

In the United States Court of Appeals for the Eighth Circuit

WYATT BURY, LLC; BALLPARK INVESTMENTS, LLC, DOING BUSINESS AS
HOPE & HEALING COUNSELING; WYATT BURY; PAMELA EISENREICH,
Plaintiffs-Appellants,

STATE OF MISSOURI EX REL. MISSOURI ATTORNEY GENERAL CATHERINE L.
HANAWAY,
Plaintiff,

v.

CITY OF KANSAS CITY, MISSOURI; JACKSON COUNTY, MISSOURI,
Defendants-Appellees.

On Appeal from the United States District Court
for the Western District of Missouri
Civil Case No. 4:25-cv-00084-RK

**BRIEF *AMICUS CURIAE* OF THE BECKET FUND
FOR RELIGIOUS LIBERTY IN SUPPORT OF
PLAINTIFFS-APPELLANTS AND REVERSAL**

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RULE 26.1 DISCLOSURE STATEMENT

The Becket Fund for Religious Liberty has no parent corporations and issues no shares of stock.

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INTEREST OF AMICUS CURIAE¹

The Becket Fund for Religious Liberty is a non-profit law firm dedicated to protecting the free exercise of all religious traditions. To that end, it has represented agnostics, Buddhists, Christians, Hindus, Jews, Muslims, Santeros, Sikhs, and Zoroastrians, among others, in litigation, including in multiple cases at the United States Supreme Court and before this Court. *See, e.g., Mahmoud v. Taylor*, 145 S. Ct. 2332 (2025); *Fulton v. City of Philadelphia*, 593 U.S. 522 (2021); *Holt v. Hobbs*, 574 U.S. 352 (2015); *Religious Sisters of Mercy v. Becerra*, 55 F.4th 583 (8th Cir. 2022).

Becket is concerned that laws like Kansas City's and Jackson County's disproportionately harm people of faith. For example, Becket currently represents Catholic counselors in Michigan whose speech is being gagged by a similar law. *See Catholic Charities of Jackson v. Whitmer*, No. 25-1105 (6th Cir., oral argument held Oct. 23, 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 Kansas City's and Jackson

¹ Counsel for all parties in this case have given consent for the filing of this brief.

County's make these voluntary, consensual conversations illegal, chilling speech and restraining religious exercise for counselors and their clients alike.

Becket submits this brief to address the severe harms that flow from these laws, and to explain why those ordinances cannot survive strict or even intermediate scrutiny.

INTRODUCTION

In recent years, the number of children and adolescents that identify as transgender has increased dramatically. Many of these youth have been diagnosed with gender dysphoria, a condition characterized by significant distress over the perceived mismatch between their biological sex and their sense of gender identity. Parents, medical professionals, and policymakers across the country are vigorously debating how best to help these young people.

On one side of this debate are those like Bury and Eisenreich (the Counselors)—mental health professionals in Missouri—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. To meet the unique needs of each individual child, these counselors offer “talk therapy”—psychological counseling consisting entirely of speech—to help each child explore and understand the root causes of their distress and, if possible, to alleviate their distress without resorting to irreversible

medical interventions. This cautious approach has long been standard practice among counselors and is supported by the best available scientific evidence. It is also supported by recently enacted laws in twenty-six states, including Missouri.

On the other side of the debate are those who advocate for a “gender-affirming” approach. This approach assumes that gender identity is relatively fixed, that clinicians can reliably predict when gender dysphoria will persist into adulthood, and that social and medical transition is an effective treatment for persistent gender dysphoria. Accordingly, the role of the counselor is not to explore the potential underlying causes of distress, but to affirm the child’s desire to alter her body to resemble the opposite sex—including via puberty-blocking drugs, cross-sex hormones, and body-altering surgeries.

Kansas City and Jackson County are suppressing the speech of licensed counselors on one side of this debate. As the Counselors have ably explained, the Counseling Ordinances that ban so-called “conversion therapy” are content- and viewpoint-based restrictions of speech. Under clear Supreme Court precedent, they must therefore pass strict scrutiny. But they can’t.

