Evidenced-Based, Medically Accurate Comments

For the

2025 K-12 Academic Standards in Health Rulemaking

(Revisor's ID No. R-04924, CAH Docket No. 65-9005-40585)

Submitted to the Hearing Record

Administrative Law Judge Ann O'Reilly Presiding

April 21, 2026

Comments by

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These Comments provide evidenced-based up-to-date information concerning human sexuality and human growth and development that appears absent from consideration thus far in this Rulemaking (R-ID: 04924) by Agency: Minnesota Department of Education (MDE).

These Comments, and materials referenced herein and those appearing in the Appendix are intended to be included in the record and actively incorporated into deliberations.

Please note that these Comments follow, and build upon, earlier contributions in this proceeding by Mr. McCarthy in his Comments filed on February 9, 2026, and in his Comments filed on July 18, 2025.

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PART 1.0 -- FORWARD

1.1 AUTHORS

Michael E. McCarthy presently serves as Chair of Fixing Stillwater Schools (FSS) a local education advocacy non-profit corporation. He is retired from a 45-year career of public service as an analyst of public policy, economics, and applied sciences. In his varied career Mr. McCarthy has been: Minnesota's liaison to the Nuclear Regulatory Commission; administrator of a 25 state and 24 utility coalition that prevailed over the US-DOE in a $2 billion lawsuit; State Elections Director in Georgia and Assistant Elections Director in Minnesota; and among US-DOE's original research scientists unlocking America's shale gas resources. He was a US-DOD Fellow determining alternative chromium sources. Under subcontract to Rockwell Hanford, he was the integrating contractor's procurement officer for the Hanford Nuclear Reservation. Mr. McCarthy has been involved in rulemakings for the State of Minnesota before the US-NRC, US-DOE, and the US-Federal Energy Regulatory Commission and numerous regulatory proceedings within the State of Minnesota.

Mr. McCarthy's contributions here build upon previously filed materials filed in this rulemaking on July 18, 2025 and on February 9, 2026.

Kate Harri, MA, Psychologist Emerita – Ms. Harri has nearly 50 years of experience in the mental health field spanning probation, psychiatric treatment, family, couples and individual counseling, crisis intervention as well as in the field of workers' compensation and disability insurance. In the latter part of her career, she worked for over 30 years in the disability and worker's compensation arena in both the US and Canada. During this time, she developed and provided practical training for conducting effective claimant interviews, applying motivational interviewing in claims work, case management and addressing accommodations for return to work. She also developed and delivered successful interventions for recovery from traumatic work incidents.

Her focus has been on positive collaboration with all parties, using strategies and interventions to improve the lives of individuals impacted by mental illness. Areas of expertise include conducting successful claims interviews, understanding mental health conditions, knowing what constitutes appropriate treatment for those conditions, and facilitating positive movement with individuals toward improving function, including return to work.

Her publications include understanding and addressing mental health concerns in the business environment, effective supervision, and best practice treatment and recovery to facilitate return to work.

1.2 SUMMARY

1.2.1 Process Context

This proposed rule of health standards must be discussed with its related benchmarks. Over the two-year rulemaking process, all parties appear to have acted on this understanding until after 8,000 comments were filed (but still not disclosed by MDE) on Draft 2 in July of 2025. Now, MDE wishes only its two-page draft rule be considered in rulemaking. Yet it does not tell the public what the mandate would require. (See line 2.2 of the proposed rule.)

Severed from its benchmarks, MDE's proposed two-page rule would now lack any content whatsoever. It would simply be an empty bucket waiting to be filled with non-rule guidance, as if such were rule. Nonetheless, MDE and proponents of its proposed rule express *expectations* that it will require and enforce in every school district uniform conversion of every child to the LGBTQIA+ sexual worldviews and beliefs of SHAPE America's National Health Education Standards, and the National Consensus for School Health Education. This would be done AFTER the rulemaking, behind MDE's closed doors with favored parties, without public accountability.

Kathy Ziebarth has been a member of the MDE Health Standards Committee since its inception. She is exceptionally well-credentialed. Her comments in the record shortly following this rulemaking's hearings contain the following assessment:

> "Has [the rulemaking] process been formally delegated to MDE without oversight? I don't think so. MDE has created a heavily flawed process that superficially appears to comply with legal and procedural requirements for the 8 standards, but has the practical effect of protecting their unique and coercive power of authority and compliance with the benchmarks process. MDE has, in my opinion, actively mishandled the process of transparency and actively sought to obfuscate notices and process from the public. They have complied "just enough" to create plausible deniability. Have they complied in good faith with the statute, and made unanticipated mistakes along the way? I am not convinced this is true. I have personally observed what I would characterize as active misdirection and proactive plans to obscure and confuse the process from the public."

MDE claims unfettered imperial discretion to impose mandates in secret, out of public view. In hearings of April 13 and 14, 2026, MDE asserted that Minn. Stat.120.023 Subd.1(d) authorizes it to divorce discussion of the benchmarks as stated in Draft 2 from passing a two-page almost empty bucket rule. An intention to enforce the benchmarks as law, when MDE has hidden them in the final rule process would be a fantastic overreach beyond the limits of delegation of power. As other Commentors have stated in this proceeding, only by MDE including the

benchmarks directly for public notice and comment can the benchmarks share in the power legislatively authorized for standards.

MDE can put meaningful content in the standards portion, but Minn. Stat. 120.023 Subd1.(d) does not and could not provide that rulemaking power is authorized outside of the notice and comment process.

Furthermore, MDE's proposed rule and its supporters would require a significant minority of students to renounce their religious beliefs and family values and replace them with a rival set of beliefs promoted by the State as a condition of grade advancement and graduation. (See Minn Stat. 120B.02 & 120B.021.) MDE has received Comments to this effect and has failed to acknowledge or address them leaving serious concerns about the proposed rule violating both the Minnesota and United States Constitutions. Again, with the exception of reviewing the amicus briefs at the end or our Comments, we will leave further argument to civil rights groups and others to address pending constitutional issues.

1.2.2 Reliance on Current, Evidenced-Bases, Medically Accurate Information

Our purpose here is to present current, evidence-based, medically accurate information for the MDE to rely upon. In its SONAR, MDE states that its process must be grounded in *current* research and national frameworks. (See p 9, p 12.) Unfortunately, the medical information MDE relies on is out-of-date regarding human sexuality and human growth and development. Some suspect that MDE refuses to rely on current evidence-based medical information on human sexuality as a way of defending a political orthodoxy which it intends to proselytize. We hope this is not the case. In that hope we offer much newer, internationally accepted information to be relied upon to fill a foundational gap in this rulemaking.

Information provided in these comments, its attachments and related citations are germane to MDE's "knowledge" standards, and to the "strands" on the following: growth & development; mental & emotional health; personal health & wellness; and personal safety & violence prevention.

Our comments address the landmark 2024 Cass Review clearly showing the accumulating international evidence and subsequently, for the need to immediately pause current practices in the treatment of pediatric gender dysphoria. Evidence provided shows almost all such cases of pediatric gender dysphoria resolve themselves by adulthood—if not interfered with—or with modest psychotherapy that does not promote any specific ideology or beliefs.

