IN THE SUPREME COURT
**STATE OF NORTH DAKOTA**

T.D., by and through his parents, Devon Dolney and Robert Dolney, DEVON DOLNEY, an individual, ROBERT DOLNEY, an individual, PAMELA ROE, by and through her parents, Peter Roe and Paula Roe, PETER ROE, an individual, PAULA ROE, an individual, JAMES DOE, by and through his parents, John Doe and Jane Doe, JOHN DOE, an individual, JANE DOE, an individual, and DR. LUIS CASAS, an individual, on behalf of himself and his patients,
Plaintiffs-Appellants,

vs.

DREW H. WRIGLEY, in his official capacity as Attorney General for the State of North Dakota, KIMBERLEE JO HEGVIK, in her official capacity as the State Attorney for Cass County, and JULIE LAWYER, in her official capacity as the State's Attorney for Burleigh County, AMANDA ENGELSTAD, in her official capacity as the State's Attorney for Stark County,
Defendants-Appellees.

**Supreme Court No. 20260075**

**District Court No. 08-2023-CV-02189**

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**On Appeal from Amended Judgment Dated December 19, 2025**
**The Honorable Jackson J. Lofgren, District Court Judge**
**Burleigh County District Court, South Central Judicial District**

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# BRIEF SUBMITTED BY ALLIANCE DEFENDING FREEDOM AS AMICUS CURIAE SUPPORTING DEFENDANTS-APPELLEES

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## INTEREST OF AMICUS CURIAE[1]

[¶1] This case is just the latest asking whether states may protect struggling children from experimental and dangerous medical interventions. Like 25 other states, North Dakota prohibits using puberty blockers and cross-sex hormones for children with gender dysphoria. For good reason: existing evidence shows uncertain benefit and certain harm. And evidence further shows many children who chemically transition will later regret it. So they'll detransition—to the extent it's possible. Some of the drugs' damaging effects are permanent, and the children will be harmed for life.

[¶2] So amicus, Alliance Defending Freedom, has an interest in this case. ADF is a public-interest law firm that defends religious freedom, free speech, the sanctity of life, parental rights, and marriage and family. That work includes advocating for laws to protect children from harmful drug treatments. That's why ADF has served as co-counsel for numerous states defending similar laws. *E.g.*, *Boe v. Marshall*, No. 2:22-cv-184-LCB, 2023 WL 3702311 (M.D. Ala. Apr. 17, 2023). It's also why ADF has filed amicus briefs in cases like this one. *E.g.*, ADF Br., *United States v. Skrmetti*, 605 U.S. 495 (2025) (No. 23-477). And it's why ADF files this brief—to urge the Court to let North Dakota protect its children.

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[1] No counsel for a party authored this brief in whole or in part. And no person other than amicus and its counsel made any monetary contribution intended to fund preparing or submitting this brief.

## ARGUMENT

[¶3] There is no need to tread new ground here. The district court correctly upheld what it termed the Health Care Law. The court rejected Dr. Luis Casas's equal-protection claim in part by following the logic of the U.S. Supreme Court's *Skrmetti* decision. That makes sense. If Tennessee's law did not classify based on sex, neither does North Dakota's. It matters not that the claim here is under North Dakota's Constitution. The logic is the same. Likewise, there's a roadmap for the fundamental-rights claim: the Sixth Circuit's *Skrmetti* decision. A fundamental right to *reject* medical treatment does not include a right to *demand* prohibited interventions. Again, that logic applies here no matter that the claim is under North Dakota's Constitution.

[¶4] So rational-basis review applies. And North Dakota's law easily clears that low hurdle, just like Tennessee's in *Skrmetti*. Rational bases supporting the Health Care Law abound. Consider two. First, there's no reliable evidence that chemical interventions benefit minors with gender dysphoria. But there's reliable evidence that such interventions harm children. Second, there is evidence that many minors may regret their transition decisions, only to be unable to undo the damage done. Those reasons are more than enough to justify North Dakota's decision to protect its children experiencing gender dysphoria.

