making a decision.<sup>127</sup> Without more compelling empirical evidence of serious harm, nothing justifies removing all avenues of consent for SOCE from minors.

Health provider bans on conversion therapy for minors seem especially incongruous when compared to the law on elective cosmetic surgery for minors.<sup>128</sup> Breast augmentation has no physical health benefits and has well-documented health risks.<sup>129</sup> Like SOCE, this procedure seems to be driven in part by complex societal sexual and gender ideals. Yet, no state bans the ability of parents or mature minors to consent to this care. In fact, approximately five thousand minors receive breast augmentation each

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parental consent.

<sup>125</sup> Despite very real autonomy concerns, health provider bans could still be justified by sufficiently compelling empirical evidence that SOCE by state-licensed healthcare providers causes serious harm to all minors and is never in their "best interests." Anecdotal evidence of harm gleaned from studies on adults, while troubling, is insufficient to counter the potential perils of health provider bans.

<sup>126</sup> *Conversion Therapy Laws*, *supra* note 29.

<sup>127</sup> One possible benefit of legislative bans put forth by some proponents is that bans stop parental coercion of minors to participate in SOCE. Forcing a minor to engage in unnecessary, likely ineffective, and potentially harmful SOCE is unethical. However, the irony of stripping autonomy to avoid coercion is profound. It makes no sense for one concerned that parents might unduly influence minors—contrary to their autonomy—to seek a solution that unconditionally strips minors of their autonomy.

<sup>128</sup> To be clear, this Article does not advocate elective cosmetic surgery for minors and would in fact suggest that in most circumstances such procedures are unethical. *See, e.g.,* Alicia Ouellette, *Body Modification and Adolescent Decision Making: Proceed with Caution*, 15 J. HEALTH CARE L. & POL'Y 129, 155–56 (2012) (advocating respect of the autonomy interests of mature minors in the context of body modification under limited circumstances). However, there are unique circumstances when "elective" cosmetic surgery may be important to mental health. (After all, it is only recently that gender confirming surgery became accepted as "medically necessary" as opposed to elective cosmetic surgery.) The real issue, of course, is who should have decision-making authority over such care for minors. Given each minor's unique health needs, this Article posits that decision-making should remain with mature minors, parents, the courts and healthcare providers—all of who can make individualized decisions. Legislatures offer only blanket bans that, even if correct in the overwhelming majority of cases, may unintentionally undermine the health of certain vulnerable individuals.

<sup>129</sup> *See Teens and Breast Implants*, BREAST IMPLANT INFO., <http://www.breastimplantinfo.org/newsroom-2/teens-and-breast-implants/> (last visited June 17, 2016) (noting that "40% of augmentation patients have at least one serious complication within three years" and "breast augmentation patients are four times more likely to commit suicide compared to other women the same age").

year.<sup>130</sup> Similarly, tens of thousands of minors have elective rhinoplasty—nose reshaping—each year.<sup>131</sup> Surely, changes to a minor’s face trigger the same sort of concerns about identity and self-worth as SOCE. Moreover, a parent’s influence over a minor’s view of the ideal face, the importance of appearance, and similar factors seems as likely to influence the decision to seek elective cosmetic surgery as to influence a minor to participate in SOCE. The disparate treatment between elective cosmetic surgery and SOCE evidences how SOCE bans rest outside the norm and undermine current notions of autonomy in medical decision-making for minors.<sup>132</sup>

Moreover, undermining autonomy and, in particular, the mature minor doctrine, could have significant, unintended consequences on other aspects of minors’ health. In recent decades, there has been a steady trend toward the view that minors should have greater authority over their own healthcare decision-making.<sup>133</sup> This deference is especially pronounced with regard to sexual health, mental health, and substance abuse treatment, often referred to as “special sphere” healthcare decisions.<sup>134</sup> While the scope and exceptions vary, all fifty states currently recognize some version of the mature minor doctrine with regard to “special” healthcare decisions.<sup>135</sup> However, expansion of the mature minor doctrine for sexual

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<sup>130</sup> See Sumanas W. Jordan & Julia Corcoran, *Considerations in Breast Augmentation in the Adolescent Patient*, 27 SEMINARS PLASTIC SURGERY 67, 67 (2013) (noting that in 2011, 4,830 adolescents under 18 years of age received breast augmentation); *Plastic Surgery for Teenagers Briefing Paper*, AM. SOC’Y PLASTIC SURGERY, <http://www.plasticsurgery.org/news/briefing-papers/plastic-surgery-for-teenagers.html> (last visited June 17, 2016) (“More than 8,234 breast augmentations were performed on 18-19 year olds in 2013.”).

<sup>131</sup> Surgeons performed 30,672 rhinoplasty procedures on patients age 13–19 in 2013. *Id.* While some small percentage of these rhinoplasty procedures may be attributable at least in part to opening breathing passages, the majority is performed to remove a hump, reshape the tip, reduce the size, or straighten the bridge. *Id.*

<sup>132</sup> This disparity also raises troubling concerns about possible religious discrimination. Because conservative Mormons, Jews, evangelical Christians, and other minority religious groups who have historically faced *de jure* and *de facto* discrimination favor SOCE, its prohibition merits close scrutiny. Bans have already faced and will almost certainly continue to face constitutional challenge on First Amendment freedom of speech and freedom of religion grounds. See, e.g., *Welch v. Brown*, 834 F.3d 1041 (9th Cir. 2016), *cert. denied*, 197 L. Ed. 2d 894 (2017).

<sup>133</sup> *Itlis*, *supra* note 10, at 333.

<sup>134</sup> *An Overview of Minors’ Consent Law*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law> (last visited Jan. 21, 2017) (“The legal ability of minors to consent to a range of sensitive health care services—including sexual and reproductive health care, mental health services and alcohol and drug abuse treatment—has expanded dramatically over the past 30 years.”).

