Litigation and Advocacy Surrounding Attacks on Gender-Affirming Care

CLE Materials

Over 330 bills have been introduced in state legislatures in 2023 targeting the LGBTQ community for discrimination. Of these, nearly a third seek to restrict or prohibit the provision or coverage of gender-affirming care, particularly for trans youth. But gender-affirming care is often critical, necessary, and life saving for many trans people. Every major medical organization supports the provision of this care and decades of study and clinical experience have proven it to be safe, effective, and non-experimental. This workshop will discuss the litigation and advocacy used to defeat these bills either in the state legislatures or the courts. The workshop, which includes panelists with lived experience, will share litigation and advocacy strategies that have proven successful to date as well as discuss some of the lessons learned as these battles have played out across the country.

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IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

DYLAN BRANDT, et al.,	:	
Plaintiff,	:	
v.	:	Case No. 4:21-CV-00450-JM
TIM GRIFFIN, et al.,	:	
Defendant.	:	

PLAINTIFFS' REDACTED POST-TRIAL BRIEF

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INTRODUCTION[1]

When the State of Arkansas banned one and only one type of medical care for adolescents—care related to "gender transition"—it took away the only evidence-based treatment option for youth with gender dysphoria. (*See* Pltfs' Proposed FOF ¶ 242.) And by enacting this sweeping prohibition, the State took away medical care from a single group of Arkansans—transgender adolescents.

Transgender individuals have a gender identity that differs from their assigned sex at birth. (*Id.* ¶ 126.) A transgender male is a boy or man who was assigned female at birth. A transgender female is a girl or woman who was assigned male at birth. Many transgender individuals experience severe distress from the incongruence between their gender identity and assigned sex at birth. The medical term for this distress is gender dysphoria. (*Id.* ¶ 135.) The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-5 ("DSM") has two diagnoses related to gender dysphoria, one for pre-pubertal children and one for adolescents and adults. (*Id.* ¶ 137.) The diagnostic criteria for gender dysphoria in adolescents and adults include incongruence between an individual's experienced or expressed gender and their sex assigned at birth lasting for at least six months and clinically significant distress or impairment in social or occupational function. (*Id.* ¶ 138.) Gender dysphoria is a serious condition that, if untreated, can have severe consequences for patients' health and well-being. (*Id.* ¶ 140.)

When the State prohibited all medical care for adolescents related to "gender transition," it discriminated on the basis of transgender status and sex, violating the equal protection rights of transgender adolescents and their doctors; infringed upon the substantive due

[1] Plaintiffs refer the Court to Plaintiffs' Proposed Findings of Fact (hereinafter, "Pltfs' Proposed FOF") for the full background and relevant facts. (*See* ECF No. 259.)

process rights of their parents to make medical decisions for their children; and violated the First Amendment rights of the families who need to receive information about obtaining treatment and the clinicians who need to provide such information.

Though Defendants claim that Act 626, ARK. CODE ANN. § 20-9-1502 ("the Act"), was passed to protect children, the evidence presented at trial made clear that the law does just the opposite. Even Dr. Stephen Levine, one of Defendants' experts, testified that the law would have "shocking" and "devastating" psychological consequences for Arkansas youth if it were to go into effect. (Pltfs' Proposed FOF ¶ 390.) He went so far as to suggest that doctors would ultimately violate the law to continue providing care to their patients. (*Id.*)

These "shocking" and "devastating" consequences were well understood by the Plaintiff families and doctors who testified about the range of serious consequences of denying patients the care prohibited by the Act. When the General Assembly was considering passage of the Act, parent Plaintiff Donnie Saxton testified at trial that his transgender son, minor Plaintiff Parker Saxton, was "broken." (*Id.* ¶ 72.) Donnie testified, "I started sleeping on the couch, you know, as close to him as I could." (*Id.*) He was fearful that Parker would hurt himself. (*Id.*) Because of the preliminary injunction, Parker was able to continue the testosterone treatment he was receiving at the gender clinic at Arkansas Children's Hospital ("ACH"). (*Id.* ¶ 73.) Because of this treatment, Parker is a "new person, . . . a complete turnaround of the broken, depressed, anxious, shell that he was before testosterone. It's amazing. Truly amazing." (*Id.* ¶ 75.) The Plaintiff families testified that if the Act were to go into effect, they would be forced to uproot their lives and families, incurring significant personal and financial hardship, to ensure that they could provide their adolescent children with the medical treatment that they need. (*Id.* ¶¶ 28-30, 56-57, 79-84, 105-08.)

Meanwhile, Defendants presented no evidence explaining how the Act would protect the minor Plaintiffs, three of whom have come to rely on the prohibited treatments for their health and well-being. (*Id.* ¶¶ 23, 54, 75-76.) Nor did Defendants provide any evidence contesting the extensive clinical experience of five doctors—three expert witnesses and two Arkansas providers—explaining the many benefits of treatment observed clinically in patients over decades. (*See e.g.*, *id.* ¶¶ 218-20.)

Ultimately, the evidence at trial showed not only that decades of clinical experience but also scientific research demonstrate that the banned treatments are safe and effective and that they benefit many adolescents with gender dysphoria. (*See e.g.*, *id.* ¶¶ 223-37.) In the United States, the widely accepted treatment protocols for gender dysphoria are published by the Endocrine Society and the World Professional Association for Transgender Health ("WPATH"). (*Id.* ¶ 146.) These guidelines were developed through a systematic review of available scientific evidence. (*Id.* ¶ 152.) Treatments that may be indicated for adolescents include puberty-delaying medication, gender-affirming hormone therapy, and less commonly, surgery—these treatments are sometimes referred to as "gender-affirming medical care." (*Id.* ¶ 158.) Prior to the initiation of any endocrine or surgical treatment for adolescents, the guidelines require comprehensive mental health evaluations and a thorough informed consent process. (*Id.* ¶ 162.) All major medical and mental health professional associations in the United States recognize these guidelines as authoritative, including the American Academy of Pediatrics, the American Medical Association, and the American Psychiatric Association. (*Id.* ¶ 154.) These guidelines are followed by doctors at the gender clinic at ACH, the main provider of gender-affirming medical care to adolescents in Arkansas. (*Id.* ¶ 191.)

By cutting off this well-supported medical treatment to adolescents in Arkansas, the State did nothing to protect children. The evidence put forth at trial made crystal clear that the Act would cause severe and irreparable harms to Plaintiffs and many other families in Arkansas and to the doctors who care for them. (*See e.g.*, *id.* ¶¶ 314-345.) Defendants have failed to justify the State's sweeping and devastating intrusion into the constitutional rights of Arkansas adolescents, their parents, and their doctors.

ARGUMENT

I. PLAINTIFFS HAVE ARTICLE III STANDING TO PURSUE THEIR CLAIMS.

The evidence presented at trial confirmed that Plaintiffs have standing to pursue their claims. "To show standing under Article III of the U.S. Constitution, a plaintiff must demonstrate (1) injury in fact, (2) a causal connection between that injury and the challenged conduct, and (3) the likelihood that a favorable decision by the court will redress the alleged injury." *Iowa League of Cities* v. *EPA*, 711 F.3d 844, 869 (8th Cir. 2013) (citations omitted). The undisputed evidence at trial established that, if the Act were to go into effect, (i) three of the minor Plaintiffs—Parker Saxton, Dylan Brandt, and Sabrina Jennen—would have to discontinue treatment that they, their parents, and their doctors all agree is medically indicated for them and benefitting their health and well-being, and minor Plaintiff Brooke Dennis would be unable to obtain treatment she will imminently need[2]; (ii) the parent Plaintiffs would have to watch their children suffer the loss of care or endure severe personal and financial hardship to access care for their children in other states, and (iii) the physician Plaintiff, Dr. Kathryn Stambough, would be unable to treat her patients who need care, leaving them to suffer, and unable to refer them to other

[2] A party has suffered an injury in fact sufficient to confer Article III standing when "[a] threatened injury [is] certainly impending." *School of the Ozarks* v. *Biden*, 41 F.4th 992, 997 (8th Cir. 2022) (citing *Whitmore* v. *Arkansas*, 495 U.S. 149, 158 (1990)).

doctors to provide care when necessary. *Infra*, Section V.A. As this Court previously explained, those injuries are directly traceable to the Act and would be redressed by an injunction barring its enforcement. (ECF No. 64, at 2-3, 12.)

Prior to trial, Defendants offered a handful of objections to Plaintiffs' standing. Each lacks merit. *First*, Defendants argued that Plaintiffs did not have standing to challenge the Act's prohibition on puberty blockers because no patient was receiving that treatment. (Defs' Trial Br. 4.) This argument was already rejected by the Eighth Circuit, and that decision is binding on this Court. *See Brandt* v. *Rutledge*, 47 F.4th 661, 668-69 (8th Cir. 2022). The Act's operative language prohibits "gender transition procedures," not puberty blockers or any other specific treatment. *See* Ark. CODE ANN. § 20-9-1502. Because the testimony showed that three of the minor Plaintiffs were receiving (and the physician Plaintiff was providing) "gender transition procedures," Plaintiffs have standing to challenge the Act in its entirety. *See Brandt*, 47 F.4th at 669 ("[T]his court declines the State's invitation to modify well-established constitutional standing principles to require that a plaintiff demonstrate an injury traceable to every possible application of the challenged statute in order to satisfy the constitutional standing requirement."). Moreover, Dr. Stambough testified that she provides puberty blockers to patients, and the evidence showed that Brooke Dennis will imminently need such treatment, so the State's Ban on that treatment clearly harms Plaintiffs in this suit. (Pltfs' Proposed FOF ¶¶ 95, 98-99, 103, 115.)[3]

[3] Defendants argued that "Plaintiffs . . . lack standing to challenge the SAFE Act's private right of action because Defendants have no 'methods of enforcement' of any such action." (Defs' Trial Br. 5 (quoting *Church* v. *Missouri*, 913 F.3d 736, 749 (8th Cir. 2019)). As the Eighth Circuit recognized, when a law includes both a private and a public enforcement mechanism, Plaintiffs have standing to enjoin the entire law. *Brandt*, 47 F.4th at 668-69. Moreover, this Court already rejected the same argument at the preliminary injunction stage. (ECF No. 60 at 61:2-63:2.)

Second, Defendants argued that Dr. Stambough lacks third-party standing to assert the rights of her patients. (Defs' Trial Br. 6.)[4] To establish third-party standing, a plaintiff must demonstrate (i) "a 'close' relationship with the person who possesses the right," and (ii) "a 'hindrance' to the possessor's ability to protect his own interests." *Kowalski* v. *Tesmer*, 543 U.S. 125, 130 (2004) (citations omitted).

Although Dr. Stambough's third-party standing is not necessary for the Court to reach the merits of the minor Plaintiffs' equal protection claim, *see Brandt*, 47 F.4th at 669 n.3, the evidence at trial established Dr. Stambough's third-party standing. She testified about her close relationship with her patients, explaining that she "get[s] to be on a journey" with each patient, which involves "learning about them" and "understanding their social support and who they have around them." (Pltfs' Proposed FOF ¶ 120.) Her patients often share important developments in their life, like achievements, or a piece of art, or even just regularly check in to share how they are doing. (*Id.*) She also testified about the burden many of her patients would face in asserting their own rights. She told the Court that many of her patients are not open about being transgender, have faced harassment because of their gender identity, and would not be able to bring a lawsuit on their own behalf to challenge the constitutionality of the Act. (*Id.* ¶¶ 121, 123.) In this respect, her testimony aligned with many decisions that have permitted third-party standing by medical professionals seeking to assert the rights of their patients. *See, e.g.*, *Pediatric Specialty Care, Inc.* v. *Arkansas Dep't of Transp.*, 293 F.3d 472, 478 (8th Cir. 2002).

[4] Defendants also argued that Dr. Stambough lacks first-party standing to assert her claims because there is "no fundamental right to perform" the procedures prohibited by the Act. (Defs' Trial Br. 6.) That argument conflates standing with the merits of Dr. Stambough's constitutional claims. *See Animal Legal Def. Fund* v. *Vaught*, 8 F.4th 714, 721 (8th Cir. 2021) (concluding that "[w]hether a plaintiff has a cause of action, however, goes to the merits of a claim and does not implicate the court's 'statutory or constitutional power to adjudicate the case.'") (citation omitted).

Defendants cannot point to any evidence in the record that contradicts Dr. Stambough's testimony. Instead, Defendants have argued that Dr. Stambough cannot establish third-party standing because of a "financial" conflict between her and her patients. (Defs' Trial Br. 6.) The premise of this argument—that doctors and patients have an inherent financial conflict of interest—would mean that no doctor could ever have third-party standing to bring claims on behalf of their patients, which is in conflict with settled precedent. *See, e.g.*, *Pediatric Specialty Care*, 293 F.3d at 478. And Defendants have not identified any decision rejecting third-party standing on that basis and have not put forward any evidence demonstrating that Dr. Stambough does not act in the best interests of her patients when providing gender-affirming medical care.

II. THE TRIAL RECORD SHOWS THAT THE ACT VIOLATES THE EQUAL PROTECTION CLAUSE.

The Act classifies based on transgender status and sex, triggering at least heightened scrutiny, and requiring Defendants to prove that the law is "substantially related" to "important governmental objectives." *United States* v. *Virginia*, 518 U.S. 515, 533 (1996).

Defendants have attempted to justify the Act by arguing that it is substantially related to the important government interests of protecting children and safeguarding medical ethics. (Defs' Trial Br. 20.) But the evidence presented at trial demonstrated that the Act does just the opposite, and that the State's asserted rationales for the Act were either factually baseless or fail to justify why only medical treatments "related to gender transition"—and all such medical treatments—are singled out for prohibition. The evidence made clear that the State's alleged concerns apply to many other kinds of medical treatments that are not prohibited such that the Act's relationship to the asserted interests is "so attenuated as to render the distinction arbitrary or irrational" and, therefore, unconstitutional under any level of scrutiny. *City of Cleburne* v. *Cleburne Living Ctr.*, 473 U.S. 432, 446 (1985) (citations omitted).

A. The Act Is Subject to Heightened Scrutiny Because It Classifies Based on Transgender Status and Sex.

1. The Act Classifies on the Basis of Transgender Status and Sex.

By its plain terms, the Act classifies on the basis of both transgender status and sex. "A facial inquiry is what it sounds like: a review of the language of the policy to see whether it is facially neutral or 'deal[s] in explicitly racial [or gendered] terms.' " *Kadel* v. *Folwell*, 2022 WL 3226731, at *18 (M.D.N.C. Aug. 10, 2022). Here, the text of the Act refers to both "sex" and "gender transition," thereby differentiating based on both transgender status and sex on its face.

Transgender Status. The Act facially differentiates based on transgender status by prohibiting care related to "gender transition." ARK. CODE ANN. § 20-9-1502. A transgender person is someone with a gender identity that does not align with their sex assigned at birth. (Pltfs' Proposed FOF ¶ 126.) Only transgender people undergo "gender transition" (*id.* ¶ 144), and the Act singularly and explicitly prohibits any and all medical care prescribed to minors for this purpose, ARK. CODE ANN. § 20-9-1502. The Act also creates a transgender status classification for the additional reason that non-transgender adolescents are able to receive puberty blockers, estrogen, testosterone suppression, or testosterone for any medically-indicated purpose, but transgender adolescents cannot. (*See* Pltfs' Proposed FOF ¶¶ 246, 254, 261, 263-64 (discussing various uses of these medications).

Though Defendants claim that it is the *conduct* of undergoing "gender transition" that is being targeted, not the *status* of being transgender, the Supreme Court has "declined to distinguish between status and conduct" in analogous contexts. *Christian Legal Soc'y Chapter of the Univ. of Cal., Hastings Coll. of the L.* v. *Martinez*, 561 U.S. 661, 689 (2010) (rejecting the idea that discrimination based on same-sex intimacy was not discrimination based on sexual orientation); *see also Lawrence* v. *Texas*, 539 U.S. 558, 583 (2003) (O'Connor, J., concurring)

(where "the conduct targeted by th[e] law . . . is closely correlated" with the status of being gay, a sodomy law "is targeted at more than conduct. It is instead directed toward gay persons as a class.").

Sex. The Act also classifies and discriminates based on sex in at least four ways. *First*, discrimination against someone because they are transgender is a form of sex discrimination. As the Supreme Court recognized, "it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex." *Bostock* v. *Clayton Cnty*., 140 S. Ct. 1731, 1741 (2020). While *Bostock* addressed the nature of sex discrimination under Title VII of the Civil Rights Act, nothing about this aspect of Court's reasoning is limited to that statutory context. *See*, *e.g*., *Kadel*, 2022 WL 3226731, at *19 (applying *Bostock*'s reasoning to the court's equal protection analysis), *appeal pending* No. 22-1721 (4th Cir.); *Eknes-Tucker* v. *Marshall*, 2022 WL 1521889, at *9 (M.D. Ala. May 13, 2022) (same), *appeal sub nom Boe* v. *Marshall*, No. 22-11707 (11th Cir.).

Second, where the state "intentionally penalizes a person identified as male at birth for . . . actions that it tolerates in [someone] identified as female at birth"—here, pursuing medical intervention to affirm a female identity—"sex plays an unmistakable and impermissible role." *Bostock*, 140 S. Ct. at 1741-42. Put another way, whether care is prohibited turns explicitly on a person's sex assigned at birth—referred to in the law as "biological sex." ARK. CODE ANN. § 20-9-1501(1). For example, a person assigned female at birth can receive testosterone suppression to counter the virilization caused by polycystic ovarian syndrome, *see* Pltfs' Proposed FOF ¶¶ 263-64, 404, but a person assigned male at birth cannot be treated with testosterone suppression to counter virilization, because that is "gender transition." As such, the plain terms of the Act create a sex-based distinction.

Third, because the Act's prohibition "cannot be stated without referencing sex . . . [o]n that ground alone, heightened scrutiny should apply." *Grimm* v. *Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 608 (4th Cir. 2020) (internal citation omitted). As the Supreme Court explained in *Bostock*, "try writing out instructions" for which treatments are prohibited "without using the words man, woman, or sex (or some synonym). It can't be done." *See Bostock*, 140 S. Ct. at 1746. The very nature of the prohibition as written out in the Act uses explicitly sex-based terms and on its face creates a sex-based classification.

