NO. 24-539

In the
Supreme Court of the United States

KALEY CHILES,

Petitioner,

v.

PATTY SALAZAR,
in her official capacity as Executive Director of the Colorado Department of Regulatory Agencies,
et al.,

Respondents.

On Writ of Certiorari to the
U.S. Court of Appeals for the Tenth Circuit

BRIEF ON THE MERITS FOR RESPONDENTS

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QUESTION PRESENTED

Whether the First Amendment allows states to regulate professional healthcare treatments—including treatments that use words—to protect patients from substandard care.

PARTIES TO THE PROCEEDING

Petitioner is Kaley Chiles, an individual.

Respondents are Patty Salazar, in her official capacity as Executive Director of the Department of Regulatory Agencies; Reina Sbarbaro-Gordon, in her official capacity as Program Director of the State Board of Licensed Professional Counselor Examiners and the State Board of Addiction Counselor Examiners; Andrew Harris, Jennifer Luttman, Kalli Likness, Laura Gutierrez, Nimita Davis, Richard Cohan, and Samuel Haynes in their official capacities as members of the State Board of Licensed Professional Counselor Examiners; and Crystal Kisselburgh, Erika Hoy, Jonathan Culwell, Kristina Daniel, Leo Alirez, Leticia Smith, and Nagy Ramzy in their official capacities as members of the State Board of Addiction Counselor Examiners.

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INTRODUCTION

Petitioner challenges Colorado's regulation of a specific healthcare "practice or treatment" that violates the standard of professional care patients have a right to expect. For centuries, states have regulated professional healthcare to protect patients from substandard treatment. Throughout that time, the First Amendment has never barred states' ability to prohibit substandard care, regardless of whether it is carried out through words. This Court should not create such a bar now.

Colorado's law prohibits licensed professionals from performing conversion therapy on minor patients. Conversion therapy is a practice or treatment performed for the purpose of changing the patient's sexual orientation or gender identity. Conversion therapy may include physical conduct, will almost always include some words, and may be conducted with words only. Regardless of how it is performed, conversion therapy is ineffective and is associated with harms that include depression, anxiety, loss of faith, and suicidality. For these reasons, laws like Colorado's exist in 25 states and have the support of every major healthcare association in the country.

Colorado's law prevents this one specific treatment only—it does not prevent healthcare professionals from sharing information or opinions with a patient (or others). Those professionals may write articles, give speeches, testify to legislatures, or post on social media about their views on conversion therapy. They may tell patients about conversion therapy and about religious ministries and others who can engage

in such practices. They may criticize Colorado's law or the standard of care.

The law also allows therapists to engage in a wide spectrum of therapeutic techniques to evaluate and support minors regarding their sexual orientation or gender identity, including minor patients who do not wish to act on their sexual attractions for religious or any other reasons. And the law does not require therapists to "affirm" any orientation or identity (indeed, the law does not mention the word "affirm"). The *only* thing that the law prohibits therapists from doing is performing a treatment that seeks the predetermined outcome of changing a minor's sexual orientation or gender identity because that treatment is unsafe and ineffective.

If adopted, Petitioner's position would gut states' power to ensure mental healthcare professionals comply with the standard of care. Moreover, because so much health care—regardless of the field—is delivered exclusively through words, Petitioner's efforts to distinguish substandard treatment involving words from substandard treatment that does not involve words would destabilize longstanding and sensible healthcare regulation.

Respondents request that this Court adhere to its long line of precedents that recognize states' power to regulate healthcare to protect patients from substandard treatment and affirm the lower courts' rulings.

STATEMENT OF THE CASE

I. Colorado prohibits the discredited practice of conversion therapy.

Under Colorado law, it is "unprofessional conduct" for a licensed practitioner to "engag[e] in . . . [c]onversion therapy with a client who is under eighteen years of age." C.R.S. § 12-245-224(1)(t)(V). "Conversion therapy" means "any practice or treatment" that "attempts or purports to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attraction or feelings toward individuals of the same sex." C.R.S. § 12-245-202(3.5)(a). It prohibits licensees' efforts to "change" minor patients' sexual orientation or gender identity in any direction.[1]

Conversion therapy does not "include practices or treatments that provide:"

> (I) Acceptance, support, and understanding for the facilitation of an individual's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change sexual orientation or gender identity; or (II) Assistance to a person undergoing gender transition.

[1] "Sexual orientation" and "gender identity" are well-established concepts in mental health. J.A.40–42.

Id. § 12-245-202(3.5)(b). The law allows mental health professionals to use any lawful therapeutic technique for any other purpose, including to help minors explore and develop their sexual orientation and gender identity. J.A.43–45; 571–72.

Historically, gay and transgender people have been subjected to efforts to "cure" their nonconforming orientations or identities, which were considered pathologies or even criminal. J.A.191–92. To "treat" these individuals, "[b]ehavior therapists tried a variety of aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks; or having the individual snap an elastic band around the wrist when the individual became aroused to same-sex erotic images or thoughts." J.A.195. Other examples of aversive treatments included intrusive practices, like satiation therapy and orgasmic reconditioning, that attempted to alter sexual desires by creating and then positively reinforcing sexual experiences associated with heterosexuality while associating physical harm or discomfort with nonconforming sexual preferences. J.A.195.[2]

Conversion therapy now more commonly includes a variety of techniques that seek to change a patient's sexual orientation by changing patient behaviors or

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[2] *See, e.g.*, *Covert Sensitization*, APA Dictionary, https://dictionary.apa.org/covert-sensitization (last visited Aug. 19, 2025); *Orgasmic Reconditioning*, APA Dictionary, https://dictionary.apa.org/orgasmic-reconditioning (last visited Aug. 19, 2025); *Masturbatory Satiation*, APA Dictionary, https://dictionary.apa.org/masturbatory-satiation (last visited Aug. 19, 2025) (all on file with the Colorado Attorney General's Office).

familial, romantic, and other relationships. For example, "affection training" directs gay teenagers to pursue opposite-sex relationships, J.A.195; or, as one witness testified to Colorado's legislature, he was directed to conform to his "correct gender role" by spending time only with the other males in his life and not speaking to his mother and sisters living in the same household *for three years*.[3] In the case of gender identity, conversion therapy includes efforts to change "demeanor, actions, and dress associated with gender roles[] and to suppress gender nonconforming behaviors" for the purpose of changing gender identity. J.A.48; 568. A transgender male patient testified that he was counseled to wear skirts, hose, heels, and make-up to "develop [his] femininity."[4]

The professional consensus now acknowledges that variations in sexual orientation and gender identity are normal, nonpathological parts of human identity, and that efforts to change these nonconforming identities, whether carried out through aversive or nonaversive techniques, are ineffective. J.A.161–62. By the early 1970s, the medical professions had removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), concluding that homosexuality "is a normal variant of human sexuality." J.A.161–62. "Gender identity disorder" was

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[3] *Prohibit Conversion Therapy for A Minor: Hearing on H.B. 19-1129 Before the H. Pub. Health Care and Hum. Serv. Comm.*, 2019 Leg., 72d Gen. Sess., 2:51:29–2:54:38 (Colo. Feb. 13, 2019) (statement of Matthew Shurka), https://drive.google.com/file/d/1ry0TbEK-L2J7r0oS0M7F7GHJ2K9L6uiR/view?usp=sharing.

[4] *Hearing on H.B. 19-1129*, 1:18:09–1:20:09 (statement of Francis Lyon), https://drive.google.com/file/d/1ry0TbEK-L2J7r0oS0M7F7GHJ2K9L6uiR/view?usp=sharing.

also removed from the DSM in 2013 after research found that "[g]ender identity diversity is not a mental disorder" and "that variations in gender identity are normal." J.A.74. Now, every major medical and mental health professional association recognizes that "[s]ame-gender sexual orientation (including identity, behavior, and attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder." J.A.522; 235.[5] There is no therapeutic need or ability to "cure" them.

Every major professional healthcare association in the country further agrees that conversion therapy is not just ineffective and unnecessary, but can be harmful, particularly to minors. J.A.24–25 & n.9; 97. Hearing that their sexual orientation or gender identity needs to and can be "fixed" can lead young people to experience chronic feelings of shame and guilt that compound into long-term emotional distress and lower levels of educational and vocational achievement. J.A.53–55. Conversion therapy efforts are associated with adolescents' increased "isolation, self-hatred, in-

[5] These include international health organizations such as the Pan American Health Organization (of the World Health Organization), the World Psychiatric Association, and the World Professional Association for Transgender Health, and collectively representing more than 880,000 members: the American College of Physicians, American Medical Association, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, the American Psychological Association, American Psychoanalytic Association, the American School Counselor Association, the National Association of Social Workers. J.A.25 n.9.

ternalized stigma, depression, anxiety, and suicidality." J.A.64. And for some religious participants, conversion therapy inflicts additional harm by distancing them from their faith institutions, worsening family relationships, and undermining their faith. J.A.67–68. Colorado, like 25 other states,[6] seeks to protect young people, and their families, from these harms.

II. Colorado law safeguards public health and safety in mental health practice.

Colorado's prohibition on conversion therapy is one specific application of Colorado's broader regulation of mental health professionals to ensure these professionals provide quality care to patients.

Colorado's Mental Health Practice Act requires that a professional be licensed, certified by, or registered with the state to practice as a mental health professional. C.R.S. §§ 12-245-203, -218, -228.[7] Mental health professionals may offer "treatment, diagnosis, testing, assessment, or counseling in a professional relationship to assist individuals or groups to alleviate behavioral and mental health disorders, understand unconscious or conscious motivation, resolve emotional, relationship, or attitudinal conflicts, or modify behaviors that interfere with effective emotional, social, or intellectual functioning." C.R.S. § 12-245-202(14)(a). Licensed professionals employ a variety of specific therapeutic modalities or techniques when

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[6] Movement Advancement Project, *LGBTQ Youth: Conversion "Therapy" Laws* (last updated July 31, 2025), https://coag.gov/app/uploads/2025/08/MAP-Conversion-Therapy-Laws.pdf.

[7] Respondents refer to such providers as "licensed professionals," "mental health professionals" or "therapists."

working with minor patients, including cognitive behavioral therapy, dialectical behavior therapy, play therapy, and family therapy, each of which calls for a specific therapeutic approach that the professional is clinically trained to provide.[8]

Mental health professionals are subject to multiple regulations that protect patients from substandard care and other harms. C.R.S. § 12-245-101 *et seq*. Among other duties, licensed therapists must practice consistent with the standard of care set forth by their profession, such as "the standards of practice generally recognized by state and national associations of practitioners in the field of the person's professional discipline." C.R.S. § 12-245-224(1)(g)(I). For professional counselors, these standards include the American Counseling Association's ("ACA") Code of Ethics, which requires a therapist, *inter alia*, to obtain and document their patients' informed consent, including explaining a treatment's objectives, risks, and benefits; avoid causing harm to patients; and avoid imposing their own values, attitudes, beliefs, and behaviors on patients.[9]

In Colorado, mental health practitioners are licensed and supervised by regulatory boards comprising licensed professionals and public representatives.

