No. 23-2681

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

DYLAN BRANDT ET AL.,
Plaintiffs-Appellees,
v.

TIM GRIFFIN, ET AL.,
Defendants-Appellants

On Appeal from the United States District Court for the
Eastern District of Arkansas
Case No. 4:21-CV-00450-JM (Hon. James M. Moody Jr.)

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Local Rule 26.1–1, the undersigned counsel for the American Academy of Pediatrics ("AAP"), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry ("AACAP"), 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 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 Medical School Pediatric Department Chairs, Inc. ("AMSPDC"), the Association of American Medical Colleges ("AAMC"), the Arkansas Chapter of the American Academy of Pediatrics ("ARAAP"), the Arkansas Council on Child and Adolescent Psychiatry ("ACCAP"), the Arkansas Medical Society ("AMS"), the Arkansas Psychiatric Society, 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 ("SPU"), and the World Professional Association for Transgender Health ("WPATH") certify that:

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

2. No corporations hold any stock in AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOP, ACP, AMA, APS, APA, AMSPDC, AAMC, ARAAP, ACCAP, AMS, the Arkansas Psychiatric Society, 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 Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry ("AACAP"), 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 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 Medical School Pediatric Department Chairs, Inc. ("AMSPDC"), the Association of American Medical Colleges ("AAMC"), the Arkansas Chapter of the American Academy of Pediatrics ("ARAAP"), the Arkansas Council on Child and Adolescent Psychiatry ("ACCAP"), the Arkansas Medical Society ("AMS"), the Arkansas Psychiatric Society, 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 ("SPU"), and the World Professional Association for Transgender Health ("WPATH") (collectively, "*amici*").[1]

Amici are professional medical and mental health organizations seeking to ensure that all adolescents, including those with gender dysphoria, receive the optimal medical and mental health care 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.

[1] The parties have consented to the filing of this brief. Fed. R. App. P. 29(a)(2). *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. Fed. R. App. P. 29(a)(4)(E).

INTRODUCTION

On April 6, 2021, the Arkansas General Assembly passed Act 626 over the Governor's veto. The Act (hereinafter "the Healthcare Ban") prohibits healthcare providers from providing patients under 18 with critical, medically necessary, evidence-based care for gender dysphoria.[2] Denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm. Below, *amici* provide the Court with an accurate description of the relevant treatment guidelines and summarize the scientific evidence supporting the gender-affirming medical care for adolescents that is prohibited by the Healthcare Ban.[3]

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

[2] Ark. Code Ann. §§ 20-9-1501 to 1502 prohibit physicians from providing certain medical treatments to adolescents including puberty-blocking drugs and cross-sex hormones. These provisions also prohibit physicians from referring adolescents to professionals who would provide those treatments. *Id.* As discussed in this brief, these treatments are medically necessary care for certain adolescents with gender dysphoria.

[3] In this brief, the term "gender-affirming medical care" refers to the use of gonadotropin-releasing hormone (GnRH) analogues and/or hormone therapy to treat gender dysphoria. Because this brief focuses primarily on adolescents, it does not discuss surgeries that are typically available to transgender adults.

patient's life.[4] 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 well-accepted protocol for treating gender dysphoria is "gender-affirming care."[5] Gender-affirming care is care that supports an individual with gender dysphoria 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.[6] For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical care

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[4] *See, e.g.*, Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) Pediatrics e20182162, at 2–3, tbl.1 (2018) (hereinafter, "AAP Policy Statement"), https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for. The American Academy of Pediatrics recently voted to reaffirm the AAP Policy Statement. See Alyson Sulaski Wyckoff, *American Academy of Pediatrics, AAP Reaffirms Gender-Affirming Care Policy, Authorizes Systematic Review of Evidence to Guide Update* (Aug. 4, 2023), https://publications.aap.org/aapnews/news/25340/AAP-reaffirms-gender-affirming-care-policy. AAP's review and reaffirmation was undertaken as part of its normal procedures to perform such reviews on a five-year basis.

[5] *Id.* at 10.

