CAUSE NO. D-1-GN-22-000977

JANE DOE, individually and as parent and next friend of MARY DOE, a minor; JOHN DOE, individually and as parent and next friend of MARY DOE, a minor; and DR. MEGAN MOONEY Plaintiffs v. GREG ABBOTT, sued in his official capacity as Governor of the State of Texas; JAIME MASTERS, sued in her official capacity as Commissioner of the Texas Department of Family and Protective Services; and the TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES, Defendants.	§	IN THE DISTRICT COURT OF TRAVIS COUNTY, TEXAS 353RD JUDICIAL DISTRICT

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS' APPLICATION FOR TEMPORARY INJUNCTION

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae are the American Academy of Pediatrics ("AAP"), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry ("AACAP"), the American Academy of Family Physicians, the American Association of Medical Colleges, the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ Equality ("GLMA"), the American College of Obstetricians and Gynecologists, the American College of Osteopathic Pediatricians ("ACOP"), American College of Physicians ("ACP"), the American Medical Association ("AMA"), the American Pediatric Society ("APS"), the American Psychiatric Association ("APA"), the Association of Medical School Pediatric Department Chairs ("AMSPDC"), the Endocrine Society, the National Association of Pediatric Nurse Practitioners ("NAPNAP"), the Pediatric Endocrine Society ("PES"), the Ray E. Helfer Society, the Society for Adolescent Health and Medicine ("SAHM"), the Society for Pediatric Research ("SPR"), the Society of Pediatric Nurses ("SPN"), the Societies for Pediatric Urology ("SPU"), the Texas Pediatric Society (Texas Chapter of the AAP), and the World Professional Association for Transgender Health ("WPATH").[1]

Amici are professional medical and mental health organizations seeking to ensure that all children and adolescents, including those with gender dysphoria, receive the optimal medical and mental healthcare they need and deserve to thrive both physically and emotionally. *Amici* include international, national, and state organizations and represent thousands of healthcare providers who have specific expertise with the issues raised in this brief. *Amici* WPATH and the Endocrine Society also publish the most widely accepted and used medical guidelines for

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[1] *Amici* affirm that no person other than *amici* or their counsel made any monetary contributions intended to fund the preparation or submission of this brief. Tex. R. App. P. 11(c).

treating gender dysphoria. The Court should consider *amici*'s brief because it provides important expertise on the topic of the appropriate treatment for gender dysphoria in adolescents.

INTRODUCTION

On February 21, 2022, Attorney General Paxton released Opinion No. KP-0401 ("Paxton Opinion"), concluding that certain evidence-based medical treatments that are critical for many adolescents suffering from gender dysphoria actually constitute "child abuse."[2] In a letter the next day incorporating the Paxton Opinion, Governor Abbott directed the Texas Department of Family and Protective Services ("DFPS") to investigate "any reported instances" of the use of those treatments as child abuse ("Abbott Letter").[3] On the same day, DFPS announced that it would comply with the Abbott Letter.[4] In actuality, the medical treatments characterized as "child abuse" in the Abbott Letter are part of the widely-accepted treatment guidelines for adolescents suffering from gender dysphoria, and are supported by the best available scientific evidence. Denying these treatments to adolescents who need them would irreparably harm their health. Additionally, the Abbott Letter and DFPS announcement place healthcare providers in Texas in an impossible position. These providers are required to falsely report adolescent patients receiving these treatments as victims of child abuse even though such reporting would inflict serious harm on their patients, thereby violating these providers' professional codes of ethics. On the other hand, if these providers do not report their patients, they face severe legal consequences, including potential civil and criminal penalties and the loss of their professional

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[2] Ken Paxton et al., Re: Whether Certain Medical Procedures Performed on Children Constitute Child Abuse (RQ-0426-KP), Opinion No. KP-0401, at 1 (Feb. 18, 2022), https://texasattorneygeneral.gov/sites/default/files/global/KP-0401.pdf.

[3] Greg Abbott, Letter to Hon. Jaime Masters, Commissioner, Tex. Dep't of Fam. & Protective Servs. (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf.