### I. The *Skrmetti* decisions' reasoning readily applies here.

[¶5] Both of Casas's claims merit only rational-basis review. To see that, the Court need look no further than *Skrmetti*. The logic of the U.S. Supreme

Court's decision applies to the equal-protection claim here. And the logic of the Sixth Circuit's decision applies to the fundamental-rights claim.

### A. The U.S. Supreme Court's reasoning applies to the equal-protection claim.

[¶6] In *Skrmetti*, the U.S. Supreme Court rejected an equal-protection challenge to a Tennessee law just like North Dakota's. Tennessee also prohibited puberty blockers and cross-sex hormones for children with gender dysphoria. *Skrmetti*, 605 U.S. at 506. Yet the Supreme Court held that the law did "not classify on any bases that warrant[ed] heightened review." *Id.* at 510. The law did not classify based on sex or transgender status. *Id.* at 511, 518.

[¶7] For the former, there was no facial sex-based classification. Just because a law references sex does not mean it classifies based on sex. *Id.* at 512. Likewise, there was no sex-based classification in application. Medical treatment includes "the underlying medical concern the treatment is intended to address." *Id.* at 513. So a biological girl identifying as a boy who takes puberty blockers to treat gender incongruence "receives a different medical treatment than a boy whose biological sex is male who takes puberty blockers to treat his precocious puberty." *Id.* at 514. The application turns on medical treatment, not sex. Indeed, the law applied to all: "*no* minor" could receive "puberty blockers or hormones to treat gender dysphoria." *Id.* But "minors of *any* sex" could receive "puberty blockers or hormones for other purposes." *Id.*

[¶8] For the latter, there was no transgender-status classification. *Id.* at 519. Tennessee's law facially classified "minors into two groups: those who

might seek puberty blockers or hormones to treat the excluded diagnoses, and those who might seek puberty blockers or hormones to treat other conditions." *Id.* And the second group included "both transgender and nontransgender individuals." *Id.* So there was "a 'lack of identity' between transgender status and the excluded medical diagnoses." *Id.* In other words, Tennessee drew lines based on the benefits and risks of treatment, not anyone's status.

[¶9] That logic applies here. The Health Care Law classifies based on age and medical treatment—not sex or transgender status. Just like Tennessee's law, North Dakota's prohibits treating minors with gender dysphoria with puberty blockers and cross-sex hormones. N.D. Cent. Code § 12.1-36.1-02(1)(c). The law's mere reference to sex does not mean it classifies based on sex. And application of the law turns on medical treatment. Drugs with "the purpose of aligning the minor's sex" with perceived sex when that's inconsistent with biological reality are prohibited; drugs with a different purpose are allowed. *Id.* And "both transgender and nontransgender individuals" alike may seek such drugs for a different purpose than that prohibited. *Skrmetti*, 605 U.S. at 519. So the "lack of identity" means there is no transgender-status classification. *Id. Skrmetti*'s logic resolves the equal-protection claim.

[¶10] Casas cannot get around that. He admits that rational-basis review applies if the Health Care Law does not classify based on a suspect class. Appellant Br. ¶77. That means, if *Skrmetti*'s logic shows that the Health Care Law

does not classify based on a suspect class, rational-basis review applies. So Casas must show the logic does not apply. Yet he can't.

[¶11] First, Casas says that North Dakota's Equal Protection Clause was not modeled on the federal clause. *Id.* ¶93. But whether there's daylight between the two makes no difference. Under both, for heightened scrutiny to apply, there must be a suspect classification. And if there's no such classification in the Health Care Law, rational-basis review applies. That's where *Skrmetti* comes in—its logic shows there is no suspect classification.

