No. 24-539

In the Supreme Court of the United States

KALEY CHILES,

Petitioner,

v.

PATTY SALAZAR, IN HER OFFICIAL CAPACITY AS EXECUTIVE DIRECTOR OF THE DEPARTMENT OF REGULATORY AGENCIES, ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE BECKET FUND FOR RELIGIOUS LIBERTY IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether a law that censors certain conversations between counselors and their clients based on the viewpoints expressed regulates conduct or violates the Free Speech Clause.

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Colo. Rev. Stat. § 13-20-403 25

Colo. Rev. Stat. § 25-1.5-106 25

Colo. Rev. Stat. § 25-48-103 25

Wash. Rev. Code § 18.225.030..... 27

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Am. Psych. Ass'n,
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Jennifer Brown, *Denver doctor helped patients with severe anorexia obtain aid-in-dying medication, spurring national ethics debate,* The Colorado Sun, Mar. 14, 2022 25

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H.B. 25-1309, 75th Gen. Assemb., 1st Reg. Sess. (Colo. 2025) 12

Dep't of Health & Human Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (May 1, 2025) ("HHS Report") 6, 7, 8, 9 10, 11, 18 20-21, 22, 29

Riittakerttu Kaltiala-Heino et al., *Gender dysphoria in adolescence: current perspectives*, 9 Adolescent Health, Med., & Therapeutics 31 (2018)..... 7-8

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United Kingdom Department of Health and Social Care, *New restrictions on puberty blockers* (May 29, 2024) 22

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INTEREST OF *AMICUS CURIAE*[1]

The Becket Fund for Religious Liberty is a nonprofit, nonpartisan law firm that protects the free expression of all religious faiths. Becket has represented agnostics, Buddhists, Christians, Hindus, Jains, Jews, Muslims, Native Americans, Santeros, Sikhs, and Zoroastrians, among others, including in this Court.

Becket is concerned that laws like Colorado's Counseling Restriction disproportionately harm people of faith. For example, Becket currently represents Catholic counselors in Michigan whose speech is being gagged by a law like Colorado's. *Catholic Charities of Jackson* v. *Whitmer*, 764 F. Supp. 3d 623, 633 (W.D. Mich. 2025). These counselors believe that when a client comes to them and seeks help to align her gender expression with her biological sex, they have an ethical and religious duty to help that client live the life she desires to live. In fact, many young people seek out these counselors precisely because they share the same faith and want to talk about how to align their conduct with their religious convictions. But laws like Colorado's make these conversations illegal, chilling speech and restraining religious exercise.

Becket submits this brief to address the severe harms that flow from laws like Colorado's and to explain why Colorado's law cannot survive strict or even intermediate scrutiny.

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[1] No counsel for a party authored this brief in whole or in part and no person other than Amicus, its members, or its counsel made a monetary contribution intended to fund the preparation or submission of this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

What drives otherwise reasonable judges to conclude that "the use of verbal language"—*talking*—is not speech?

It is not this Court's precedent. Cases like *Holder*, *Cohen*, and *303 Creative* teach otherwise.

Instead, what appears to drive the outcome is the supposed "medical consensus" that "conversion therapy is ineffective and harmful to minors." Pet. App. 63a-72a (mentioning "consensus" ten times). That is, if talk therapy is sufficiently harmful—if it is truly "known to increase suicidality in minors"—then maybe it makes sense to fudge the free-speech analysis by relabeling the "use of verbal language" as "conduct" and allowing states to ban it. Pet. App. 61a, 46a.

One response to this move is to refute it doctrinally—to explain why, under *Holder*, *Cohen*, and *303 Creative*, "[s]peech cannot lose its protection just because it is relabeled conduct and then banned." Volokh Amicus Br. 2. But if all this Court does is apply *Holder*, *Cohen*, and *303 Creative* and remand for application of strict scrutiny, the problem won't go away. Lower courts will split again, with at least some judges citing the supposed "medical consensus" to uphold the same bans under strict scrutiny.

That is why the Court should also resolve the question of strict scrutiny, which has been fully briefed by the parties, and which lends itself to clear resolution on the current record.

To accurately apply strict scrutiny, it is essential to understand the two competing approaches to helping

children who struggle with gender dysphoria: the cautious approach and the "gender-affirming" approach. The cautious approach, followed by Chiles and many other counselors, relies on talk therapy to help children address the underlying causes of their dysphoria and grow comfortable with their bodies without resorting to irreversible medical interventions.

The gender-affirming approach, mandated by Colorado, requires counselors to affirm a child's assertion of a gender identity that diverges from their biological sex and encourages children down the path of gender transition—which often includes irreversible medical interventions like puberty blockers, cross-sex hormones, and surgeries.

So, the question on strict scrutiny is not whether Colorado's abstract and intentionally mis-defined bogeyman ("conversion therapy") is harmful. The question is whether banning cautious talk therapy like Chiles's—*and thus pushing children toward a gender-affirming approach*—is the least restrictive means of protecting children from harm.

It is not. In fact, mounting evidence indicates that Colorado's approach is affirmatively harmful. Two comprehensive national reports—the 2024 Cass Review in the U.K. and the 2025 Health and Human Services Report in the U.S.—found "no good evidence" that the gender-affirming approach improves mental-health outcomes in children. And it is undisputed that gender-affirming medical interventions carry serious physical health risks, such as increased likelihood of sexual dysfunction, infertility, coronary artery disease, liver dysfunction, and cancer. The evidence also indicates that most children who suffer from gender

dysphoria will grow out of it—meaning harmful medical interventions are often unnecessary to begin with.

The Cass Review and HHS Report have also identified laws like Colorado's as a significant barrier to care for children with gender dysphoria, chilling counselors who would otherwise offer compassionate counseling to help children resolve their dysphoria without harmful medical interventions. Predictably, the burden of such bans falls disproportionately on religious youth, who often seek such counseling to help them align their conduct with their deeply held religious beliefs. Thus, Colorado's ban not only pushes children toward harmful medical interventions but also deprives them of the assistance they both need and want to live in accordance with their faith.

