IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CHRISTOPHER DOYLE, LPC, LCPC, *Plaintiff*, v. LAWRENCE J. HOGAN, JR., *et al*., *Defendants*.	Civil Action No. 1:19-CV-00190-DKC

BRIEF OF *AMICUS CURIAE* FREESTATE JUSTICE, INC. IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS AND DEFENDANTS' OPPOSITION TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Amicus curiae FreeState Justice, Inc., hereby submits this Brief in Support of Defendants' Motion to Dismiss and Defendants' Opposition to Plaintiff's Motion for Preliminary Injunction.

BACKGROUND

Maryland's Youth Mental Health Protection Act, codified as Md. Code. Ann., Health Occ. § 1-212.1 (hereinafter, "Section 1-212.1"), is based on the consensus of the nation's leading medical and mental health organizations that efforts to change a person's sexual orientation or gender identity are ineffective, unethical, and unsafe. In 2009, the American Psychological Association surveyed then-existing scientific literature in a report entitled "Appropriate Therapeutic Responses to Sexual Orientation." *See* Am. Psychological Ass'n, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (Aug. 5, 2009), *available at* https://perma.cc/KX75-3KW4 (hereinafter, "APA Report"). The APA Report concluded that "sexual orientation change efforts" (SOCE) are not only ineffective, but put patients—and especially minors—at risk of serious long-term harms. The APA's conclusions included the following:

- **The APA Report recognized that "conversion therapy" is another commonly used term for SOCE:** "[W]e use the term sexual orientation change efforts (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person's same-sex sexual orientation to other-sex[.]" APA Report at 2 n.**; *id.* at 93-117 (citing numerous studies and references concerning "conversion therapy").[1]

- **The APA Report found that conversion therapy for minors is ineffective:** "We found no empirical evidence that providing any type of therapy in childhood can alter adult same-sex sexual orientation." APA Report at 79.

- **The APA Report concluded that the available research demonstrated evidence of harm from conversion therapy:** "[S]cientific evidence shows that SOCE is not likely to produce its intended outcomes and can produce harm for some of its participants." APA Report at 83.

- **The APA Report cited recent studies documenting harm from "non-aversive" techniques:** With respect to recent studies, "the reported negative social and emotional consequences include self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction." APA Report at 42.

- **The APA Report concluded that licensed mental health providers <u>should not engage in sexual orientation change efforts with minors under any circumstances</u>, <u>regardless of whether techniques are aversive or non-aversive, and including for "children and adolescents who present a desire to change their sexual orientation"</u>**: "We recommend that LMHP provide multiculturally competent and client-centered therapies to children, adolescents, and their families *rather than SOCE*. . . . These approaches would support children and youth in identity exploration and development *without seeking predetermined outcomes*." APA Report at 79-80 (emphasis added).

- **The APA Report concluded that conversion therapy offers no unique benefits.** "The positive experiences clients report in SOCE are not unique, and "the benefits reported by participants in SOCE may be achieved through treatment approaches that do not attempt to change sexual orientation." APA Report at 68; *see also id*. at 53 (same).

- **The APA Report concluded that conversion therapy could not be justified by invoking client autonomy or self-determination.** "We believe that simply providing

[1] Although Plaintiff refers to conversion therapy as a "political" term, Dkt. 2 at 6, it is in fact one of several terms, which also include "reparative" or "reorientation" therapy, commonly used in the relevant research literature and by the country's leading medical and mental health organizations to refer to therapeutic attempts to change sexual orientation or gender identity. All of these terms appear in the statements of medical and mental health organization relied on by the legislature in enacting § 1-212.1. *See* Dkt. 25-3.

> SOCE to clients who request it does not necessarily increase self-determination but rather abdicates the responsibility of LMHP [licensed mental health professionals] to provide competent assessment and interventions that have the potential for benefit with a limited risk of harm." APA Report at 70.

In 2015, the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services conducted an updated survey of existing research on conversion therapy and published a report and recommendations based on "consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance." Substance Abuse and Mental Health Serv. Admin., U.S. Dep't of Health and Human Serv., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* (Oct. 2015), at 1, *available at* https://perma.cc/KAC4-BHXD (hereinafter, "SAMHSA Report"). The report found "none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation." *Id*. It concluded: "Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment." *Id*.