<sup>135</sup> *Itlis*, *supra* note 10. Admittedly, most other special sphere care has a far more compelling justification on public health or best interests of the child grounds than SOCE. However, erosion of minor autonomy in the areas of sexual and mental health could create a slippery slope that jeopardizes critical special sphere care like

and mental health decision-making remains both incomplete and fragile.<sup>136</sup> Many social conservatives seek to repeal existing laws and oppose any further expansion.<sup>137</sup> These repeal efforts are deeply troubling from a public health perspective because most experts acknowledge that robust recognition of the mature minor doctrine is essential to ensuring minors' utilization of sexual and mental health care.<sup>138</sup> Stripping mature minors of autonomy regarding SOCE sets a dangerous precedent. It undermines the mature minor doctrine in the critical "special" healthcare decision-making areas of sexual and mental health at a vulnerable time. In doing so, SOCE health provider bans imperil existing progress on the mature minor doctrine and thereby risk harming minors' overall sexual and mental health.<sup>139</sup>

Having established that licensed provider SOCE bans are too narrow to effectively limit abuses or to send a strong expressive message, and having raised concerns that bans may actually jeopardize health by driving participants to less safe providers and by undermining autonomy, this Article turns to other possible solutions.

#### IV. PRESCRIPTIVE RELIEF: IMPROVE INFORMED CONSENT, INCREASE ACCOUNTABILITY, ELIMINATE STATE FUNDING

In particular, this Article suggests that efforts to combat SOCE should focus on improving informed consent, increasing accountability for deceptive practices, and eliminating state funding. While this Article

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contraception, treatment and testing for sexually transmitted diseases, substance abuse treatment or mental healthcare.

<sup>136</sup> While largely beyond the scope of this Article, I believe it is important that states expand the mature minor doctrine in these "special" areas, with broader, more clearly defined autonomy, especially regarding contraceptive use. While parents generally play an effective role in healthcare decision-making for (or ideally with) minors outside the "special" sphere, in the context of sexual health, parents are often poor surrogate decision makers. With regard to sexual health, parental decision-making is often obscured by moral concerns rather than influenced by sound science and best health interests.

<sup>137</sup> See, e.g., *Republican Platform 2016*, GOP 37, <https://prod-cdn-static.gop.com/static/home/data/platform.pdf> (last visited Feb. 5, 2017) ("We support the right of parents to determine the proper medical treatment and therapy for their minor children. We support the right of parents to consent to medical treatment for their minor children . . .").

<sup>138</sup> See Soc'y. Adolescent Med., *supra* note 122 ("Efforts to repeal minor consent laws or to place limits on the confidentiality of services for adolescents who are minors could undermine their access to essential services and should be opposed."); and Hill, *supra* note 112; see also Iltis, *supra* note 10; and Rosato, *supra* note 121, at 170–71.

<sup>139</sup> Even if one assumes that health provider bans might protect at least some vulnerable teens, my concern is that the manner in which SOCE bans undermine the mature minor doctrine will, on balance, have a greater deleterious impact on teen's mental and sexual health. Lack of confidential access to and decision-making regarding contraception, diagnosis and treatment for sexually transmitted diseases, and substance abuse simply pose a greater health risk to more teens.

recommends these strategies in lieu of health provider bans, these tools could also be used to supplement bans. Informed consent, consumer protection, and defunding together promise broader relief. They can be used to deter most paid providers and to educate, empower, and offer relief to adults as well as minors. These approaches can be used immediately in most states, even those without SOCE bans. Further, emphasizing these widely accepted rights increases the likelihood that efforts to combat abuses associated with SOCE will also improve social norms regarding sexual minorities more generally.

*A. Improved Informed Consent is Essential, if Imperfect*

Robust informed consent offers a targeted and appropriate way to decrease demand for SOCE among all potential participants, without the limitations and negative side effects of health provider bans.<sup>140</sup> Informed consent refers to the process whereby a patient and healthcare practitioner communicate regarding a proposed treatment's nature, risks, benefits and alternatives.<sup>141</sup> Informed consent offers a good starting place for combatting SOCE abuses because it is an already existing legal obligation that applies to all potential participants, not merely minors, and because SOCE providers have reportedly frequently failed to obtain appropriate informed consent.<sup>142</sup>

With regard to SOCE, meaningful informed consent requires that a potential participant understand and appreciate the following:<sup>143</sup>

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<sup>140</sup> See, e.g., Caitlin Sandley, Note, *Repairing the Therapist? Banning Reparative Therapy for LGB Minors*, 24 HEALTH MATRIX 247, 274–75 (2014) (arguing that improved informed consent is superior to SOCE bans, in particular supporting legal reform to expressly allow minors of a certain age the right to refuse outpatient mental health treatment like SOCE).

<sup>141</sup> JANET L. DOLGIN & LOIS L. SHEPARD, *BIOETHICS AND THE LAW* 51–52 (3d ed. 2013); see also Nadia N. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, 216 U. ILL. L. REV. 821, 823 (2016).

<sup>142</sup> Informed consent is widely recognized in every state. However, its scope varies. See Nadia N. Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 AM. J. L. & MED. 85, 110–11 (2016).

<sup>143</sup> Some may argue that more robust informed consent also constitutes interference with traditional physician-deference because the state is attempting to control doctor-patient communication. Admittedly, informed consent requirements can constitute a form of interference in the doctor-patient relationship, but at least as proposed, the interference is both milder and more justified. It is milder because it does not prohibit the provision of any service but instead merely requires disclosures relating thereto. It is more justified because, without informed consent, potential participants cannot meaningfully exercise autonomy (a central principle of ethical medical decision-making). While informed consent is always essential to autonomous medical decision-making, it is especially critical when the proposed care is medically unnecessary, likely ineffective, and possibly harmful—as in the case of SOCE. These circumstances, coupled with SOCE's history of reportedly deceptive practices, justify more stringent consent requirements.

