No. 25-840

In the
Supreme Court of the United States

INTERNATIONAL PARTNERS FOR ETHICAL CARE, INC., ET AL.,

Petitioners,

v.

BOB FERGUSON, GOVERNOR OF WASHINGTON, et al.,

Respondents.

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

BRIEF OF *AMICUS CURIAE* DR. ERICA E. ANDERSON IN SUPPORT OF PETITIONERS

LUKE N. BERG
Counsel of Record
RICHARD M. ESENBERG

WISCONSIN INSTITUTE FOR LAW & LIBERTY

1241 N. Franklin Place
Milwaukee, WI 53202
(414) 727-9455
luke@will-law.org
rick@will-law.org

EMILY RAE

CALIFORNIA JUSTICE CENTER

18002 Irvine Blvd.
Suite 108
Tustin, CA 92780
(949) 237-2573
emily@calpolicycenter.org

Counsel for Amicus Dr. Erica E. Anderson

September 15, 2026

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Regulations

Other Authorities

INTEREST OF AMICUS[1]

Dr. Erica E. Anderson, PhD, is a clinical psychologist practicing in California and Minnesota with over 45 years of experience. 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 a clinic at Benioff Children's Hospital at the University of California, San Francisco (2016 to 2021), and at a private practice (2016 to present). She has seen hundreds of children and adolescents for gender-identity-related issues, many of whom transition, with her guidance and support. Courts have recognized Dr. Anderson's expertise. *See Mirabelli v. Olson*, 691 F. Supp. 3d 1197, 1207 (S.D. Cal. 2023).

As a practitioner serving children and adolescents experiencing gender incongruence, Dr. Anderson has a strong interest in ensuring that such children receive the best possible care (whether or not they ultimately transition), which, in her view, requires involving their parents.

---

[1] As required by Supreme Court Rule 37.6, Amicus states as follows: No counsel for a party authored this brief in whole or in part. No counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than Amicus or its counsel made such a monetary contribution.

INTRODUCTION AND SUMMARY OF ARGUMENT

In 2023, Washington passed a law replacing parents with government social workers for runaway children who want "gender-affirming treatment." Washington amended its "Family Reconciliation Act" to provide that families of runaway children will *not* be promptly notified and reunited with their child if the minor seeks "protected health care services," which includes "gender-affirming treatment." Wash. Rev. Code § 13.32A.082(2)–(3). Previously, parents would be informed within 72 hours if their runaway child arrived at a shelter, but now the law only requires notice to the Department of Children, Youth and Family Services—not the parents. In the meantime, the Department is directed to "make referrals on behalf of the minor for appropriate behavioral health services," which is undefined but presumably includes the very "gender-affirming treatment" that triggers the anomalous exception. *Id.* § 13.32A.082(3)(b)(i); *see* Pet. App. 53a (Tung, J., dissenting).

As this Court has long recognized and recently reaffirmed, parents have a constitutional right "to direct the upbringing and education of their children." *Mirabelli v. Bonta*, 607 U.S. 492, 497 (2026); *Mahmoud v. Taylor*, 606 U.S. 522 (2025). Any attempt by the government to "supersede parental authority" is both unconstitutional and "repugnant to American tradition." *Parham v. J. R.*, 442 U.S. 584, 603 (1979). The "decisional framework" is what matters; government must apply a "presumption that a fit parent will act in the best interest of his or her child," *Troxel v. Granville*, 530 U.S. 57, 69 (2000) (plurality op.), and may only override parents after providing

procedural due process and a sufficiently high substantive standard, such as "clear and convincing evidence" of harm or abuse, *id.*; *Santosky v. Kramer*, 455 U.S. 745 (1982). Government may not "transfer the power to make [a] decision from the parents to some agency or officer of the state," "[s]imply because the decision of a parent is not agreeable to a child or because it involves risks." *Parham*, 442 U.S. at 603. Yet that is exactly what Washington's law does—it "transfer[s] the power to [decide]" whether gender-affirming care will benefit or harm a minor child from the parents to government employees and/or the children themselves, even when there are no allegations of abuse or neglect against the parents.