[6] *See, e.g.*, Christy Mallory et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (June 2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf.

to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including gender-affirming medical care provided to carefully evaluated patients who meet diagnostic criteria, can alleviate clinically-significant distress and lead to significant improvements in the mental health and overall well-being of adolescents with gender dysphoria.[7]

The Healthcare Ban disregards this medical evidence by precluding healthcare providers from providing adolescent patients with treatments for gender dysphoria in accordance with the well-accepted protocol. Accordingly, *amici* urge this Court to affirm the district court's permanent injunction.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the professionally 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 supports the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief corrects multiple inaccuracies regarding the professionally accepted medical guidelines for treating

[7] *See* Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 NEW ENG. J. MED. 579, at 2 (2021), https://www.nejm.org/doi/full/10.1056/NEJMp2106314 (providing an overview of the scientific basis underlying gender-affirming care and its demonstrated effectiveness in "alleviat[ing] gender dysphoria").

gender dysphoria and explains how the Healthcare Ban would irreparably harm adolescents with gender dysphoria by denying crucial 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.[8] Most people have a gender identity that aligns with their sex assigned at birth.[9] However, transgender people have a gender identity that does not align with their sex assigned at birth.[10] In the United States, it is estimated that approximately 1.4 million individuals are transgender.[11] Of these individuals, approximately 10% are teenagers aged 13 to 17.[12] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

Today, there is an increasing understanding that being transgender is a normal

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[8] AAP Policy Statement, *supra* note 4, at 2 tbl.1.

[9] *See* Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) AMERICAN PSYCHOLOGIST 832, 862 (2015), https://www.apa.org/practice/guidelines/transgender.pdf.

[10] *See id.* at 832.

[11] *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.

[12] See *id.* at 3.

variation of human identity.[13] However, 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."[14] Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR).[15]

If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.[16] 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

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[13] 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.

[14] AAP Policy Statement, *supra* note 4, at 3.

[15] See Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022).

[16] *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/.

preceding two weeks.[17] Even more troubling, more than 50% of this population reported having seriously considered attempting suicide,[18] and more than one in three transgender adolescents reported having attempted suicide in the preceding 12 months.[19]

II. The Widely Accepted Guidelines for Treating Adolescents with Gender Dysphoria Provide for Gender-Affirming Medical Care 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 care is necessary.[20] Gender-affirming care greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated.[21]

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[17] *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.

[18] *See id*. at 2.

[19] *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.

[20] *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.

[21] See *id.*

A. The Gender Dysphoria Treatment Guidelines Include Thorough Mental Health Assessments and, for Some Adolescents, Gender-Affirming Medical Care.

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 Transgender and Gender Diverse People (together, the "Guidelines").[22] The Guidelines have been developed by expert clinicians and researchers who have worked with patients with gender dysphoria for many years.

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

[22] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (Nov. 2017) (hereinafter, "Endocrine Soc'y Guidelines"), https://academic.oup.com/jcem/article/102/11/3869/4157558; WPATH, *Standards of Care for the Health of Transgender and Gender Diverse People* (8th Version) (hereinafter "WPATH Guidelines"), https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.

1. The Guidelines Do Not Recommend Gender-Affirming Medical Care for Prepubertal Children.

For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family, such as through psychotherapy and social transitioning.[23] The Guidelines do *not* recommend that prepubertal children with gender dysphoria receive gender-affirming medical care or surgeries.[24]

2. A Robust Diagnostic Assessment Is Required Before Gender-Affirming Medical Care Is Provided.

In contrast to prepubertal children, the Guidelines do contemplate the possibility that transgender adolescents with gender dysphoria could receive gender-affirming medical care, provided certain criteria are met. According to the Guidelines, gender-affirming medical care should be provided only after a thorough evaluation by a HCP who: (1) is licensed by their statutory body and holds a master's degree or equivalent in a relevant clinical field; (2) has expertise and received theoretical and evidence-based training in child, adolescent, and family mental health; (3) has expertise and received training in gender identity development, gender diversity in children and adolescents, can assess capacity to

[23] *See id.* at S73–S74; Endocrine Soc'y Guidelines, *supra* note 22, at 3877–78..