- (1) SOCE likely provides no benefit:
  - (a) Same-sex attraction is a normal variant of sexual behavior;<sup>144</sup> and
  - (b) No empirical studies support the effectiveness of SOCE at creating lasting change to sexual orientation.<sup>145</sup>
- (2) SOCE involves some risk of harm:
  - (a) Potential harm includes anecdotal reports and clinical observation of depression, anxiety, suicidal ideation, self-hatred and other negative social and emotional consequences.<sup>146</sup>
- (3) There are less risky alternative treatment approaches:
  - (a) Alternatives include active coping therapy that can be provided in an environment that respects religious beliefs and encourages abstinence, if desirable. This alternative is supportive and remains neutral regarding sexual orientation outcome.<sup>147</sup>

Improving informed consent can directly address many problems reported with existing SOCE practices. It can counter misinformation regarding “benefits” reportedly used to encourage SOCE, such as that same-sex attraction is a mental disorder or that SOCE offers a “cure.”<sup>148</sup> It can ensure that potential participants (and their parents) have full and complete knowledge regarding the risks of and alternatives to SOCE. When potential participants better understand the availability of safer alternatives consistent with their religious beliefs, they will be more likely

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<sup>144</sup> See, e.g., *APA Report*, *supra* note 3 (“[S]ame-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity . . . .”); Am. Psychiatric Ass’n, *supra* note 15 (opposing treatment “based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual homosexual orientation”); Am. Acad. Child & Adolescent Psychiatry, *supra* note 15 (“[T]here is no medically valid basis for attempting to prevent homosexuality, which is not an illness.”); see also *The Lies and Dangers of Efforts to Change Sexual Orientation or Gender Identity*, *supra* note 19 (quoting position statements of fourteen leading professional organizations).

<sup>145</sup> *APA Report*, *supra* note 3, at 41–42

<sup>146</sup> *Id.*

<sup>147</sup> *Id.* at v.

<sup>148</sup> See *FTC Complaint*, *supra* note 57, at 31–33; *Complaint and Jury Demand*, *supra* note 14, at 2. Of course, informed consent could not be used to reign in the non-medical providers.

to select alternatives. Moreover, any who continue to demand SOCE will at least do so without the damaging false hope currently peddled.<sup>149</sup> Through education and the opportunity to persuade potential participants that they have options consistent with their values, robust informed consent empowers potential participants while also effectively deterring participation in SOCE. Focusing on informed consent enhances rather than undermines autonomy and should cause as large or larger decrease in SOCE than health provider bans.<sup>150</sup>

While improving informed consent appears promising, it also has limitations and is not an adequate remedy standing alone for several reasons. First, non-medical SOCE providers do not have informed consent obligations. So, like health provider bans, informed consent fails to address misinformation or lack of information arising from these providers.<sup>151</sup> Second, some states limit informed consent requirements to surgery or other invasive treatment.<sup>152</sup> Even medical providers may not be required to make SOCE disclosures in these states. Third, regardless of factual information provided, the persuasive opportunity presented by an informed consent discussion may be limited when SOCE providers handle the communication.<sup>153</sup> Fourth, even robust informed consent leaves lingering concerns about capacity and voluntariness of consent for SOCE.<sup>154</sup> As long

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<sup>149</sup> Conversion therapy's false promises are especially concerning because they seem likely to cause a broader breach of trust with the medical establishment, endangering other aspects of a participant's health.

<sup>150</sup> After all, informed consent applies in more states and provides protection to adults as well as minors. Further, through informed consent, potential participants are educated, engaged, and offered a palatable alternative instead of a prohibition that likely just drives them to unregulated providers or a more permissive state.

<sup>151</sup> As discussed below, consumer protection laws might be used to require non-medical providers to disclose similar information to potential participants (or to suffer liability if harm arises from the unfair or deceptive failure to disclose same), as long as such providers are paid.

<sup>152</sup> See Sawicki, *supra* note 142, at 110–11.

<sup>153</sup> While First Amendment analysis is beyond the scope of this Article, it is worth noting that compelled (or restricted) professional speech raises potential free speech challenges. See, e.g., Claudia Haupt, *Professional Speech*, 125 YALE L.J. 1150 (2016) (analyzing the First Amendment free speech implications of SOCE bans).

<sup>154</sup> Informed consent has at least two other potential limitations. First, there is seldom liability for failure to provide adequate informed consent. Among other reasons, this is due to the difficulty of establishing damages proximately caused by insufficient disclosure. While largely beyond the scope of this Article, one partial solution to this problem would be to directly tie inadequate disclosures regarding SOCE to consumer protection violation. See, e.g., 405 ILL. COMP. STAT. ANN. 48 / 25 (2016) (“[O]ffering conversion therapy services in a manner that represents homosexuality as a mental disease . . . constitutes an unlawful practice under the Consumer Fraud and Deceptive Business Practices Act.”); and 2017 Conn. Acts 17-5, § 3 (Reg. Sess.) (“It shall be unlawful for any person who practices or administers conversion therapy [to minors] to practice or administer such therapy while in the conduct of trade or commerce . . . [to do so] shall be considered an unfair or deceptive trade practice . . . .”); see also *Quimby v. Fine*, 724 P.2d 403 (Div. 1 1986) (alleging a claim for lack of informed consent covered by UDAP). But see PRIDGEN, *infra*

as society, families, and certain religious organizations stigmatize and discriminate against sexual minorities, an individual experiencing same-sex attraction may be desperate for any possible solution, no matter how unlikely or risky.<sup>155</sup> Improving disclosures without addressing the structural violence and internalized stigma currently impeding truly voluntary consent is an imperfect solution.<sup>156</sup> It is an important first step though, and when coupled with increased accountability for deceptiveness and the expressive message of defunding discussed below, improving informed consent remains a superior strategy to health provider bans.