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[8] *See* Am. Acad. of Child and Adolescent Psychiatry, *Psychotherapy for Children and Adolescents: Different Types* (April 2019), https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Psychotherapies-For-Children-And-Adolescents-086.aspx (on file with the Colorado Attorney General's Office); *see also* J.A.47; 297.

[9] ACA, Code of Ethics Rule A.2, A.4 (2014), https://coag.gov/app/uploads/2025/08/2014-aca-code-of-ethics.pdf.

C.R.S. §§ 12-245-302, -402, -502, -602, -702, -802. Among other things, these boards may issue licenses and impose discipline on licensees who violate their field's licensure requirements. C.R.S. §§ 12-245-209, -222, -225. In Colorado, the disciplinary process for licensed professionals begins when a regulatory board receives a complaint. C.R.S. § 12-245-226(1)(II)(A). After receiving the professional's response and conducting further investigation, the board may impose discipline.[10] A board's determination is subject to administrative appeal, C.R.S. §§ 12-245-226(2), 24-4-105(14)–(16), and judicial review, *id.* §§ 24-4-106, 13-4-102(2)(s).

Finally, the Act exempts from its requirements "[a] person engaged in the practice of religious ministry," C.R.S. § 12-245-217, reflecting the State's regulation of professional mental healthcare only—not spiritual or pastoral counseling or other religious ministry.

In addition, Colorado, like many other states, authorizes malpractice actions against licensed mental health professionals if they provide substandard care that causes harm to a patient. *See, e.g.*, *Fried v. Leong*, 946 P.2d 487, 488 (Colo. App. 1997) (affirming judgment of liability for "psychological malpractice").

III. District court proceedings.

Colorado's prohibition on conversion therapy went into effect on September 5, 2019. More than three years later, Petitioner filed this preenforcement

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[10] *See* C.R.S. § 12-245-222(1)(b), (d); Colo. State Bd. of Licensed Pro. Couns. Policy 10-3 (adopted Mar. 16, 2012), https://coag.gov/app/uploads/2025/08/Professional-Counselor-Policies.pdf.

challenge to the law and sought a preliminary injunction. Pet.App.178a; 230a.

A. Petitioner Kaley Chiles.

Petitioner Kaley Chiles is licensed in Colorado as a professional counselor and addiction counselor. Pet.App.181a. To receive these licenses, she completed a master's degree and thousands of hours of clinical work experience. C.R.S. §§ 12-245-604, -804. These licenses allow her to offer professional mental health care to Coloradans, including evaluation, assessment, diagnosis, treatment or intervention, planning, consultation, case management, education, psychotherapy, and crisis intervention. *See* C.R.S. §§ 12-245-202(14), -603, -803; *see also* Pet.App.176a.

Petitioner's factual allegations are set forth exclusively in her Complaint. She submitted no other evidence to support her claims. Petitioner's practice focuses on treating trauma, addictions, and personality disorders, and she alleges that she "periodically" receives requests for counseling "related to sexual attractions and gender identity." Pet.App.215a–16a. Petitioner claims she has "helped clients freely discuss sexual attractions, behaviors, and identity," including "gender roles, identity, sexual attractions, root causes of desires, behavior and values." Pet.App.206a. Petitioner contends that she is "unable to fully explore certain clients' bodily experiences around sexuality and gender" because of Colorado's law. Pet.App.215a.

Petitioner states she wants to help her patients with "their stated desires and objectives," which may include seeking to "grow in the experience of harmony with one's physical body." Pet.App.207a. With respect to sexual orientation, Petitioner states that she "does

not seek to 'cure' clients of same-sex attractions or to 'change' clients' sexual orientation." Pet.App.207a. Petitioner "does not imply that categorical change in attractions is a therapeutic goal." Pet.App.206a. She also "does not begin counseling with any predetermined goals," Pet.App.207a, and does not allege that any of her minor clients have requested therapy with a predetermined goal to change their sexual orientation or gender identity. Pet.App.206a–08a.

Petitioner alleges that she fears professional discipline if she engages in her desired counseling practices with minors. Pet.App.229a. However, Colorado has not taken any disciplinary action against Petitioner, nor has Colorado ever taken disciplinary action against any licensed professional for violating the challenged law.[11] And none of what Petitioner alleges she seeks to do would violate Colorado's law, because she expressly does not seek to change any patient's sexual orientation or gender identity. *See* Pet.App.206a–07a; 210a.

B. The record evidence established that conversion therapy is ineffective and harmful.

Based on evidence submitted by Respondents, J.A.17–659, the district court found that "conversion therapy is ineffective and harms minors who identify as gay, lesbian, bisexual, transgender, or gender nonconforming." Pet.App.158a.

Respondents' evidence established that Colorado enacted its conversion therapy law in response to a

[11] Decl. of Reina Sbarbaro-Gordon at ¶4, *Chiles v. Salazar*, No. 1:22-cv-02287 (D. Colo. Dec. 6, 2022), ECF 52-1.

growing mental health crisis among Colorado teenagers and mounting evidence that conversion therapy is associated with increased depression, anxiety, suicidal thoughts, and suicide attempts. Pet.App.61a–67a; 157a.[12] During a hearing on the House floor, numerous speakers, including therapists, conversion therapy survivors, and clergy, testified in support of the law.[13]

Respondents also submitted the declaration of Dr. Judith Glassgold, a licensed clinical psychologist with more than thirty years of practice. Dr. Glassgold—a recognized expert in the field of applied psychology—served as the Chair of the American Psychological Association ("APA") Task Force on Appropriate Therapeutic Responses to Sexual Orientation. *See* J.A.19–20 ¶9. Her declaration reviewed the available research on conversion therapy, citing numerous studies by multiple authors documenting its associated ineffectiveness and harms. Regarding ineffectiveness, her review found no study showing that

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[12] At the time the law was passed in 2019, suicide was the leading cause of death for Colorado kids aged 10–24, and LGBTQ+ kids were at even higher risk. Colo. Dep't of Pub. Health and Env't, *Office of Suicide Prevention Annual Report 2019-2020* 31 (2020). A staggering number of high school students aged 15 years or younger had seriously considered attempting suicide during the previous year: 51.5% of transgender students; 44.1% of bisexual students; 35.3% of gay or lesbian students. Colo. Dep't of Pub. Health and Envir., *Healthy Kids Colorado Survey Dashboard* (2019), https://coag.gov/app/uploads/2025/08/Healthy-Kids-Colorado-Survey-Dashboard.xlsx.

[13] *Hearing on H.B. 19-1129*, 1:05:25–1:09:23 (statement of Robert Werthwein), https://drive.google.com/file/d/1ry0TbEK-L2J7r0oS0M7F7GHJ2K9L6uiR/view; *id.* at 2:07:46–2:10:08 (statement on behalf of Michael Hidalgo); *see also id.* at 2:10:25–2:12:56, 2:22:19–2:24:32, 2:24:36–2:27:39.

conversion therapy worked. J.A.23–25 ¶14; J.A.66 ¶70 (citing study of 1,600 individuals reporting that "participants' same-sex attractions and arousal persisted despite the individuals' efforts to change"); ¶71 (citing five additional studies reporting conversion therapy's failure to change sexual orientation). And it identified the availability of effective treatments that support and acknowledge the values of religious patients without seeking to change those patients' orientations or identities. J.A.32 n.19; 95–96 ¶¶107–08.

Her declaration also reviewed numerous studies by multiple authors documenting the harms associated with conversion therapy. J.A.60–61 ¶61 (describing studies "dating across two decades"); J.A.62–64 ¶65 (documenting both verbal and behavioral treatment); ¶¶66–67 (citing the APA Task Force Report, J.A.131–517); J.A.67 ¶72 (citing study with 1,600 participants in which 37% of participants reported harms of conversion therapy including decreased self-esteem, depression, and anxiety as well as patients' increased distance from their faith and family); J.A.68 ¶73 (citing multiple additional studies reporting similar harms); J.A.69 ¶75 (describing study of 34,000 LGBT-identified individuals that found higher rates of suicide attempts and suicidality among those who reported undergoing conversion therapy); J.A.70–74 (citing additional seven studies involving tens of thousands of participants identifying harms of conversion therapy); J.A.84–86 (describing how conversion therapy causes harm).

Dr. Glassgold also explained that further study of conversion therapy—particularly on minors—would

be unethical. J.A.58–59. "Directly studying an intervention that has no benefits and poses a risk of harm" on a population that may not be able to "freely consent to treatment due to age" or is otherwise vulnerable violates "basic ethical principles that should underlie the conduct of biomedical and behavioral research." J.A.58–59 ¶¶57–58.

Finally, Dr. Glassgold discussed the specific harms that conversion therapy causes for religious patients and their families. J.A.67–69. In one study, participants reported harms that included increased feelings of distance from God and from their faith institutions, as well as negative impacts on their relationships with their families. J.A.67–68. Some religious patients perceived themselves as weak or as unworthy in God's eyes when conversion therapy failed to change their orientation. J.A.277 (APA Task Force Report).

Respondents also submitted the 2009 Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation ("Task Force Report"). J.A.131–517. Assessing the evidence regarding the appropriate treatment for "children and adolescents who present a desire to change either their sexual orientation or their behavioral expression of their sexual orientation, or both," J.A.156, the Task Force conducted a systematic review of 55 studies with more than 2500 adult research subjects. J.A.506–17. The Task Force Report "found no empirical evidence that providing any type of therapy in childhood can alter adult same-sex sexual orientation." J.A.360. The studies reviewed in the Task Force Report provided "no sound basis for claims that people's mental health and quality of life

improve" following conversion efforts. J.A.251. The studies also identified the adverse effects of conversion therapy to include loss of all sexual feeling, anxiety, depression, suicidal ideation, nightmares, loss of religious faith, and feelings of guilt and hopelessness. J.A.252–53; 276–77.

Respondents also submitted a 2015 report by the Substance Abuse and Mental Health Services Administration ("SAMHSA"), part of the U.S. Department of Health and Human Services ("HHS"). J.A.518–659. The purpose of the report was to "provide mental health professionals and families with accurate information about effective and ineffective therapeutic practices related to children's and adolescents['] sexual orientation and gender identity . . . based on professional consensus statements arrived at by experts in the field." J.A.521. Based on an extensive literature review, J.A.623–49, the report concluded that no credible evidence supported the effectiveness of conversion therapy. J.A.521; 569–70. While the experts acknowledged that there was limited research on conversion therapy involving children, "none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation." J.A.535. The report further concluded that "[i]nterventions 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." J.A.535.

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On this record, the district court denied Petitioner's Motion for Preliminary Injunction, concluding that she failed to demonstrate a likelihood of success on the merits. Pet.App.171a–73a. Petitioner did not challenge any of the district court's factual findings, and the court of appeals affirmed. Pet.App.28a, 72a.

