No. 23-601

IN THE
SUPREME COURT OF THE UNITED STATES

JOHN AND JANE PARENTS 1, ET AL.,
PETITIONERS,

V.

MONTGOMERY COUNTY BOARD OF EDUCATION, ET AL.,
RESPONDENTS.

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

BRIEF OF *AMICI CURIAE* THE LIBERTY JUSTICE CENTER, WISCONSIN INSTITUTE FOR LAW & LIBERTY, AND DR. ERICA ANDERSON IN SUPPORT OF PETITIONER

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INTEREST OF THE *AMICI CURIAE*[1]

The Liberty Justice Center and Wisconsin Institute for Law & Liberty are both nonprofit, nonpartisan public-interest litigation firms 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

[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.

the best possible support and assistance for those children. In her view, appropriate care requires parental involvement.

SUMMARY OF ARGUMENT

The Montgomery County, Maryland, School District, like many other school districts around the country, has adopted a policy allowing children of any age to secretly 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 coexisting issues, to provide ongoing support, and ultimately, to decide whether a transition will be in their child's best interests. Yet the District Court held that this critical decision is merely a "curriculum" decision that school districts may not only exclude parents from, but also hide from them. It is the first federal court in the country to hold—on a motion to dismiss, no less—that such a policy does not violate parents' constitutional rights. The Fourth Circuit declined to address the merits of the case, instead finding Petitioners lacked Article III standing.

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

ARGUMENT

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

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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,*

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 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

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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.

[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.

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]

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

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[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.

[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/.

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]

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," Steensma (2013), *supra* n. 5, at 588–89.

Another group of researchers recently wrote that "early childhood social transitions are a contentious issue within the clinical, scientific, and broader public

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

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 (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence."[13]

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.[14] WPATH

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[13] Hembree, Wylie C., et al., *Endocrine Treatment of Gender-Dyshporic/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, Endocrine Society, 102(11) J Clin. Endocrinol. Metab. 3869–3903, at 3879 (2017), https://doi.org/10.1210/jc.2017-01658.

[14] The latest version of WPATH's standards of care guidelines (version 8), continues to acknowledge that "there is a dearth of

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 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

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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

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."[15] The Endocrine Society likewise recommends "a complete psychodiagnostic assessment." *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.[16] WPATH also recommends that mental health professionals "discuss the potential benefits and risks of a

[15] 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.

[16] WPATH SOC8, *supra* n. **Error! Bookmark not defined.**, at S 45, 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."

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" 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.* 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.[17]

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

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[17] 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.

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.[18]

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 845; Endocrine Society Guidelines, *supra* n. 13, at 3876.

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.

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

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.

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 [the Supreme] 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." *Parham*, 442 U.S. 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 Montgomery County 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 in more detail 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 Excambia 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 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 comorbidities, 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.

III. Treating a child or adolescent as the opposite sex while at school, in secret from their parents, is not a "curriculum" decision, nor is a child's request for secrecy sufficient to exclude parents.

Although the Fourth Circuit's decision was based on Article III standing and not the merits, there are important questions that the District Court answered

incorrectly on the merits that this Court should address. The District Court made three errors in its analysis.

First, the District Court reframed the Policy to allow and facilitate secret gender identity transitions at school as a matter of "curriculum." *E.g.*, Pet'rs' App. ("PA") 72 ("[T]he *Meyer-Pierce* line of cases do not establish a 'fundamental right' for parents to dictate the nature of their children's education."); PA79–80 ("[I]t is clear in the case law that parents do not have a constitutional right to dictate a public school's curriculum."); PA93 ("This case involves 'how' the MCPS teaches its students.").

The portion of the policy challenged by Appellants has nothing at all to do with curriculum. Parents of course cannot "dictate" what a school district teaches during the day, but they do have authority over their minor children, and when a major decision point arises—like whether staff will treat their child as the opposite sex—schools must defer to parents, even if the issue surfaces at school. Indeed, one of the cases cited by the District Court draws this exact distinction: in *C.N.*, 430 F.3d at 184, the Third Circuit emphasized that exposing children to an objectionable survey is not "of comparable gravity" to "depriv[ing] [parents] of their right to make decisions concerning their child." That is exactly what is at stake here.