Even assuming Colorado's ban furthered its interest in protecting children—rather than undermining it—Colorado hasn't chosen the least restrictive alternative to its total ban on consensual talk therapy. Short of a total ban, Colorado could, among other things: (1) ban aversive or coercive methods, rather than consensual talk therapy; (2) ban efforts to change gender identity when doing so contradicts the client's self-defined goals; (3) grant a religious exemption for counseling that furthers a client's religious exercise; (4) enforce professional malpractice torts against bad acts that produce actual harm; or (5) require informed consent. Colorado has not even attempted to explain why these alternatives would be ineffective, much less tried employing them. It therefore fails strict scrutiny.

* * *

Earlier this Term, Colorado told this Court that "[e]ven when forms of treatment involve heightened

medical risks," the "longstanding approach of States in this area has been to enable minors and their parents to make informed medical decisions." See Amicus Br. of Colorado et al. at 8, *United States* v. *Skrmetti*, No. 23-477 (Sept. 3, 2024). To that end, Colorado allows minors to pursue a host of risky medical interventions with informed consent and similar guardrails—from electroconvulsive therapy to medical marijuana, gender transitions, and more. Colorado Medicaid will even *pay* for minors to have cross-sex hormones, mastectomies, and genital surgeries—permanently stripping young girls of the opportunity to ever bear or nurse children. According to Colorado, children can safely make those momentous decisions. But it is too dangerous for a child even to talk with a counselor who tells her that her body is a healthy gift from God. That is not only backwards and harmful but also a violation of the Free Speech Clause.

ARGUMENT

I. The Counseling Restriction promotes "gender-affirming" counseling and suppresses cautious counseling.

Our nation is engaged in a vigorous debate over how best to help children who experience gender dysphoria. It is impossible to understand Colorado's Counseling Restriction, or assess whether it meets strict scrutiny, without understanding the two sides of this debate.

1. On one side are mental-health professionals like Chiles—professional counselors and psychotherapists—who follow a cautious approach. These professionals recognize that a child's experience of gender

dysphoria is complex and individualized, can be influenced by a variety of factors, and can change over time. Instead of immediately affirming a child's desire to "transition" to the other sex, they offer "talk therapy"—counseling consisting entirely of speech—to help the child explore the underlying causes of distress and, if possible, alleviate that distress without resorting to irreversible medical interventions. This cautious approach has long been standard practice among counselors.[2]

On the other side of the debate are mental-health professionals who advocate a "gender-affirming" approach. This approach assumes that children who assert a transgender identity "know their gender as clearly and as consistently as their developmentally equivalent peers."[3] Accordingly, the role of a counselor is not to explore potential underlying causes of distress, but to "follow the child's lead" and "reassure[] [the child] that there is nothing wrong with their gender identity or expression."[4] If puberty is imminent, counselors may also encourage families to seek out

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[2] Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report* at 67-70 (2024) https://perma.cc/WB8Y-RR43 ("Cass Review"); Dep't of Health & Human Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* at 142-145 (May 1, 2025), https://perma.cc/7B96-VTXG ("HHS Report").

[3] Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics 4 (Oct. 2018), https://perma.cc/S7U2-Z8K4.

[4] Gabe Murchison et al., *Supporting & Caring for Transgender Children* at 16, Human Rights Campaign Foundation & American Academy of Pediatrics (Sept. 2016), https://perma.cc/N5HW-KYJ6.

doctors who can prescribe "puberty-delaying medications," which may be followed later by other medical interventions, like cross-sex hormones and surgeries.[5] For biological girls, these surgeries may include a mastectomy, hysterectomy, facial masculinization, and phalloplasty; for biological boys, this may include breast augmentation, orchiectomy, facial feminization, and vaginoplasty. See HHS Report at 175. This is called "pediatric medical transition." *Id.* at 9.

2. The benefits and risks of these competing approaches are currently the subject of vigorous national and international debate. However, the most robust and recent scientific evidence favors the cautious approach.

The cautious approach is premised on the notion that gender identity and gender dysphoria are "complex and poorly understood," and that "[y]oung people's sense of identity is not always fixed and may evolve over time." Cass Review at 193, 21. This is borne out by the evidence, which indicates that a substantial majority of minors experiencing gender dysphoria—some studies indicate up to 80-95%—naturally desist after puberty, meaning they become comfortable with their biological sex without invasive medical interventions.[6]

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[5] *Id.* at 16-17.

[6] *L. W. by & through Williams* v. *Skrmetti*, 83 F.4th 460, 487 (6th Cir. 2023), cert granted *sub nom. United States* v. *Skrmetti,* No. 23-477 (U.S. June 24, 2024) (citing Detransitioners' Amicus Br. at 19-25); see also Devita Singh et al., *A Follow-Up Study of Boys with Gender Identity Disorder*, 12 Frontiers in Psychiatry 632784 (2021), https://perma.cc/58FQ-TK6U (reporting 87.8% desistence); Riittakerttu Kaltiala-Heino et al., *Gender dysphoria in*

Minors with gender dysphoria also experience a disproportionately high rate of co-occurring mental-health issues, including "depression, anxiety, suicidality, self-harm, and eating disorders," and "neurodevelopmental conditions like autism spectrum disorder." HHS Report at 65-66, 248-251; Cass Review at 90-97. Counseling is an effective, evidence-based treatment for these co-occurring issues. HHS Report at 248-251. And "[t]he effectiveness of psychotherapy for a wide range of mental health problems * * * that often present with [gender dysphoria] suggests it may also be beneficial for [gender dysphoria] specifically." *Id.* at 254. At minimum, "there is no reliable evidence to suggest that psychotherapy for [gender dysphoria] is harmful." *Id.* at 252. And while the evidence is still very low certainty, "several studies suggest that psychotherapy for [gender dysphoria] may effectively resolve the condition noninvasively." *Id.* at 251.

By contrast, the gender-affirming approach is premised on the notion that gender identity is relatively fixed, that clinicians can reliably predict when gender dysphoria will persist, and that social and medical transition is an effective treatment for persistent gender dysphoria. See HHS Report at 68. But these assumptions are not supported by the data.