To understand why the Counseling Ordinances can’t satisfy strict scrutiny, it’s essential to first understand the two competing approaches to helping gender dysphoric youth and what results those two approaches yield. That’s because the question under strict scrutiny is whether

stamping out the Counselors’ cautious, speech-based counseling is the least restrictive means of accomplishing the City’s and County’s stated goal of protecting children and youth.

But mounting evidence indicates that the City’s and County’s preferred, gender-affirming approach is affirmatively *harmful* to children. It is undisputed that gender-affirming medical interventions carry serious and potentially irreversible physical health risks, such as increased likelihood of sexual dysfunction, infertility, coronary artery disease, liver dysfunction, and cancer. Yet, the Counseling Ordinances actively push children toward this fate by banning the cautious counseling that could help them resolve their gender dysphoria without resorting to harmful, and often permanent, medical interventions.

The evidence also refutes the City’s and County’s insistence that the gender-affirming approach benefits children psychologically. 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 for children. Both reports also identified laws like the ordinances challenged here as a significant barrier to the ability of children with gender dysphoria to access mental health care *at all*. That means that gender-dysphoric children who also suffer from other mental health conditions have a much harder time accessing high-quality mental health care for any of their conditions. These difficulties are compounded

by the fact that the burden of such bans falls disproportionately on religious youth, who often seek the type of counseling offered by the Counselors to help them align their conduct with their deeply held religious beliefs.

Even if the Counseling Ordinances helped—rather than hurt—youth, the City and County have many alternatives available to them for advancing their alleged interests that would be far less restrictive of speech than a complete ban on consensual talk therapy. Among other things, the City and County could: (1) ban aversive or coercive methods, rather than consensual talk therapy; (2) ban efforts to change gender identity only when doing so contradicts the client’s self-defined goals; (3) provide a religious exemption for counseling provided in a religious context; (4) enforce malpractice torts when counselors cause actual harm; or (5) require informed consent. The City and County provide no explanation for why these alternatives would not suffice to keep children from harm. Their Counseling Ordinances thus fail strict and even intermediate scrutiny.

ARGUMENT

I. The Counseling Ordinances promote “gender-affirming” counseling and suppress cautious counseling.

To accurately assess whether the Counseling Ordinances can satisfy strict scrutiny, it is first necessary to understand the two sides of the

debate over how to best help youth experiencing gender dysphoria: the cautious approach, and the gender-affirming approach.

A. The best available evidence favors the cautious approach over the “gender-affirming” approach.

The cautious approach is premised on the notions 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.”² To best help a child experiencing gender dysphoria, cautious counselors, like the Counselors here, work with the child to explore, and ultimately address, the root causes of their distress through simple talk therapy. This allows the child to better understand their own internal struggles with their gender identity and to work through any co-occurring psychological issues in a safe setting before (and hopefully without) resorting to potentially irreversible medical interventions.

This approach has long been the standard practice among counselors.³ It is also supported by the most robust and recent scientific evidence. A substantial majority of minors experiencing gender dysphoria—some studies indicate up to 80-95%—naturally desist after puberty, meaning

² Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report* at 193, 21 (2024), (“Cass Review”).

³ *Id.* at 67-70; Dep’t of Health & Human Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* at 142-45 (May 1, 2025), <https://perma.cc/7B96-VTXG> (“HHS Report”).

they become comfortable with their biological sex without the need for invasive, irreversible medical interventions.⁴

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, 248-51; Cass Review at 90-97. Counseling is an effective, evidence-based treatment for these co-occurring issues. HHS Report at 248-51. 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

⁴ *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 487 (6th Cir. 2023), *aff’d sub nom. United States v. Skrmetti*, 145 S. Ct. 1816 (2025) (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 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%”).

the evidence is still of very low certainty, “several studies suggest that psychotherapy for [gender dysphoria] may effectively resolve the condition noninvasively.” *Id.* at 251.

In contrast, the gender-affirming approach is premised on the notion that children who assert a transgender identity “know their gender as clearly and as consistently as their developmentally equivalent peers.”⁵ 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.”⁶ If puberty is imminent, counselors may also encourage families to seek out doctors who can prescribe “puberty-delaying medications,” which may be followed later by other medical interventions, like cross-sex hormones and surgeries.⁷ For biological girls, these surgeries may include mastectomy, hysterectomy, facial masculinization, and phalloplasty; for biological boys, these may include breast augmentation, orchiectomy, facial feminization, and vaginoplasty.