The 2025 U.S. Health and Human Services (HHS) study subsequently builds upon the CASS Review. Based on current research from multiple sources, HHS directly repudiates materials that MDE represents as being relied upon as root sources (e.g., World Professional Association for Transgender Health (WPATH)) and, therefore, demonstrates their unreliability. Importantly, the

HHS study extends its contributions to address the prejudicial use of language in schools and other institutions, and factors contributing to the neglect of evidence and open debate in American corporate medicine today (i.e., pediatric gender patient being excellent for corporate medical P&L forecasts, as each of them requires expensive lifelong treatments and for motivations of ideological capture).

As part of the process utilized to persuade children and parents of the "need" for aggressive treatment of gender dysphoria (i.e., puberty blockers, surgeries) medical professionals have consistently stated these individuals are at increased risk of self-harm including suicide if the child's beliefs are not affirmed and "gender affirming" treatment provided. Both the Cass Review and HSS studies robustly and scientifically rebut these claims based on growing evidence to the contrary. There is no scientific evidence that the global trend to abandon the old "gender affirming" model of treatment results in suicide. None.

The American Society of Plastic Surgeon's Position Statement is included to illustrate the beginning of the American medical communities' shift to recognize accumulating evidence supporting the international retreat from the "gender affirming" model.

The rapidly expanding global understanding of human sexuality in growth and development is further represented in the April 4, 2026 Finnish paper "Psychiatric Morbidity Among Adolescents and Young Adults Who Contracted Specialized Gender Identity Services in Finland in 1996 -2019: A Register Study." Here again, not only has the past "gender affirming" model been shown to have failed to provide benefits, but resulted in even greater harm to the patients.

In sum, the global reversal from providing "gender-affirming" treatments to children reflects a rejection of the underlying premise: that the multi-gender-fluidity worldview has a biological basis.

To avoid unethical complicity, MDE must incorporate into its health education the understanding that neither gender dysphoria in itself, nor the absence of "gender affirming" medical procedures, are a cause of suicide.

To illustrate how this new evidence-based medical understanding is relevant to educational settings, amicus briefs for three lawsuits are provided.

In the amicus brief in *Mahmoud, et al, versus Taylor, et al* before the U.S. Supreme Court, the groups "Our Duty-USA" and "Partners for Ethical Care" demonstrate that the multi-gender-fluidity worldview is not science-based. This brief demonstrates when the gender-dogma agenda is embedded in a school system, real and substantial harm is inflicted on children.

In *Mahmoud*, our U.S. Supreme Court explains parents and children have a right to be free from school-district or school-system mandates of "LGBTQ+-inclusive" instruction, where it would undermine their ability to raise their children in their religious tradition. The Court uses "LGBTQ+-inclusive" as the general term for the contemporary progressive dogma of non-binary gender pluralism in its many parts. MDE has specifically stated its intention to mandate this LGBTQ+-inclusion, in spite of clear federal illegality as a requirement, but with regard to this rulemaking process, MDE does not make that plain strictly within the text of the proposed Rule.

Two additional briefs are provided by the Child & Parental Rights Campaign, Inc. (CPRC). Similar to the MDE proposal, CPRC demonstrates that based on accumulating medical evidence, the proposed educational rule would require educators to facilitate harm to children. It would violate parental rights to direct the education and upbringing of their children in accordance with parental worldview and values. It would foster a wedge between children and their parents that could interfere with their medical care and mental health and introduce unnecessary entanglements with social services. Finally, it violates girls' privacy and safety protections under Title IX, which we recognize but will not focus on in these comments.

If MDE's intent is to proceed in secret regarding these proposals, relying on out-of-date medical and legal information--and violating federal law--it would be a grave mistake. It would result in real and lasting harm to real children and inflict lasting damage to Minnesota's educational institutions.

Therefore, we request Your Honor to reject this rulemaking, or in lieu of that, to direct this newly submitted information be incorporated into the rulemaking and applied to the remedies requested by Michael McCarthy, Chair of Fixing Stillwater Schools, in his February 9, 2026 Comments. We endorse his previous comments on the need for remedies to this rulemaking process and his plea for robust "knowledge content" as set forth in his earlier Comments. We also endorse the alternative "Pro-Family K-12 Academic Health Standards Rule" submitted in Mr. McCarthy's February 9th Comments. It honestly and forthrightly states what should be taught in our school's health classes if this mandate proceeds.

It is our intention that all materials cited in these Comments are included in the current record and become part of this rulemaking's due diligence process.

1.3 INTRODUCTION

How many genders are there? Does an individual's gender change? If so, how often? Why do you believe your answers are true? These are defining questions of the times.

The answers pertain directly to the rule's "Knowledge" Standard and to the following supporting strands: growth & development; mental & emotional health; personal health & wellness; and personal safety & violence prevention.

With regard to the final question of "why", MDE is charged to apply current, evidence-based knowledge in this rulemaking. Unfortunately, with regard to these questions, MDE appears so far unable, or unwilling, to reverse its earlier understandings of gender dysphoria and its relationship to childhood growth and development even in the face of accumulating scientific evidence driving changes away from the "gender affirming" model globally.

MDE presented its initial answers to the above questions in its summer 2025 Minnesota K-12 Academic Standards in Health – Draft 2 (hereafter, "Draft 2"). Michael McCarthy filed Comments on July 18, 2025 in this proceeding extensively addressing on pages 13-26 details of Draft 2's "Sexual Health Strand". For example, on Draft 2 page 24, to advance grade level *third graders* would have been *required* to "define gender identity and expression" (code 3.4.1.05), "explain the difference between sex assigned at birth and gender identity and expression" (code 3.4.1.06), and to "demonstrate giving and receiving verbal consent in [sexual] interactions with family members, peers, and other adults" (code 3.4.4.01). One might reasonably ask why is an 8-year-old would be required to learn about gender fluidity theory in the first place? Why are they required to learn only sexual *consent* (rather than refusal) and why between 8-year-olds and ADULTS? McCarthy's Comments address many more examples similar to this.

In the SONAR for this rulemaking, MDE notes it received eight thousand (8,000) comments on Draft 2. (See SONAR p. 16) Although electronically filed and easily posted, these comments have not been made public and would represent an enormous portion of this rulemaking record. One might imagine they were not favorable, and therefore, MDE had reason to not disclose them to the public … and to attempt to withhold them from the ALJ assigned to this proceeding.

MDE has since been attempting to create this rule while saying as little as possible about it – especially about what it would mandate being taught. As noted in Comments by Mr. McCarthy filed on February 9, 2026, MDE has suddenly and inappropriately attempted to shrink this proceeding to a two-page draft rule that, while overriding all elected school boards, leaving what would be taught in its resulting mandate for millions of children undisclosed until later, behind closed doors, out of public view. (See proposed MDE rule line 2.2.)

Similarly, the MDE's standards and benchmarks distributed to all schools in December in advance of this rule completion left so much to the imagination even MDE's supporters said it was too vague and incomplete to use effectively. (See 2025 Minnesota K-12 Health Academic Standards – Commissioner Approved). It would be inconsistent with Minnesota's rulemaking process to hold, undisclosed, knowledge content for later adoption outside of the public's view,

particularly if such material contradicted up-to-date knowledge on human sexuality and children's growth and development as presented in these comments, and perhaps in those 8,000 undisclosed comments from July 2025.

