IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER et al., Plaintiffs, v. KAY IVEY, et al. Defendants.	Case No. 2:22-cv-184-LCB-SRW

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

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Civil Procedure 7.1, the undersigned counsel for the American Academy of Pediatrics ("AAP"), the Alabama Chapter of the American Academy of Pediatrics ("AL-AAP"), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry ("AACAP"), the American Academy of Family Physicians ("AAFP"), the American Academy of Nursing ("AAN"), 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 ("ACOG"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"), the American Medical Association ("AMA"), the American Pediatric Society ("APS"), the American Psychiatric Association ("APA"), the Association of American Medical Colleges ("AAMC"), 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 Society for Adolescent Health and Medicine ("SAHM"), the Society for Pediatric Research ("SPR"), the Society of Pediatric Nurses ("SPN"), the Societies for Pediatric Urology, and the World Professional Association for Transgender Health ("WPATH") certify that:

1. AAP, AL-AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AMA, APS, APA, AAMC, AMSPDC, the Endocrine Society, NAPNAP, PES, SAHM, SPR, SPN, SPU, and WPATH, respectively, have no parent corporation.

2. No corporations hold any stock in AAP, AL-AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AMA, APS, APA, AAMC, AMSPDC, the Endocrine Society, NAPNAP, PES, SAHM, SPR, SPN, SPU or WPATH.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae are the American Academy of Pediatrics ("AAP"), the Alabama Chapter of the American Academy of Pediatrics ("AL-AAP"), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry ("AACAP"), the American Academy of Family Physicians ("AAFP"), the American Academy of Nursing ("AAN"), 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 ("ACOG"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"), the American Medical Association ("AMA"), the American Pediatric Society ("APS"), the American Psychiatric Association ("APA"), the Association of American Medical Colleges ("AAMC"), 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 Society for Adolescent Health and Medicine ("SAHM"), the Society for Pediatric Research ("SPR"), the Society of Pediatric Nurses ("SPN"), the Societies for Pediatric Urology, and the World Professional Association for Transgender Health ("WPATH").[1]

[1] Plaintiffs and Plaintiff-Intervenor have consented to the filing of this brief; Defendants have not consented to the filing of this brief. *Amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* or their counsel made any monetary contributions intended to fund the preparation or submission of this brief.

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. *Amici* represent thousands of healthcare providers who have specific expertise with the issues raised in this brief. The Court should consider *amici*'s brief because it provides important expertise and addresses misstatements about the treatment of transgender adolescents.

INTRODUCTION

Alabama Senate Bill 184 ("the Healthcare Ban") would prohibit healthcare providers from providing or even referring patients under the age of 19 for critical, evidence-based treatments for gender dysphoria. Denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm to their mental health. The legislative findings in the Healthcare Ban mischaracterize the well-accepted medical guidelines for treating gender dysphoria in adolescents and the guidelines' supporting evidence. Below, *amici* provide the Court with an accurate description of these well-accepted treatment guidelines and summarize the scientific evidence supporting the medical interventions prohibited by the Healthcare Ban.

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.[2] 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,"[3] which Plaintiffs refer to as "transition."[4] 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 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

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[2] *See* Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) *Pediatrics* e20182162, at 2 (tbl. 1), 3 (2018) (hereinafter, "AAP Policy Statement"), https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for.

[3] *Id*. at 10.

[4] *See, e.g.*, Memorandum in Support of Preliminary Injunction at 12-16 (Dkt. # 8) (April 21, 2022).

improvements in the mental health and overall well-being of adolescents with gender dysphoria.

The Healthcare Ban disregards this medical evidence by threatening providers with a felony conviction simply for treating adolescent patients in accordance with the accepted standard of care. In addition, the Healthcare Ban prevents healthcare providers from utilizing their medical expertise in treating these adolescent patients and profoundly intrudes on the patient-provider relationship by banning referrals for gender-affirming medical treatments. Accordingly, *amici* urge this Court to grant Plaintiffs' motion for a temporary restraining order and preliminary injunction.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the well-accepted medical guidelines for treating gender dysphoria as they apply to adolescents and the evidence that suggests the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief explains how the Healthcare Ban would irreparably harm adolescents with gender dysphoria by denying care to those who need it.

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.[5] Most people have a gender identity that aligns with their sex assigned at birth.[6] However, transgender people have a gender identity that does not align with their sex assigned at birth.[7] In the United States, it is estimated that approximately 1.4 million individuals are transgender.[8] Of these individuals, approximately 10% are teenagers aged 13 to 17.[9] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

While being transgender is a normal variation of human identity,[10] 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."[11] Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5).

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[5] AAP Policy Statement at 2 (tbl. 1).

[6] *See* Am. Psychological Ass'n, *Guidelines for psychological practice with transgender and gender nonconforming people*, 70(9) American Psychologist 832, 862 (2015) (hereinafter, "Am. Psychological Ass'n Guidelines"), https://www.apa.org/practice/guidelines/transgender.pdf.

