IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Civil Procedure 7.1, the undersigned counsel for the American Academy of Pediatrics ("AAP"), the Academic Pediatric Association ("APA"), the American Academy of Child & 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 Association of American Medical Colleges ("AAMC"), Association of Medical School Pediatric Department Chairs, Inc. ("AMSPDC"), the Endocrine Society ("ES"), the Florida Chapter of the American Academy of Pediatrics ("FCAAP"), the National Association of Pediatric Nurse Practitioners ("NAPNAP"), the Pediatric Endocrine Society ("PES"), the Societies for Pediatric Urology ("SPU"), the Society for Adolescent Health and Medicine ("SAHM"), the Society for Pediatric Research ("SPR"), the Society of Pediatric Nurses ("SPN"), and the World Professional Association for Transgender Health ("WPATH") certify that:

1. AAP, APA, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP,

AMA, APS, AAMC, AMSPDC, ES, FCAAP, NAPNAP, PES, SPU, SAHM, SPR, SPN, and WPATH, respectively, have no parent corporation.

2. No corporations hold any stock in AAP, APA, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AMA, APS, AAMC, AMSPDC, ES, FCAAP, NAPNAP, PES, SPU, SAHM, SPR, SPN, or WPATH.

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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 Medical Association, the American Pediatric Society, the Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, Inc., the Endocrine Society, the Florida Chapter of the American Academy of Pediatrics, the National Association of Pediatric Nurse Practitioners, the Pediatric Endocrine Society, the Societies for Pediatric Urology, the Society for Adolescent Health and Medicine, the Society for Pediatric Research, the Society of Pediatric Nurses, and the World Professional Association for Transgender Health (collectively, "*amici*").[1]

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

[1] Plaintiffs consent to the filing of this brief; Defendants oppose the filing of this brief. *Amici* affirm that no counsel for a party auth

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.

INTRODUCTION

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 standard of care for treating gender dysphoria is "gender-affirming care."[5] Gender-affirming care is care that supports an adolescent 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 interventions to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including gender-affirming medical

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[4] *See, e.g.*,

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 variation of human identity.[13] However, many transgender people suffer from

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[8] AAP Policy Statement,

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 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

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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*

three transgender adolescents reported having attempted suicide in the preceding 12 months.[19]

II. The Widely Accepted Guidelines for

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").[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 interventions that are tailored to the patient's individual needs.

1. A Robust Diagnostic Assessment Is Required Before Medical Interventions Are Provided.

According to the Guidelines, gender-affirming care for adolescents begins with 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

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[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* (8thVersion) (hereinafter "WPATH Guidelines"), https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.

mental health; (3) 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; (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.[23]

Prior to developing a treatment plan, the HCP should conduct a "comprehensive biopsychosocial assessment" of the adolescent patient.[24] 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.[25] This assessment must

2. The Guidelines Recommend Only Non-Medical Interventions for Prepubertal Children With Gender Dysphoria.

For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family.[27] The Guidelines do *not* recommend that any medical interventions (such as medications or surgery) be provided to prepubertal children with gender dysphoria.[28]

3. In Certain Circumstances, the Guidelines Provide for the Use of Medical Interventions 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, medical interventions may be indicated. Before an adolescent may receive any medical interventions for gender dysphoria, a qualified HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender incongruence according to the World Health Organization's International Classification of Diseases; (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

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

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

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.[29] 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.[30]

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.[31] 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.[32]

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

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

[31] WPATH Guidelines, *supra* note 22, at S64; Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 NEW E

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.[33] Puberty blockers have well-known efficacy and side-effect profiles,[34] and their effects are generally reversible.[35] In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.[36] The risks of any serious adverse effects from these treatments are exceedingly rare when provided under clinical supervision.[37]

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.[38]

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

[34] *See* Martin, *supra* note 31, at 2.

[35] *See id.*

[36] *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).

[37] *See, e.g.*, Annemieke S. Staphorsius et al., *Puberty Suppression and Executive Functioning: An Fmri-Study in Adolescents with Gender Dysphoria*, 6 PSCYHONEUROENDOCRINOLOGY 190 (2015), https://pubmed.ncbi.nlm.nih.gov/25837854 (no adverse impact on executive functioning); Ken C. Pang et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) PEDIATRICS e20191606 (2019), https://watermark.silverchair.com/peds_20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).

[38] Martin, *supra* note 31, at 2.

Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[39] Hormone therapy is only prescribed when a qualified mental health professional ("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.[40] 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 informed consent.[41] 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.[42]

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.[43] Decisions regarding the

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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."[44]

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 subj

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.[52] Nine studies have been published that investigated the use of puberty blockers on adolescents with gender dysphoria,[53] and nine studies have been

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[52] *See* Martin, *supra* note 31, at 2.

[53] *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/articleubertoe2 TD29escentsogical Outcome Afte.198

published that investigated the use of hormone therapy to treat adolescents with gender dysphoria.[54] 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.[55]

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/.