[24] *See* WPATH Guidelines, *supra* note 22, at S64, S67; Endocrine Soc'y Guidelines, *supra* note 22, at 3871.

consent, and possesses knowledge about gender diversity across the life span; (4) has expertise and received training in autism spectrum disorders and other neurodevelopmental presentations, or collaborates with a developmental disability expert when working with neurodivergent patients; and (5) continues engagement in professional development in areas relevant to gender diverse children, adolescents, and families.[25]

Prior to developing a treatment plan, the HCP should conduct a "comprehensive biopsychosocial assessment" of the adolescent patient.[26] The HCP conducts this assessment to "understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs," so that the resulting treatment plan is appropriately individualized.[27] This assessment must be conducted collaboratively with the patient and their caregiver(s).[28]

3. In Certain Circumstances, the Guidelines Provide for the Use of Gender-Affirming Medical Care to Treat Adolescents with Gender Dysphoria.

For youths with gender dysphoria that continues into adolescence—after the onset of puberty—the Guidelines provide that, in addition to mental health care,

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[25] *See* WPATH Guidelines, *supra* note 22, at S49.

[26] *Id.* at S50.

[27] *Id.*

[28] *Id.*

gender-affirming medical care may be indicated. Before an adolescent may receive any gender-affirming medical care for treating gender dysphoria, the Guidelines, collectively provide that a qualified HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender dysphoria or gender incongruence according to an established taxonomy;[29] (2) the adolescent has demonstrated a sustained and persistent pattern of gender nonconformity or gender dysphoria; (3) the adolescent has demonstrated the emotional and cognitive maturity required to provide informed consent for treatment; (4) any coexisting psychological, medical, or social problems that could interfere with diagnosis, treatment, or the adolescent's ability to consent have been addressed; (5) the adolescent has been informed of the reproductive effects of treatment in the context of their stage in pubertal development and discussed fertility preservation options; and (6) the adolescent has reached Tanner stage 2 of puberty to initiate pubertal suppression.[30] Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (7) agree with the indication for treatment, (8) confirm the patient has started puberty, and (9) confirm that there are no medical contraindications.[31]

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[29] Endocrine Soc'y Guidelines, *supra* note 24, at 3876; WPATH Guidelines, *supra* note 22, at S47, S48.

[30] WPATH Guidelines, *supra* note 22, at S59–65.

[31] Endocrine Soc'y Guidelines, *supra* note 22, at 3878 tbl.5.

If all of the above criteria are met, and the patient and their parents provide informed consent, gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty.[32] 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.[33] Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible bodily changes such as protrusion of the Adam's apple or breast growth.[34] Puberty blockers have well-known efficacy and side-effect profiles.[35] Their effects are generally reversible, and when a patient discontinues their use, the patient resumes endogenous puberty.[36] In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.[37] The risks of any serious adverse effects from

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[32] WPATH Guidelines, supra note 22, at S61–62; Endocrine Soc'y Guidelines, supra note 22, at 3878 tbl.5; Martin, *supra* note 7.

[33] WPATH Guidelines, *supra* note 22, at S112.

[34] *See* AAP Policy Statement, *supra* note 4, at 5.

[35] *See* Martin, *supra* note 7, at 2.

[36] See *id.*

[37] See F. Comite et al., *Short-Term Treatment of Idiopathic Precocious Puberty with a Long-Acting Analogue of Luteinizing Hormone-Releasing Hormone — A Preliminary Report*, 305 NEW ENG. J. MED. 1546 (1981).

puberty blockers are exceedingly rare when provided under clinical supervision.[38]

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.[39] Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[40] Hormone therapy is only prescribed when a qualified mental health professional has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity to consent to the treatment, and that any coexisting problems have been addressed.[41] A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, and the patient and their parents or guardians must be informed of the potential effects and side effects and give their

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[38] *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:// https://pubmed.ncbi.nlm.nih.gov/31974217/ (exceedingly low risk of delayed bone mineralization from hormone treatment).