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adolescence: current perspectives, 9 Adolescent Health, Med., & Therapeutics 31, 33 (2018), https://perma.cc/84D8-MDNR ("Evidence from the 10 available prospective follow-up studies from childhood to adolescence (reviewed in the study by Ristori and Steensma) indicates that for ~80% of children who meet the criteria for GDC, the GD recedes with puberty."); Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1895 (2008), https://perma.cc/75GQ-483Z ("estimates range from 80-95%").

As noted above, up to 80-95% of minors experiencing gender dysphoria may naturally grow out of it after puberty. And there is "no evidence" that clinicians can "reliably predict" which minors "will have longstanding gender incongruence in the future" and which "might regret or detransition at a later date." Cass Review at 194, 34.

Nor is there any reliable evidence that social and medical transition helps improve long-term outcomes in children with gender dysphoria. See HHS Report at 84-88. For example, "there is no evidence that gender-affirmative treatments reduce" "deaths by suicide in trans people," and "no good evidence on the long-term outcomes of interventions to manage gender-related distress." Cass Review at 195, 13.

Meanwhile, "no one disputes" that pediatric medical transitions carry serious health risks. *L. W. by & through Williams* v. *Skrmetti*, 83 F.4th 460, 489 (6th Cir. 2023), cert granted *sub nom. United States* v. *Skrmetti,* No. 23-477 (U.S. June 24, 2024). Puberty blockers "can cause diminished bone density, infertility, and sexual dysfunction." *Ibid.* Cross-sex testosterone "increases the risk of erythrocytosis, myocardial infarction, liver dysfunction, coronary artery disease, cerebrovascular disease, hypertension, and breast and uterine cancer." *Ibid.* And cross-sex estrogen "can cause sexual dysfunction and increases the risk of macroprolactinoma, coronary artery disease, cerebrovascular disease, cholelithiasis, and hypertriglyceridemia." *Ibid.* For either sex, a full medical transition renders an individual permanently sterile. See HHS Report at 112, 122. These adverse health effects are undisputed—and confirmed by the experiences of

numerous individuals who have suffered from their medical transitions and later sought to reverse them.[7]

Gender-affirming counseling thus pushes children toward harmful, irreversible medical interventions, even though most children will grow out of their dysphoria—meaning that such interventions are ultimately unnecessary. See p. 7 n.6, *supra*.

3. Notwithstanding this evidence, Colorado's Counseling Restriction comes down hard against cautious counseling and in favor of the gender-affirming approach. Colorado bans "any practice," including pure speech, that seeks to "change" an individual's "gender expression," "behavior[ ]," or "gender identity." Colo. Rev. Stat. § 12-245-202(3.5)(a). Thus, if a young person comes to Chiles, and voluntarily seeks help to change her conduct and gender expression to align with her biological sex, Chiles cannot legally help her. If she does so, Chiles faces potential loss of her counseling license and $5,000 fines. Colorado law also pejoratively and inaccurately labels cautious counseling as "conversion therapy." Cass Review at 150; HHS Report at 252-254.

"Conversion therapy" is not an appropriate label for the cautious counseling Chiles seeks to provide. In

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[7] *Skrmetti*, 83 F.4th at 487 (citing Detransitioners' Amicus Br. 19-25); see also Lisa Littman, Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners, 50 Archives of Sexual Behav. 3353 (2021), https://perma.cc/UVQ6-KVDE (noting that in a sample of 100 individuals who had gone through medical or surgical gender transition and then detransitioned, 49% cited concerns about medical complications as their reason for detransitioning).

the latter half of the 20th century, some providers developed various forms of conversion therapy—also known as reparative therapy or "sexual orientation change efforts"—sometimes characterized by the use of coercion, shaming, or "aversive" conditioning in efforts to change an individual's sexual orientation.[8] Those practices have been broadly repudiated, even by former practitioners, and are rare to nonexistent today.[9] More recently, the term conversion therapy has been used to describe any practice that is not fully gender-affirming, including the mainstream, cautious use of pure talk therapy.[10] This conflation of distinct practices is highly questionable and creates confusion.[11] It is undisputed that Chiles does not engage in any coercive or aversive practices. Pet. App. 205a-206a. Nevertheless, because she offers counseling that helps young people who want to change in the direction of embracing their biological sex, Colorado labels her practice "conversion therapy" and bans it completely.

By contrast, a counselor who provides "[a]ssistance to a person undergoing gender transition" is categorically exempt from the Counseling Restriction, even if the goal of her counseling is to help a minor "change" her "behavior[]" and "gender expression" to conform to that of the opposite sex, and even if the result of that counseling is to lead the minor down the path of cross-

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[8] See Roberto D'Angelo, *Supporting autonomy in young people with gender dysphoria: psychotherapy is not conversion therapy* at 3, J. of Med. Ethics (2023), https://perma.cc/3ZZH-M2HR.

[9] *Ibid.*

[10] See *ibid.*

[11] See *ibid.*; HHS Report at 242-254.

sex hormones and other irreversible medical interventions. Colo. Rev. Stat. § 12-245-202(3.5)(b). What is more, her counseling is paid for. Colorado requires all health benefit plans in the state to cover "gender-affirming" counseling, as well as hormone therapy, facial reconstruction, and genital surgery prescribed to treat gender dysphoria. H.B. 25-1309, 75th Gen. Assemb., 1st Reg. Sess. (Colo. 2025).[12]

4. Counseling restrictions like Colorado's have pernicious and predictable results. Perhaps most importantly, there is widespread recognition that bans like Colorado's prevent children with gender dysphoria from accessing needed mental-health care. The Cass Review found that conversion therapy bans left "some clinical staff fearful of accepting referrals of" gender dysphoric youth. Cass Review at 202. Other UK clinicians expressed concern that they would be accused of conversion therapy "when following an approach that would be considered normal clinical practice when working with other groups of children and young people." *Ibid.*

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[12] Colorado also covers genital surgery, mastectomies, and facial surgery for minors under Health First Colorado, the state's Medicaid plan. Colo. Dep't of Health Care Pol'y & Fin., *Gender-Affirming Care Billing Manual*, https://perma.cc/MF3E-3R9T. This care is readily available to Colorado residents, as the University of Colorado Health System boasts that it offers a "[v]ast spectrum of gender-affirming hormone therapy and gender-affirming surgery," Univ. Colo. Anschutz School of Medicine, *UCHealth Integrated Transgender Program*, https://perma.cc/4D98-A6EC, despite acknowledging that "[t]here is no way to predict what your response to hormones will be," UCHealth Integrated Transgender Program Anschutz Medical Campus, *Understanding Feminizing Gender-Affirming Hormone Therapy*, https://perma.cc/J9GJ-YQFK.