Fourth, the Act prohibits care solely based on whether it comports with stereotypes about sex. Treatment is prohibited when it "alter[s] . . . features" the State considers "typical" of a person's assigned sex at birth or when it "create[s] physiological or anatomical characteristics that resemble a sex different from the individual's biological sex." ARK. CODE ANN. § 20-9-1501(4, 6). This is a "form of sex stereotyping where an individual is required effectively to maintain his or her natal sex characteristics." *Boyden* v. *Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018). The Act goes so far as to make an explicit exemption for the same treatments for individuals with intersex conditions (referred to in the Act as disorders of sexual development), including surgery on infants to bring the appearance of their bodies into alignment with what is deemed typical of their assigned sex. *See* ARK. CODE ANN. § 20-9-1501(6)(B)(i); (Pltfs' Proposed FOF ¶¶ 300 & n.20 (describing feminizing genitoplasty surgery performed on infants and young children with differences of sexual development).)

The fact that one sex is not categorically treated worse than another does not change the fact that the law discriminates based on sex for purposes of equal protection. "[T]he Equal Protection Clause, extending its guarantee to 'any person,' reveals its concern with rights of individuals, not groups." *J.E.B.* v. *Alabama ex rel. T.B.*, 511 U.S. 127, 152 (1994) (Kennedy, J.,

concurring); *see also Waters* v. *Ricketts*, 48 F. Supp. 3d 1271, 1282 (D. Neb. 2015) ("The 'equal application' of [bans on same-sex marriage] to men and women as a class does not remove them from intermediate scrutiny"), *aff'd on other grounds*, 798 F.3d 682 (8th Cir. 2015); *Loving* v. *Virginia*, 388 U.S. 1, 8 (1967) (rejecting "the notion that the mere 'equal application' of a statute containing racial classifications is enough to remove the classifications from the Fourteenth Amendment's proscription of all invidious racial discriminations").

Defendants have argued that the law does not facially classify on the basis of sex or transgender status, citing the Supreme Court's decision in *Geduldig* v. *Aiello*, 417 U.S. 484 (1974). But Defendants' reliance on *Geduldig* is misplaced. In *Geduldig*, the Supreme Court determined that discrimination based on pregnancy was not necessarily discrimination based on sex. *Id.* at 494-95. There, the policy at issue did not explicitly reference sex and the question was, in essence, whether pregnancy was a close enough proxy for sex to create a facial classification. *Id.* at 489-90. Here, the statute at issue facially classifies based on sex and for that reason alone *Geduldig* is inapposite. With respect to the question of whether a "gender transition" classification is a "transgender status" classification, *Geduldig* is likewise not controlling. "Gender transition" is a close proxy for "transgender status" such that the prohibition is a facial classification. And the more analogous cases are those holding that laws targeting same-sex relationships and intimacy are sexual orientation classifications. *See, e.g.*, *Christian Legal Soc'y*, 561 U.S. at 689.

2. Classifications Based on Sex and Transgender Status Each Independently Trigger Heightened Scrutiny.

When government differentiates, as the State has done here, based on sex and/or transgender status, its line-drawing triggers heightened scrutiny.

Sex. "[A]ll gender-based classifications today warrant heightened scrutiny." *Virginia*, 518 U.S. at 555 (internal quotation marks omitted). There is no exception for sex

discrimination based on physiological or biological characteristics. *See Tuan Anh Nguyen* v. *INS*, 533 U.S. 53, 70, 73 (2001) (applying heightened scrutiny to different standard of establishing citizenship through fathers and mothers, which was based on biological differences related to procreation).

Transgender status. As this Court previously held, transgender people satisfy all the indicia of a suspect class: (1) they have historically been subject to discrimination; (2) they have a defining characteristic that bears no relation to their ability to contribute to society; (3) they may be defined as a discrete group by obvious, immutable, or distinguishing characteristics; and (4) they are a minority group lacking political power. *See*, *e.g.*, *Windsor* v. *United States*, 699 F.3d 169, 181 (2d Cir. 2012) (identifying the four considerations used to identify a suspect classification), *aff'd on other grounds*, 570 U.S. 744, 770 (2013); *see also Grimm*, 972 F.3d at 611-13 (holding that transgender status is a quasi-suspect classification that requires such classifications to be tested under heightened scrutiny); *Karnoski* v. *Trump*, 926 F.3d 1180, 1200-01 (9th Cir. 2019) (same).[5]

History of discrimination. "There is no doubt that transgender individuals historically have been subjected to discrimination on the basis of their gender identity, including high rates of violence and discrimination in education, employment, housing, and healthcare access." *Grimm*, 972 F.3d at 611 (citation omitted). As the Fourth Circuit detailed in *Grimm*, there is extensive data documenting the staggering discrimination that transgender people face in all aspects of life. *Id.* at 611-12. This pattern of discrimination is long-standing, including through

[5] Although there is record evidence related to some of these factors, when courts decide the legal question of what level of equal protection scrutiny applies to a classification, they are not confined to record evidence presented by the parties. *See, e.g., Frontiero v. Richardson*, 411 U.S. 677, 684-86 (1973) (referencing diverse sources including history books and law review articles in its analysis supporting its conclusion that classifications based on sex are inherently suspect); *Grimm*, 972 F.3d at 611-12 (referencing congressional records and law review articles).

formal governmental action. Expression of a person's transgender identity was criminalized for much of the nineteenth and twentieth centuries through cross-dressing laws. *See* Jennifer Levi & Daniel Redman, *The Cross-Dressing Case for Bathroom Equality*, 34 SEATTLE U. L. REV. 133, 152-53, 171 (2010). More recently, Congress explicitly excluded transgender people from protection under four civil rights statutes over the past thirty years. *See* Kevin M. Barry et al., *A Bare Desire to Harm: Transgender People and the Equal Protection Clause*, 57 B.C. L. REV. 507, 556-57 (2016). And state legislatures in Arkansas and across the country have introduced numerous bills targeting the transgender community in the past few years. (Pltfs' Proposed FOF ¶ 309); Sam Levin, *Mapping the anti-trans laws sweeping America: 'A war on 100 fronts,'* GUARDIAN (June 14, 2021), https://www.theguardian.com/society/2021/jun/14/anti-trans-laws-us-map [https://perma.cc/9Z2L-T9V4]. Dylan Brandt and Dr. Stambough testified about the fear for one's safety and harassment experienced by transgender people in Arkansas. (Pltfs' Proposed FOF ¶¶ 27, 122.)

Defining characteristic that bears no relation to the ability to contribute to society. Transgender people have a defining characteristic that "bears no relation to ability to perform or contribute to society." *See Cleburne*, 473 U.S. at 441. The relevant question is not whether every person in the class is the same but rather whether they share a characteristic that "tend[s] to be irrelevant to any proper legislative goal." *Plyler* v. *Doe*, 457 U.S. 202, 216 n.14 (1982). Transgender people share the defining characteristic of having a gender identity that does not align with their birth-assigned sex. (Pltfs' Proposed FOF ¶ 126.) And "[s]eventeen of our foremost medical, mental health, and public health organizations agree that being transgender implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." *Grimm*, 972 F.3d at 612 (internal quotation marks omitted).

Obvious, immutable, or distinguishing characteristics. There is no requirement that a characteristic be immutable in a literal sense in order to trigger heightened scrutiny. For example, heightened scrutiny applies to classifications based on alienage and "illegitimacy" even though both classifications are subject to change. *Windsor*, 699 F.3d at 183 n.4; *see Nyquist* v. *Mauclet*, 432 U.S. 1, 9 n.11 (1977) (rejecting argument that alienage did not deserve strict scrutiny because it was mutable). "Rather than asking whether a person *could* change a particular characteristic, the better question is whether the characteristic is something that the person *should* be required to change [in order to avoid government discrimination] because it is central to a person's identity." *Wolf* v. *Walker*, 986 F. Supp. 2d 982, 1013 (W.D. Wis. 2014) (emphasis in original), *aff'd sub nom*, *Baskin* v. *Bogan*, 766 F.3d 648 (7th Cir. 2014); *see also Latta* v. *Otter*, 771 F.3d 456, 464 n.4 (9th Cir. 2014). "A transgender person's awareness of themselves as male or female is no less foundational to their essential personhood and sense of self than it is for those [who are not transgender]." *Grimm*, 972 F.3d at 624 (Wynn, J., concurring). A person's gender identity is a core part of who they are. (Pltfs' Proposed FOF ¶ 124.) In any case, the evidence showed that gender identity is not something that can be changed voluntarily or by external forces. (*Id.* ¶ 129.) Efforts to try to change a transgender person's gender identity have been unsuccessful and harmful. (*Id.* ¶¶ 130-32, 130 n.3.)

Political powerlessness. The final factor concerns whether the class of persons is "in a position to adequately protect themselves from the discriminatory wishes of the majoritarian public." *Windsor*, 699 F.3d at 185. As the 2021 session of the Arkansas General Assembly made clear (*see* Pltfs' Proposed FOF ¶ 303), transgender people are not in such a position.

B. Defendants Failed to Carry Their Burden Under Heightened Scrutiny.

Heightened scrutiny imposes a burden "rest[ing] entirely on the State" to demonstrate an "exceedingly persuasive" justification for the differential treatment. *Virginia*, 518

U.S. at 533 (cleaned up). Defendants "must show at least that the [challenged] classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *Id*. (internal quotation marks and citations omitted). And "[t]he justification must be genuine, not hypothesized or invented *post hoc* in response to litigation." *Id*.

Defendants have claimed that the Act advances an interest in protecting children and safeguarding medical ethics, but after a two-week trial, they have failed to meet their demanding burden of showing how the Act advances these interests. To the contrary, the evidence showed that the prohibited medical care improves the mental health and well-being of patients and that, by prohibiting it, the State undermined the interests it claimed to be advancing. Further, the various claims underlying Defendants' arguments that the Act protects children and safeguards medical ethics are unsupported by the record and do not explain why *only* gender-affirming medical care—and *all* gender-affirming medical care—is singled out for prohibition. See Section II(B)(2), *infra.*

1. The Banned Care Improves Patient Health.

The evidence at trial showed that the prohibited medical care improves the health and well-being of many adolescents who need it. That conclusion—which is supported by the testimony of well-credentialed experts, doctors who provide gender-affirming medical care in Arkansas, and families that rely on that care—directly refutes any claim by the State that the Act advances an interest in protecting children.

Three of Plaintiffs' experts and two Arkansas doctors detailed the significant mental health benefits of gender-affirming medical care for adolescents with gender dysphoria, which they have observed clinically. Drs. Dan Karasic, Jack Turban, and Deanna Adkins have collectively treated thousands of patients with gender dysphoria and testified about their own

clinical experiences witnessing the positive, life-changing impact of gender-affirming medical interventions on their adolescent patients as well as the comparable experiences of their colleagues around the country. (*See* Pltfs' Proposed FOF ¶¶ 217, 220.) Drs. Stambough and Michele Hutchison similarly testified about the many positive impacts of gender-affirming medical interventions on the health and well-being of their adolescent patients in Arkansas. (*Id.* ¶¶ 77-78, 116, 217, 220.) And the testimony showed that the benefit of this care is long lasting. (*Id.* ¶ 222.) Defendants put forth no evidence contesting the extensive clinical experience of Plaintiffs' witnesses. In fact, Defendants' only expert witness to have ever treated patients for gender dysphoria, Dr. Levine, testified about his concern that removing care from patients currently receiving it would have "shocking" and "devastating" psychological consequences. (*Id.* ¶ 322.)[6]

This expert testimony was bolstered by the unrebutted testimony of the Plaintiff families who explained how gender-affirming medical care positively transformed the lives of their adolescent children with gender dysphoria. For adolescents, like minor Plaintiffs Parker Saxton, Dylan Brandt, and Sabrina Jennen, this care allowed them to grow from depressed, anxious, and withdrawn young people into happy and healthy teenagers who looked forward to their futures. (*See id.* ¶¶ 1-84.)

In addition to the uncontested testimony about the clinical benefits of treatment from clinicians and Plaintiff families, Plaintiffs' experts testified about the body of research demonstrating that the banned medical interventions improve patient health. (*Id.* ¶¶ 223-31.) Dr. Turban testified about the sixteen studies conducted in multiple countries over the past twenty

[6] Dr. Levine made clear that he was not offering testimony in support of the law. (Pltfs' Proposed FOF ¶ 389.) In addition to expressing his concern that it will cause psychological harm to youth who would have to discontinue care, he testified that he would be concerned if the law resulted in doctors having their licenses taken away for providing care. (*Id.* ¶¶ 390-92.) Dr. Levine himself has written letters authorizing hormone therapy for minors with gender dysphoria and would consider doing so on a case-by-case basis going forward. (*Id.* ¶ 392.)

years that collectively show that use of pubertal suppression and gender-affirming hormones to treat adolescents with gender dysphoria improves patient health and prevents the worsening of distress upon the onset of puberty. (*Id.* ¶ 224.) He testified as well that the studies about the efficacy of hormone therapy show positive outcomes consistent with dozens of studies about the efficacy of such therapy to treat gender dysphoria in adults. (*Id.* ¶ 226.). Additionally, Dr. Turban testified about studies showing the benefits of chest masculinization surgery for adolescent transgender males. (*Id.* ¶ 227.)

Defendants' proposed findings of fact do not even attempt to contend with Plaintiffs' experts' testimony regarding the benefits of the banned medical care. All they offer is testimony from one of their experts critiquing the methodology and quality of the research studies demonstrating efficacy. But even if the Court were to credit the remarkable suggestion that an entire body of research is meaningless—and it should not, *see* Section II(B)(2)(a), *infra*—Defendants offer no evidence to refute the decades of clinical experience demonstrating the efficacy of gender-affirming medical care. Additionally, Defendants' experts offered no evidence-based treatment alternatives. When asked at trial what would happen, as both a researcher and a clinician, if a law like the Act were to go into effect, Dr. Turban explained:

> It would be emotional to think about. Because the reality is that we frequently in clinic have families that are coming to us with these young people who are really struggling with severe anxiety, depression, sometimes suicidal thoughts, sometimes their mental health is declining so dramatically that they can't go to school, and it's my job to tell families what the evidence-based approaches are to help their child. So if these treatments were not an option, I'd be left without any evidence-based approaches to treat this young person's gender dysphoria.

(*Id.* ¶ 317.)

The evidence showed that based on the decades of clinical experience and scientific research, it is widely recognized in both the medical and mental health fields—including by major medical and mental health professional associations—that gender-affirming medical care can

relieve the clinically significant distress associated with gender dysphoria in adolescents. (*Id.* ¶¶ 143, 154, 241, 304 n.21.)Defendants' claim that the Act can be justified because it advances an interest in protecting children cannot be squared with the evidence showing the substantial benefits of this treatment for the adolescents who need it. Rather than protecting children or safeguarding medical ethics, the Act harms children and undermines the ethical duties of doctors to protect the health and well-being of their patients.

2. The Arguments Underlying Defendants' Claim That the Act Advances an Interest in Protecting Children Are Unsupported by the Record and Do Not Justify the Act.

Throughout this litigation, Defendants have attempted to meet their heavy burden by offering the following assertions in support of banning gender-affirming medical care for adolescents: (i) that there is a lack of evidence of efficacy of the banned care; (ii) that the banned treatment has risks and side effects; (iii) that many patients will desist in their gender incongruence; (iv) that some patients will later come to regret having received irreversible treatments; and (v) that treatment is being provided without appropriate evaluation and informed consent. As explained below, none of those arguments are supported by the record; nor do these arguments explain why *only* gender-affirming medical care—and *all* gender-affirming medical care—is singled out for prohibition.

In an attempt to support their assertions, Defendants have offered proposed findings of fact that reflect an inaccurate and selective portrayal of the testimony presented at trial. Those findings include several assertions about how gender-affirming medical care is provided in Arkansas that are not supported by the record. For instance, Defendants claim that "[t]he Gender Spectrum Clinic would consider on a case-by-case basis prescribing puberty blockers or hormones to individuals who do not have gender dysphoria but request those treatments." (*See* Defs' Proposed FOF ¶ 177 (citing Dr. Hutchison's testimony).) But Dr. Hutchison's testimony was clear

that a gender dysphoria diagnosis was required prior to initiating gender-affirming medical treatments at the ACH gender clinic. (Pltfs' Proposed FOF ¶ 200; *see also* Vol. 3, at 527:13-20, 528:1-4 (Hutchison).) In the testimony cited by Defendants, Dr. Hutchison was discussing how the clinic would approach treatment for non-binary patients—that is, treatment would be considered on a case-by-case basis. (Vol. 3, at 570:2-12 (Hutchison).) Defendants' proposed findings of fact similarly say that Dr. Janet Cathey prescribes hormone therapy to minor patients without a gender dysphoria diagnosis. (*See* Defs' Proposed FOF ¶ 167 (citing Dr. Cathey's testimony).) But Dr. Cathey said the opposite. (Vol. 4, at 759:10-761:14 (Cathey).) And Defendants say that Dr. Stephanie Ho prescribes puberty blockers to patients with gender dysphoria. (*See* Defs' Proposed FOF ¶ 172 (citing Dr. Ho's testimony).) But she testified that she does not prescribe puberty blockers as gender-affirming medical care. (Vol. 4, at 749:3-5 (Ho).)

Other misrepresentations are made throughout Defendants' proposed findings of fact. For example, they claim that "[o]ther than for gender dysphoria, Plaintiff Dr. Katheryn [*sic*] Stambough does not administer medical treatments that will lead to infertility, outside of treating cancer." (Defs' Proposed FOF ¶ 84.) But Dr. Stambough offered that as one *example* of treatment that can affect fertility; she never suggested it was the only treatment. (Vol. 3, at 614:15-615:5.) And, astonishingly, Defendants claim that "[a]mong adults who medically transition, some studies show that over 20% later desist[]." (Defs' Proposed FOF ¶ 28.) They offer this proposed finding despite the fact that Dr. Levine acknowledged (after initially misrepresenting the figure as 30%) that the 20% figure represented the number who had "stop[ped] hormones," which can happen for

a variety of reasons apart from detransitioning. (Vol. 5, at 949:24-954:19.)[7] These are just some of the numerous misrepresentations of the record made by Defendants.