[39] Martin, *supra* note 7, at 2.

[40] *See* AAP Policy Statement, *supra* note 4, at 6.

[41] Endocrine Soc'y Guidelines, *supra* note 22, at 3878 tbl.5.

informed consent.[42] Although some of the changes caused by hormone therapy become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones.[43]

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.[44] 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 health care team. There is "no one-size-fits-all approach to this kind of care."[45]

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[42] See *id.*

[43] *See* AAP Policy Statement, *supra* note 4, at 5–6.

[44] *See* Endocrine Soc'y Guidelines, *supra* note 22, at 3871, 3876.

[45] Martin, *supra* note 7, at 1.

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 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.[46] The Endocrine Society imposes strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[47] That GRADE assessment is then reviewed, re-reviewed, and reviewed again by multiple, independent groups of professionals.[48] Reviewers are subject to

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[46] *See, e.g.*, Endocrine Soc'y Guidelines, *supra* note 22, at 3872–73 (high-level overview of methodology).

[47] *See* Gordon Guyatt et al., *GRADE Guidelines: 1. Introduction - GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. CLINICAL EPIDEMIOLOGY 383 (2011), https://ahpsr.who.int/docs/librariesprovider11/publications/supplementary-material/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.ncbi.nlm.nih.gov/pmc/articles/PMC2335261.

[48] Endocrine Soc'y, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology.

strict conflict of interest rules, and there is ample opportunity for feedback and debate through the years-long review process.[49] Further, the Endocrine Society continually reviews its own guidelines and recently determined that the 2017 transgender care guidelines continue to reflect the best, most up-to-date available evidence.

First published in 1979, the WPATH Standards of Care are currently in their 8th Edition. The current Standards of Care are the result of a robust drafting, comment, and review process that collectively took five years.[50] The draft guidelines went through rigorous review and were publicly available for discussion and debate, receiving a total of 2,688 comments.[51] 119 authors were ultimately involved in the final draft, including feedback from experts in the field as well as from transgender individuals and their families.[52]

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

Multiple studies indicate that adolescents with gender dysphoria who receive gender-affirming medical care experience improvements in their overall well-

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[49] See *id.*

[50] *See* WPATH Guidelines, *supra* note 22, at S247-51.

[51] See *id.*

[52] See *id.*

being.[53] A number of studies have been published that investigated the use of puberty blockers on adolescents with gender dysphoria,[54] and/or the use of hormone therapy to treat adolescents with gender dysphoria.[55] These studies find positive

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[53] *See* Martin, *supra* note 7, at 2.

[54] 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); Diana M. Tordoff et al., *Mental Health Outcomes In Transgender And Nonbinary Youths Receiving Gender-Affirming Care*, 5(2) JAMA NETWORK OPEN e220978 (2022), https://pubmed.ncbi.nlm.nih.gov/35212746/.

[55] *See, e.g.*, Achille, *supra* note 54; Luke R. Allen et al., *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*, 7(3) CLINICAL
(continued…)

mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.[56]

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.[57] The study found that those who received puberty

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PRAC. PEDIATRIC PSYCH. 302 (2019), https://psycnet.apa.org/record/2019-52280-009; Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388(3) NEW ENG. J. MED 240-50 (2023); 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); Kuper, *supra* note 54; 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.

[56] The data likewise indicates that adults who receive gender-affirming care experience positive mental health outcomes. *See, e.g.*, Zoe Aldridge et al., *Long Term Effect of Gender Affirming Hormone Treatment on Depression and Anxiety Symptoms in Transgender People: A Prospective Cohort Study*, 9 ANDROLOGY 1808–1816 (2021).

[57] See Turban, *Pubertal Suppression For Transgender Youth And Risk of Suicidal Ideation*, *supra* note 54.

blocking 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.[58] Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.[59] 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.[60] A study published in January 2023, following 315 participants age 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated with decreased symptoms of depression and anxiety.[61]

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.[62] A six-year follow-up study of 55 individuals from the 2011 study found that

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[58] See *id.*

[59] See *id.*

[60] *See* Allen, *supra* note 55.

