No. 23-12155

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

AUGUST DEKKER, ET AL,
Plaintiffs-Appellees,

v.

SECRETARY, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, ET AL,
Defendants-Appellants

On Appeal from the United States District Court for the
Northern District of Florida
Case No: 4:22-cv-00325-RH-MAF

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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CERTIFICATE OF INTERESTED PERSONS
AND 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 Obstetricians and Gynecologists ("ACOG"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"), the American Medical Association ("AMA"), the American Pediatric Society ("APS"), the American Psychiatric Association ("APA"), the Association of Medical School Pediatric Department Chairs, Inc. ("AMSPDC"), the Association of American Medical Colleges ("AAMC"), the Endocrine Society, the Florida Chapter of the American Academy of Pediatrics ("FCAAP"), 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, ACOG, ACOP, ACP, AMA, APS, APA, AMSPDC, AAMC, the Endocrine Society, FCAAP, 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, ACOG, ACOP, ACP, AMA, APS, APA, AMSPDC, AAMC, the Endocrine Society, FCAAP, NAPNAP, PES, SAHM, SPR, SPN, SPU, or WPATH.

3. Counsel certifies that the following persons and parties, in addition to the above-named amici, may have an interest in the outcome of this case:

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5. Antommaria, Armand – Witness
6. Bailey, Andrew – Counsel for Amicus
7. Baker, Kellan – Witness
8. Bardos, Andy – Counsel for Amicus

9. Barnes, Brian – Counsel for Amicus

10. Beato, Michael – Counsel for Defendants

11. Biggs, Michael – Witness

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63. Hutton, Kim – Witness

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65. Jacobs, Dylan L. – Counsel for Amicus

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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 American Psychiatric Association, 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]

[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).

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.

STATEMENT OF THE ISSUE

Whether the district court correctly enjoined Defendants-Appellants from enforcing Rule 50G-1.050(7) of the Florida Administrative Code.

SUMMARY OF ARGUMENT

Rule 59G-1.050(7) of the Florida Administrative Code (the "Medicaid Ban") eliminates Florida Medicaid coverage for critical, medically necessary, evidence-based treatments 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 medical interventions prohibited by the Medicaid Ban. While the Medicaid Ban affects all patients who are receiving treatment for gender dysphoria, this brief focuses primarily on the experience of transgender adolescents.[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

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[2] Rule 59G-1.050(7) prohibits Florida Medicaid coverage for medical treatments that are administered for the purpose of treating gender dysphoria, including "puberty blockers," and "hormones and hormone antagonists" which, as discussed in this brief, are medically necessary care for certain adolescents with gender dysphoria.

[3] Because this brief focuses primarily on adolescents and because the district court's injunction does not apply to surgeries, this brief 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 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 interventions provided to carefully evaluated patients who meet diagnostic criteria,

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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.

[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.

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 Medicaid Ban disregards this medical evidence by precluding Florida Medicaid reimbursement for the treatment of patients with gender dysphoria in accordance with the accepted standard of care. Accordingly, *amici* urge this Court to affirm the district court's order granting an 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 gender dysphoria and explains how the Medicaid Ban would irreparably harm adolescents with gender dysphoria by denying crucial care to those who need it.

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[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").

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, *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 863.

[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.

[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 (Feb. 2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

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 three transgender adolescents reported having attempted suicide in the preceding

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[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 PRAC. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668.

[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.

12 months.[19]

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

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for some adolescents, gender-affirming medical interventions are necessary.[20] This care greatly reduces the negative physical and mental health consequences that result when gender dysphoria is untreated.[21]

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

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transgender and

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[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 MORBIDITY & MORTALITY WKLY. REP. 67, 70 (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), https://www.endocrine.org/advocacy/position-statements/transgender-health.

[21] *See id.*

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 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 mental health; (3) has expertise and received training in gender identity development, gender diversity in children and adolescents, can assess capacity to

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

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 be conducted collaboratively with the patient and their caregiver(s).[26]

2. 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

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

[24] *Id.* at S50.

[25] *Id.*

[26] *Id.*

psychotherapy and social transitioning.[27] The Guidelines do *not* recommend that prepubertal children with gender dysphoria receive gender-affirming medical care or surgeries.[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, the Guidelines provide, collectively, that 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 or other 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

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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.