SUMMARY OF THE ARGUMENT

Colorado's law prohibits licensed professionals from performing one specific treatment—conversion therapy—on minors. It does so because conversion therapy does not work and can lead to a lifetime of harms for young people, including separation from their faith and family. This is not controversial—even Petitioner disclaims that she intends to engage in this discredited practice.

From this country's infancy, states have exercised their power to regulate professional healthcare treatment to protect patients from substandard care. They have done so both through malpractice law and through professional practice laws. These laws have long included mental health and have long included treatments that were performed with words. This is because these words are used by a professional in a fiduciary relationship, to provide individualized treatment based on specialized knowledge, for the sole purpose of promoting the patient's health. As this Court recently recognized in *National Institute of Family & Life Advocates v. Becerra* ("*NIFLA*"), the First Amendment allows states to prohibit treatment that violates the standard of care—and the fact that substandard treatment often involves words does not change this constitutional analysis. 585 U.S. 755, 769–70 (2018).

Nevertheless, Petitioner asserts that—because conversion therapy may be performed in whole or in part through words—the law must satisfy strict scrutiny. Distinguishing treatments that use words from those that do not ignores the reality of professional healthcare. And requiring the application of strict scrutiny to states' regulation of harmful treatments that involve words would strip states of their power to protect patients from substandard care.

The Court should review Colorado's law under a rational-basis standard, but it satisfies any level of scrutiny. The State's interest in protecting minors from ineffective and harmful healthcare practices is of the highest possible order. The law is narrowly tailored to regulate only the one specific discredited practice of conversion therapy. It does so without limiting any other communication that licensed professionals wish to have with their patients or others about sexual orientation, gender identity, or their views on conversion therapy. And it does so without imposing any limitation on other treatment for patients.

Petitioner's request for this unprecedented restriction on the states' power to ensure quality healthcare should be rejected, and the judgment of the lower court should be affirmed.

ARGUMENT

I. Colorado prohibits one specific treatment that violates the standard of care.

Petitioner's case depends almost entirely on her significant overreading of Colorado's law. The scope of the law is critical to multiple aspects of this case—whether Petitioner has standing, *infra* n.18; how the law is treated for purposes of the First Amendment,

infra Sections II, III; and whether the law satisfies the appropriate level of scrutiny, *infra* Section IV.

The scope of this law is exceedingly narrow—it prohibits licensed mental health professionals from engaging in a "practice or treatment" with a minor "that attempts or purports to change [the minor's] sexual orientation or gender identity." C.R.S. § 12-245-202(3.5)(a); -224(1)(t)(V). That's it.

As described above, treatments that attempt to change sexual orientation or gender identity can include a wide range of activities, from electric shocks, to hypnosis, to role-playing, to cognitive behavioral therapies, to efforts to change a patient's behavior, appearance, or relationships. All these techniques likely involve some words. Some may consist of words only. The defining characteristic of the prohibited treatments, however, is that they are employed *for the purpose of* changing sexual orientation or gender identity, because such treatments have been found to be unsafe and ineffective. *See United States v. Skrmetti*, 145 S. Ct. 1816, 1830 (2025) ("[A] key aspect of any medical treatment [is] the underlying medical concern the treatment is intended to address.").

The law does not compel therapists to affirm nonconforming orientations and identities but instead allows them to help minor patients examine and explore their identity without a predetermined goal of changing it. J.A.43–45; 95–96. Just as a therapist may not pursue an *a priori* goal of making a minor patient heterosexual or cisgender, the law likewise prohibits them from seeking to make a minor gay or transgender. Therapists have many tools available to

explore patients' identity development without seeking to achieve a predetermined goal. And a licensed professional doesn't violate the law as long as she does not perform a treatment that seeks to change a minor's sexual orientation or gender identity.

The allegations in Petitioner's Complaint do not establish that she intends to violate the law. Indeed, she disclaims this intent, asserting that she "does not seek to 'cure' clients of same-sex attractions or to 'change' clients' sexual orientation." Pet.App.207a.

Instead, Petitioner alleges that she helps patients "explore certain . . . bodily experiences," including concerns over "unwanted sexual attractions" that "may arise" during her counseling sessions, and that she desires to discuss the topics of "sexual attractions, behaviors, and identity" with patients, including "gender roles, identity, sexual attractions, root causes of desires, behavior and values." Pet.App.206a–15a. All of this is expressly allowed by Colorado's law. C.R.S. § 12-245-202(3.5)(b)(I) (allowing "treatments that provide . . . [a]cceptance, support, and understanding" or facilitate "identity exploration"); J.A.30–31; 44–45; 95–96.

Finally, Petitioner's Complaint states she wants to help her patients "grow in the experience of harmony with one's physical body," Pet.App.207a, but provides no details as to how she plans to pursue this. If she wishes to perform a treatment to change the minor's sexual orientation or gender identity, that is not allowed. But the law allows any other treatment to assist the minor with exploring their identity, facilitating their coping, or feeling "harmonious with their body."

Petitioner's opening brief argues that the law prevents her from freely discussing sexual orientation and gender with her patients, including those who desire change. OB18. But the law imposes no barriers to professionals sharing information about sexual orientation, gender identity, or conversion therapy. It does not prevent them from criticizing Colorado's law or their profession's standards of care. It does not prevent them from recommending a patient to those not subject to the law, like those engaged in religious ministry. C.R.S. § 12-245-217(1). It *only* prevents mental health professionals from treating a young patient for the purpose of changing sexual orientation or gender identity—a treatment that Petitioner says *she does not pursue*. Therapists are otherwise free to provide any treatment within the standard of care.[14]

Petitioner argues that the law prohibits her from treating patients who, for religious or other reasons, do not wish to engage in behaviors consistent with their nonconforming attractions or identities. OB50. It does not. There are many reasons why a minor who is

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[14] Other states' laws are equally narrow. *See, e.g.*, Utah Code Ann. § 58-1-511(3) ("A health care professional who is not intending to change a minor client's sexual orientation or gender identity, or to impose a different sexual orientation or gender identity upon a minor client, may engage in any professional and lawful conduct," including providing a minor client "with acceptance, support, and understanding;" facilitating a minor client's "exploration and development" of their identity, "including sexual orientation or gender identity;" and discussing "moral, philosophical, or religious beliefs or practices."); *Tingley v. Ferguson*, 47 F.4th 1055, 1090 (9th Cir. 2022) (Washington); *Otto v. City of Boca Raton*, 981 F.3d 854, 875 (11th Cir. 2020) (Martin, J., dissenting) (Florida city and county ordinances); *Pickup v. Brown*, 740 F.3d 1208, 1229–30 (9th Cir. 2014) (California).

gay may not want to engage in same-sex sexual relationships—for example, they may choose celibacy for religious, cultural, or family reasons. J.A.270–71 (citing studies involving religious adults who wished to maintain heterosexual marriages). Colorado's law allows this. As long as the therapist does not seek a predetermined outcome for a minor's sexual orientation, the law poses no bar to their ability to help that minor explore their identity, including helping them cope with unwanted sexual attractions or otherwise meet their goals with regard to behavior without trying to change their identity.[15] *See* J.A.30–31; 572–73 (identifying appropriate therapeutic approaches).

Petitioner also argues that Colorado's law requires therapists to encourage a minor toward a nonconforming gender identity. OB16. It does not. A therapist treating a minor who seeks to understand whether they identify as a girl or boy should help that patient explore that question, including by addressing co-occurring mental health issues. And there are many reasons why a transgender minor may choose not to express themselves consistently with their gen-

[15] While the prohibited practices or treatments include "efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attraction or feelings towards individuals of the same sex," those efforts are prohibited only if they are undertaken *for the purpose of* "chang[ing] an individual's sexual orientation or gender identity." C.R.S. § 12-245-202(3.5)(a). If undertaken for a different purpose, they do not satisfy the definition of conversion therapy. *See, e.g., id.* § 12-245-202(3.5)(b). The district court similarly held that "conversion therapy" applies only to practices "that promote particular sexual orientations or gender identities." Pet.App.149a.

der identity: they may not have access to gender-affirming care for legal or financial reasons; they may have concerns about medical interventions; they may fear for their safety or societal acceptance. Numerous therapeutic practices within the standard of care support a young person's choices about how to express themselves. *See* J.A.30–31; 42–44.[16]

Petitioner also asserts that the law allows therapists to support a minor who is pursuing gender transition, but not detransition. OB40–41.[17] This is also incorrect. Providing therapeutic support to a patient—whether they are transitioning or detransitioning—does not seek to change gender identity: in both cases, the patient has already determined their gender identity. *See* C.R.S. § 12-245-202(3.5)(b)(II); *see also* Utah Code Ann. § 58-1-511(3)(c) (making clear that its conversion therapy ban allows professionals to provide "treatment to a minor client who is considering a gender transition in any direction, including exploration of the timing thereof"). Because neither process seeks

[16] Petitioner repeatedly invokes current disputes over medical interventions such as puberty blockers, hormones, or gender-affirming surgeries. *E.g.*, OB2–3; 16–17; 45–47. But Colorado's statute has nothing to do with medications, surgeries, or any other medical treatments. Nothing in this law encourages, much less requires, a medicalized pathway for minors experiencing gender dysphoria. It simply prohibits a single, harmful practice.

[17] "Affirmative" practices in psychotherapy should not be conflated with "gender affirming care." In psychology, "affirmative approaches" means "provid[ing] a safe space where the different aspects of the evolving self can be acknowledged, explored, respected, and potentially rewoven into a more coherent sense of self that feels authentic to the client, and it can be helpful to those who accept, reject, or are ambivalent about" their sexual orientation or gender identity. J.A.148.

to change gender identity, therapists may support both. What the therapist cannot do is try to achieve a predetermined gender identity for the minor—regardless of whether that is or isn't a transgender identity.[18]

II. The First Amendment poses no bar to states' power to regulate professional healthcare treatments that violate the standard of care.

Patients seek—and pay for—professional health care to receive individualized treatment informed by knowledge in a fiduciary relationship that exists for the sole purpose of promoting the patient's health. *See* Claudia Haupt, *The Limits of Professional Speech*, 128 Yale L.J. F. 185, 191 (2018) ("Fiduciary duties address the knowledge asymmetries between professionals and their clients or patients, creating duties of loyalty and care. The patient, for example, entrusts the doctor with providing guidance regarding their health decisions. In return, the doctor must act in the patient's

[18] As this Section demonstrates, Petitioner has failed to make the clear showing that she is likely to establish each element of standing, as required at the preliminary injunction stage. *Murthy v. Missouri*, 603 U.S. 43, 58 (2024). Petitioner has never alleged an intention to engage in conduct arguably prohibited by the law, nor can she establish the objectively credible threat of prosecution necessary for preenforcement standing. *See Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 159 (2014). Respondents haven't enforced the law against any licensees, let alone Petitioner. And Petitioner can request a declaratory order from Respondents to clarify any uncertainty she may have about the law. C.R.S. § 24-4-105(11) (agencies must provide "prompt disposition of petitions . . . to remove uncertainties as to the applicability . . . of any statutory provision"); 4 Colo. Code Regs. § 737-1:1.4; *id.* § 744-1:1.4. Petitioner's misinterpretation of the law does not establish standing.

best interests according to the knowledge of the profession."). Patients' dependence on healthcare providers "create[s] conditions of intense vulnerability, which magnify the role that trust plays in medical relationships." Mark A. Hall, *Law, Medicine, and Trust*, 55 Stan. L. Rev. 463, 471 (2002).