[7] *See id.* at 863.

[8] *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.

[9] *See id.* at 3.

[10] 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.

[11] AAP Policy Statement at 3.

If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.[12] Indeed, over 60% of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75% reported symptoms of generalized anxiety disorder in the preceding two weeks.[13] Even more troubling, more than 50% of this population reported having seriously considered attempting suicide,[14] and more than one in three transgender adolescents reported having attempted suicide in the preceding 12 months.[15]

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, gender-affirming medical interventions are necessary.[16] This care

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[12] *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.

[13] *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.

[14] *See id*. at 2.

[15] *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 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf.

[16] *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.

greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated.[17]

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: (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 (together, the "Guidelines").[18]

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. A Robust Mental Health Assessment Is Required Before Medical Interventions Are Provided.

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

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[17] *See id.*

[18] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. Clinical Endocrinology & Metabolism 3869 (Nov. 2017) (hereinafter, "Endocrine Society Guidelines"), 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 (hereinafter, "WPATH Guidelines").

evaluation by 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 for MHPs working with adults.[19] These include: (1) a master's degree or 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.[20]

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,

[19] *See* WPATH Guidelines at 13.

[20] *See id.* at 22.

and peers."[21] The MHP also must screen for coexisting mental health concerns, [22] which "need to be optimally managed prior to, or concurrent with, treatment of gender dysphoria."[23] If gender dysphoria is diagnosed, the Guidelines provide that the MHP should discuss treatment for gender dysphoria and any coexisting concerns, including potential risks.[24]

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.[25] The Guidelines do *not* recommend that any physical interventions (such as medications or surgery) be provided to prepubertal children with gender dysphoria.[26]

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. Before an adolescent may receive any

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[21] *Id.* at 23-24.
[22] *Id.* at 24-25.
[23] *Id.* at 25.
[24] *Id.* at 24.
[25] *See id.* at 16-17; Endocrine Society Guidelines at 3877-78.
[26] *See* WPATH Guidelines at 17-18, Endocrine Society Guidelines at 3871.

medical interventions for gender dysphoria, a qualified MHP must determine that: (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.[27] Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (5) agree with the indication for treatment, (6) confirm the patient has started puberty, and (7) confirm that there are no medical contraindications.[28]

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.[29] The purpose of puberty blockers is to delay pubertal development until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments.[30] Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible changes such as protrusion of the Adam's apple or breast

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[27] WPATH Guidelines at 19.

[28] Endocrine Society Guidelines at 3878 (tbl. 5).

[29] 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.

[30] WPATH Guidelines at 19.

growth.[31] Puberty blockers have well-known efficacy and side-effect profiles.[32] In addition, their effects are generally reversible.[33] In fact, puberty blockers have been used by pediatric endocrinologists for more than 30 years for the treatment of precocious puberty.[34] The risks of any serious adverse effects of these treatments are exceedingly rare when provided under clinical supervision.[35]

Later in adolescence—and if the criteria below are met—hormone therapy may be used to initiate puberty consistent with the patient's gender identity.[36] 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 have been addressed.[37] A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, the patient and their parents or guardians must be informed of the potential effects and side effects, and the patient and the patient's

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

[32] Martin, *supra* note 29 at 2.

[33] *See id.*

[34] *See id.*

[35] *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty suppression and executive functioning: an fMRI-study in adolescents with gender dysphoria*, 6 Psychoneuroendocrinology 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).

[36] Martin, *supra* note 29 at 2.

[37] Endocrine Society Guidelines at 3878 (tbl. 5).

parents or guardians must give their informed consent.[38] Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[39] 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.[40]

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 monitoring to mitigate any potential risks.[41] 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."[42]

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process, Employing the Same Scientific Rigor That Underpins Other Medical Guidelines.

The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous

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[38] *See id.*

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

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

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

[42] Martin, *supra* note 29, at 1.

requirements—as other guidelines promulgated by *amici* and other medical organizations.

For example, the Endocrine Society's Guidelines were developed following a 26-step, 26-month drafting, comment, and review process.[43] The Endocrine Society imposes strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[44] That GRADE assessment is then reviewed, re-reviewed, and reviewed again by multiple, independent groups of professionals. [45] Further, the Endocrine Society continually reviews its own guidelines and recently determined the 2017 transgender care guidelines continue to reflect the best available evidence.

The WPATH standards are the result of a drafting, comment, and review process that took five years.[46] The draft guidelines went through journal peer-review and were publicly available for discussion and debate, including multiple rounds of feedback from experts in the field as well as from transgender individuals.[47] They

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[43] *See, e.g.*, Endocrine Society Guidelines at 3872-73 (high-level overview of methodology).

[44] *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.

[45] Endocrine Society, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology (last visited May 4, 2022).

