In the

Supreme Court of Ohio

MADELINE MOE, *ET AL.*,	:	Case No. 2025-0472
Appellees,	:	On appeal from the Franklin County Court of Appeals,
v.	:	Tenth Appellate District
DAVE YOST, *ET AL.*,	:	Court of Appeals Case No. 24AP-483
Appellants.	:	

BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF APPELLEES' MEMORANDUM IN RESPONSE TO MEMORANDUM IN SUPPORT OF JURISDICTION

D. Jean Veta* (*pro hac vice* pending)
*Counsel of Record
William Isasi (*pro hac vice* pending)
COVINGTON & BURLING LLP
One CityCenter
850 Tenth St., N.W.
Washington, D.C. 20001
Phone: (202) 662-6000
jveta@cov.com

Subodh Chandra (0069233)
THE CHANDRA LAW FIRM LLC
The Chandra Law Building
1265 West Sixth Street, Suite 400
Cleveland, Ohio 44113
Phone: (216) 578-1700
Subodh.Chandra@ChandraLaw.com

Counsel for Amici Curiae

FREDA J. LEVENSON* (0045916)
*Counsel of Record
AMY GILBERT (100887)
ACLU of Ohio Foundation, Inc.
4506 Chester Avenue

Dave Yost (0056290)
OHIO ATTORNEY GENERAL
T. Elliot Gaiser * (0096145)
SOLICITOR GENERAL
*Counsel of Record
Erik Clark (0078732)
DEPUTY ATTORNEY GENERAL
Stephen P. Carney (0063460)
DEPUTY SOLICITOR GENERAL
Amanda Narog (0093954)
ASSISTANT ATTORNEY GENERAL
30 East Broad Street, 17th Floor
Columbus, Ohio 43215
614.466.8980
614.466.5087 fax
thomas.gaiser@ohioago.gov

Counsel for Appellants
Dave Yost, et al.

Cleveland, Ohio 44103
flevenson@acluohio.org
agilbert@acluohio.org

DAVID J. CAREY (0088787)
CARLEN ZHANG-D'SOUZA (93079)
ACLU of Ohio Foundation, Inc. 1108
City Park Ave., Ste. 203
Columbus, Ohio 43206
dcarey@acluohio.org
czhangdsouza@acluohio.org

Counsel for Appellees Madeline Moe, et al.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae are the American Academy of Pediatrics, the Academic Pediatric Association, the American Academy of Child & Adolescent Psychiatry, the American Academy of Family Physicians, the American Academy of Nursing, the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality, the American College of Obstetricians and Gynecologists, the American College of Osteopathic Pediatricians, the American College of Physicians, the American Pediatric Society, the American Psychiatric Association, the Association of American Medical Colleges, the Endocrine Society, the National Association of Pediatric Nurse Practitioners, the Northeast Ohio Society of Child and Adolescent Psychiatry, the Ohio Academy of Family Physicians, the Ohio Chapter of the American Academy of Pediatrics, the Ohio Psychiatric Physicians Association, the Pediatric Endocrine Society, the Pediatric Endocrinology Nursing Society, the Societies for Pediatric Urology, the Society for Adolescent Health and Medicine, the Society of Pediatric Nurses, and the World Professional Association for Transgender Health (collectively, "amici").

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 scientific expertise and consensus, and addresses misstatements about the treatment for transgender adolescents.

INTRODUCTION

On April 24, 2024, H.B. 68 ("the Ban") took effect in Ohio, banning healthcare providers from providing patients under 18 with critical, medically necessary, evidence-based treatments for

gender dysphoria. H.B. 68, 135th Legis. (2024). The Ban makes the provision of such treatments "unprofessional conduct," excludes coverage for such treatments under the Ohio Medicaid program, and subjects healthcare providers to professional discipline. Ohio Rev. Code Ann. § 3129.02–06. Denying such evidence-based medical care to adolescents who meet the requisite criteria puts them at risk of significant harm. An Ohio Court of Appeals held that the Ban is unconstitutional, but Appellants ask this Court to overturn this decision. Below, *amici* provide the Court with an accurate description of the treatment guidelines and summarize the scientific evidence supporting the gender-affirming medical care for adolescents prohibited by the Ban.[1]

Gender dysphoria is a recognized medical condition characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to a marked incongruence between the patient's gender identity (i.e., the innate sense of oneself as being a particular gender) and sex assigned at birth. 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), https://perma.cc/DB5G-PG44 ("AAP Policy"). If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with suicidality. Effective treatment of gender dysphoria saves lives.