⁵ Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 *Pediatrics*, no. 4, Oct. 2018, at 4, <https://perma.cc/S7U2-Z8K4>.

⁶ Gabe Murchison et al., *Supporting & Caring for Transgender Children* at 16, Human Rights Campaign Foundation & American Academy of Pediatrics (Sep. 2016), <https://perma.cc/N5HW-KYJ6>.

⁷ *Id.* at 16-17.

See HHS Report at 175. This is called “pediatric medical transition.” *Id.* at 9.

The assumptions underlying the gender-affirming approach are not supported by the data. 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 34, 194.

Nor is there any reliable evidence that social and medical transition 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. *Skrmetti*, 83 F.4th at 489. Puberty blockers “can cause diminished bone density, infertility, and sexual dysfunction.” *Id.* Cross-sex testosterone “increases the risk of erythrocytosis, myocardial infarction, liver dysfunction, coronary artery disease, cerebrovascular disease, hypertension, and breast and uterine cancer.” *Id.* And cross-sex estrogen “can cause sexual dysfunction and increases the risk of macroprolactinoma, coronary artery disease, cerebrovascular disease,

cholelithiasis, and hypertriglyceridemia.” *Id.* 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.⁸

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 supra* p. 9.

B. The Counseling Ordinances push youth toward the gender-affirming approach.

Despite the evidence favoring the cautious approach, the Counseling Ordinances come down hard against cautious counseling and in favor of the gender-affirming approach. Kansas City’s ordinance makes it “unlawful for any provider to” provide for compensation “any practice” that “seeks to change” a minor’s “gender expression,” “behaviors,” or “gender identity.” Kansas City Ordinance § 50-234(b)(1), (c). Jackson County’s ordinance imposes a substantively identical prohibition. *See*

⁸ *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).

Jackson Cnty. Ordinance § 5575.1(a). At the same time, these ordinances expressly permit counseling that “provides acceptance” for a minor who identifies as transgender and “provides support and assistance to a person undergoing gender transition.” Kansas City Ordinance § 50-234(b)(1), (c); *see also* Jackson Cnty. Ordinance § 5575.1(a). Thus, if a young person comes to any of the Counselors and seeks affirmation of their transgender identity and assistance with a gender transition, that is permitted. But if a young person seeks help in changing her conduct and gender expression to re-align her gender identity with her biological sex, the Counselors are forbidden from helping her. If the Counselors were to do so, they would be subject to combined fines of up to \$1500.

Both the City and the County also pejoratively and inaccurately label cautious counseling as “conversion therapy.” Cass Review at 150; HHS Report at 252-54. But “conversion therapy” is not an appropriate label for the cautious counseling the Counselors seek to provide. In 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.⁹ Those practices have been broadly

⁹ *See* Roberto D’Angelo, *Supporting autonomy in young people with gender dysphoria: psychotherapy is not conversion therapy*, 51 J. Med. Ethics 3, 5 (2023), <https://perma.cc/V2YE-ZVBH>.

repudiated, even by former practitioners, and are rare to nonexistent today.¹⁰ 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.¹¹ This conflation of distinct practices is highly questionable, and it creates confusion.¹² It is undisputed that Appellants provide counseling only through verbal communications, not through any aversive or coercive techniques. *See* Verified Compl. ¶¶ 64-81, *Wyatt Bury*, No. 4:25-cv-84 (W.D. Mo. Feb. 7, 2025) (“Verified Compl.”). Nevertheless, because they offer counseling that helps young people who want to change in the direction of embracing their biological sex, the City and County label the Counselors’ practice “conversion therapy” and ban it completely.

By contrast, a counselor who provides “support and assistance to a person undergoing gender transition” is categorically exempt from the City’s and County’s restrictions, even if the counseling helps 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-sex hormones and other irreversible medical interventions. Kansas City Ordinance § 50-234(b)(1); *see also* Jackson Cnty. Ordinance § 5575.1(a).

¹⁰ *Id.*

¹¹ *See id.*

¹² *See id.*; HHS Report at 242-54.