There is concern our educational institutions have taken it upon themselves to only promote a particular set of politically progressive answers to the questions posed at the start of this section. Parents raising their children outside of the progressive worldview fear this proceeding will result in "health" education designed to convert their children to an antagonistic belief-system and to do so before the age of reason. These parents fear "health" standards being used to reinforce state-approved progressive beliefs in daily school life and the suppression of any other belief system. For example, through the MDE Equity, Diversity and Inclusion Center newsletters and other materials, MDE promotes and celebrates the "trans day of visibility" and other "pride" calendar markers in Minnesota schools (See School Climate & Culture Newsletter, March, 2026). However, they do not publish or promote other belief systems that would, for example, celebrate the binary (man/woman), heteronormative nuclear family.

Reasons for such concerns include the MDE publication on "A Toolkit for Ensuring Safe and Supportive Schools and Gender Nonconforming Students" which measures Minnesota school culture as "good" only to the extent it enforces universal adoption of LGBTQIA+ worldviews in each student's daily life. Similarly, MDE's Equity, Diversity, and Inclusion (EDI) website notes their mission is to help children "unlearn" and "relearn" their worldview to conform with state-approved values. (See EDI Framework.) The very fact of the presence of an EDI organization and mission within the MN Department of Education in itself reinforces a progressive bias.

Why does this matter in this rulemaking? In its December 2025 SONAR on page 20, one of the sources MDE intends to rely on is the Center of Disease Control and Prevention (CDC), Health Education Curriculum Analysis Tool (HECAT) from 2021. Note the publication is now half a decade old, relying on even older material that predates current, evidence-based understandings of human sexuality, growth and development, and well-being.

The opening page of the CDC's 2021 version of the HECAT now states:

> "Per a court order, HHS is required to restore this website as of 11:59PM ET, February 14, 2025. Any information on this page promoting gender ideology is extremely inaccurate and disconnected from the immutable biological reality that there are two sexes, male and female. The Trump Administration rejects gender ideology and condemns the harms it causes to children, by promoting their chemical and surgical mutilation, and to women, by depriving them of their dignity, safety, well-being, and opportunities. This page does not reflect biological reality and therefore the Administration and this Department rejects it."

The HECAT and many other policy documents are now the subject of increasing litigation as corporate medical culture and political dogma stalls American adoption of the most up-to-date, evidence-based information. (See Chapters 9 -14, Treatment for Pediatric Gender Dysphoria Review of Evidence and Best Practices, US HHS, Nov. 11, 2025.)

This also applies to older publications by the Society of Health and Physical Educators (SHAPE), America National Health Education Standards, the National Health Consensus Standards, and the National Sex Education Standards; all of which MDE has a stated preference to "align with". With regard to human sexuality, and growth and development, doing so would be an explicit violation of MDE's charge to use "current evidence-based" materials.

Similarly, Title IX litigation is ongoing and increasing over protections for females. Is a male classmate who has had his body modified by surgery and/or drugs to change his appearance to resemble a "female", truly now a female classmate sharing my daughter's bathroom, locker room and competing for her position on the softball team? (See MN AG lawsuit against US DOJ)

Given its mandate to rely upon current, evidence-based materials, at the very least these controversies must be actively addressed as part of this rulemaking. Simply ignoring them would undermine the very legitimacy of the rulemaking process, rendering the outcome an imposition of progressive political power.

Modern, evidence-based medicine is rapidly concluding the risks of social and medical interventions for children experiencing gender dysphoria far outweigh any benefits that might occur. Current legal wisdom is reinforcing this medical reality. Parties are increasingly prevailing in litigation that protects children from the harm inflicted by schools inculcating gender dogma under the guise of education.

The logic of the most current medical studies presented in these comments contradicts the philosophy underlying the sexualizing of children as MDE's rulemaking suggests needs to happen, beginning in kindergarten.

The information we are presenting herein has numerous links and abundant citations for all persons with honest interest to pursue. This information helps fill an important void in this rulemaking proceeding. It illustrates MDE's failure to properly gather the most current evidence-based information for consideration and the resulting dangers such neglect poses.

Although the following comments reference over one thousand (1,000) pages of material, it is not an exhaustive assembly of such content. Rather, it is intended to inform Your Honor of the existence of such credible perspectives, and to direct your attention to particular parts of these documents to pursue with focus, ensuring their rightful consideration in this proceeding.

PART 2.0 – CURRENT EVIDENCE-BASED MEDICAL UNDERSTANDINGS

2.1 Relevance to this MN Rulemaking

Our purpose here is to provide for Your Honor's consideration up-to-date, evidence-based medical information concerning the nature of human sexuality as it may be taught under mandate of MDE's proposed rule (or the alternative Pro-Family K-12 Academic Standards Rule). This material largely contradicts out-of-date, dogmatic materials on human sexuality and growth and development advocated by The Society of Health and Physical Educators (SHAPE), American National Health Education Standards, the National Health Consensus Standards, the National Sex Education Standards, as well as the outdated version of CDC's HECAT and WPATH's Standards of Care 8.

We begin by sharing parts of recent Congressional testimony by Dr. Miriam Grossman. (See: She Destroys Gender Ideology in 5 Min, link provided by email from Beth Serio, Vice President of Outreach, Do No Harm)

Dr. Miriam Grossman, MD, is a board-certified child, adolescent and adult psychiatrist with 45 years of experience, author, lecturer and Senior Fellow at Do No Harm. She offered the following observations that we would like to share. Dr. Grossman states:

> "Sex is not assigned at birth. It is *established* at conception, and it is *recognized* at birth, if not earlier."

> "To claim that sex is assigned at birth is without any scientific basis whatsoever. Its language misleads people, especially children, into thinking that male and female are arbitrary designations and can change. That is simply not true."

She notes that claims are made that social and medical interventions are lifesaving; that without affirming children's belief that they were "born in the wrong body", children would commit suicide. The accumulating evidence shows this is not true.

As many countries have banned procedures the American gender theory movement advocates, there has been no associated spike in suicides. None.

This has been the case in Finland, Sweden, Norway, England, France, Australia, and New Zealand and in the state of Florida here in America. Dr. Gossman asserts:

> "Kids don't need their development interrupted. The girls don't need their periods stopped and their voices lowered. The boys don't need to grow breasts. What they need is psychotherapy."

She quotes Finland's gender expert Dr. Rita Kaltiala as saying the lifesaving, suicide preventing storyline is "… purposeful disinformation the spreading of which is irresponsible."