*B. Increasing Accountability and Transparency: The Promise of Consumer Protection Litigation Combating Abuses Associated with SOCE*

Pursuing consumer protection litigation offers several comparative advantages over health provider bans.<sup>157</sup> First, a consumer protection approach provides a broader solution, available to more SOCE participants and addressing more SOCE providers. Second, successful consumer protection litigation directly and unequivocally discredits the same-sex attraction disorder diagnosis. Third, litigation offers an immediate solution and empowers former participants to actively participate in vindicating their rights.<sup>158</sup> Fourth, the public nature of consumer protection litigation

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note 168, § 4:36 (summarizing case law limiting consumer protection claims involving certain professional activities). If inadequate or misleading SOCE disclosures constitute a deceptive business practice as a matter of law, informed consent will be easier and, given potential attorneys' fees and treble damages, more economical to enforce.

Second, informed consent is also sometimes criticized because disclosures are seen as ineffective at increasing autonomous decision-making. This commonly results from an overload of information or from the information being presented in language above the patient's comprehension level. While challenging, the best way to combat these problems is to require that the information be provided clearly and prominently, and then to hold providers accountable for the failure to do so.

<sup>155</sup> To be clear, spiritual well-being is an integral part of health. Religious organizations (as well as families and societal structures) can greatly improve health. So, while some religious institutions have historically played an ignominious role with regard to SOCE, it is important to acknowledge that religious organizations can and often are essential partners in realizing health.

<sup>156</sup> Individuals may be influenced by societal stigma, but this cannot justify stripping their autonomy. Even if competent, informed individuals sometimes fail to make the best decisions for themselves, they are still generally better decision-makers than legislators who lack personal interest and have a long history of discriminatory legislation. Individuals are capable of understanding the risks and choices involved in SOCE, and the best way to ensure their rights are protected is to ensure that they retain decision-making autonomy.

<sup>157</sup> When this Article primarily discusses state unfair and deceptive acts and practices statutes, a truly comprehensive solution would also pursue unfair or deceptive acts and practices through the Federal Trade Commission and through other state deceptive-based regulatory enforcement mechanisms.

<sup>158</sup> One benefit of a consumer protection approach is that it does not generally require the passage of new, SOCE-specific legislation in order to establish liability for unfair or deceptive SOCE practices by paid providers. Specific legislation could, however, make liability both more certain and less expensive. *See, e.g.* 405 ILL.



provides a multiplier effect, increasing knowledge, reshaping social norms, and otherwise deterring SOCE. Fifth, by highlighting general rather than specific rights, consumer protection litigation emphasizes similarities between sexual minorities and the general population, helping to decrease stigma and discrimination. This section explains these benefits while acknowledging certain limitations to this approach.

### 1. Consumer Protection Litigation Offers Broader Accountability for Anyone Deceived by SOCE

Consumer protection litigation offers potential redress to a wider range of participants than bans.<sup>159</sup> Most legislative efforts to date apply only to licensed health professionals providing SOCE to minors and fail to offer any remedy to adults.<sup>160</sup> Yet, the sense of having a “disorder” that SOCE arguably reinforces, as well as the false hope of a “cure,” likely impact adults similarly to minors.<sup>161</sup> Likewise, health provider bans offer no redress against non-licensed providers, who can cause as much (or more) harm as licensed providers.<sup>162</sup> As compared to most current legislative bans, consumer protection litigation expands both the group of people who have a legal remedy and the providers who can be called to account.<sup>163</sup> Litigation promises to compensate more victims and punish more deceptive providers, thereby more effectively deterring future SOCE abuses.<sup>164</sup>

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COMP. STAT. ANN. 48 / 25 (West 2016); 2017 Conn. Acts 17-5, § 3 (Reg. Sess.).

<sup>159</sup> While refined and revised herein, some of my preliminary thoughts on the benefits of consumer protection litigation were published in Alexander, *supra* note 8, at 2.

<sup>160</sup> See CAL. BUS. & PROF. CODE §§ 865–865.2 (West 2013); D.C. CODE § 7-1231.14a (2015); 405 ILL. COMP. STAT. ANN. 48 / 1–30 (2016); N.J. STAT. ANN. §§ 45:1–54, 55 (West 2014); OR. REV. STAT. § 675.850 (2016); VT. STAT. ANN. tit. 18, §§ 8351–53 (2016).

<sup>161</sup> See *APA Report*, at 3.

<sup>162</sup> See, e.g., Levine, *supra* note 71 (describing “Christian” residential camp providing SOCE that utilized isolation, shackles, and beating on minors); Madden, *supra* note 71; Epstein, *supra* note 71; *FTC Complaint*, *supra* note 57, at 2. Compare 2017 Conn. Acts 17-5, § 3 (Reg. Sess.) (Connecticut incorporates consumer protection accountability and defunding into its health provider ban statute but only for minors) with CAL. BUS. & PROF. CODE §§ 865–865.2 (West 2013), D.C. CODE § 7-1231.14a (2015), 405 ILL. COMP. STAT. ANN. 48 / 1–30 (2016), N.J. STAT. ANN. §§ 45:1–54, 55 (West 2014), OR. REV. STAT. § 675.850 (2016), and VT. STAT. ANN. tit. 18, §§ 8351–53 (2016).

<sup>163</sup> Even if consumer protection litigation is generally effective at enhanced accountability for abuses associated with SOCE, over time, providers may be able to avoid liability by making more complete and more accurate disclosures. For example, a savvy provider could literally quote the conclusions of the American Psychological Association in its literature and have participants initial that they understand that the medical establishment does not endorse a conversion therapy approach. While imperfect, better disclosures are a step forward. Accurate information might deter some participants, and those who are not deterred would at least have a more realistic understanding of the likelihood of success, possible risks, and alternatives available.