[¶12] Second, Casas argues that *Skrmetti* is neither controlling nor persuasive authority because the case was on a preliminary injunction. *Id.* ¶96. That makes no sense. If a U.S. Supreme Court decision is not persuasive authority, nothing is. And that it was a preliminary-injunction decision doesn't lessen its pervasive value here. Whether a law has a suspect classification is a legal question. The analysis for a preliminary injunction or after trial is the same.

[¶13] Third, Casas claims that *Skrmetti* applied a medical-context carve out to hold that Tennessee's law did not classify based on sex. *Id.* ¶97. But *Skrmetti* did no such thing. The Court expressly stated that it had "never suggested that mere reference to sex is sufficient to trigger heightened scrutiny." *Skrmetti*, 605 U.S. at 512. And then it said that approach "would be especially inappropriate in the medical context." *Id.* So at a minimum, mere reference to sex in the medical context cannot evidence a sex-based classification. That does not mean other contexts have a different result.

[¶14] Fourth, Casas argues that the Court disregarded the plain language of Tennessee's law. Appellant Br. ¶98. He suggests that the law including the word "sex" means it must classify based on sex. *Id.* But that does not follow. The Court explained thoroughly that mere reference to sex does not mean there's a sex-based classification. *Skrmetti*, 605 U.S. at 512.

[¶15] Likewise, no amicus brief supporting Casas distinguishes *Skrmetti*'s logic. Two try. The Brennan Center brief argues generally that state constitutions should not mirror the federal. Brennan Ctr. Br. ¶¶10–29. But the brief does not explain how *Skrmetti*'s logic about sex and transgender-status classifications is inapposite. And the NWLC brief does no better. That brief argues that the North Dakota Equal Protection Clause protects individuals, and from that perspective the Health Care Law classifies based on sex. NWLC Br. ¶16. But that argument cannot distinguish *Skrmetti*. The federal Equal Protection Clause also protects individuals. *Enquist v. Or. Dep't of Agric.*, 553 U.S. 591, 598 (2008). And *Skrmetti* analyzed Tennessee's law from the perspective of an individual. 605 U.S. at 513–14. *Skrmetti*'s logic applies.

### B. The Sixth Circuit's reasoning applies to the fundamental-rights claim.

[¶16] Move to the fundamental-rights claim. The U.S. Supreme Court's *Skrmetti* decision does not speak to that claim. But the Sixth Circuit's does.

[¶17] In *L.W. ex rel. Williams v. Skrmetti*, the Sixth Circuit considered whether there is a fundamental right under the federal Constitution for children with gender dysphoria to receive puberty blockers and cross-sex

hormones. 83 F.4th 460, 472 (6th Cir. 2023). It held no. There is no deeply rooted tradition of preventing governments from regulating certain medical treatment—particularly not when there is medical and scientific uncertainty. *Id.* at 473. Case after case says that "the States may regulate or ban medical technologies they deem unsafe." *Id.* at 474. Indeed, even if there's a "right to refuse medical treatment in some settings," that right "cannot be 'transmuted' into a right to obtain treatment." *Id.* (citation omitted). There is "a material distinction between the State effectively sticking a needle in someone over their objection and the State prohibiting the individual from filling a syringe with prohibited drugs." *Id.* at 476.

[¶18] That logic also applies here. Casas argues that there is a fundamental right under North Dakota's Constitution for children with gender dysphoria to receive puberty blockers and cross-sex hormones—even if such treatments are experimental and dangerous in this context. Appellant Br. ¶49. Casas suggests that the right to refuse medical treatment includes the right to receive it. *Id.* ¶56. But that does not follow, as *L.W.* makes clear.

[¶19] Perhaps recognizing as much, Casas argues that the right allows only access to medical treatment necessary to preserve one's life. *Id.* Even if true, that cannot help Casas. The separate opinions he cites address receiving an abortion "when reasonably necessary to preserve the individual's life." *Access Indep. Health Servs., Inc. v. Wrigley*, 28 N.W.3d 850, 891 (N.D. 2025) (mem.) (Tufte, J., op.). Yet any such right is limited to "prevention of physical injury

of similar seriousness as the serious bodily injury" justifying "deadly force in self-defense." *Id.* And no reliable evidence suggests that chemical interventions reduce the risk of self-harm, as discussed below. Even putting that inconvenient fact aside, nothing suggests that preventing serious physical injury includes a self-imposed injury. An individual cannot demand prohibited drugs on threat of self-harm. Yet that is what Casas's theory boils down to. At bottom, he can't escape that a right to refuse doesn't include a right to obtain.