Counseling restrictions like the City’s and County’s have pernicious and predictable results. Most importantly, there is widespread recognition that such bans prevent children with gender dysphoria from accessing needed mental-health care. The Cass Review found that so-called conversion therapy bans left “some clinical staff fearful of accepting referrals of” gender dysphoric youth. Cass Review at 202. Other United Kingdom 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.” *Id.*

The HHS Report identified the same dynamic in the U.S., pointing out these laws 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.” HHS Review at 255-56. In other words, conversion therapy bans make it harder for gender dysphoric youth to find counseling for *any* mental-health issues, not just for gender dysphoria.

The impact of the Counseling Ordinances also falls disproportionately on counselors and youth who are religious. It is well understood that such laws 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 Thus, religious individuals are most directly affected by laws like the Counseling Ordinances here.

The City’s and County’s approach is also in serious conflict with the State of Missouri’s. Recognizing the myriad and severe harms to young people from gender-transition procedures, Missouri forbids medical providers from providing surgical and chemical interventions to minors. *See* Mo. Rev. Stat. § 191.1720. But that’s the very thing the Counseling Ordinances push youth to do by making cautious counseling that aligns with their faith entirely unavailable in their area. This will almost certainly deter vulnerable youth—who may be suffering from multiple mental health conditions—from seeking or obtaining *any* assistance at all. The City and County have no explanation for how this could possibly benefit the youth they insist they’re trying to protect.

II. The Counseling Ordinances fail strict scrutiny.

With an accurate understanding of what the Counseling Ordinances actually accomplish—steering kids toward a harmful, scientifically

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

dubious treatment approach—it becomes clear why they fail 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, the City and County must “prove” that the Counseling Ordinances “further[] a compelling interest and [are] narrowly tailored to achieve that interest.” *Missourians for Fiscal Accountability v. Klahr*, 892 F.3d 944, 952 (8th Cir. 2018). The Counseling Ordinances fail on both fronts.

A. The Counseling Ordinances do not further a compelling governmental interest.

Before the District Court, the City and County claimed one interest for their ordinances: “protecting the health and safety of minors.” Defs.’ Suggestions in Opp. to Pls.’ Mot. for Prelim. Inj. at 19-20, *Wyatt Bury*, No. 4:25-cv-84 (W.D. Mo. Mar. 24, 2025), ECF 20 (“Def.’s Suggestions”). For that interest to be compelling, the City and County would need to demonstrate that there is “an ‘actual problem’ in need of solving,” and that “the curtailment of free speech [is] actually necessary to the solution.” *United States v. Anderson*, 759 F.3d 891, 895 (8th Cir. 2014). This requires the City and County to show that they have a compelling interest in the “application of the challenged law ‘to the person’—the particular claimant” whose free speech is silenced. *Gonzales v. O Centro*

Espirita Beneficente Uniao do Vegetal, 546 U.S. 418, 430-31 (2006). “Mere speculation of harm does not constitute a compelling state interest.” *Consol. Edison Co. of N.Y. v. Pub. Serv. Comm’n*, 447 U.S. 530, 543 (1980). Nor is it enough 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 v. Ent. Merchs. Ass’n*, 564 U.S. 786, 799-800 (2011). Rather, the City and County must demonstrate a “direct causal link between [the Counselors’ speech]”—non-aversive talk therapy—“and harm to minors.” *Id.* at 799. The City and County cannot make that showing for at least three reasons.

First, “there is no reliable evidence to suggest that psychotherapy for [gender dysphoria] is harmful.” HHS Report at 252. Indeed, “several studies suggest that psychotherapy for [gender dysphoria] may effectively resolve the condition noninvasively.” *Id.* at 251.