[4] *See* Isaac Windes, *Texas AG says trans healthcare is child abuse. Will Fort Worth schools have to report?*, Fort Worth Star-Telegram (Feb. 23, 2022), https://www.star-telegram.com/news/local/crossroads-lab/article258692193.html.

licenses.[5] Thus, action taken pursuant to the Abbott Letter and DFPS announcement, if not enjoined, will irreparably harm both transgender adolescents and healthcare providers in Texas.

Below, *amici* provide the Court with an accurate description of the well-accepted treatment guidelines for gender dysphoria, including the medical treatments mischaracterized by the Abbott Letter; summarize the scientific evidence supporting these medical interventions for some adolescents suffering from gender dysphoria; and detail the severe consequences that patients and providers will face if action is taken pursuant to the Abbott Letter and DFPS announcement.

Gender dysphoria is a clinical condition that is marked by distress due to an incongruence between the patient's gender identity (*i.e.*, the innate sense of oneself as being a particular gender) and sex assigned at birth. This incongruence can lead to clinically significant distress and impair functioning in many aspects of the patient's life.[6] If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with higher rates of suicide. As such, the effective treatment of gender dysphoria saves lives.

The widely accepted recommendation of the medical community, including that of the respected professional organizations participating here as *amici*, is that the standard of care for treating gender dysphoria is "gender-affirming care."[7] Gender-affirming care is care that supports a child or adolescent as they explore their gender identity—in contrast with efforts to change the individual's gender identity to match their sex assigned at birth, which are known to

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[5] *See* Abbott, Letter to Hon. Jaime Masters, *supra* note 3.

[6] *See* AAP Policy Statement at 2 tbl. 1, 3.

[7] *Id*. at 10.

be ineffective and harmful. For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical interventions to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including gender-affirming medical interventions, can alleviate clinically significant distress and lead to significant improvements in the mental health and overall well-being of adolescents with gender dysphoria.

The Abbott Letter, however, disregards this medical evidence by mischaracterizing gender-affirming care as child abuse and directing DFPS to investigate healthcare providers who treat adolescent patients with gender dysphoria in accordance with the widely-accepted treatment guidelines. As such, enforcement of the Abbott Letter and DFPS announcement will prevent healthcare providers from providing critical medical care to adolescent patients. It would also put healthcare providers in the impossible position of either failing to report their clients who receive gender-affirming care at pain of suffering civil and criminal penalties; or following the Abbott Letter's flawed directive and thus inflict serious harm on patients in contravention of their ethical obligation to do no harm.[8] It is for these reasons, among others, that pediatricians,

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[8] *See, e.g., AAP, Texas Pediatric Society Oppose Actions in Texas Threatening Health of Transgender Youth*, AAP News Room (Feb. 24, 2022), https://www.aap.org/en/news-room/news-releases/aap/2022/aap-texas-pediatric-society-oppose-actions-in-texas-threatening-health-of-transgender-youth/; *Endocrine Society alarmed at criminalization of transgender medicine*, Endocrine Society News Room (Feb. 23, 2022), https://www.endocrine.org/news-and-advocacy/news-room/2022/endocrine-society-alarmed-at-criminalization-of-transgender-medicine; *APA president condemns Texas governor's directive to report parents of transgender minors*, American Psychological Association Press Room (Feb. 24, 2022), https://www.apa.org/news/press/releases/2022/02/report-parents-transgender-children; *Physicians Oppose Texas Efforts to Interfere in the Patient-Physician Relationship and Criminalize Gender-Affirming Care*, AAP News Room (Feb. 28, 2022), https://www.aap.org/en/news-room/news-releases/aap/2022/physicians-oppose-texas-efforts-to-interfere-in-the-patient-physician-relationship-and-criminalize-gender-affirming-care/; *AACAP Statement Opposing Actions in Texas Threatening the Health, Mental Heather and Well-Being of Transgender and Gender Diverse Youth and Their Families*, AACAP News (Mar. 1, 2022),
(continued…)

endocrinologists, psychiatrists, nurse practitioners, medical experts in diagnosing child abuse and neglect, and other medical professionals practicing in Texas oppose DFPS' enforcement of the Abbott Letter.[9] Accordingly, *amici* support plaintiffs' application for a statewide temporary injunction enjoining enforcement of the Abbott Letter.