The medical community, including the respected professional organizations participating here as *amici*, widely recognizes that the appropriate protocol for treating gender dysphoria in transgender adolescents is "gender-affirming care." *Id*. at 10. Gender-affirming care supports an

[1] 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, nor does it discuss the treatment guidelines for gender dysphoria in transgender adults affected by the Ban.

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. Christy Mallory et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (June 2019), https://perma.cc/HXY3-UX2J. For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical care to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including the prescription of puberty blockers and hormone therapy to carefully evaluated patients who meet diagnostic criteria, can alleviate clinically significant distress and lead to significant improvements in the mental health and overall wellbeing of adolescents with gender dysphoria. 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://perma.cc/BR4F-YLZS.

The Ban disregards this medical evidence by effectively denying adolescents' access to treatments for gender dysphoria in accordance with the well-accepted protocol. Accordingly, *amici* urge this Court to rule in favor of Appellees and uphold the Appellate Decision.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria, and 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, the evidence that supports the effectiveness of this care, and how the Ban would irreparably harm adolescents with gender dysphoria by effectively denying access to crucial care.

I. Understanding Gender Identity and Gender Dysphoria.

Gender identity refers to a person's deep internal sense of belonging to a particular gender.

AAP Policy at 2 tbl.1. Most people are "cisgender:" meaning they have a gender identity that aligns with their sex assigned at birth. Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) AMERICAN PSYCHOLOGIST 832, 861–62 (2015), https://www.apa.org/practice/guidelines/transgender.pdf. But transgender people have a gender identity that does not align with their sex assigned at birth. *Id.* at 863. In the United States, approximately 1.6 million individuals identify as transgender. Jody L. Herman et al., *How Many Adults and Youth Identify as Transgender in the United States?*, Williams Inst., at 2 (June 2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf. Of these individuals, approximately 10% are teenagers aged 13 to 17. *Id.* at 3. Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

Today, there is an increasing acceptance of being transgender as a normal variation of human identity. 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; Am. Psychological Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (Feb. 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf. But 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." AAP Policy at 5. Gender dysphoria is a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR). Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022); *see also* World Health Org., International Classification of Diseases,

Eleventh Revision (ICD-11) (2019/2021) ("Gender incongruence is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.").

If untreated or inadequately treated, gender dysphoria may lead to depression, anxiety, self-harm, and suicidality. Brayden N. Kameg & Donna G. Nativio, *Gender Dysphoria In Youth: An Overview For Primary Care Providers*, 30(9) J. AM. ASS'N NURSE PRAC. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668. In contrast, with treatment, transgender adolescents with gender dysphoria can mature into thriving adults. *See infra* Section II.C.

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, puberty blockers and hormone therapy are necessary. *See, e.g.*, Endocrine Soc'y, *Transgender Health: An Endocrine Society Position Statement* (2020), https://www.endocrine.org/advocacy/position-statements/transgender-health. Gender-affirming care greatly reduces the negative physical and mental-health consequences that result when gender dysphoria is untreated. *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"). Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (Nov. 2017) ("ES Guidelines"),

https://academic.oup.com/jcem/article/102/11/3869/4157558; WPATH, *Standards of Care for the Health of Transgender and Gender Diverse People* (8thVersion) ("WPATH SOC-8"), https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644. 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 healthcare professional ("HCP"). Further, the Guidelines provide that each patient who receives gender-affirming care should receive only medically necessary and appropriate care that is tailored to the patient's individual needs and that is based on the best evidence possible along with clinical experience. WPATH SOC-8 at S16–S18; ES Guidelines at 3872–73.

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. WPATH SOC-8 at S73–S74; ES Guidelines at 3877–78. ("Social transition" refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm. WPATH SOC-8 at S75.) The Guidelines do *not* recommend that prepubertal children with gender dysphoria receive puberty blockers, hormone therapy, or surgeries. WPATH SOC-8 at S64, S67; ES Guidelines at 3871.

The State justifies the Ban by claiming that gender dysphoria experienced by children may not persist into adulthood. H.B. 68 § 2(C), 135th Legis. (2024). The State improperly conflates prepubertal children—who are *ineligible* under the Guidelines for any medical care targeted in the Ban—with adolescents. 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, Yale L. Sch. 1, 18 (Apr. 28, 2022), https://perma.cc/HG68-A5DQ. 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. *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 (2012), https://perma.cc/MYL6-G4L5. Rather, studies examining transgender individuals over a period of time have observed that individuals who experience a worsening of gender dysphoria with the onset of puberty have a very high likelihood of being a transgender adult. Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sex. Med. 1892, 1895 (2008), https://perma.cc/D5HJ-QAHS; Peggy T. Cohen-Kettenis & Daniel Klink, *Adolescents with Gender Dysphoria*, 29 Best Practices & Research Clin. Endocrin. & Metabolism 485, 492 (2015), https://perma.cc/TUG9-DDTV.