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

[47] *See id.*

are periodically updated to account for new developments in the research and practice, and WPATH is in the process of its eighth revision.[48]

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.[49] Eight studies have been published that investigated the use of puberty blockers on adolescents suffering from gender dysphoria,[50] and six studies have been published that investigated the use of hormone therapy to treat adolescents suffering from gender dysphoria.[51] These

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

[49] *See* Martin, *supra* note 29, at 2.

[50] *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).

[51] *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.,

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.[52] 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.[53] Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it

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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; 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 (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.

[52] *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.

[53] *See id.*

reported lifetime suicidal ideation.[54] Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically-significant degree after receiving gender-affirming hormone treatment.[55]

As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning.[56] A 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.[57] "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."[58]

As scientists and researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming

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[54] *See id.*

[55] *See* 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.

[56] *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.

[57] 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.

[58] Stephen M. Rosenthal, *Challenges in the care of transgender and gender-diverse youth: an endocrinologist's view*, 17(10) Nature Rev. Endocrinology 581, 586 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/34376826.

treatments prohibited by the Healthcare Ban are effective for the treatment of gender dysphoria. For these reasons, and as at least one court has recognized, the use of the gender-affirming medical interventions specified in the Guidelines is supported by all mainstream pediatric organizations, representing thousands of physicians across multiple disciplines.[59]

D. The Legislative Findings Are Factually Inaccurate and Ignore the Recommendations of the Medical Community.

1. There Is No Accepted Protocol of "Watchful Waiting" for Adolescents With Gender Dysphoria.

The Healthcare Ban's legislative findings endorse a "wait-and-see approach," based on the assumption that "a large majority" of children with signs of gender nonconformity will ultimately "resolve[] to an identity congruent with their sex by late adolescence."[60] This assertion lacks scientific support.

While some prepubertal children who experience gender dysphoria may go on to identify with their sex assigned at birth by the time they reach puberty, there are *no* studies to support the proposition that *adolescents* with gender dysphoria will come to identify with their sex assigned at birth, whether they receive treatment or

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[59] *See, e.g.*, *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 890 (E.D. Ark. 2021) ("The consensus recommendation of medical organizations is that the only effective treatment for individuals at risk of or suffering from gender dysphoria is to provide gender-affirming care.")

[60] Ala. Vulnerable Child Compassion and Protection Act, S.B. 184, No. 2022-289, § 2(5) (Ala. 2022).

not.[61] On the contrary, "[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult."[62] In this regard, while some practitioners use "watchful waiting"—i.e., waiting until puberty begins before considering social transition[63]—with prepubertal children, it is not recommended for *adolescents*. Using "watchful waiting" with gender-dysphoric adolescents can cause immense harm by denying them treatment that could alleviate their distress and forcing them to experience full endogenous puberty, resulting in physical changes that may be reversed—if at all—only through surgery.

2. Claims That the Medical Community Is "Aggressively Pushing" for Medical Interventions Are False.

The Healthcare Ban's legislative findings assert that "[s]ome in the medical community are aggressively pushing for interventions on minors."[64] This is false—adolescents are only provided medical interventions if they meet the rigorous criteria under the Guidelines. While it is true that the number of referrals to gender clinics has increased in recent years, this increase has coincided with a decrease in the

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[61] *See, e.g.*, Stewart L. Adelson, *Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents*, 51 J. Am. Acad. of Child & Adolescent Psychiatry 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211 ("In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood").

[62] Rosenthal, *supra* note 58 at 585.

[63] AAP Policy Statement at 4.

[64] S.B. 184 § 2(6).

stigma against transgender people, an increase in public awareness of the existence of gender dysphoria and the availability of gender-affirming care, and improvements in insurance coverage, all of which likely led more people with gender identity issues to seek help. In any event, not all patients who seek care at gender clinics receive medical interventions. In fact, a 2018 study showed that the percentage of patients who presented to a gender clinic for evaluation and received medical interventions has actually *decreased* over time.[65]

III. The Healthcare Ban Would Irreparably Harm Many Adolescents With Gender Dysphoria By Denying Them the Treatment They Need.

The Healthcare Ban denies adolescents with gender dysphoria access to medical interventions that alleviate suffering, are grounded in science, and are endorsed by the medical community. The medical treatments prohibited by the Healthcare Ban can be a crucial part of treatment for adolescents with gender dysphoria and necessary to preserve their health. As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of

[65] *See* Chantal M. Wiepjes et al., *The Amsterdam cohort of gender dysphoria study (1972-2015): trends in prevalence, treatment, and regrets*. 15(4) J. Sexual Med. 582, 582 (Feb. 2018), https://pubmed.ncbi.nlm.nih.gov/29463477.

suicide attempts and significant improvement in quality of life.[66] In light of this evidence supporting the connection between lack of access to gender-affirming care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, Plaintiffs' motion for a temporary restraining order and preliminary injunction should be granted.

[66] *See* M. Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) Clinical Endocrinology 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; *see also* Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, *supra* note 50.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on May 4, 2022, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to counsel of record.

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Of Counsel