No. 23-2681

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

DYLAN BRANDT ET AL.,

,

v.

TIM GRIFFIN, ET AL.,JM (Hon. James M. Moody Jr.)

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

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Local Rule 26.1–1, the undersigned counsel for the American Academy of Pediatrics (“AAP”), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry (“AACAP”), American Academy of Family Physicians (“AAFP”), the American Academy of Nursing (“AAN”), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality (“GLMA”), the American College of Osteopathic Pediatricians (“ACOP”), the American College of Physicians (“ACP”), the American Medical Association (“AMA”), the American Pediatric Society (“APS”), the American Psychiatric Association (“APA”), the Association of Medical School Pediatric Department Chairs, Inc. (“AMSPDC”), the Association of American Medical Colleges (“AAMC”), the Arkansas Chapter of the American ofhuJ0 TTc 0.428.1 ehias,

Urology ("SPU"), and the World Professional Association for Transgender Health ("WPATH") certify that:

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

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

Appellate Case: 23-2681 Page: 3 Date Filed: 12/18/2023 Entry ID: 5345422

TABLE OF CONTENTS

CORPORATE DISCLOSURE STATEMENT ii

TABLE OF CONTENTS iv

TABLE OF AUTHORITIES vi

STATEMENT OF INTEREST OF AMICI CURIAE 1

INTRODUCTION 3

ARGUMENT 5

I. Understanding Gender Identity and Gender Dysphoria. 6

II. The Widely Accepted Guidelines for Treating Adolescents with Gender Dysphoria Provide for Gender-Affirming Medical Care When Indicated. 8

A. The Gender Dysphoria Treatment Guidelines Include Thorough Mental Health Assessments and, for Some Adolescents, Gender-Affirming Medical Care. 9

1. The Guidelines Do Not Recommend Gender-Affirming Medical Care for Prepubertal Children. 10

2. A Robust Diagnostic Assessment Is Required Before Gender-Affirming Medical Care Is Provided. 10

3. In Certain Circumstances, the Guidelines Provide for the Use of Gender-Affirming Medical Care to Treat Adolescents with Gender Dysphoria. 11

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. 16

C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines. 17

III. The Legislative Findings Are Factually Inaccurate and Ignore the Recommendations of the Medical Community. 21

TABLE OF AUTHORITIES

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STATEMENT OF INTEREST OF *AMICI CURIAE*

are the American Academy of Pediatrics ("AAP"), the Academic Pediatric Association, the American Academy of Child and Adolescent Psychiatry ("AACAP"), American Academy of Family Physicians ("AAFP"), the American Academy of Nursing ("AAN"), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality ("GLMA"), the American College of Osteopathic Pediatricians ("ACOP"), the American College of Physicians ("ACP"),

INTRODUCTION

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

Gender dysphoria is a clinical condition that is marked by distress due to an incongruence between the -

patient's 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 , is that the well-accepted protocol for treating gender dysphoria is "gender-affirming care."[5] Gender-affirming care is care that supports an individual with gender dysphoria as they explore their gender identity—in contrast with efforts to change the individual's gender identity to match their sex assigned at birth, which are known to be ineffective and harmful.[6] For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical care

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[4] , Jason Rafferty, , 142(4) Pediatrics e20182162, at 2–3, tbl.1 (2018) (hereinafter, "AAP Policy Statement"), https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for. The American Academy of Pediatrics recently voted to reaffirm the AAP Policcrrb1rb1rb17.9 (pre)4 3 ("))-3.8ric 0 Twun44 0.6 refEM

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

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

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the professionally accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that supports the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief corrects multiple inaccuracies regarding the professionally accepted medical guidelines for treating

[7] Simona Martin et al., , 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-

gender dysphoria and explains how the Healthcare Ban would irreparably harm adolescents with gender dysphoria by denying crucial care to those who need it.

I. Understanding Gender Identity and Gender Dysphoria.

A person's gender identity is a person's deep internal sense of belonging to a particular gender.[8] Most people have a gender identity that aligns with their sex assigned at birth.[9] However, transgender people have a gender identity that does not align with their sex assigned at birth.[10] In the United States, it is estimated that approximately 1.4 million individuals are transgender.[11] Of these individuals, approximately 10% are teenagers aged 13 to 17.[12] Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

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

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

[9] Am. Psychological Ass'n, , 70(9) AMERICAN PSYCHOLOGIST 832, 862 (2015), https://www.apa.org/practice/guidelines/transgender.pdf.

[10] at 832.

[11] Jody L. Herman et al., , Williams Inst., at 2 (Jan. 2017), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Age-Trans-Individuals-Jan-2017.pdf.