[29] WPATH Guidelines, *supra* note 22, at S48.

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]

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

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

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

[32] WPATH Guidelines, *supra* note 22, at S61–62, S64; Endocrine Soc'y Guidelines, *supra* note 22, at 3878 tbl.5; Martin, *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, *supra* note 7.

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

the Adam's apple or breast growth.[34] Puberty blockers have well-known efficacy and side-effect profiles,[35] and their effects are generally reversible.[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 these treatments 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]

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[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).

[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://watermark.silverchair.com/peds_20191606.pdf (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.

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

[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 care experience improvements in their overall well-being.[53] Nine

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[49] *See id*.

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

[51] *See id*.

[52] *See id.*

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

studies have been published that investigated the use of puberty blockers on adolescents with gender dysphoria,[54] and nine studies have been published that investigated the use of hormone therapy to treat adolescents with gender dysphoria.[55]

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[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

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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.[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 subsequent treatment with hormone therapy followed by surgery in adulthood was

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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.

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 treatments prohibited by the Medicaid Ban are effective for the treatment of gender dysphoria. As the U.S. Court of Appeals for the Eighth Circuit recently recognized 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."[65]

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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] *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 670-71 (8th Cir. 2022); *see also Brandt v. Rutledge*, 551 F. Supp. 3d 882, 890 (E.D. Ark. 2021) ("The consensus recommendation of medical organizations is that the only effective treatment for individuals at risk of or suffering from gender dysphoria is to provide gender-affirming care."); *see also Brandt v. Rutledge*, --- F. Supp. 3d ----, 2023 WL 4073727 (E.D. Ark. June. 20, 2023) (enjoining enforcement of a similar Arkansas statute), *appeal docketed*, No. 23-2681 (8th Cir. July 21, 2023).

III. The Material Supporting the Medicaid Ban Is Factually Inaccurate and Ignores the Recommendations of the Medical Community.

The purported basis for the Medicaid Ban is the Division of Florida Medicaid's "Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria" (the "GAPMS Report").[66] The GAPMS Report asserts that puberty blockers, gender-affirming hormone therapy, and gender-affirming surgeries are not consistent with professional medical standards and that there is insufficient evidence that these interventions are safe and effective.[67] However, this assertion is premised on speculative and discredited claims about gender dysphoria and mischaracterizations of the Guidelines and scientific research regarding these gender-affirming medical interventions.

A. There is No Evidence That Gender Dysphoria Can Be Caused by Underlying Mental Illness or "Social Contagion."

The GAPMS Report speculates that mental health concerns such as

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[66] Available at: https://ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf (June 2, 2022). The GAPMS report also serves as the basis for Rules 64B8-9.019 and 64B15-14.014 of the Florida Administrative Code, recently promulgated rules which prohibit healthcare providers from providing patients under 18 with medical treatments for gender dysphoria. The U.S. District Court for the Northern District of Florida recently permanently enjoined Rules 64B8-9.019 and 64B15-14.014. *See Doe v. Ladapo*, --- F. Supp. 3d ----, 2023 WL 3833848 (N.D. Fla. June 6, 2023).

[67] GAPMS Report, *supra* note 66, at 38.

depression and anxiety may cause individuals to develop a gender identity that is incongruent with their sex assigned at birth.[68] 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,[69] and that these experiences lead to mental health concerns, including, for example, depression and anxiety.[70]

The GAPMS Report also claims that exposure to "peer groups and social media that emphasized transgender lifestyles" can cause "rapid-onset gender

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[68] GAPMS Report, *supra* note 66, at 6. (In light of the "number of adolescents who reported anxiety and depression diagnoses prior to transitioning," the GAPMS Report asserts that "available research raises questions as to whether [individuals'] distress is secondary to pre-existing behavioral health disorders[.]")

[69] *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).

[70] *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).

dysphoria" in adolescents.[71] 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.[72] 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.[73] 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."[74] Significantly, the GAPMS Report

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[71] GAPMS Report, *supra* note 66, at 12–13.

[72] *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).

[73] *See, e.g.*, 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*, 1, 18 (Apr. 28, 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4102374.