ARGUMENT

This brief begins by providing background on gender identity and gender dysphoria. It then describes the well-accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that suggests the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief explains how action taken pursuant to the Abbott Letter and DFPS statement would irreparably harm both adolescents with gender dysphoria and healthcare providers who treat these adolescents.

I. Understanding Gender Identity and Gender Dysphoria.

A person's gender identity is a person's deep internal sense of belonging to a particular gender.[10] Most people have a gender identity that aligns with their sex assigned at birth.[11] However, transgender people have a gender identity that does not align with their sex assigned at birth.[12] In the United States, it is estimated that approximately 1.4 million individuals are

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https://www.aacap.org/AACAP/zLatest_News/AACAP_Statement_Opposing_Actions_in_Texas.aspx.

[9] *See* sources cited *supra* note 8.

[10] AAP Policy Statement at 2 tbl.1.

[11] *See* Am. Psychological Ass'n Guidelines at 834.

[12] *See id.* at 832.

transgender. [13] Of these individuals, approximately 10 percent are teenagers aged 13 to 17.[14] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

The medical community's understanding of transgender people and gender identity has evolved considerably over the past two decades.[15] There is now a widely held recognition that simply being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[16] The general consensus of the medical and mental health communities is that transgender identities are "normal variations of human identity and expression."[17]

While being transgender is a normal variation of human identity, many transgender people suffer from gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to "impairment in peer and/or family relationships, school performance, or other aspects of their life."[18] The American Psychiatric Association's

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[13] *See* Jody L. Herman et al., *Ages of Individuals Who Identify as Transgender in the United States*, Williams Inst., at 2 (Jan. 2017), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Age-Trans-Individuals-Jan-2017.pdf.

[14] *See id.* at 3.

[15] *See* Am. Psychological Ass'n Guidelines at 832.

[16] Jack Drescher et al., *Position Statement on Discrimination Against Transgender and Gender Diverse Individuals*, Am. Psychiatric Ass'n (APA), 1 (2018), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Discrimination-Against-Transgender-and-Gender-Diverse-Individuals.pdf.

[17] James L. Madara, *AMA to states: Stop interfering in healthcare of transgender children*, Am. Med. Ass'n (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children; *see also* Am. Psychological Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

[18] AAP Policy Statement at 3.

Diagnostic and Statistical Manual defines the diagnostic criteria for gender dysphoria as including: (1) a marked incongruence between one's experienced or expressed gender and assigned gender of at least 6 months' duration, and (2) clinically significant distress or impairment in social, occupational, or other important areas of functioning.[19]

If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.[20] Research suggests the highly elevated rate of suicidality among transgender people. Indeed, in one recent national survey, over 60 percent of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75 percent reported symptoms of generalized anxiety disorder in the preceding two weeks.[21] Even more troubling, more than 50 percent of this population reported having seriously considered attempting suicide,[22] and more than one in three transgender adolescents reported having attempted suicide in the preceding 12 months.[23]

II. The Widely Accepted Guidelines for Treating Adolescents With Gender Dysphoria Provide for Medical Interventions When Indicated.

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for some adolescents,

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[19] *See* DSM-5 at 452-53.

[20] *See* Brayden N. Kameg & Donna G. Nativio, *Gender dysphoria in youth: An overview for primary care providers*. 30(9) J. Am. Assoc. Nurse Pract. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668/.

[21] *See* Amit Paley, *The Trevor Project 2020 National Survey*, at 1, https://www.thetrevorproject.org/wp-content/uploads/2020/07/The-Trevor-Project-National-Survey-Results-2020.pdf.

[22] *See id*. at 2.

[23] *See* Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students–19 States and Large Urban School Districts, 2017*, US Dep't of Health and Human Servs., Centers for Disease Control & Prevention, 68(3) MMWR 67, 70 (Jan. 25, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf.

gender-affirming medical interventions are necessary.[24] This care greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated.[25] The accepted guidelines for providing this care to adolescents were developed through a professional and transparent process and are supported by empirical research.