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

In contrast to prepubertal children, the Guidelines do contemplate that, for some transgender adolescents with gender dysphoria, gender-affirming medical care may be indicated if certain criteria are met. According to the Guidelines, puberty blockers and hormone therapy may be provided only after a thorough evaluation by a qualified HCP who: is licensed by their statutory body and holds a master's degree or equivalent in a relevant clinical field; has expertise and received theoretical and evidence-based training in child, adolescent, and family mental health; has expertise and received training in gender identity development, gender diversity in children and adolescents, can assess capacity to consent, and possesses knowledge about gender diversity

across the life span; 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 continues engagement in professional development in areas relevant to gender diverse children, adolescents, and families. WPATH SOC-8 at S49.

Before developing a treatment plan, the HCP should conduct a robust diagnostic assessment—specifically, a "comprehensive biopsychosocial assessment"—of the adolescent patient. *Id.* at S50. 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. *Id.* This assessment must be conducted collaboratively with the patient and their caregiver(s). *Id.*

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

For youth with gender dysphoria that continues into adolescence—after the onset of puberty—the Guidelines provide that, in addition to mental-health care, gender-affirming medical care may be indicated. Before an adolescent may receive any gender-affirming medical care for treating gender dysphoria, a qualified HCP must determine that such medical care is indicated. The Guidelines collectively provide that, before prescribing puberty blockers, the HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender dysphoria or gender incongruence according to an established taxonomy; ES Guidelines at 3876; WPATH SOC-8 at S47, S48; (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. WPATH SOC-8 at S59–65. 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. ES Guidelines at 3878 tbl.5.

If all 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. WPATH SOC-8 at S61–62, S64; ES Guidelines at 3878 tbl.5; 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://perma.cc/BR4F-YLZS **Error! Bookmark not defined.**. The purpose of puberty blockers is to delay the development of permanent secondary sex characteristics—which may result in significant distress for transgender youth—until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments. WPATH SOC-8 at S112. 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. AAP Policy at 5. Puberty blockers have well-known efficacy and side-effect profiles. Martin, 385 New Eng. J. Med. 579, at 2. Their effects are generally reversible, and when a patient discontinues their use, the patient resumes endogenous puberty. *Id.* In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty. 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 NEJM 1546 (1981). The risks of any serious adverse effects from puberty blockers are exceedingly rare when provided under clinical supervision. *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty Suppression and Executive Functioning*, 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).

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 including to allow adolescents to develop secondary sex characteristics consistent with their gender identity. Martin, 385 New Eng. J. Med. 579, at 2; AAP Policy at 6. Hormone therapy is only prescribed when a qualified HCP 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. ES Guidelines at 3878 tbl.5. A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, and the patient and their parents must be informed of the potential effects and side effects and give their informed consent. *Id*. 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. AAP Policy at 5–6.

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. ES Guidelines at 3871, 3876. Decisions regarding the appropriate

treatment for each patient with gender dysphoria are made in consultation with the patient, their parents, and the medical and mental-health-care team. There is "no one-size-fits-all approach to this kind of care." Martin, 385 New Eng. J. Med. 579, 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 regarding other areas of medicine, such as treatments for cancer, diabetes, or cardiovascular disease.

For example, the Endocrine Society Guidelines were developed following a 26-step, 26-month drafting, comment, and review process. *See, e.g.*, ES Guidelines at 3872–73. The Endocrine Society imposed strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. 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. That GRADE assessment was then reviewed, re-reviewed, and reviewed again by independent groups of professionals. Endocrine Soc'y, *Methodology*, https://www.endocrine.org/clinical-practice-guidelines/methodology. Reviewers were subject to strict conflict of interest rules, and there was ample opportunity for feedback and debate through the years-long review process. *Id*. 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. Endocrine Soc'y, *Endocrine Soc'y Statement in*

Support of Gender-Affirming Care (May 8, 2024), https://perma.cc/J4Y2-RUJ2 ("ES Statement").

