No. 23-1280

IN THE
SUPREME COURT OF THE UNITED STATES

PARENTS PROTECTING OUR CHILDREN, UA,
PETITIONER,

V.

EAU CLAIRE AREA SCHOOL DISTRICT, WISCONSIN, TIM NORDIN, LORI BICA, MARQUELL JOHNSON, PHIL LYONS, JOSHUA CLEMENTS, STEPHANIE FARRAR, ERICA ZERR, and MICHAEL JOHNSON,
RESPONDENTS.

On Petition for Writ of Certiorari
to the United States Court of Appeals
for the Seventh Circuit

BRIEF OF *AMICI CURIAE* THE LIBERTY JUSTICE CENTER, AND DR. ERICA ANDERSON IN SUPPORT OF PETITIONER

Jacob Huebert
Counsel of Record
Emily Rae
LIBERTY JUSTICE CENTER
13341 W. U.S. Highway 290
Building 2
Austin, Texas 78737
(512) 481-4400
jhuebert@ljc.org

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INTEREST OF THE *AMICI CURIAE*[1]

The Liberty Justice Center is a nonprofit, nonpartisan public-interest litigation firm that seek to protect economic liberty, private property rights, free speech, and other fundamental rights, including the fundamental right to parent under the Fourteenth Amendment.

Dr. Erica E. Anderson, PhD, is a clinical psychologist practicing in California and Minnesota with over 40 years of experience, and is a transgender woman. Between 2019 and 2021, Dr. Anderson served as a board member for the World Professional Association for Transgender Health (WPATH) and as the President of USPATH (the United States arm of WPATH). Since 2016, Dr. Anderson's work has focused primarily on children and adolescents dealing with gender-identity-related issues, at the Child and Adolescent Gender Clinic at Benioff Children's Hospital at the University of California, San Francisco (2016 to 2021), and at her private consulting and clinical psychology practice (2016 to present). She has seen hundreds of children and adolescents for gender-identity-related issues in that time, many of whom transition, with her guidance and support. As a practitioner serving children and adolescents experiencing gender incongruence, Dr. Anderson has a strong interest in ensuring the best possible support and assistance for those children. In her view, appropriate care requires parental involvement.

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[1] Rule 37 statement: No counsel for any party authored any part of this brief, and no person or entity other than *amicus* funded its preparation or submission. All parties received timely notice of amicus's intent to file this brief.

SUMMARY OF ARGUMENT

The Eau Claire, Wisconsin, School District (the "District"), like many other school districts around the country, has adopted a policy allowing children of any age to adopt a new gender identity at school, requiring all staff to treat them as though they were the opposite sex, without parental notice or consent, and even directing staff to conceal this from parents in various ways.

Many mental-health professionals believe that a gender-identity transition during childhood is a profound and difficult decision, and that parental involvement is necessary to properly assess the underlying sources of the child's feelings, to evaluate the risks and benefits of a transition, to identify and address any co-existing issues, to provide ongoing support, and ultimately to decide whether a transition will be in their child's best interests.

Further, parents have the firmly established constitutional right to know about issues concerning their children's health and well-being and make decisions for their children—particularly on matters of great importance. The District's Policy (i) violates parents' constitutional right to decide whether a social transition is in their child's best interest; (ii) conceals serious mental-health issue from parents; and (iii) interferes with parents' ability to provide professional assistance their children may urgently need.

This Court should grant the petition and reaffirm these parents' rights to direct the upbringing and education of their own children.

ARGUMENT

When a child requests to socially transition at school, the first thing a school should do is involve the child's parents. Yet here the District's Policy is to exclude parents from the equation entirely *unless* the minor consents.

Deciding whether a child should socially transition requires a careful consideration of numerous factors that necessitates involving parents and healthcare professionals. The District's practice of not informing parents not only presents dangers to the child's health and well-being; it is also unconstitutional.

I. Whether a minor experiencing gender incongruence should transition socially is a major and potentially life-altering decision that requires parental involvement.

When children and adolescents express a desire to socially transition to a different gender identity (to change their name and pronouns to ones at odds with their natal sex), there is a major fork in the road, a decision to be made about whether a transition will be in the youth's best interests. Parents must be involved in this decision, for many reasons.