## II. Many rational bases support the Health Care Law.

[¶20] Because the Health Care Law neither classifies based on a suspect class nor violates a fundamental right, rational-basis review applies. So the law is constitutional unless "patently arbitrary" or lacking any "rational relationship to a legitimate government interest." *Condon v. St. Alexius Med. Ctr.*, 926 N.W.2d 136, 141 (N.D. 2019). And the law easily satisfies that low bar. Again, the Court need look no further than *Skrmetti*. The U.S. Supreme Court there easily held that Tennessee's similar law had several rational bases. *Skrmetti*, 605 U.S. at 522–23. But lest there's any doubt, take a closer look at two.

### A. No reliable evidence shows chemical interventions benefit minors, but evidence shows those drugs cause harm.

[¶21] Start with the Health Care Law protecting children from experimental and harmful drug treatments. There is no reliable evidence that chemical interventions help children with gender dysphoria. No systematic reviews show children with gender dysphoria benefit from puberty blockers and cross-sex hormones. And systematic reviews are the gold standard in evidence-based

medicine. *See* David L. Sackett et al., *Evidence based medicine: what it is and what it isn't*, 312 BMJ 71, 71 (1996), https://www.bmj.com/content/312/7023/71. They pull together all available relevant evidence and assess its strength. *Id.* Yet time and again, systematic reviews show the evidence is too low to support treating gender dysphoria in children with puberty blockers and cross-sex hormones. Take just some recent examples.

[¶22] First, HHS's 2025 report examined 17 systematic reviews of various interventions for children with gender dysphoria. Dep't of Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (2025), https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf. HHS concluded that the quality of evidence supporting interventions—including chemical ones—is very low, with limited data on harms and insufficient proof of sustained benefits.

[¶23] Second, the Cass Review, which commissioned multiple systematic reviews by researchers at the University of York, concluded that the evidence supporting using puberty blockers in children is highly limited and uncertain. The Cass Rev., *Independent review of gender identity services for children and young people: Final report* (2024), https://perma.cc/5ZAL-Z3BK. That caused the United Kingdom to prohibit treating gender dysphoria with puberty blockers and cross-sex hormones. Gov't U.K., *Ban on puberty blockers to be made indefinite on experts' advice* (Dec. 11, 2024), https://perma.cc/QW2R-TQUZ;

Jacqui Wise, *NHS halts cross-sex hormone treatment for under 18s* (Mar. 10, 2026), https://doi.org/10.1136/bmj.s461.

[¶24] Third, a group of German researchers in 2024 updated the U.K. National Institute for Health & Care Excellence's 2020 systematic reviews. Those prior NICE reviews found the evidence for puberty blockers and cross-sex hormones benefiting children with gender dysphoria was very low. The 2024 update found nothing to change the NICE conclusions. Florian D. Zepf et al., *Beyond NICE: Updated systematic review on the current evidence for using puberty blockers and cross-sex hormones in minors with gender dysphoria* (2024), https://pubmed.ncbi.nlm.nih.gov/38410090/.