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 took five years. WPATH SOC-8 at S247-51. The draft guidelines went through rigorous review and were publicly available for discussion and debate, receiving 2,688 comments. *Id*. There were 119 authors ultimately involved in the final draft, including feedback from experts in the field as well as from transgender individuals and their families. *Id.* (Inclusion of input from the relevant patient population during development of medical guidelines adheres to national standards and best practices. National Academy of Sciences, *Clinical Practice Guidelines We Trust* at 89–92 (2011)). Each recommendation in the Standards of Care was formally approved using the Delphi process, WPATH SOC-8 at S247-51, which is one of the most commonly adopted consensus development strategies for medical clinical practice guidelines. National Academy of Sciences, *Clinical Practice Guidelines We Trust* at 88 (2011).

The State claims that Ohio "join[s] a worldwide trend" by categorically banning gender-affirming medical care for adolescents—this is simply untrue. Br. at 8. For example, as recently as March 2025, the AWMF—an umbrella organization comprising over 150 German medical societies that promulgates healthcare guidelines in Germany—published guidelines upholding its previous findings that the provision of gender-affirming medical care to adolescents is appropriate when medically indicated. *Geschlechtsinkongruenz und Geschlechtsdysphorie im Kindes- und Jugendalter – Diagnostik und Behandlung (S2k)*, AWMF (Mar. 2025), https://perma.cc/V623-FW2B (in German). Appellants' claim largely relies on the systematic review conducted for NHS England. Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report*, Cass Review (Apr. 2024), https://perma.cc/A8UR-Q2WD ("Cass Review").

But the Cass Review does not recommend a ban on gender affirming medical care. Cass Review at 35; Meredithe McNamara et al., *An Evidence-Based Critique of the Cass Review on Gender-Affirming Care for Adolescent Gender Dysphoria* (2024) at 4, https://perma.cc/39RR-FAM6 ("Cass Critique"). Moreover, like other systematic reviews, it is simply a summary of some of the existing research, as selected by the author. It does not purport to offer any new studies or findings regarding the efficacy and safety of prescribing gender-affirming medical care for adolescents that conflict with the recommendations in the Guidelines, which themselves are based on the available existing studies and research, as well as clinical experience. ES Statement. Finally, the Cass Review has been the subject of much criticism, including that it is not an accurate restatement of the available medical evidence on the treatment of gender dysphoria. Cass Critique at 35.

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-being. 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.

A longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically significant degree after receiving gender-affirming hormone treatment. 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. 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. Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388(3) NEJM 240–

250 (2023). A 2020 study analyzed survey data from 89 transgender adults with access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not. 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 ("Turban Outcomes"). The study found that those who received puberty blocking treatment had lower odds of lifetime suicidal ideation than those who wanted this treatment but did not receive it, even after adjusting for demographic variables and level of family support. *Id*. Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation. *Id.*

Further, 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. Annelou L.C. de Vries et al., *Puberty Suppression In Adolescents With Gender Identity Disorder*, 8(8) J. SEXUAL MED. 2276–83 (2011), https://pubmed.ncbi.nlm. nih.gov/ 20646177. 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. 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. "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." 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. As clinicians

and scientific researchers, *amici* always welcome more research, including on this crucial topic. Yet the available data indicate that the gender-affirming medical care targeted in the Ban is effective for the treatment of gender dysphoria.

III. The Ban Would Irreparably Harm Many Adolescents with Gender Dysphoria By Effectively Denying Them Access to the Treatment They Need.

The Ban denies adolescents with gender dysphoria in Ohio 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. Following enactment of the Ban, hospitals throughout Ohio were forced to cease providing this care to new patients—including Akron's Children's Hospital and Nationwide Children's Hospital. The gender-affirming medical care targeted in the Ban can be a crucial part of treatment for transgender adolescents with gender dysphoria and necessary to preserve their health. Clinicians who are members of the *amici* associations have witnessed the benefits of this treatment as well as the harm that results when such treatment is denied or delayed.

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 suicide attempts and significant improvement in quality of life. 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; Turban Outcomes. Given 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 Court should rule in favor of Appellees.

Dated: May 29, 2025

Respectfully submitted,

/s/ Subodh Chandra

Subodh Chandra (0069233)
THE CHANDRA LAW FIRM LLC
The Chandra Law Building
1265 West Sixth Street, Suite 400
Cleveland, Ohio 44113
Phone: (216) 578-1700
Subodh.Chandra@ChandraLaw.com

D. Jean Veta
William Isasi
COVINGTON & BURLING LLP
One CityCenter
850 Tenth St., N.W.
Washington, D.C. 20001
Phone: (202) 662-6000
jveta@cov.com
wisasi@cov.com

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on May 29, 2025, my office served the above document via email under Ohio Civ. R. 5(B)(2)(f) and S. Ct. Prac. R. 3.11(B)(1) on all counsel of record.

/s/ Subodh Chandra
Subodh Chandra