<sup>164</sup> Consumer protection litigation allows individuals who were victimized by false claims of

## 2. Consumer Protection Litigation Directly Discredits the “Same-Sex Attraction Disorder” Diagnosis that Stigmatizes All Sexual Minorities

Successful consumer protection litigation attacks the so-called “same-sex attraction disorder” (“SSAD”) diagnosis directly, establishing that such diagnosis is deceptive and unsupported by credible medical professionals.<sup>165</sup> There is enormous vindication in a judge or jury recognizing SSAD as a fraudulent diagnosis.<sup>166</sup> Such a finding reinforces the notion that same-sex attraction is not an illness to be cured but rather a normal, if less prevalent, way to experience sexuality. This expressive recognition increases respect for the dignity of all sexual minorities. So, unlike existing legislative bans on SOCE that express an opinion only regarding what is appropriate for minors, while remaining neutral on appropriate treatment for adults, consumer protection litigation unequivocally rejects any same-sex attraction disorder diagnosis as unfounded.<sup>167</sup> In this way, consumer protection litigation provides a superior expressive remedy.

## 3. The Value of Active Participation and Immediate Relief

Consumer protection litigation also builds the capacity of rights-bearers to claim their rights. It empowers former recipients of SOCE, who actively participate in vindicating their rights, thereby transitioning from victims to victors. Litigation is preferable to bans because it develops the capacity of

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effective conversion therapy to seek recompense for any deceptive or misleading business practices that cause them injury. This removes at least some of the economic incentive to pedal false hope based on dubious science. Over time, removing the economic incentive and punishing deceptive providers should decrease the number of providers who offer patients ineffective conversion therapy services.

<sup>165</sup> Judgment, *Ferguson v. JONAH*, 136 A.3d 447 (N.J. Super. Ct. Law Div. 2015) (No. HUDL54731).

<sup>166</sup> JONAH focused on deceptive statements (1) that same sex attraction is disordered and (2) that the JONAH program could change a participant’s sexual orientation. It may also be possible to use UDAP laws to challenge other SOCE practices. For example, some SOCE providers undermine transparency and make it difficult if not impossible to monitor the quality of care by requiring participants to agree in advance that they will not disclose their SOCE experiences. See, e.g., *Agreements and Liability Release*, JOEL INT’L 2:25 ¶¶ 2, 8, 11, <https://rightsignature.com/forms/Joel-2-25-Partici-55e0b2/token/410568c383a> (last visited July 25, 2016) (requiring participants to keep their own experiences with SOCE confidential and to agree to liquidated damages and attorneys’ fees if they disclose their experiences). Some providers also impede accountability by requiring SOCE participants to agree in advance that they control the outcome of SOCE and/or to release the provider from liability. *Id.* ¶¶ 5, 7 (releasing Joel from liability and affirming that change is determined by each individual). It is worth considering whether some of these practices, which hinder effective oversight, could also be successfully challenged.

<sup>167</sup> Compare *id.*, with CAL. BUS. & PROF. CODE §§ 865–865.2 (West 2013), and D.C. CODE § 7-1231.14a (2015), and 405 ILL. COMP. STAT. ANN. 48 / 1–30 (2016), and N.J. STAT. ANN. §§ 45:1-54, 55 (West 2014), and OR. REV. STAT. § 675.850 (2016), and VT. STAT. ANN. tit. 18, §§ 8351–53 (2016).

the rights-holders and empowers them personally as they take action to address SOCE.

Individual legal action also provides immediate relief. Most, if not all, states already have consumer protection laws.<sup>168</sup> Accordingly, through consumer protection litigation, most individuals harmed by SOCE can pursue damages and other relief without waiting for further legislative reforms.<sup>169</sup> Consumer protection litigation offers a meaningful accountability measure and enables many harmed consumers to actively challenge SOCE practices today.

#### 4. Public Trials Increase Transparency and Deter SOCE

Such litigation also tends to generate publicity, shining light on degrading and inhumane SOCE practices and helping to mobilize public opposition to SOCE.<sup>170</sup> For example, the *JONAH* trial brought to light that the SOCE providers were making some men undress and stand naked in a circle, and making other men undress and touch their genitals in front of the counselors.<sup>171</sup> Exposing specific, seemingly absurd practices helps to galvanize public opposition. In this way, impact litigation effectively reshapes social norms and deters SOCE.

Increasing public awareness of the lack of credible scientific support for SOCE, and of the harm SOCE has caused some participants, can have a multiplier effect. It both educates potential participants about the pitfalls of SOCE and engenders greater sympathy in the general public for those who struggle with same-sex attraction. In fact, personal narratives, as developed and told in litigation, have a greater impact on changing behavior and social norms than information alone.<sup>172</sup> As more people appreciate the harm caused by deceptive SOCE practices and relate to the individuals injured

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<sup>168</sup> See DEE PRIDGEN & RICHARD M. ALDERMAN, *CONSUMER PROTECTION AND THE LAW* § 1:1, 5 (2016–2017 ed.).

<sup>169</sup> However, not all states' consumer protection laws are broad enough to allow a claim for any unspecified unfair and deceptive business practice. See Dubrowski, *supra* note 8, at 77–90 (a practice-oriented article analyzing state laws to demonstrate opportunities and obstacles in applying the *JONAH* model); Satira, *supra* note 8, at 645 (discussing possible roadblocks to widespread consumer protection attacks); PRIDGEN, *supra* note 168, Ch. 4.

<sup>170</sup> Of course, this assumes that arbitration clauses are not used in SOCE provider contracts to circumvent public trials.