A. The Guidelines for Treating Gender Dysphoria Include Thorough Mental Health Assessments and, for Some Adolescents, Medical Interventions.

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: specifically, (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (collectively, the "Guidelines").[26]

The Guidelines provide that youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified mental health professional ("MHP"). Further, the Guidelines provide that each patient who receives gender-affirming care receives only evidence-based, medically necessary, and appropriate interventions that are tailored to the patient's individual needs.

1. Gender-Affirming Care Begins With a Robust Mental Health Assessment, Which Is Required Before Any Further Medical Interventions Are Provided.

According to the Guidelines, gender-affirming care begins with a thorough evaluation by

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[24] *See, e.g.*, Endocrine Soc'y, *Transgender Health: An Endocrine Society Position Statement* (2020) (hereinafter "Endocrine Soc'y Position Statement"), https://www.endocrine.org/advocacy/position-statements/transgender-health.

[25] *See id.*

[26] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. Clinical Endocrinology & Metabolism 3869 (Nov. 2017) ("Endocrine Society Guideline), https://academic.oup.com/jcem/article/102/11/3869/4157558; WPATH, Standards of Care (7th Version), https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf ("WPATH Guidelines").

a qualified mental health professional, who: (1) is trained in childhood and adolescent developmental psychopathology, (2) is competent in diagnosing and treating the ordinary problems of children and adolescents, and (3) meets the competency requirements that the Guidelines specify for MHPs working with adults.[27] These requirements include: (1) a master's degree or its equivalent in a clinical behavioral science field, (2) competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes, (3) the ability to recognize and diagnose coexisting mental health concerns and distinguish them from gender dysphoria, (4) documented supervised training and competence in psychotherapy or counseling, (5) being knowledgeable about gender identities and expressions, and the assessment and treatment of gender dysphoria, and (6) continuing education in the assessment and treatment of gender dysphoria.[28]

When evaluating a patient with gender dysphoria, the MHP must, among other things, assess the patient's "gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers."[29] The MHP also must screen the patient for coexisting mental health concerns.[30] Any coexisting mental health concerns "need to be optimally managed prior to, or concurrent with, treatment of gender dysphoria."[31] If gender dysphoria is diagnosed, the Guidelines provide that the MHP should discuss with the patient available treatment for gender dysphoria and any coexisting concerns, including potential

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[27] *See* WPATH Guidelines at 13.

[28] *See id.* at 22.

[29] *Id.* at 23-24.

[30] *Id.* at 24-25.

[31] *Id.* at 25.

benefits and risks.[32]

2. The Guidelines Recommend Only Non-Physical Interventions for Prepubertal Children Suffering From Gender Dysphoria.

For prepubertal children suffering from gender dysphoria, the Guidelines provide for mental healthcare and support for the child and their family.[33] The Guidelines do *not* recommend that any physical interventions (such as medications or surgery) be provided to prepubertal children with gender dysphoria.[34]

3. In Certain Circumstances, the Guidelines Provide For the Use of Medical Interventions To Treat Adolescents Suffering From Gender Dysphoria.

For patients whose gender dysphoria continues into adolescence—after the onset of puberty—the Guidelines provide that in addition to mental healthcare, medical interventions may also be indicated. Gender affirmative care recognizes that not all transgender adolescents may need or desire medical interventions. Before an adolescent may receive any medical interventions for gender dysphoria, a qualified MHP determines when treatment is indicated based on criteria including: (1) the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria, (2) the gender dysphoria emerged or worsened after the onset of puberty, (3) any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed, and (4) the adolescent and the parents or guardians have given informed consent to the treatment.[35] Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (5) agree with the

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[32] *Id.* at 24.

[33] *See id.* at 16-17; Endocrine Society Guidelines at 3877.

[34] *See* WPATH Guidelines at 17-18, Endocrine Society Guidelines at 3871.