The HHS Report identified the same dynamic in the U.S., pointing out these laws' "chilling effect on the ethical psychotherapists' willingness to take on complex" cases of gender dysphoria, "which will make it much harder for [gender dysphoric] individuals to access quality mental health care." HHS Review at 255-256. In other words, conversion therapy bans like Colorado's make it harder for gender dysphoric youth to find counseling for *any* mental-health issues, not just for gender dysphoria.

The impact of Colorado's law also falls disproportionately on youth who are religious. It is well understood that laws like the Counseling Restriction burden "overwhelmingly—if not exclusively—religious" speech. *Tingley* v. *Ferguson*, 57 F.4th 1072, 1084 (9th Cir. 2023) (Bumatay, J., dissenting from denial of rehearing). For example, the American Psychological Association has admitted that "most" counseling prohibited by such laws is "directed to those holding conservative religious" beliefs, and that research on such counseling "includes almost exclusively individuals who have strong religious beliefs."[13] In other words, religious youth are most directly affected by laws like Colorado's.

Indeed, after Michigan passed a conversion therapy ban in 2023, some Muslim mental-health providers were "forced to curtail or abandon their practices out of fear that religiously grounded therapy—consistent with their own and their patients' beliefs—

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[13] Am. Psych. Ass'n, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* at 25 (Aug. 2009) ("APA Task Force Report"), https://perma.cc/6FWH-XJ5D.

[would] trigger professional sanctions" under the Michigan ban. Amicus Br. of the Council on American-Islamic Relations at 10, *Catholic Charities of Jackson* v. *Whitmer*, No. 25-1105 (6th Cir. Apr. 4, 2025). One therapist "ceased treating patients entirely," while another left her job working with young people. *Id.* at 10-11, 13. And because Michigan's law (like Colorado's) has no exemption for licensed counselors who work for religious organizations, a respected religious nonprofit feared that it could no longer "lawfully serve its faith community without violating state law." *Id.* at 11.

Michigan's law also affects Catholic counselors like Emily McJones. Out of respect for her clients and their autonomy, McJones believes that when a client comes to her and seeks to change her gender identity or gender expression to match her biological sex, it is McJones's ethical and religious duty to help that client live the life she desires to live. See Decl. of Emily McJones at 2-4, *Catholic Charities of Jackson* v. *Whitmer*, 1:24-cv-718 (W.D. Mich. July 19, 2024), ECF 15-3. One of McJones's teenage clients, for example, had intrusive thoughts while attending Catholic Mass and felt as though she was in the wrong body—that she should be a male, not female. *Id* at 7-8. This client sought McJones's help specifically because McJones is a Catholic counselor, and the client did not want these intrusive thoughts to be affirmed. *Ibid.* Through talk therapy, McJones helped this client feel more comfortable in her body, reduce her cognitive dissonance in attending Mass, and feel more fully herself. *Ibid.* McJones's counseling was legal because her client was 19 years old. But if the same young person had come to her a year earlier, McJones would have been in violation of Michigan's conversion therapy ban, which is

nearly identical to Colorado's (but imposes fines up to $250,000).

All of this is the opposite of the approach that Colorado takes for other treatments sought by young people suffering from mental illness. If young people in Colorado believe that their mental distress would be alleviated by medical marijuana—or electroconvulsive therapy, psychiatric hospitalization, or surgery to remove their genitals—then Colorado allows them to pursue these treatments. See p. 25, *infra*. But when it comes to simply talking with a counselor to help accept their own bodies, Colorado has imposed an absolute ban. Colorado has never explained why the safeguards that are sufficient for these high-risk medical treatments are insufficient for talk therapy. See pp. 24-26, *infra*.

II. The Counseling Restriction fails strict scrutiny.

For the reasons detailed in Chiles's brief, Pet. Br. 26-44, Colorado's Counseling Restriction is a content-based speech restriction that triggers strict scrutiny, "the most demanding test known to constitutional law." *City of Boerne* v. *Flores*, 521 U.S. 507, 534 (1997). "It is rare that a regulation restricting speech because of its content will ever be permissible." *United States* v. *Playboy Ent. Grp.*, 529 U.S. 803, 818 (2000). To survive strict scrutiny, Colorado must show that the Counseling Restriction "serve[s] a compelling interest and [is] narrowly tailored to that end." *Kennedy* v. *Bremerton Sch. Dist.*, 597 U.S. 507, 532 (2022). It has not done so.

A. The Restriction does not further a compelling state interest.

Below, Colorado claimed a two-fold interest in "maintaining the integrity of the mental-health profession" and in "protecting children" from "harmful therapeutic practices known to increase suicide among youth." 5/1/23 Resp. C.A. Br. 48-50. These interests fail to satisfy strict scrutiny for numerous reasons.

1. "[A]morphous" goals—like "maintaining the integrity of the mental health profession"—don't count as compelling government interests because they "cannot be subjected to meaningful judicial review." *Students for Fair Admissions, Inc.* v. *President & Fellows of Harvard Coll.*, 600 U.S. 181, 214 (2023) ("*SFFA*"). As *SFFA* explained, goals like achieving the "educational benefits of diversity" may be "commendable," but "they are not sufficiently coherent for purposes of strict scrutiny" because it is "unclear how courts are supposed to measure" them or reliably determine "when they have been reached." *Id.* at 214, 224. Strict scrutiny requires a "'more focused' inquiry" that "look[s] beyond broadly formulated interests." *Burwell* v. *Hobby Lobby Stores, Inc.*, 573 U.S. 682, 726-727 (2014).