States have long regulated healthcare professionals to ensure that this relationship of trust, dependence, and vulnerability serves its function of promoting patient health. *See Dent v. West Virginia,* 129 U.S. 114, 122 (1889) (recognizing states' regulation of healthcare professionals "from time immemorial" to protect patients from substandard care). Specifically, malpractice and professional practice laws have long and routinely regulated professional healthcare treatment, including mental healthcare treatment, to require that treatment's consistency with the standard of care.

These laws have also long regulated *the words* used by healthcare professionals in delivering treatment that violates the standard of care because professional healthcare treatment so often requires words for its delivery. Substandard treatment harms patients regardless of whether that treatment involves words: a surgeon who incompetently closes a suture harms a patient—as does a cardiologist who fails to ask a patient about her family medical history, an oncologist who provides inadequate explanation of treatment options, and a therapist who subjects a patient to an unsafe and ineffective technique.

At no time has the First Amendment been understood to confer on professionals a constitutional right to use words to deliver treatment that violates the

standard of care. To be sure, states regulate healthcare professionals in a variety of other ways, and for a variety of reasons. But this case requires this Court to consider only the First Amendment's application to the regulation of professional healthcare treatment to protect patients from substandard care.

A. In the modern era, states routinely regulate professional healthcare treatment to protect patients from substandard care, including treatment that uses words.

States' malpractice laws and professional practice acts (also known as licensing laws) routinely regulate professional healthcare treatment—including treatment that uses words—to require consistency with the standard of care.

First, states widely recognize the tort of medical malpractice that subjects medical providers (including mental health professionals[19]) to liability for harm arising from a breach of the standard of care, which encompasses "the care, skill, and knowledge regarded as competent among similar medical providers in the same or similar circumstances." Restatement (Third) of Torts: Medical Malpractice §§ 4–5 (A.L.I. 2024); 61

[19] "Medical provider" is defined for malpractice purposes as any professional that provides medical treatment, including mental health treatment. Restatement (Third) of Torts: Medical Malpractice § 1, comment 3 (Patient and Provider Defined). The American Law Institute approved the Restatement of the Law Third, Torts: Medical Malpractice in May 2024. *See* https://www.ali.org/news/articles/alis-torts-medical-malpractice-approved. Section 1 was approved in 2022 as Restatement of the Law Third, Torts: Concluding Provisions and later moved to Medical Malpractice.

Am. Jur. 2d *Physicians, Surgeons, Etc.* §§ 180–81 (2025). Courts typically rely on expert testimony to establish both the standard of care and whether it was breached. Restatement (Third) of Torts: Medical Malpractice § 6; *see also* H.H. Henry, *Necessity of expert evidence to support an action for malpractice against a physician or surgeon,* 81 A.L.R.2d 597*,* § 2 (1962). A healthcare professional who harms a patient by departing from the standard of care must compensate the plaintiff for that harm. *E.g.*, *McDougald v. Garber*, 536 N.E.2d 372, 374–76 (N.Y. 1989).

Malpractice law recognizes that a healthcare professional's words in providing treatment that falls below the standard of care can be just as harmful as a botched procedure. *E.g.*, *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972) (explaining that due care may require a physician to disclose symptoms, warn of risks, recommend alternatives, or tell the patient when a treatment isn't working); *Malone v. State, Dep't of Health & Hum. Res., Office of Hosps.*, 569 So. 2d 1098, 1100–01 (La. Ct. App. 1990) (doctor committed malpractice "in not instructing [plaintiff] to return to the emergency room if his condition worsened"); *Harris v. Kreutzer*, 624 S.E.2d 24, 32–33 (Va. 2006) (psychologist's alleged verbal abuse of patient during examination could constitute a breach of the applicable standard of care); *Roberts v. Salmi*, 866 N.W.2d 460, 474 (Mich. Ct. App. 2014) (considering malpractice actions against therapist alleged to have used discredited therapeutic practices that caused young patients to have false memories of parents' sexual abuse); *Mower v. Baird*, 422 P.3d 837, 844 (Utah 2018) (same).

Second, every state has enacted laws that require medical and mental health professionals to be licensed and to comply with professional practice standards as a condition of licensure. *Brokamp v. James*, 66 F.4th 374, 383 n.6 (2d Cir. 2023); Respondents' Appendix at 2a–8a (hereinafter "App.").[20] Under these professional practice laws, professionals may be disciplined for what they do or don't say, like claiming that they can cure incurable disease, App.9a–11a, or failing to disclose certain information about patient treatment options.[21]

States widely provide for the imposition of discipline on practitioners who fail to meet their profession's standards of care. App.2a–10a. And states frequently discipline professionals for the words they use to deliver treatment that violates the standard of care. *See, e.g.*, Fla. Dep't of Health Discipline & Admin. Action No. 2020-05957 (state board of health complaint seeking to impose professional discipline for therapist's failure to discuss a suicidal patient's reasons to live, hope for the patient's future, coping skills); Fla. Dep't of Health Discipline & Admin. Action No. 1999-60963 (complaint seeking to impose discipline for therapist's failure, when counseling couple

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[20] *See* Fed'n of State Med. Bds., *Guide to Medical Regulation in the United States*, https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/ (last visited Aug. 19, 2025) (on file with the Colorado Attorney General's Office).

[21] *See, e.g.*, Kan. Stat. Ann. § 65-2836(m) (licensed professionals subject to discipline for failing to inform patients with breast tissue abnormalities for which surgery is recommended about alternative treatments consistent with duty of care); Md. Code Ann., Health Occ. § 14-404(a)(26) (similar).

in abusive relationship, to provide information relevant to abuse victim's safety and to develop treatment plan for partner's anger management issues); N.J. Pro. Couns. Exam. Comm., State Bd. of Marriage and Fam. Exam'rs, License No: 37PC00581700 (2022) (professional discipline imposed for therapist's failure to explain to patient the reason for abrupt cessation of therapy); Minn. Bd. of Behav. Health and Therapy, License No: 00133 (2012) (professional discipline imposed for therapist's disparaging remarks to a patient regarding their mental health).

B. For centuries, states have regulated professional healthcare to protect patients from substandard treatment without running afoul of the First Amendment.

This regulatory practice is by no means new—states have long regulated professional healthcare treatment through malpractice and professional practice laws that sought to protect patients from substandard treatment.

As William Blackstone reported, English common law has long held doctors liable for harm caused by their negligent medical treatment. 3 William Blackstone, *Commentaries on the Laws of England* 122 (William Draper Lewis ed., Geo. T. Bisel Co. 1922) (1768) (describing "mala praxis" as occurring when a practitioner's "negligence or unskilful [sic] management" harms a patient, which "breaks the trust which the party has placed in his physician, and tends to the patient's destruction"). State courts in the United States soon followed suit. *E.g.*, *Cross v. Guthery*, 2 Root 90, 91 (Conn. Super. Ct. 1794) (affirming judgment for plaintiff where the defendant surgeon performed an

operation "contrary to all the well-known rules and principles of practice in such cases"); *Grannis v. Branden*, 5 Day 260, 261, 267 (Conn. 1812) (affirming jury verdict holding defendant surgeon liable for injuries caused by "ignorance, carelessness, wickedness and want of skill"); *Mertz v. Detweiler*, 8 Watts & Serg. 376, 378 (Pa. 1845) (discussing the relevance of expert testimony in establishing doctor's malpractice); *Wood v. Clapp,* 36 Tenn. (4 Sneed) 65, 67 (1856) (affirming jury verdict holding defendant physician liable for malpractice); *Ritchey v. West,* 23 Ill. 385, *1–*2 (1860) (same). Medical malpractice lawsuits dramatically increased in frequency starting around 1840 and remain a significant feature of American tort law to this day. *See* James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 273 J. Am. Med. Ass'n 1731, 1731–32 (2000).

In addition to enforcing malpractice law, states have long enacted professional practice laws to protect patients from substandard care by requiring practitioners to demonstrate certain levels of knowledge and experience before they could be licensed to practice medicine—a tradition that began in the colonies in the mid-17th century, when Virginia adopted legislation that punished physicians who neglected their patients. Ruth Horowitz, *In the Public Interest: Medical Licensing and the Disciplinary Process* 39 (2013). By the early 19th century, penalties for the unlicensed practice of medicine were in place in eighteen states. David A. Johnson & Humayun J. Chaudhry, *Medical*

Licensing and Discipline in America 18 (2012).[22] By 1910, nearly every state in the union had a medical licensing board. *Id*. at 24.

States' efforts to protect patients from substandard care have long extended to care for mental "ailment[s]." *See, e.g.*, *Dee v. State*, 9 So. 356, 356 (Miss. 1891) (practice of medicine defined to include treatment "of any ailment or disease of mind or body"); *Parks v. State*, 64 N.E. 862, 864 (Ind. 1902) (discussing statute requiring licensing for those seeking to heal diseases of the mind as engaged in the practice of medicine); *Bennett v. Ware*, 61 S.E. 546, 548 (Ga. Ct. App. 1908) (to practice medicine includes treatment "for the cure, relief, or palliation of any ailment or disease of the mind or body"); *Ex parte Collins*, 121 S.W. 501, 502 (Tex. Crim. App. 1909) (statute defining practice of medicine as including to "treat, or offer to treat any disease or disorder, mental or physical"); *Smith v. People*, 117 P. 612, 613 (Colo. 1911) (statute regulating practice of medicine defined to include "any form of treatment for the intended palliation, relief, or cure of any physical or mental ailment of any person"); *Locke v. Ionia Circuit Judge*, 151 N.W. 623, 625 (Mich. 1915) (statute defining practice of medicine to include diagnosing or curing things of "physical or mental origin"); *La. State Bd. of Med. Exam'rs v. Cronk*, 102 So. 415,

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[22] Amidst an anti-regulatory climate, nearly every state repealed its licensing laws between 1826 and 1852. Johnson & Chaudhry, *Medical Licensing and Discipline in America* 18 (2012). But that retraction was short-lived. North Carolina enacted a medical practice act in 1859, and between 1873 and 1890, eleven more states adopted laws regulating medical practice. *Id*. at 23.

416 (La. 1924) (practicing medicine includes "treating, curing or relieving any bodily or mental disease").

States' longstanding malpractice laws and professional practice acts frequently regulated healthcare treatment performed through words. For instance, doctors could be held liable for medical malpractice for providing negligent medical advice. In *Edwards v. Lamb*, 45 A. 480 (N.H. 1899), a doctor treated a man's infected sore and told his wife she was in no danger, even instructing her to help dress the wound. She later became infected. The court rejected the argument that the absence of hands-on care shielded the doctor from liability: "[t]he fact that his duty, as to her, was merely to advise, and not to administer treatment, is immaterial . . . . He knew of her danger, and negligently advised her as to it, and she was injured by following his advice." *Id*. at 480–81.

