Repairing the Therapist? Banning Reparative Therapy for LGB Minors

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suggest erring on the side of accurate information at the cost of immedi-
ate, strict enforcement of the letter of the law to bolster better evidence-
based decisions in the future. Fortunately (at least in this context),
administrative agencies are afforded tremendous discretion in their
enforcement policies, especially when enforcement involves a complicated
balancing of a number of factors that are peculiarly within the agency’s
expertise.\textsuperscript{141} Given the complexity of the legal framework here, the
informational limits of scientific evidence and diagnostic coding, the
vulnerability of the patient populations insured under Medicare and
Medicaid, and the opportunities to improve both individual patient
safety and public health tied up in this enforcement policy, it seems
unlikely that any federal court would compel CMS to apply the strict
letter of the coverage laws.

Accordingly, in order to better control federal health care costs and
improve public health in the long-term (possible only through collection
and use of accurate information), CMS should make inclusion of an ICD-
10-CM diagnostic code a condition of payment for all Medicare Part D
and Medicaid claims for outpatient prescription drugs but suspend strict
enforcement of the coverage laws unless there is widespread consensus in
the medical community that a particular treatment is always ineffective
or harmful. The alternatives are unsatisfying: either a continuation of
the status quo—essentially unchecked federal spending on prescription
drugs that further threatens the fiscal stability of the Medicare and
Medicaid programs, exacerbated by poorly understood prescription drug
use in vulnerable populations— or worse.

While the inclusion of ICD-10-CM codes on outpatient prescriptions
may be a simple proposal with significant potential for improving public
health and patient safety, it is neither an easy nor inexpensive one. It
would be a tremendous disservice to patients, taxpayers, health care
providers, researchers, and policymakers alike to implement the proposal
solely as a means of reducing federal health care spending on off-label
prescriptions. With strict enforcement of the coverage laws and the
accompanying systemic incentives to miscode created by widespread
coverage denials, we could easily end up with the worst of all options—a
significant investment of time and money in a claims database corrupted
by inaccurate information that neither meaningfully polices federal
health care spending nor provides sufficiently robust data for improved
practice of pharmacy, drug safety surveillance, or comparative effective-
ness research. Let us hope it does not come to that.

\textsuperscript{141} See generally Heckler v. Chaney, 470 U.S. 821, 831 (1985) (“[A]n agency’s
decision not to prosecute or enforce, whether through civil or criminal
process, is a decision generally committed to an agency’s absolute
discretion.”).
INTRODUCTION

Mercy House is a Christian treatment facility where they deal with everything from drug abuse, to alcoholism, to de-gayification and unwed mothers... Mercy House doesn’t really exist for the people who get sent there. It exists more for the people who do the sending.

In the film Saved!, Dean, a teenaged boy, is sent to Mercy House, a residential faith-based counseling facility, by his fundamentalist Christian parents after they discover that he is gay. Dean’s parents expect that Mercy House will “cure” Dean’s same-sex attractions. In the end, Dean meets a boyfriend at Mercy House and emerges from the experience “uncured” but with a happy, healthy acceptance of his same-sex attractions.

Saved! provides a fictional depiction of sexual orientation change efforts (SOCE), also known as reparative therapy or conversion therapy, designed “to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.” Mercy House has numerous real-life counterparts that provide SOCE through residential3 and outpatient4 counseling programs, retreats,5 and camps.6

SOCE is a widely debated practice. Many believe that SOCE is ineffective and unnecessary—the stuff of satirical movies like Saved! SOCE’s opponents believe that many recipients of the therapy do not emerge happy and healthy like Saved!’s Dean but rather suffer emotional harm from the therapy.7 On the other side, SOCE’s proponents continue to believe that it is a valid treatment option for individuals with unwanted same-sex attractions. In 1999, University of Southern California professor David Cruz published a groundbreaking law review article addressing the legal and policy issues raised by the “noisy national debate” on SOCE.8 Fifteen years after Cruz’s article, the national debate about SOCE and the acceptance of same-sex relationships in general is as noisy as ever: state bans on SOCE for minors have been passed in California9 and New Jersey,10 several lawsuits challenging these bans made headlines, and popular opinion of same-sex marriage and lesbian, gay, and bisexual (LGB) individuals’ rights has shifted tremendously.

On September 30, 2012, California Governor Jerry Brown signed SB 1172, a law that requires state licensing agencies to discipline licensed mental health professionals who provide SOCE to LGB minors.11 New Jersey passed a similar law months later,12 and in several other states bills banning SOCE are pending.13 Just weeks after California’s Governor Brown signed SB 1172 into law, the Southern Poverty Law Center filed an administrative complaint against a social worker in Illinois who provides SOCE.14 Additionally, on November 27, 2012 the Southern Poverty Law Center filed a lawsuit on behalf of plaintiffs who allege that SOCE practitioners caused them economic and emotional harm.15

SOCE providers and parents seeking SOCE for their children promptly filed lawsuits challenging California and New Jersey’s bans on multiple grounds.16 These lawsuits allege violations of the First Amendment

1. SAVED! (United Artists 2004).
5. Id.
7. See, e.g., Sanchez, supra note 3.
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ment's guarantees of free speech and free exercise of religion and parents' fundamental liberty interest in raising their children as they see fit. California's SB 1172 was challenged on constitutional grounds nearly immediately upon its enactment despite the non-partisan California Legislative Counsel Bureau's assurance to Governor Brown that the bill was constitutional. 17

In light of these significant developments in the debate about SOCE, this Note will argue that while SOCE should be eradicated, a ban like California's SB 1172 could have negative consequences for LGB youth and set a dangerous precedent of legislating health care regulations that are not founded in credible scientific research. Instead, the LGB advocacy movement should advance its campaign to eliminate SOCE by pursuing statutory informed consent requirements.

Part I will outline the history and current status of SOCE. Part II will explain how SB 1172 is a novel approach to curtailing the practice of SOCE. Parts III through V will explore the constitutional implications of an SB 1172-style ban on SOCE, particularly as they relate to the free exercise of religion, freedom of speech, and parents' freedom to raise their children as they see fit. Part VI will argue that a ban on SOCE will have unintended consequences for LGB youth and the progressive movement. Finally, Part VII will propose informed consent requirements for licensed mental health providers as an alternative strategy for hastening the eradication of SOCE.

I. REPARATIVE THERAPY: ALIVE AND (UN)WELL

A. The History of SOCE

Sexual orientation change efforts, also known as reparative or conversion therapy, are typically provided to individuals who experience unwanted same-sex sexual attractions. For those who believe that sexual orientation is an immutuable characteristic or that homosexuality is a natural variant of human sexuality, the concept of “unwanted” same-sex attractions is difficult to understand. However, there are a number of reasons why an individual may not “want” to be attracted to members of the same sex. These reasons include: a deep religious conviction that homosexuality is wrong; a belief that homosexuality is a diagnosable illness or disorder; a belief that same-sex attractions stem from flawed parental relationships or prior sexual abuse; fear of familial and commu-

20. Id. at 31.
23. GLASSGOLD ET AL., supra note 19, at 21.
24. Id. at 11.
25. GLASSGOLD ET AL., supra note 19, at 23.
26. Id.
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SOCE focuses on “efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.”18 SOCE is usually provided by a licensed mental health provider (LMHP), a non-licensed counselor, or a clergy member.19 Therapy may include individual counseling sessions, group therapy, and, in faith-based settings, prayer and scriptural study.20 Historically, reparative therapy utilized physically invasive techniques such as electroshock therapy, hormone therapy, and surgery.21 While these techniques have largely been rejected even by proponents of reparative therapy, it is worth noting that one of the three named plaintiffs in the Pacific Justice Institute’s challenge to California’s SB 1172 does in fact prescribe pharmaceuticals “to help control sex drive” as a part of SOCE.22