[61] *See* Chen, *supra* note 55.

[62] See Vries, *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, *supra* note 54.

subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety.[63] "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."[64]

As scientists and researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming medical care prohibited by the Healthcare Ban is effective for the treatment of gender dysphoria.

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

To justify the Healthcare Ban, the Arkansas Legislature makes a number of findings which are factually incorrect and contradicted by the available scientific evidence.[65] These findings assert that puberty blockers and gender-affirming hormone therapy are not consistent with professional medical standards and that there is insufficient evidence that gender-affirming medical care is safe and

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[63] Vries, *Young Adult Psychological outcome After Puberty Suppression and gender Reassignment*, *supra* note 54.

[64] 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.

[65] *See* Ark. HB 1570 § 2.

effective.[66] However, this assertion is premised on speculative and discredited claims about gender dysphoria and mischaracterizations of the Guidelines and scientific research regarding this gender-affirming medical care.

A. There Is No Evidence That Transgender Identity Is Caused by Underlying Mental Illness.

The Arkansas Legislature speculates that mental health concerns such as depression and anxiety may cause individuals to develop a gender identity that is incongruent with their sex assigned at birth.[67] However, the report cites no evidence for this assertion, and the scientific research suggests that the reverse is true: research has shown that transgender individuals frequently experience discrimination, harassment, and even violence on account of their gender identity,[68]

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[66] *See id.* at §§ 2(2)(6)(B) & 2(15).

[67] *Id.* at 2(2)(A)(4). ("[I]ndividuals struggling with distress at identifying with their biological sex often have already experienced psychopathology, which indicates these individuals should be encouraged to seek mental health services to address comorbidities and underlying causes of their distress before undertaking any hormonal or surgical intervention[.]")

[68] *See, e.g.*, Rebecca L. Stotzer, *Violence Against Transgender People: A Review of United States Data*, 14(3) AGGRESSION & VIOLENT BEHAV. 170–179 (2009); Joseph G. Kosciw et al., *The 2017 National School Climate Survey*, GLSEN, at 94 (2018), https://www.glsen.org/sites/default/files/2019-10/GLSEN-2017-National-School-Climate-Survey-NSCS-Full-Report.pdf; *see also* Amit Paley, *The Trevor Project 2020 National Survey*, https://www.thetrevorproject.org/survey-2020/ ("Discrimination & Physical Harm" section) (noting that 40 percent of transgender students reported being physically threatened or harmed due to their gender identity).

and that these experiences lead to mental health concerns, including, for example, depression and anxiety.[69]

B. The Vast Majority of Adolescents Diagnosed with Gender Dysphoria Will Persist Through Adulthood.

The Arkansas Legislature asserts that "[f]or the small percentage of children who are gender nonconforming . . . the majority come to identify with their biological sex in adolescence or adulthood."[70] These legislative findings improperly conflate prepubertal children with adolescents, which is an important distinction, as prepubertal children are not eligible under the Guidelines for any of the gender-affirming medical care prohibited by the Healthcare Ban.[71] The Guidelines endorse the use of gender-affirming medical care only to treat adolescents and adults with

[69] See Rylan J. Testa et al., *Suicidal Ideation in Transgender People: Gender Minority Stress and Interpersonal Theory Factors*, 126(1) J. ABNORMAL PSYCH. 125–36 (2017); Jessica Hunter et al., *Gender Minority Stress in Trans and Gender Diverse Adolescents and Young People*, 26(4) CLINICAL CHILD PSYCH. & PSYCHIATRY 1182–1195 (2021).

[70] Ark. HB 1570, *supra* note 65, at § 2(3).