[¶25] In short, systematic review after review agrees: there is no reliable evidence that puberty blockers and cross-sex hormones benefit children with gender dysphoria. And that includes reducing the risk of suicide or self-harm. WPATH's own commissioned review could draw no "conclusions about the effects of hormone therapy on death by suicide." Kellan E. Baker et al., *Hormone Therapy, Mental Health, & Quality of Life Among Transgender People: A Systematic Review*, 5:4 J. Endocrine Soc'y 1, 12 (2021), https://doi.org/10.1210/jendso/bvab011. Other studies agree. *E.g.*, C.M. Wiepjes et al., *Trends in suicide death risk in transgender people: results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017)*, 141 Acta Psychiatrica Scandinavica 486, 490 (2020), https://doi.org/10.1111/acps.13164. And studies even suggest suicide ideation and attempts *increased* after minors

began using puberty blockers and cross-sex hormones. J. J. Straub et al., *Risk of suicide and self-harm following gender-affirmation surgery*, Cureus 16(4), Article e57886 (2024), https://perma.cc/8EZY-635K.

[¶26] Likewise, studies suggest no mental health improvement following a chemical intervention. *E.g.*, Riittakerttu Kaltiala et al., *Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria*, 74:3 Nordic J. Psychiatry 213, 217 (2020), https://perma.cc/4KFT-99HK. And that goes for adults too. A study from this year shows that neither surgery nor cross-sex hormones directly reduce depression or anxiety in adults. Chun Yip Wong et al., *Effect of Gender-Affirming Treatments on Depression and Anxiety Symptoms in Transgender People: A Retrospective Cohort Study*, Frontiers Psychiatry (2026), https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2025.1709778/full.

[¶27] But studies *do* suggest harmful and perhaps permanent side effects to chemical interventions. To list a few: Declines in bone density. *E.g.*, Michael Biggs, *Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria*, J. of Pediatric Endocrinology & Metabolism 34, 937–939 (2021), https://perma.cc/6X2W-E73F. Disruptions of psychosocial and psychosexual development. *E.g.*, Michael Biggs, *Psychosocial Functioning in Transgender Youth after Hormones*, N. Engl. J. Med. 389, 1536–1537 (2023), https://www.nejm.org/doi/full/10.1056/NEJMc2302030. And organ poisoning and nervous system disorders. *Id.*

[¶28] Worse still, the effects of puberty blockers and cross-sex hormones are largely unknown when it comes to both neurological development and fertility. But studies "indicate a possible detrimental impact on IQ." Sallie Baxendale, *The impact of suppressing puberty on neuropsychological function: A review*, Acta Paediatrica 113, 1156–1167, 1164 (2024), https://doi.org/10.1111/apa.17150. And the infertility risks of using cross-sex hormones are significant. C. De Roo et al., *Fertility in transgender and gender diverse people: systematic review of the effects of gender-affirming hormones on reproductive organs and fertility*, Hum. Reprod. Update 31, 183–217 (2025), https://doi.org/10.1093/humupd/dmae036.

[¶29] At bottom, all the reliable evidence suggests chemical transitions for children is high risk, no reward. That shows a rational basis, to say the least.

### B. Evidence suggests many minors will regret using puberty blockers and cross-sex hormones.

[¶30] Another rational basis is that many minors may regret their decision to use puberty blockers and cross-sex hormones. As the Cass Review notes, clinicians cannot "determine with any certainty which children and young people will go on to have an enduring trans identity." Cass, *Final Report, supra*, at 22. And the studies suggest a high desistence rate. *E.g.*, C. J. Bachmann et al., *Gender Identity Disorders Among Young People in Germany: Prevalence and Trends, 2013-2022*. Deutsches Arzteblatt Int'l, 121, 370–371 (2024), https://perma.cc/YW9N-NEVU. In fact, "studies show that most

children with gender dysphoria grow out of it." *Eknes-Tucker v. Governor of Ala.*, 114 F.4th 1241, 1268 (11th Cir. 2024) (mem.) (Lagoa, J., concurring).