[35] WPATH Guidelines at 19.

indication for treatment, (6) confirm that the patient has started puberty, and (7) confirm that there are no medical contraindications.[36]

If all of the above criteria are met, the Guidelines instruct that gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty.[37] The purpose of puberty blockers is to delay irreversible pubertal development until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments.[38] GnRH analogues have well-known efficacy and side-effect profiles.[39] In addition, their effects are generally reversible; if the treatment is suspended, endogenous puberty will resume.[40] In fact, GnRH analogues have been used by pediatric endocrinologists for more than 30 years for the treatment of precocious puberty.[41] The risks of any serious adverse effects of these treatments are exceedingly rare when provided under clinical supervision.[42]

Puberty blockers are a valuable treatment for many adolescents suffering from gender dysphoria because, for these patients, the onset of puberty often produces physical changes that

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[36] Endocrine Society Guidelines at 3878 tbl. 5.

[37] WPATH Guidelines at 18; Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 New Eng. J. Med. 579 (2021), https://www.nejm.org/doi/full/10.1056/NEJMp2106314.

[38] WPATH Guidelines at 19.

[39] Martin, *supra* note 37 at 2.

[40] *See id*; AAP Policy Statement at 5.

[41] Martin, *supra* note 37 at 2.

[42] *See, e.g.*, Annemieke S. Staphorsius et al, *Puberty suppression and executive functioning: an fMRI-study in adolescents with gender dysphoria*, 6 Pscyhoneuroendocrinology 190 (2015), https://pubmed.ncbi.nlm.nih.gov/25837854/, (no adverse impact on executive functioning); Ken C. Pang, et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) Pediatrics e20191606 (2019), https://watermark.silverchair.com/peds_20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).

can significantly increase their gender dysphoria and psychological distress.[43] The experience of full endogenous puberty is an "undesirable condition for [transgender] individual[s] and may seriously interfere with healthy psychological functioning and well-being."[44] Delaying puberty through puberty blockers is a measured treatment because it delays the need for patients to make less-reversible decisions regarding their gender identity, and instead provides patients with time to understand their gender identity while preserving the widest spectrum of potential treatments and outcomes. Puberty blocking treatment consistent with the Guidelines also can make pursuing additional forms of transition (*i.e.*, surgical treatment) unnecessary, because this treatment prevents irreversible physical changes such as protrusion of the Adam's apple or breast growth.[45]

Later in adolescence—and if the patient, their parents or guardians, and medical team all agree it is medically indicated—hormone therapy may be used to initiate puberty consistent with the patient's gender identity.[46] Hormone therapy is only prescribed when a qualified MHP has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity to assent to the treatment, and that any coexisting problems that could interfere with treatment have been addressed.[47] A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication for the treatment, the patient and their parents or guardians must be informed of the potential effects and side effects, and the patient and the

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[43] *See* AAP Policy Statement at 5.

[44] Endocrine Society Guidelines at 3880.

[45] *See* AAP Policy Statement at 5.

[46] Martin, *supra* note 37 at 2.

[47] Endocrine Society Guidelines at 3878 tbl. 5.

patient's parents or guardians must give their informed consent.[48] Hormone therapy involves using cross-sex hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[49] Although some of these changes become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones.[50]

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and close surveillance to mitigate any potential risks.[51] Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents or guardians, and the medical and mental healthcare team. There is "no one-size-fits-all approach to this kind of care."[52]

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process.

The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous requirements—as other medical guidelines promulgated by *amici* and other professional medical organizations. These processes are specifically designed to ensure that treatment recommendations are based on the best available scientific evidence, and include subjecting the proposed guidelines to multiple rounds

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[48] *See id*.

[49] *See* AAP Policy Statement at 6.

[50] *See id.* at 5-6.

[51] *See* Endocrine Society Guidelines at 3871, 3876.

[52] Martin, *supra* note 37, at 1.

of scientific review.

For example, the Endocrine Society's Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons (CPG) was developed following a 26-step, 26-month drafting, comment, and review process.[53] The Endocrine Society imposes strict evidentiary requirements based on the internationally recognized and methodologically sound Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[54] That assessment of the evidence using GRADE is then reviewed, re-reviewed, and reviewed again by multiple, independent groups of medical professionals. Reviewers are subject to strict conflict of interest rules, and there is ample opportunity for feedback and debate through the years-long review process.[55] Further, the Endocrine Society Clinical Guidelines Committee (CGC) continually surveils the portfolio of published clinical practice guidelines for potential updates to these and other guidelines. Recently, the CGC reviewed the Transgender CPG and determined the 2017 guideline continues to reflect the best, most up-to-date medical evidence.