In an interview in Tablet (See **Finland Takes Another Look at Youth Gender Medicine - Science - Tablet Magazine**) , Dr. Riittakerttu Kaltiala's positions are summed up:

> "… the suicide discourse is being pushed by 'adults who have themselves benefited from gender reassignment, have a desire to go out and save children and young children. But they lack understanding that a child is not a small adult.' Activists are driven by a combination of motives including misguided empathy, a savior complex, and projection."
>
> "Unlike American doctors who dare question 'gender affirmative' orthodoxies, Kaltiala has the backing of professional medical groups in her country. The Finnish Pediatric Society, the counterpart to the American Academy of Pediatrics, has **come out** against governmental support for gender self-identification in minors in a statement to the Finnish parliament. Likewise, the Finnish Medical Association **wrote**, 'the decision to limit legal gender recognition to adults is a good one.' These statements run directly counter to the American Academy of Pediatrics' **policy** since 2018, which, drawing on a highly distorted interpretation of the available research, recommends immediate and uncritical 'affirmation' of minors, regardless of age. It also conflicts with the **de facto practice** in American schools of socially transitioning children upon request, often without knowledge or consent from parents."

Doctors Grossman and Kaltiala represent the rising tide of global medical understanding. The following two landmark studies have been widely publicized and have been readily available to MDE. There is no evidence in the record of MDE acknowledging their existence in this rulemaking. Links to the full text of these studies is provided. It is our intent that both reports are entered in their entirety into this rulemaking proceeding record for consideration.

2.2 CASS REVIEW: INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE

(Source: The Cass Review)

The Cass Review's essential "bottom line" is there should be a pause in routine "affirming" social and medical treatments of pediatric gender incongruence (dysphoria) that had been recently normalized, since almost all cases resolve without such interventions by adulthood.

Also of special importance is the observation that there is no evidence that reversing standards from previous "affirming" standards has resulted in any increase in suicides.

Prepared in 2025 for the UK National Health Service under the leadership of Dr. Hilary Cass, The Cass Review carefully limits itself to the issue of evidence-based medical treatment for youth. The review team gathered observations and data, applied deductive reasoning, then reached clearly supported conclusions. This is the scientific method. It did not affirm the worldview of the social-justice gender-identity movement which has treated it as an affront to their belief system, or more accurately, as a heresy. MDE apparently has chosen to ignore the Cass Review.

While its length of 388 pages can be daunting, the Cass Review is especially well-documented, and openly presents its methodologies and evidence relied upon for all who care to know. Given its length, I respectfully suggest Your Honor initially focus on the following:

Pages 6-9 --Table of Contents (for overview and context)

Pages 20-22 --Summary

Pages 23-45 --Key Points & Recommendations

Pages 52-53 -- Building On Evidence

Especially relevant to this MDE rulemaking is the Cass Review's observation that diagnosis and treatment of gender incongruity is not a matter for the untrained, especially for activist amateurs in our schools.

Many later sections in the Cass Review are also relevant to a fully informed MDE K-12 Academic Health Curriculum rulemaking. These include observations about exposure to pornography at early ages and the explosively rapid change in "generational beliefs" about gender fluidity among Gen Z youth in the 2020-21 school year.

As an aside, the fact that is regularly occurring in Minnesota public schools is well documented in the 2024 Report "Gender Identity Indoctrination" by Fixing Stillwater Schools (See www.MN834.org).

(Citation: First edition published April 2024. Updated December 2024 for minor amendments and accessibility. Reference as: Cass, H. (2024). Independent review of gender identity services for children and young people: Final report. **https://cass.independent-review.uk/home/publications/final-report/**)

(Additional related material is found at **[ARCHIVED CONTENT] Cass Review Independent Review of Gender Identity Services for Children and Young People)**

2.3 TREATMENT FOR PEDIATRIC GENDER DYSPHORIA: REVIEW OF EVIDENCE AND BEST PRACTICES – U.S. HHS, November 11, 2025

(Source: United States Department of Health and Human Services Report: gender-dysphoria-report.pdf)

This recent 410-page U.S. Federal study has the advantage of building upon the Cass Review and subsequent international reassessments. For purposes of this MDE rulemaking, the HSS report reinforces medical cautions set forth in the Cass Review and, importantly, directly assails corporate American medicine for its reluctance to adjust its practices to this growing body of new evidence. In addition, it clearly recognizes the importance of language used in our schools and elsewhere as proselytizing a particular worldview. Of special relevance to this rulemaking, the HSS report also considers the factors contributing to neglect of evidence and open debate. Like the Cass Review, HHS finds no evidence of increased suicide risk occurring with the ending of essentially on-demand “affirming” medical procedures.

Because of its length, we respectfully request Your Honor begin by reading the Executive Summary on pages 12-18 which separately addresses each of the five parts of the report.

We then suggest reading Chapter 1, Introduction, on pages 31-41 where the premise of the study is presented: good medicine is good science, relying on the asking of questions, the gathering of evidence, then the deductive reasoning of conclusions. OF UTMOST IMPORTANCE TO THIS PROCESS IS THE ADOPTION OF NEW CONCLUSIONS, BASED ON NEW EVIDENCE.

The peanut story told there is a good illustration of medical standards reversal. Where once medical consensus was to keep nut products from infants due to an increase in peanut allergies, accumulated evidence showed this had the opposite effect from what was intended – nut allergies skyrocketed. Medical consensus changed; standards reversed.

As noted on page 30:

> “The innovation and responsiveness of the U.S. medical system has made it the envy of the world. However, errors are unavoidable in healthcare. The test of a medical system is not its ability to avoid mistakes, but rather how it responds once mistakes become apparent.”

So too must those who rely on the medical industry adjust once mistakes become apparent with new research, including the MDE in its underlaying assumptions in this rulemaking; still based on now significantly out-of-date healthcare knowledge.

Chapter 2, Terminology in Pediatric Medicine, provides powerful cautions about the use of words to obscure objective reality (based on observations and deductive reasoning) in favor of subjective reality (based on individual feelings and related belief systems.)

Contradicting the MDE's institutionalized use of the term "sex assigned at birth", including in this rulemaking, the HHS study notes on page 34:

> "'Assigned sex at birth' is not a harmless euphemism. It suggests an arbitrary decision— not unlike 'assigned seating'—rather than the observation of a characteristic present long before birth, namely the child's sex."

Material throughout 2.1 provides relevant insights into the importance of language in instilling a particular worldview and belief system, especially in young children before the age of reason. Of importance is the use of "labeling" language which can impede a student's growth and development and even restrict medical options to the detriment of the child.

For MDE to use language in its mandated health instruction that is used by advocates of medical "affirming" treatments for gender dysphoria, would be expected to result in the harms described in Chapter 2. So, don't. And don't force teachers to inflict such harm. If MDE goes forward with their current beliefs and positions on human growth and development regarding sexuality, harm will result.

Chapter 3, History and Evolution of Adult and Pediatric Gender Medicine (page 42) notes differences between adults and children. Children are not just little adults. In this light, HHS makes several observations about flaws in WPATH's evolving "Standards of Care" (SOC) publications over time.

Chapter 4, International Retreat from the "Gender Affirming" Model (page 59), systematically walks through the logic of change:

> "Since the publication of the Dutch Protocol in 2006, the practice of 'gender-affirming' (or 'affirmative' care) has rapidly expanded. Now, a global reversal is underway. Several national health authorities have restricted hormonal and surgical interventions for minors. Section 4.1 provides a brief overview of the rise of pediatric medical transition (PMT) as the primary response to childhood and adolescent gender dysphoria (GD). Section 4.2 summarizes the ongoing practice reversal that is now taking place in an increasing number of countries. Section 4.3 explores the reasons behind these reversals."