[54] *See, e.g.*, Christal Achille et al., *Longitudinal Impact of Gender-Affirming Endocrine Intervention on The Mental Health and Well-Being of Transgender Youths: Preliminary Results*, 8 INT'L J. PEDIATRIC ENDOCRINOLOGY 1–5 (2020), https://pubmed.ncbi.nlm.nih.gov/32368216; Luke R. Allen et al., *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*

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.[56] The study found that those who received puberty 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.[57] Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it

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.[61] 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.[62] "Remarkably, this study demonstrated that these transgender adolescents and young

in affirming an order preliminarily enjoining enforcement of a similar Arkansas law, "there is substantial evidence … that the [Arkansas] Act prohibits medical treatment that conforms with the recognized standard of care."[64]

III. The Material Supporting the Healthc

interventions are safe and effective.[66]

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

The GAPMS Report also claims that exposure to "peer groups and social media that emphasized transgender lifestyles" can cause "rapid-onset gender dysphoria" in adolescents.[70] However, there is no credible evidence to support this argument. The term "rapid onset gender dysphoria" was coined in 2018 by the author of an anonymous survey of parents of transgender youth, who were recruited from websites that promote the belief that "social contagion" causes transgender identity.[71] The survey, which is the only source cited by the GAPMS Report in support of its claim, suffers from numerous flaws and has been widely discredited.[72]

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students reported being physically threatened or harmed due to their gender identity).

[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] GAPMS Report, *supra* note 65, at 12–13.

[71] *Id.* at 12; Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*. 14(3) PLOS ONE e0214157, at 2, 8–9 (Aug. 2018), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330 (stating that survey participants were recruited from the websites YouthTransCriticalProfessionals.org, TransgenderTrend.com, and 4thWaveNow.com).

[72] *See, e.g.*

Moreover, the journal in which the survey was published subsequently published an extensive correction stating, among other things, that "[r]apid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis," and that the "report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon."[73]

On the contrary, one recent study showed that most adolescents—nearly 70%—referred to a clinic for puberty blockers or hormone therapy had known their gender was different from the one assigned at birth for three or more years.[76] The study also showed no correlation between recent gender knowledge (defined as two years or less having passed since you "realized your gender was different from what other people called you") and support from online friends or transgender friends.[77]

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

The GAPMS Report asserts that "the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex[.]"[78] However, the sources it cites in support of its "desistance" claim—an editorial written by James Cantor and an "assessment" that Cantor prepared for AHCS—state only that "desistance" is common among *prepubertal children* with gender dysphoria.[79] The GAPMS Report improperly conflates prepubertal children

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[76] *See id*. at 225 fig.

[77] Id. at 224–27.

[78] GAPMS Report, *supra* note 65, at 14.

[79] *See id.*

with adolescents, which is an important distinction, as prepubertal children are not eligible under the Guidelines for any of the gender-affirming medical interventions prohibited by the Healthcare Ban.[80] The Guidelines endorse the use of medical interventions only to treat adolescents and adults with gender dysphoria, and only when the relevant criteria are met.[81]

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

not the same as regret. The State incorrectly assumes that an individual who detransitions—the definition of which varies from study to study[84]—must do so because they have come to identify with their sex assigned at birth. This ignores the most common reported factors that contribute to a person's choice to detransition, such as pressure from parents and discrimination.[85]

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.[86] Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expadua16953m0 Tcoptran

C. There Is No Accepted Protocol

whether to provide gender-affirming care, at all.[91] It attempts to rely on examples from, *inter alia,* France, Sweden, and Finland,[92] but all of these countries provide gender-affirming care to adolescents when medically indicated. France's health care system covers gender-affirming care for young people.[93] Sweden offers gender-affirming care through its national health care system, and youth in Sweden are able to access gender-affirming care when their providers deem it medically necessary.[94]

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[91] *See* GAPMS Report, *supra* note 65, at 35–37.

[92] The GAPMS report also discusses the United Kingdom. *See* GAPMS Report, *supra* note 65, at 36. Policies regarding gender-affirming care for adolescents vary throughout the jurisdictions in the United Kingdom and permit gender affirming medical care for adolescents. *See, e.g.*, NHS Services, *The Young People's Gender Service*, available at https://www.sandyford.scot/media/4173/304280_2_0-yp-gender-service-information_s-1.pdf. The NHS in England and Wales recently closed a public comment period on an interim service specification that may alter some of their policies regarding gender-affirming medical treatments for adolescents. The interim service specification has yet to be published, and a non-interim (i.e. "a national service specification") is not expected for several months.

[93] *See* Emmanuel Allory et al., *The Expectations of Transgender People in the Face of their Health-Care Access Difficulties and How They Can Be Overcome: A Qualitative Study in France*, 21 P

Finland also offers gender-affirming care to transgender adolescents through its national healthcare system.[95]

Transgender youth also have access to gender-affirming care in developed nations across the world including Australia,[96] Canada,[97] Denmark,[98] Germany,[99]

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[95] *Recommendation (In Finnish)*, COHERE (June 2020), https://palveluvalikoima.fi/documents/1237350/22895838/Transsukupuolisuus+suositus.pdf/82b60104-291c-7d8c-9e88-1b1fc9bba527/Transsukupuolisuus+s

Dated: April 24, 2023

Respectfully submitted,

/s/ Cortlin H. Lannin

D. Jean Veta (

CERTIFICATE OF WORD COUNT

According to Microsoft Word, the word processing system used to prepare this brief, there are 6,444 total words contained within the brief.

/s/ Noah S. Goldberg
Noah S. Goldberg

CERTIFICATE OF SATISFACTION OF ATTORNEY-CONFERENCE REQUIREMENT

Pursuant to Local Rule 7.1(B), counsel for *amici* conferred with counsel for the parties on April 24, 2023. Plaintiffs consent to the filing of *amici*'s brief; Defendants oppose the filing.

/s/ Noah S. Goldberg
Noah S. Goldberg