In addition to their misrepresentations of the testimony, Defendants simply failed to contend with the testimony of Plaintiffs' experts. They make no argument challenging the qualifications of Plaintiffs' experts. Nor do they offer any basis to challenge their credibility.

On an accurate view of the factual record, none of the State's asserted justifications support its ban on gender-affirming medical care for adolescents. None of them justify the State's decision to single out for prohibition *only* gender-affirming medical care. And none of them justify the State's decision to prohibit *all* gender-affirming medical care.

a. The Assertion That There Is a Lack of Evidence of Efficacy Does Not Justify the Act.

The Act's legislative findings and Defendants' experts assert that there is a lack of evidence of efficacy of the banned treatments. That is incorrect. As discussed above, the evidence presented at trial showed that there is substantial clinical and research evidence demonstrating the efficacy of the banned medical care. *See* Part II.B.1, *supra*. The defense experts did not even attempt to refute the clinical evidence. Nor did they deny the existence of research showing benefits of gender-affirming medical care; rather, one of their experts, Dr. Paul Hruz, quarreled with the methodology of individual studies and the quality of the evidence.[8]

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[7] Defendants also made misrepresentations about the care of Plaintiff Sabrina Jennen. [redacted] None of this is material to Plaintiffs' claims, but further illustrates the lack of trustworthiness of Defendants' representations in their proposed findings of fact.

[8] Dr. Hruz failed to offer any evidence showing the banned treatments are ineffective. Additionally, despite critiquing Plaintiffs' experts' reliance on studies with certain methodological limitations, he himself relied on one of those studies in his testimony. (Pltfs' Proposed FOF ¶ 403(a).) Ultimately, Dr. Hruz's testimony should be viewed with suspicion given some of the extreme statements he has signed onto regarding transgender people, *e.g.*, a brief

Methodology: Dr. Hruz critiqued the methodology of the studies showing the effectiveness of gender-affirming medical care for minors, suggesting the entire body of research should be disregarded for this reason. But, as Dr. Turban explained, all medical research has limitations (as Dr. Hruz conceded, Vol. 8, at 1273:1-2), which makes it necessary to consider the body of research as a whole. (Pltfs' Proposed FOF ¶ 228.) Here, the entire body of research on gender-affirming medical care, which uses a variety of methods, all points to the same result: Treatment is effective. *See* Part II.B.1, *supra.*[9]

Quality of evidence: Defendants' witnesses focused on the lack of randomized controlled trials in support of the banned treatment.[10] But experts on both sides testified that medical care is often provided without the benefit of randomized controlled trials—generally considered the highest quality evidence—and is therefore based on lower quality evidence such as cross-sectional and longitudinal studies. (Pltfs' Proposed FOF ¶¶ 232-40.) That is necessary because it is often not feasible or ethical to have randomized controlled trials in support of a particular treatment. (*Id.* ¶¶ 237-39.) Banning medical treatment that is not supported by

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that referred to support for transgender youth through social transition as "maintain[ing] his or her delusion" by "requiring others in the child's life to go along with the charade," and that his articles on gender-affirming medical care were published by a Catholic bioethics organization that takes the position that "[g]ender transitioning insists on affirming a false identity and, in many cases, mutilating the body in support of that falsehood." (Pltfs' Proposed FOF ¶ 405; *see also* Vol. 8, at 1322:10-1324:16, 1326:11-21.)

[9] Defendant's expert, Dr. Hruz, claimed that research studies from a clinic in the Netherlands cannot be relied upon because those studies' participants were a selective group and received mental health support in addition to medical interventions. But that critique does not justify the ban. As Dr. Turban testified, there is research from other clinics that likewise found that the care is effective, and many aspects of the Dutch protocols are mirrored in the WPATH and Endocrine guidelines. (Vol. 2, at 306:2-308:25.)

[10] Defendants' experts agree that more research on gender-affirming medical care in adolescents is needed, but if the Act were to go into effect, no such research could be conducted in Arkansas, including the randomized controlled trials that Defendants claim are necessary. (Pltfs' Proposed FOF ¶ 331.)

randomized controlled trials would significantly limit treatments that are routinely administered and would ultimately have a substantial negative effect on patient welfare. (*Id.* ¶ 239.)

Expert witnesses on both sides agreed that in medicine, clinicians do not always have the level of research that they would prefer in support of a particular intervention but, when patients are suffering, it is necessary to make treatment decisions based on the available evidence. (*Id.* ¶¶ 238-40.)[11] Patients who are suffering cannot afford to wait until more research is accumulated.

The State's medical regulations apparently recognize that fact. Arkansas does not limit medical care to treatments supported by a particular threshold level of evidence and allows care even in the absence of *any* evidence of a treatment being effective. For example, even though the Arkansas Department of Health advised that there is no evidence that ivermectin is effective for the treatment of COVID-19, the State leaves it to doctors whether to prescribe the drug for this off-label purpose. (PX 9, at 148:13-16 (Embry); PX 18, at 81:21-82:21 (Branman).)

Given the decades of clinical experience and scientific research showing the effectiveness of gender-affirming medical care, major medical professional organizations in the United States support this treatment[12] and strongly opposed the Act as undermining the well-being of adolescents with gender dysphoria. (Pltfs' Proposed FOF ¶¶ 154, 304 n.21.) This is relevant not because states must follow medical association guidelines—the straw man that Defendants

[11] For example, one of the State's experts, Dr. Lappert, performs surgeries on patients that are supported only by his own anecdotal experience of the treatment being effective, which he recognizes is the lowest-level evidence. (Pltfs' Proposed FOF ¶ 238 n.13.)

[12] Defendants suggest that some European countries have enacted treatment guidelines for minors with gender dysphoria that are consistent with the Act. (Defs' Proposed FOF ¶ 37.) While some countries have guidelines that urge greater caution in providing such care, none of them prohibit care and they all contemplate that gender-affirming medical care is appropriate for some minors. (*See* Pltfs' Proposed FOF ¶¶ 381-82.)

attack—but rather because such widespread support undermines their claim that the care has not been shown to be effective.

Defendants urge the Court to disregard the major medical organizations' views about gender-affirming medical care for adolescents with gender dysphoria, claiming they are based on ideology rather than science. To support this claim, they offered the testimony of Professor Mark Regnerus, but his testimony did not offer any support for this assertion. (*See* Pltfs' Proposed FOF ¶ 383.) To accept this claim would require the Court to both credit Professor Regnerus' testimony and the notion that every major medical association in the United States is driven by ideology rather than science and patient well-being. There is no basis and no evidence supporting such a conspiratorial assessment of all of the major medical associations.

b. The Potential Risks of Treatment Do Not Justify the Act.

The testimony at trial also undermined the claim that the potential risks of the banned treatments justify the Act. First, the testimony showed that adverse health consequences are rare when treatment is provided by a physician.[13] And witnesses on both sides testified that the potential risks of hormone therapy, with the exception of potential risks to fertility for hormonal interventions, are present regardless of whether (i) the treatment is provided for gender transition or for another medically indicated purpose or (ii) the treatment is provided to birth-assigned males or birth-assigned females.[14] Ultimately, as both sides' experts agree, all medical interventions involve weighing risks and benefits (Pltfs' Proposed FOF ¶ 243), but it is only for "gender

[13] Dr. Hutchison testified about her concern that, if the Act takes effect, adolescents will find ways to get medications outside of the care of a physician and may suffer harm from doing so. (Pltfs' Proposed FOF ¶ 330.)

[14] Drs. Hruz and Adkins testified that potential risks of hormone therapy, like risk of stroke from estrogen, for example, are present when the treatment is used to treat birth-assigned males for gender dysphoria or birth-assigned females for different indications. (Pltfs' Proposed FOF ¶ 265.) Dr. Adkins also testified that non-fertility related side effects of testosterone are the same when the treatment is used for other indications. (*Id.* ¶ 255.)

transition" treatments that the State has removed from adolescent patients and their families the ability to weigh the risks and benefits of care.

Defendants' experts focused on the potential risk of infertility, but not all of the banned treatments pose a risk to fertility, and the banned medical treatments are not the only pediatric medical interventions that can impair fertility. As Dr. Adkins testified, puberty blockers on their own do not affect fertility, and many patients treated with hormone therapy are able to biologically conceive children. (*Id.* ¶ 253.) Although fertility may be affected, that is not necessarily the case, and there are ways to adjust treatment to protect fertility if that is important to the patient and their family.[15] Chest masculinization, among treatments banned by the Act, also has no effect on fertility.

In addition to greatly overstating the risk of impaired fertility, Defendants cannot explain why only this treatment is banned given that it is not the only medical care that involves that risk. As Plaintiffs' experts testified, some treatments for pediatric patients with certain rheumatologic conditions, kidney diseases, and cancers can also cause infertility. (*Id.* ¶ 274.) Yet those treatments are not prohibited.

Defendants' expert, Dr. Hruz, also focused on the impact of pubertal suppression on the accrual of bone mineral density. This potential side effect is relevant only for pubertal suppression and does not justify a ban on all other forms of gender transition care. But even focusing on pubertal suppression, this is an expected effect of treatment, and once puberty is

[15] For the very small number of patients who go directly from pubertal suppression at the very beginning of puberty (Tanner Stage 2) to gender-affirming hormone therapy, the treatment can be sterilizing. That risk is discussed with families and there are options for adjusting treatment to maximize fertility preservation if that is a priority. Ultimately, as with other treatments that can impair fertility, the decision is made by the patient and their parents after weighing the risks and benefits. (Pltfs' Proposed FOF ¶ 252 & n.15.)

started, either through cross-sex hormone therapy or endogenous puberty, rapid bone mineral density accrual resumes. As Dr. Adkins testified, data shows that bone density accrual reaches normal levels "two to three years after [after a patient is] on either gender-affirming hormones or go[es] through their own puberty." (*Id.* ¶ 250.)[16]

The evidence at trial showed that there is nothing unique about the risks of the prohibited treatments that would justify a prohibition. As Dr. Antommaria testified—with no dispute from Defendants' experts—there are many forms of pediatric medical care that carry greater or comparable risks (*id.* ¶ 245), but only treatment related to "gender transition" is prohibited.[17] For other medical treatments that have risks, the State leaves it to patients and their parents and doctors to weigh the possible risks of treatment against the benefits of treatment. (Pltfs' Proposed FOF ¶ 288.) That is true even when there are known serious risks related to a particular treatment. (*Id.*) As Drs. Adkins, Stambough, and Hutchison all testified, under existing guidelines and in clinical practice around the country and in Arkansas, patients and parents are advised of the potential risks of treatment, including potential risks to fertility. And as with other medical interventions that can affect fertility, patients and their families are informed about fertility preservation. (*Id.* ¶¶ 211, 269, 274.) Despite this, the State has removed from patients, their families, and their doctors the ability to weigh the potential benefits and risks of treatment only for medical treatments related to "gender transition." Asserted concerns about risks related to

[16] Dr. Levine also asserted that there are potential psychosocial harms of delaying puberty beyond when their peers are going through puberty. (Vol. 5, at 826:19-827:19.) But Dr. Adkins, the only expert witness who has treated gender dysphoria patients with puberty blockers, testified that when blockers are used to treat gender dysphoria, patients go through puberty within the normal age range, albeit within the latter part of that range. (Vol. 1, at 211:8-21.) At the ACH gender clinic, puberty blockers are provided in the same way and patients go through puberty within the same age range as their peers. (Vol. 3, at 538:15-19 (Hutchison).)

[17] Dr. Antommaria testified that the risks of chest surgeries were comparable when provided for gender transition and other indications. (Vol. 2, at 391:10-392:16.)

treatment therefore do not justify the Act's singling out for prohibition only treatment related to "gender transition."

c. The Claim That a Majority of Patients Will Desist in their Gender Incongruence Does Not Justify the Act.

The Act's legislative findings state that "[f]or the small percentage of children who are gender nonconforming or experience distress at identifying with their biological sex, studies consistently demonstrate that the majority come to identify with their biological sex in adolescence or adulthood, thereby rendering most physiological interventions unnecessary." Act 626, Section 2(3). That claim is unsupported by the record at trial.

As Drs. Turban and Karasic testified, the research relied upon by the Arkansas General Assembly and by Defendants' experts regarding so-called desistence rates all focus on pre-pubertal children (for whom no gender-affirming medical interventions are indicated) and not the adolescent population affected by the Act. (Pltfs' Proposed FOF ¶¶ 358-59.) Additionally, these studies were older and tracked patients using diagnostic criteria that preceded the current gender dysphoria in childhood diagnosis. In those older studies, many of the youth included were gender non-conforming children who never identified as a different sex in the first place because previous diagnoses did not require a cross-sex identification to meet the diagnostic criteria. (*Id.* ¶ 359.)

The evidence presented at trial showed that once a patient reaches the start of puberty with persistent and consistent gender dysphoria, the likelihood that they will come to identify with their assigned sex is low.[18] (Pltfs' Proposed FOF ¶ 361.) Given that all the banned

[18] Seemingly in an attempt to support the position that there is a high rate of desistance among adolescents, Defendants offered the testimony of a fact witness, Dr. Roger Hiatt, who testified that about 6 to 10 of the more than 200 youth with gender dysphoria who have been committed to the residential psychiatric facility where he works came to identify with their birth-assigned sex. (Pltfs' Proposed FOF ¶ 362.) But because Dr. Hiatt did not treat their gender

treatments are provided to patients only after the onset of puberty, the fact that some younger children may not ultimately persist in a transgender identity does not explain why adolescents who need medical intervention should have it banned by the State.

d. The Possibility That Patients Will Regret Irreversible Treatment Does Not Justify the Act.

Defendants' expert witness, Dr. Levine also claimed that there is a high risk that minors will detransition later in life and come to regret irreversible[19] treatments that they have received. That claim is also unsupported by the trial record. The evidence showed that regret is rare for gender-affirming medical care and is possible for all medical interventions. (*Id.* ¶¶ 373, 380.) But it is only treatment related to "gender transition" that is categorically banned on this asserted basis.

In the decades of clinical experience of doctors who testified for both parties, it was rare for individuals who have received gender-affirming medical care to regret treatment because they have come to identify as their birth-assigned sex. In Dr. Karasic's clinical experience treating thousands of patients with gender dysphoria over 30 years, none of his patients who had received gender-affirming medical care later came to identify with their sex assigned at birth. (*Id.* ¶ 374.) Similarly, there have been no patients at the ACH gender clinic who received gender-affirming medical care and later indicated that they regretted treatment or detransitioned. This is true for both current patients and former patients who were contacted by the clinic into their twenties. (*Id.*

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dysphoria—he only treated the other mental health conditions that prompted their hospitalization—and did not offer context that would allow conclusions to be drawn about this group of patients, his testimony does not support the claim that desistance among adolescents with gender dysphoria is common. (*Id.*)

[19] Not all of the prohibited treatments are irreversible. As Dr. Adkins testified, pubertal suppression is just a pause on the progression of puberty and once the treatment is stopped, endogenous puberty resumes. (Pltfs' Proposed FOF ¶¶ 249, 253.)

¶ 375.) And in his more than 50 years seeing patients with gender dysphoria, many of whom medically transitioned, Defendants' expert Dr. Levine was aware of only two patients who detransitioned. (*Id.* ¶ 376.)[20]

There are few studies on rates of regret among those who received gender-affirming medical care but, like the clinical observations of the trial witnesses, these studies show very low rates of regret. (*Id.* ¶ 377.) On direct examination, Dr. Levine claimed that there were high rates of detransition, but ultimately could not support his claim with actual data. (*See* Part II.B., *supra*; Pltfs' Proposed FOF ¶ 378 & n.34.)[21]

Ultimately, the fact that some patients come to regret treatment is also not unique to gender-affirming medical care. (*Id.* ¶ 380.) Concerns over a very small subset of patients regretting treatment cannot justify a categorical ban on the treatment for all those who need it.[22] If that were sufficient, then all medical treatments could be banned based on the outlier experiences of a minority of patients.

e. Claims About Treatment Being Provided Without Appropriate Assessment or Informed Consent Do Not Justify the Act.

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[20] Defendants put on two witnesses who had detransitioned. Their anecdotal experiences are especially irrelevant to this case because both had transitioned and detransitioned as adults, neither received treatment in Arkansas, and both testified that their detransition was prompted by a religious experience. (Pltfs' Proposed FOF ¶ 379.)

[21] While Defendants say the rate of detransitioning is increasing, citing Dr. Levine (*see* Defs' Proposed FOF ¶ 29), Dr. Levine offered nothing to support this assertion. In fact, the evidence showed that the studies on detransitioning do not examine changing rates of detransition and regret. (Pltfs' Proposed FOF ¶ 377.) The studies show that detransition is a broad and inconsistent term in the literature and can be used to refer to things like pausing or discontinuing a particular medical intervention for a wide variety of reasons (*e.g.*, lack of insurance or harassment) or changing identification from transgender to non-binary but does not necessarily involve identifying with one's birth assigned sex or regretting treatment. (*Id.* ¶ 378.)

[22] Although the proportion of patients who detransition is small, the WPATH standards of care version 8 recognizes this population and discusses the need to provide them with effective treatment. (Pltfs' Proposed FOF ¶ 372 & n.31.)

Defendants claim that gender-affirming medical treatment is provided to adolescents without appropriate mental health assessment and without properly informing families of the risks and evidence base of treatment. (Defs' Proposed FOF ¶¶ 44, 52-53, 167, 172, 215.) That claim was not supported by evidence at trial; nor would it explain why a categorical ban on treatment would be the appropriate response.