Similarly, in *Skillings v. Allen*, 173 N.W. 663 (Minn. 1919), a doctor told parents it was safe to take their child—sick with scarlet fever—home from the hospital. The father took the advice and fell ill. The court was clear: "[t]o advise them that they ran no risk . . . necessarily exposed them to danger if they acted on the advice, and defendant was bound to know that they would be likely to follow his advice." *Id*. at 664.

States' professional practice acts have similarly long regulated the words professionals use to deliver treatment to protect patients from substandard care. These laws expressly defined medical practice to include the giving of "suggestions," "recommendations," and "advice," and courts approved those laws' application to individuals who purported to offer medical treatment or advice through words. *Crane v. Johnson*,

242 U.S. 339, 340 (1917) (upholding licensing requirements for "drugless practitioner" who "does not employ either medicine, drugs, or surgery in his practice" but rather "faith, hope, and the processes of mental suggestion and mental adaptation"); *People v. Allcutt*, 102 N.Y.S. 678, 680 (N.Y. App. Div. 1907) (recognizing that medical practice could involve solely the giving of advice, and observing that the act of diagnosing is medical practice even if not accompanied by physical intervention); *Smith*, 117 P. at 613 (statute regulating practice of medicine defined to include "the suggestion, recommendation, or prescribing any form of treatment").

Courts uniformly rejected the few free speech challenges brought to these medical licensure laws. For example, in *State Bd. of Med. Exam'rs v. Kempkes*, a healer claiming supernatural powers asserted that the state's regulation of medical practice "restrain[ed] freedom of speech." 160 A. 827, 828 (N.J. 1932). The court disagreed, observing that "the regulation of the practice of medicine has been held to be a proper exercise of the police power." *Id.* In *Blass v. Weigel*, an unlicensed practitioner objected that licensure requirements interfered with his First Amendment right to disseminate information about his particular form of healing treatments. 85 F. Supp. 775, 782 (D.N.J. 1949). The federal district court rejected his challenge, emphasizing the state's power to regulate medical practice. *Id.* at 783; *see also Ghadiali v. Del. State Med. Soc.*, 48 F. Supp. 789, 792–93 (D. Del. 1943) (same).

C. As *NIFLA* confirms, the First Amendment allows states to prohibit treatment that violates the standard of care—and the fact that substandard treatment often involves words does not change this constitutional analysis.

At no time has the First Amendment been understood to confer on professionals a constitutional right to use words to deliver treatment that violates the standard of care.

NIFLA confirms this. There this Court identified malpractice law and informed-consent law as regulations that do not trigger strict scrutiny even where they regulate healthcare professionals' treatment that involves words. 585 U.S. at 769–70. It described malpractice law as falling within the "traditional purview of state regulation of professional conduct." *Id.* at 769 (quoting *NAACP v. Button*, 371 U.S. 415, 438 (1963)). Malpractice laws regulate professional healthcare treatment for its consistency with the standard of care—regardless of whether that treatment involves scalpels, MRIs, medication, diagnosis, advice, talk therapy, or psychotherapy. And these laws have long done so without triggering First Amendment scrutiny. *See* Claudia E. Haupt, *Professional Speech and the Content-Neutrality Trap*, 127 Yale L.J. F. 150, 159 (2017) (explaining that "the First Amendment provides no defense" to malpractice liability).[23]

[23] States' history and tradition of regulating the words used to perform substandard professional healthcare treatment can also be understood as establishing a narrow category of speech unprotected by the First Amendment. As explained above, states have

In the same vein, *NIFLA* described laws that require healthcare professionals to speak to obtain their patients' informed consent as regulating those professionals' speech "'as part of the *practice* of medicine, subject to reasonable licensing and regulation by the State.'" 585 U.S. at 769–70 (quoting, emphasis added, *Planned Parenthood v. Casey*, 505 U.S. 833, 884 (1992)). A species of malpractice law, informed-consent law likewise seeks to ensure that professional healthcare treatment achieves its patient-centered objectives. *See Canterbury*, 464 F.2d at 781 ("[D]ue care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve.").

Both malpractice and informed-consent law routinely regulate the words healthcare professionals use when providing treatment to their patients. Both do so to protect patients from substandard care. At the same time, neither distinguishes treatments that involve

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routinely applied malpractice law and professional practice acts to protect patients from substandard treatment that uses words, and this longstanding regulation offers "persuasive evidence . . . of a long (if heretofore unrecognized) tradition of proscription" necessary to identify an additional category of unprotected speech. *Brown v. Ent. Merchs. Ass'n*, 564 U.S. 786, 792 (2011); *see also NIFLA,* 585 U.S. at 773 (finding no such tradition with respect to a broad category of "professional speech" that included all speech by professionals in their professional capacity, but leaving open whether some narrow category of professional speech could be identified as unprotected through historical analysis).

"procedures" from those that do not.[24] Indeed, substandard professional healthcare unrelated to a "procedure" routinely triggers malpractice liability. *See generally*, *supra*, II.A, B. And healthcare professionals generally must obtain informed consent to any treatment, regardless of whether it involves a procedure. Restatement (Third) of Torts: Medical Malpractice § 12; *see Allen v. Harrison,* 374 P.3d 812, 817 (Okla. 2016) (requiring doctor to inform patient who accidentally swallowed a nail of risks and benefits of doctor's recommendation that patient let the nail pass through her digestive system); *Matthies v. Mastromonaco*, 733 A.2d 456, 464 (N.J. 1999) (requiring doctor to inform patient of risks and benefits of doctor's recommendation of bed rest to treat a fracture); *see also* ACA Rule A.2 (requiring therapists to obtain and document their patients' informed consent to treatment that includes explaining the treatment's objectives, risks, and benefits).[25]

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[24] Nor does *NIFLA* support such a divide. Although the Court offered *Casey* as an example of a permissible requirement of informed consent to a medical procedure, 585 U.S. at 769–70, the Court did not state that the First Amendment permits informed-consent requirements *only* with respect to procedures, nor does the reasoning of *Casey* or *NIFLA* support any such distinction.

[25] To be sure, not everything a healthcare professional does, or says, is professional healthcare treatment. The law invalidated in *NIFLA*, for example, was "not an informed-consent requirement or any other regulation of professional conduct" because it did not regulate the words used by healthcare professionals when treating their patients in an individualized fiduciary relationship to protect those patients from substandard care. 585 U.S. at 770. It instead informed consumers about the availability of state-sponsored healthcare services. *Id.*

As *NIFLA* observed, the First Amendment allows states to regulate substandard professional healthcare treatment. This remains the case regardless of whether that treatment involves words, as it so often does.

III. The First Amendment poses no bar to Colorado's law that regulates the words used to deliver substandard professional healthcare treatment.

States' regulation of the words used in healthcare treatment to protect patients from substandard care does not trigger heightened scrutiny. Nor does Colorado's law, which prohibits an unsafe and ineffective treatment and thus falls within the "traditional purview of state regulation of professional conduct" that includes malpractice liability. *NIFLA*, 585 U.S. at 769 (citations omitted).

A. Colorado's law, which prohibits a harmful and ineffective treatment, is a specific application of states' routine regulation of substandard professional health care.

Colorado's law—part of its Mental Health Practice Act—prohibits a specific healthcare treatment that violates the standard of care. Colorado's law is no different, for First Amendment purposes, from barring doctors from urging lung cancer patients to take up smoking.

Not only does Colorado's law serve the same function as malpractice law in regulating treatment to ensure its consistency with the standard of care, it also operates like malpractice law. *Compare* C.R.S. §§ 12-245-222(1)(b) and 12-20-403 *with* Restatement (Third) of Torts: Medical Malpractice § 6. Both are complaint-

driven processes. After the filing of a lawsuit (for malpractice) or an administrative complaint (for Colorado's law), the fact-finder considers evidence about the healthcare professional's actions. Once that is determined, the fact-finder considers expert testimony about whether the professional's treatment violated the professional standard, which then determines the appropriateness of damages (for malpractice) or discipline (for Colorado's law).

Colorado's law thus falls within the "traditional purview of state regulation of professional conduct" that includes malpractice liability. *NIFLA*, 585 U.S. at 769 (citations omitted); *see also id.* at 768 ("States may regulate professional conduct, even though that conduct incidentally involves speech."); *id.* at 770 (states may regulate speech as part of the practice of medicine subject to "reasonable licensing and regulation"). For the same reason that the First Amendment does not bar malpractice liability for substandard care, it does not bar Colorado's law.

B. State regulations of the words used to perform substandard treatment do not impermissibly regulate speech based on content or viewpoint.

Petitioner's arguments rest on the fundamentally flawed premise that interactions between healthcare professionals and their patients are no different, for First Amendment purposes, than interactions between laypersons. Not so. Healthcare treatment involves a professional's application of their expert knowledge to a patient in an individualized fiduciary relationship to achieve outcomes that promote patient health. The standard of care enforced by malpractice

and professional practice laws thus routinely precludes treatments that are harmful and ineffective, while requiring treatments that are safe and effective. This does not make such regulations impermissibly content- or viewpoint-based under the First Amendment.

Whether treatment comports with the standard of care frequently requires consideration of that treatment's content: think of a doctor's diagnosis, a psychotherapist's therapy, or a healthcare professional's explanation of treatment options, risks, or benefits. But this has never been understood to trigger heightened First Amendment scrutiny because assessing a treatment's content is necessary to determine whether it is promoting patient health. Malpractice and professional practice laws, for example, don't engage in impermissible content- or viewpoint-based speech regulation when they prohibit a healthcare professional from advising a patient with anorexia to eat less rather than more, or from advising a cardiology patient to adjust their diet and exercise to raise (rather than lower) cholesterol and blood pressure. *See* Haupt, *Content-Neutrality Trap*, *supra*, at 172 ("The professional malpractice liability regime is but one example of content regulation to ensure that professionals give their clients, to whom they owe a fiduciary duty, comprehensive and accurate advice . . . . [B]ad advice is subject to malpractice liability, and the First Amendment provides no defense.").