SOCE originated during the mid-nineteenth century in conjunction with increasing social, political, and legal stigmatization of homosexual and gender non-conforming behavior.23 In the mid-twentieth century, Alfred Kinsey and other researchers and psychotherapists demonstrated that same-sex attractions were more common than previously thought. This research ushered in a paradigm shift among LMHP who began describing homosexuality as a normal variant of human sexuality rather than a clinical diagnosis.24

With this paradigm shift came considerable professional condemnation of SOCE. In 1972, the American Psychiatric Association removed homosexuality from its Diagnostic and Statistical Manual used for diagnosing mental disorders.25 The next year the American Psychological Association passed a resolution affirming this decision.26 Most major mental health professional organizations support the position that same-sex attraction and behavior is a normal variant of human sexuality that


20. Id. at 31.


23. GLASSGOLD ET AL., supra note 19, at 21.

24. Id. at 21.

25. GLASSGOLD ET AL., supra note 19, at 23

26. Id.
should be supported rather than treated as an illness. In more recent years, numerous mental health professional organizations have issued declarations and position statements asserting that SOCE is ineffective, unethical, and even harmful to patients.

The very premise of SOCE—that same-sex attractions ought to be and can be reduced or eradicated—derives from the now mainstream ideas that same-sex attractions are a normal variant of human sexuality and that individuals should not want to and probably cannot change their sexual orientation. As stated in the legislative findings of SB 1172, being gay, lesbian, or bisexual is not a “disease, disorder, illness, deficiency, or shortcoming.” While many people know this intuitively, the positions of nearly every major mental health professional organization and the removal of homosexuality from the Diagnostic and Statistical Manual evidence the widespread professional and scientific acceptance of this notion. However, while the argument about whether homosexuality is an illness is nearly history, the moral argument about homosexuality is alive and well and drives the SOCE industry.

Notwithstanding nearly every major mental health professional organization’s condemnation of SOCE, some LMHP continue to provide reparative therapy. One of the primary organizational proponents of reparative therapy is the National Association for Research and Therapy of Homosexuality (NARTH).

According to its mission statement, NARTH is a multi-disciplinary professional and scientific organization dedicated to the service of persons who experience unwanted homosexual (same-sex) attractions. NARTH’s website goes on to claim that its members and allies include “practitioners, scholars, and researchers from many fields of the mental health and medical arts and sciences, as well as educational, pastoral, legal, and other community leaders and laypersons who are united in this shared organizational commitment.” NARTH’s faith-based counterpart was Exodus International, a Christian organization that promoted SOCE. In June 2013, Exodus International closed its doors. The organization’s head, Alan Chambers, issued a final, formal apology to the LGBT community for “years of undue suffering and judgment at the hands of the organization and the Church as a whole.” At one time Exodus International had over 260 member ministries, many of which will continue under autonomous leadership even though Exodus International has dissolved.

It is worth noting that many LGBT individuals accept that they cannot change their sexual orientation but choose to live celibately. This choice is common among some Christian LGBT people who believe that same-sex relationships are incompatible with Christian teaching. For example, the Gay Christian Network (GCN), an online community of over 20,000 individuals who are LGBT, transgender, or heterosexual allies, supports “Side A” individuals who affirm same-sex relationships and sexual expressions as well as “Side B” individuals who accept the immutability of sexual orientation but live celibately rather than engaging in sexual relations with members of the same sex.

While celibacy is not typically considered in the dialogue about SOCE, it merits consideration. Choosing to live celibately is arguably an “effort to change behaviors” within SB 1172’s definition of SOCE. While these individuals do not seek counseling to “cure” their homosexuality, they may seek counseling that affirms their choice of celibacy. Thus, efforts to regulate and eradicate conventional reparative therapy may, intentionally or not, also limit counseling services for individuals who choose to be celibate. Despite the increasing societal acceptance of same-sex attraction as a normal, healthy variant of human sexuality, a significant number of individuals—“Side B” people included—still believe that SOCE is necessary to treat same-sex attractions that they believe are pathological, immoral, or simply undesirable.

27. GLASSGOE ET AL., supra note 19, at 1.
29. Id.
30. Id.
33. Id.
35. Id.
36. Id.
38. Steffan, supra note 34.
40. What is GCN?, supra note 39.
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\(^{27}\) GLASSGOO ET AL., supra note 19, id. 1.


\(^{29}\) Id.

\(^{30}\) Id.

\(^{31}\) Id.

\(^{32}\) Id.

\(^{33}\) Id.

\(^{34}\) Id.

\(^{35}\) Id.

\(^{36}\) Id.


\(^{38}\) Id., supra note 34.


\(^{40}\) What is GCN?, supra note 39.

B. The Dearth of Scientific Research on SOCE

Evidence of SOCE’s harms is varied and inconsistent. The anti-SOCE advocacy organization Truth Wins Out features a number of testimonials from former SOCE participants who claim to have experienced psychological harm as a result of the treatment. Similar anecdotes from other “ex-ex-gays” have been published in a number of media outlets. The American Psychological Association Task Force noted that a number of mid-twentieth century studies on reparative therapy reported negative effects or harm experienced by participants as well as high dropout rates that could be an indicator of harm.42

There are recent studies that indicate that some SOCE patients perceived harmful effects as a result of SOCE.43 These self-reported harms included anger, depression, suicidal ideation, and sexual dysfunction.44 However, LGB individuals are already predisposed to some of these symptoms, including suicidal ideations and depression.45 Thus, in order to demonstrate the SOCE causes harm rather than attracts individuals who are predisposed to certain mental health problems, there must be specific evidence that SOCE caused or amplified mental problems rather than evidence of the presence of those symptoms generally.46 The APA Task Force concluded that due to the absence of scientifically adequate studies on SOCE, no causal connection could be drawn between SOCE and specific harms or benefits.47 Notably, the statistics cited in the legislative findings of SB 1172 relate only to serious health risks faced

by LGB youth who experience rejection from their families, not health risks related to reparative therapy.48 This is likely because of the lack of concrete scientific evidence that SOCE causes mental health problems rather than statistically correlates with mental health problems that LGB individuals are already more likely than heterosexuals to experience. Whether SOCE is harmful is a determining factor as to whether a state has a legitimate interest in regulating the practice. A statute must be in furtherance of a legitimate state interest in order to survive several kinds of constitutional challenges.49 SOCE proponents argue that scientific evidence of SOCE’s harmfulness is not conclusive enough to establish a legitimate state interest in protecting LGB youth. These proponents cite testimonial evidence, such as the personal statements of “ex-gays,” as evidence of the effectiveness and benefits of SOCE.50 Defenders of SOCE argue that even if sexual orientation is immutable, individuals should have the option to try to alter their behavior through SOCE if they choose to do so as long as such behavior alterations do not pose a scientifically established public health risk. Proponents may analogize SOCE to a number of elective procedures that are not required to treat an illness but are wholly optional such as cosmetic surgery.51 While such procedures are not medically necessary, they are available to patients who choose to have them because they have not been proven medically harmful.52

44. GLASGOLD ET AL., supra note 19, at 41-42.
45. Id. at 42.
46. Id.; supra note 19, at 41-42.
49. GLASGOLD ET AL., supra note 19, at 42.
50. The legislative findings in S.B. 1172 state: “Minors who experience family rejection based on their sexual orientation face especially serious health risks. In one study, lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 4.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection.” S.B. 1172, 2011-2012 Reg. Sess. (Cal. 2012).
51. Id.
52. See, e.g., Prince v. Massachusetts, 321 U.S. 158, 166 (1944); Conant v. Walker, 309 F.3d 629, 639 (9th Cir. 2002).
55. See Cruz, supra note 6, at 1305.
56. Professor David Cruz notes that while some LMBHs who provide SOCE do believe that SOCE is medically necessary, other LMBHs believe that SOCE is simply a valid elective treatment choice. Cruz, however, acknowledges that this framework of providing SOCE as an elective treatment is still problematic for the larger LGB equality movement because it affirms the individual’s belief that being LGB is wrong or harmful. Id.
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35. See supra note 19, at 41-42.