This issue is strikingly similar to a rising trend in school districts around the country that have policies to secretly facilitate social transitions at school without notice to the parents or their consent. *See, e.g.*, *Mirabelli*, 607 U.S. 492; *Parents Protecting Our Children, UA v. Eau Claire Area Sch. Dist.*, 145 S. Ct. 14 (2024) (Alito, J., dissenting from denial of certiorari) (noting that this is an issue "of great and growing national importance"). As this Court is now well aware, the facts in many of the cases challenging these policies are deeply "troubling—and tragic." *Lee v. Poudre Sch. Dist. R-1*, 608 U.S. __, 146 S. Ct. 26 (2025) (Alito, J., statement respecting the denial of certiorari).

Washington's amended law is more egregious because the parents are not even told of their missing child's whereabouts, lengthening the child's separation from home, with the obvious goal of helping facilitate "gender-affirming treatment."

Yet a transition—even just a social transition—is a major, health-related decision with long-term implications. *Infra* Part I. And excluding parents from this decision violates their constitutionally protected decision-making authority. *Infra* Part II. Children cannot even receive a Tylenol without parental consent; facilitating a secret gender transition is far more serious, particularly when the parent does not even know the location of or any information about their child's well-being. The transfer of decision-making authority from the parents to the state is a sufficient *present* injury to support parents' standing. *Infra* Part III.

This Court should reverse.

ARGUMENT

I. Whether to Provide Gender-Affirming Care Is a Major Health-Related Decision That Requires Parental Involvement, for Many Reasons

When children and adolescents express a desire to transition to a different gender identity—either socially (to change their name and pronouns to ones at odds with their natal sex) or medically (to undergo sex-change surgery or receive cross-sex hormones or puberty blockers)—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. While medical transitions are obviously very serious and involve life-altering and irreversible procedures for which parents must be able to provide informed consent, social transitions are also very serious and often have long-term consequences. 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. Childhood transitions were "[r]elatively unheard-of 10 years ago" but have become far more frequent in recent years.[2] Before the recent trend in some circles to immediately "affirm" every child's and adolescent's expression of a desire for an alternate gender identity, a robust body of research had found that, for the vast majority of children (roughly 80 to 90 percent), 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]

These studies were conducted before the recent trend to quickly transition, whereas 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

---

[2] James R. Rae, 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://gendergp.s3.eu-west-2.amazonaws.com/media/Standards-of-Care-V7-2011-WPATH.pdf.

[4] James M. Cantor, *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.

important predictors of persistence, especially among natal boys."[5] Another recent study of 317 transgender youth found that 94% continued to identify as transgender five years after transitioning.[6]

Considering 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 affect the likelihood that a child's or adolescent's experience of gender incongruence will persist.

In the UK, for example, a recent, comprehensive review of the evidence by the National Health Service concluded that "social transition in childhood may change the trajectory of gender identity development for children with early gender incongruence."[7] This review also found that "those who had socially transitioned at an earlier age and/or prior to being seen in clinic were more likely to proceed to a medical pathway," with all the associated risks and complications. In view of this evidence, the report

---

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

[7] Hilary Cass, *Independent review of gender identity services for children and young people: Final report* at 31–32 (April 2024), https://cass.independent-review.uk/home/publications/final-report/.

concluded that "parents should be actively involved in decision making" about a social transition.[8]

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 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."[9] He has also written that "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."[10]

The authors of the 2013 study referenced 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

---

[8] *Id.* at 31, 164.

[9] Jesse Singal, *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.

[10] Kenneth J. Zucker, *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.

"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 communities. [citations omitted]. 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 (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."[11]

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

---

[11] Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/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.

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.[12]

In short, when a child or adolescent expresses a desire to change 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, n.12, at S45.

While the mental health community continues to debate whether socially transitioning is generally beneficial or not, it is beyond dispute that there is currently little solid evidence about who is right, given how recent a trend this is. *See supra* n.12.

Even setting aside the debate about socially transitioning, there is near-universal agreement that, when a child or adolescent exhibits signs of gender incongruence, each should be considered separately

---

[12] The latest version continues to acknowledge "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.

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."[13] The Endocrine Society likewise recommends "a complete psychodiagnostic assessment." *Supra* n.11, 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.[14] WPATH also recommends that mental health professionals "discuss the potential benefits and risks

---

[13] American Psychological Association, *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*, 70(9) APA 832–864, at 843 (2015), https://www.apa.org/practice/guidelines/transgender.pdf.