[12] See at 3.

variation of human identity.[13] However, many transgender people suffer from gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to “impairment in peer and/or family relationships, school performance, or other aspects of their life.”[14] Gender dysphoria is a formal diagnosis under the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-5-TR).[15]

If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.[16] Indeed, over 60% of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75% reported symptoms of generalized anxiety disorder in the

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[13] James L. Madara,
, 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,
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Appellate Case: 23-2681 Page: 18 Date Filed: 12/18/2023 Entry ID: 5345422

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

II. The Widely Accepted Guidelines for Treating Adolescents with Gender Dysphoria Provide for

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

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transgender and Gender Diverse People (together, the "Guidelines").[22] The Guidelines have been developed by expert clinicians and researchers who have worked with patients with gender dysphoria for many years.

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

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[22] Wylie C. Hembree et al.,
, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869

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

For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family, such as through psychotherapy and social transitioning.[23] The Guidelines do recommend that prepubertal children with gender dysphoria receive gender-affirming medical care or surgeries.[24]

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

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

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

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

Appellate Case: 23-2681 Page: 21 Date Filed: 12/18/2023 Entry ID: 5345422

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

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

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

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

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gender-affirming medical care may be indicated. Before an adolescent may receive any gender-affirming medical care for treating gender dysphoria, the Guidelines, collectively provide that a qualified HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender dysphoria or gender incongruence according to an established taxonomy;[29] (2) the adolescent has demonstrated a sustained and persistent pattern of gender nonconformity or gender dysphoria; (3) the adolescent has demonstrated the emotional and cognitive maturity required to provide informed

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

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

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[38] , Annemieke S. Staphorsius et al., , 6 PSCYHONEUROENDOCRINOLOGY 190 (2015), https://pubmed.ncbi.nlm.nih.gov/25837854 (no adverse impact on executive functioning); Ken C. Pang et al., , 145(2) PEDIATRICS e20191606 (2019), https:// https://pubmed.ncbi.nlm.nih.gov/31974217/ (exceedingly low risk of delayed bone mineralization from hormone treatment).

[39] Martin, note 7, at 2.

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

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

Appellate Case: 23-2681 Page: 25 Date Filed: 12/18/2023 Entry ID: 5345422

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 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] , Endocrine Soc'y Guidelines, note 22, at 3872–73 (high-level overview of methodology).

[47] Gordon Guyatt et al., , 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., , 336 BMJ 924 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2335261.

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

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

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[53] Martin, note 7, at 2.

[54] See, e.g., Christal Achille et al.,

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.,
, 388(3) NEW ENG. J. M

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

transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.[59] Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically-significant degree after receiving gender-affirming hormone treatment.[60] A study published in January 2023, following 315 participants age 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated with decreased symptoms of depression and anxiety.[61]

As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning.[62] A six-year follow-up study of 55 individuals from the 2011 study found that

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[58] See

[59] See

[60] Allen, note 55.

[61] Chen, note 55.

[62] See Vries,

, note 54.

Appellate Case: 23-2681 Page: 31 Date Filed: 12/18/2023 Entry ID: 5345422

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

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

The Arkansas Legislature speculates that mental health concerns such as depression and anxiety may cause individuals to develop a gender identity that is incongruent with their sex assigned at birth.[67] However, the report cites no evidence for this assertion, and the scientific research suggests that the reverse is true: m[(i)1 for

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

There are studies to support the proposition that adolescents with gender dysphoria are likely to later identify as their sex assigned at birth, whether they receive treatment or not.[73] On the contrary, "[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult."[74]

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

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

[73] See, e.g., Stewart L. Adelson, , 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211 ("In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood").

[74] Rosenthal, note 64, at 585.

[75] Michael S. Irwig, , 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.").

Appellate Case: 23-2681 Page: 35 Date Filed: 12/18/2023 Entry ID: 5345422

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

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

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

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

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

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

The Healthcare Ban denies adolescents with gender dysphoria in Arkansas access to medical care that is designed to improve health outcomes and alleviate suffering and that is grounded in science and endorsed by the medical community. The gender-affirming medical care prohibited by the Healthcare Ban can be a crucial part of treatment for adolescents with gender dysphoria and necessary to preserve their health.

As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression,

[80] Jason Rafferty, , AM. ACAD. OF PEDIATRICS, at 4 (Oct. 2018).

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

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

Appellate Case: 23-2681 Page: 37 Date Filed: 12/18/2023 Entry ID: 5345422

anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life.[83] In light of this evidence supporting the connection between lack of access to gender-

CERTIFICATE OF COMPLIANCE

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

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

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

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Cortlin H. Lannin