The WPATH standards are the result of a drafting, comment, and review process that took five years.[56] The draft guideline papers went through journal peer-review and were then publicly available for discussion and debate, including multiple additional rounds of feedback

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[53] *See* Endocrine Society Guidelines at 3872-73.

[54] *See* Gordon Guyatt et al., *GRADE guidelines: 1. Introduction - GRADE evidence profiles and summary of findings tables*, 64 J. Clinical Epidemiology 383 (2011), https://www.who.int/alliance-hpsr/resources/publications/HSR-synthesis-Guyatt-2011.pdf; Gordon H. Guyatt et al., *GRADE: an emerging consensus on rating quality of evidence and strength of recommendations*, 336 BMJ 924 (2008), https://www.who.int/hiv/topics/treatment/grade_guyatt_2008.pdf.

[55] Endocrine Society, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology (last visited Jan. 17, 2022).

[56] *See* WPATH Guidelines at 109-10.

from experts in the field, as well as from transgender individuals.[57] They are periodically updated to account for new developments in the research and practice, and WPATH is currently in the process of its eighth revision.[58]

C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines.

The results of multiple studies indicate that adolescents suffering from gender dysphoria who receive medical interventions as part of their gender-affirming care experience improvements in their overall well-being.[59] Eight studies have been published that investigated the use of puberty blockers on adolescents suffering from gender dysphoria,[60] and eight studies have been published that investigated the use of hormone therapy to treat adolescents suffering

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[57] *See id*.

[58] WPATH, *Standards of Care 8: History and Purpose*, https://www.wpath.org/soc8/history.

[59] *See* Martin, *supra* note 37, at 2.

[60] *See, e.g.*, Christal Achille, et al., *Longitudinal impact of gender-affirming endocrine intervention on the mental health and wellbeing of transgender youths: preliminary results*, 8 Int'l J Pediatric Endocrinology 1-5 (2020), https://pubmed.ncbi.nlm.nih.gov/32368216/; Polly Carmichael, et al., *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*, 16(2) PloS One e0243894 (2021), https://pubmed.ncbi.nlm.nih.gov/33529227/; Rosalia Costa, et al., *Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria*, 12(11) J. Sexual Med. 2206–2214 (2015), https://pubmed.ncbi.nlm.nih.gov/26556015/; Annelou L.C. de Vries, et al., *Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study*, 8(8) J. Sexual Med. 2276-2283 (2011), https://pubmed.ncbi.nlm.nih.gov/20646177/; Annelou L.C. de Vries, et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134(4) Pediatrics 696-704 (2014), https://pubmed.ncbi.nlm.nih.gov/25201798/; Laura E. Kuper, et al., *Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy*, 145(4) Pediatrics e20193006 (2020), https://pubmed.ncbi.nlm.nih.gov/32220906/; Jack L. Turban, et al., *Pubertal suppression for transgender youth and risk of suicidal ideation*, 145(2) Pediatrics e20191725 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269/; Anna I.R. van der Miesen, *Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers*, 66(6) J. Adolescent Health 699-704 (2020).

from gender dysphoria.[61] These studies find positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.

For example, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not.[62] The study found that those who received puberty blocking hormone treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.[63] Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.[64] A 2021 study analyzing a survey of over 34,000