[74] Lisa Littman, *Correction: Parent Reports of Adolescents and Young Adults*
(continued…)

does not cite or even mention this correction.[75]

Moreover, subsequent peer-reviewed research has not found support "for a new etiologic phenomenon of rapid onset gender dysphoria during adolescence."[76] 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.[77] 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.[78]

Perceived to Show Signs of a Rapid Onset of Gender Dysphoria, 14(3) PLOS ONE e0214157 (Mar. 2019), https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0214157.

[75] The GAPMS Report's reliance on the survey is also puzzling: According to the report, studies (such as surveys) that "rel[y] heavily" on participants' subjective responses "likely [have] biased and invalid" results. GAPMS Report, *supra* note 66, at 15.

[76] Greta R. Bauer et al., *Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"?*, 243 J. PEDIATRICS 224, 225–26 (2022), https://www.jpeds.com/article/S0022-3476(21)01085-4/pdf ("This putative phenomenon was posited based on survey data from a convenience sample of parents recruited from websites, and may represent the perceptions or experiences of those parents, rather than of adolescents, particularly those who may enter into clinical care." (internal citations omitted)).

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

[78] *Id*. at 224–27.

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[.]"[79] 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.[80] The GAPMS Report improperly conflates 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 interventions excluded from coverage by the Medicaid Ban.[81] 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.[82]

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[79] GAPMS Report, *supra* note 66, at 14.

[80] *See id.* at 20, 27–28, 39; James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. Sex & Marital Therapy 307, 308–09 (2019), https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI/Other/Rebekah_Murphy_20191214_JamesCantor-fact-checking_AAP-Policy.pdf; James M. Cantor, *The Science of Gender Dysphoria and Transsexualism* (May 17, 2022), GAPMS Report, *supra* note 65, Attach. D ¶¶ 14–16.

[81] *See* Boulware, *supra* note 73, at 18.

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

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.[83] 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."[84]

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[85]—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.[86]

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[83] *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").

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

[85] 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.").

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

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.[87] Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expanded care options.[88]

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 GAPMS Report questions the medical necessity of puberty blockers and hormone therapy for adolescents and suggests that a "watchful waiting" approach may be more appropriate.[89] In this regard, some practitioners use a "watchful waiting" approach for *prepubertal* children with gender dysphoria, which involves waiting until the patient reaches adolescence before considering social transition.[90] However,

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

[88] *See* Boulware, *supra* note 73, at 20.

[89] *See* GAPMS Report, *supra* note 66, at 12, 20.

[90] Jason Rafferty, *Ensuring Comprehensive Care & Support for Transgender & Gender-Diverse Children & Adolescents*, Am. Acad. of Pediatrics, at 4 (Oct. 2018).

"watchful waiting" is not recommended for adolescents with gender dysphoria.[91] 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.[92]

D. Gender-Affirming Medical Care Is Provided Internationally.

The GAPMS Report wrongly suggests that there is a vigorous international debate over whether to ban gender-affirming medical care.[93] It attempts to rely on examples from the United Kingdom, Sweden, and Finland but, in fact, none of these countries—in contrast to Florida—categorically ban coverage for gender-affirming medical care. The United Kingdom offers gender-affirming medical care through its National Health Service.[94] Sweden offers gender-affirming medical care through

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[91] *Id.*; AAP Policy Statement, *supra* note 4, at 4; WPATH Guidelines, *supra* note 22, at S112–113; *see also Brandt v. Rutledge*, *supra* note 65, 2023 WL 4073727, at *20 ("Watchful waiting . . . [although] used by some health care providers with pre-pubertal children with gender dysphoria . . . is not a recognized approach for adolescents with gender dysphoria.").

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

[93] *See* GAPMS Report, *supra* note 66, at 35–37.

[94] Policies vary throughout the countries of the United Kingdom with regard to the circumstances under which gender-affirming medical care may be provided to 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-
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its national health care system, and youth in Sweden are able to access gender-affirming medical care when their providers deem it medically necessary.[95] Finland also offers gender-affirming medical care to transgender adolescents through its national healthcare system.[96]

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service-information_s-1.pdf (gender-affirming care in Scotland). The National Health Service in England and Wales recently published an *interim* service specification that narrows some of their policies on gender-affirming medical care for adolescents to incorporate research protocols, but the interim specification does not contemplate a categorical ban on coverage for such care. *See* NHS Services, *Interim Service Specification for Specialist Gender Incongruence Services for Children and Young People*, available at https://www.england.nhs.uk/wp-content/uploads/2023/06/Interim-service-specification-for-Specialist-Gender-Incongruence-Services-for-Children-and-Young-People.pdf. A non-interim (i.e. "a national service specification") is not expected for several months.