To reach the opposite conclusion, the City and County rely on evidence that conflates talk therapy with the aversive or coercive techniques that have been widely repudiated and are rarely practiced today. *See* Defs.’ Suggestions at 2-7; Decl. of Douglas C. Haldeman, Ph.D. at 4-14, *Wyatt Bury*, No. 4:25-cv-84 (W.D. Mo. Mar. 24, 2025), ECF 20-3. No study relied on below addressed the results of talk therapy (as opposed to aversive or coercive techniques) provided by a licensed mental-health professional to a minor. *Cf. Chiles v. Salazar*, 116 F.4th 1178, 1240-44 (10th Cir. 2024)

(Hartz, J., dissenting) (reaching same conclusion after surveying available studies). That’s because “[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) (quoting APA Task Force Report at 43); *cf.* Br. for Am. Psych. Ass’n as Amicus Curiae Supporting Defendants-Appellees at 23, *Chiles v. Salazar*, 116 F.4th 1178 (10th Cir. 2024) (Nos. 22-1445 & 23-1002) (“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 868-69.

At minimum, there is significant uncertainty about how best to help minors experiencing gender dysphoria—and the government “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 the City and County cannot carry their burden with such “ambiguous proof.” *Brown*, 564 U.S. at 800.

Second, contrary to the City and County’s insistence below, *see* Defs.’ Suggestions at 4, 6-7, “there is no evidence that gender-affirmative treatments reduce” “deaths by suicide in trans people,” Cass Review at 195. 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 Appellants offer—*is* effective at reducing both suicide rates and suicidality in youth generally. HHS Report at 248-50. Yet the City and County prevent Appellants from offering talk therapy to help their clients relieve their distress and address suicidality without gender transition. This is exactly backwards.

Third, there is “no good evidence” that the gender-affirming approach helps to “manage gender-related distress” in the “long-term.” Cass Review at 13, 195. Instead, mounting evidence demonstrates the 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 these risks, 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 of puberty blockers and cross-sex hormones

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>.

for new minor patients.¹⁶ Twenty-six states have also banned gender-transition treatments for minors. *See* Brief for Petitioner at 17, *Chiles v. Salazar*, No. 24-539 (U.S. June 6, 2025), <https://perma.cc/N2NY-VBBX> (collecting citations).

Despite the growing evidence of harm—and despite Missouri’s own law prohibiting gender transitions for minors—the Counseling Ordinances push youth toward the gender-affirming approach. Rather than advancing the government’s interest in preventing harm to youth, the Counseling Ordinances themselves inflict significant harm on minors. Thus, they cannot satisfy strict scrutiny.

B. The Counseling Ordinances are not narrowly tailored.

Even if the Counseling Ordinances served a compelling interest, they would still fail strict scrutiny’s narrow tailoring requirement. “A narrowly tailored regulation is one that actually advances the [government’s] interest.” *281 Care Comm. v. Arneson*, 766 F.3d 774, 787 (8th Cir. 2014) (quoting *Republican Party of Minn. v. White*, 416 F.3d 738, 751 (8th Cir. 2005)). Moreover, “[a] narrowly tailored regulation must be the least-restrictive alternative, not too under- or over-inclusive.” *Miller v. Ziegler*, 109 F.4th 1045, 1052 (8th Cir. 2024). The Counseling Ordinances flunk narrow tailoring on each of these metrics.

¹⁶ United Kingdom Dep’t of Health and Social Care, *New restrictions on puberty blockers* (May 29, 2024), <https://perma.cc/8LLN-DY29>.

As explained, the Counseling Ordinances do not “actually advance[]” the City’s and County’s stated interest in protecting youth. *White*, 416 F.3d at 751. Banning cautious talk therapy affirmatively harms youth by pushing them toward invasive medical interventions that have no proven psychological benefits but *do* have severe, well-documented health harms. *See supra* pp. 7-9.

Kansas City goes even a step further with its Public Accommodation Ordinance, which forbids the Counselors from declining to provide counseling services to a gender-dysphoric youth, even when providing counseling compliant with the Counseling Ordinance violates their religious beliefs. *See* Kansas City Ordinance § 38-113(a). Thus, the Counselors *must* provide counseling to gender-dysphoric youth and, because of the Counseling Ordinance, that counseling *must* be gender-affirming. This essentially ensures children will be shepherded toward the gauntlet of lifelong harms that come with the gender-affirming approach.