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[61] *See, e.g.*, Christal Achille, et al., *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results*, 8 Int'l J. Pediatric Endocrinology 1-5 (2020), https://pubmed.ncbi.nlm.nih.gov/32368216/; Luke R. Allen, et al., *Well-being and suicidality among transgender youth after gender-affirming hormones*, 7(3) Clinical Prac. Pediatric Psych. 302 (2019), https://psycnet.apa.org/record/2019-52280-009; Diego Lopez de Lara, et al., *Psychosocial assessment in transgender adolescents*, 93(1) Anales de Pediatria 41-48 (English ed. 2020), https://www.researchgate.net/publication/342652073_Psychosocial_assessment_in_transgender_adolescents; Annelou L.C. De Vries, et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134(4) Pediatrics 696-704 (2014); Rittakerttu Kaltiala, et al., *Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria*, 74(3) Nordic J. Psychiatry 213-219 (2020); Laura E. Kuper, et al., *Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy*, 145(4) Pediatrics e20193006(2020), https://pubmed.ncbi.nlm.nih.gov/32220906/; Amy E. Green, et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, J. Adolescent Health (2021), https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext; Jack L. Turban, et al., *Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults*, J. Plos One (2022), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261039.

[62] *See* Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145(2) Pediatrics e20191725 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269/.

[63] *See id*.

[64] *See id.*

LGBTQ youth found that the use of gender-affirming hormone treatment was associated with lower odds of depression and suicidality, compared to those transgender youth who wanted gender-affirming hormone treatment but did not receive it.[65] And a 2022 study analyzing a survey of over 27,000 transgender adults found that access to gender-affirming hormones was associated with lower odds of suicidal ideation when compared to survey participants who desired but never had access to gender-affirming hormones.[66]

As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 by de Vries et al. found that treatment with puberty blockers was associated with decreased depression and improved overall functioning.[67] A prospective six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety.[68] "Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population."[69]

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[65] *See* Amy E. Green, et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, J. Adolescent Health (2021), https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext.

[66] Jack L. Turban, et al., *Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults*, J. Plos One (2022), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261039.

[67] *See* Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8(8) J. Sexual Medicine 2276 (2011), https://pubmed.ncbi.nlm.nih.gov/20646177/.

[68] Annelou L.C. de Vries et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134(4) Pediatrics 696 (2014), https://pubmed.ncbi.nlm.nih.gov/25201798/.

[69] Stephen M. Rosenthal, *Challenges in the care of transgender and gender-diverse youth: an endocrinologist's view*, 17 Nature Rev. Endocrinology 581 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/34376826/.

As scientists and researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming treatments mischaracterized by the Abbott Letter are effective for the treatment of gender dysphoria. For these reasons, and consistent with the clinical experience of healthcare providers, the use of the gender-affirming medical interventions specified in the Guidelines are supported by all mainstream pediatric organizations.[70] As the president of the Texas Pediatric Society explained, "[e]vidence-based medical care for transgender and gender diverse children is a complex issue that pediatricians are uniquely qualified to provide."[71]

III. Enforcement of the Abbott Letter and DFPS Announcement Would Irreparably Harm Many Adolescents With Gender Dysphoria By Denying Them the Treatment They Need.

If enforced, the Abbott Letter and DFPS announcement will prevent adolescents with gender dysphoria from accessing well-respected and evidence-based medical interventions that treat their condition. For example, the Abbott Letter mischaracterizes the use of puberty

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[70] *See, e.g.*, AMA, *Advocating for the LGBTQ community*, https://www.ama-assn.org/delivering-care/population-care/advocating-lgbtq-community (last visited Mar. 9, 2022) (American Medical Association stating "Improving access to gender-affirming care is an important means of improving health outcomes for the transgender population"); *An Endocrine Society Position Statement*, Endocrine Society (Dec. 15, 2020), https://www.endocrine.org/advocacy/position-statements/transgender-health (Endocrine Society and Pediatric Endocrine Society position paper stating "Youth who are able to access gender-affirming care […] experience significantly improved mental health outcomes over time, similar to their cis-gender peers"); *AACAP Statement Responding to Efforts to ban Evidence-Based Care for Transgender and Gender Diverse Youth*, (Nov. 8, 2019), https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx ("The American Academy of Child and Adolescent Psychiatry (AACAP) supports the use of current evidence-based clinical care with minors.")