First, there is an ongoing debate in the mental health community about how quickly and under what conditions children and adolescents who experience gender incongruence (a mismatch between their natal sex and perceived or desired gender identity) should transition socially. Childhood social transitions were

"[r]elatively unheard-of 10 years ago," but have become far more common in recent years.[2] The recent trend in some circles is to immediately "affirm," without question, every child's and adolescent's expression of a desire for an alternate gender identity. But before that trend began, a robust body of research—multiple studies across different locations and times—had found that, for the vast majority of children (roughly 80-90%), gender incongruence does not persist.[3] As one researcher summarized, "*every* follow-up study of GD [gender diverse] children, without exception, found the same thing: Over puberty, the majority of GD children cease to want to transition."[4]

Some newer studies of youth who *have* socially transitioned show much higher rates of persistence. A study in 2013 found that "[c]hildhood social transitions were important predictors of persistence, especially among natal boys."[5] Another recent study of 317

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[2] Rae, James R., et al., *Predicting Early-Childhood Gender Transitions*, 30(5) Psychological Science 669–681, at 669–70 (2019), https://doi.org/10.1177/0956797619830649.

[3] *See, e.g.*, The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* ("WPATH SOC7") at 11 (Version 7, 2012), available at https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf.

[4] Cantor, James M., *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46(4) Journal of Sex & Marital Therapy 307–313 (2019), https://doi.org/10.1080/0092623X.2019.1698481.

[5] Steensma, T. D., et al., *Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*, 52(6) Journal of the American Academy of Child & Adolescent Psychiatry 582–590, at 588 (2013), https://doi.org/10.1016/j.jaac.2013.03.016.

transgender youth found that 94% continued to identify as transgender 5 years after transitioning.[6]

In light of the vastly different rates of persistence between youth who transition and those who do not, many experts in the field are concerned that a social transition may make a child's or adolescent's experience of gender incongruence more likely to persist. Dr. Kenneth Zucker, who for decades led "one of the most well-known clinics in the world for children and adolescents with gender dysphoria," has argued publicly that a social transition can "become[ ] self-reinforcing," because "messages from family, peers, and society do a huge amount of the work of helping form, reinforce, and solidify gender identities."[7] Dr. Zucker elsewhere has written that, in his view, "parents who support, implement, or encourage a gender social transition (and clinicians who recommend one) are implementing a psychosocial treatment that will increase the odds of long-term persistence."[8]

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[6] Olson, Kristina R., et al., *Gender Identity 5 Years After Social Transition*, 150(2) Pediatrics (Aug. 2022), https://doi.org/10.1542/peds.2021-056082.

[7] Singal, Jesse, *How the Fight Over Transgender Kids Got a Leading Sex Researcher Fired*, The Cut (Feb. 7, 2016), https://www.thecut.com/2016/02/fight-over-trans-kids-got-a-researcher-fired.html.

[8] Zucker, K., *The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al.*, 19(2) International Journal of Transgenderism 231–245 (2018), available at https://www.researchgate.net/publication/325443416.

The U.K.'s NHS is currently reconsidering its model of transgender care,[9] and the doctor in charge of the review, Dr. Hilary Cass, wrote in her interim report: "[I]t is important to view [social transition] as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes."[10]

Dr. Stephen Levine, another well-known practitioner in the field,[11] in an expert report for a related case, writes that "therapy for young children that encourages transition cannot be considered to be neutral, but instead is an experimental procedure that has a high likelihood of changing the life path of the child, with highly unpredictable effects on mental and physical health, suicidality, and life expectancy."[12]

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[9] *See Independent review into gender identity services for children and young people*, NHS England, https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/gender-dysphoria/independent-review-into-gender-identity-services-for-children-and-young-people/.

[10] Cass, H., *Independent review of gender identity services for children and young people: Interim report* (February 2022), https://cass.independent-review.uk/publications/interim-report/.

[11] Dr. Levine was the court-appointed expert in the first major case to reach a federal court of appeals about surgery for transgender prisoners. *Kosilek v. Spencer*, 774 F.3d 63, 77 (1st Cir. 2014).