37. See also The Ex-Gay Survivor’s Survey Results, BEYONDEXGAY (2013), http://www.beyondexgay.com/survey/results.html.

38. See supra note 8, at 1305.

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demned SOCE, the therapy remains sought after. Unfortunately, there is
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individuals and merits government intervention. This lack of scientific
research has given rise to legal challenges to bans on SOCE and should
provoke SOCE’s opponents to encourage and facilitate research about
SOCE’s harmfulness.

II. SB 1172: A NOVEL APPROACH

Legal scholars have proposed a number of legislative and litigation
tactics for limiting or eradicating reparative therapy. Some scholars have
supported initiating child abuse and neglect proceedings against parents
who subject their minor children to reparative therapy. Other scholars
have focused on tort-based causes of action against practitioners who
falsely obtain informed consent for reparative therapy. Similarly, other
proposals examine tort remedies for professional malpractice and
negligent or intentional infliction of emotional distress. The original
version of SB 1172 incorporated several of these proposed remedies by
banning SOCE for minors under eighteen and creating a cause of action
for adult plaintiffs who claim injury as a result of SOCE that was
provided without informed consent or by means of therapeutic decep­
tion. The cause of action for adult plaintiffs was later removed from the
bill during Senate debate. SB 1172 was crafted in the context of the battle over California’s
Proposition 8 ballot measure to amend the state’s constitution to define
marriage as between a man and a woman. During the ballot initiative
campaign and subsequent litigation, proponents of Proposition 8 spewed
rhetoric regarding the alleged immorality of homosexuality. SB 1172 also grew out of a widely publicized rash of LGB teen suicides in 2010.68


Another catalyst for SB 1172 was psychiatrist Dr. Robert Spitzer’s
public repudiation of his study that purportedly proved that SOCE
could successfully change some individuals’ sexual orientations.65 In April
2012, the same month in which the California State Assembly first
considered a regulation of SOCE, Spitzer retracted the study because of
methodological flaws.66

SB 1172’s mandate that state professional licensing agencies disci­
pline LMHP who provide SOCE to minors emerged as a novel approach to
limiting the practice of reparative therapy. States rarely legislate
restrictions on psychotherapy treatments. For example, lobotomy, a
procedure that involves actually cutting parts of the brain in order to
change behavior, and which is nearly universally rejected by practition­
ers, has never been officially outlawed in any state.67 Electroshock
therapy, which has been the subject of great controversy, is still legal
and used in some cases.68 Even rebirthing therapy, a highly criticized
treatment “designed to simulate the birth process”69 through breathing
e exerceses and spatial constraints has only been outlawed by Colorado
and North Carolina.70 LMHP who provide controversial and harmful
treatments are generally regulated by tort law and state licensing
boards. SB 1172 and its copypasts are a rarely seen attempt to regulate
directly a controversial and largely discredited psychotherapeutic
practice through a statutory ban.

Unsurprisingly given its novelty, SB 1172 was challenged nearly im­
mmediately upon enactment. On October 2, 2012 the Pacific Justice
Institute (“PJI”) filed a complaint in the U.S. District Court for the
Eastern District of California challenging SB 1172 on constitutional
grounds.71 PJI’s plaintiffs include a family therapist, a psychiatrist, and a


64. Eckholm, supra note 4.
Times (May 18, 2012), http://www.nytimes.com/2012/05/19/health/dr-robert-spitzer-noted-psychiatrist-apologizes-for-study-on-gay­
cure.html?pagewanted=all.
67. See id.
68. Deborah Joesnond, Rebirthing Therapy Banned after Girl Died in 70
69. Ferguson, supra note 66.
While the professional mental health community has widely condemned SOCE, the therapy remains sought after. Unfortunately, there is a dearth of scientific research demonstrating that SOCE harms LGB individuals and merits government intervention. This lack of scientific research has given rise to legal challenges to bans on SOCE and should provoke SOCE’s opponents to encourage and facilitate research about SOCE’s harmfulness.

II. SB 1172: A NOVEL APPROACH

Legal scholars have proposed a number of legislative and litigation tactics for limiting or eradicating reparative therapy. Some scholars have supported initiating child abuse and neglect proceedings against parents who subject their minor children to reparative therapy. Other scholars have focused on tort-based causes of action against practitioners who falsely obtain informed consent for reparative therapy. Similarly, other proposals examine tort remedies for professional malpractice and negligent or intentional infliction of emotional distress. The original version of SB 1172 incorporated several of these proposed remedies by banning SOCE for minors under eighteen and creating a cause of action for adult plaintiffs who claim injury as a result of SOCE that was provided without informed consent or by means of therapeutic deception. The cause of action for adult plaintiffs was later removed from the bill during Senate debates.

SB 1172 was crafted in the context of the battle over California’s Proposition 8 ballot measure to amend the state’s constitution to define marriage as between a man and a woman. During the ballot initiative campaign and subsequent litigation, proponents of Proposition 8 espoused rhetoric regarding the alleged immorality of homosexuality. SB 1172 also grew out of a widely publicized rash of LGB teen suicides in 2010.

man studying to become an SOCE therapist who claims to have successfully undergone SOCE himself. 71 PFI’s lawsuit alleged that SB 1172 would violate plaintiffs’ constitutional rights to privacy, free speech, free exercise of religion, associational rights, and parents’ fundamental right to raise their children as they see fit. Plaintiffs also alleged that SB 1172 would violate the First Amendment’s Establishment Clause and was unconstitutionally vague and overbroad. The Liberty Council, another legal defense organization, also filed a challenge to SB 1172 on behalf of plaintiffs including NARTH, the American Association for Christian Counselors, individual counselors (such as SOCE “guru” Joseph Nicolosi), parents, and children. 72 The Liberty Council’s suit alleged that SB 1172 would violate plaintiffs’ First Amendment free speech and free exercise of religion rights and parental rights under the First and Fourteenth Amendments in addition to analogous state law claims. 73 Two different judges in the U.S. District Court for the Eastern District of California heard the PJI and Liberty Counsel motions for preliminary injunction and issued divergent rulings. Judge William Shubb granted PJI’s motion for a preliminary injunction limited to the three named plaintiffs. 74 Judge Shubb found that the plaintiffs were likely to succeed on the merits of their First Amendment free speech claims. 75 In contrast, Judge Kimberly Mueller denied Liberty Counsel’s motion for a preliminary injunction, finding that the plaintiffs were not likely to succeed on the merits of any of their claims. 76 Liberty Counsel appealed Judge Mueller’s decision to the Ninth Circuit Court and filed an emergency motion for temporary injunction pending appeal. On December 21, 2012, the Ninth Circuit granted the emergency motion for temporary injunction, staying SB 1172’s January 1, 2013 enactment until the appeal could be heard. 77 Also, California appealed the order granting preliminary injunction in the PJI case. 78 The Ninth Circuit consolidated the two cases and upheld the law. 79

73. Id. at 36-46.
75. Id. at 1121.

III. FREE EXERCISE CLAUSE CHALLENGES

Given the large portion of SOCE providers and recipients who are affiliated with faith communities that believe that homosexuality is immoral and incompatible with their religious tenets, both supporters and opponents of SOCE should consider the merits of a Free Exercise Clause challenge to a ban on SOCE. In fact, both lawsuits challenging SB 1172 alleged that the law would violate the Free Exercise Clause of the First Amendment, but neither District Court judge considered the free exercise claims in ruling on the plaintiffs’ motions for preliminary injunction.