Nor does Colorado's law impermissibly distinguish between treatments based on their viewpoint. It instead permissibly distinguishes between treatments based on whether they seek outcomes that promote

patients' health. Colorado's law regulates mental health professionals' treatment, not their viewpoints, when it bars licensees from treating minors with the predetermined outcome of changing their sexual orientation or gender identity because that treatment is unsafe and ineffective.[26]

As this Court recently observed, different healthcare treatments seek different outcomes, such that a treatment's permissibility may turn on the outcome it seeks to achieve: "[When] a transgender boy (whose biological sex is female) takes puberty blockers to treat his gender incongruence, he receives a different medical treatment than a boy whose biological sex is male who takes puberty blockers to treat his precocious puberty." *See Skrmetti*, 145 S. Ct. at 1830. So too is a treatment that seeks to change a minor's sexual orientation or gender identity an entirely different

[26] Petitioner misses the mark when she suggests that strict scrutiny is required to prevent states from using professional regulation to censor disfavored speech—for example, by prohibiting gynecologists from discussing birth control, or prohibiting therapists from discussing divorce, with their patients. OB24. Laws (like Colorado's specifically, and malpractice and professional practice laws more generally) that require professionals to comply with their discipline's standard of care are grounded in the evidence-based consensus of the professional community: they regulate treatment not on the grounds that it's disfavored by the state but instead because it's been found to be unsafe and ineffective. These laws routinely call upon courts and administrative agencies to receive and assess expert evidence about the profession's standard of care. In contrast, Petitioner's hypothetical laws do not prohibit treatment inconsistent with the profession's standard of care. This case does not require this Court to determine the level of scrutiny applicable to states' regulation of the words used to perform professional healthcare treatment for purposes other than to ensure compliance with the standard of care.

treatment than one that seeks to explore or support a minor's sexual orientation or gender identity.

C. Petitioner's cases do not involve states' regulation of the words used to deliver substandard treatment.

Rather than engage the precedent and practice that makes clear that the First Amendment poses no bar to states' regulation of the words used to deliver substandard professional treatment, Petitioner relies on a series of cases that have nothing to do with the regulation of that treatment, and thus where very different First Amendment rules apply.

For example, the law at issue in *Holder v. Humanitarian Law Project* did not regulate words used by lawyers in order to protect their clients from substandard representation, but instead prohibited anyone from providing material support to foreign terrorist organizations. 561 U.S. 1, 7, 21–23 (2010). The fact that some of the plaintiffs challenging that law were professionals did not transform the law into one enforcing a professional standard of care.

Nor did the law invalidated in *NAACP v. Button* regulate the words used by lawyers when representing their clients to protect those clients from substandard representation. Rather, it barred the NAACP from referring prospective litigants to attorneys affiliated with the NAACP, thus interfering with the organization's legal advocacy. 371 U.S. at 432–36. And the law invalidated in *Legal Services Corp. v. Velasquez* forbade federally funded legal services lawyers from challenging welfare laws—not to protect clients from substandard representation, but instead to insulate

the government from certain types of litigation. 531 U.S. 533, 544–49 (2001).

For the same reason, the other cases Petitioner relies upon are also readily distinguishable from the case at hand. Very different First Amendment rules applied in *Cohen v. California*, 403 U.S. 15 (1971) and *303 Creative, LLC v. Elenis*, 600 U.S. 570 (2023) because they had nothing to do with the regulation of the words used by licensed professionals to provide substandard care in an individualized fiduciary relationship.

D. Petitioner's position would erode states' power to ensure that patients receive treatment consistent with the standard of care.

Petitioner's insistence that strict scrutiny should apply to states' regulation of the words used to perform substandard treatment would imperil many of states' malpractice and professional practice laws. This is true not only of states' regulation of mental health treatment specifically, but also of states' regulation of healthcare treatment more generally.

First, her position would strip states of their power to require mental healthcare professionals to comply with the standard of care because mental health treatment so often involves therapy delivered through words. As the Court of Appeals recognized, adopting Petitioner's position "could insulate swaths of professional conduct by therapists from regulation, such as Colorado's prohibitions on administering 'demonstrably unnecessary' treatments without clinical justification and 'perform[ing] services outside of the

[provider's] area of training, expertise, or competence." Pet.App.52a (citing C.R.S. § 12-245-224(1)(h), (t)(II)). This would include not only professional practice laws like Colorado's, but also malpractice liability for the same treatment: if strict scrutiny applies to Colorado's law, it would also apply to malpractice liability for that same substandard care.

Second, even outside the mental healthcare setting, Petitioner's position would require courts to apply strict scrutiny to states' regulation of the words used to deliver professional healthcare treatment that falls below the standard of care. This would include malpractice actions against doctors who fail to ask about a patient's medical history; who fail adequately to explain treatment options, risks, and benefits; or who recommend particular treatments that violate the standard of care. Petitioner would apply strict scrutiny to states' regulation of those treatments, thus destabilizing longstanding and sensible regulation that protects patients.

E. Even if the regulation of substandard treatment was found to implicate some First Amendment interest, it should not be subject to strict scrutiny.

States' regulation of substandard professional healthcare treatment protects the patient health interests at the heart of the professional-patient relationship. Applying scrutiny less than strict thus finds support in this Court's commercial speech doctrine, where the government can altogether prohibit commercial speech that is false or misleading in order to protect consumers' interests in informed decision-making. *See Cent. Hudson Gas & Elec. Corp. v. Pub.*

Serv. Comm'n, 447 U.S. 557, 563–64 & n.6 (1980); *see also NIFLA,* 585 U.S at 768–69 (discussing the lower levels of scrutiny that apply to compelled commercial disclosures that accurately inform listeners' decisions). Just as false or misleading commercial speech undercuts consumers' interests in accurate information, so too does the delivery of substandard professional healthcare treatment undermine patients' health and safety interests.

And the government's regulation of commercial speech that is not false or misleading receives intermediate, not strict scrutiny. *Cent. Hudson,* 447 U.S. at 563–64. This strikes the right balance, this Court stated, because of "'the "commonsense" distinction between speech proposing a commercial transaction, which occurs in an area traditionally subject to government regulation, and other varieties of speech.'" *Id.* at 562 (quoting *Ohralik v. Ohio State Bar Ass'n*, 436 U.S. 447, 455–56 (1978)).

Here, too, "commonsense" distinctions separate the words used to perform professional healthcare treatment from other varieties of speech. Patients seek out professional health care because of the professional's greater knowledge and expertise and because health law holds professionals to higher standards and expectations—like the fiduciary duty to put their patients' interests before their own, the duty of confidentiality, and the duty to provide treatment consistent with the standard of care. States, too, recognize these commonsense distinctions through their longstanding and widespread regulation of the words used to provide treatment to protect patients from substandard care. Patients' dependence on health-

care professionals provides an especially strong basis for avoiding strict scrutiny of regulation that protects against substandard treatment.

As this Court recently observed, courts should be slow to choose doctrinal rules that upset longstanding and widespread regulations. *See Free Speech Coal. v. Paxton,* 145 S. Ct. 2291, 2310 (2025) (emphasizing the importance of not applying strict scrutiny to laws that incidentally burden expression that "are traditional, widespread, and not thought to raise a significant First Amendment issue"). In such settings, the choice of lesser scrutiny reflects respect for politically accountable actors' longstanding judgments, especially when those judgments have proven wise and workable over time. *Id.* at 2316. ("A decision 'contrary to long and unchallenged practice . . . should be approached with great caution,' 'no less than an explicit overruling' of a precedent." (citation omitted)). The same is true of longstanding and widespread laws that regulate professional healthcare treatment—including treatment that involves words—to protect patients from substandard care.[27]

[27] Indeed, while the Solicitor General urges that strict scrutiny should apply, he simultaneously maintains that states should have "little trouble" justifying professional standards of care under strict scrutiny. US Br. at 26–27. As we show below, Colorado's law satisfies even strict scrutiny. But the very concession that such laws should have "little trouble" satisfying strict scrutiny argues *against* applying strict scrutiny because strict scrutiny is not designed for laws that will generally be upheld. To do so would risk watering down strict scrutiny to the point that it would be strict in theory, but easily satisfied in fact.

IV. Colorado's law satisfies any level of scrutiny.

The district court applied rational-basis review to Colorado's law, concluding that it was rationally related to Colorado's legitimate interests in protecting the health and safety of minor patients and in regulating and maintaining the integrity of the mental health profession. Pet.App.155a–60a.

Colorado's law clears the hurdles of intermediate and strict scrutiny as well. It "advances important governmental interests unrelated to the suppression of free speech and does not burden substantially more speech than necessary to further those interests." *Free Speech Coal.*, 145 S. Ct. at 2302 (quotation omitted); *see also id.* at 2317. And it satisfies even strict scrutiny because it is narrowly tailored to serve the State's compelling interests. *See Reed v. Town of Gilbert*, 576 U.S. 155, 163 (2015).

A. Colorado's interest in ensuring minors receive safe and effective mental health care is legitimate, important, and compelling.

Colorado's evidence—including expert testimony, comprehensive literature reviews, and authoritative policy statements from every major national mental health and medical organization—demonstrates that its interests in protecting young people from harmful and ineffective professional healthcare treatment and in regulating and maintaining the integrity of the mental health profession are legitimate, important, and compelling. *E.g., New York v. Ferber*, 458 U.S. 747, 756–57 (1982) (recognizing state's compelling interest in "safeguarding the physical and psychological

well-being of a minor" (quotation omitted)); *Goldfarb v. Va. State Bar*, 421 U.S. 773, 792 (1975) (recognizing state's compelling interest in preventing licensed professionals from engaging in unethical behavior); *see*, *supra*, Statement of the Case § III.B.

As the Tenth Circuit observed, Petitioner "conceded she did not present evidence with her preliminary injunction motion or put on expert testimony to contradict the studies proffered by Defendants." Pet.App.69a. Nor did she challenge any of the district court's factual findings on appeal. Pet.App.28a.

Petitioner now argues that those findings are unsupported by the evidence, but her arguments are unpersuasive. First, she argues that no study shows conversion therapy through talk therapy is harmful to gender-dysphoric minors. OB13. But the Tenth Circuit confirmed that Respondents' evidence included studies of both aversive and nonaversive therapies. Pet.App.70a–71a. Dr. Glassgold explains in detail that conversion therapy is affirmatively harmful. J.A.27–30 ¶¶18–19. Specifically, she described the evidence that those who reported undergoing conversion therapy were more than "twice as likely to report having attempted suicide and having multiple suicide attempts" and to report negative mental and physical health effects that included depression, isolation, and illicit drug use. J.A.69; 62–64; 63 ¶66 (citing verbal forms of therapy); 71–72. Dr. Glassgold emphasized that conversion therapy of *any modality* is contrary to accepted standards of clinical care because it has no

basis in science and has been discredited by decades of scientific research. J.A.47 ¶40.[28]

In addition, the Task Force Report found no empirical evidence that conversion therapy is effective no matter the modality and that conversion therapy is associated with depression, suicidal ideation, and substance abuse. J.A.205–56. These findings were reaffirmed in the 2015 SAMHSA Report, which warned against directive treatments aimed at changing a minor's gender identity or sexual orientation. J.A.535–38 (acknowledging that although "[t]here is limited research on conversion therapy efforts among children and adolescents, . . . none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation"). Petitioner offered no expert opinion to rebut this evidence.