[12] Expert Affidavit of Dr. Stephen B. Levine, Dkt. 31, *Doe v. Madison Metropolitan Sch. Dist.*, No. 20-CV-454 (Dane County Wis. Cir. Ct., filed Feb. 19, 2020), available at https://will-law.org/wp-

The authors of the 2013 study mentioned above expressed concern that "the hypothesized link between social transitioning and the cognitive representation of the self" may "influence the future rates of persistence," while noting that this "possible impact of the social transition itself on cognitive representation of gender identity or persistence" had "never been independently studied."[13]

Another group of researchers recently wrote that "early childhood social transitions are a contentious issue within the clinical, scientific, and broader public communities. Despite the increasing occurrence of such transitions, we know little about who does and does not transition, the predictors of social transitions, and whether *transitions impact children's views of their own gender*." Rae (2019), *supra* n. 2, at 669–70 (citations omitted, emphasis added).

The Endocrine Society's guidelines similarly recognize that "[s]ocial transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult. However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence."[14]

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content/uploads/2021/02/affidavit-stephen-levine-with-exhibit.pdf.

[13] Steensma (2013), *supra* n. 5, at 588–89.

[14] Hembree, Wylie C., et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, Endocrine Society, 102(11) J Clin.

The World Professional Association for Transgender Health (WPATH), which takes a decidedly pro-transitioning stance, has acknowledged that "[s]ocial transitions in early childhood" are "controversial," that "health professionals" have "divergent views," that "[f]amilies vary in the extent to which they *allow* their young children to make a social transition to another gender role," and that there is insufficient evidence "to predict the long-term outcomes of completing a gender role transition during early childhood." WPATH SOC7, *supra* n. 3, at 17.[15] WPATH encourages health professionals to *defer to parents* "as they work through the options and implications," *even* "[i]f parents do not allow their young child to make a gender role transition." *Id.*

In short, when a child or adolescent expresses a desire to change name and pronouns to an alternate gender identity, mental health professionals do not universally agree that the best decision, for *every such* child or adolescent, is to immediately "affirm" their desire and begin treating that child or adolescent as the opposite sex. And whether transitioning will be helpful or harmful likely depends on the individual child or

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Endocrinol. Metab. 3869–3903, at 3879 (2017), https://doi.org/10.1210/jc.2017-01658.

[15] WPATH SOC7, *supra* n. 3, at 17. The latest version of WPATH's standards of care guidelines (version 8), continues to acknowledge that "there is a dearth of empirical literature regarding best practices related to the social transition process." *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, WPATH, 23 International J. Trans. Health 2022 S1–S258, at S76 (2022), *available at* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644

adolescent. As WPATH emphasizes, "an individualized approach to clinical care is considered both ethical and necessary." WPATH SOC8, *supra* n. 14, at S45.

While the mental-health community continues to debate whether socially transitioning is generally beneficial, it is beyond dispute that there is currently little solid evidence about who is right, given how recent this trend is.

Even setting aside the debate about socially transitioning, there is near universal agreement that, when a child or adolescent exhibits signs of gender incongruence (and a request to change name/pronouns would certainly qualify), each should be considered separately and individually and can benefit from the assistance of a mental-health professional, for multiple reasons.

Every major professional association recommends a thorough professional evaluation to assess, among other things, the underlying causes of the child's or adolescent's feelings and consider whether a transition will be beneficial. The American Psychological Association, for example, recommends a "comprehensive evaluation" and consultation with the parents and youth to discuss, among other things, "the advantages and disadvantages of social transition during childhood and adolescence."[16] The Endocrine Society likewise recommends "a complete psychodiagnostic as-

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[16] American Psychological Association, *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*, 70(9) APA 832–64, at 843 (2015), https://www.apa.org/practice/guidelines/transgender.pdf.

sessment." *Supra* n. 13, at 3877. WPATH, too, recommends a comprehensive "psychodiagnostic and psychiatric assessment," covering "areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement," "an evaluation of the strengths and weaknesses of family functioning," any "emotional or behavioral problems," and any "unresolved issues in a child's or youth's environment." WPATH SOC7, *supra* n. 3, at 15.[17] WPATH also recommends that mental health professionals "discuss the potential benefits and risks of a social transition with families who are considering it." WPATH SOC8, *supra* n. 14, at S69.