Here, Colorado's interest in regulating the mental-health profession by maintaining its "integrity" is far too "amorphous" to "be subjected to meaningful judicial review." *SFFA*, 600 U.S. at 214. If such a "broadly formulated interest[]" were sufficient, strict scrutiny would be toothless in any case implicating public health. But see *Burwell*, 573 U.S. at 726-727 (rejecting government interests "couched in very broad terms, such as promoting 'public health'"). Thus, the "mere invocation" of the government's backdrop regulatory

goal "cannot carry the day." See *Gonzales* v. *O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 432 (2006). Strict scrutiny demands "a more precise analysis." *Fulton* v. *City of Philadelphia*, 593 U.S. 522, 541 (2021).

2. That leaves Colorado's interest in "protecting children" from "harmful therapeutic practices known to increase suicide among youth." 5/1/23 Resp. C.A. Br. 48-49. For such an interest to be compelling, Colorado must identify an "'actual problem' in need of solving." *Brown* v. *Entertainment Merchs. Ass'n*, 564 U.S. 786, 799 (2011). "Mere speculation of harm does not constitute a compelling state interest." *Consolidated Edison Co.* v. *Public Serv. Comm'n*, 447 U.S. 530, 543 (1980); see also *Fulton*, 593 U.S. at 542 ("speculation is insufficient to satisfy strict scrutiny"). It is not enough for the legislature to "make a predictive judgment" based on "competing psychological studies," or to show a "correlation" between the regulated speech and "harmful effects on children." *Brown*, 564 U.S. at 799-800. Instead, Colorado must "show a direct causal link" between Chiles's speech—talk therapy—and "harm to minors." *Id.* at 799. Colorado hasn't made that showing.

No evidence of harm from talk therapy for minors. Colorado's briefing in this Court touts "overwhelming" scientific evidence that "conversion therapy" is "unsafe and ineffective." BIO 6. But as Judge Hartz explained in detail, "[n]one" of Colorado's cited studies addressed "the results of conversion therapy (1) by licensed mental-health professionals (2) limited to talk therapies (as opposed to aversive therapies) (3) provided to minors." Pet. App. 120a (Hartz, J., dissenting). Indeed, Colorado admitted below that it "know[s] of no such

studies" focusing on "talk therapy" for minors. Audio of Oral Arg. at 13:42-15:32, perma.cc/2VKB-LJSN.

Instead, Colorado's evidence lumps together distinct practices, practitioners, and patients. First, the "great bulk" of Colorado's studies "do not describe the therapy provided" at all, so "there is no way to know whether any of the therapy was limited to speech," as opposed to the aversive techniques that Chiles does not use. Pet. App. 120a (Hartz, J., dissenting). And the "one [study] that did distinguish between the types of therapy found that the negative effects of aversion therapy were far greater." *Ibid.* Second, nearly "half" of the studies "did not indicate who gave the therapy," while "a little more than half said that the therapy was provided by both licensed *and* unlicensed practitioners." *Ibid.* (emphasis added). Third, "half" of the studies "did not say" whether any minors were involved, and "only one provided results specifically for those receiving conversion therapy as minors." *Ibid.* Thus, Colorado identified *no* "study (good or bad) that focuses on the type of therapy at issue in this case: talk therapy for a minor provided by a licensed mental-health professional." *Id.* at 1243.

As the HHS Report confirms, "[t]here is a dearth of research on psychotherapeutic approaches to managing gender dysphoria in children and adolescents." HHS Report at 16; see also Cass Review at 157 (noting "lack of evidence about alternative approaches for managing gender-related distress"). The American Psychological Association has "concede[d] that nonaversive and recent approaches to [conversion therapy] have not been rigorously evaluated." *Otto* v. *City of Boca Raton*, 981 F.3d 854, 868 (11th Cir. 2020) (citing APA Task Force Report at 43); cf. C.A. Amicus

Br. for Am. Psych. Ass'n at 23 ("Studies post-dating the [APA Task Force] Report do not alter its original conclusions."). Rather, there is a "complete lack" of "rigorous recent prospective research," with some "recent research indicat[ing]" that some individuals "perceive they have benefited from nonaversive" approaches. *Otto*, 981 F.3d at 868-869.

At minimum, there is significant uncertainty about how best to help minors experiencing gender dysphoria—and Colorado "bears the risk of uncertainty" on strict scrutiny. *Brown*, 564 U.S. at 799-800. Gender dysphoria "is a relatively new diagnosis with ever-shifting approaches to care over the last decade or two." *Skrmetti*, 83 F.4th at 491. The "nature of treatments" is "unsettled, developing, [and] in truth still experimental." *Id.* at 488. "The reality is that we have no good evidence on the long-term outcomes of interventions to manage gender-related distress." Cass Review at 13. And Colorado cannot carry its burden with such "ambiguous proof." *Brown*, 564 U.S. at 800.

No evidence that gender-affirming treatment reduces suicide. Colorado previously claimed that its interest in the Counseling Restriction is in "preventing deaths by suicide." Dist. Ct. Resp. Opp'n Prelim. Inj. 22-23; see also 5/1/23 Resp. C.A. Br. 49. But the suicide myth has now been debunked. "[T]here is *no evidence* that gender-affirmative treatments reduce" "deaths by suicide in trans people." Cass Review at 195 (emphasis added); see also Oral Argument Tr. at 88:9-18, *United States* v. *Skrmetti*, No. 23-477 (conceding "no evidence" that "[gender-affirming] treatment reduces completed suicide"). And "the evidence for whether [pediatric medical transition] reduces *suicidality*-related outcomes in adolescents—such as self-reported frequency

of suicidal thoughts, or healthcare utilization for self-harm or suicide attempts—is inconsistent" at best. HHS Report at 72.