What’s more, and equally fatal, the Counseling Ordinances are not the least restrictive means of accomplishing the City’s and County’s stated goal. “The least-restrictive-means standard is exceptionally demanding.” *Holt*, 574 U.S. at 364-65. “If a less restrictive alternative would serve the Government’s purpose,” then the government “must use that alternative.” *Playboy Ent. Grp.*, 529 U.S. at 813. The City and County

have at least six options for protecting children that are less restrictive of Appellants' speech than a prophylactic ban.

First, the City and County could enact a narrower ban specifically targeting aversive or coercive methods, rather than consensual talk therapy. Neither government has presented evidence that pure talk therapy with a minor is harmful. Before the District Court, the City and County relied upon studies that conflated talk therapy with coercive and aversive methods. *Compare* Defs.' Suggestions at 2-7 (collecting studies) *with* Decl. of D. Paul Sullins at 38-39, *Wyatt Bury*, No. 4:25-cv-84 (W.D. Mo. Apr. 14, 2025), ECF 31-2 (noting numerous shortcomings in various of these studies and "authorities") *and* Decl. of Stephen B. Levine at 99-106, *Wyatt Bury*, No. 4:25-cv-84 (W.D. Mo. Apr. 14, 2025), ECF 31-1 (same). But "[n]one of the cited papers specifically studied 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." *Chiles*, 116 F.4th at 1244 (Hartz, J., dissenting). Likewise, the Counseling Ordinances reference the findings of various medical bodies about "conversion therapy," but those findings fail to separate aversive methods from pure talk therapy. Nor may the government "simply surmise that it is serving a compelling ... interest" by claiming a supposed consensus—particularly on a matter as sharply contested nationally and internationally as this one is. *Interactive Digit. Software Ass'n v. St. Louis County*, 329 F.3d 954, 959 (8th Cir. 2003).

Second, the City and County 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 Counseling Ordinances, both the City and County sought to protect minors “from exposure to the serious harms and risks caused by conversion therapy or reparative therapy”—coercive and aversive methods that seek to do what the patient does not want, and finds exceptionally distressful. Kansas City Ordinance § 50-234(a); *accord* Jackson Cnty. Ordinance § 5575.1. A law that focused on unwanted change efforts would not sweep in those like the Counselors, who “support the[ir] minor clients to achieve their own self-selected goals,” Verified Compl. ¶ 73, who “do not impose their Christian faith on their clients,” *id.* ¶ 52, and who work with their minor clients only so long as those minors are willing to participate with them, *see id.* ¶ 74.

Third, the City and County could require informed consent. This would ensure that minors and their families are fully informed of any alleged risks without muzzling therapists like the Counselors or depriving willing patients of the therapies that they themselves deeply want. The City and County offer no explanation for why this alternative would not sufficiently protect minor patients. In fact, the evidence in the record demonstrates its efficacy. Here, the Counselors required informed consent from each of their minor patients before beginning counseling. *See id.* ¶ 57. Whenever a minor client no longer wanted their counseling,

that client was free to stop attending their sessions—as in fact happened. *See id.* ¶¶ 174.

Ironically, Kansas City appears to believe that minors and their parents *are* capable of giving informed consent to risky medical gender transitions. When Missouri considered a law banning medical gender transitions for minors (which ultimately passed), Kansas City passed a resolution opposing it, declaring its view that “persons seeking ... gender-affirming healthcare” should be able to receive it, including minors. K.C. Res. No. 230385 (May 11, 2023), <http://bit.ly/4nn9nrh>. As councilmembers explained, the City wanted to “leave[] that decision with that child and their parents.” K.C. Council Legislative Session at 21:25-22:15 (May 11, 2023), <https://bit.ly/4jRzJB1>. In other words, according to the City, a young girl and her parents *can* safely give informed consent to cross-sex hormones, mastectomies, and genital surgeries—permanently stripping her of the opportunity to ever bear or nurse children. But it is too dangerous for a child even to *talk* with a counselor who helps her accept her body as a healthy gift from God. The City never explains why informed consent works for the former but not the latter.

Fourth, the City and County could provide a religious exemption, as other similar laws do. *See, e.g.*, 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 denomination.”).

Fifth, the City and County 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)). These tools would allow the City and County to address harms, if they exist, without sweeping overbroadly and chilling counseling that helps distressed youth. *See also infra* Part III.B.