For the MDE rulemaking, I highlight the following items from Section 4.3.1 Rationale for International Reversals (page 67) discussing social contagion:

> "Research into experiences of detransition and regret … have suggested social influence or pressure have played a role in the transient transgender identifications of some patients. Concerns about the possible role of social influence underlying epidemiological shifts in presentations have been articulated elsewhere in the literature, including by some proponents of [pedeatric medical treatment]. WPATH's guidelines note that 'susceptibility to social influence impacting gender may be an important differential to consider' for some adolescents; the guidelines also acknowledge 'situations in which a young person experiences very recent or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and social media influence on a young person's current self-gender concept.'" (HHS Page 70)

MDE's rulemaking would be irresponsible if it systemically fostered the "gender affirming" harms that would result from such "social influence" pressure as was clearly presented in Draft 2 and as might reappear out of public view, if allowed post-rulemaking.

Section 4.3.3, Concerns About Treatment-Associated Risks and Harms (page 73) follows up on earlier discussions noting that the attaching of the "trans kid" label can prematurely lock a child into an identity path; social transitioning further solidifies this path to later puberty blockers and surgery. In a school setting, facilitated and celebrated by trusted adults and peers, our schools foster the very social influence described in Section 4.3.1. The resulting detransition and regret, may well be laid at the doors of our schools and educational institutions promoting such a "climate."

Section 4.3.4 More Appropriate Understanding of Suicide (pages 74 - 77) lays bare the nightmare threat long presented to parents of children experiencing gender dysphoria: lack of "gender affirming care" does not cause suicide. HHS states bluntly:

> "Proponents of ['gender affirming' medical treatment] often describe it as lifesaving. Some physicians recommending [it] have urged anxious parents to consent to irreversible interventions for their distressed children, warning that not doing so may increase the risk of suicide. Such claims are not supported by the evidence and have been criticized as unethical. … Moreover, there is no evidence that elevated suicidality can be attributed solely to [Gender Dysphoria (GD)], as it frequently co-occurs with other mental health conditions."

To avoid unethical complicity, MDE must incorporate into its health education the understanding that neither gender dysphoria in itself, nor the absence of "gender affirming" medical procedures, are a cause of suicide.

Section 4.3.6 Lack of Reliable Evidence of Benefit (page 79) drives to the heart of the matter: known "costs" of medical "gender affirming treatment" are high while the demonstrated benefits are low or absent.

Part II of the HHS study "Evidence Review" (page 81) provides the technical background on various studies in the field and their methodological and/or sampling strengths and weaknesses. I will just highlight one particular insight. Section 6.3, Publication Bias (page 110) presents widely applicable insights into what we typically get to read and why. In the context of America's corporate for-profit medical industry the expression "follow the money" and perhaps, "follow the political power" becomes all the more important. This can explain the recent proliferation of gender specific clinics and surgical procedures as well as the reluctance of the medical community to change procedures despite the growing body of evidence showing the minimal benefit and great harm being done to children.

Part III of the HHS study, Clinical Realities (page 137), is an assessment of international clinical guidelines and America's failure to adjust to new evidence. Relevance to the MDE rulemaking is in recognizing the changed underlying assumptions about human sexuality and the high risk, low benefit aspects of "gender affirming" medical procedures on human bodies.

Chapter 9, Review of International Guidelines (page 138), and part 9.2.3 WPATH, Endocrine Society, and American Academy of Pediatrics Guidelines and Practice Statements (page 146) is especially noteworthy. HHS is especially critical of those organizations' standards. MDA, and its sources, should give appropriate caution to continued reliance, directly or indirectly, on past materials those organizations have produced. Part 9.2.4, More Recent International Guidelines (page 149) offers up-to-date information as an alternative, including descriptions of respected studies in Finland, the UK, and Sweden.

Chapter 10 WPATH's Standards of Care (page 157) examines failings of the SOC-8 in detail and the extent to which it leads the American medical establishment.

Chapter 11 Collapse of Medical Safeguarding (page 188) explores the recent failings of our medical institutions to protect the patient. This is important only if MDE chooses to outsource its judgement relating to health education to these parties.

Starting on page 213, Section 12.2, Factors Contributing to the Neglect of Evidence and Open Debate is relevant in its entirety to the MDE rulemaking, which some might describe as an exercise in neglecting evidence and open debate. HHS makes the following three observations which are exactly the same pitfalls educational institutions risk:

> "First, in managing unusual or complex conditions, [institutional leaders] often rely on the expertise of specialists to inform their … decisions. … they often defer to specialized committees—such as committees devoted to LGBT issues—whose

> members they regard as the organization's content experts. These committees typically are composed of professionals whose careers are closely tied to supporting or delivering ['gender affirming'] medical transition, limiting their ability to impartially evaluate the evidence due to significant intellectual and financial conflicts of interest. While reliance on specialist committees poses fewer risks in well-established subspecialties with decades of robust research, pediatric gender medicine remains a new, highly controversial field characterized by a limited and low-certainty evidence base.
>
> Second, the framing of ['gender affirming' medical procedures] as a civil rights matter may have contributed to premature and uncritical support at both the individual and institutional levels. …
>
> Third, by the time the weak evidence and growing international retreat from the practice [of 'gender affirming' practices] became difficult to ignore, several major U.S. MMHAs had been actively promoting [such practices] and denouncing its critics. As a result, some organizations responded to international developments defensively rather than reflectively, viewing the shifts as a potential challenge to their institutional credibility."
>
> (See HHS Pages 113-114)

It is understandable how a large, complex institution such as the MDE would share such propensities. However, once alerted to them, corrective measures should be employed. Such are the remedies requested by Mr. McCarthy in his Comments of February 9, 2026.

Part IV Ethics Review (page 218) offers an interesting discussion on "consent" in section 13.1 (page 220). The primary discussion regards an adolescent's competency to give informed consent for "gender affirming" medical procedures. Scientific studies have shown their bodies, brains, and mental abilities are not yet fully formed. They are typically not emancipated from their parents, yet MDE health education, in Draft 2, has inserted itself in place of parents in many instances without the parent's consent.

Part V, Psychotherapy (page 248) presents material most applicable to trained professionals who might collaborate with the school or its counselors' training. MDE should be aware of these discussions in benchmarks that contemplate introducing students to the existence of available care.

2.4 American Society of Plastic Surgeon's Position Statement –

(Source: Position Statement on Gender Surgery for Children and Adolescents)

The American Society of Plastic Surgeons (ASPS) position paper is a succinct six pages plus an extensive three-page bibliography. Issued only weeks ago on February 3, 2026, this position statement by the ASPS affirms the landmark studies reviewed above, referring society members to Appendix 4 of the HHS report for the evidence summary of earlier studies. Providing substantial additional material, the position statement notes for youth the benefits of surgical "gender affirming care" are uncertain and perhaps absent, while the risks and harms are known, may be substantial and permanent, and involve a lifetime of medical dependency.