By contrast, there is substantial evidence that talk therapy—the very treatment Chiles offers—*is* effective at reducing both suicide rates and suicidality in youth generally. HHS Report at 248-250. Yet Colorado permits and promotes pediatric medical transition, while preventing Chiles from offering talk therapy to help her clients relieve their distress and address suicidality without gender transition. This is exactly backwards.

If "mere speculation of harm does not constitute a compelling state interest," *Consolidated Edison Co.*, 447 U.S. at 543, then speculation contrary to the evidence is *a fortiori* insufficient. Colorado has failed to carry its burden.

3. If anything, mounting evidence indicates that the Counseling Restriction *undermines* Colorado's interest in protecting children. By prohibiting Chiles's talk therapy, Colorado leaves children experiencing gender dysphoria with no alternative but the gender-affirming approach—which affirms children in their chosen gender identity, helps them socially transition, and routinely leads to medical interventions like puberty blockers, cross-sex hormones, and surgeries. See pp. 8-12, *supra*.

There is "no good evidence" that the gender-affirming approach helps to "manage gender-related distress" in the "long-term." Cass Review at 195, 13. But there are abundant "risks of pediatric medical transition," including "infertility/sterility, sexual dysfunction, impaired bone density accrual, adverse cognitive

impacts, cardiovascular disease and metabolic disorders, psychiatric disorders, surgical complications, and regret." HHS Report at 14. Because of those risks, at least twenty-six states have restricted gender transitions for minors. Pet'r Br. 17.

Many of "the same European countries that pioneered these treatments" have "now express[ed] caution about them" and "pulled back on their use." *Skrmetti*, 83 F.4th at 477. Sweden has found that for most children, the risks of gender-transition treatments likely outweigh any benefits.[14] Finland now recommends robust and comprehensive counseling as the first-line intervention for asserted pediatric gender dysphoria.[15] And the United Kingdom, which previously ran one of the world's largest pediatric gender identity clinics, shuttered that clinic following a government investigation that found it had failed children by providing invasive interventions without any evidence of their efficacy. Cass Review at 32-33. The United Kingdom has now banned even the private use

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[14] Gunilla Sonnebring, *Systematic review on outcomes of hormonal treatment in youths with gender dysphoria*, Karolinska Institutet (Apr. 20, 2023) (Swed.), https://perma.cc/W444-9VZY.

[15] *Suositus: Transsukupuolisuudesta johtuvan dysforian lääketieteelliset hoitomenetelmät [Recommendation: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors]*, Palveluvalikoimaneuvoston [Council for Choices in Health Care in Finland/COHERE Finland] at 6-8 (June 11, 2020) (Fin.), https://perma.cc/CV8A-FLRV, *unofficial English translation*, https://perma.cc/AA6WP5HJ.

of puberty blockers and cross-sex hormones for new minor patients.[16]

The Tenth Circuit questioned the "relevance" of this evidence, reasoning that "[t]he questions raised * * * about the efficacy of hormone treatment" "do not apply to the efficacy of psychotherapy." Pet. App. 30a n.17. But that is a dodge. The efficacy of both treatments is inextricably linked, because laws like Colorado's deprive children of cautious psychotherapy and push them toward gender-affirming "hormone treatment" and surgeries. *Ibid.* As the Cass Review noted, therapists are "fearful of accepting referrals of" "gender-questioning young people" due to "potential accusations of conversion practice when following an approach that would be considered normal clinical practice when working with other groups of children." Cass Review at 202. The HHS Report similarly found "evidence that the specter of being labeled a 'conversion therapist' * * * has created a climate of anxiety among mental health professionals," who "worry that failing to affirm or recommend medical interventions for youth" could "jeopardize their careers and reputations." HHS Report at 253-254. Thus, the Counseling Restriction pushes children into harmful medical transitions by protecting counselors who refer children for risky, life-altering "gender-affirming" treatment—and banning the alternative, cautious approach. See pp. 8-12, *supra*.

Far from advancing a compelling state interest in protecting children, then, Colorado's law inflicts harm

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[16] United Kingdom Department of Health and Social Care, *New restrictions on puberty blockers* (May 29, 2024), https://perma.cc/8LLN-DY29.

on vulnerable youth. The Counseling Restriction itself—not Chiles's speech—is the "direct causal link" with "harm to minors." *Brown*, 564 U.S. at 799. Colorado thus fails strict scrutiny.

B. The Restriction is not narrowly tailored.

Colorado has also failed to show that the Counseling Restriction is the least restrictive means of advancing its interests and is "narrowly tailored" to those ends. *Kennedy*, 597 U.S. at 525. "The least-restrictive-means standard is exceptionally demanding." *Holt* v. *Hobbs*, 574 U.S. 352, 364-365 (2015). "If a less restrictive alternative would serve the Government's purpose, the legislature must use that alternative." *Playboy Ent. Grp.*, 529 U.S. at 813. And because the Counseling Restriction "affect[s] First Amendment rights," it "must be pursued by means that are neither seriously underinclusive nor seriously overinclusive." *Brown*, 564 U.S. at 805; see also Slip Op. at 13-15, *Catholic Charities Bureau* v. *Wisconsin Labor & Indus. Rev. Comm'n,* No. 24-154 (June 5, 2025). Colorado cannot carry that burden.

There are many available options that are less restrictive than Colorado's prophylactic ban on speech.

First, Colorado could enact a narrower ban specifically targeting aversive or coercive methods rather than consensual talk therapy. Colorado has presented no evidence that pure talk therapy with a minor is harmful; its evidence was largely based on studies addressing aversive or coercive methods. Pet. App. 119a (Hartz, J., dissenting) (noting the admitted "absence of any study" focusing on "talk therapy for a minor"). Colorado could pass a law aimed specifically at these discredited techniques that Chiles does not practice.