Defendants' position is based on testimony from their expert, Dr. Levine, who offers a description of what he calls the "affirmative model" of care, where doctors provide hormones immediately without assessing patients and addressing other mental health conditions or informing patients and their parents of the risks and the limitations of the evidence regarding treatments. (*See* Defs' Proposed FOF ¶¶ 32, 38-42, 52; *see also* Vol. 5, at 809:18-810:4; 811:21-812:10; 824:5-14 (Levine).) And Defendants claim that the director of the ACH gender clinic, Dr. Stambough, provides care in accordance with that "model." (Defs' Proposed FOF ¶ 42.) But this so-called model of care bears no resemblance to the guidelines for care recommended by WPATH and the Endocrine Society, and the undisputed testimony showed that it is not how care is provided at ACH's gender clinic, the main provider of gender-affirming medical care to gender dysphoric adolescents in Arkansas. (Pltfs' Proposed FOF ¶¶ 190-216.)

Plaintiffs' experts testified about the comprehensive mental health evaluations and thorough informed consent process that are recommended under the WPATH and Endocrine Society guidelines before medical interventions are initiated to treat gender dysphoria in adolescents. (*Id.* ¶¶ 181-89.) And Drs. Stambough and Hutchison testified that care at ACH is provided consistently with the guidelines. (*Id.* ¶¶ 191, 200, 211-14.)

Though Dr. Levine claimed that care is being provided without appropriate evaluation and informed consent, he admitted to having no personal knowledge of how care is

provided in clinics across the United States or in Arkansas and did not contest the testimony of the Arkansas clinicians. (*Id.* ¶ 369 n.30.) In short, Dr. Levine's testimony amounted to nothing more than setting up and then attacking a straw man, all based on no actual evidence.

Even if there were individual doctors providing care in the way Dr. Levine describes, this would not justify a complete prohibition of care. The Arkansas State Medical Board has mechanisms for addressing improper conduct by medical providers, including the authority to discipline doctors for unethical treatment—up to rescinding a license—and to enact regulations to address systemic problems. (*Id.* ¶¶ 281-84.) For example, when Arkansas faced a public health crisis caused by over-prescription of opioids, the Board enacted a regulation to monitor doctors' prescriptions and establish discipline for misconduct. And when the State had concerns about the significant risks of gastric bypass surgery, the State enacted a regulation dictating a comprehensive informed consent requirement. In neither case did the State ban care. Any concerns about improper care of adolescents with gender dysphoria by specific health care providers can be addressed through these processes, without banning the care provided by responsible practitioners who are treating patients in need. (*See id.* ¶¶ 281-89.)

C. The Act Does Not Survive Any Level of Scrutiny.

Although the Act is properly subject to heightened scrutiny, it ultimately fails any level of scrutiny for a number of independent reasons.

First, the stated justifications for banning gender-affirming medical care for minors "ma[k]e no sense in light of how" Arkansas treats medical care provided for purposes other than "gender transition." *Bd. of Trustees of Univ. of Ala.* v. *Garrett*, 531 U.S. 356, 366 n.4 (2001) (citation omitted). What the law does is "so far removed from [the asserted] justifications that . . . it [is] impossible to credit them." *Romer* v. *Evans*, 517 U.S. 620, 635 (1996).

The Act is "at once too narrow and too broad." *Id.* at 633. If the object of the law, as Defendants suggest, is to ban care that can cause infertility, or that has potential risks, or that is not supported by particular types of evidence, or that is "irreversible," then the law is entirely too narrow, covering only a tiny subset of care that falls into each of those categories, and specifically authorizing irreversible surgical treatments to change the genital appearance of infants with intersex conditions. The law is likewise too broad for all of the State's alleged concerns. If the State were seeking to prevent treatment that can cause infertility or that is irreversible, that would not explain why it bans puberty blockers for transgender adolescents.

The evidence presented at trial showed that many of the State's criticisms of the banned care, in addition to being inaccurate, are not unique to treatments related to gender transition. Even indulging some of the State's critiques of the banned treatments, those criticisms apply to many medical treatments—including the use of the same hormone therapies to treat other conditions. Yet it is only care related to "gender transition" that is categorically banned.

Defendants cannot explain why the State bans only this medical care when other medical care that presents the same or greater risks or is supported by the same or less evidence of efficacy is not banned. In every other context, the State leaves medical decision-making to patients, their parents, and their doctors. Where there are concerns about a particular type of medical care, the Board enacts regulations to help ensure that patients are informed of risks and care is provided appropriately. (Pltfs' Proposed FOF ¶ 285.) Here, there was no such measured response to any purported concerns; just an anomalous, sweeping, categorical ban. There is no rational basis to conclude that allowing adolescents with gender dysphoria to receive gender-affirming medical care that they, their parents, and their doctors agree is medically necessary "would threaten legitimate interests of [Arkansas] in a way that" allowing other types of care

"would not." *Cleburne*, 473 U.S. at 448; *see also Eisenstadt* v. *Baird*, 405 U.S. 438, 453 (1972) (health risks of birth control pills not a rational basis for banning access for unmarried people while allowing access for married people where risks are the same).

Act 626 also fails rational basis review because the text of the Act makes explicit that its purpose is not to protect minors by limiting care that lacks a certain level of evidence or that may cause particular harms, but rather to limit care that affirms their gender identity when it differs from their sex assigned at birth. Under any level of scrutiny, laws with the "peculiar property of imposing a broad and undifferentiated disability on a single named group" are "invalid." *Romer*, 517 U.S. at 632. Unconstitutional discrimination "rises not from malice or hostile animus alone. It may result as well from insensitivity caused by simple want of careful, rational reflection or from some instinctive mechanism to guard against people who appear to be different in some respects from ourselves." *Bd. of Trustees of Univ. of Ala.*, 531 U.S. at 374 (Kennedy, J., concurring); *see also Romer*, 517 U.S. at 632-35. And impermissible discrimination can arise from "profound and deep convictions." *Lawrence*, 539 U.S. at 571. Even on matters in which "[m]en and women of good conscience can disagree, [the] Court's obligation is to define the liberty of all, not to enforce a particular moral code." *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U.S. 833, 850 (1992), *overruled by Dobbs* v. *Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022); *see Lawrence*, 539 U.S. at 571.

Ultimately, the trial record also showed that the Act was passed based on negative attitudes about transgender people, likewise making it unconstitutional under any standard of review. (Pltfs' Proposed FOF ¶¶ 306-09.) The legislative record makes clear that the Act was reflective of lawmakers' views about transgender people. The Act was part of a package of bills aimed at limiting the rights of transgender people, and proponents of the bill expressed their

disapproval of transgender people and gender transition. (*Id.*.) But even if there were no evidence of negative attitudes towards transgender people in the legislative record, Act 626 would still fail rational basis review for the reasons addressed above.

III. THE TRIAL RECORD SHOWS THAT THE ACT VIOLATES THE DUE PROCESS CLAUSE.

The evidence presented at trial shows that the Act also violates the Due Process Clause, which "provides heightened protection against government interference with certain fundamental rights and liberty interests." *Washington* v. *Glucksberg*, 521 U.S. 702, 719-20 (1997). As this Court has recognized, " '[t]he liberty interest at issue in this case—the interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by th[e Supreme] Court' " (ECF No. 64 at 9 (quoting *Troxel* v. *Granville*, 530 U.S. 57, 65 (2000)),) and "includes the right to direct their children's medical care." (ECF No. 64 at 10 (quoting *Kanuszewski* v. *Mich. Dep't of Health & Human Servs*, 927 F.3d 396, 419 (6th Cir. 2019)); *see also Parham* v. *J.R.*, 442 U.S. 584, 602 (1979) (substantive due process includes a "right . . . to recognize symptoms of illness and to seek and follow medical advice") (internal quotation marks and citations omitted).[23]

At trial, Plaintiffs presented substantial evidence, which Defendants did not contest, that the Act infringes the parent Plaintiffs' "fundamental right to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary." (*See* ECF No. 64 at 10.) For example, each of the parent Plaintiffs testified that they routinely make medical decisions for their

[23] The Due Process Clause protects *parents'* right to the care, custody, and control of their children, and is not derivative of a child's right—*i.e.*, it is its own right and not merely a right to assert one's child's rights. *See, e.g.*, *Michael H.* v. *Gerald D.*, 491 U.S. 110, 130 (1989) (comparing legal and biological parents' fundamental liberty interest in a relationship with their child while noting that "[w]e have never had occasion to decide whether a child has a liberty interest, symmetrical with that of her parent, in maintaining her filial relationship").

children, and that the Act would remove their ability to do so. (Pltfs' Proposed FOF ¶¶ 20, 49, 74, 104.)

The parent Plaintiffs testified that their decision to pursue gender-affirming medical care for their minor children was considered and deliberate and included consultation with health care professionals to determine the best course of treatment. (*See id.* ¶¶ 11-20, 37-38, 41-52, 64-71, 73-74, 95-104.) If permitted to go into effect, the Act would deprive the parent Plaintiffs—and all parents of transgender adolescents in Arkansas—of their fundamental right to seek and follow medical advice and make medical decisions for their children. (*See id.* ¶¶ 332-39.)

As this Court correctly held in its ruling granting the preliminary injunction, "[s]trict scrutiny is the appropriate standard of review for infringement of a fundamental parental right." (ECF No. 64 at 10 (citing *Glucksberg*, 521 U.S. at 719-20).) Because Defendants have not carried their burden to show that the Act satisfies heightened scrutiny (*see* Part II.B, *supra*), they necessarily have not met the more onerous strict scrutiny. The Act's categorical prohibition of gender-affirming medical care for all adolescents is not "narrowly tailored," as even Dr. Levine conceded that gender-affirming medical care for adolescents is sometimes appropriate. (Pltfs' Proposed FOF ¶ 392.)

IV. THE TRIAL RECORD ESTABLISHES THAT THE ACT'S REFERRAL PROHIBITION VIOLATES THE FIRST AMENDMENT.

The First Amendment prohibits states from "restrict[ing] expression because of its message, its ideas, its subject matter, or its content." *Reed* v. *Town of Gilbert*, 576 U.S. 155, 163 (2015) (internal quotations and citation omitted). Content-based regulations of speech are "presumptively unconstitutional" and are subject to strict scrutiny. *Id.* Regulations that additionally discriminate on the basis of viewpoint are a "more blatant" and "egregious form of content discrimination." *Id.* at 168 (internal quotations and citation omitted).

The trial record established that the Act's prohibition on referrals (the "Referral Prohibition")—which bars healthcare professionals from "refer[ring] any individual under eighteen (18) years of age to any healthcare professional for gender transition procedures"—constitutes content and viewpoint discrimination, and cannot withstand the demanding scrutiny required by the First Amendment. (Pltfs' Proposed FOF ¶¶ 297, 337-45.)

A. The Referral Prohibition Prohibits Speech.

At the outset, the State cannot avoid First Amendment scrutiny of the Referral Prohibition by arguing that it regulates only conduct. The Supreme Court has consistently held that the First Amendment protects the "dissemination of information," *Sorrell* v. *IMS Health Inc*., 564 U.S. 552, 570 (2011), and applies even when speech is intertwined with conduct, *Spence* v. *State of Wash.*, 418 U.S. 405, 409-10 (1974).

As this Court already ruled, "Act 626's ban on referrals by healthcare providers is a regulation of speech," not professional conduct. (ECF No. 64 at 11.) By prohibiting healthcare professionals from "refer[ring] any individual under eighteen (18) years of age to any healthcare professional for gender transition procedures," the Act infringes protected speech on its face. (*See* Pltfs' Proposed FOF ¶ 297.) The context of the doctor-patient relationship only increases the importance of protecting such speech. *See Wollschlaeger* v. *Governor, Fla.*, 848 F.3d 1293, 1328 (11th Cir. 2017) (Pryor, W., concurring) (holding that "the doctor-patient relationship provides more justification for free speech, not less").

The trial record established that the Referral Prohibition infringes Plaintiffs' right to engage in and receive protected speech.[24] Dr. Stambough testified that, in the course of her

[24] While Defendants claimed there was a lack of testimony about the Act's impact on provider referrals, as Defendants conceded, the Act is currently enjoined. (Vol. 4 at 712:22-713:13.)

practice, she refers patients to other healthcare providers, which involves discussions with her patients and their families. (Pltfs' Proposed FOF ¶ 118.) Specifically, in making a referral, Dr. Stambough discusses with her patients where they can obtain the treatment they need. (*Id*.)

Speech is afforded less protection in only two circumstances, neither of which applies here: (1) when a law "require[s] professionals to disclose factual, noncontroversial information in their 'commercial speech' "; and (2) when a law regulates "conduct that incidentally involves speech." *Nat'l Inst. of Fam. & Life Advoc.* v. *Becerra*, 138 S. Ct. 2361, 2366, 2372 (2018).

First, the Referral Prohibition does not require professionals to disclose any factual information. Although Defendants have claimed that the Referral Prohibition requires medical professionals to "disclose that state law prohibits them from sending a child to another practitioner" (ECF 44 at 96), the Referral Prohibition does not require healthcare professionals to make any statement at all. Rather, it *prohibits* them from making referrals for gender-affirming medical care. *Second*, the Referral Prohibition is not a regulation of "conduct that incidentally involves speech." Courts have found that regulations are subject to less scrutiny when, in the course of targeting some underlying conduct, they incidentally involve or burden speech. *See Sorrell*, 564 U.S. at 567 (explaining that incidental burdens include regulations such as "a ban on race-based hiring [that] require[s] employers to remove 'White Applicants Only' signs'" or "an ordinance against outdoor fires [that] forbid[s] burning a flag") (internal quotations and citations omitted). But "there is a real difference between laws directed at conduct sweeping up incidental speech on the one hand and laws that directly regulate speech on the other. The government cannot regulate speech by relabeling it as conduct." *Otto* v. *City of Boca Raton, Fla*., 981 F.3d 854, 865 (11th Cir. 2020). As the Court has emphasized, "[s]peech is not unprotected merely because it is

uttered by 'professionals," and "a State may not, under the guise of prohibiting professional misconduct, ignore constitutional rights." (ECF No. 64 at 11 (quoting *NAACP* v. *Button*, 371 U.S. 415, 439 (1963)); *Becerra*, 138 S. Ct. at 2371-72). Here, the Referral Prohibition directly prohibits speech by healthcare providers who wish to make referrals for gender-affirming medical care.

B. The Referral Prohibition Constitutes Content and Viewpoint Discrimination.

The Referral Prohibition discriminates based on content and viewpoint and is subject to strict scrutiny. A regulation is content-based when it "target[s] speech based on its communicative content," *Reed*, 576 U.S. at 163, or "exacts a penalty on the basis of the content of speech." *Telescope Media Grp.* v. *Lucero*, 936 F.3d 740, 753 (8th Cir. 2019) (internal quotations omitted). A regulation constitutes viewpoint discrimination "when the rationale for [the government's] regulation of speech is 'the specific motivating ideology or the opinion or perspective of the speaker.' " *Gerlich* v. *Leath*, 861 F.3d 697, 705 (8th Cir. 2017). This Court already observed that the Act "is a content and viewpoint-based regulation because it restricts healthcare professionals only from making referrals for 'gender transition procedures,' not for other purposes." (ECF No. 64 at 11.)

C. The Evidence Confirmed That the Referral Prohibition Fails Strict Scrutiny.

Strict scrutiny imposes a heavy burden on Defendants, and, as the Supreme Court has emphasized, "it is rare that a regulation restricting speech because of its content will ever be permissible." *United States* v. *Playboy Ent. Grp.*, 529 U.S. 803, 818 (2000). Defendants must show that the speech restrictions were the "last—not first—resort." *Thompson* v. *W. States Med. Ctr.*, 535 U.S. 357, 373 (2002). Here, again, the State attempts to justify its Referral Prohibition on the ground that it is necessary to protect children and to regulate the medical profession. (Vol. 4, at 721:3-9.) But courts routinely strike down laws that regulate protected speech, including laws that, as here, prohibit the sharing of information, such as a healthcare professional's

recommendation. *See, e.g.*, *Conant* v. *Walters*, 309 F.3d 629, 639 (9th Cir. 2002) (striking down regulation that prohibited doctors from providing patients with information about the benefits of medical marijuana); *see also Sorrell*, 564 U.S. at 557 (striking down regulation that prohibited the sale, disclosure, and use of pharmacy records). And as this Court has emphasized, Arkansas's interest in protecting minors "does not include a free-floating power to restrict the ideas to which children may be exposed." (ECF No. 64 at 12 (quoting *Brown* v. *Ent. Merch. Ass'n*, 564 U.S. 786, 794 (2011).) Speech "cannot be suppressed solely to protect the young from ideas or images that a legislative body thinks unsuitable." *Erznoznik* v. *City of Jacksonville*, 422 U.S. 205, 213 (1975).

For the same reasons that Defendants have not met their burden under heightened scrutiny on Plaintiffs' equal protection claim, *see* Part II.B, *supra*, Defendants also have not met their burden of showing that the Referral Prohibition is narrowly tailored to further a compelling government interest. The evidence at trial confirmed that the Act does not advance the State's interest in protecting minors, and actually undermines that interest by harming adolescents with gender dysphoria. (*See* Part II.B.1, *supra*; *see also, e.g.*, Pltfs' Proposed FOF ¶¶ 316, 314-31.) Additionally, Defendants have come nowhere close to carrying their burden of showing that the Referral Prohibition "could be replaced by no other regulation that could advance the [asserted] interest as well with less infringement of speech," and thus, have not shown, as they must, that the Referral Prohibition is the least restrictive alternative. *281 Care Comm*. v. *Arneson*, 766 F.3d 774, 787 (8th Cir. 2014) (citations omitted). As discussed above, the State routinely employs a number of mechanisms to regulate the medical profession that do not infringe speech at all. *See* Part II.B.2.e, *supra*.

V. A STATEWIDE PERMANENT INJUNCTION IS NECESSARY.

Substantial evidence at trial demonstrated that the Act violates Plaintiffs' constitutional rights and that, if the Act goes into effect, it would cause irreparable harm to

transgender minors, families, and healthcare providers throughout Arkansas. A permanent injunction is warranted to address those constitutional violations. And because there are no circumstances in which the Act would be lawful, facial relief is necessary.