Sixth, the City and County could follow the lead of many jurisdictions with the same interests that have not adopted these bans at all—including their own state, Missouri. *Cf. Holt*, 574 U.S. at 369 (“[W]hen 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.”). Missouri and many other states have the same interest as the City and County in the welfare of minors, yet still manage to protect these interests without a categorical ban. Neither the City nor County has explained why it alone needs to take a different course—especially when Missouri, *parens patriae* for all Missouri children, has not only refused such bans, but has affirmatively spoken out against the gender-affirming approach and banned gender transitions for minors.

In short, the City and County have failed to carry their “obligation to prove” that all of these less restrictive alternatives “will be ineffective to achieve [their] goals.” *Playboy Ent. Grp.*, 529 U.S. at 816. The Counseling Ordinances thus cannot satisfy strict scrutiny.

III. The Counseling Ordinances fail even intermediate scrutiny.

Even if the Counseling Ordinances burdened speech only incidentally, the appropriate level of review would be intermediate scrutiny—not rational basis review, as the district court concluded. *See Brandt v. Griffin*, 147 F.4th 867, 890 (8th Cir. 2025). 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)). The Counseling Ordinances fail even this intermediate standard.

A. The Counseling Ordinances do 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 speech,” *Free Speech Coal., Inc. v. Paxton*, 606 U.S. 461, 495-96 (2025); *see also TikTok, Inc. v. Garland*, 604 U.S. 56, 73 (2025) (requiring “an important government interest unrelated to the suppression of free expression”). 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).

To the extent the City and County have asserted a legitimate interest in preventing harm to young people, that interest extends, at most, only to coercive and aversive techniques. But the ordinances go *beyond* that interest by striking at consensual talk therapy, for which “there is no

reliable evidence to suggest” harm. HHS Report at 252. Thus, “the scope of the [Counseling Ordinances] is too broad to satisfy the First Amendment.” *Animal Legal Def. Fund v. Reynolds*, 8 F.4th 781, 787 (8th Cir. 2021).

Worse, the Counseling Ordinances actually *undermine* the City’s and County’s asserted interest. *See supra* pp. 18-19. 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 the Counseling Ordinances 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 255-56. This harms the youth the City and County claim they are trying to protect by creating barriers to accessing needed mental-health care. *See supra* pp. 1-12, 18-20.

B. The Counseling Ordinances are not narrowly tailored.

To be narrowly tailored under intermediate scrutiny, a law “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 Ordinances fail this standard because the City and County have “available to [them] a variety of approaches that appear

capable of serving [their] interests” without silencing Plaintiffs’ speech. *McCullen*, 573 U.S. at 493-94.

NIFLA illustrates this point. There, 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 launched “a public-information campaign” or “post[ed] the information on public property near crisis pregnancy centers.” *Id.* 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.

The same is true here. The City and County could take several other approaches to accomplish their goals—such as banning only aversive and coercive treatments; banning treatments that contradict a client’s goals; granting a religious exemption; requiring informed consent; or enforcing existing malpractice laws to address any potential harms. *See supra* Part II.B.

“The point is not that [the City and County] must enact all or even any of” these “proposed measures.” *McCullen*, 573 U.S. at 493. The point is that they have “not shown that [they] seriously undertook to address the problem with less intrusive tools readily available to [them].” *Id.* at 494. Nor is there any “hint that the [City or County] even considered these or

any other alternatives,” *Thompson v. W. States Med. Ctr.*, 535 U.S. 357, 373 (2002), much less that such alternatives would “fail to achieve [either] government’s interests.” *McCullen*, 573 U.S. at 495. The Counseling Ordinances thus “go[] much further than is necessary to serve the interest[s] asserted” and fail even intermediate scrutiny. *Matal*, 582 U.S. at 246.

CONCLUSION

The District Court’s decision should be reversed.

Date: October 24, 2025

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this *amicus* brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and 32(a)(7)(B)(i) because it contains 6,323 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f). This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Century Schoolbook) using Microsoft Word (the program used for the word count).

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on October 24, 2025, a true and correct copy of the foregoing Brief *Amicus Curiae* of the Becket Fund for Religious Liberty was served electronically on the counsel registered for service via the CM/ECF system.

Date: October 24, 2025

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