Other medical and mental health organizations that have reached similar conclusions include: the American Medical Association, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American College of Physicians, American Association for Marriage and Family Therapy, National Association of Social Workers, American Psychoanalytic Association, American Counseling Association, American School Counselor Association, American School Health Association, American Academy of Nursing, American Osteopathic Association, Pan American Health Organization, and World Psychiatric Association. *See* Nat'l Ctr. For Lesbian Rights, *Born Perfect:*

Toolkits, Resources & Statements, *available at* http://www.nclrights.org/bornperfect-toolkit-resources-statement/ (collecting statements) (last accessed Mar. 14, 2019).

Subsequent research has only further strengthened these conclusions. A recent peer-reviewed study found that lesbian, gay, bisexual and transgender (LGBT) adolescents subjected to conversion therapy were *nearly three times more likely to attempt suicide and experience serious depression* than other LGBT youth. *See* Caitlin Ryan et al, *Parent-Initiated Sexual Orientation Change Efforts with LGB Adolescents: Implications for Young Adult Mental Health and Adjustment*, Journal of Homosexuality (2018) (attached as Exhibit 1).

The National Institutes of Health list suicide as the second leading cause of death for youth between the ages of 10 and 24. *See* Nat'l Inst. of Mental Health, *Suicide*, *available at* https://www.nimh.nih.gov/health/statistics/suicide.shtml (last accessed Mar. 14, 2019). According to a 2018 survey of existing research, sexual minority youth are more than three times more likely to have attempted suicide than heterosexual youth. *See* Ester de Giacomo et al., *Estimating the Risk of Attempted Suicide Among Sexual Minority Youths: A Systematic Review and Meta-Analysis*, *JAMA Pediatrics* (Dec. 2018), at E3, *available at* https://perma.cc/53Y3-B4LS.

In light of this evidence, Maryland has a compelling interest in protecting youth from a discredited medical treatment that increases the rate of attempted suicide by three times among a population that already is at a dangerously high risk of suicidality.

ARGUMENT

I. SECTION 1-212.1 DOES NOT VIOLATE THE FIRST AMENDMENT'S SPEECH CLAUSE.

Under Supreme Court and Fourth Circuit precedent, Section 1-212.1 is subject to rational basis review, like other regulations of health care treatments that incidentally impact speech while protecting the public from harmful practices. Here, the harms caused by conversion therapy are so

great, the medical consensus recognizing those harms is so strong, and the statute is so narrowly-tailored to protect minors from those harms, that it would survive not only rational basis review, but any level of review.

A. *NIFLA* Confirms That States May Regulate Medical Treatment To Protect Public Health and Safety, Just As Section 1-212.1 Does Here.

In *National Institute of Family and Life Advocates ("NIFLA") v. Becerra*, 138 S. Ct. 2361, 2373 (2018), the Supreme Court invalidated a California law requiring licensed pregnancy clinics to notify women that California provides free or low-cost services including abortion, and requiring unlicensed clinics to notify women that California has not licensed them to provide medical services. 138 S. Ct. at 2368. In doing so, the Court expressly reaffirmed the settled proposition that governments may protect patients from harm by regulating medical *treatments* provided by licensed health care practitioners: "[t]he First Amendment does not prevent restrictions directed at commerce or conduct from imposing incidental burdens on speech . . . and professionals are no exception to this rule." *Id.* at 2373. *NIFLA* confirmed that states may regulate medical practice to protect patients from harm, even when doing so restricts some speech that is "part of the practice of medicine." *Id.* at 2373.

The Court explained that California's law triggered heightened scrutiny because its required disclosures were "not tied to a [medical] procedure" and instead "applie[d] to all interactions between a covered facility and its clients, regardless of whether a medical procedure is ever sought, offered, or performed." The law therefore directly regulated speech as such and improperly "compel[led] individuals to speak a particular message." *Id*. at 2371.