A. Permanent Injunctive Relief Is Warranted.

To obtain a permanent injunction, Plaintiffs were required to "show actual success on the merits." *Miller* v. *Thurston*, 967 F.3d 727, 735 (8th Cir. 2020). As explained above, Plaintiffs have proven that the Act violates the Equal Protection Clause, Due Process Clause, and First Amendment.

Once success on the merits is established, courts must consider three additional factors to decide whether to issue a permanent injunction: (1) "the threat of irreparable harm to the moving party"; (2) "the balance of harms with any injury an injunction might inflict on other parties"; and (3) "the public interest." *Id*. at 735-36. The final two factors—"the balance of harms" and the "public interest"—"merge when the government is the opposing party." *Religious Sisters of Mercy* v. *Azar*, 513 F. Supp. 3d 1113, 1152 (D.N.D. 2021) (citing *Nken* v. *Holder*, 556 U.S. 418, 435 (2009)). Each of those factors decisively favors an injunction here.

Irreparable harm: Absent an injunction, the Act would cause serious and lasting harms to (i) transgender adolescents that need gender-affirming medical care to treat their gender dysphoria, (ii) parents who wish to obtain gender-affirming medical care for their children, and (iii) healthcare professionals who provide gender-affirming medical care in Arkansas. Each of those harms is independently sufficient to support a permanent injunction.

For adolescents with gender dysphoria in Arkansas, discontinuing or delaying gender-affirming medical care when indicated puts patients at risk of worsening anxiety, depression, hospitalization, and suicidality. (Pltfs' Proposed FOF ¶316.) The State's expert, Dr. Levine, described the psychological impact of cutting off gender-affirming medical care for

those currently receiving it as "shocking" and "devastating." (*Id.* ¶ 322.) Plaintiffs' experts testified in detail that denying care to those who need it can lead to severe suffering, including self-harm and suicide attempts. (*E.g.*, *id.* ¶¶ 316, 318-20, 327-29.) Dr. Hutchison explained that, after Act 626 was introduced but before it was enacted into law, six or seven of the ACH gender clinic's patients were hospitalized for attempted suicide and additional patients were hospitalized at mental health facilities for suicidal ideation. (*Id.* ¶ 328.) She additionally expressed concern that transgender adolescents who are banned from receiving care through medical providers in Arkansas will find ways to access gender-affirming medical care outside of the care of a doctor, putting them at risk. (*Id.* ¶ 330.)

The parent Plaintiffs testified about their fears about having to stop gender-affirming medical treatment for their minor children given the dramatic benefits they have seen. (*Id.* ¶¶ 23-24, 28-30, 52-53, 56, 75-77, 79-84.) Dylan likewise testified about how difficult it would be for him to cut off the treatment that has transformed his life. (*Id.* ¶ 28.) Sabrina, who would not go to public restrooms, became visibly anxious about having her picture taken, and did not see the point of life, now is happy, loves taking selfies, and her gender dysphoria is almost entirely alleviated. (*Id.* ¶¶ 39, 53-56.) Dylan was distressed and anxious about his gender for many years and avoided seeing himself—it is hard to find pictures of him from before treatment and he is rarely seen smiling in them; now, his mom describes a confident, comfortable 17-year-old who has finally been able to relax. (*Id.* ¶¶ 23-24.) The parent Plaintiffs testified that stopping treatment is not an option for their children. (*Id.* ¶¶ 28, 56, 84.) They also testified about the burdens the Act would create for their families to continue their children's care. Joanna Brandt explained that her family has discussed moving to another state where gender-affirming medical care was available. (*Id.* ¶¶ 29-30.) She also testified that leaving Arkansas would be emotionally

and financially difficult for her family, and would require uprooting Dylan and his brother from their community in Greenwood and leaving her business that supports the family. (*Id.*) Other parent Plaintiffs echoed those concerns. Aaron Jennen testified that his family has discussed leaving Arkansas if the Act goes into effect, even though that decision could compromise his livelihood as a government attorney and would take the family out of the state they have called home all their lives. (*Id.* ¶¶ 56-57.) For the Dennis family, leaving Arkansas to get care for Brooke would have consequences not just for their immediate family but also for Brooke's grandfather, who has advanced Parkinson's and depends on care from her parents, Amanda and Shayne Dennis. (*Id.* ¶¶ 105-08.)

Dr. Stambough testified that the Act would prevent her from providing necessary medical care to her patients and from making the referrals they need to receive care from another provider. (*E.g.*, *id.* ¶ 337; *see also id.* ¶¶ 117.) Ms. Embry, the Director of the Arkansas State Medical Board, also shared her view that the Act conflicts with physicians' ethical duty to not abandon their patients. (*Id.* ¶¶ 340-43; *see also id.* ¶ 338.) And Defendants' expert Dr. Levine noted how the broader community would be harmed by physicians losing their medical licenses on account of the Act. (*Id.* ¶ 339.)[25]

Public interest: the balance of harms and public interest factors also support an injunction. As explained above, Defendants' evidence was wholly inadequate to justify their asserted interest in protecting minors or regulating the medical profession. *See* Part II.B.2, *supra*.

[25] Finally, the denial of constitutional rights is itself an irreparable harm. *See Powell* v. *Noble*, 798 F.3d 690, 702 (8th Cir. 2015) ("[T]he loss of First Amendment freedoms, for even for minimal periods of time, unquestionably constitutes irreparable injury."); *Portz* v. *St. Cloud State Univ.*, 196 F. Supp. 3d 963, 973 (D. Minn. 2016) ("[W]hen the constitutional right at issue is protected by the Fourteenth Amendment, the denial of that right is an irreparable harm.").

Without any support in the record, Defendants are left to argue that the State is irreparably harmed any time a law is enjoined. (*See, e.g.*, Def's Pre-trial Br. 30.) But "[t]he public is served by the preservation of constitutional rights." *D.M ex rel. Bao Xiong* v. *Minn. State High Sch. League*, 917 F.3d 994, 1004 (8th Cir. 2019). Because the State has no interest in enforcing an unconstitutional law, s*ee Rodgers* v. *Bryant*, 942 F.3d 451, 457 (8th Cir. 2019), "it is always in the public interest to prevent the violation of a party's constitutional rights" by granting injunctive relief. *D.M.*, 917 F.3d at 1004 (quoting *G&V Lounge, Inc*. v. *Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994)).).

B. A Statewide Facial Injunction Is Necessary.

A facial injunction is warranted here. Facial relief is appropriate when there is "no set of circumstances . . . under which the Act would be valid." *United States* v. *Salerno*, 481 U.S. 739, 745 (1987). In applying that test, "the proper focus of the constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *City of Los Angeles* v. *Patel*, 576 U.S. 409, 418 (2015) (quoting *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U.S. 833, 894 (1992)). The Act is a restriction for every transgender minor in Arkansas who needs gender-affirming medical care and whose parents and doctors support that care, and there is no set of facts under which denying those patients access to care would be constitutionally valid.

"The scope of injunctive relief is dictated by the extent of the violation established." *Rodgers*, 942 F.3d at 458 (quoting *Califano* v. *Yamasaki*, 442 U.S. 682, 702 (1979)). Therefore, the Eighth Circuit has held that "injunctive relief should extend statewide [when] the violation established . . . impacts the entire state of Arkansas." *Id*. That is the case here, as the Act bars every transgender minor in Arkansas from obtaining care proscribed by the law, and bars every provider in the State from offering that care or referring patients to other providers.

CONCLUSION

The trial record demonstrates that Plaintiffs should prevail on the merits of each of their constitutional claims and are entitled to a permanent statewide facial injunction of Act 626.

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United States Court of Appeals
For the Eighth Circuit

No. 21-2875

Dylan Brandt, by and through his mother Joanna Brandt; Joanna Brandt; Sabrina Jennen, by and through her parents Lacey and Aaron Jennen; Lacey Jennen; Aaron Jennen; Brooke Dennis, by and through her parents Amanda and Shayne Dennis; Amanda Dennis; Shayne Dennis; Parker Saxton, by and through his father Donnie Saxton; Donnie Saxton; Michele Hutchison, on behalf of herself and parents; Kathryn Stambough, on behalf of herself and her parents

Plaintiffs - Appellees

v.

Leslie Rutledge, in her official capacity as the Arkansas Attorney General; Amy E. Embry, in her official capacity as the Executive Director of the Arkansas State Medical Board; Sylvia D. Simon, in official capacity as member of the Arkansas State Medical Board; Robert Breving, Jr., in official capacity as member of the Arkansas State Medical Board; John H. Scribner, in official capacity as member of the Arkansas State Medical Board; Elizabeth Anderson, in official capacity as member of the Arkansas State Medical Board; Rhys L. Branman, in official capacity as member of the Arkansas State Medical Board; Edward Gardner, "Ward"; in official capacity as member of the Arkansas State Medical Board; Rodney Griffin, in official capacity as member of the Arkansas State Medical Board; Betty Guhman, in official capacity as member of the Arkansas State Medical Board; Brian T. Hyatt, in official capacity as member of the Arkansas State Medical Board; Timothy C. Paden, in official capacity as member of the Arkansas State Medical Board; Don R. Philips, in official capacity as member of the Arkansas State Medical Board; William L. Rutledge, in official capacity as member of the Arkansas State Medical Board; David L. Staggs, in official capacity as member of the Arkansas State Medical Board; Veryl D. Hodges, in official capacity as member of the Arkansas State Medical Board

Defendants - Appellants

Keira Bell; Laura Becker; Sinead Watson; Kathy Grace Duncan; Laura Reynolds; Carol Freitas; Yaacov Sheinfeld; Jeanne Crowley; Ted Hudacko; Lauren W.; Martha S.; Kellie C.; Kristine W.; Bri Miller; Helen S.; Barbara F.; State of Alabama; State of Alaska; State of Arizona; State of Georgia; State of Idaho; State of Indiana; State of Kansas; State of Kentucky; State of Louisiana; State of Mississippi; State of Missouri; State of Montana; State of Nebraska; State of South Carolina; State of South Dakota; State of Tennessee; State of Texas; State of Utah; State of West Virginia; Family Research Council; Women's Liberation Front; Quentin L. Van Meter, MD; Michael K. Laidlaw, MD; Andre Van Mol, MD; Jeffrey E. Hansen, Ph. D.

Amici on Behalf of Appellant(s)

Lambda Legal Defense and Education Fund; National Women's Law Center; Equality South Dakota; Family Equality; Freedom for All Americans; Gender Justice; GLBTQ Legal Advocates & Defenders; Human Rights Campaign; Intransitive (Mabelvale, Arkansas); Legal Voice; Lucie's Place (Little Rock, Arkansas); National Center for Lesbian Rights; National Center for Transgender Equality; National LGBTQ Task Force; One Iowa; OutNebraska; PFLAG; SisterReach; South Dakota Transformation Project; Southwest Women's Law Center; Transformation Project Advocacy Network; Women's Law Project; American Academy of Pediatrics; Academic Pediatric Association; American Academy of Child and Adolescent Psychiatry; American Association of Physicians for Human Rights, Inc.; American College of Osteopathic Pediatricians; American Medical Association; American Pediatric Society; American Psychiatric Association; Arkansas Chapter of the American Academy of Pediatrics; Arkansas Council on Child and Adolescent Psychiatry; Arkansas Medical Society; Arkansas Psychiatric Society; Association of Medical School Pediatric Department Chairs; Endocrine Society; National Association of Pediatric Nurse Practitioners; Pediatric Endocrine Society; Society for Adolescent Health and Medicine; Society for Pediatric Research; Society of Pediatric Nurses; Societies for Pediatric Urology; World Professional Association for Transgender Health; Biomedical Ethics and Public Health Scholars; United States; LiveRamp Holdings, Inc.; Acxiom LLC; Kinesso, LLC; The Walton Family Foundation, Inc.; Arkansas State Chamber of Commerce; Northwest Arkansas Council; Asana, Inc.; Xperi Holding Corp.; Interpublic Group of Companies, Inc.; Winthrop Rockefeller Foundation; Acoustic, L.P.; CYCLQ LLC, doing business as Blue Star Business Services; Institute for Justice; State of California; State of Colorado; State of Connecticut;

State of Delaware; State of Hawaii; State of Illinois; State of Maine; State of Maryland; State of Massachusetts; State of Michigan; State of Minnesota; State of Nevada; State of New Jersey; State of New Mexico; State of New York; State of North Carolina; State of Oregon; State of Rhode Island; State of Vermont; State of Washington; District of Columbia; Stonewall UK; Swedish Federation for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Rights; Australian Professional Association for Trans Health; Professional Association for Transgender Health Aotearoa New Zealand; LGBT+ Denmark; Bundesverband Trans e.V.; Federacion Estatal de Lesbianas, Gais, Trans, Bisexuales, Intersexuales y mas; Fundacion Colectivo Hombres XX, AC; Norwegian Organization for Sexual and Gender Diversity; The Trevor Project, Inc.; Elliot Page and 57 Other Individuals; Families with Transgender Children

Amici on Behalf of Appellee(s)

Appeal from United States District Court
for the Eastern District of Arkansas - Central

Submitted: June 15, 2022
Filed: August 25, 2022

Before LOKEN and KELLY, Circuit Judges, and MENENDEZ, District Judge.[1]

KELLY, Circuit Judge.

Arkansas state officials (collectively, Arkansas or the State) appeal the order of the district court[2] preliminarily enjoining Act 626 of the 93rd General Assembly

[1]The Honorable Katherine M. Menendez, United States District Judge for the District of Minnesota, sitting by designation.

[2]The Honorable James M. Moody, Jr., United States District Judge for the Eastern District of Arkansas.

of Arkansas. This court has jurisdiction under 28 U.S.C. § 1292(a)(1) to review an interlocutory order granting a preliminary injunction, and we affirm.

I. Background

On April 6, 2021, the Arkansas state legislature overrode the governor's veto and enacted Act 626. The Act prohibits a healthcare professional from "provid[ing] gender transition procedures to any individual under eighteen (18) years of age" or "refer[ring] any individual under eighteen (18) years of age to any healthcare professional for gender transition procedures." Ark. Code Ann. § 20-9-1502(a), (b). "Gender transition procedures" is defined to include "any medical or surgical service, including without limitation physician's services, inpatient and outpatient hospital services, or prescribed drugs" that are intended to "[a]lter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex" or "[i]nstill or create physiological or anatomical characteristics that resemble a sex different from the individual's biological sex." Id. § 20-9-1501(6)(A). Specifically identified services include "puberty-blocking drugs, cross-sex hormones, or other mechanisms to promote the development of feminizing or masculinizing features in the opposite biological sex, or genital or nongenital gender reassignment surgery performed for the purpose of assisting an individual with a gender transition." Id. "Gender transition procedures" specifically does not include "[s]ervices to persons born with a medically verifiable disorder of sex development." Id. § 20-9-1501(6)(B).

Act 626 was set to take effect on July 28, 2021. In May, Plaintiffs in this matter—transgender youth (Minor Plaintiffs), their parents (Parent Plaintiffs), and two healthcare professionals (Physician Plaintiffs)—filed a complaint seeking declaratory and injunctive relief. Plaintiffs allege that Act 626 violates the Equal Protection Clause of the Fourteenth Amendment because it discriminates against Minor Plaintiffs and Physician Plaintiffs' minor patients on the basis of sex and transgender status. Parent Plaintiffs further allege the Act violates the Due Process Clause of the Fourteenth Amendment by limiting their fundamental right to seek and

follow medical advice for their children. Finally, Plaintiffs allege that, by banning referrals, Act 626 violates their First Amendment rights by limiting what Physician Plaintiffs can say and what Minor and Parent Plaintiffs can hear.

In June, Plaintiffs moved for a preliminary injunction to stop Act 626 from going into effect. Arkansas moved to dismiss the complaint pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). After a hearing on the motions, the district court denied the motion to dismiss and granted the motion for preliminary injunction, concluding that Plaintiffs had standing and showed a likelihood of success on the merits of each of their claims and a likelihood of irreparable harm. Arkansas appeals.

II. Standing

As an initial matter, the State challenges Plaintiffs' standing to seek an injunction of specific aspects of the Act. Constitutional standing requires that at least one plaintiff demonstrate they have suffered a concrete and particularized injury that is fairly traceable to the challenged action and is likely to be redressed by a court ruling in the plaintiff's favor. See Lujan v. Defenders of Wildlife, 504 U.S. 555, 560–61 (1992). Arkansas argues that because no Minor Plaintiff has declared an intent to undergo gender-reassignment surgery as a minor, no Plaintiff has established standing to challenge the ban as to that type of gender transition procedure. The State also argues that Plaintiffs lack standing to challenge the section of the statute that provides for private enforcement because no defendant is involved in enforcement of the Act by private right of action. But Arkansas does not contest that Plaintiffs have met their burden under Lujan to challenge other parts of the Act, and this court declines the State's invitation to modify well-established constitutional standing principles to require that a plaintiff demonstrate an injury

traceable to every possible application of the challenged statute in order to satisfy the constitutional standing requirement.[3]

III. Preliminary Injunction

A. Legal Standard

"In reviewing the issuance of a preliminary injunction, we consider the threat of irreparable harm to the movant, the likelihood that the movant will succeed on the merits, the balance between the harm to the movant and injury that an injunction would inflict on other parties, and the public interest." Brakebill v. Jaeger, 932 F.3d 671, 676 (8th Cir. 2019) (citing Dataphase Sys., Inc. v. C L Sys., Inc., 640 F.2d 109, 113 (8th Cir. 1981) (en banc)). A party challenging a state statute must show that she is likely to prevail on the merits. See Planned Parenthood Minn., N.D., S.D. v. Rounds, 530 F.3d 724, 730 (8th Cir. 2008). "The plaintiff[s] need only establish a likelihood of succeeding on the merits of any one of [their] claims." Richland/Wilkin Joint Powers Auth. v. U.S. Army Corps of Eng'rs, 826 F.3d 1030, 1040 (8th Cir. 2016) (quotation omitted).