Second, Petitioner urges that psychotherapy and counseling are generally effective techniques for helping young people. OB13–14. Respondents agree: the record below identifies numerous safe and effective therapies that provide support for patients—including religious patients—uncertain or distressed about their

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[28] Petitioner claims that, at oral argument, "Colorado's counsel conceded that she 'kn[e]w of no . . . studies' focusing on 'talk therapy' by a licensed counselor with a willing minor seeking change on issues of gender identity or sexual orientation." OB12–13. The Tenth Circuit rejected this mischaracterization, noting that the argument was focused on why, due to ethical reasons, there are no studies that focus on comparing aversive and nonaversive techniques. Pet.App.71a n.47. As described above, Respondents submitted extensive expert evidence on the ineffectiveness and harms of nonaversive conversion therapy on minors; Petitioner, on the other hand, submitted nothing.

sexual orientation or gender identity without seeking to change their orientation or identity. J.A.92–93 (citing sources working with Orthodox Jewish women attracted to women and British Pakistani men who identify as Muslim and gay); J.A.32 n.19 (citing work with Christian patients). This, of course, does not provide any support for the use of conversion therapy, which not only exposes patients to harms such as worsening of family relationships, J.A.67–69; 85–86, and undermining their religious faith, J.A.265, but delays patients from receiving effective treatments. J.A.92–95.

Having presented no evidence below, Petitioner now relies on sources not presented to the district court and thus not subject to adversarial testing that would have exposed their flaws.[29] Even on their face, however, these materials fail to rebut the evidence that conversion therapy is unsafe and ineffective. For

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[29] The trial court is best suited to vet technical evidence. *Diaz v. United States*, 602 U.S. 526, 554 (2024) (citations omitted) (Gorsuch, J., dissenting) ("As part of its 'gatekeeping' functions, a federal court must ensure that any expert testimony it permits is reliable, grounded on widely accepted principles, and will 'assist the trier of fact to understand the evidence.'"); *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152 (1999) (the trial court can "make certain that an expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field"). But the support Petitioner now invokes is subject to no such probing. Petitioner's brief presents skewed, flawed, and new information, OB6–8; 13–15, and appellate briefing provides an inadequate forum to resolve the legitimacy of this contested evidence. *See also* Pet.App.28a–30a n.17.

example, Petitioner now relies heavily on the Cass Review, which focuses on gender-affirming medical care rather than therapy. But the Cass Review unequivocally states that "no LGBTQ+ group should be subjected to conversion practice," and observes that "[n]o formal science-based training in psychotherapy, psychology or psychiatry teaches or advocates conversion therapy." Hilary Cass, *The Cass Review: Independent Review of Gender Identity Services for Children and Young People* 150 § 11.5; 151 § 11.7 (2024). The Cass Review also explicitly distinguishes between exploratory therapy—which Colorado's law allows–and prohibited conversion therapy. *Id.* at 66–68; *see also id.* at 150 § 11.5; 150 § 11.6. It provides:

> The intent of psychological intervention is not to change the person's perception of who they are but to work with them to *explore* their concerns and experiences and help alleviate their distress, regardless of whether they pursue a medical pathway or not. *It is harmful to equate this approach to conversion therapy* as it may prevent young people from getting the emotional support they deserve.

Id. (emphases added). Indeed, the Cass Review supports the approach taken by Colorado's law: "If an individual were to carry out [conversion therapy] they would be acting outside of professional guidance, and

this would be a matter for the relevant regulator." *Id.* at 151 § 11.7.[30]

Third, Petitioner states that most children who experience gender dysphoria before puberty "resolve those feelings either naturally or through counseling—and live consistent with their sex with no issues." OB6–7. If that's the case, that underscores that conversion therapy is unnecessary and thus inappropriate. Colorado's law allows exploratory approaches to support young people as they explore their identity.

Fourth, Petitioner mischaracterizes the relevant research developed after submission of this case's record. Recent reviews of research on conversion therapy from multiple sources—including adolescents who report receiving such therapy—show that none of those efforts, including those that took the form of talk therapy, were effective in changing a minor's sexual orientation or gender identity. *See* Decl. of Dr. Judith Glassgold ¶¶42–44, *Catholic Charities v. Whitmer*, No. 1:24-cv-00718-JMB-SJB (W.D. Mich. Aug. 16, 2024), Dkt. No. 27-1. More recent reviews of the scientific literature also confirm that no studies have found any

[30] Petitioner's nonrecord sources also include a widely criticized 2025 HHS report that was generated in 90 days, identifies no author, and cites dubious sources like news stories and online posts. *See* Press Release, Am. Acad. of Pediatrics, *AAP speaks out against HHS report on gender dysphoria, infringement on physician-patient relationship* (May 1, 2025), https://coag.gov/app/uploads/2025/08/AAP-speaks-out-against-HHS-Report.pdf; Press Release, WPATH & USPATH, *WPATH and USPATH Response to the HHS Report on Gender Dysphoria* (May 2, 2025), https://coag.gov/app/uploads/2025/08/WPATH-USPATH-Response-to-HHS-Report-02May2025-3.pdf.

therapeutic benefit to efforts to change sexual orientation or gender identity.[31] This 2023 report, entirely ignored by the flawed 2025 HHS report upon which Petitioner now relies, included a comprehensive index citing 418 sources. *Id*. at 75–103.

In short, Petitioner's efforts cast no doubt on Colorado's legitimate, important, compelling interests in protecting minors from an unsafe and ineffective professional healthcare treatment.[32]

B. The law is reasonably related, substantially related, and narrowly tailored to achieving its compelling interests.

As the district court found, Colorado's law is rationally related to the State's legitimate interests. Pet.App.72a. And the law satisfies even higher levels of scrutiny.

Colorado's law satisfies intermediate scrutiny because it "advances important governmental interests unrelated to the suppression of free speech," "does not burden substantially more speech than necessary to further those interests," and is adequately tailored such that the government's important interests would be less effectively achieved absent the regulation. *Free Speech Coal.*, 145 S. Ct. at 2302, 2317. The law applies

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[31] SAMHSA, *Moving Beyond Change Efforts: Evidence and Action to Support and Affirm LGBTQI+ Youth* 26–27 (2023), https://coag.gov/app/uploads/2025/08/samhsa-lgbtqia-youth-report.pdf.

[32] To the extent this Court believes more recent evidence must be considered, it should remand so these facts may be fully developed.

only to licensed professionals and only when they provide treatment to minors. It does not apply to those engaged in religious ministry or any others who do not hold themselves out as healthcare professionals.

Colorado's law also satisfies strict scrutiny because it is the least restrictive means of achieving the State's compelling interests. It prohibits a specific, harmful treatment while otherwise leaving therapists free to engage in any other appropriate therapy with their patients. Nor does it constrain professionals' speech when not providing treatment in an individualized provider-patient relationship. It thus prohibits therapists from doing one thing, and one thing only: performing a treatment to change a minor patient's sexual orientation or gender identity. And Petitioner disavows any intent to do that.

None of Petitioner's proposed alternatives would enable Colorado to achieve its important, indeed compelling, interests.

Allowing healthcare professionals to engage in conversion therapy if a patient consents to it would not enable Colorado to protect young people from an unsafe and ineffective treatment—indeed, professional practice laws and codes of ethics do not allow professionals to provide unsafe or ineffective treatments, even if patients request and consent to them. C.R.S. § 12-245-224(1)(g)(I) (incorporating "the standards of practice generally recognized by state and national associations of practitioners"); *see also id.* § 12-245-224(1)(t)(III) (licensed professionals are prohibited from performing treatment that is unnecessary and "contrary to the generally accepted standards of the person's practice and without clinical justification");

see also ACA Rule A.1.c (counselors are to work jointly with patients to devise counseling plans that "offer reasonable promise of success"); A.4.a (counselors are ethically obligated to avoid harming their patients); C.7 (counselors must use well-supported techniques/modalities that do not risk harm, even if requested by a patient). Informed-consent requirements are even less reliable safeguards with respect to minors, who are subject to influence from their communities, parents, and therapists, and depending on their age, cannot consent to their own care due to normal developmental limitations in their decision-making capabilities. *See* C.R.S. § 12-245-203.5.

Nor would prohibiting only aversive forms of conversion therapy achieve Colorado's interests, given the evidence that *no* form of conversion therapy has been found to be safe or effective. J.A.53–55; 62–65. Nor would "a public information campaign," or posting a list of "preferred counselors," or offering "preferred counseling services directly" to Coloradans achieve Colorado's interests, as all would allow licensed healthcare professionals to perform an unsafe and ineffective treatment on minors and would leave patients on their own to sort through practitioners that do and don't comply with the standard of care. Finally, relying solely on fraud liability to protect patients would fail to put healthcare professionals on notice that they will be disciplined for engaging in this unsafe and ineffective treatment. *See Ohralik,* 436 U.S. at 464 (emphasizing states' "strong" interest in "prophylactic measures whose objective is the prevention of harm [by licensed professionals] before it occurs"). Indeed, malpractice liability (which, like fraud actions, provides monetary compensation to patients

injured by professionals' departure from the standard of care) and professional practice laws (which seek to ensure safe and competent treatment and prevent harm) have long worked side-by-side to ensure safe and effective professional treatment.

Nor is the law underinclusive. Like malpractice and professional practice laws more generally, Colorado's law regulates only licensed providers acting with the imprimatur of the State—and not those engaged in religious ministry, among other nonprofessionals—to ensure that the professional/patient relationship serves its patient-protective functions. And in barring this specific unsafe and ineffective healthcare treatment, Colorado's law responded to a growing mental health crisis among Colorado's youth to prevent injury—injury that may not manifest for years—to particularly vulnerable young people. *See*, *supra*, n.12.

CONCLUSION

Respondents respectfully request that this Court dismiss the writ for lack of standing or, alternatively, affirm the judgment of the lower court.