<sup>171</sup> *Complaint and Jury Demand*, *supra* note 14, at 13–14.

<sup>172</sup> See *cf.* Richard Delgado, *Legal Storytelling: Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2414 (1989); Kimberlianne Podlas, Symposium, *The Tales Television Tells: Understanding the Nomos Through Television*, 13 TEX. WESLEYAN L. REV. 31, 36 (2006).

thereby, same-sex attraction will be de-stigmatized. Consumer protection litigation can be used effectively, as it was in the *JONAH* case, to sway public opinion, creating a multiplier effect, reshaping social norms, and deterring SOCE.

#### 5. Emphasizing General Rather than Specific Rights Builds Bridges

Similarly, by focusing on deception, consumer protection litigation emphasizes rights of general application rather than “special” rights for sexual minorities.<sup>173</sup> No one should be deceived into paying for services by false promises. In this way, consumer protection litigation highlights common ground between those who experience same-sex attraction and those who do not. In doing so, consumer protection litigation helps build a bridge and emphasizes the universal application of rights. This general rights approach plays an important role in reshaping social norms regarding sexual minorities.

#### 6. The Limitations of a Consumer Protection Litigation Strategy

While consumer protection litigation is a promising tool to empower rights-holders, to combat deceptive SOCE practices, and to change social norms, it also has limitations.

##### i. Remedy After Harm Accrues, But Primarily Indirect Prevention

First, consumer protection litigation arguably only offers a remedy *after* harm occurs. It provides relief for any economic harm caused by unfair or deceptive SOCE practices. However, it fails to *prevent* such harm from occurring in the first place, at least directly. While over time successful litigation should deter SOCE participants and providers, it does not

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<sup>173</sup> See cf. Kenji Yoshino, *The New Equal Protection*, 124 HARV. L. REV. 747, 797–97 (2011) (“[General] claims . . . emphasize what all Americans . . . have in common. The claim that we all have a right to sexual intimacy, or that we all have a right to access the courts, will hold no matter how many new groups appear in this country. As such, [general] claims may be one way in which we fashion a new, more inclusive sense of ‘we.’”); Victor, *supra* note 8, at 1537–38 (criticizing bans for generating political backlash as “special” rights for sexual minorities and praising the utilization of deceptive-based regulation as “general” rights that help unite all people). The success of a general rights approach to sexual orientation under international law also evidences its efficacy. By focusing on equality, privacy and non-discrimination, sexual minorities have made enormous strides over the last twenty-five years in United Nations-affiliated human rights monitoring and implementing bodies. This is not intended to suggest, however, that specific rights are never appropriate to combat unique discrimination faced by a marginalized group.

immediately decrease access to SOCE (even for minors with regard to licensed mental health providers). Despite this short-term limitation, given consumer protection litigation's substantially broader scope—all SOCE participants who were deceived and any providers who were paid—it should decrease SOCE as much or more than bans in the long run.

## ii. Inefficiency and Cost Concerns

Second, some may argue that consumer protection litigation can be inefficient and costly.<sup>174</sup> It usually addresses harm caused to individual plaintiffs by the particular providers sued. Each case can be expensive and time consuming to try, and damages tend to be relatively low.<sup>175</sup> Each case also requires a plaintiff who is willing to testify that he or she attempted conversion therapy and failed, with invasive, personal discovery of his or her mental health and sexual preferences made public.

However, two years post-verdict in JONAH, these concerns appear less substantial.<sup>176</sup> Cost concerns can be mitigated by the fact that many states allow prevailing plaintiffs to recover attorneys' fees and state attorney generals to prosecute actions.<sup>177</sup> Further, a case-by-case strategy may not be required. Some states will allow an agency to enjoin specific deceptive practices from all providers who have received notice and an opportunity to be heard<sup>178</sup> and other state courts may be willing to certify a class action.<sup>179</sup> Even without these aggregating mechanisms, a case-by-case approach may

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<sup>174</sup> See Diane Hoffmann & Jack Schwartz, *Stopping Deceptive Health Claims: The Need for a Private Right of Action Under Federal Law*, 42 AM. J. L. & MED. 53, 78–79 (2016) (noting problems and inefficiencies with current state-based consumer protection causes of actions).

<sup>175</sup> See Hoffmann & Schwartz, *supra* note 174, at 79 (noting how some state consumer protection laws have imposed ceilings as low as \$1,000 on civil penalties). In SOCE cases, actual damages are typically only the amounts paid for the conversion therapy, a relatively small amount even when trebled. Attorneys' fees are the real deterrent to providers, as such cases can accrue seven-figure attorneys' fees, costs, and expenses. For example, in JONAH, the court awarded \$3.5 million for attorneys' fees and costs, while the plaintiffs themselves received only thousands of dollars in recovery. *Order*, *supra* note 52, at 2.

<sup>176</sup> Shortly after the JONAH verdict, I was somewhat more skeptical regarding consumer protection liability's efficiency. See Alexander, *supra* note 8. However, after observing sweeping disclosure changes post-JONAH, gaining a better understanding of SOCE networks, and discussing the issue with Jacob Victor, I have become convinced that consumer protection litigation can be a cost effective means for widespread change.

<sup>177</sup> See PRIDGEN, *supra* note 168, § 6:17 (attorneys' fees) and § 7:1 (state agency enforcement).

<sup>178</sup> When the Federal Trade Commission ("FTC") issues a final cease and desist order adjudicating an act unfair or deceptive, it can enforce that order as a de facto industry-wide rule by seeking civil penalties from any non-respondent who engages in similar conduct with actual knowledge that its act or practice is unfair or deceptive. 15 U.S.C. § 45(m)(1)(B). Some states allow injunctions that accomplish a similar end state-wide. See PRIDGEN, *supra* note 168, § 6:9 (injunctions).