In a Free Exercise Clause challenge, a federal court would apply the Employment Division Department of Human Resources of Oregon v. Smith standard. Under Smith, in order to survive a Free Exercise Clause challenge a statute must be (1) neutral and generally applicable and (2) supported by a legitimate government interest. 80 In Church of the Lukumi Babalu Aye v. City of Hialeah, a set of city ordinances targeted the Santeria practice of ritual animal slaughter while exempting other forms of animal slaughter. 81 There, the Court clarified the Smith standard, holding that strict scrutiny judicial review is triggered when a law is either not neutral or not generally applicable. 82 Under strict scrutiny, the state must demonstrate that it has a compelling interest that justifies burdening religious expression and that the burden is narrowly tailored to serve that interest. 83 Before examining an SOCE ban under the Court’s free exercise standards, it should be noted that there is some question as to whether strict scrutiny could apply under a hybrid situation theory in which plaintiffs allege a violation of a fundamental right or liberty in addition to their free exercise claim. 84 For example, a law that implicates both First Amendment religious liberty and the liberty of parents to direct the upbringing of their children, such as limiting the choice between

83. Id. at 521.
84. Id.
85. Smith, 494 U.S. at 881.
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private and public schools, might trigger heightened scrutiny under this theory. In fact, Smith specifically mentions the rights of parents, which are involved in both P.J.I and the Liberty Counsel’s challenges to SB 1172, as a possible ground for a hybrid claim that would necessitate strict scrutiny. However, no circuit court has applied strict scrutiny to a hybrid claim in a published opinion.

A. Neutrality and General Applicability

Under the first prong of the Smith standard, a court analyzes whether a law is neutral and generally applicable. While neutrality and general applicability are two distinct requirements, “failure to satisfy one requirement is a likely indication that the other has not been satisfied.” In determining whether a statute is neutral, a court must look both for the facially obvious intent of the law and for any “discriminatory intent of legislators.” A law is not neutral when it targets particular religious beliefs. In determining whether a statute is generally applicable, a court must examine the “design, construction, or enforcement of a law.” A law is not generally applicable when its enforcement imposes burdens “only on conduct motivated by religious belief.” Considering the factors outlined in Lukumi, a ban on SOCE would be neutral and generally applicable. The first factor addresses whether the language of the law reflects intent to suppress a central element of a particular religion. If the statute reflects intent to suppress, it may not be neutral or generally applicable. SB 1172, however, contains no religious language or explicit acknowledgment of the close tie between SOCE and religions that believe same-sex relationships are sinful.

Opponents of a ban on SOCE argue that individuals almost exclusively seek reparative therapy for religious reasons, and thus even without explicit intent to suppress a particular religion, such a ban is not neutral and generally applicable because it inherently targets religious individuals.

However, Lukumi leaves unsettled whether it is appropriate to consider a legislature’s subjective intent in determining neutrality if the text of the statute contains no indication of such intent. Justice Scalia, who concurred in the judgment, did not agree with the majority’s examination of the subjective intent of the City of Hialeah legislature, noting that the Supreme Court has a long tradition of “refraining from such inquiries” because it is “virtually impossible to determine the singular motive of a collective legislative body.” Additionally, courts generally are reluctant to engage in “acts of legislative mind reading” to determine the subjective intent or rationale of a legislature.

The second factor in Lukumi addresses whether a ban on SOCE is “gerrymandered,” or specially crafted, to prohibit only religiously motivated reparative therapy. If the ban is gerrymandered, it may not be neutral or generally applicable. Considering Lukumi, SB 1172’s provisions do not appear to be “gerrymandered” to prohibit only religiously motivated SOCE because they also apply to non-religiously motivated SOCE. Though religiously motivated SOCE overwhelmingly dominates the practice, there are providers and clients who engage in the therapy for reasons other than religious ones. SB 1172 would affect these individuals in the same way as religiously motivated providers and clients.

The third factor in Lukumi addresses whether a ban on SOCE “pursues the [state’s] governmental interests only against conduct motivated by religious belief.” If so, then the ban is not neutral and generally applicable. Religious adherents bear the heaviest burden of a ban on reparative therapy since they make up the vast majority of individuals seeking and providing the therapy. But unlike the statute in Lukumi, a

97. GLASSGOLD ET AL., supra note 19, at 25.
98. Church of Lukumi, 508 U.S. at 558 (Scalia, J. concurring in part, concurring in the judgment).
99. Id.
101. Church of Lukumi, 508 U.S. at 521.
102. See Cruz, supra note 8, at 1325 (citing Joseph Nicolosi’s secular rationale for supporting SOCE).
103. Church of Lukumi, 508 U.S. at 545.
104. Id.
105. See GLASSGOLD ET AL., supra note 19, at 24; The Ex-Gay Survivor’s Survey Results: Conclusion, BeyondExGay (2013), http://www.beyondexgay.com/survey/results/conclusion.html (reporting that in a survey of over 400 former SOCE participants, only five were atheist at the time they sought SOCE).
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96. Kaplan, supra note 68, at 1077.
97. Id. at 511.
98. Id.
99. Id.
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101. Church of Lukumi, 508 U.S. at 545.
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113. A ban like SB 1172 regulates both religiously and non-religiously motivated activity. And in Stormans, Inc. v. Selecky, a free exercise challenge to the Washington State Board of Pharmacy’s role denying pharmacies the right to conscientiously object to providing certain FDA-approved drugs, particularly “Plan B” contraception, the court held that “[t]he Free Exercise Clause is not violated even though a group motivated by religious reasons may be more likely to engage in the prescribed conduct.” By analogy, a ban on SOCE like SB 1172 would not be constitutionally impermissible even though individuals who are motivated by religious reasons are more likely to seek and provide SOCE.

B. Legitimate State Interest

The second prong of the Smith analysis, determining whether the state is pursuing a legitimate interest with its law, is also critical to determining a ban on SOCE’s compliance with the Free Exercise Clause. First, a state’s interest in regulating SOCE is enhanced when the state is regulating the provision of SOCE to minors. Any harms of SOCE are compounded by the emotional and legal vulnerability of minors. States have a duty as parens patriae to protect the health and well being of minors. Just as a state has the authority to compel lifesaving blood transfusions and impose child labor laws, it should have the authority to prohibit LMHP from providing SOCE to minors if it determines that SOCE is harmful.

Second, and less clear, is the issue of whether SOCE is harmful. There are few examples of cases in which a court has recognized the harms of SOCE. The most notable example is Pitscherminis v. INS, an asylum case in which the Ninth Circuit recognized SOCE as “persecution.” Notably, the case involved a petitioner who was involuntarily subjected to reparative therapy by Russian government officials, a context which is quite different from SOCE in the United States.114

There is no specific quantum of scientific evidence that a legislature must produce in order to establish that a particular regulation is necessary. As to the legislative findings in SB 1172, unfortunately, the California General Assembly did not make a strong case for why SOCE is harmful. In the legislative findings of SB 1172, California cited a number of statistics demonstrating that LGB youth have disproportionately higher rates of depression and suicide. The legislative findings acknowledge the stigma and familial rejection faced by many LGB youth. The statute implicitly concludes that treating same-sex attraction as an illness or a moral wrong to be corrected must logically increase the stigma and depression experienced by LGB youth. SB 1172’s legislative findings do not cite any scientific studies as evidence of this correlation.

Nevertheless, even though the scientific evidence of the harmfulness of SOCE is sparse, a ban on SOCE “would still be a valid legislative enactment.” A ban on SOCE is “not subject to courtroom fact-finding and may be based on rational speculation unsupported by evidence or empirical data.” Thus, insufficient scientific evidence is not enough to make a ban on SOCE fail under the legitimate interest prong of the Smith test. A state can claim a legitimate interest in eradicating an unnecessary practice and in reducing the societal oppression and stigma experience by LGB individuals.