Respectfully submitted,

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August 19, 2025

STATUTORY APPENDIX

STATUTORY APPENDIX
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State statutes providing for discipline of medical and mental health care professionals who fail to comply with professional practice standards

State	Medical	Mental Health
Ala.	Ala. Code §34-24-360(9)	Ala. Admin. Code r. 255-X-11-.01 Attach.1(A.1.a), (SP-22) Ala. Admin. Code r. 255-X-8-.02
Alaska	Alaska Stat. § 08.64.326(a)(8)(A)	Alaska Stat. § 08.29.400(a)(4)–(5) Alaska Admin. Code tit. 12, § 62.900(a)
Ariz.	Ariz. Rev. Stat. § 32-1451(A) Ariz. Rev. Stat. § 32-1401(27)(m)	Ariz. Rev. Stat. § 32-3281(L) Ariz. Rev. Stat. § 32-3251(16) (k), (p), (r)
Ark.	Ark. Code Ann. § 17-95-409(a)(2)(G)	Ark. Code Ann. § 17-27-309(a)(1) 17 Ark. Code § 75-1001(a)
Cal.	Cal. Bus. & Prof. Code § 2234(c)	Cal. Bus. & Prof. Code § 4999.90(d), (i)
Colo.	Colo. Rev. Stat. § 12-240-121(1)(j), (aa)	Colo. Rev. Stat. § 12-245-224(1)(g)(I), (t)(III)

State	Medical	Mental Health
Conn.	Conn. Gen. Stat. § 20-13c(4)	Conn. Gen. Stat. § 20-195ee(1), (5)
Del.	Del. Code Ann. tit. 24, § 1731(b)(11)	Del. Code Ann. tit. 24, §§ 3001(b); 3009(a)(5) 24 Del. Admin. Code 3000-2.7
D.C.	D.C. Code § 3-1205.14(a)(26)	D.C. Code § 3-1205.14(a)(26) D.C. Code § 3-1201.01 (1), (7), (8)
Fla.	Fla. Stat. § 458.331(1)(t)(1)–(3) Fla. Stat. § 456.50(1)(g)	Fla. Stat. § 491.009(1)(r)
Ga.	Ga. Code Ann. § 43-34-8(a)(7)	Ga. Code Ann. § 43-10A-17(a)(6)
Haw.	Haw. Rev. Stat. § 453-8(a)(7)–(9)	Haw. Rev. Stat. § 453D-12(a)(7)–(8)
Idaho	Idaho Code § 54-1814(7)	Idaho Code § 54-3408(1) Idaho Admin. Code r. 24.15.01.002 Idaho Admin. Code r. 24.15.01.200.01
Ill.	225 Ill. Comp. Stat. 60/22(A)(4)	225 Ill. Comp. Stat. 107/80(a)(5)–(6)

State	Medical	Mental Health
Ind.	Ind. Code § 25-1-9-4(a)(4)(A)–(B)	Ind. Code §§ 25-1-9-1, -2, 4(a) Ind. Code §§ 25-0.5-11-1, -16
Iowa	Iowa Code § 148.6(2)(f)	Iowa Admin. Code r. 481-893.1(1)(b)
Kan.	Kan. Stat. Ann. § 65-2836(b)	Kan. Admin. Regs. § 102-3-12a(a), (b)(10)
Ky.	Ky. Rev. Stat. Ann. § 311.595(9), (12), (20)	Ky. Rev. Stat. Ann. § 335.540(1)(d), (g) 201 Ky. Admin. Regs. 36:040 sec. 11
La.	La. Stat. Ann. § 37:1285(A)(14)	La. Stat. Ann. § 37:1110(A)(3) La. Admin Code tit. 46, pt. LX, § 2107.A.1.a
Me.	Me. Stat. tit. 32, § 3282-A(2)(E)–(F)	Me. Rev. Stat. Ann. tit. 10, § 8003(5-A)(A)(2) Me. Rev. Stat. Ann. tit. 32 § 13861-A

State	Medical	Mental Health
Md.	Md. Code Ann., Health Occ. § 14-404(a)(22)	Md. Code Ann., Health Occ. § 17-509(8), (11), (16) Md. Code Regs. 10.58.03.04
Mass.	Mass. Gen. Laws ch. 112, § 61(1)	Mass. Gen. Laws ch. 112, § 169(2) Mass. Gen. Laws ch. 112, § 163 262 Mass. Code Regs. 8.03
Mich.	Mich. Comp. Laws § 333.16221(a)	Mich. Comp. Laws § 333.16221(a) Mich. Comp. Laws Ann. § 333.16105(1), (2) Mich. Comp. Laws Ann. § 333.18103
Minn.	Minn. Stat. § 147.091(k)	Minn. Stat. § 148B.59(a)(3)
Miss.	Miss. Code Ann. § 73-25-29(11)	Miss. Code Ann. § 73-30-21(1)(e)
Mo.	Mo. Rev. Stat. § 334.100(4)(c), (f), 334.100(5)	Mo. Rev. Stat. § 337.525(2)(5)

State	Medical	Mental Health
Mont.	Mont. Code Ann. § 37-3-323(1)(b) Mont. Code Ann. § 37-1-316(r)	Mont. Code Ann. § 37-1-316(r)
Neb.	Neb. Rev. Stat. § 38-178(6), (24) Neb. Rev. Stat. § 38-179	Neb. Rev. Stat. § 38-179 Neb. Rev. Stat. § 38-2138(1)
Nev.	Nev. Rev. Stat. § 630.301(4) Nev. Rev. Stat. § 630.306(1)(p) Nev. Admin. Code § 630.230	Nev. Rev. Stat. § 641A.310(6)–(8). Nev. Admin. Code § 641A.252
N.H.	N.H. Rev. Stat. Ann. § 329:17(VII)(c)–(d)	N.H. Rev. Stat. Ann. § 330-A:27(II)(c) N.H. Code Admin. R. Ann. Mhp 501.02
N.J.	N.J. Stat. Ann. § 45:1-21(c)–(e)	N.J. Stat. Ann. § 45:1-21(d)–(e)
N.M.	N.M. Stat. Ann. § 61-6-15(D)(12), (19)	N.M. Stat. Ann. § 61-9A-26(A)(7), (9)
N.Y.	N.Y. Educ. Law § 6530(2)–(6) (McKinney)	N.Y. Educ. Law § 6509(2), (9) (McKinney)
N.C.	N.C. Gen. Stat. § 90-14(a)(6)	N.C. Gen. Stat. § 90-340(a)(9)

State	Medical	Mental Health
N.D.	N.D. Cent. Code § 43-17-31(1)(f), (o)	N.D. Cent. Code § 43-47-07 N.D. Admin. Code 97-02-03-01
Ohio	Ohio Rev. Code Ann. § 4731.22(B)(6)	Ohio Rev. Code Ann. § 4757.36(C)(10) Ohio Admin. Code 4757-5-01(D)
Okla.	Okla. Stat. tit. 59, § 503 Okla. Stat. tit. 59, § 509(8), (13), (15)	Okla. Stat. tit. 59, § 1912(A)(4)–(5) Okla. Admin. Code § 86:10-3-2
Or.	Or. Rev. Stat. § 677.190(13)	Or. Rev. Stat. § 675.745(1)(d), (f) Or. Admin. R. 833-100-0011(1), (2)
Pa.	63 Pa. Cons. Stat. § 422.41(8)(i)–(ii)	63 Pa. Cons. Stat. § 1911(a)(2)–(3) 49 Pa. Code § 49.71
R.I.	5 R.I. Gen. Laws § 5-37-6.3 5 R.I. Gen. Laws § 5-37-5.1(19)	5 R.I. Gen. Laws § 5-63.2-21(6)–(7) 216 R.I.C.R. 40-05-11.4.1
S.C.	S.C. Code Ann. § 40-47-20(55)	S.C. Code Ann. § 40-75-110(A)(8) S.C. Code Ann. Regs. 36-22

State	Medical	Mental Health
S.D.	S.D. Codified Laws § 36-4-29 S.D. Codified Laws § 36-4-30	S.D. Codified Laws § 36-32-84 S.D. Codified Laws § 36-32-83(10) S.D. Admin. R. 20:68:08:01
Tenn.	Tenn. Code Ann. § 63-6-214(b)(1), (4), (12) Tenn. Comp. R. & Regs. 0880-02-.12, -.14	Tenn. Code Ann. § 63-22-110(b)(3)–(4) Tenn. Comp. R. & Regs. 0450-01-.13(1)
Tex.	Tex. Occ. Code Ann. § 164.051(a)(6), (8)	Tex. Occ. Code Ann. § 503.401(a)(1) 22 Tex. Admin. Code §§ 681.31–.53
Utah	Utah Code Ann. § 58-1-401(2)(a) Utah Code Ann. § 58-67-503(2)(a) Utah Code Ann. § 58-1-501(2)(a)(vii), (ix)–(x)	Utah Code Ann. § 58-1-401(2)(a) Utah Code Ann. § 58-1-501(2)(a)(ii), (vii), (ix)–(x)
Vt.	Vt. Stat. Ann. tit. 26, § 1374(b)(1) Vt. Stat. Ann. tit. 26, § 1354(a)(19), (22), (b)(1)–(2)	Vt. Stat. Ann. tit. 3, § 129a(a), (b)(1)–(2)

State	Medical	Mental Health
Va.	Va. Code Ann. § 54.1-2915(A)(3), (12)–(13)	Va. Admin. Code § 115-20-140(A)(4)–(6) 18 Va. Admin. Code § 115-20-130
Wash.	Wash. Rev. Code § 18.130.080(4), (7)	Wash. Rev. Code § 18.130.180(7) Wash. Admin. Code § 24-16-800-810
W. Va.	W. Va. Code § 30-3-14(c)(14)–(15), (20)	W. Va. Code § 30-31-12(g)(3) W. Va. Code R. § 27-1-11, -.1, -.2
Wis.	Wis. Stat. § 448.12(c)	Wis. Stat. § 457.26(2)(f) Wis. Admin. Code MPSW § 20.02
Wyo.	Wyo. Stat. Ann. § 33-26-402(a)(xxii)	Wyo. Stat. Ann. § 33-38-110(c)(iii) 078-11 Wyo. Code R. § 7(b)

Sample of state statutes allowing discipline for untruthful statements about effects of medical treatment

1. Alabama

"Use of any untruthful or deceptive or improbable statements concerning . . . the effects or results of his or her proposed treatment." Ala. Code § 34-24-360(7).

2. Arizona

"Representing that a manifestly incurable disease or infirmity can be permanently cured, or that any disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if this is not true." Ariz. Rev. Stat. § 32-1401(27)(n).

3. Arkansas

"Representing to a patient that a manifestly incurable condition of sickness, disease, or injury can be permanently cured." Ark. Code Ann. § 17-95-409(a)(2)(I).

4. District of Columbia

"Willfully makes a misrepresentation in treatment; . . . [m]akes a false or misleading statement regarding his or her skill or the efficacy or value of a medicine, treatment, or remedy prescribed or recommended by him or her, at his or her discretion, in the treatment of any disease or other condition of the body or mind." D.C. Code § 3-1205.14(a)(11), (40).

5. Idaho

"Willfully and intentionally representing that a manifestly incurable disease or injury or other manifestly incurable condition can be permanently cured." Idaho Code § 54-1814(16).

6. Illinois

"Making a false or misleading statement regarding their skill or the efficacy or value of the medicine, treatment, or remedy prescribed by them at their direction in the treatment of any disease or other condition of the body or mind." 225 Ill. Comp. Stat. 60/22(A)(10).

7. Maryland

"Offers, undertakes, or agrees to cure or treat disease by a secret method, treatment, or medicine." Md. Code Ann., Health Occ. § 14-404(a)(20).

8. Minnesota

"Knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo." Minn. Stat. § 147.091(subd.1)(v).

9. Missouri

"Misrepresenting that any disease, ailment or infirmity can be cured by a method, procedure, treatment, medicine or device." Mo. Rev. Stat. § 334.100(2)(4)(e).

10. North Dakota

"The representation to a patient that a manifestly incurable condition, sickness, disease, or injury can be cured." N.D. Cent. Code § 43-17-31(1)(l).

11. Ohio

"Representing, with the purpose of obtaining compensation or other advantage as personal gain or for any other person, that an incurable disease or injury, or other incurable condition, can be permanently cured." Ohio Rev. Code Ann. § 4731.22(B)(7).

12. Oregon

"Representing to a patient that a manifestly incurable condition of sickness, disease or injury can be cured." Or. Rev. Stat. § 677.190(3).