<sup>179</sup> See PRIDGEN, *supra* note 168, § 6:28 (class actions). Of course, this assumes that providers do not receive class action waivers and that participants are able to establish commonality and other class certification prerequisites.

be unnecessary. SOCE providers tend to be a relatively close-knit network, sharing practices and communicating, making it far more likely that targeted litigation would effectively deter deceptive or unfair practices more broadly. In fact, demonstrable improvement in disclosures practices following the JONAH verdict evidences the power of consumer protection liability.<sup>180</sup> The JONAH and Alabama cases also indicate that courageous individuals will be willing to come forward and testify if necessary to stop abusive practices.<sup>181</sup> So, cost and inefficiency should not prevent consumer protection litigation from serving as an effective strategy in combatting deceptive SOCE practices.

### iii. Danger of Loss: States Where Recovery Could Be Difficult

While a state-by-state analysis of the challenges of consumer protection litigation attacking SOCE abuses is beyond the scope of this Article, another potential limitation is that prevailing could be difficult in some states.<sup>182</sup> This limits the breadth of the consumer protection remedy and creates the need to consider the risk of bad precedent in tougher jurisdictions.<sup>183</sup> After all, while successful consumer protection litigation

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<sup>180</sup> For example, most national SOCE organizations changed their websites to downplay promises of success after JONAH. People Can Change even changed its organization name to Brothers Road. See BROTHERS ON A ROAD LESS TRAVELED, <http://www.brothersroad.org> (last visited Jun. 28, 2017). The Alliance for Therapeutic Choice and Scientific Integrity stopped using the phrase sexual orientation change efforts and instead switched to the arguably less misleading description, sexual attraction fluidity exploration in therapy (SAFE-T). See Rosik, *supra* note 2. Of course, other changes—including legislative health provider bans—may also have contributed to the positive changes that have occurred post-JONAH.

<sup>181</sup> See *Ferguson v. JONAH*, 136 A.3d 447 (N.J. Super. Ct. Law Div. Dec. 18, 2015) (No. HUDL547312); Levine, *supra* note 71; Madden, *supra* note 71; Epstein, *supra* note 71.

<sup>182</sup> Hoffmann & Schwartz, *supra* note 174, at 79 (noting how some state consumer protection laws require litigants to demonstrate a provable falsehood rather than lack of substantiation); Dubrowski, *supra* note 8 (a practice-oriented article analyzing state laws to demonstrate opportunities and obstacles in applying the JONAH model); Satira, *supra* note 8, at 671–79 (discussing possible roadblocks to widespread consumer protection attacks).

To identify four potential obstacles to consumer protection success: (1) some states require proof of reliance for consumer protection claims, (2) some states do not allow recovery of attorneys' fees making such cases economically infeasible, (3) many states follow the more flexible *Daubert* standard for determining the reliability (and admissibility) of expert testimony, rather than the *Frye* standard used in the JONAH case, and (4) some states exempt professional activities, like providing healthcare although typically not advertising, from consumer protection coverage. Dubrowski, *supra* note 8, at n.30, 93, 96; see also PRIDGEN, *supra* note 168, Ch. 4. Under the *Daubert* standard, it is more likely that a proponent of SOCE would be able to offer competing expert testimony, increasing the likelihood that at least some juries might refuse to find SOCE deceptive.

<sup>183</sup> Another potential litigation loss risk arises from First Amendment concerns. Because the provision of SOCE is closely associated with both free speech and the free exercise of religion, regulating it may pose First Amendment challenges. While a case lost on these grounds might not have the same detrimental effect as a case in which SOCE practices were found not to be unfair or deceptive, it would still create a barrier to future

effectively counters at least the expressive harm of a same-sex attraction diagnosis, unsuccessful litigation could have the opposite effect. A defense verdict could serve to legitimize the proposition that sexual minorities are disordered and should be avoided. Even with the danger of loss, consumer protection litigation remains a broader and more promising solution than health provider bans.<sup>184</sup> On balance, consumer protection litigation provides the best solution to increase accountability, respect autonomy, and deter harmful SOCE practices.<sup>185</sup>

### *C. Defunding Is Essential as Good Stewards of Taxpayer Dollars*

The third component to addressing SOCE should be defunding.<sup>186</sup> Regardless of one's views on same-sex attraction, the empirical lack of efficacy of SOCE mandates that limited state healthcare funds be spent on other more effective health initiatives.<sup>187</sup> The ineffectiveness of SOCE justifies Medicaid Opinion Letters or other means to eliminate any state

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accountability efforts. Nonetheless, consumer protection attacks seem less likely to run afoul of constitutionally protected rights than health provider bans (since only deceptive practices are targeted), and First Amendment risk is inherent in any effort to address SOCE abuses. *See, e.g.,* Central Hudson Gas & Elec. Corp. v. Public Service Commission of New York, 447 U.S. 557, 566 (1980) (deceptive or misleading speech may be regulated without violation of the First Amendment).

<sup>184</sup> Like health provider bans, consumer protection litigation offers no solution to unpaid SOCE providers.

<sup>185</sup> While this Article primarily focuses on consumer protection litigation, I also agree with Jacob M. Victor that utilizing deceptive-based regulation should be part of a comprehensive solution. Victor, *supra* note 8 (arguing in favor of deceptive-based regulation but skeptical of JONAH-style consumer litigation). The Article emphasizes consumer protection litigation because I believe it to be the more promising solution. While regulatory enforcement could be effective, it is notoriously underfunded for both investigation and prosecution. Moreover, discipline and censure are often private (or at least unheralded), and as such, litigation seems more effective for changing social norms and deterring future participants and providers.