A professional assessment is especially important given the "sharp increase in the number of adolescents requesting gender care" recently, particularly among adolescent girls ("2.5-7.1 times" rates affecting adolescent boys). WPATH SOC8, *supra* n. 14, at S43. As WPATH acknowledges, an increasing number of "adolescents [are] seeking care who have not seemingly experienced, expressed (or experienced and expressed) gender diversity during their childhood years," indicating that "social factors also play a role," including "susceptibility to social influence." *Id.* at S44–S45.

There is also growing awareness of adolescents who come to "regret gender-affirming decisions made during adolescence" and later "detransition," which many find to be a "difficult[ ]" and "isolating experience." *Id.*

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[17] WPATH SOC8, *supra* n. **Error! Bookmark not defined.**, at S45, likewise states that "a comprehensive clinical approach is important and necessary," "[s]ince it is impossible to definitively delineate the contribution of various factors contributing to gender identity development for any given young person."

at S47. In one recent survey of 237 detransitioners (over 90% of which were natal females), 70% said they realized their "gender dysphoria was related to other issues," and half reported that transitioning did not help.[18]

Another reason for professional involvement is to assess whether the child or adolescent needs mental-health support. Many transgender youth experience dysphoria—psychological distress—associated with the mismatch between their natal sex and perceived or desired gender identity. Indeed, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders' (DSM-V) official diagnosis for "gender dysphoria" is *defined by* "clinically significant distress" associated with the mismatch. *See What Is Gender Dysphoria?*, American Psychiatric Association.[19]

Gender incongruence is also frequently associated with other mental-health issues. WPATH's SOC8 surveys studies showing that transgender youth have higher rates of depression, anxiety, self-harm, suicide attempts, eating disorders, autism spectrum disorders, and other emotional and behavioral problems than the general population. *Supra* n. 14, at S62–63. All major professional organizations recommend screening for these coexisting issues and treating them, if needed. *Id.*; APA Guidelines, *supra* n. 15, at

[18] Vandenbussche, E., *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, 69(9) Journal of Homosexuality 1602–1620, at 1606 (2022), https://doi.org/10.1080/00918369.2021.1919479.

[19] American Psychiatric Association, *What is Gender Dysphoria?* https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria.

845; Endocrine Society Guidelines, *supra* n. 13, at 3876. By failing to inform parents of their children's situations, the District is placing these children in danger of suffering mental health difficulties, including the possibility of suicidal or self-harming activity, without sufficient support from mental health professionals or parents.

In *State v. Neumann* the Wisconsin Supreme Court held that "[i]t is the *right* and duty of parents under the law of nature as well as the common law and the statutes of many states to protect their children, to care for them in sickness and in health, and to do whatever is necessary for their care . . ." when it affirmed the trial court's jury instructions. *State v. Neumann*, 348 Wis. 2d 455, 512 (emphasis added). But the District's policy usurps that legal right by preventing the parent from seeking the appropriate treatment for their child. In fact, the Wisconsin Legislature has determined that if a parent refuses or is unable to seek treatment for their children's mental health issues, it is grounds for assigning child protective services to the case when it passed Wis. Stat. 48.13(11) which reads in relevant part:

> [T]he court has exclusive original jurisdiction over a child alleged to be in need of protection or services which can be ordered by the court if . . . [t]he child is suffering emotional damage for which the parent, guardian or legal custodian has neglected, refused or been unable and is neglecting, refusing or unable, for reasons other than poverty, to obtain necessary treatment or to take necessary steps to ameliorate the symptoms.

Wis. Stat. Ann. § 48.13 (2023)

It is difficult to imagine that the legislature could intend to charge parents with a duty to protect their children under threat of action by child protective services while also enabling an apparatus of the state to deprive parents of their ability to protect their children by keeping vital information about their children's well-being secret from them. A parent unaware that their child's mental and emotional health is in jeopardy is certainly unable to seek treatment.