Under a Free Exercise Clause analysis, a ban on SOCE similar to SB 1172 would be both neutral and generally applicable, satisfying first prong of the Smith test. Furthermore, there is enough scientific evidence to show that SOCE is harmful, giving the state a legitimate interest to intervene on behalf of minors. Since a ban like SB 1172 would satisfy both prongs of the Smith test, it would not violate the First Amendment’s Free Exercise Clause.

106. Stormans, Inc. v. Selecky, 586 F.3d 1199, 1116-17 (9th Cir. 2009).

107. Stormans, 586 F.3d at 1131 (citing Reynolds v. U.S., 98 U.S. 145, 166-67 (1878)).

108. The state as parens patriae may “act to guard the general interest in youth’s well being” by restricting “the parent’s control.” Prince v. Massachusetts, 321 U.S. 158, 166 (1944).


111. Prince, 321 U.S. at 176 (holding that child labor laws apply to the employment of children for religious proselytization).

112. See supra Part I.B.

113. Pitscherminis v. INS, 118 F.3d 641, 648 (9th Cir. 1997).

114. Id. at 644-45.


116. Id.

117. Id.

118. Id.

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117. Id.
IV. PARENTS' RIGHT TO RAISE THEIR CHILDREN AS THEY SEE FIT

Parents have a fundamental liberty interest in raising their children as they see fit. Courts balance this interest against the state's parens patriae interest in protecting the health and well-being of children. Parents' religiously motivated choices of how to raise their children have been outweighed by the state's parens patriae interest in cases involving religious practices that violate child labor laws and religious beliefs that prevent children from receiving lifesaving blood transfusions. Principally, the Court held in Prince v. Commonwealth of Massachusetts that "[t]he right to practice religion freely does not include liberty to expose . . . the child . . . to ill health or death." Parents in both the Liberty Counsel and the PIJ lawsuits have alleged that SB 1172 would violate their fundamental right to raise their children as they see fit. If a legislature determines, as the California General Assembly did, that SOCE is harmful to children, it is permitted to regulate SOCE in order to protect the health and safety of children. As discussed above, even though the scientific evidence of SOCE's harmfulness is weak, the legislature's determination that SOCE is harmful is not subject to scientific scrutiny or an independent factual inquiry by a court.

Additionally, patients (and parents acting on a child-patient's behalf) do not have a fundamental right to choose a particular medical treatment that is reasonably prohibited by the government. Courts balance this interest against the state's parens patriae interest in protecting the health and well-being of children. Parents' religiously motivated choices of how to raise their children have been outweighed by the state's parens patriae interest in cases involving religious practices that violate child labor laws and religious beliefs that prevent children from receiving lifesaving blood transfusions.

In a parental rights challenge, a ban on SOCE similar to SB 1172 would be subject to a balancing test. Parents' fundamental right to raise their children as they see fit would be weighed against the states' broad power to protect the health and safety of children. Where a state legitimately finds that SOCE poses a danger to children, a ban on SOCE would be analogous to the lifesaving medical treatments and child labor laws that the Supreme Court has held outweigh parents' fundamental right to raise their children as they see fit. Thus, a ban on SOCE similar to SB 1172 would likely survive a challenge based on parents' right to raise their children as they see fit.

V. THE FIRST AMENDMENT'S GUARANTEE OF FREEDOM OF SPEECH

Psychotherapy is a uniquely speech-based service, a trait that will invariably raise free speech concerns whenever a limit is imposed on the practice. In both lawsuits challenging SB 1172, plaintiffs alleged that the statute is an unconstitutional prior restraint on their First Amendment right to speak freely and to receive information. Specifically, LHHF plaintiffs have alleged that the statute presents unconstitutional viewpoint discrimination because it prohibits them from offering SOCE, providing referrals for SOCE, and even discussing SOCE.

120. See, e.g., Meyer v. Nebraska, 262 U.S. 390, 411 (1923) (holding that parents are free to enroll their children in foreign language instruction); Pierce v. Society of Sisters, 268 U.S. 510, 534 (1925) (holding that parents are free to enroll their children in private schools); Wisconsin v. Yoder, 466 U.S. 320, 322 (1984) (holding that Amish parents may withdraw their children from school after the eighth grade for religious reasons).


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Additionally, parents (and patients acting on a child-patient’s behalf) do not have a fundamental right to choose a particular medical treatment. Hospitals and other health care providers may set their own policies regarding medical treatments, whether those treatments are SOCE or other forms of medical intervention. The Ninth Circuit has held that such a right does not exist for cancer patients who desire a treatment that has not been approved by the FDA. If a legislature reasonably bans SOCE, a patient’s parents no longer have the right to choose SOCE as a clinical treatment. Furthermore, as the district court noted in its ruling on the Liberty Counsel’s motion for preliminary injunction of SB 1172, parents may still seek SOCE for their children from unlicensed providers.

In a parental rights challenge, a ban on SOCE similar to SB 1172 would be subject to a balancing test. Parents’ fundamental right to raise their children as they see fit would be weighed against the states’ broad power to protect the health and safety of children. Where a state legitimately finds that SOCE poses a danger to children, a ban on SOCE would be analogous to the lifesaving medical treatments and child labor laws that the Supreme Court has held outweigh parents’ fundamental right to raise their children as they see fit. Thus, a ban on SOCE similar to SB 1172 would likely survive a challenge based on parents’ right to raise their children as they see fit.

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120. See, e.g., Meyer v. Nebraska, 262 U.S. 390, 401 (1923) (holding that parents are free to enroll their children in foreign language instruction); Pierce v. Society of Sisters, 268 U.S. 570, 582 (1925) (holding that parents are free to enroll their children in private schools); Wisconsin v. Yoder, 466 U.S. 302, 312 (1984) (holding that Amish parents may withdraw their children from school after the eighth grade for religious reasons).


129. Carnohan v. United States, 616 F.2d 1120, 1122 (9th Cir. 1980) (per curiam); Rutherford v. United States, 616 F.2d 455, 457 (10th Cir. 1980).


tionality of a ban on SOCE would turn on whether the ban prohibits all discussion of SOCE or simply prohibits the practice of SOCE. Licensed professionals do not automatically lose their free speech rights by virtue of being members of a state-regulated profession. In Rust v. Sullivan, the Supreme Court held that restrictions on a doctors’ free speech might violate the doctor-patient relationship. Furthermore, and critical for the SB 1172 cases pending in the Ninth Circuit, the court in Conant v. Walters struck down a statute that prohibited doctors from discussing medical marijuana with their patients, holding that it was an unconstitutional restriction on doctors’ free speech rights even though prescribing medical marijuana was illegal. However, where speech (or silence) is required to comply with a statute, the First Amendment is not necessarily implicated at all. The Supreme Court held in Giboney v. Empire Storage & Ice Co. that “it has never been deemed an abridgment of freedom of speech or press to make a course of conduct illegal merely because the conduct was in part initiated, evidenced, or carried out by means of language, either spoken, written, or printed.” When speech is an integral part of a treatment, such speech may be regulated just as any other medical or psychotherapeutic treatment could be. In Catholic Charities of Sacramento, Inc. v. Superior Court, a challenged statute required employers who provided group health care to include coverage for prescription contraceptives. Catholic Charities alleged that the requirement violated its free speech rights by requiring “symbolic speech” that affirmed the use of contraceptives, the use of which Catholic Charities condemned. The court held that “compliance with a law regulating health care benefits is not speech.” Even though complying with regulations on mental health services involves speech—or the inability to say a certain thing—compliance itself is not speech, thus it is not protected under the First Amendment. In considering the constitutionality of a statute like SB 1172, a key issue is whether the statute prohibits LMHPs from even discussing SOCE with a patient. Two U.S. District Court judges who addressed challenges to SB 1172 disagreed as to whether SB 1172 prohibits speech about SOCE as well as the practice of it. Judge William Shubb found that SB 1172 barred LMHPs from discussing SOCE and that SB 1172 is unconstitutional in light of Conant. Conversely, in the Liberty Council lawsuit, Judge Kimberly Mueller found that under SB 1172 LMHPs would be allowed to discuss SOCE and even refer clients to SOCE provided by non-LMHPs, and thus, SB 1172 does not violate the First Amendment. Judge Mueller found that “[n]othing in SB 1172 prevents a therapist from mentioning the existence of SOCE, recommending a book on SOCE or recommending SOCE treatment by another unlicensed person such as a religious figure.” The Ninth Circuit agreed with Judge Mueller, concluding that SB 1172 is a “regulation of professional conduct, where the state’s power is great, even though such regulation may have an incidental effect on speech.”