The District's policy prohibits teachers (i.e. coerces them) from discussing with parents their child's transition at school, without the child's consent, as the District Court acknowledged. PA85–86 ("[The Policy] advis[es] that school personnel [must] keep a

transgender or gender nonconforming student's gender identity confidential unless and until that student consents to disclosure"); PA66 ("the Guidelines instruct MCPS staff to keep a student's gender identity confidential until the student consents to the disclosure"). By coercing teachers to refrain from openly communicating with parents about their child's request to transition to a different gender identity at school, the Policy prevents parents from advising their children—and providing professional guidance and support—at the critical moment when their child is considering whether to transition.

Second, the District Court heavily emphasized that the District will not *always* hide a social transition at school from parents, but only if the student requests secrecy from their parents. PA63–66. That is beside the point. School districts *may never* hide this major decision from parents solely because the minor student wants to keep a secret from their parents. The District effectively treats school like Las Vegas: "What happens at school stays at school.". If minor students—of any age, no less—want to hide a gender identity transition at school from their parents, the District will happily oblige, no questions asked. To ensure secrecy, the District directs teachers to hide records of the transition (violating education records laws, as the District Court recognized), PA103, and to engage in deception by using different names/pronouns around parents than at school, PA116 ("[W]hen contacting the parent/guardian of a transgender student, MCPS school staff members should use the student's legal name and pronoun that correspond to the student's sex assigned at birth."). And the District prohibits teachers from communicating with parents

about their own children. PA154 (staff shall not "disclose a student's status to others, *including parents/guardians* … unless legally required to do so or unless students have authorized such disclosure."). The District's Policy effectively communicates to its minor students that deceiving and hiding things from their parents is ok.

Unsurprisingly, the District Court did not identify any case holding that schools may conspire with minor students to hide a major life decision from their parents. Never mind case law, it also did not identify *any comparable situation or example* in which schools help their students hide things from their parents when everyone at school is aware. As any parent can testify, schools regularly send home parental consent forms, for even the most minor of things. Yet the District and others have carved out this one, major life decision, and decided that parents not only do not get to be involved in the decision, *they do not even get to know* what is happening.

Finally, the District Court held that the District's Policy is substantially justified and appropriately tailored to protect children *from their own parents*. PA84–87. This holding flies directly in the face of the "traditional *presumption*"—constitutionally mandated, by the way—that parents act in their children's best interests. *Troxel*, 530 U.S. at 69 ("The decisional framework employed by the Superior Court directly contravened the traditional presumption that a fit parent will act in the best interest of his or her child."); *Doe v. Heck*, 327 F.3d 492, 521 (7th Cir. 2003) (finding a violation of parents' rights where state actors "not only failed to presume that the plaintiff parents would

act in the best interest of their children, they assumed the exact opposite"). It is never constitutionally permissible to usurp parental authority solely at the say-so of a minor, without requiring any evidence or allegation of harm, or giving parents any process or opportunity to respond or defend themselves. *See Santosky v. Kramer*, 455 U.S. 745 (1982). School districts do not have power to act as ad hoc family courts, litigating family law issues or deciding on their own, independent of any court process, which parents have authority over which decisions.

* * * * *

At bottom, the District simply disagrees with parents who might say "no" to an immediate transition. That is not sufficient to override their parental role. Schools cannot and should not exclude parents from decisions involving their own children, solely based on their assessment of how "supportive" they are. The District's Policy, and others like it around the country, are a stunning deviation from what parents expect when they send their minor children to school. If this Court affirms the District Court's ruling, parents in this circuit will have no choice but to preemptively withdraw their children from public school to preserve their parental role. Parents should not have to cede their decision-making authority merely by sending their children to public school.

CONCLUSION

The Court should grant the petition.

Respectfully Submitted,
January 4, 2024

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