The Court contrasted these untethered speech requirements with the informed consent requirement upheld in *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 884 (1992), which "regulated speech only as part of the *practice* of medicine." *NIFLA*, 138 S. Ct. at

2373 (emphasis in original). Here, like the regulation in *Casey*, the Maryland law is limited to a specific treatment—the practice by licensed therapists of conversion therapy for minors, a dangerous and discredited mental health treatment. The statute is extremely narrow, applying only to the actual provision of that discredited treatment, and exempts all speech between therapists and their clients that is not part of the provision of that specific treatment.

For this reason, Section 1-212.1 is subject only to rational basis review, which it plainly survives in light of the strong professional consensus of leading national medical and mental health organizations that conversion therapy for minors is ineffective and puts minor patients at risk of serious harm, including depression and suicidality. In contrast, there was no such medically-based justification for the disclosure requirements at issue in *NIFLA*, which were "not tied to a procedure at all." 138 S. Ct. at 2373.

B. Section 1-212.1 Is Permissible Under The First Amendment As A Reasonable Regulation Of A Particular Mental Health Treatment.

Laws enacted pursuant to a state or locality's police power generally are entitled to "a presumption of legislative validity." *Kelley v. Johnson*, 425 U.S. 238, 247 (1976). "A statute that governs the practice of an occupation is not unconstitutional as an abridgment of the right to free speech, so long as 'any inhibition of that right is merely the incidental effect of observing an otherwise legitimate regulation.'" *Accountants' Soc'y of Va. v. Bowman,* 860 F.2d 602, 604 (4th Cir. 1988) (quoting *Underhill Assoc. v. Bradshaw*, 674 F.2d 293, 296 (4th Cir. 1982)) (upholding statute prohibiting unlicensed accountants from using terms such as "generally accepted accounting standards" in financial reports).

To be sure, regulations of medical professionals may implicate the First Amendment "when the government tries to control public discourse through the regulation of a profession," such as by limiting "public discussion and commentary." *Nat'l Ass'n for Advancement of*

Multijurisdiction Prac. v. Lynch, 826 F.3d 191, 196 (4th Cir. 2016) (citation and internal quotation marks omitted). "When the First Amendment rights of a professional are at stake, the stringency of review thus slides 'along a continuum' from 'public dialogue' on one end to 'regulation of professional *conduct*' on the other." *Stuart v. Camnitz*, 774 F.3d 238, 248 (4th Cir. 2014) (quoting *Pickup v. Brown*, 740 F.3d 1208, 1227, 1229 (9th Cir. 2013)) (emphasis in original). "Because the state has a strong interest in supervising the ethics and competence of those professions to which it lends its imprimatur, this sliding-scale review applies to traditional occupations, such as medicine or accounting, which are subject to comprehensive state licensing, accreditation, or disciplinary schemes." *Greater Baltimore Ctr. for Pregnancy Concerns, Inc. v. Mayor & City Council of Baltimore*, 879 F.3d 101, 109 (4th Cir. 2018). "Quite simply, '[t]here is a difference, for First Amendment purposes, between regulating professionals' speech to the public at large versus their direct, personalized speech with clients.'" *Otto v. City of Boca Raton*, 353 F. Supp. 3d 1237, 2019 WL 588645, at *13 (S.D. Fla. 2019) (quoting *Locke v. Shore*, 634 F.3d 1185, 1191 (11th Cir. 2011). Thus, "[t]he speech of medical providers is routinely limited through prescription drug laws, medical malpractice lawsuits, accreditation requirements, and other means." *Id.*

Like the Supreme Court in *NIFLA*, the Fourth Circuit has recognized the critical "distinction between professional speech and professional conduct when deciding on the appropriate level of scrutiny to apply to regulations of the medical profession." *Stuart*, 774 F.3d at 248. In *Stuart*, for example, the court struck down a law that required physicians to perform an ultrasound while displaying the resulting images and describing the fetus to women seeking abortions. The court concluded that on the "continuum" of professional regulations, such a law must be regarded as an instance of content-based compelled speech requiring at least intermediate scrutiny. *Id.* at 245. In so concluding, the court emphasized the "extraordinary" nature of the

compelled disclosures, which were "intended to convey not the risks and benefits of the medical procedure to the patient's own health, but rather the full weight of the state's moral condemnation" of the patient's decision to seek abortion. *Id.* at 254, 255. The compelled disclosures were not related to patient health and safety, but were entirely "ideological": "[t]he state freely admit[ted] that the purpose and anticipated effect . . . [was] to convince women seeking abortions to change their minds or reassess their decisions." *Id.* at 246. "[F]ar from promoting the psychological health of women," this compelled speech "risk[ed] the infliction of psychological harm" on women. *Id.* at 253.