Perhaps as an emerging Americal model:

> "This position statement is not a retroactive judgement but a forward-looking response to evolving evidence. It is intended to support continued learning and ethical practice …" (See p.3)

ASPS is acting on:

> "… emerging concerns about potential long-term harms and the irreversible nature of surgical interventions in children and adolescents." (See p.3)

In conclusion:

> **"ASPS recommends that surgeons delay gender-related breast/chest, genital, and facial surgery until a patient is at least 19 years old."** (Bold in original. See p.3)

Regarding suicide, the ASPS makes the following statement:

> "… [P]ediatric gender-related interventions are sometimes characterized as 'life-saving', including claims that withholding or delaying the intervention substantially increases suicide risk. Because the best available evidence indicates suicides deaths are fortunately rare … ethical decision making should not be driven by crisis claims." (See p. 6)

The position paper also briefly explores ethical issues regarding legitimate consent by youth and the propensity for "spontaneous resolution" following in the footsteps of the HHS study.

2.5 NEWEST RESEARCH CONTINUES RETREAT FROM "GENDER AFFIRMING" TREATMENT

Source: *Zeale*, by Hannah Hiester, Landmark Finnish study finds youths' mental health problems increase after gender "transitions" - Zeale, download on April 14, 2026. Original Study at Psychiatric Morbidity Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996–2019: A Register Study - Ruuska - Acta Paediatrica - Wiley Online Library

We offer one final data point representing the on-going global reversal of past "gender affirming" treatments. Published just two weeks prior to this writing, our intent is not to be comprehensive, but representative of the ongoing trend in current evidence-based medicine.

On April 4, 2026, a landmark Finnish study was published, finding "Psychiatric needs do not subside after medical gender reassignment." Psychiatric problems often worsen. As reported in *Zeale*,

> "A new study of more than 2,000 Finnish youth found that the mental health problems of young people with gender dysphoria did not diminish after they sought 'gender identity' services — and in some cases their mental health issues increased.
>
> The study, published April 4, 2026 in the *Acta Paediatrica* journal, tracked the mental health of 2,083 people who were referred between 1996 and 2019 for gender services before they turned 23. Finland uses mandatory health register reporting, so the study encapsulated every instance of a gender identity referral in the country.
>
> According to the researchers, the cohort showed 'markedly higher' levels of mental health disorders both before and after referrals compared with control groups. The need for intense psychiatric treatment often continued or escalated after medical interventions. The study also discovered that those who were referred for gender services after 2010 had greater psychiatric needs compared with those referred before 2010.
>
> Mental health problems increased from 9.8% to 60.7% for youths who underwent male to female 'transition' procedures and 21.6% to 54.5% for those who went through 'female to male' procedures.
>
> After adjusting for those who previously received psychiatric treatment, gender-referred adolescents had similarly heightened risks of mental health issues — about three times higher than the female control group and five times higher than the male control group participants.

> ‘Regardless of gender, adolescents suffering from [gender dysphoria] present with excessive psychiatric morbidity,’ the study’s authors note. ‘Subsequent to medical [gender reassignment], psychiatric treatment needs appear to increase. It should be noted that in some individuals, medical [gender reassignment] appears to be linked to deterioration in mental health.’
>
> The authors also stressed that physicians must address the effects of gender ‘reassignments’ and the expectations of patients before going forward with gender identity procedures.
>
> The findings that young people tend to experience “considerable severe” mental health issues before receiving a referral to gender identity procedures and that as these issues worsen over time indicates that gender dysphoria might occur after mental health challenges in some adolescents, according to the researchers.
>
> They concluded, ‘Psychiatric needs do not subside after medical gender reassignment.’ ”

This high quality, evidence-based research further gives pause to the “born in the wrong body” dogma that MDA and others appear to continue incorrectly advocating.

We respectfully ask Your Honor to apply this information in the protection of Minnesota’s children.

PART 3.0 -- RELEVANT LEGAL BRIEFS

The application of current, evidence-based medicine is now becoming part of America’s litigative record. We have overviews of (and links to) 3 legal briefs by Our Duty-USA, Partners for Ethical Care and the Parents Rights Campaign (PRC) that are highly relevant to the MDE’s course of action in this proceeding

3.1 *MAHMOUD V. TAYLOR*, U.S. SUPREME COURT

(Cite: No. 24-297 In the Supreme Court of the United States, TAMER MAHMOUD, ET AL. Petitioners, v. THOMAS W. TAYLOR, ET AL., Respondents. On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit BRIEF FOR AMICUS CURIAE OUR DUTY–USA AND PARTNERS FOR ETHICAL CARE IN SUPPORT OF PETITIONERS AND REVERSAL)

In the attached amicus brief in *Mahmoud, et al, versus Taylor, et al* before The U.S. Supreme Court, the groups “Our Duty-USA” and “Partners for Ethical Care” demonstrate that the multi-

gender-fluidity worldview is not science based. (See 67ea6c67ae5317c4be8c25da_Mahmound v. Taylor.pdf).

For purposes of making consistent reference to the comprehensive gender and orientation dogma, the Court uses the catch-all term "LGBTQ+-inclusive" concerning the prohibited mandates on a spectrum of topics concerning sexuality and gender. The Court provides a history of protection of parents' and children's rights to religious development from violative education mandates of state agencies. The *Mahmoud* case involves gender-and-sexuality-focused instructional material that the Montgomery County, Maryland school district stopped allowing parents to opt-out of, because the opt-outs were extremely and increasingly popular with the parents, forcing several parents to remove their children from the public schools in order to avoid these LGBTQ+-inclusive materials designed to "disrupt" their religious traditions.

In page one of this binding holding, The Court states, "Government cannot condition the benefit of free public education on parents' acceptance" of LGBTQ+-inclusion dogma where it would pose "'a very real threat of undermining the religious beliefs and practices that the parents wish to instill." Citing *Wisconsin v. Yoder*, 406 U.S. 205, 208 (1972).

The nature of MDE standards rulemakings under Minn. Stat. Chapter 120B is that these are things districts and teachers must or should do in the course of, or manner of instruction. As such, these mandates and guidance impact and instruct what school districts must or may require parents to accept in order to receive the benefit of public education. This parallels the government overreach in the *Mahmoud* decision. A school district imposing graduation requirements consistent with the MDE rulemaking, as proposed by MDE in these drafts (and as would "align" with "Sex Education for Social Change," etc.), would violate constitutionally protected rights. "Government schools, like all government institutions, may not place unconstitutional burdens on religious exercise," the Court rules on page 17 of the *Mahmoud* holding.

We respectfully ask Your Honor read the amicus brief of "Our Duty USA" and "Partners for Ethical Care" in its entirety. It is well-documented concerning the personal stories of 10 youth who were harmed by their school's promotion of this dogma. The stories are especially heartbreaking.

3.1.1 The parties are not "haters" or political partisans.

As described in the brief:

> "Our Duty-USA is a secular nonprofit corporation with members comprising of more than 1,000 parents from all fifty states who have varied political backgrounds,

ethnicities, and sexual orientations but share the experience of raising former and current trans-identified children. The members' children adopted transgender identities after being introduced to the concept through school settings, peer groups and online. Our Duty appreciates that the distress is genuine, but the adoption of transgender identities is not organic, and the cure is not drugs or surgeries.