Finally, professional support can be vital *during* any transition. A transition can "test [a young] person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports," and "[d]uring social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of [ ] counseling." Endocrine Society Guidelines, *supra* n. 13, at 3877.

Of course, parents cannot obtain a professional evaluation, screen for dysphoria and other coexisting issues, or provide professional mental-health support for their children, if their school hides from them what is happening at school.

To summarize, *no* professional association recommends that teachers and school officials, who have no expertise whatsoever in these issues, should facilitate a social transition while at school, treating minors as if they are really the opposite sex, in secret from their

parents, solely because they are concerned that their parents might not be "supportive" of a transition.

II. Parental decision-making authority over their minor children includes the right to be involved in how school staff refer to their child while at school.

Not only is it prudent—from a medical and mental health perspective—for parents to be involved when a school decides to socially transition a child, but parents have the constitutional right to be involved in these decisions.

A long line of cases from this Court establishes that parents have a constitutional right "to direct the upbringing and education of children under their control." *Troxel v. Granville*, 530 U.S. 57, 65 (2000) (plurality opinion) (quoting *Pierce v. Society of Sisters*, 268 U.S. 510, 534–35 (1925)). This is "perhaps the oldest of the fundamental liberty interests recognized by this Court." *Troxel*, 530 U.S. at 65 (plurality op.). Over the years, this Court has described this right as "essential," *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923), "commanding," *Santosky v. Kramer*, 455 U.S. 745, 759 (1982), a "basic civil right[ ] of man," *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942), "far more precious . . . than property rights," *May v. Anderson*, 345 U.S. 528, 533 (1953), and "established beyond debate as an enduring American tradition," *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972).

This line of cases establishes four important principles with respect to parents' rights that are relevant to the case at hand.

First, parents are the primary decision-makers with respect to their minor children—not their school, or even the children themselves. *Parham v. J. R.*, 442 U.S. 584, 602 (1979) ("Our jurisprudence historically has reflected . . . broad parental authority over minor children."); *Troxel*, 530 U.S. at 66 (plurality opinion) ("[W]e have recognized the fundamental right of parents to *make decisions* concerning the care, custody, and control of their children.") (emphasis added); *Yoder*, 406 U.S. at 232 (emphasizing the "primary role of the parents in the upbringing of their children"). Parental decision-making authority rests on two core presumptions: "that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions," *Parham*, 442 U.S. at 602, and that "natural bonds of affection lead parents to act in the best interests of their children," far more than anyone else. *Id.*; *Yoder*, 406 U.S. at 232 ("The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children.").

Second, parental rights reach their peak, and thus receive the greatest constitutional protection, on "matters of the greatest importance." *See C.N. v. Ridgewood Bd. of Educ.*, 430 F.3d 159, 184 (3d Cir. 2005) (calling this "the heart of parental decision-making authority"); *Yoder*, 406 U.S. at 233–34. One such area traditionally reserved for parents is medical and health-related decisions, as this Court recognized long ago: "Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments." *Parham*, 442 U.S. at 603.

Third, a child's disagreement with a parent's decision "does not diminish the parents' authority to decide what is best for the child." *Id.* at 603–04. *Parham* illustrates how far this principle goes. That case involved a Georgia statute that allowed parents to voluntarily commit their minor children to a mental hospital (subject to review by medical professionals). *Id.* at 591–92. A committed minor argued that the statute violated his due process rights by failing to provide him with an adversarial hearing, instead giving his parents substantial authority over the commitment decision. *Id.* at 587. The Court rejected the minor's argument, confirming that parents "retain a substantial, if not the dominant, role in the [commitment] decision." *Id.* at 603–04. "The fact that a child may balk at hospitalization or complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority." *Id.* at 604.

Fourth, the fact that "the decision of a parent is not agreeable to a child or . . . involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603. Likewise, the unfortunate reality that some parents "act[ ] against the interests of their children" does not justify "discard[ing] wholesale those pages of human experience that teach that parents generally do act in the child's best interests." *Id.* at 602–03. The "notion that governmental power should supersede parental authority in *all* cases because *some* parents abuse and neglect children" is "statist" and "repugnant to American tradition." *Id.* at 603 (emphasis in original). Thus, as long as a parent is fit, "there will normally be no reason for the State to

inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children." *Troxel*, 530 U.S. at 68–69 (plurality opinion).