[14] WPATH SOC8, *supra* n. 12, 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."

of a social transition with families who are considering it." WPATH SOC8, *supra* n.12, 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.12, 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 whom were natal females), 70% said they realized their "gender dysphoria was related to other issues," and half reported that transitioning did not help.[15]

Another reason for professional involvement is to assess whether the child or adolescent needs mental health support. Many experience dysphoria—psychological distress—associated with the mismatch between their natal sex and perceived or desired gender identity. Indeed, the American Psychiatric

---

[15] Elie Vandenbussche, *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.

Association's Diagnostic and Statistical Manual of Mental Disorders' (DSM-5) official diagnosis for "gender dysphoria" is *defined by* "clinically significant distress." *See What Is Gender Dysphoria?*, American Psychiatric Association.[16]

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.12, at S62–63. All major professional organizations recommend screening for these coexisting issues and treating them if needed. *Id.*; APA Guidelines, *supra* n.13, at 845; Endocrine Society Guidelines, *supra* n.11, 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.11, at 3877.

It should go without saying, but parents cannot obtain a professional evaluation, screen for dysphoria and other coexisting issues, or provide professional mental health support for their children, if their

---

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

government hides from them what is happening to their child, what treatment their child is receiving, or even where their child is located.

To summarize, no professional association recommends that social workers or government employees, who have no expertise whatsoever in these issues, should help facilitate a gender transition without involving the parents.

II. Parental Authority Includes the Right to Decide How to Address a Child's Struggles with Gender

A long line of cases from this Court establishes that parents have a constitutional right "to direct the upbringing and education of their children." *Mirabelli*, 607 U.S. at 497; *Mahmoud*, 606 U.S. at 547; *Troxel*, 530 U.S. at 65 (plurality op.); *Pierce v. Soc'y 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.), and is "established beyond debate as an enduring American tradition," *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972). It is 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).

The "decisional framework" is what matters—government must apply a "presumption that a fit parent will act in the best interest of his or her child," *Troxel*, 530 U.S. at 69 (plurality op.), and may only override parents after providing procedural due process and a sufficiently high substantive standard, such as "clear and convincing evidence" of harm or abuse, *id.*; *Santosky*, 455 U.S. 745.

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.").

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; *cf. Mahmoud*, 606 U.S. at 585 (Thomas, J., concurring). 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 op.).

Washington's law violates parents' decision-making authority in at least three different ways.

First, parents have the constitutional right to *make the decision* about whether "gender-affirming treatment" is in their child's best interest. When children or adolescents experience gender dysphoria, whether they should transition is one "of the most consequential decisions in their children's lives." *Mirabelli*, 607 U.S. at 497. 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 transition. Parental rights include the right to "participat[e] in [this] decision[ ]." *Id.*; *Parham*, 442 U.S. at 603.

The law takes this life-altering decision out of parents' hands and places it with government employees 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 withholding children from parents to help them obtain "gender-affirming treatment" without parental involvement, Washington's law usurps and/or circumvents parental decision-making authority. 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 agree to a transition is not sufficient to override their decision-making role. A parent's job is sometimes to say "no" to protect their children from decisions against their long-term interests.

Second, Washington's law also violates parental rights by withholding their child's whereabouts, circumventing their involvement altogether on this sensitive issue. *See Mahmoud*, 606 U.S. at 560

(emphasizing that the district "will not notify parents when the books are being read"); *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 Cnty., Ala.*, 880 F.2d 305, 313 (11th Cir. 1989). Parents cannot guide their children through difficult decisions without access to their children. During the delay in returning a child to the parents, the law effectively substitutes shelter staff and social workers for parents as the primary source of input for children navigating difficult decisions, with long-term implications.

Third, Washington's law interferes with parents' ability to provide professional assistance that 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. Government employees with no medical degrees 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 what treatment is in their child's best interest, but also to obtain professional support for their child.

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 providing any process or opportunity for the parents to respond or defend themselves. *See Santosky*, 455 U.S. 745. Shelters housing runaway children do not have the power to act as ad hoc family courts, litigating family law issues or deciding on their own, independent of any court process, which parents will be included in which decisions.

The idea that government actors can override parents solely because they think they know better is, in this Court's words, "statist" and "repugnant to American tradition." *Parham*, 442 U.S. at 603. Parents must be informed if their child requests to receive gender-affirming care, whether that happens at school or in a shelter after a child has run away.