Section 1-212.1 is unlike the law invalidated in *Stuart*. As two federal courts of appeals have recognized in upholding laws similar to Section 1-212.1, the purpose of legislation protecting minors from the discredited practice of conversion therapy is entirely based on the need to protect the health and well-being of minors and firmly grounded in the broad professional consensus that conversion therapy is ineffective, harmful, and unethical. These laws' sole purpose and effect is to prevent minor patients from being subjected to an unsafe treatment, not to restrict therapists' speech or compel communication of the government's preferred message. *See Pickup*, 740 F.3d at 1230 ("Because SB 1172 regulates only treatment, while leaving mental health providers free to discuss and recommend, or recommend against, [conversion therapy], we conclude that any effect it may have on free speech interests is merely incidental"); *King v. Governor of N.J.*, 767 F.3d 216, 237 (3d Cir. 2014) ("The New Jersey legislature has targeted [conversion therapy] counseling for prohibition because it was presented with evidence that this particular form of counseling is ineffective and potentially harmful to clients."); *see also Otto*, 2019 WL 588645, at *15 (concluding that conversion therapy ordinance was closer to the regulations upheld in *Casey* than those invalidated in *NIFLA*).

Like the conversion therapy laws in California, New Jersey, and the City of Boca Raton, Florida, all of which federal courts have upheld, Section 1-212.1 does not compel any speech or prevent therapists from expressing their opinion on any topic. Section 1-212.1 only prevents licensed therapists from subjecting minor patients to a specific course of medical treatment that has been overwhelmingly rejected by the medical community as dangerous and ineffective for minors. "The public marketplace of ideas is not limited in any way. What *is* limited, is the therapy (delivered through speech and/or conduct) by a licensed practitioner to his or her minor patient, within the confines of a therapeutic relationship." *Otto*, 2019 WL 588645, at *16.

Rational basis review thus applies here because, like the challenged regulation in *Casey*, which "regulated speech only as part of the *practice* of medicine," *NIFLA*, 138 S. Ct. at 2373, Section 1-212.1 prohibits only the *practice* of conversion therapy. To the extent speech is implicated at all, it is only because in mental health therapy, speech ordinarily is "the *manner* of delivering the treatment. [Therapists] are essentially writing a prescription for a treatment that will be carried out verbally." *Otto*, 2019 WL 588645, at *15 (emphasis in original). In imposing that restriction on the conduct of licensed therapists, Section 1-212.1 exempts speech between therapists and their clients that is not part of the provision of that specific treatment to minors. The statute does not prohibit mental health professionals from publicly or privately stating a belief in the efficacy or propriety of conversion therapy for minors or adults, or from publicly or privately stating religious or other beliefs about LGBT people. It does not require mental health professionals to make any affirmative statements at all, whether about conversion therapy or any other subject. And it does not apply to the conduct of individuals not operating under a state license.

For these reasons, under both Supreme Court and Fourth Circuit precedent, Section 1-212.1 is subject only to rational basis review, which it easily survives.

C. Plaintiff's Theory Would Call Into Question The Validity Of Numerous Well-Established Regulations of Mental Health Professionals As Content-Based Speech Restrictions.