In accordance with these principles, courts have recognized that a school violates parents' constitutional rights if it attempts to usurp their role in significant decisions. *See Gruenke v. Seip*, 225 F.3d 290, 306–07 (3d Cir. 2000) ("It is not educators, but parents who have primary rights in the upbringing of children. School officials have only a secondary responsibility and must respect these rights.").

The Eau Claire Area School District's Policy violates parents' decision-making authority over their minor children in at least three different ways.

First, the Policy violates parents' constitutional right to decide whether a social transition is in their child's best interest. When children or adolescents experience gender dysphoria, the decision whether they should socially transition is a significant and impactful healthcare-related decision that falls squarely within "the heart of parental decision-making authority," *C.N.*, 430 F.3d at 184; *Parham*, 442 U.S. at 603. As described above, there is an ongoing debate among mental health professionals over how to respond when a child experiences gender incongruence, and, in particular, whether and when children should socially transition by being addressed as though they were the opposite sex.

The District's Policy takes this life-altering decision out of parents' hands and places it with educators

and young children, who lack the "maturity, experience, and capacity for judgment required for making life's difficult decisions." *Parham*, 442 U.S. at 602. By enabling children to transition at school, in secret from parents, without parental involvement, the District is effectively making a treatment decision without the legal authority to do so and without informed consent from the parents. Given the significance of changing gender identity, especially at a young age, parents "can and must" make this decision. *Parham*, 442 U.S. at 603.

A child's fear that his or her parents might not "support" a transition is not sufficient to override their decision-making authority. Parents' role is sometimes to say "no" to protect their children from decisions against their long-term interests.

Second, the District's Policy also violates parental rights by concealing a serious mental-health issue from parents, circumventing their involvement altogether on this sensitive issue. *See H. L. v. Matheson*, 450 U.S. 398, 410 (1981) (parents' rights "presumptively include[ ] counseling [their children] on important decisions"); *Arnold v. Bd. of Educ. of Escambia County, Ala.*, 880 F.2d 305, 313 (11th Cir. 1989). Parents cannot guide their children through difficult decisions without knowing what their children are facing. That is why federal and state laws give parents complete access to all of their children's education records. *E.g.*, 20 U.S.C. § 1232g(a)(1)(A). By prohibiting staff from communicating with parents about this one issue, the District's Policy effectively substitutes school

staff for parents as the primary source of input for children navigating difficult life decisions, with long-term implications. *See Gruenke*, 225 F.3d at 306–07.

Third, the Policy interferes with parents' ability to provide professional assistance their children may urgently need. As explained above, gender dysphoria can be a serious psychological issue that requires support from mental health professionals. And gender incongruent children often present other psychiatric co-morbidities, including depression, anxiety, suicidal ideation and attempts, and self-harm. Teachers and staff do not have the training and experience necessary to properly diagnose children with gender dysphoria or to opine and advise on the treatment options. They cannot provide professional assistance for children dealing with these issues, and parents cannot obtain it either for their child if they are kept in the dark. Thus, parents must be notified and involved not only to make the decision about whether a social transition is in their child's best interest, but also to obtain professional support for their child.

CONCLUSION

This Court should grant certiorari to protect the rights of parents who are fighting to protect their children. The District's policy prevents parents from being notified of significant, life-altering events in their children's lives. Such a policy runs counter to American tradition, natural law, and the constitutionally protected rights of parents to make decisions regarding their own children and substitutes untrained and unqualified teachers and school administrators for parents.

Respectfully Submitted,
July 8, 2024

Jacob Huebert
Counsel of Record
Emily Rae
Liberty Justice Center
13341 W. U.S. Highway 290
Building 2
Austin, Texas 78737
(512) 481-4400
jhuebert@ljc.org
Attorneys for Amicus Curiae
Dr. Erica E. Anderson, PhD