III. Washington's Law Presently Harms Parents by Transferring Their Decision-Making Role to Government Officials

This Court has warned against "mak[ing] standing law more complicated than it needs to be." *Thole v. U. S. Bank N.A.*, 590 U.S. 538, 547 (2020). There are only three basic requirements: injury, causation, and redressability. *Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 199 (2023). Petitioners explain multiple ways that they meet these requirements. This brief adds one additional angle for the Court to consider.

Washington parents are presently injured by the loss of their exclusive decision-making authority over whether "gender-affirming treatment" is in their child's best interest. Washington's law transfers that authority to government officials by sheltering runaway children from the parents for longer than would otherwise be allowed. The goal of the law is

transparent on its face—to circumvent parents who might say "no" to "gender-affirming treatment." Indeed, why else hide from the parents that a runaway child has been found?

As explained above, this Court has long framed parental rights in terms of *who decides*. And government may not "transfer the power to make [a] decision from the parents to some agency or officer of the state," "[s]imply because the decision of a parent is not agreeable to a child or because it involves risks." *Parham*, 442 U.S. at 603. Yet that is exactly what Washington's law attempts to do. That transfer of decision-making power results in a loss of parental control. That loss is immediate, ever-present, and is a sufficient injury, by itself, for Article III standing. It is a "harm[ ] specified by the Constitution itself." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 425 (2021).

This Court has already recognized that the arrogation of an exclusive authority is an injury sufficient for standing. In *Arizona State Legislature v. Arizona Independent Redistricting Commission*, 576 U.S. 787, 800 (2015), the Arizona Legislature challenged an amendment to the Arizona Constitution that transferred "redistricting authority from the Arizona Legislature and vest[ed] that authority in an independent commission." 576 U.S. at 792. The Legislature's claim was that "the Elections Clause vests in it 'primary responsibility' for redistricting," such that the Legislature "must have at least the opportunity to engage (or decline to engage) in redistricting before the State may involve other actors in the redistricting process." *Id.* at 800. Arizona's constitutional amendment, however, "g[ave] [an independent body] binding authority over

redistricting, regardless of the Legislature's action or inaction, strip[ping] the Legislature of its alleged prerogative to initiate redistricting." *Id.* Although the Court ultimately rejected the claim on the merits, *id.* at 804–24, it held that the Arizona Legislature had standing to bring this claim because "th[e] asserted deprivation"—the loss of "'primary responsibility' for redistricting"—was an injury that "would be remedied by a court order enjoining the enforcement of [Arizona's constitutional amendment]." *Id.* at 800.

This case mirrors that one. The claim is that parents have the "primary responsibility" for decisions involving their own children, yet Washington's law "strip[s] [them] of [their] alleged prerogative" to decide whether "gender-affirming treatment" is in their child's best interest. *Id.* And the policy allows "other actors" to make this decision for them, "regardless of the [parent]'s action or inaction," *id.*, and to withhold the child's whereabouts from them. And this transfer of decision-making authority "would be remedied by a court order enjoining the enforcement of [Washington's law]." *Id.*

The dissenters below got it exactly right: "The very existence of a state regulatory regime that encourages and facilitates the transition of children without the consent of their parents presently interferes with the protected parent–child relationship by subverting a parent's authority." Pet. App. 44a (Van Dyke, J., dissenting from the denial of rehearing en banc). It creates a "workaround to parental consent," "intentionally allow[ing] for and encourag[ing] minors to seek and obtain gender transition services over the objections of fit parents." Pet. App. 46a–47a.

CONCLUSION

This Court should reverse the Ninth Circuit's decision.

Dated: September 15, 2026.

Respectfully submitted,

LUKE N. BERG
Counsel of Record
RICHARD M. ESENBERG
WISCONSIN INSTITUTE FOR LAW & LIBERTY
1241 N. Franklin Place
Milwaukee, WI 53202
(414) 727-9455
luke@will-law.org
rick@will-law.org

EMILY RAE
CALIFORNIA JUSTICE CENTER
18002 Irvine Blvd.
Suite 108
Tustin, CA 92780
(949) 237-2573
emily@calpolicycenter.org

Counsel for Amicus Curiae Dr. Erica E. Anderson