The sweeping, categorical approach proposed by Plaintiff would gut the well-established governmental authority to regulate licensed practitioners in order to protect public health and safety. Taken to its logical end, this approach would mean that virtually *any* regulation of professional counseling must withstand strict scrutiny, since virtually all such counseling consists largely of speech. That approach would jeopardize many important existing regulations. For example, current Maryland regulations prohibit licensed therapists from:

- representing to the public that they possess a license or certification to practice a type of counseling or therapy that they do not possess, Md. Code Ann., Health Occ. § 17-601, 17-603;
- practicing outside "the boundaries of a counselor's competence, based on education, training, supervised experience, and professional credentials," Md. Code Regs. § 10.58.03.03(A)(1);
- failing to obtain "written authorization to provide counseling services for minors or other clients unable to give informed consent," *Id.* §10.58.03.04(A)(5);
- entering into "relationships that could compromise a counselor's objectivity or create a conflict of interest," *Id.* § 10.58.03.04(B)(3);
- failing to "[i]nform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed," *Id.* § 10.58.03.05(A)(1)(a);
- "[f]oster[ing] dependent counseling relationships," *Id.* § 10.58.03.05(A)(2)(d);
- failing to "[m]aintain the privacy and confidentiality of a client and a client's records," *Id.* § 10.58.03.08(A)(1); or
- "represent[ing] to a client or individual in close personal contact with a client that sexual contact or activity by or with a counselor is consistent with or part of a client's therapy," *Id.* § 10.58.03.09 (F)(2).

Under Plaintiff's approach, all of these requirements would be subject to strict scrutiny. But no court has held that any professional regulation of counselors that may incidentally restrict the speech that occurs within the counseling relationship automatically triggers heightened scrutiny. To the contrary, courts routinely view such regulations as a legitimate exercise of the state's police power to protect health and safety.

Indeed, because licensed mental health professionals use speech as their medical treatment, under Plaintiff's logic, they could not be required to adhere to any professional standards of ethics or care in performing any such treatment, unless those standards could survive strict scrutiny. That is not, and cannot be, the law. *See Otto*, 2019 WL 588645, at *25-26.

D. Section 1-212.1 Also Satisfies Heightened Scrutiny.

Section 1-212.1 also would survive even heightened scrutiny because it is "justified by a compelling interest and is narrowly drawn to serve that interest." *Brown v. Ent. Merch. Ass'n*, 564 U.S. 786, 799 (2011).

1. Maryland Has A Compelling Interest In Protecting Children From Harm.

Maryland enacted Section 1-212.1 to carry out its "compelling interest in protecting the physical and psychological well-being of minors." Dkt. 25-3 at 4. Governments have a compelling interest in the health and well-being of their citizens. *See Goldfarb v. Va. State Bar*, 421 U.S. 773, 792 (1975); *Watson v. Md.*, 218 U.S. 173, 176 (1910).

Furthermore, "[a] democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies." *Prince v. Mass.*, 321 U.S. 158, 168 (1944). Consequently, the Supreme Court "ha[s] sustained legislation aimed at protecting the physical and emotional well-being of youth even when the laws have

operated in the sensitive area of constitutionality protected rights." *N.Y. v. Ferber*, 458 U.S. 747, 757 (1982). That interest is unquestionably served here, where the government seeks to protect minors who are "especially vulnerable to [the] practices" barred by the Section 1-212.1. *King*, 767 F.3d at 238.

In enacting Section 1.212.1, the legislature relied on a broad professional consensus that conversion therapy poses real dangers to Maryland's children. The detailed legislative findings summarize relevant research and the conclusions of well-known, reputable professional and scientific organizations that conversion therapy is highly correlated with depression, suicidality, substance abuse, and other serious harms. *See* Dkt. 25-3. As discussed above, subsequent research and clinical experience have corroborated these risks for children.

Plaintiff complains that the research showing the harms of conversion therapy is not absolutely conclusive. But the First Amendment does not require the government to delay action to protect children from serious threats of harm until it possesses conclusive scientific proof, particularly when acquiring such proof would produce the very harm the government seeks to avoid. *See FCC v. Fox Television Stations*, 556 U.S. 502, 519 (2009). Significantly, responsible professionals stopped conducting double-blind studies on conversion therapy precisely because it was harmful, particularly to minors, and therefore would be unethical to attempt. *See* APA Report at 91; *Otto,* 2019 WL 588645, at *18 & n.12.