Partners for Ethical Care ('PEC') is a secular, nonpartisan, grassroots, nonprofit organization of people across the globe including members of the LGB communities. PEC's mission is to raise awareness and support efforts to stop the unethical treatment of children under the banner of 'gender identity affirmation.' PEC believes that 'no child is born in the wrong body' and that all parents should have the option to protect their children from rejecting their body in the first instance."

3.1.2 They Are Their Parent's Children

The amici's interest is plainly stated and mirrors circumstances in this rulemaking's handling of growth and development and human sexuality:

> "The amici believe that the best interest of the children is served when parents can control whether their child is exposed to an ideology that has no basis in reality or evidence-based science. Permanent harm occurs when they [attach themselves to a theoretical] identity that requires them to reject their natural bodies and become tethered forever to the medical industry in a Don Quixote-esque quest to do the impossible. No human can ever change [their biological] sex."

3.1.3 Arguments of Our Duty USA and Partners for Ethical Care

The argument summary of the amici's brief is as follows:

> "The meteoric surge [up to recent times] in youth rejecting their sex by adopting a gender identity contrary to their sex is unprecedented and emblematic of a concerted effort to solicit the involvement of children through a social contagion. Children do not adopt transgender identities organically. The existence of a 'gendered soul' – some ethereal feeling that can emerge at any time, that is both fluid and static – is a modern creation, tantamount to a new pseudo religion. There is no diagnostical test for gender identity, no science demonstrating the existence of a gender identity and certainly no scientific evidence that sex is determined by 'assignment' of a doctor or that there are more than two sexes. Yet, schools are teaching these beliefs as indisputable truth to impressionable children in every class; not just sex education.

Transgender advocacy groups have targeted schools to insert transgenderism into every classroom, in every subject and every grade, even utilizing peer-to-peer influence.

Parents are desperately trying to keep their children safe from the transgender ideology that has permeated every facet of society with lightning speed, influencing medicine, government, commercial enterprises, and education. Schools are the incubators of children and young adults denying their sex. The incredible tsunami of children rejecting their bodies coincides with schools not only teaching about it but celebrating it, while hiding from parents that their student has adopted an identity contrary to their sex. A child who adopts a transgender identity sets a course for invasive and irreversible medical interventions that permanently alter the child's body, disrupt or destroy sexual function, and potentially lead to missing body parts and numerous physical harms." [The author's note, leading to increasing psychological harm as well.]

"A massive social contagion is underway with schools as the catalyst. Schools are introducing topics that are well beyond the ability of children to comprehend and offering reading material that is extremely disruptive to children under the guise of 'inclusivity' .The schools take pains to conceal this information from parents. This is a grooming tactic with cult-like features and include:

1) identifying the potential target;
2) persuading them to join;
3) 'love bombing' ;
4) selling through relentless celebrations and advertisements (flags, posters, etc.);
5) renouncing and separating the parent/child bond;
6) instructing core beliefs through simple mantras and new language (e.g., 'cis,' 'transwomen are women', 'pregnant people' 'sex assigned at birth'); and
7) stifling criticism through shameful name calling, e.g., 'bigot', 'transphobe', 'hater'. These tactics are illustrated by the Amici stories."

3.1.4 Amicus Brief Table of Contents Overview

The following section headings of this briefing's argument provide an overview of the scope and section location in the briefing itself:

I. Gender Identity is not based on science but stems from Queer Theory. p5
II. The surge in youth adopting a transgender identity continues unabated. p8

III. Nonprofits utilized schools as pathways to create gender-confused children, planting seeds that children could have been "born in the wrong body." p11
IV. Transgender identities as social contagion. p15
A. History of social contagions p15
B. Gender Identity as a Social Contagion p17
V. Transgender medicine is dangerous p21
VI. Amici members' stories illustrate the dangers of schools introducing transgender subject matter. …………………………………………………….............. p22

Given that last summers "Draft 2" in this proceeding required K-12 children to annually affirm multi-gender-fluidity dogma to advance grade level and to graduate – the relevance of the content of this brief to the MDE's rulemaking is abundantly clear.

3.2 – Briefs of Child & Parental Rights Campaign, Inc., as Amicus Curiae: State of Kansas v. U.S. DOE and State of Tennessee v Christian Educators Association, Inc.

(Source: Amicus brief: forcing educators to harm children; parent rights. 67ea6c23b150b1d3614bd9de_State Of Kansas v. US DOE.pdf and at 67ea6cb16dc61041edb72fbc_State of Tennessee v. Christian Educators Assoc.pdf)

The U.S. Department of Education introduced via rulemaking federal mandates closely resembling policies of MDE, which have been invalidated in Federal Court. These mandates were attempted to be introduced via Rulemaking under the agency's Title IX authority (of the Education Amendments of Act of 1972), but the Court found the agency lacked specific authorization, among other violations and problems, including the fact the purpose of Title IX was the opposite of allowing biological males to compete in girl's and women's supports in educational programs.

The Kansas et al. case challenged the U.S. Department of Education rule when it was promulgated and in the course of litigation the U.S. Department of Education stipulated to the ruling U.S. District Judge John W. Broomes:

> "[The] Rule redefines sex discrimination under Title IX such that it conflicts with the plain language of Title IX. According to the Final Rule, sex discrimination includes discrimination on the basis of gender identity, sexual orientation, sex stereotypes, and sex characteristics. This court held that Plaintiffs will likely prevail on their claim that the Final Rule is contrary to Title IX….The court further found that DoE offered an implausible explanation for agency action, it is a sharp

> departure from prior action without a reasonable explanation, and the DoE failed to consider important interests as discussed herein."
>
> (Referencing Doc. 53 from Case no. 24-4041-JWB). 739 F.Supp.3d 902 https://caselaw.findlaw.com/court/us-dis-crt-d-kan/116354181.html or https://ecf.ksd.uscourts.gov (search Case No. 24-4041-JWB)

The Tennessee et al. case led to the nationwide vacatur of this U.S. Department of Education Rule. The District Court ruling noted the:

> "Rule also has serious First Amendment implications. The rule includes a new definition of sexual harassment which may require educators to use pronouns consistent with a student's purported gender identity rather than their biological sex. Based on the 'pervasive' nature of pronoun usage in everyday life, educators likely would be required to use students' preferred pronouns regardless of whether doing so conflicts with the educator's religious or moral beliefs. A rule that compels speech and engages in such viewpoint discrimination is impermissible. [¶] Additionally, the Department's actions with respect to this rulemaking are arbitrary and capricious. The Department fails to provide a reasoned explanation for departing from its longstanding interpretations regarding the meaning of sex and provide virtually no answers to many of the difficult questions that arose during the public comment phase. Notably, the Department does not…meaningfully respond to commentor's concerns regarding risks posed to student and faculty safety."
>
> (See Page 92 of June 17th 2024 ruling by U.S. District Court of the Eastern District of Kentucky, Judge Danny C. Reeves, which reached merits and led to nationwide vacatur.)