We review the decision to grant a preliminary injunction for abuse of discretion. See Rodgers v. Bryant, 942 F.3d 451, 456 (8th Cir. 2019). "An abuse of discretion occurs where the district court rests its conclusion on clearly erroneous factual findings or erroneous legal conclusions." Rounds, 530 F.3d at 733 (quotation omitted). "If a factual finding is supported by substantial evidence on the record, it is not clearly erroneous." Dixon v. Crete Med. Clinic, P.C., 498 F.3d 837, 847 (8th Cir. 2007). "Clear error exists when despite evidence supporting the finding, the evidence as a whole leaves us with a definite and firm conviction that the finding is a mistake." Richland/Wilkin, 826 F.3d at 1036 (quotation omitted).

[3]The State also argues that Physician Plaintiffs lack third-party standing to sue on behalf of their minor patients. But since there is at least one plaintiff with standing to bring each of Plaintiffs' claims, we need not address this argument at this juncture.

B. Likelihood of Success on the Merits

To evaluate Plaintiffs' likelihood of success on the merits of their equal protection claim, we must first determine the appropriate level of scrutiny. Cf. Libertarian Party of Ark. v. Thurston, 962 F.3d 390, 399 (8th Cir. 2020) (determining as a threshold matter what level of scrutiny applied to the challenged statute governing ballot access). Act 626 prohibits "gender transition procedures," which are defined as procedures or medications that are intended to change "the individual's biological sex." Ark. Code Ann. § 20-9-1501(6)(A). The statute defines "biological sex" as the person's sex "at birth, without regard to an individual's psychological, chosen, or subjective experience of gender." Id. § 20-9-1501(1). Thus, under the Act, medical procedures that are permitted for a minor of one sex are prohibited for a minor of another sex. A minor born as a male may be prescribed testosterone or have breast tissue surgically removed, for example, but a minor born as a female is not permitted to seek the same medical treatment. Because the minor's sex at birth determines whether or not the minor can receive certain types of medical care under the law, Act 626 discriminates on the basis of sex.

Arkansas's characterization of the Act as creating a distinction on the basis of medical procedure rather than sex is unpersuasive. Arkansas argues that administering testosterone to a male should be considered a different procedure than administering it to a female because the "procedure allows a boy to develop normally" whereas for a girl it has the effect of "disrupting normal development." But this conflates the classifications drawn by the law with the state's justification for it. The biological sex of the minor patient is the basis on which the law distinguishes between those who may receive certain types of medical care and those who may not. The Act is therefore subject to heightened scrutiny. See Heckler v. Mathews, 465 U.S. 728, 744 (1984). Cf. Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ., 858 F.3d 1034, 1051 (7th Cir. 2017) (holding that where "the School District's policy cannot be stated without referencing sex, as the School District decides which bathroom a student may use based upon the sex listed on the student's birth certificate," the policy "is inherently based upon a sex-

classification and heightened review applies") (abrogation on other grounds recognized by Ill. Republican Party v. Pritzker, 973 F.3d 760 (7th Cir. 2020)).[4]

Statutes that discriminate based on sex must be supported by an "exceedingly persuasive justification." United States v. Virginia, 518 U.S. 515, 531 (1996). The government meets this burden if it can show that the statute is substantially related to a sufficiently important government interest. Id. at 533. Arkansas relies on its interest in protecting children from experimental medical treatment and regulating ethics in the medical profession to justify Act 626.

The district court found that the Act prohibits medical treatment that conforms with "the recognized standard of care for adolescent gender dysphoria," that such treatment "is supported by medical evidence that has been subject to rigorous study," and that the purpose of the Act is "not to ban a treatment [but] to ban an outcome that the State deems undesirable." The record at this stage provides substantial evidence to support these factual findings.

Arkansas complains the district court failed to consider the medical evidence it submitted. Both parties provided scientific literature and declarations from medical experts and discussed the expert opinions in their briefs and at the motion hearing. The district court acknowledged at the hearing that "experts [on both] sides of this case don't agree, and I get that. That's part of the deal." We find no clear error in the district court's weighing of the competing evidence. See Med. Shoppe Int'l, Inc. v. S.B.S. Pill Dr., Inc., 336 F.3d 801, 803 (8th Cir. 2003) ("Our deferential review [of preliminary injunctions] arises from the district court's institutional advantages in evaluating witness credibility and weighing evidence.").

[4]The district court also concluded that heightened scrutiny was appropriate because the Act facially discriminates against transgender people, who constitute a quasi-suspect class. We discern no clear error in the district court's factual findings underlying this legal conclusion, but we need not rely on it to apply heightened scrutiny because the Act also discriminates on the basis of sex.

Furthermore, substantial evidence in the record supports the district court's factual findings, despite the contrary assertions of the State's experts. For example, while Arkansas's experts criticize the structure and scale of research on hormone therapies for adolescents with gender dysphoria, study design is only one factor among many that medical professionals properly consider when they review research and determine what course of action to recommend to a patient. And there is evidence in the record that these hormone treatments have been evaluated in the same manner as many other medical innovations. According to surveys of the research on hormone treatment for adolescents done by the British National Institute for Health & Care Excellence, several studies have shown statistically significant positive effects of hormone treatment on the mental health, suicidality, and quality of life of adolescents with gender dysphoria. None has shown negative effects.

Additionally, there is substantial evidence to support the district court's conclusion that the Act prohibits medical treatment that conforms with the recognized standard of care. Even international bodies that consider hormone treatment for adolescents to be "experimental" have not banned the care covered by Act 626. For example, Arkansas submitted to the district court a report from the Council for Choices in Health Care in Finland in which the council concluded that "[i]n light of available evidence, gender reassignment of minors is an experimental practice," but the report still recommends that gender-affirming care be available to minors under appropriate circumstances. In fact, the Finnish council's recommendations for treatment closely mirror the standards of care laid out by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society, two organizations the State repeatedly criticizes. Like WPATH, the Finnish council concluded that puberty-suppressing hormones might be appropriate for adolescents at the onset of puberty who have exhibited persistent gender nonconformity and who are already addressing any coexisting psychological issues. Similarly, the WPATH Standards of Care and the Finnish council both recommend that cross-sex hormones be considered only where the adolescent is

experiencing persistent gender dysphoria, other mental health conditions are well-managed, and the minor is able to meet the standards to consent to the treatment.[5]

In sum, having reviewed the evidence as a whole, we are not left with the "definite and firm conviction" that the district court's factual findings are clearly erroneous. Rather, substantial evidence in the record supports its factual findings. In light of those findings, the district court did not err in concluding Act 626 is not substantially related to Arkansas's interests in protecting children from experimental medical treatment and regulating medical ethics, and Plaintiffs have demonstrated a likelihood of success on the merits of their equal protection claim.

C. Balance of the Equities

In considering the risk of irreparable harm to the Plaintiffs, the district court found that if Act 626 went into effect, Minor Plaintiffs would be denied access to hormone treatment (including needing to stop treatment already underway), undergo endogenous puberty—a process that cannot be reversed—and suffer heightened gender dysphoria. These factual findings are supported by Minor Plaintiffs' affidavits and are not clearly erroneous. The findings support the conclusion that Plaintiffs will suffer irreparable harm absent a preliminary injunction.

Additionally, it is "always in the public interest to prevent the violation of a party's constitutional rights." Bao Xiong ex rel. D.M. v. Minn. State High Sch. League, 917 F.3d 994, 1004 (8th Cir. 2019) (quoting Awad v. Ziriax, 670 F.3d 1111,

[5]The State also emphasized the judicial decision in Bell v. Tavistock & Portman NHS Foundation Trust, 2020 EWHC (Admin) 3274, in the United Kingdom, in which the court decided that minors under 16 years old could not consent to receive hormone therapies and required court approval because it is "a very unusual treatment" with "limited evidence as to its efficacy." Id. at ¶ 134. That judgment has since been reversed, however, with the court of appeals concluding that "[n]othing about the nature or implications of the treatment with puberty blockers allows for a real distinction to be made" from other medical treatment an adolescent might seek. 2021 EWCA (Civ) 1363, at ¶ 76.

1132 (10th Cir. 2012)). These interests, weighed against the potential harm to Arkansas of not enforcing Act 626 between now and a final ruling on the merits of the litigation, convince us that the district court did not abuse its discretion in granting Plaintiffs' motion for preliminary injunction.

D. Scope of the Injunction

Arkansas's final argument is that the district court abused its discretion by granting a facial injunction. It is true, as the State points out, that some minors experiencing gender dysphoria may choose not to pursue the gender transition procedures covered by the Act and therefore would not be harmed by its enforcement. A party bringing a facial challenge must "establish that no set of circumstances exists under which the Act would be valid," United States v. Salerno, 481 U.S. 739, 745 (1987), but the State describes minors for whom the Act simply would have no application, see City of Los Angeles v. Patel, 576 U.S. 409, 418–19 (2015) ("The proper focus of the [facial] constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." (quotation omitted)). Moreover, Arkansas has failed to offer a more narrowly tailored injunction that would remedy Plaintiffs' injuries. The district court did not abuse its discretion by granting a facial injunction.

IV. Conclusion

Because we conclude the district court did not abuse its discretion in granting a preliminary injunction based on Plaintiffs' equal protection claim, we need not address the State's challenges to Plaintiffs' other claims. The decision of the district court is affirmed.

CAUSE NO. _____

PFLAG, INC.; MIRABEL VOE, individually and as parent and next friend of ANTONIO VOE, a minor; WANDA ROE, individually and as parent and next friend of TOMMY ROE, a minor; ADAM BRIGGLE and AMBER BRIGGLE, individually and as parents and next friends of M.B., a minor,	§	
Plaintiffs,	§	
	§	IN THE DISTRICT COURT OF
v.	§	TRAVIS COUNTY, TEXAS
	§	_____ JUDICIAL DISTRICT
GREG ABBOTT, sued in his official capacity as Governor of the State of Texas; JAIME MASTERS, sued in her official capacity as Commissioner of the Texas Department of Family and Protective Services; and the TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES,	§	
Defendants.	§	

PLAINTIFFS' ORIGINAL PETITION, APPLICATION FOR TEMPORARY RESTRAINING ORDER, TEMPORARY AND PERMANENT INJUNCTION, AND REQUEST FOR DECLARATORY RELIEF

Plaintiffs PFLAG, Inc. ("PFLAG"); Mirabel Voe, individually and as parent and next friend of Antonio Voe, a minor; Wanda Roe, individually and as parent and next friend of Tommy Roe; and, Adam Briggle and Amber Briggle, individually and as parents and next friends of M.B., a minor (collectively, "Plaintiffs")[1] file this Original Petition, Application for Temporary

[1] Plaintiffs M.B., Mirabel Voe, Antonio Voe, Wanda Roe, and Tommy Roe proceed pseudonymously in order to protect their right to privacy, particularly that of M.B., Antonio Voe, and Tommy Roe, who are minors. The Texas Rules of Civil Procedure recognize the need to protect a minor's identity. *See* Tex. R. Civ. P. 21c(a)(3). That goal would not be possible if the identities of M.B., Mirabel Voe, Antonio Voe, Wanda Roe, and Tommy Roe were public. Indeed, not only do Texas rules "require the use of an alias to refer to a minor" but courts "may also use an alias 'to [refer to] the minor's parent or other family member' to protect the minor's identity." *Int. of A.M.L.M.*, No. 13-18-00527-CV, 2019 WL 1187154, at *1 (Tex. App. – Corpus Christi Mar. 14, 2019). Moreover, the disclosure of M.B., Mirabel Voe, Antonio Voe, Wanda Roe, and Tommy Roe's identities "would reveal matters of a highly sensitive and

Restraining Order, Temporary and Permanent Injunction, and Request for Declaratory Relief ("Petition") against Defendants Greg Abbott, in his official capacity as Governor of the State of Texas ("Governor Abbott" or the "Governor"), Jaime Masters, in her official capacity as Commissioner of the Texas Department of Family and Protective Services ("Commissioner Masters" or the "Commissioner"), and the Texas Department of Family and Protective Services ("DFPS") (collectively, "Defendants"). In support of their Petition, Plaintiffs respectfully show the following:

I. PRELIMINARY STATEMENT

1. After the Texas Legislature failed to pass legislation criminalizing well-established and medically necessary treatment for adolescents with gender dysphoria, the Texas Governor, Attorney General, and Commissioner of the Department of Family and Protective Services have attempted to legislate by fiat and press release. Governor Abbott's letter instructing DFPS to investigate the families of transgender children is entirely without constitutional or statutory authority; and despite this, the Commissioner nonetheless has implemented a substantive regulatory change, starting with a statement directing DFPS to carry out the Governor's wishes and subsequently carried out through an unauthorized process that defies both the agency's authority and its longstanding policies and practices.

2. The Governor and Commissioner have circumvented the will of the Legislature and, in so doing, they have run afoul of numerous constitutional and statutory limits on their power.

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personal nature, specifically [M.B., Antonio Voe, and Tommy Roe]'s transgender status and [their] diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019). "[O]ther courts have recognized the highly personal and sensitive nature of a person's transgender status and thus have permitted transgender litigants to proceed under pseudonym." *Id.* (collecting cases). Furthermore, as courts have recognized, the disclosure of a person's transgender status "exposes them to prejudice, discrimination, distress, harassment, and violence." *Arroyo Gonzalez v. Rossello Nevares*, 305 F. Supp. 3d 327, 332 (D.P.R. 2018); *see also Foster*, 2019 WL 329548, at *2. Such is the case here.

Additionally, by their actions, Defendants have trampled on the constitutional and statutory rights of transgender children and their parents. The Defendants have, without constitutional or statutory authority, acted to create a new definition of "child abuse" that singles out a subset of loving parents for scrutiny, investigation, and potential family separation. Their actions have caused terror and anxiety among transgender youth and their families across the Lone Star State and singled out transgender youth and their families for discrimination and harassment. What is more, the Governor's and Commissioner's actions threaten to endanger the health and well-being of transgender youth in Texas by depriving them of medically necessary care, while communicating that transgender people and their families are not welcome in Texas.

3. The Governor has also declared that teachers, doctors, and the general public should be required, on pain of criminal penalty, to report to DFPS any person who provides or is suspected of providing medical treatment for gender dysphoria, a recognized condition with well-established treatment protocols.[2] And DFPS has launched investigations into families for child abuse based on reports that the families have followed doctor-recommended treatments for their adolescent children. The Commissioner and DFPS have recently resumed these unlawful investigations, which have already caused lasting harm to Plaintiffs in this case.

4. The actions of the Governor, the Commissioner, and DFPS violate the Texas Administrative Procedure Act, are *ultra vires* and therefore invalid, violate the separation of powers guaranteed by the Texas Constitution, and violate equality and due process protections guaranteed by the Texas Constitution. Plaintiffs ask the Court for declaratory and injunctive relief to remedy these violations of Texas law and of the plaintiffs' rights and to immediately return to

[2] The impact of the Governor's, Attorney General's, and Commissioner's actions on mandatory reporters is not being challenged in this suit, but such claims are raised in *Doe v. Abbott*, Cause No. D-1-GN-22-000977, in the 353rd District Court of Travis County, Texas.

the *status quo ante*. Plaintiffs also seek a temporary restraining order and preliminary injunction only against the Commissioner and DFPS to maintain the *status quo ante* and prevent them from continuing to cause Plaintiffs irreparable harm while this case proceeds.

II. PARTIES

5. Plaintiff PFLAG is the first and largest organization for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people, their parents and families, and allies. PFLAG is a network comprised of over 250 local chapters throughout the United States, 17 of which are located in the state of Texas. Individuals who identify as LGBTQ+ and their parents, families, and allies join PFLAG directly or through one of its local chapters. Of approximately 250,000 members and supporters nationwide, PFLAG has a roster of more than 600 members in Texas. PFLAG's mission is to create a caring, just, and affirming world for LGBTQ+ people and those who love them. Encouraging and supporting parents and families of transgender and gender expansive people in affirming their children and helping them access the supports and care they need is central to PFLAG's mission. PFLAG asserts its claims in this lawsuit on behalf of its members.[3] The Voe, Roe, and Briggle families are members of PFLAG, and two additional members of PFLAG have submitted declarations in support of this lawsuit. *See* Ex. 1, Decl. of Samantha Poe; Ex. 2, Aff. of Lisa Stanton.

6. Plaintiffs Mirabel Voe, Wanda Roe, and Adam and Amber Briggle are the respective parents and next friends of Antonio Voe, Tommy Roe, and M.B., who are minors (collectively, "Plaintiff Families"). Plaintiffs Antonio Voe, Tommy Roe, and M.B. are

[3] Texas courts readily accept that membership organizations may have standing to sue on behalf of their members, and determine such standing with a three-prong test. *See Texas Ass'n of Businesses v. Texas Air Control Board*, 852 S.W.2d 440 (Tex. 1993); *see also Hunt v. Washington State Apple Advertising Commission*, 432 U.S. 333 (1977). The three-prong test set forth in *Texas Ass'n of Businesses* allows organization to sue on behalf of their members when: (1) the members would otherwise have standing to sue in their own right; (2) the interests the organization seeks to protect are germane to the organization's purpose; and (3) neither the claim asserted nor the relief requests requires the participation of individual members in the lawsuit. 852 S.W.2d at 447. Each of these prongs is met here.

transgender; have been diagnosed with gender dysphoria, a medical condition; and have been prescribed medical care for the treatment of gender dysphoria determined by their doctors to be medically necessary. The Plaintiff Families are all residents of Texas.

7. Defendant Greg Abbott is the Governor of the State of Texas and is sued in his official capacity only. He may be served at 1100 San Jacinto Boulevard, Austin, Texas 78701.

8. Defendant Jaime Masters is the Commissioner of the Texas Department of Family and Protective Services and is sued in her official capacity only. She may be served at 701 West 51st Street, Austin, Texas 78751.

9. Defendant Texas Department of Family and Protective Services is a state agency that is statutorily tasked with promoting safe and healthy families and protecting children and vulnerable adults from abuse, neglect, and exploitation. DFPS fulfills these statutory obligations through investigations, services and referrals, and prevention programs. It may be served at 701 West 51st Street, Austin, Texas 78751.