[95] *See Care of Children and Adolescents with Gender Dysphoria: Summary*, SOCIALSTYRELSEN (2022), https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf.

[96] *See Medical Treatment Methods for Dysphoria Associated with Variations in Gender Identity in Minors – Recommendation*, COHERE (2020), https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en.pdf/aaf9a6e7-b970-9de9-165c-abedfae46f2e/Summary_minors_en.pdf.

Transgender youth also have access to gender-affirming medical care in developed nations across the world including Australia,[97] Canada,[98] Denmark,[99] Germany,[100] Mexico,[101] New Zealand,[102] Norway,[103] and Spain,[104] among others. Although some of these countries have debated how best to care for transgender patients, none has come close to banning coverage for gender-affirming medical care for all minors. The Medicaid Ban would make Florida an outlier in the international medical community, not the norm.

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[97] *See Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents*, ROYAL CHILDREN'S HOSP. MELBOURNE (Oct. 2021), https://auspath.org.au/wp-content/uploads/2021/10/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents_v1-3.pdf.

[98] *See* Greta R. Bauer et al., *Transgender Youth Referred to Clinics for Gender-Affirming Medical Care in Canada*, 148(5) PEDIATRICS 1 (2021).

[99] *See Guidelines on Healthcare Concerning Gender Identity Matters*, RETSINFORMATION (2018), https://www.retsinformation.dk/eli/retsinfo/2019/9060.

[100] *See Ethics Council Publishes Ad Hoc Recommendation on Transgender Identity in Children and Adolescents*, GERMAN ETHICS COUNSEL (Feb. 20, 2020), https://www.ethikrat.org/mitteilungen/mitteilungen/2020/deutscher-ethikrat-veroeffentlicht-ad-hoc-empfehlung-zu-trans-identitaet-bei-kindern-und-jugendlichen.

[101] *See Protocol for Access Without Discrimination to Health Care Services for Lesbian, Gay, Bisexual, Transsexual, Transvestite, Transgender and Intersex Persons and Specific Care Guidelines*, GOV'T OF MEX. (June 15, 2020), https://www.gob.mx/cms/uploads/attachment/file/558167/Versi_n_15_DE_JUNIO_2020_Protocolo_Comunidad_LGBTTI_DT_Versi_n_V_20.pdf.

[102] *See Transgender New Zealanders: Children and Young People*, NEW ZEALAND MINISTRY OF HEALTH (2020), https://www.health.govt.nz/your-health/healthy-

(continued…)

IV. The Medicaid Ban Would Irreparably Harm Many Adolescents with Gender Dysphoria By Denying Them the Treatment They Need.

The Medicaid Ban denies Medicaid recipients in Florida with gender dysphoria access to medical interventions that are designed to improve health outcomes and alleviate suffering and that are grounded in science and endorsed by the medical community. The medical treatments excluded from coverage by the Medicaid Ban can be a crucial part of treatment for adolescents with gender dysphoria and necessary to preserve their health.

As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life.[105] In light of this evidence supporting the connection

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living/transgender-new-zealanders/transgender-new-zealanders-children-and-young-people.

[103] *See Gender Incongruence: National Academic Guideline*, HELSEDIREKTORATET (2020), https://www.helsedirektoratet.no/retningslinjer/kjonnsinkongruens.

[104] *See* Diego Lopez de Lara et al., *Psychosocial Assessment in Transgender Adolescents*, 93 ANALES DE PEDIATRÍA ENGLISH EDITION 1 (2020), https://europepmc.org/article/MED/32144041.

[105] 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.

between lack of access to gender-affirming care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, the district court's order granting the injunction should be affirmed.

Dated: December 1, 2023

Respectfully submitted,

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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 6,279 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.

/s/ Cortlin H. Lannin
Cortlin H. Lannin

CERTIFICATE OF SERVICE

I hereby certify that on December 1, 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
Cortlin H. Lannin