2. Section 1-212.1 Is Narrowly Tailored To Advance The State's Compelling Interest.

Plaintiff contends that there are less restrictive alternatives to protect the mental health and well-being of Maryland youth than a prohibition of conversion therapy for minors. But because there are inherent, potentially deadly, dangers whenever a licensed professional attempts to reach the fixed outcome of changing a minor's sexual orientation or gender identity, there are no practical

alternatives to a prohibition on licensed mental health professionals performing such so-called therapy on minors. The "less restrictive alternatives" Plaintiff proposes would still allow minors to be exposed to the very physical and mental harms that are the subject of the medical literature cited by the legislature and that Section 1-212.1 seeks to prevent. *See Otto*, 2019 WL 588645, at *23-24.

First, there is no way for the statute to prohibit only "coercive" and "involuntary" conversion therapy for minors. Conversion therapy is *inherently* coercive because it does not accommodate as a successful outcome any result other than conversion of the patient's sexual orientation or gender identity. And it is inherently involuntary for minors, who have no legal power or practical ability to refuse these efforts if their parents want them to be subjected to it.

As explained by the United States Department of Health and Human Services, the "Professional Consensus on Conversion Therapy with Minors" is that: "*Interventions aimed at a fixed outcome*, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation *are coercive*, can be harmful, and should not be part of behavioral health treatments." SAMHSA Report at 11 (emphasis added). Simply put, the very nature of this therapy—because its goal is a fixed and predetermined outcome—makes it coercive for minors.

Moreover, Maryland law generally does not allow children under the age of 18 to consent to their own medical treatment, leaving all such decisions in the hands of their parents. *See* Md. Code. Ann., Health-Gen. § 20-102. Although Maryland law permits minors aged 16 years or older to consent to treatment of a "mental or emotional disorder," being gay, lesbian, or bisexual is not a disorder, and in any event, minors over 16 are not permitted to refuse treatment for which a parent, guardian, or custodian has given consent. *Id.* § 20-104(b). Given this reality, limiting the

statute to instances of "involuntary" conversion therapy would be meaningless; virtually all such therapy is involuntary where minors are concerned, as a matter of law.

In sum, Maryland law provides no avenue by which minors of any age can effectively refuse or resist conversion therapy treatments wanted by their parents or other adult authorities. Indeed, in rejecting this form of treatment as unethical and unprofessional, professional organizations have recognized that any purported distinction between voluntary and involuntary treatment is meaningless in practice for minors. Minors are under the legal control of parents or guardians and thus cannot themselves decide to legally consent to, or refuse, medical care that could be dangerous to them and that provides no potential benefits. *See also Otto,* 2019 WL 588645, at *23.

For essentially the same reasons, the proposal that minors give "informed consent" before undergoing conversion therapy is not an acceptable alternative. As the Third Circuit noted in rejecting a similar argument, "[m]inors constitute an 'especially vulnerable population,' and may feel pressured to receive [conversion therapy] counseling by their families and their communities despite their fear of being harmed." *King*, 767 F.3d at 240 (quoting APA Report at 121); *see also* APA Report at 77 (noting that minors "are emotionally and financially dependent on adults."). Conversion therapy "is condemned by numerous professional organizations as contraindicated, harmful, and ineffective, because minors' 'immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely.'" *Otto,* 2019 WL 588645, at *21 & n.13 (quoting *Hodgson v. Minnesota,* 497 U.S. 417, 444 (1990)).

Finally, restricting the statute only to so-called "aversive" treatments such as electroshock therapy would completely disregard the overwhelming medical consensus that being subjected to non-aversive conversion therapy also puts minors at risk of depression, suicide, and other serious

harms. *See* APA Report at 42, 79-80; *Otto,* 2019 WL 588645, at *23. The government has a "compelling interest" in protecting minors from that harm, just as it does with aversive methods.

CONCLUSION

For the reasons stated above, as well as those set forth in Defendants' memoranda, *Amicus Curiae* FreeState Justice respectfully asks that the Court deny the Plaintiff's request for a preliminary injunction and grant Defendants' motion to dismiss.

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Respectfully submitted,

/s/

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* Motions for admission *pro hac vice* forthcoming.