III. JURISDICTION AND VENUE

10. The subject matter in controversy is within the jurisdictional limits of this Court, and the Court has jurisdiction over this action pursuant to Article V, Section 8, of the Texas Constitution and Section 24.007 of the Texas Government Code, as well as the Texas Uniform Declaratory Judgments Act, Texas Civil Practice & Remedies Code Sections 37.001 and 37.003, and the Texas Administrative Procedure Act, Texas Government Code Section 2001.038.

11. This Court has jurisdiction over the parties because all Defendants reside or have their principal place of business in Texas.

12. Plaintiffs seek non-monetary relief.

13. Venue is mandatory and proper in Travis County because Plaintiffs challenge the validity or applicability of a rule, and the rule or its threatened application interferes with or

impairs, or threatens to interfere with or impair, a legal right or privilege of the Plaintiffs. Tex. Gov't Code § 2001.038(a), (b). Additionally, venue is proper because Defendants have their principal office in Travis County. Tex. Civ. Prac. & Rem. Code § 15.002(a)(3).

IV. DISCOVERY CONTROL PLAN

14. Plaintiffs intend for discovery to be conducted under Level 3 of Texas Rule of Civil Procedure 190.

V. FACTUAL BACKGROUND

A. Governor Abbott, Attorney General Paxton, and Commissioner Masters Create New Definitions of "Child Abuse" Under State Law.

15. On February 21, 2022, Attorney General Paxton released Opinion No. KP-0401 ("Paxton Opinion") dated February 18, 2022, which addressed "Whether certain medical procedures performed on children constitute child abuse."[4] The Paxton Opinion was issued in response to Representative Matt Krause's request dated August 23, 2021, about whether certain enumerated "sex-change procedures" when used to treat a minor with gender dysphoria constitute child abuse under state law. Specifically, Representative Krause inquired about and Attorney General Paxton purportedly addressed the following procedures: "sterilization through castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty; . . . mastectomies; and . . . removing from children otherwise healthy or non-diseased body part or tissue."[5] The Paxton Opinion also responded to Representative Krause's additional inquiries about: whether "the following categories of drugs: (1) puberty-suppression or puberty-blocking drugs; (2) supraphysiologic doses of testosterone to females; and

[4] Ken Paxton et al., Re: Whether Certain Medical Procedures Performed on Children Constitute Child Abuse (RQ-0426-KP), Opinion No. KP-0401, at 1 (Feb. 18, 2022), https://texasattorneygeneral.gov/sites/default/files/global/KP-0401.pdf.
[5] *Id.*

(3) supraphysiologic doses of estrogen to males" when used to treat minors with gender dysphoria could constitute child abuse.[6]

16. In summary, Attorney General Paxton's Opinion concluded that the enumerated procedures *could* constitute child abuse. The Paxton Opinion was based on the premise that "elective sex changes to minors often has [sic] the effect of permanently sterilizing those minor children."[7] The Paxton Opinion specifies that it "does not address or apply to *medically necessary* procedures,"[8] though it did not take into account the medical consensus that certain procedures described in the Paxton Opinion—including puberty blockers and hormone therapy—*are* medically necessary when prescribed to treat gender dysphoria.

17. In response to the Paxton Opinion, Governor Abbott sent a letter to DFPS Commissioner Jaime Masters dated February 22, 2022 (the "Abbott Letter" or "Abbott's Letter") directing the agency "to conduct a prompt and thorough investigation of any reported instances" of "sex-change procedures," without any regard to medical necessity.[9] The Abbott Letter claimed that "a number of so-called 'sex change' procedures constitute child abuse under existing Texas law."[10] In addition to directing DFPS to investigate reports of procedures referenced in the Paxton Opinion, under threat of criminal prosecution, the Abbott Letter directs "all licensed professionals who have direct contact with children" and "members of the general public" to report instances of minors who have undergone the medical procedures outlined in his Letter and the Paxton Opinion.[11]

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[6] *Id.*
[7] *Id.* at 2.
[8] *Id.* at 2 (emphasis added).
[9] Greg Abbott, Letter to Hon. Jaime Masters, Commissioner, Tex. Dep't of Fam. & Protective Servs. (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf.
[10] *Id.*
[11] *Id.*

18. During the 87th Regular session, the Texas Legislature considered, but did not pass, proposed legislation that would have changed Texas law to include treatment for gender dysphoria under the definition of child abuse. Specifically, Senate Bill 1646 ("SB 1646") would have amended Section 261.001 of the Family Code to add certain treatments to the definition of "child abuse." The bill would have amended this provision of the law to include within the definition of "child abuse": "administering or supplying, or consenting to or assisting in the administration or supply of, a puberty suppression prescription drug or cross-sex hormone to a child, other than an intersex child, for the purpose of gender transitioning or gender reassignment; or performing or consenting to the performance of surgery or another medical procedure on a child other than an intersex child, for the purpose of gender transitioning or gender reassignment."[12] SB 1646 did not pass. The Legislature considered additional bills that would have prohibited medical treatment for gender dysphoria in minors, including House Bill 68 and House Bill 1339. None of these bills was passed by the duly elected members of the Legislature.

19. On July 19, 2021, after the above-referenced legislation failed to pass, Governor Abbott explained on a public radio show that he had a "solution" to what he called the "problem" of medical treatment for minors with gender dysphoria.[14]

20. Following the issuance of the Paxton Opinion and the Abbott Letter, on February 22, 2022, DFPS announced that it would "follow Texas law as explained in (the) Attorney General opinion" and comply with the Governor's directive to "investigate[]" any reports of the procedures outlined in the new directives ("DFPS Statement"), again, without any regard to medical necessity.[13]

[12] S.B. 1646, 87th Leg. (Tex. 2021), https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB01646E.pdf.
[13] Isaac Windes, *Texas AG says trans healthcare is child abuse. Will Fort Worth schools have to report*?, Fort Worth Star-Telegram (Feb. 23, 2022), https://www.star-telegram.com/news/local/crossroads-lab/article258692193.html.

21. Commissioner Masters claimed that, prior to the issuance of the Paxton Opinion and Abbott Letter, the agency had "no pending investigations of child abuse involving the procedures described in that opinion."[14]

22. Previously, on September 3, 2021, Commissioner Masters responded to an inquiry from Representative Bryan Slaton about the same underlying medical treatment and explained, "I will await the opinion issued by the Attorney General's office before I reach any final decisions on the matters you raise."[15]

23. On February 24, 2022, DFPS convened a meeting where investigators and supervisors with Child Protective Services (CPS) were told that, for the first time, they would be required to investigate cases involving medical care for transgender youth as "child abuse" in accordance with Paxton's Opinion and Abbott's Letter.

24. Before February 22, CPS investigations teams had discretion to screen out or de-prioritize reports that did not meet the statutory definition of abuse and neglect, nor pose any harm to a child. According to long-established DFPS policy, CPS only "accepts reports for investigation" where "DFPS appears to be the responsible department under the law" and "the child's apparent need for protection warrants an investigation."[16]

25. During the meeting on February 24, CPS investigators were told that they would be required to investigate *all* reports of minors receiving the prescribed treatments of gender dysphoria mentioned in Paxton's Opinion and Abbott's Letter. Investigators were told that they had to treat these "specific cases" differently from all other reports of abuse or neglect and would

[14] *Id.*
[15] Jaime Masters, Letter to Hon. Bryan Slaton, Representative, District 2, Re: Correspondence (Sept. 3, 2021), http://thetexan.ews/wp-content/uploads/2021/09/Response-Letter_Representative-Slaton_Addressing-Gender-Reassignment-090321.pdf.
[16] DFPS Child Protective Services Handbook, Section 2141, available at https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_2140.asp (last visited June 6, 2022).

not be able to "priority none" these investigations or send them to "alternative response"—both of which are available for other reports that DFPS receives. But following Abbott's Letter and DFPS's Statement, DFPS told investigators to speak directly with their supervisors and the agency's general counsel to discuss "dispositioning these specific cases." Unlike all other reports of alleged abuse or neglect, CPS investigators were told that they no longer had discretion to close out investigations of medically necessary care for gender dysphoria.

26. On and after February 24, CPS investigators and supervisors were also instructed in writing not to discuss anything about these "specific cases" in writing, but instead that "[a]ny communication you have regarding these cases needs to be done in a Teams meeting, telephone call, or face to face. Do not send text messages or emails in regards to these specific cases." This instruction was highly irregular and antithetical to DFPS's longstanding policies and practices, since investigators and supervisors are tasked with documenting every aspect of each investigation to safeguard the interests of Texas children.

27. On or around February 24, DFPS opened investigations into families across Texas for allegedly providing their children with the medically necessary treatments referred to in Paxton's Opinion and Abbott's Letter. A DFPS spokesperson told the media that nine investigations were opened statewide.

28. These sudden and substantive changes reflected in DFPS's new rule, and the sudden shift in longstanding agency policies, along with Abbott's Letter, had immediate and harmful effects across the state. Faced with the purported changed definition of "child abuse" under Texas law, some medical providers temporarily discontinued medically necessary care for transgender adolescents with gender dysphoria. Teachers, social workers, and other mandatory reporters were confused about whether they needed to report their students and clients to CPS. Phone calls and

messages to mental health and suicide crisis hotlines skyrocketed across the state, and incidents of bullying and harassment towards transgender students spiked in Texas schools.

29. On March 1, a family under active CPS investigation and a licensed psychologist sued the Governor, Commissioner, and DFPS in Travis County District Court. *See Doe v. Abbott*, Cause No. D-1-GN-22-000977 in the 353rd District Court of Travis County, Texas (referred to hereinafter as the "*Doe v. Abbott* Litigation"). That action resulted in a temporary injunction from the District Court and a temporary order on appeal from the Court of Appeals blocking statewide DFPS investigations based on DFPS's new rule implementing Paxton's Opinion and Abbott's Letter. Instead of dismissing or closing out these cases following those rulings, DFPS put them on pause, effectively freezing them in place.

30. On May 13, the Texas Supreme Court upheld the Court of Appeals' temporary order but narrowed its scope of relief to apply only to the specific plaintiffs in the *Doe v. Abbott* Litigation based on a technical reading of the scope of relief that may be granted under Texas Rule of Appellate Procedure 29.3. The Defendants' appeal of the temporary injunction remains pending at the Court of Appeals. At this time, only the investigation against the Doe family is enjoined.

31. On May 19, DFPS released a statement to the media that "DFPS treats all reports of abuse, neglect, and exploitation seriously and will continue to investigate each to the full extent of the law."[17] Although this statement was vaguely worded, it was reported in the media that investigations were actually continuing following internal discussions among DFPS, the Governor and Attorney General's offices.[18] Families, including Plaintiffs in this case, have since heard from DFPS about investigations moving forward.

[17] Madeleine Carlisle, *I'm Just Waiting for Someone to Knock on the Door.' Parents of Trans Kids in Texas Fear Family Protective Services Will Target Them*, Time (May 19, 2022), https://time.com/6178947/trans-kids-texas-familes-fear-child-abuse-investigations/
[18] *Id.*

32. As DFPS resumed investigating families of transgender youth for possible treatment with medically indicated health care for gender dysphoria, upon information and belief, CPS investigators and supervisors were once again told not to put anything about these specific cases in writing—again departing from agency procedures. These investigations are not being conducted pursuant to any Texas statute or duly enacted DFPS policy but are being pushed forward under the purported color of law based on Paxton's Opinion and Abbott's Letter. Through the DFPS Statement, Commissioner Masters and DFPS have established a new rule and created a presumption that the medical care described in Paxton's Opinion and Abbott's Letter constitutes "child abuse", without any regard for medical necessity (hereinafter the "new rule" or "new DFPS rule"). Even though Governor Abbott and Attorney General Paxton have no authority to direct DFPS or to change longstanding agency policies, DFPS is still pushing forward investigations that are unlawful and causing irreparable harm, as if Texas law has substantively changed and without adhering to the requirements of the Texas Administrative Procedure Act.

B. Responses to New Child Abuse Directives

33. Following the recent attempts by Defendants to change the definition of "child abuse" under Texas law, experts in pediatric medicine, endocrinology, mental health care, and social work issued statements condemning these actions and warning that they run counter to established protocols for treating gender dysphoria, could force providers to violate their professional ethics, and cause substantial harm to minors and their families in Texas.

34. In response to the actions taken by Defendants, the National Association of Social Workers issued the following statement: "The continued attempts in Texas to change the definition of child abuse are in direct opposition to social work values, principles, and Code of Ethics and pose an imminent danger to transgender youth and their families. Furthermore, these shameful actions undermine the established truth supported by every credible medical and mental health

organization in the country that the concepts of sexual orientation and gender identity are real and irrefutable components of one's individual identity."[19]

35. The American Academy of Pediatrics and the Texas Pediatric Society condemned the actions of Texas executive officials explaining that "[t]he AAP has long supported gender-affirming care for transgender youth, which includes the use of puberty-suppressing treatments when appropriate, as outlined in its own policy statement, urging that youth who identify as transgender have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space in close consultation with parents."[20]

36. The president of the Texas Pediatric Society explained of the efforts to change the definition of "child abuse" under Texas law: "Evidence-based medical care for transgender and gender diverse children is a complex issue that pediatricians are uniquely qualified to provide. This directive undermines the physician-patient-family relationship and will cause undue harm to children in Texas. TPS opposes the criminalization of evidence-based, gender-affirming care for transgender youth and adolescents. We urge the prioritization of the health and well-being of all youth, including transgender youth."[21]

37. The Endocrine Society condemned the efforts to re-define "child abuse" explaining that these efforts "reject[] evidence-based transgender medical care and will restrict access to care

[19] *NASW Condemns Efforts to Redefine Child Abuse to Include Gender-Affirming Care*, Nat'l Ass'n Soc. Workers (Feb. 25, 2022), https://www.socialworkers.org/News/News-Releases/ID/2406/NASW-Condemns-Efforts-to-Redefine-Child-Abuse-to-Include-Gender-Affirming-Care.
[20] *AAP, Texas Pediatric Society Oppose Actions in Texas Threatening Health of Transgender Youth*, Am. Acad. Pediatrics (Feb. 24, 2022), https://www.aap.org/en/news-room/news-releases/aap/2022/aap-texas-pediatric-society-oppose-actions-in-texas-threatening-health-of-transgender-youth/.
[21] *Id.*

for teenagers experiencing gender incongruence or dysphoria."[22] The Endocrine Society statement went on to explain: "Health care providers should not be punished for providing evidenced-based care that is supported by major international medical groups—including the Endocrine Society, American Medical Association, the American Psychological Association, and the American Academy of Pediatrics—and Clinical Practice Guidelines."[23]

38. The President of the American Psychological Association issued the following statement: "This ill-conceived directive from the Texas governor will put at-risk children at even higher risk of anxiety, depression, self-harm, and suicide. Gender-affirming care promotes the health and well-being of transgender youth and is provided by medical and mental health professionals, based on well-established scientific research. The peer-reviewed research suggests that transgender children and youth who are treated with affirmation and receive evidence-based treatments tend to see improvements in their psychological well-being. Asking licensed medical and mental health professionals to 'turn in' parents who are merely trying to give their children needed and evidence-based care would violate patient confidentiality as well as professional ethics. The American Psychological Association opposes politicized intrusions into the decisions that parents make with medical providers about caring for their children."[24]

39. Prevent Child Abuse America issued the following statement: "Prevent Child Abuse America (PCA America) knows that providing necessary and adequate medical care to your child is not child abuse, and that transgender and non-binary children need access to age-appropriate, individualized medical care just like every other child. Therefore, PCA America

[22] *Endocrine Society Alarmed at Criminalization of Transgender Medicine*, Endocrine Soc'y (Feb. 23, 2022), https://www.endocrine.org/news-and-advocacy/news-room/2022/endocrine-society-alarmed-at-criminalization-of-transgender-medicine.
[23] Id.
[24] *APA President Condemns Texas Governor's Directive to Report Parents of Transgender Minors*, Am. Psych. Ass'n (Feb. 24, 2022), https://www.apa.org/news/press/releases/2022/02/report-parents-transgender-children.

opposes legislation and laws that would deny healthcare access to any child, regardless of their gender identity. Such laws threaten the safety and security of our nation's most vulnerable citizens—children and youth."[25]

40. The Ray E. Helfer Society, an international, multi-specialty society of physicians having substantial research and clinical experience with all medical facets of child abuse and neglect, likewise condemned Defendants' actions. The Helfer Society "opposes equating evidence based, gender affirming care for transgender youth with child abuse, and the criminalization of such care. The provision of medical and mental health care, consistent with the standard of care, is in no way consistent with our definitions of child abuse."[26]

41. On May 2, 2022, legal and medical experts from Yale Law School, the Yale School of Medicine's Child Study Center and Departments of Psychiatry and Pediatrics, and the University of Texas Southwestern issued a detailed report comprehensively examining the Texas Attorney General opinion targeting medical care for transgender youth. The report, "Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Statements," strongly refutes the misguided scientific claims that inform Paxton's Opinion and highlights that the Paxton Opinion omitted important evidence demonstrating the benefits of treatment for gender dysphoria and exaggerated potential harms, painting "a warped picture" of the scientific evidence.[27] Among

[25] Melissa Merrick, *A Message from Dr. Melissa Merrick in Response to Texas AG Opinion on Gender-Affirming Care*, Prevent Child Abuse Am. (Feb. 23, 2022), https://preventchildabuse.org/latest-activity/gender-affirming-care/.
[26] *Position Statement of the Ray E. Helfer Society On Gender Affirming Care Being Considered Child Abuse and Neglect*, Ray E. Helfer Soc'y (Feb. 2022), https://www.helfersociety.org/assets/docs/Helfer%20Society%20Statement%20On%20Texas%20Transgender%20Action%2002.22.pdf.
[27] Susan D. Boulware, M.D.; Rebecca Kamody, PhD; Laura Kuper, PhD; Meredithe McNamara, M.D., M.S., FAAP; Christy Olezeski, PhD; Nathalie Szilagyi, M.D.; and Anne Alstott, J.D., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims* (April 28, 2022),

other things, the report by the Yale University and University of Texas Southwestern experts found that:

a. "The Texas Attorney General either misunderstands or deliberately misstates medical protocols and scientific evidence.";

b. "The AG Opinion falsely implies that puberty blockers and hormones are administered to prepubertal children, when, in fact, the standard medical protocols recommend drug treatments only for adolescents (and not prepubertal children).";

c. "The AG Opinion also omits mention of the extensive safeguards established by the standard protocols to ensure that medication is needed and that adolescents and their parents give informed assent and consent, respectively, to treatment when it is determined to be essential care.";

d. "By omitting the evidence demonstrating the substantial benefits of treatment for gender dysphoria, and by focusing on invented and exaggerated harms, the AG Opinion … portray[s] a warped picture of the scientific evidence."; and

e. "The repeated errors and omissions in the AG Opinion are so consistent and so extensive that it is difficult to believe that the opinion represents a good-faith effort to draw legal conclusions based on the best scientific evidence."