<sup>186</sup> New York provides an excellent model of refusing to use public funds to pay for SOCE. *See, e.g.,* N.Y. St. Dep't. of Health, *supra* note 45; *see also* N.Y. COMP. CODES R. & REGS. tit. 14, § 527.8(d) (2016) ("Notwithstanding the provisions of this section, no facility shall provide services to minor patients that are intended to change such minor's sexual orientation or gender identity . . ."). States should not follow New York's model, however, regarding prohibiting private parties from including SOCE funding in insurance contracts, as that unjustifiably interferes with freedom of contract. *See* N.Y. COMP. CODES R. & REGS. tit. 11, § 52.16(n)(2) (2016) ("No policy or certificate shall provide coverage for conversion therapy rendered by a mental health professional to an individual under the age of 18 years.").

Connecticut also provides a possible defunding model. *See* 2017 Conn. Acts 17-5, § 4 (Reg. Sess.) (prohibiting public funds from being expended to practice, to provide a referral, or to provide benefits for conversion therapy to minors). Connecticut limits defunding to minors; this Article proposed defunding SOCE for adults as well as a matter of good stewardship.

<sup>187</sup> Because defunding SOCE stems from the lack of scientific evidence of efficacy, as opposed to moral judgments of right or wrong, it is not analogous to defunding Planned Parenthood.

funds from being expended for these futile efforts. Good stewardship requires refusing public reimbursement for SOCE.<sup>188</sup>

Defunding SOCE serves the additional goal of directly decreasing access.<sup>189</sup> Unlike informed consent and consumer protection that primarily deter through education and accountability, defunding should immediately stop at least some SOCE participants. In this regard, defunding is like banning, only substantially broader in its application and somewhat more limited in its restriction of autonomy.<sup>190</sup>

Prohibiting state reimbursement for SOCE also serves the same expressive aims as bans, only more effectively. By refusing to fund SOCE, states warn the public, distance themselves, and de-medicalize SOCE. Implicitly, defunding conveys the message that SOCE are unnecessary and ineffective and that same-sex attraction is not a medical disorder. Defunding also distances states from any SOCE providers. More progressive states may use Opinion Letters or other means, as New York has, to explicitly state that SOCE will not be funded because “homosexuality is not considered a medical condition that requires treatment.”<sup>191</sup> However, even if states refuse to explicitly recognize that same-sex attraction is within normal variants of human sexuality, eliminating state funding of SOCE would decrease access, free state healthcare funds for more effective healthcare services, and serve an expressive purpose.<sup>192</sup>

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<sup>188</sup> Without commenting on the relative merits (and potential costs) of such restriction, the ban on federal funding for sterilization of an individual below the age of twenty-one is akin to my recommendation that states refuse to fund SOCE. Both allow individual autonomy, while stewarding resources based on legitimate, historically based concerns of abuse and healthcare priorities.

<sup>189</sup> While decreasing access to care based on ability to pay might be problematic for effective, high quality care, it does not pose the same concerns with regard to SOCE. Justice allows, and arguably requires, that limited public funds be saved for more beneficial care.

<sup>190</sup> Through bans, legislatures usurp individual autonomy. While defunding also decreases access, it leaves some modicum of individual choice for those who can find a way to pay. Defunding represents an appropriate exercise of legislative authority; states can and should determine appropriate use of state funds. In contrast, bans signal state interference with autonomous, informed healthcare decision-making that should generally be left to individuals and their care providers.

<sup>191</sup> N.Y. St. Dep’t. of Health, *supra* note 45; *see also* Knauer, *supra* note 80; Stein, *supra* note 80.

<sup>192</sup> *See The Lies and Dangers of Efforts to Change Sexual Orientation or Gender Identity*, *supra* note 19 (quoting positions of fifteen leading professional organizations); *see also Position Statement on Gender Identity and Same-sex Orientation, Attraction, and Behaviors*, WORLD PSYCHIATRIC ASS’N (Mar. 2016), [http://www.wpanet.org/detail.php?section\\_id=7&content\\_id=1807](http://www.wpanet.org/detail.php?section_id=7&content_id=1807); *Being Gay is Just as Healthy as Being Straight*, AM. PSYCHOL. ASS’N (May 28, 2003), <http://www.apa.org/research/action/gay.aspx>.



V. CONCLUSION: CONSUMER PROTECTION LITIGATION AND ENHANCED INFORMED CONSENT, RATHER THAN LEGISLATIVE BANS, SHOULD BE EMPHASIZED TO COMBAT ABUSES ASSOCIATED WITH SOCE

Many states have recently or will soon address the best health policy response to SOCE. Several states (and even more cities) have responded to SOCE concerns by prohibiting licensed health professionals from providing SOCE to minors.<sup>193</sup> Non-profits have focused on asserting consumer protection claims against both licensed and unlicensed SOCE providers who deceive potential participants regarding the appropriateness and efficacy of SOCE.<sup>194</sup> These approaches have similar goals and are not inconsistent, but each has consequences for larger health policy and for social norms regarding sexual minorities.

This Article argues that the potential benefit of health provider bans, delay or deterrence of SOCE for some minors and expressive condemnation, can also be realized through other means that pose less risk to SOCE participants and to autonomy in healthcare decision-making. By focusing on enhanced informed consent, increased consumer protection accountability, and defunding SOCE, states avoid undermining the mature minor doctrine and potentially sending SOCE participants to unmonitored, untrained, less-accountable providers. Moreover, these tools provide a much broader remedy. They offer a potential solution to adults as well as to minors and promise to hold both healthcare and non-healthcare providers accountable. Further, this approach presents an immediate avenue of relief for minors in states that have not yet, or will not, pass SOCE health provider bans. For these reasons, states and human rights activists should emphasize robust informed consent, consumer protection accountability, and defunding in the fight against SOCE abuses.

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<sup>193</sup> See, e.g., OR. REV. STAT. § 675.850 (2016).

<sup>194</sup> *FTC Complaint*, *supra* at 57, at 9–36.