A. A Statute That Does Not Limit LMHPs’ Ability to Discuss SOCE Would Be Constitutional

SB 1172 prohibits LMHPs from “engag[ing]” in SOCE and defines SOCE as “practices.” Judge Mueller found that SB 1172 only limits the practice of SOCE, not discussion of it, and further the statute “does not require affirmation of the patient’s homosexuality.” This interpretation may even leave room for counseling that empowers a patient to choose celibacy in response to her perceived same-sex attractions, though Judge Mueller did not explicitly address this issue since it was not raised by the plaintiffs. To survive a constitutional challenge, a ban on SOCE must be broad enough to allow speech about SOCE. The First Amendment requires that, like the plaintiffs in Conant who were free to share information and even express opinions about medical marijuana, LMHP must be able to discuss and even recommend SOCE.


133. See Thomas v. Collins, 323 U.S. 516, 531 (1945) (holding that “the rights of free speech and a free press are not confined to any field of human interest”).


135. Conant v. Walters, 309 F.3d 629, 639 (9th Cir. 2002).


139. Id. at 88.

140. Id. at 89.
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135. Conant v. Walters, 309 F.3d 699, 699 (9th Cir. 2002).


139. Id. at 88.

140. Id. at 89.


143. Id. at 16.


147. Conant v. Walters, 309 F.3d 629, 632 (9th Cir. 2002).
B. A Statute That Limits LMHPs’ Ability to Discuss SOCE Would Be Unconstitutional

If a ban is found to prohibit LMHPs from discussing SOCE, then a court would find that the ban is not content neutral and examine its constitutionality under strict scrutiny review. Under First Amendment strict scrutiny a statute that curtails speech must be (1) actually necessary to solve (2) an actual problem. The Supreme Court has noted that the chances of a content-based regulation’s surviving strict scrutiny are slim.

1. Actually Necessary

In order for a statute to be actually necessary, “there must be a direct causal link between the restriction imposed and the injury to be prevented.” In Brown v. Entertainment Merchants Association, where California passed a statute restricting minors’ access to violent video games, the Court held that there was insufficient evidence that violent video games cause children to be more aggressive. A ban on SOCE that prohibits LMHPs from discussing SOCE would not survive under Brown. Though there is some evidence that SOCE is unnecessary, there is little reliable evidence of a direct causal link between SOCE and harms experienced by recipients of the therapy. As in Brown, without evidence of this causal link, a ban would not be “actually necessary.”

2. Actual Problem

A statute that restricts speech based on content also must address an actual problem. In U.S. v. Alvarez, a federal statute criminalized individuals who make false claims of receiving military honors. The Court found no actual problem where the government could point to no evidence that false claims of military honors diluted public opinion of those honors. Here, again, the weak scientific evidence of SOCE’S harms may make it difficult for proponents of a ban on SOCE to establish its constitutionality. However, proponents of a ban might be able to demonstrate an actual problem by arguing that LGB individuals are receiving unnecessary treatment—an assertion that has more scientific support. Nevertheless, without establishing a clear causal link to satisfy the “actually necessary” prong, a ban on SOCE that prohibits LMHPs from even discussing SOCE would not survive First Amendment strict scrutiny review.

VI. UNINTENDED CONSEQUENCES OF A BAN ON SOCE

A statutory ban on SOCE may be constitutional but that does not mean it is the best policy for addressing the problem of SOCE. For the many LGB individuals and their allies who know in their guts that same-sex attraction is not a disorder or illness to be cured, passing state-level bans on SOCE may seem like the quickest, most direct method for eradicating the problem. However, such a ban can have negative consequences. First, a ban on SOCE provided by LMHPs could force LGB youth who will still be subjected to SOCE despite the ban into the shadows of unlicensed mental health care and faith-based counseling. Second, encouraging legislators to rely on inconclusive and inconsistent scientific research may have unintended consequences for other progressive causes, such as women’s reproductive rights.

A. The Shadows of Unregulated SOCE

Even after a statutory ban on SOCE, individuals will still choose SOCE. In the counseling context, an individual’s religious beliefs deserve the same respect as his or her sexual orientation. Many individuals would reasonably choose their religious beliefs over conflicting sexual orientation. Bans on SOCE like SB 1172 will not eradicate reparative therapy; they will only de-professionalize it by driving these individuals to non-LMHP SOCE providers.

Reparative therapy is often inextricably intertwined with faith-based support groups, clergy, and pastoral counselors. Bans on professionally provided reparative therapy may lead individuals to seek counseling services exclusively from non-licensed pastoral counselors or clergy. With practitioners who are “not trained to handle concomitant mental health problems” providing mental health services, LGB youth who are already vulnerable to suicide and depression are placed in a precarious situa-


150. U.S. v. Playboy Entm’t Grp., Inc., 529 U.S. 801, 818 (2000) (“It is rare that a regulation restricting speech because of its content will ever be permissible.”).


152. Brown, 131 S. Ct. at 2739.

153. Supra Part I-B.


155. Id.


B. A Statute That Limits LMHPs’ Ability to Discuss SOCE Would Be Unconstitutional

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In his concurring opinion in Conant v. Walters, Judge Kosinski noted the dangers of completely silencing licensed practitioners on a particular issue: "word-of-mouth and the Internet are poor substitutes for a medical doctor; information obtained from chat rooms and tabloids cannot make up for the loss of individualized advice from a physician with many years of training and experience." LMHP, even those who provide SOCE, are guaranteed to have received training in treating clients who are depressed and suicidal and will know how to respond to LGB youth who are experiencing depression and suicide. This is undeniably a safeguard that is not guaranteed to exist when unlicensed individuals provide SOCE.

Additionally, SOCE will not disappear immediately if states across the country enact bans similar to California’s; rather, SOCE will be driven into the shadows of unregulated conduct. While SOCE provided by LMHP may not be any more scientifically or ethically sound than SOCE provided by unlicensed counselors, there is something about leaving a practice in the realm of state regulation that provides some measure of societal accountability. Further, stigmatizing the practice itself could make it harder for LGB individuals who are entrenched in a community that promotes SOCE to repudiate the practice and come out of the closet. These individuals would not only have to reject their culture, community, and family but also the stereotypes associated with individuals who receive SOCE — that they are fundamentalist Christians; that they are self-loathing; that they are less intelligent or naïve; that they are traitors to the larger LGB community. Instead, leaving SOCE within government oversight and public accountability will prevent further stigmatization of SOCE recipients and allow them to arrive at a repudiation of SOCE at their own pace.