3.2.1 The Child & Parental Rights Campaign (CPRC)

As described in their briefs:

> "CPRC is a nonprofit, public-interest law firm that represents Plaintiffs across the country in challenging actions that threaten parental rights, including, … policies, practices, and customs that intentionally violate parental rights and endanger the well-being of children."
>
> "In particular, CPRC represents parents challenging school districts which have concealed from parents that their children are being treated as something other than their sex at

school, including the use of alternate names and pronouns and permitted use of opposite sex privacy facilities. …"

"CPRC also represents students who have been harmed by the implementation of school policies based on subjective gender identity, rather than objective biological reality. Thomas v. City Sch. of Decatur, No. 23-13467 (11th Cir.)."

3.2.2 The CPRC Legal Arguments

The legal arguments presented by CPRC in both of these cases are very similar so we will focus on The State of Kansas v US DOE. The Introduction and Argument Summary in this brief by CPRC is as follows:

> "The Department's regulations compel schools to immediately and unquestionably affirm a student's assertion of a discordant gender identity or face liability for violating Title IX. (See e.g., 34 C.F.R. §106.31(a)(2), which defines refusing to treat a student in accordance with his or her stated gender identity as 'more than de minimis harm' for purposes of establishing a violation of Title IX). Notification to or the consent of minor students' parents is not required or even mentioned. This will have wide-ranging consequences for the student asserting a discordant identity, other students, school staff, and parents. CPRC respectfully submits this amicus curiae brief detailing the damage caused by the Department compelling schools to, inter alia, facilitate harmful interventions for gender dysphoric children, violate parents' fundamental rights to direct the upbringing and mental health/ medical care of their children, and violate female students' rights to Appellate Case: 24-3097 Document: 209 Date Filed: 10/16/2024 Page: 12 safety and privacy. CPRC respectfully requests that this Court affirm the district court's order."

The outline for CPRC's argument and section locations is as follows:

A. The Regulations Compel Educators to Facilitate Harming Children. .... Page 3
B. The Regulations Violate Parents' Fundamental Constitutional Rights. .... Page 9
  1. The Rules Violate The Fundamental Right of Parents to Direct The Education and Upbringing of Their Children.. Page 12
  2. The Regulations Violate Parental Rights To Direct the Medical and Mental Health Decision-making For Their Children. .... Page 15
  3. The Regulations Will Trigger Child Protective Services Reports. . ... Page 17
  4. The Regulations Interfere with States' Rights. .... Page 19
C. The Regulations Violate Girls' Privacy and Safety Under Title IX. . ... Page 20

Arguments made by CPRC in those proceedings present important considerations here and now in the MDE-proposed rules for K-12 Academic Health Standards.

As a mandate, it would likewise compel school employees and volunteers "to facilitate harmful interventions for gender dysphoric children, violate parents' fundamental rights to direct the upbringing and mental health/medical; care of their children, and violate female students' rights to safety and privacy."

The facts of this harm are internationally accepted and are well documented in the Cass Review, the HSS study, and elsewhere as described in detail in this Comment document.

As a mandate, MDE's considerations in this rulemaking should likewise provide latitude, not now apparent, to ensure it does not place school teachers, counselors, and administrators (e.g., "trusted adults") in roles usurping parental roles. This is especially true when teaching worldviews to children before the age of reason as "facts" when this is clearly theoretical and in opposition to parental and family beliefs.

It is no secret the State of Minnesota and the US government are in conflict regarding whether to preserve girls' privacy and safety under Title IX. The Department of Justice has sued the state of Minnesota over their policy regarding Title IX. The scale and scope of this dispute, with its resolution not being immediate, is good cause for the present rulemaking to NOT proceed absent recognition and resolution of the related uncertainty.

As noted by CPRC:

> "The regulations also require that girls and women surrender their rights to privacy and safety in ways that are antithetical to decades of Supreme Court precedent and to the raison d'etre for Title IX's passage over 50 years ago. The subjective 'inner feelings of gender identity' on the part of some students do not change the fact that '[p]hysical differences between men and women ... are enduring.' United States v. Virginia, 518 U.S. 515, 533 (1996). Those inherent physical differences create privacy and safety concerns that must be addressed by separate but equal facilities for engaging in undressing, personal hygiene, and other private bodily functions outside the presence of members of the opposite sex. Id. at 551 n.19."

PART 4.0 –CONCLUSIONS AND REMIDIES REQUESTED

In promoting anything to trusting, vulnerable children as early as age 5, well before the age of reason, it is essential to compare the desired outcome to the actual outcome. Accumulating evidence shows that sexual indoctrination, based on "gender-affirming" theory is not scientifically based, and imbuing such beliefs well before the age of reason can continue to harm children for the duration of their life.

Nearly all children who identify as the opposite gender self-correct with either no intervention or modest counseling by the time they reach adulthood. The international medical consensus is that this best leads to health and well-being.

Specifically, evidence provided here, and separately submitted into the record, demonstrates there is almost no benefit in attempting to address sexual body dysphoria with drugs, surgery, or affirmation of the delusional belief. In contrast, the physical and psychological harm coupled with the societal costs of such attempts are extremely high and completely contradictory to children's health and well-being.

What important lessons do we learn from those who are "de-transitioning"? Children are not equipped to make "informed consent". Contrary to the tales of promoters and advocates, there are irreversible, life-long consequences. Those experiencing such recovery should be embraced rather than shunned as "traitors" to the social-political movement that led them to submit to this harmful process that results in sterilization and mutilation.

Our schools are institutions of trust. We surrender our children to the care of the school trusting our children will not be harmed as unsuspecting subjects of a social-political experiment. As proposed, this rulemaking is a betrayal of that trust and subjects children to real and lasting harm.

Based on the preponderance of evidence-based scientific information, MDE must not be allowed to subvert "health" education that results in destructive sexual indoctrination and exploitation and to divert educational resources into the promotion of their progressive worldview, beliefs and values.

Finally, to avoid unethical complicity, MDE must incorporate into its health education the understanding that neither gender dysphoria in itself, nor the absence of "gender affirming" medical procedures, are a cause of suicide.

REMIDIES AND RELIEF

The failure of the MDE to obtain and address this readily available material in these Comments represents an important failure in MDE's process and suggests that it may have been purposefully excluded. This conspicuous exclusion, along with MDE's other failings such as the non-disclosure of the 8,000 public comments on Draft 2 and failure to notify those filers of ongoing proceeding opportunities for engagement, along with other failings noted elsewhere, justify Your Honor rejecting MDE's proposed rule as it now exists. MDE fails lawful execution of its duties. MDE andsupporters of the proposed Rule openly state they expect outcomes that are unconstitutional.

In lieu of rejecting MDE's proposed rule, we respectfully request you direct MDE to:

1) Align its rulemaking and the standards, and benchmarks implementation with the up-to-date, evidence-based medical information provided in this filing;
2) Replace its proposal with the "Pro-Family K-12 Academic Health Standards Rule" submitted in comments on February 9th by Michael McCarthy, the Chair of Fixing Stillwater Schools;
3) Implement the rulemaking remedies as Mr. McCarthy requested in his comments of February 9, 2026; and
4) Align its standards, strands, and benchmarks in accordance with Mr. McCarthy's comments of February 9, 2026.