Second, Colorado could ban efforts to "change" gender identity, expression, or behavior when doing so is contrary to the client's self-defined goals. In passing the Restriction, lawmakers focused on counseling that was carried out *against a minor's will*. See, *e.g.*, Senate Committee Meeting on State, Veterans, & Military Affairs at 3:43:08-20 (Mar. 18, 2019), https://bit.ly/3RDpRfX (statement of primary Senate sponsor focused on "harmful practices such as rejection, and shame, and psychological abuse"); Senate Second Reading Debate at 1:11:1-1:12:17 (Mar. 21, 2019), https://bit.ly/3B2FcPO (focused on "so-called gay conversion therapy" that is "essentially against their will"). A law that focused on unwanted change efforts would not sweep in counselors like Chiles, who "honors her clients' autonomy and right to self-determination." Pet. App. 176a.

Third, Colorado could require informed consent. This would ensure that minors and their families are fully informed of any alleged risks without muzzling therapists like Chiles.

Informed consent is the only less restrictive means that Colorado addressed below, where it argued that informed-consent requirements can never protect minors from the harms of voluntarily-sought pure talk therapy. 5/1/23 Resp. C.A. Br. 53. The State cited no evidence to support this blanket assertion. Instead, it offered only a Colorado statute that authorizes minors twelve or older to receive psychotherapy services *without a parent's consent*. Colo. Rev. Stat. § 12-245-203.5(2)(a). In other words, Colorado law actually recognizes that many young people (those 12 or older) *do* have the capacity to consent to talk therapy, even without their parents' guidance.

Indeed, Colorado relies on informed consent and other guardrails in a wide variety of high-risk medical and mental-health contexts. It has special rules that allow minors and their parents to consent to psychiatric electroconvulsive therapy. See Colo. Rev. Stat. § 13-20-403(2)-(3) (requiring consent of two medical providers and the patient's parents). It allows children who suffer from PTSD or have Autism Spectrum Disorder to use medical marijuana. See Colo. Rev. Stat. § 25-1.5-106(2)(a.7), (2.5)(i), (j) (also allowing children to use some forms of medical marijuana "upon the grounds of the preschool or primary or secondary school in which the student is enrolled"). And of course, Colorado also relies on guardrails when it allows adults who are suffering from a terminal illness to choose assisted suicide. See Colo. Rev. Stat. § 25-48-103 (End-of-Life Options Act).[17]

As Colorado recently told this Court, "[e]ven when forms of treatment involve heightened medical risks, States rarely enact categorical bans" and instead "States have adopted specialized medical regulations to ensure that minors and (where appropriate) their parents or guardians are fully apprised of the risks of certain healthcare decisions." Amicus Br. of Colorado et al. at 8, *Skrmetti*, No. 23-477. "Rather than ban care entirely, the longstanding approach of States in this

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[17] Although Colorado law currently limits the use of assisted suicide to people suffering from terminal illnesses, one Colorado physician has gone further and used assisted suicide drugs to end the lives of three of her mentally ill patients suffering from anorexia. Jennifer Brown, *Denver doctor helped patients with severe anorexia obtain aid-in-dying medication, spurring national ethics debate,* The Colorado Sun, Mar. 14, 2022, https://perma.cc/Y7EG-BW3X.

area has been to enable minors and their parents to make informed medical decisions." *Ibid.*

Colorado has not explained or offered any evidence to show why the informed consent rules, second provider review, and other safeguards that are adequate for electroconvulsive therapy, marijuana use, cross-sex hormones, or sterilizing genital surgeries will not suffice here. "Where the government permits other activities to proceed with precautions," it must show that Chiles's consensual talk therapy "is more dangerous than those activities even when the same precautions are applied." *Tandon* v. *Newsom*, 593 U.S. 61, 63 (2021). "Otherwise, precautions that suffice for other activities suffice" for Chiles's counseling too. *Ibid.*

Fourth, Colorado could provide a religious exemption. The burden that the Counseling Restriction places on religious believers is severe. Colorado bans a Catholic or Muslim counselor from talking with a Catholic or Muslim teenager about how to live a life that reflects the teen's own religious beliefs about sex and gender—even if that is what the teen wants to do. See pp. 13-14, *supra.*

Colorado has failed to justify its ban on this kind of consensual, non-aversive religious speech. See pp. 16-19 *supra*. And Colorado has expressly disclaimed any interest in regulating so-called conversion therapy when it is carried out by religious leaders. 5/1/23 Resp. C.A. Br. 46 (suggesting that Chiles refer her clients to religious leaders for conversion therapy); Colo. Rev. Stat. § 12-247-217(1), (2)(f) (exempting "religious ministry."). But Colorado has never explained why, having exempted many other religious speakers, it cannot exempt *Chiles's* religious speech as well. Its failure to do

so is fatal. Cf. *O Centro*, 546 U.S. at 420 (holding, under the Religious Freedom Restoration Act, that the government must show that strict scrutiny is "satisfied through application of the challenged law 'to the person'—the particular claimant whose sincere exercise of religion is being substantially burdened").

Colorado has religious exemption examples ready at hand. Washington's parallel counseling restriction, which was challenged in *Tingley*, is subject to a broad, pre-existing religious exemption in the state's mental-health licensing scheme. See Wash. Rev. Code § 18.225.030 ("Nothing in this chapter shall be construed to prohibit or restrict: * * * mental health counseling * * * under the auspices of a religious organization."). Indeed, in *Skrmetti*, Colorado pointed to this religious exemption as an example of appropriate narrow tailoring. Amicus Br. of Colorado et al. at 9 n.10, *Skrmetti*, No. 23-477. But Colorado has never explained why it has not tailored its own law in the same way.

Fifth, Colorado could rely on the "'[l]ongstanding torts for professional malpractice' or other state-law penalties for bad acts that produce actual harm." *Otto*, 981 F.3d at 870 (quoting *NIFLA* v. *Becerra*, 585 U.S. 755, 769 (2018)). Many other states have the same interest as Colorado in the welfare of minors yet still manage to protect these interests without a categorical ban like Colorado's. Cf. *Holt*, 574 U.S. at 369 ("when so many prisons offer an accommodation, a prison must, at a minimum, offer persuasive reasons why it believes that it must take a different course"). Colorado already has at its disposal the same laws and regulations it uses to police specific instances of harm by practitioners. These tools allow Colorado to address

circumstances with reference to their specific facts without sweeping overbroadly and chilling counseling that helps distressed youth. See also Part III.B, *infra*. Colorado has never addressed why the broad set of tools that it already possesses would not suffice.