[¶31] That explains why there are so many detransitioners—individuals who regret and seek to undo their interventions. Just look at some of the stories recounted in the *Skrmetti* amicus briefs. First, take the story of Jane Smith. *See* Isabelle Ayala et al. Br. at 20–23, *Skrmetti*, 605 U.S. 495 (No. 23-477). Jane had a traumatic upbringing and suffered from mental-health issues. *Id.* at 20. Through therapy, she was referred to a gender clinic at 16. *Id.* at 21. She was put on cross-sex hormones for almost six years, then detransitioned. *Id.* at 22. Yet she cannot escape the effects of the hormones. Her voice has permanently deepened. *Id.* Jane doesn't recognize her own voice, and it surprises others who "hear a man's voice" with her returning female appearance. *Id.* So much so that Jane thinks she has lost job opportunities because of the mismatch. *Id.* Jane also has to shave her facial hair, which grew because of the cross-sex hormones. *Id.* She struggles with eating disorders, joint issues, fatigue, and increased vascularity (visibility of veins). *Id.* She has vaginal atrophy and other genital problems. *Id.* And Jane believes her cognitive functioning is diminished. *Id.* Once she was a successful student, graduating high school early with scholarship offers; now she struggles to keep a job. *Id.*

[¶32] Second, turn to the story of Sue Y's daughter, G. *See* Our Duty-USA Br. at 18–19, *Skrmetti*, 605 U.S. 495 (No. 23-477). When she was 12, G became suicidal and said she was transgender. *Id.* at 18. A gender clinician told her

mother she could have "a dead daughter or a live son." *Id.* So Sue consented to giving G puberty blockers and socially transitioned her. But after two and half years, G's mental health continued to deteriorate—she became more suicidal and began cutting herself. *Id.* at 19. Then a new psychiatrist traced G's mental-health struggles to a different source than her gender. *Id.* So G stopped the puberty blockers and social transition. *Id.* Today, G is doing better. She is a well-adjusted woman who accepts her gender. *Id.*

[¶33] And third, consider the story of Brendan D. *See* Larger Detran. Cmty. Br. at 25–27, *Skrmetti*, 605 U.S. 495 (No. 23-477). Brendan transitioned as a minor but "regret[s]" doing so "each and every day." *Id.* at 26. He "resent[s]" that he's "infertile over a completely avoidable medical treatment." *Id.* He "feel[s] experimented on" and "abused." *Id.* He "will never achieve the dreams [he] had of having a family" and will "never fully finish puberty and experience the body [he] was meant to have." *Id.* And "as an adult," Brendan wonders why he "wasn't protected by the adults in [his] life" and why he "wasn't afforded time to grow within [his] own body." *Id.* at 27.

[¶34] Those stories just scratch the surface. *E.g.*, ABAJournal, *Patient awarded $2M by jury in malpractice suit over gender-care surgery* (Feb. 4, 2026), https://perma.cc/CWH7-VBD5. Time and again, children who transition regret their decision, detransition, and live with the lasting effects.

[¶35] Casas's only response to that reality is to say the State hasn't identified a minor *in North Dakota* "who regrets receiving gender-affirming care."

Appellant Br. ¶90. But legislators needn't wait for serious harm to befall North Dakota children. Nor does rational-basis review require doing so. The Health Care Law fails that standard only if it has no "rational relationship to a legitimate government interest." *Condon*, 926 N.W.2d at 141. And evidence of individuals across the country regretting their decisions to transition as minors gives that relationship. If some out-of-state minors regret their choice, there's a good chance some in-state minors will too. Rational bases abound.

## CONCLUSION

[¶36] The North Dakota Constitution might differ from the U.S. Constitution. But logic is universal. The *Skrmetti* decisions' logic applies to both claims here, and the Health Care Law passes the low bar of rational-basis review. North Dakota can protect its children. The Court should affirm.

Respectfully submitted this 13th day of May, 2026.

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## CERTIFICATE OF COMPLIANCE

Under Rule 32(d), I hereby certify that this brief complies with the page limitation. The brief contains 19 pages, excluding addendum.

By: /s/ *Reed A. Soderstrom*

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## CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of May, 2026, I electronically filed the foregoing document with the Clerk of Court using the Supreme Court electronic filing system, which served all counsel of record.

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