[71] See Susan D. Boulware et al., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims*, 18 (Apr. 28, 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4102374.

gender dysphoria, and only when the relevant criteria are met.[72]

There are *no* studies to support the proposition that adolescents with gender dysphoria are likely to later identify as their sex assigned at birth, whether they receive treatment or not.[73] 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."[74]

Moreover, while detransitioning may occur for many reasons, detransitioning is not the same as regret. The State incorrectly assumes that an individual who detransitions—the definition of which varies from study to study[75]—must do so because they have come to identify with their sex assigned at birth. This ignores the

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[72] *See* Endocrine Soc'y Guidelines, *supra* note 22, at 3871, 3879; WPATH Guidelines, *supra* note 22, at S32, S48.

[73] 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. 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").

[74] Rosenthal, *supra* note 64, at 585.

[75] Michael S. Irwig, *Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly Complex Phenomenon*, J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 1 (June 2022), https://pubmed.ncbi.nlm.nih.gov/35678284 ("Detransition refers to the stopping or reversal of transitioning which could be social (gender presentation, pronouns), medical (hormone therapy), surgical, or legal.").

most common reported factors that contribute to a person's choice to detransition, such as pressure from parents and discrimination.[76]

In addition, while the percentage of adolescents seeking gender-affirming care has increased, that percentage remains very low—only 1.8% of high-school students identify as transgender.[77] Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expanded care options.[78]

C. There Is No Accepted Protocol of "Watchful Waiting" for Adolescents with Gender Dysphoria.

Based on its unsupported claim that many adolescents with gender dysphoria will eventually come to identify as their sex assigned at birth, the Arkansas legislature questions the medical necessity of puberty blockers and hormone therapy for adolescents and suggests that a "watchful waiting" approach may be more appropriate.[79] In this regard, some practitioners use a "watchful waiting" approach for *prepubertal* children with gender dysphoria, which involves waiting until the

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[76] *See id.* (discussing "largest study to look at detransition").

[77] *See* Johns et al., *supra* note 19, at 68.

[78] *See* Boulware, *supra* note 71, at 20.

[79] *See* Ark. HB 1570, *supra* note 65, at § 2(3) (For the small percentage of children who are gender nonconforming . . . the majority come to identify with their biological sex in adolescence or adulthood, thereby rendering most physiological interventions unnecessary[.]").

patient reaches adolescence before considering social transition.[80] However, "watchful waiting" is not recommended for adolescents with gender dysphoria.[81] It can cause immense harm by denying these patients the evidence-based treatments that could alleviate their distress, and forcing them to experience full endogenous puberty, resulting in some physical changes that may be reversed—if at all—only through surgery or other invasive procedures.[82]

IV. 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 in Arkansas access to medical care that is designed to improve health outcomes and alleviate suffering and that is grounded in science and endorsed by the medical community. The gender-affirming medical care 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,

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[80] Jason Rafferty, *Ensuring Comprehensive Care & Support for Transgender & Gender-Diverse Children & Adolescents*, AM. ACAD. OF PEDIATRICS, at 4 (Oct. 2018).

[81] *Id.*; AAP Policy Statement, *supra* note 4, at 4; WPATH Guidelines, *supra* note 22, at S112–113.

[82] AAP Policy Statement, *supra* note 4, at 4.

anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life.[83] In light of this evidence supporting the connection between lack of access to gender-affirming medical care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, the District Court's decision granting the permanent injunction should be affirmed.

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Respectfully submitted,

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[83] 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(2) CLINICAL ENDOCRINOLOGY 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; *see also* Turban, *supra* note 54.

CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the type-volume limitations set forth in Fed. R. App. P. 32(a)(7)(B)(i) and. This brief contains 5,406 words, including all headings, footnotes, and quotations, and excluding the parts of the response exempted under Fed. R. App. P. 32(f).

2. In addition, this brief complies with the typeface and type style requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman font.

3. Additionally, pursuant to Eighth Circuit Local Rule 28A(h)(2), the undersigned counsel certifies that this PDF file was scanned for viruses, and no viruses were found on the file.

/s/ Cortlin H. Lannin
Cortlin H. Lannin

CERTIFICATE OF SERVICE

I hereby certify that on December 14, 2023, 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.

/s Cortlin H. Lannin
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