If society is truly concerned about the safety and health of LGB young people, forcing some of them further into the shadows of unregulated, unprofessional SOCE is not a solution. Such a ban would place individuals who receive SOCE in danger of receiving inadequate care and might prevent existing mental health problems related to their conflicted view of their sexual orientation. And further stigmatizing a practice that many LGB individuals would choose out of an understandable devotion to their religious beliefs or commitment to the values of their community will only make it harder for those individuals to repudiate the practice later.

159. Conant v. Walters, 309 F.3d 629, 644 (9th Cir. 2002).
160. See, e.g., CAL. CODE RUS. & PROF. § 4999.33(c)(1)(A) (West 2013) (requiring training in handling mental health crises for clinical counseling licensees).

B. The Problem of Inefficient Research

Though many LGBT individuals and their allies know on a visceral level that SOCE is nonsense, statutes like SB 1172 rely on "squishy" research that is methodologically sound or inconclusive. There is substantial and reliable research supporting the notion that same-sex attraction is a normal variant of human sexuality, and there is also anecdotal evidence that SOCE can cause depression and suicide in individuals who become frustrated with their inability to become heterosexual. But the research suggesting that SOCE causes harm (rather than merely correlating with harms to which LGB people are already predisposed) is not scientifically conclusive.

Legislation based on "squishy" research might ultimately produce results that are contrary to the interests of individuals in the LGB movement who also support women’s reproductive rights. For example, the Eighth Circuit recently upheld South Dakota’s requirement that doctors inform abortion seekers of "statistically significant risk factors to which the woman would be subjected," including increased risk of suicide and sexual ideation despite an absence of virtually any scientific research that demonstrates that abortion and these risk factors are causally linked. The Eighth Circuit held that the Supreme Court "has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty," and "[m]edical uncertainty does not foreclose the exercise of legislative power." The court in Rounds turned the "burden of evidence on its head," requiring opponents of the law to prove that the scientific claims behind the suicide advisory requirement were false rather than requiring the state to prove that they were true. Opponents of the law argue that
many LGBT individuals would choose out of an understandable devotion of their sexual orientation. And further stigmatizing a practice that might worsen existing mental health problems related to their conflicted identity, LMHP, even those who provide SOCE, are guaranteed to have received training in treating clients who are depressed and suicidal and will know how to respond to LGBT youth who are experiencing depression and suicide. This is undeniably a safeguard that is not guaranteed to exist when unlicensed individuals provide SOCE.

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the result "legalizes lies." These opponents argue that there is no definitive evidence that abortion causes an increased risk in suicidal ideation; rather, there is a correlation between abortion and an increased risk of suicidal ideation. In other words, abortion and suicidal ideation tend to occur at higher rates among the same populations of women, but the fact that one causes the other has not been established. One critic of the Rounds opinion stated that proponents of SOCE should take comfort in the decision as a rejection of scientific consensus in favor of "ideological fictions." However, where a ban on SOCE is at issue, opponents of SOCE are more likely to benefit from Rounds than the therapy's proponents. There is almost no reliable science indicating that SOCE causes harm. Opponents of a ban on SOCE could argue that there is no reliable research demonstrating a causal link between SOCE and mental health problems. Rather, existing research merely proves that those who seek SOCE, like many other LGB people, also tend to experience mental health problems.

Many proponents of SB 1172 have argued that even where scientific research may be somewhat unreliable, deference to the legislature is owed "because legislatures are better equipped than courts to amass and evaluate the data bearing on legislative questions." The American Civil Liberties Union of Northern California (ACLU), perhaps looking to Rounds, appeared to recognize the current tension between arguments in the reproductive rights context and in the SOCE context. In its amicus brief, the ACLU argued that in determining whether a regulation is consistent with the norms of medical practice, a court should not simply defer to the legislature's fact-finding but conduct an independent review of the record to determine medical norms. The organization went on to argue that some degree of scientific certainty must be required: "If popularly-elected legislatures can ban any medical practice—regardless of the medical profession's consensus as to the efficacy or even necessity of that practice—then regulation of the profession could be driven entirely by the ideological goals of the legislature." Ultimately, however, like most other proponents of SB 1172, the ACLU concluded that professional organizations' policy statements are sufficient to support a ban on SOCE even in the absence of reliable scientific research.

The question of how much science is required to support legislation will continue to be an issue for decades to come. Members of the progressive community, which includes both LGB equality advocates and reproductive rights advocates, may want to come to a consensus on this issue, rather than staking out opposing positions depending on which social problem is addressed by a particular piece of legislation. Hopefully all can agree that the mental health of some of the nation's most vulnerable populations—LGB young people and pregnant women—is critically important. Both the Rounds case and the dearth of research on SOCE are a call to action to advocates on both ends of the political spectrum to promote scientific research on those important issues.

VII. Informed Consent: An Alternative Strategy for Curing the Practice of SOCE

While a ban on SOCE may be constitutional, it is not the best solution for eradicating SOCE and protecting against its harms. Instead, imposing an informed consent requirement on LMHP would be a more effective alternative strategy for curbing the practice of SOCE. In the abortion context, informed consent requirements have been utilized for several decades and upheld as constitutional. The Supreme Court in Planned Parenthood of Southeastern Pennsylvania v. Casey upheld an informed consent requirement for minors seeking abortion. The Casey requirement provides a useful starting point for crafting an informed consent requirement for the provision of SOCE.

A. Minors and Informed Consent

Generally, parents can consent to medical and mental health treatment on behalf of children. However, in many states, "mature minors" (generally between twelve and fourteen years old) may consent to medical and mental health treatment on behalf of children. For example, in 2013, the ACLU concluded that professional organizations' policy statements are sufficient to support a ban on SOCE even in the absence of reliable scientific research.

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Generally, parents can consent to medical and mental health treatment on behalf of children.179 However, in many states, “mature minors” (generally between twelve and fourteen years old) may consent to...
outpatient mental health treatment without parental consent.\textsuperscript{180} For minors, the right to consent does not automatically confer the right to refuse treatment.\textsuperscript{181} States could modify their informed consent statutes to allow minors of certain ages both to consent and to refuse outpatient mental health treatment. Wisconsin, for example, allows minors over fourteen to object to outpatient mental health care.\textsuperscript{182} If parents object to the minor’s refusal, administrative and judicial review processes are available to determine the best interest of the child.\textsuperscript{183} Analyzing SOCE under a “best interest” standard raises similar issues to those raised by a ban with respect to the dearth of scientific research on the treatment itself. To avoid this problem, the following model informed consent statute would specifically provide minors over the age of twelve with the right to refuse SOCE without the possibility for parental override.

B. Key Provisions of a Model SOCE Informed Consent Statute

The following is a proposed model SOCE informed consent statute. The model statute includes several key components. First, the model statute sets the age of consent and refusal at twelve years old because that is the median age at which puberty occurs in adolescents and also typically the youngest age at which minors are recognized as “mature minors” for legal purposes.\textsuperscript{184} Second, the model statute requires LMHP to provide the name, address, and telephone number of the state licensing agency with which a patient can file a complaint regarding failure to obtain informed consent. This provision is modeled after a provision in Minnesota’s informed consent requirement for homoeopathic health care providers.\textsuperscript{185}

Finally, rather than requiring the disclosure of scientific research or information about the harms of SOCE, the model statute would require LMHP to make available the position statements on SOCE of several

\textsuperscript{180} See, e.g., CAL. FAM. CODE § 6924 (West 2014); CONN. GEN. STAT. § 19a-14c (2014); OHIO REV. CODE § 5122.04 (West 2014); OR. REV. STAT. § 106.675 (2014); WIS. STAT. § 51.14 (2014).