[71] *AAP, Texas Pediatric Society Oppose Actions in Texas Threatening Health of Transgender Youth*, AAP News Room (Feb. 24, 2022), https://www.aap.org/en/news-room/news-releases/aap/2022/aap-texas-pediatric-society-oppose-actions-in-texas-threatening-health-of-transgender-youth/.

blockers and hormone therapy as "child abuse."[72] In fact, and as discussed above in Part II.C, research has shown that adolescents with gender dysphoria who received puberty blockers and/or hormone therapy experienced less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy consistent with the Guidelines is associated with reductions in the rate of suicide attempts and significant improvement in quality of life for transgender individuals.[73] In light of the evidence indicating a relationship between a lack of access to gender-affirming care and lifetime suicide risk, it is not surprising that mental health professionals have attested that, should the Abbott Letter be enforced, "at-risk children [will be put] at even higher risk of anxiety, depression, self-harm, and suicide."[74]

In addition, action taken pursuant to the Abbott Letter and DFPS announcement would increase the likelihood that adolescents with gender dysphoria will seek out dangerous, non-medically supervised treatments. When medically-supervised care is available, patients are less likely to seek out "harmful self-prescribed hormones, use of construction-grade silicone injections, and other interventions that have potential to cause adverse events."[75] The use of hormones purchased on the street or online "may be significant health problems if used improperly."[76] Even more commonplace tactics such as chest binding (which seeks to minimize

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[72] Abbott, Letter to Hon. Jaime Masters, *supra* note 3.

[73] *See* M. Hassan Murad et al., H*ormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 Clinical Endocrinology 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; *see also* Turban et al., *supra* note 62.

[74] *APA president condemns Texas governor's directive to report parents of transgender minors*, American Psychological Association Press Room (Feb. 24, 2022), https://www.apa.org/news/press/releases/2022/02/report-parents-transgender-children.

[75] Am. Med. Ass'n, *supra* note 17.

[76] David A. Levine, *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, 132(1) Pediatrics e297 (July 2013), https://pediatrics.aappublications.org/content/132/1/e297.

physical characteristics incongruent with one's gender identity) can lead to chronic injury and pain.[77]

IV. Enforcement of the Abbott Letter and DFPS Announcement Would Irreparably Harm Healthcare Providers in Texas By Forcing Them to Either Risk Civil and Criminal Penalties or Endanger Their Own Patients.

The Abbott Letter and DFPS announcement put healthcare providers in Texas in an impossible situation. Providers who do not comply with the Abbott Letter would face civil penalties, criminal prosecution, and possibly the loss of their ability to practice. Complying with the Abbott Letter, however, would force providers to endanger their own patients and contravene their professional ethics. Falsely reporting that adolescents who are receiving gender-affirming care are experiencing child abuse would violate the most foundational ethical responsibility of all healthcare providers: to do no harm to their patients.[78] Making such a report would subject patients to immense and irreversible harm, including the possible discontinuation of vital medical treatments as well as investigation by the DFPS and possible family separation—all of which would only exacerbate the risks of depression, self-harm, and suicide among transgender adolescents. Furthermore, practitioners could be subject to malpractice lawsuits for failing to

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[77] *See, e.g.*, Sarah M. Peitzmeier et al., *Time to First Onset of Chest Binding-Related Symptoms in Transgender Youth*, 147(3) Pediatrics e20200728 (2021), https://publications.aap.org/pediatrics/article-abstract/147/3/e20200728/77086/Time-to-First-Onset-of-Chest-Binding-Related?redirectedFrom=fulltext.

[78] *See, e.g.*, Council on Medical Sub Specialties' (CMSS) Ethics Statement, https://cmss.org/policies-positions/ethics-statement/ ("The physician's primary, inviolate role is as an active advocate for each patient's care and well-being."); AMA Principles of Medical Ethics, https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics ("A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."); AACAP Code of Ethical Principles, https://www.aacap.org/AACAP/Member_Resources/Ethics/Foundation/AACAP_Code_of_Ethical_Principles.aspx ("[T]he obligation to promote the optimal wellbeing, functioning and development of youth, both as individuals and as a group … should be prioritized over familial or societal pressures.").

adhere to ethical guidelines and confront harsh consequences for reporting “child abuse” that is anything but.

CONCLUSION

For the foregoing reasons, the Plaintiffs’ Application for Temporary Injunction should be granted.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that foregoing Brief was served by electronic service upon counsel of record on March 10, 2022:

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