With the exception of informed consent (discussed above), Colorado has failed to address any of these alternatives—although it is Colorado's "obligation to prove" that less restrictive alternatives "will be ineffective to achieve its goals." *Playboy Ent. Grp.*, 529 U.S. at 816. These many alternatives also demonstrate that Colorado's ban is "far more severe" than necessary to pursue the interests it has asserted. *Roman Catholic Diocese of Brooklyn* v. *Cuomo*, 592 U.S. 14, 18 (2020). Even when it comes to laws intended to protect public health, the strict scrutiny standard "is not watered down; it really means what it says." *Tandon*, 593 U.S. at 65 (cleaned up). Colorado has not met that high standard here.

III. The Counseling Restriction fails intermediate scrutiny.

Even if the Counseling Restriction burdened speech only incidentally, it would still need to satisfy intermediate scrutiny. This Court applies "First Amendment scrutiny in 'cases involving governmental regulation of conduct that has an expressive element.'" *TikTok Inc.* v. *Garland*, 145 S. Ct. 57, 65 (2025) (quoting *Arcara* v. *Cloud Books, Inc.*, 478 U.S. 697, 703-704 (1986)). In such cases, "regulations that are unrelated to the content of speech are subject to an intermediate level of scrutiny." *Turner Broad. Sys., Inc.* v. *FCC*, 512 U.S. 622, 642 (1994). Under intermediate scrutiny, a law must "be 'narrowly tailored to serve a significant governmental interest.'" *McCullen* v. *Coakley*, 573

U.S. 464, 486 (2014) (quoting *Ward* v. *Rock Against Racism*, 491 U.S. 781, 796 (1989)). Colorado's Counseling Restriction fails even this intermediate standard.

A. The Restriction does not serve a significant state interest.

Under intermediate scrutiny, the government's interest must be at least "significant," *McCullen*, 573 U.S. at 486, and "unrelated to the suppression of free expression." *United States* v. *O'Brien*, 391 U.S. 367, 377 (1968); see also *TikTok*, 145 S. Ct. at 67 (requiring "important governmental interests unrelated to the suppression of free speech"). And of course, "a restriction of speech must serve" the government's asserted interests and "may extend only as far as the interest it serves." *Matal* v. *Tam*, 582 U.S. 218, 245 (2017).

As discussed above, the Counseling Restriction *undermines* Colorado's interest in protecting young people from harm. See pp. 20-23, *supra*. That's because most children with gender dysphoria naturally desist, and cautious counseling helps those children become comfortable with their biological sex without hormonal and surgical interventions that cause long-term harms. In addition, bans like Colorado's have a "chilling effect on the ethical psychotherapists' willingness to take on complex" cases of gender dysphoria, "which will make it much harder for [gender dysphoric] individuals to access quality mental health care" to address any other mental-health concerns they may have. HHS Report at 255-256. This harms the youth Colorado says it is trying to help by creating barriers to needed mental-health care. See p.13, *supra*.

B. The Restriction is not narrowly tailored.

To be narrowly tailored for intermediate scrutiny purposes, a law "need not be the least speech-restrictive means of advancing the Government's interests." *Turner Broad.*, 512 U.S. at 662. But it still "must not burden substantially more speech than is necessary to further the government's legitimate interests." *McCullen*, 573 U.S. at 486 (cleaned up). The Counseling Restriction fails this requirement because Colorado "has available to it a variety of approaches that appear capable of serving its interests" without silencing Chiles's speech. *Id.* at 493-494.

In *McCullen*, this Court invalidated a Massachusetts statute that prohibited standing within 35 feet of the entrance of abortion clinics. 573 U.S. at 471. Although the statute advanced "legitimate interests" in promoting "public safety, patient access to healthcare, and the unobstructed use of public sidewalks," it still failed intermediate scrutiny because Massachusetts did not show "that it seriously undertook to address the problem with less intrusive tools readily available to it." *Id.* at 486, 494. Specifically, the Court noted that local and state ordinances already made it a crime to knowingly obstruct entry and exit from an abortion clinic, that Massachusetts could pass an ordinance to prevent harassment, and that generic criminal statutes forbade assault, breach of the peace, trespass, vandalism, and the like. *Id.* at 490-492.

Similarly, in *NIFLA*, California's licensed-notice requirement for pregnancy centers failed intermediate scrutiny in part because the state had several alternatives for "inform[ing] low-income women about its services without burdening a speaker with unwanted speech." 585 U.S. at 775 (cleaned up). California could

have, for example, launched "a public-information campaign" or "post[ed] the information on public property near crisis pregnancy centers." *Ibid.* Because it "identified no evidence" that these alternatives would not be effective at accomplishing its goals, the licensed-notice requirement "[could] not survive even intermediate scrutiny." *Id.* at 773, 775.

So too here. Colorado "has available to it a variety of approaches that appear capable of serving its interests, without" restricting Chiles's speech. *McCullen*, 573 U.S. at 493-494. Colorado could ban aversive treatments, ban treatments that contradict a client's goals, grant a religious exemption, require informed consent, or enforce existing malpractice laws to address any potential harms. See Part II.B, *supra*.

"The point is not that [Colorado] must enact all or even any of" these "proposed measures." *McCullen*, 573 U.S. at 493. The point is that Colorado "has not shown that it seriously undertook to address the problem with less intrusive tools readily available to it." *Ibid.* Nor has it "demonstrate[d]" that it even considered any of these "alternative measures"—much less that they would "fail to achieve the government's interests." *Id.* at 495; see also *Thompson* v. *Western States Med. Ctr.*, 535 U.S. 357, 373 (2002) ("[T]here is no hint that the Government even considered these or any other alternatives.") Colorado's law thus "goes much further than is necessary to serve the interest[s] asserted" and fails even intermediate scrutiny. *Matal*, 582 U.S. at 246.

CONCLUSION

The decision below should be reversed.

Respectfully submitted.

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