\textsuperscript{181} S.J. ex rel. S.H.J. v. Issaquah LMHP information about the harms of health care providers.\textsuperscript{185} provision in Minnesota’s informed consent requirement for homeopathic licensing mino­

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\textsuperscript{184} See, e.g., CAL. FAM. CODE § 6924 (West 2014); CONN. GEN. STAT. § 19a-14c (2014); OHIO REV. CODE § 5122.04 (West 2014); OR. REV. STAT. § 106.675 (2014); WIS. STAT. § 51.14 (2014).

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outpatient mental health treatment without parental consent. For minors, the right to consent does not automatically confer the right to refuse treatment. States could modify their informed consent statutes to allow minors of certain ages the rights both to consent and to refuse outpatient mental health treatment. Wisconsin, for example, allows minors over fourteen to object to outpatient mental health care. If parents object to the minor’s refusal, administrative and judicial review processes are available to determine the best interest of the child. Analyzing SOCE under a “best interest” standard raises similar issues to those raised by a ban with respect to the dearth of scientific research on the treatment itself. To avoid this problem, the following model informed consent statute would specifically provide minors over the age of twelve with the right to refuse SOCE without the possibility for parental override.

B. Key Provisions of a Model SOCE Informed Consent Statute

The following is a proposed model SOCE informed consent statute. The model statute includes several key components. First, the model statute sets the age of consent and refusal at twelve years old because that is the median age at which puberty occurs in adolescents and also typically the youngest age at which minors are recognized as “mature minors” for legal purposes. Second, the model statute requires LMHP to provide the name, address, and telephone number of the state licensing agency with which a patient can file a complaint regarding failure to obtain informed consent. This provision is modeled after a provision in Minnesota’s informed consent requirement for homoeopathic health care providers.

Finally, rather than requiring the disclosure of scientific research or information about the harms of SOCE, the model statute would require LMHP to make available the position statements on SOCE of several major mental health professional organizations. In her dissenting opinion in Akron v. Akron Center for Reproductive Health, Justice O’Connor noted that requiring physicians to communicate the State’s ideology may violate the First Amendment. Subsequently, in Casey the Court (with Justice O’Connor joining in the plurality) upheld a requirement that physicians inform abortion seekers that informational materials about alternatives to abortion are available for their review. The Court held that this requirement complied with the First Amendment. Here, requiring notice of the availability of information about professional organizations’ opposition to SOCE is very similar to the requirement in Casey and would likely survive First Amendment challenges.

C. Model Informed Consent Statute

(a) General rule – No SOCE shall be provided except with the voluntary and informed consent of the individual to whom the SOCE is to be provided (the “patient”). Persons age 12 years and over shall personally have and exercise the rights under this statute.

(b) Informed consent – Consent to SOCE is voluntary and informed if and only if prior to the provision of any SOCE, the licensed mental health provider who is to provide the SOCE or the referring licensed mental health provider has informed the patient and the patient’s legal guardian(s) of:

(i) The nature of the proposed procedure or treatment and of those risks and alternatives to the procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo the SOCE.

(ii) The availability of printed versions of the organizational position or policy statements regarding SOCE from the following mental health professional organizations: the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers.

(iii) The name, address, and telephone number of the office of the mental health provider’s state li

180. See, e.g., CAL. FAM. CODE § 6924 (West 2014); CONN. GEN. STAT. § 19a-14c (2014); OHIO REV. CODE § 5122.04 (West 2014); OR. REV. STAT. § 109.675 (2014); WIS. STAT. § 51.14 (2014).


183. Id.


censing entity and notice that a client may file complaints regarding the provider's failure to obtain informed consent with the office.

(c) Informational materials - If a patient requests to see the materials described in paragraph (b)(ii), the provider shall provide those materials to the patient and make reasonable accommodations in accordance with paragraph (e) to ensure that the patient can understand them.

(d) Written consent - After fully complying with paragraph (b) of this statute, a provider shall obtain written consent from the patient or his legal guardian if the guardian has the authority to consent on the patient's behalf.

(e) Reasonable accommodations - In complying with the informed consent requirements in paragraph (a), licensed mental health providers shall provide interpretation and translation services or read information aloud for those patients who cannot read or who have communication impairments and for those who do not read or speak English.

(f) Enforcement and penalty - The state licensing entities responsible for licensing mental health professionals shall enforce the terms of this statute. Any licensed mental health provider who fails to obtain written consent in accordance with the provisions of this statute shall be found in violation of this statute and subject to discipline by the provider's licensing entity. Additionally, any provider who is found by a preponderance of the evidence to have violated any provision in this statute shall be subject to discipline by the provider's licensing entity. For violations of this statute, state licensing entities may impose a fine or suspend or revoke the mental health provider's license.

D. Advantages of an Informed Consent Requirement

There are several advantages to pursuing an informed consent requirement as a means of reducing the practice of SOCE. First, the dearth of credible scientific research about SOCE is not an obstacle in promulgating an informed consent requirement. Thus, instead of waiting for or commissioning in-depth, reliable scientific studies on the negative effects of SOCE, legislators can require LMHP to make available information such as the statements of major mental health professional organizations. This solution also avoids the conflict emerging within the progressive movement of whether or not to support legislation based on inconclusive scientific research. Instead of forcing LMHP to make assertions based on unreliable science, an informed consent requirement only requires LMHP to make available information from professional organizations.

Second, an informed consent requirement avoids the problem of the "shadows" more than a statutory ban. While parents and minors may still seek SOCE from non-LMHP under both a ban and an informed consent requirement, they will not be forced to seek counseling from non-LMHP under an informed consent requirement. Patients may still seek SOCE from LMHP after giving informed consent, lessening the danger of non-LMHP providing counseling without adequate training in addressing mental health crises. Third, an informed consent requirement such as the one modeled above would apply to both adult and minor patients age twelve and over who are deciding whether to receive SOCE.

Thus, an informed consent requirement could provide broader protection than a ban like California's SB 1172.

Finally, an informed consent requirement may reduce the number of patients who seek SOCE. Any information that causes patients to pause or reconsider seeking SOCE may help deter patients from the therapy. Even though the benefits of a statute like the one modeled above to minors under age twelve would be limited by the wishes of the minor's legal guardians, the dissemination of additional information may prevent parents from seeking SOCE, whether licensed or unlicensed, for their children.

Conclusion

SOCE should be eradicated, but policymakers should be mindful of the collateral consequences of attempts to regulate and eradicate SOCE. While a ban on SOCE, such as California's SB 1172, is probably constitutional, it is not the best strategy for eradicating SOCE. Bans on SOCE, like SB 1172 could drive some LGB youth into the shadows of unregulated SOCE provided by unlicensed counselors who are not trained to treat mental health crises. Further, bans on SOCE like SB 1172 could create a dangerous precedent of regulating medicine and medicine.

189. See Planned Parenthood of Minn. v. Rounds, 686 F.3d 889, 896 (8th Cir. 2012) (rehearing en banc) (holding that an abortion informed consent requirement need not be based on scientific consensus).

190. See Part VI.D.
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**Conclusion**

SOCE should be eradicated, but policymakers should be mindful of the collateral consequences of attempts to regulate and eradicate SOCE. While a ban on SOCE, such as California’s SB 1172, is probably constitutional, it is not the best strategy for eradicating SOCE. Bans on SOCE like SB 1172 could drive some LGB youth into the shadows of unregulated SOCE provided by unlicensed counselors who are not trained to treat mental health crises. Further, bans on SOCE like SB 1172 could create a dangerous precedent of regulating medicine and

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190. See Part VI.B.
psychotherapy based on insufficient scientific research. This will create
dangerous legal precedents for other social movements' goals, such as the
reproductive rights movement.

The negative collateral effects of a ban on SOCE will outweigh the
benefits. Instead, advocacy organizations should focus their resources
and efforts on: (1) strengthening the body of scientific literature on
SOCE and (2) legislating SOCE-specific informed consent requirements
for licensed mental health professionals.