42. Defendants' attempts to rewrite Texas law and define medically necessary health care for transgender youth as "child abuse" have also spurred condemnation from current and former DFPS employees. More than half a dozen current employees have resigned or are actively looking for other jobs because they view the targeting of transgender youth and their families as a

https://medicine.yale.edu/childstudy/policy/lgbtq-youth/report%20on%20the%20science%20of%20gender-affirming%20care%20final%20april%2028%202022_437080_54462_v2.pdf.

betrayal of the agency's values and mission.[28] Fifteen current and former DFPS employees submitted an *amicus* brief to the Texas Supreme Court, in which they described how "[t]he February 22 Directive and new DFPS Rules represent a radical departure from the status quo meaning of the term 'abuse' as it has been interpreted by Texas courts and by DFPS and its predecessor agencies throughout history prior to February 22, 2022."[29] As career DFPS employees, *amici* advised the Court that "DFPS is already deeply in crisis and is failing Texas's most vulnerable children, violating their Constitutional rights, and subjecting them to further abuse," and condemned the agency's "politically motivated decision to compel DFPS employees like themselves to investigate non-abusive loving and supportive families who merely rely in good faith on their doctor's advice."

43. Parents and families across the state of Texas are fearful that if they follow the recommendations of their medical providers to treat their adolescent children's gender dysphoria, they could face investigation, criminal prosecution, and the removal of their children from their custody. As a result, parents are scared to remain in Texas, to send their children to school or to the doctor, and to otherwise meet their basic survival needs. They are also afraid that if they do not pursue this medically prescribed and necessary care for their children in order to avoid investigation and criminal prosecution, their children's mental and physical health will suffer dramatically.

44. DFPS has so broadly implemented its new rule affecting the families of transgender and gender nonconforming youth that even parents whose gender nonconforming children are still

[28] Eleanor Klibanoff, *Distraught over orders to investigate trans kids' families, Texas child welfare workers are resigning*, Tex. Trib. (Apr. 11, 2022), https://www.texastribune.org/2022/04/11/texas-trans-child-abuse-investigations/.

[29] Brief of Amici Curiae Current & Former Employees of Tex. DFPS, *In re Abbott*, No. 22-0229 (Mar. 30, 2022), available at https://search.txcourts.gov/SearchMedia.aspx?MediaVersionID=5b5a0304-a87e-4482-b153-97bc5350949d

figuring out who they are and/or not receiving any medical care for the treatment of gender dysphoria are scared. Indeed, DFPS has initiated and continued investigations into such families notwithstanding assurances and documentation that their gender nonconforming children are not receiving any medical care for the treatment of gender dysphoria. *See* Ex. 1, Decl. of Samantha Poe.

45. The actions taken by Defendants have already caused severe and irreparable harm to families across the State of Texas, including members of PFLAG and the Voe, Roe, and Briggle families.

C. Treatment for Gender Dysphoria is Well Established and Medically Necessary.

46. The health care that DFPS now considers child abuse, following the issuance of Abbott's Letter and the Paxton Opinion, is medically necessary, essential, and often lifesaving. This medical care is endorsed and adopted by every major medical organization in the United States. *See generally* Ex. 3, Expert Decl. of Dr. Cassandra C. Brady.

47. Doctors in Texas use well-established guidelines to diagnose and treat youth with gender dysphoria. Medical treatment for gender dysphoria is prescribed to adolescents only after the onset of puberty and only when doctors determine it to be medically necessary. Parents, doctors, and minors work together to develop a treatment plan consistent with widely accepted protocols supported by every major medical organization in the United States.

48. "Gender identity" refers to a person's internal, innate, and immutable sense of belonging to a particular gender.

49. Although the precise origin of gender identity is unknown, a person's gender identity is a fundamental aspect of human development. There is a general medical consensus that there is a significant biological component to gender identity.

50. Everyone has a gender identity. A person's gender identity is durable and cannot be altered through medical intervention.

51. A person's gender identity usually matches the sex they were designated at birth based on their external genitalia. The terms "sex designated at birth" or "sex assigned at birth" are more precise than the term "biological sex" because there are many biological sex characteristics, including gender identity, and these may not always be in alignment with each other. For example, some people with intersex characteristics may have a chromosomal configuration typically associated with a male sex designation but genital characteristics typically associated with a female sex designation. For these reasons, the Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, warns practitioners that the terms "biological sex" and "biological male or female" are imprecise and should be avoided.[30]

52. Most boys were designated male at birth based on their external genital anatomy, and most girls were designated female at birth based on their external genital anatomy.

53. Transgender youth have a gender identity that differs from the sex assigned to them at birth. A transgender boy is someone who was assigned a female sex at birth but persistently, consistently, and insistently identifies as male. A transgender girl is someone who was assigned a male sex at birth but persistently, consistently, and insistently identifies as female.

54. Some transgender people become aware of having a gender identity that does not match their assigned sex early in childhood. For others, the onset of puberty, and the resulting physical changes in their bodies, leads them to recognize that their gender identity is not aligned

[30] *See* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869, 3875 (2017), https://academic.oup.com/jcem/article/102/11/3869/4157558 (hereinafter "Endocrine Society Guideline") ("Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.").

with their sex assigned at birth. The lack of alignment between one's gender identity and sex assigned at birth can cause significant distress.

55. According to the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM-V"), "gender dysphoria" is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and the sex assigned to them at birth. In order to be diagnosed with gender dysphoria, the incongruence must have persisted for at least six months and be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

56. Being transgender is not itself a medical condition to be cured. But gender dysphoria is a serious medical condition that, if left untreated, can result in debilitating anxiety, severe depression, self-harm, and suicidality.

57. The World Professional Association for Transgender Health ("WPATH") and the Endocrine Society have published widely accepted guidelines for treating gender dysphoria.[31] The medical treatment for gender dysphoria is to eliminate the clinically significant distress by helping a transgender person live in alignment with their gender identity. This treatment is sometimes referred to as "gender transition," "transition related care," or "gender-affirming care." These standards of care are recognized by the American Academy of Pediatrics, which agrees that this

[31] Endocrine Society Guideline; World Prof'l Ass'n for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (7th Version, 2012), https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341 (hereinafter, "WPATH SOC").

care is safe, effective, and medically necessary treatment for the health and well-being of youth suffering from gender dysphoria.[32]

58. The precise treatment for gender dysphoria for any individual depends on that person's individualized needs, and the guidelines for medical treatment differ depending on whether the treatment is for an adolescent or an adult. No medical treatment is recommended or necessary prior to the onset of puberty, however.

59. Before puberty, gender transition does not include any pharmaceutical or surgical intervention. Instead, it involves social transition, such as using a name and pronouns typically associated with the child's gender identity and dressing consistently with their gender identity.

60. Under the WPATH Standards of Care and the Endocrine Society Guideline, medical interventions may become medically necessary and appropriate after transgender youth reach puberty. In providing medical treatments to adolescents, pediatric physicians and endocrinologists work in close consultation with qualified mental health professionals experienced in diagnosing and treating gender dysphoria.

61. For many transgender adolescents, going through puberty as the sex assigned to them at birth can cause extreme distress. Puberty-delaying medication allows transgender adolescents to pause puberty, thus minimizing and potentially preventing the heightened gender dysphoria and permanent physical changes that puberty would cause.

62. Under the Endocrine Society Guideline, transgender adolescents may be eligible for puberty-delaying treatment if:

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[32] Jason Rafferty, et al., Am. Academy Pediatrics, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics (2018), https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for; Lee Savio Beers, *American Academy of Pediatrics Speaks Out Against Bills Harming Transgender Youth*, Am. Academy Pediatrics (Mar. 16, 2021), https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-speaks-out-against-bills-harming-transgender-youth/.

- A qualified mental health professional has confirmed that:
    - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
    - gender dysphoria worsened with the onset of puberty,
    - coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
    - the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment,
- And the adolescent:
    - has sufficient mental capacity to give informed consent to this (reversible) treatment,
    - the adolescent has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
    - the adolescent has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

- And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
    - agrees with the indication for gonadotropin-releasing hormone ("GnRH") agonist treatment,
    - has confirmed that puberty has started in the adolescent, and
    - has confirmed that there are no medical contraindications to GnRH agonist treatment.

63. Puberty-delaying treatment is reversible. When the adolescent discontinues the medication, puberty will resume. Contrary to the assertions in the Paxton Opinion, puberty-delaying treatment does not cause infertility.

64. For some adolescents, it may be medically necessary and appropriate to initiate puberty consistent with the young person's gender identity through gender-affirming hormone therapy (testosterone for transgender boys, and estrogen and testosterone suppression for transgender girls).

65. Under the Endocrine Society Guideline, transgender adolescents may be eligible for gender-affirming hormone therapy if:

- A qualified mental health professional has confirmed:
    - the persistence of gender dysphoria,
    - any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's environment and functioning are stable enough to start sex hormone treatment,

- the adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,

- And the adolescent:
  - has been informed of the partly irreversible effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
  - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
- And a pediatric endocrinologist or other clinician experienced in pubertal induction:
  - agrees with the indication for sex hormone treatment, and
  - has confirmed that there are no medical contraindications to sex hormone treatment.

66. Gender-affirming hormone therapy is not necessarily sterilizing and many individuals treated with hormone therapy can still biologically conceive children.

67. As with all medications that could impact fertility, transgender adolescents and their parents are counseled on the potential risks of the medical intervention, and treatment is only initiated where parents and adolescents are properly informed and consent to the care.

68. Under the WPATH Standards of Care, transgender young people may also receive medically necessary chest reconstructive surgeries before the age of majority, provided the young person has lived in their affirmed gender for a significant period of time. Genital surgery is not recommended until patients reach the age of majority.

69. Chest reconstructive surgeries have no impact on fertility.

70. Medical treatment recommended for and provided to transgender adolescents with gender dysphoria can substantially reduce lifelong gender dysphoria and can eliminate the medical need for surgery later in life.

71. The treatment protocols for gender dysphoria supported by every major medical organization in the United States are based on extensive research and clinical experience. When existing protocols are followed, no minor is rushed into treatment. Instead, the process requires extensive mental health evaluation and informed consent procedures.

72. Providing gender-affirming medical care can be lifesaving treatment and change the short and long-term health outcomes for transgender youth.

73. All of the treatments used to treat gender dysphoria are also used to treat other conditions in minors with comparable side effects and risks.

74. Many forms of treatment in pediatric medicine and medicine generally are prescribed "off-label." Use of medication for "off-label" non-FDA approved purposes is a common and necessary practice in medicine.

75. Many forms of medical treatment carry comparable risks and side effects to those that can be present when treating gender dysphoria. Treatment for gender dysphoria is not uniquely risky.

D. Legal Status of Treatment for Gender Dysphoria in the United States

76. No state in the country considers medically recommended treatment for gender dysphoria to be a form of child abuse.

77. And notwithstanding some politicized efforts to the contrary, no state in the country prohibits doctors from treating, or parents from consenting to treatment for, minor patients with gender dysphoria.

78. Arkansas and Alabama are the only states to pass laws prohibiting such treatment, but the laws were enjoined in court and do not classify the treatment as a form of child abuse.[33] When the Arkansas General Assembly passed the bill prohibiting treatment for minors with gender dysphoria, Governor Asa Hutchinson vetoed it, explaining: "I vetoed this bill because it creates new standards of legislative interference with physicians and parents as they deal with some of the most complex and sensitive matters concerning our youths. It is undisputed that the number of minors who struggle with gender incongruity or gender dysphoria is extremely small. But they, too, deserve the guiding hand of their parents and the counseling of medical specialists in making the best decisions for their individual needs. H.B. 1570 puts the state as the definitive oracle of medical care, overriding parents, patients, and health-care experts. While in some instances the state must act to protect life, the state should not presume to jump into the middle of every medical, human and ethical issue. This would be—and is—a vast government overreach."[34]

79. In Arkansas, a simple majority of the General Assembly overrode Governor Hutchinson's veto and nonetheless enacted a ban on health care treatments for minors with gender

[33] *Eknes-Tucker v. Marshall*, Case No.: 2:22-CV-184-LCB, 2022 WL 1521889 (M.D. Ala. May 13, 2022); *Brandt v. Rutledge*, 551 F. Supp. 3d 882 (E.D. Ark. 2021). Arizona recently passed a law, not slated to take effect until 2023, prohibiting the provision of gender-affirming surgeries for minors in that state. The Arizona law, however, is limited only to surgery and does not classify gender-affirming medical care as a form of child abuse.

[34] Asa Hutchinson, Opinion, *Why I Vetoed My Party's Bill Restricting Health Care for Transgender Youth*, Wash. Post (Apr. 8, 2021), https://www.washingtonpost.com/opinions/asa-hutchinson-veto-transgender-health-bill-youth/2021/04/08/990c43f4-9892-11eb-962b-78c1d8228819_story.html.

dysphoria. In July 2021, that law was enjoined in federal court. Based on an extensive preliminary injunction record, the court found: "If the Act is not enjoined, healthcare providers in this State will not be able to consider the recognized standard of care for adolescent gender dysphoria. Instead of ensuring that healthcare providers in the State of Arkansas abide by ethical standards, the State has ensured that its healthcare providers do not have the ability to abide by their ethical standards which may include medically necessary transition-related care for improving the physical and mental health of their transgender patients."[35] The court further held that the law "cannot withstand heightened scrutiny and based on the record would not even withstand rational basis scrutiny if it were the appropriate standard of review."[36]

80. In Alabama, again based on an extensive preliminary injunction record and after a two-day evidentiary hearing, a federal court enjoined the provisions of S.B. 184 that made it a felony to prescribe or administer puberty blockers and hormone therapies to transgender youth. The court cited the clear legal precedent that "parents have a fundamental right to direct the medical care of their children subject to accepted medical standards" and that "discrimination based on gender-nonconformity equates to sex discrimination."[37] The court found that Defendants "fail[ed] to produce evidence showing that transitioning medications jeopardize the health and safety of minors suffering from gender dysphoria" and that "[p]arents, pediatricians, and psychologists—not the State or this Court—are best qualified to determine whether transitioning medications are in a child's best interest on a case-by-case basis."[38] Without transitioning medications, the minor plaintiffs would "suffer severe medical harm, including anxiety,

[35] *Brandt*, 551 F. Supp. 3d at 891.
[36] *Id.*
[37] *Eknes-Tucker v. Marshall*, Case No.: 2:22-CV-184-LCB, 2022 WL 1521889, at *1 (M.D. Ala. May 13, 2022).
[38] *Id.* at *8.

depression, eating disorders, substance abuse, self-harm, and suicidality," along with "significant deterioration in their familial relationships and educational performance."[39]

VI. PROCEDURAL HISTORY

81. On March 1, 2022, the parents of a transgender adolescent and Dr. Megan Mooney, a psychologist who treats transgender adolescents (collectively, the "*Doe v. Abbott* Plaintiffs"), challenged Governor Abbott's Letter by filing a Petition and Application for Temporary Restraining Order (TRO), Temporary Injunction, and Permanent Injunction, and Request for Declaratory Relief against Greg Abbott, in his official capacity as Governor of the State of Texas, Jaime Masters, in her official capacity as Commissioner of DFPS, and DFPS itself. *See Doe v. Abbott*, Cause No. D-1-GN-22-000977 in the 353rd District Court of Travis County, Texas.

82. The *Doe v. Abbott* Plaintiffs' underlying causes of action included: (1) a claim for a declaratory judgment that the DFPS Statement constitutes an invalid rule under the Texas APA; (2) a claim for a declaratory judgment that the Governor and the Commissioner engaged in ultra vires conduct that exceeded their authority; and (3) claims of various constitutional violations arising from the *Doe v. Abbott* Plaintiffs' fundamental parental rights and other equality and due process guarantees of the Texas Constitution.

83. In their petition, the *Doe v. Abbott* Plaintiffs requested a temporary restraining order, temporary injunction, permanent injunction, and declaratory judgment.

84. Their application for a temporary restraining order was heard on March 2, 2022. Minutes before the hearing, Defendants filed a plea to the jurisdiction but did not request it be set for submission or considered at hearing. At the TRO hearing, neither the trial court nor the parties addressed the merits of the plea to the jurisdiction.

[39] *Id.* at *12.

85. At the conclusion of the hearing, the trial court granted the TRO enjoining Defendants from, *inter alia*, taking any employment action or investigating reports against the *Doe v. Abbott* Plaintiffs based solely on facilitating or providing gender-affirming care to transgender adolescents based on the fact that they are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment. The trial court also set a temporary injunction hearing to consider granting state-wide injunctive relief for March 11, 2022. The trial court did not rule on Defendants' plea to the jurisdiction, which Defendants filed mere minutes before the TRO hearing was set to begin.

86. Within hours of the Court granting the *Doe v. Abbott* Plaintiffs' TRO application, Defendants took an interlocutory appeal to the Third Court of Appeals in Austin, arguing that the trial court's grant of the TRO application "implicitly denied" Defendants' plea to the jurisdiction.

87. On March 3, 2022, the *Doe v. Abbott* Plaintiffs filed an emergency motion to dismiss the appeal for want of jurisdiction, for expedited briefing, and for reinstatement of the TRO under Texas Rule of Appellate Procedure 29.3 ("Rule 29.3"). The *Doe v. Abbott* Plaintiffs argued that, unlike temporary injunctions, TROs are not appealable and that the TRO makes no determination as to the Defendants' plea to the jurisdiction.

88. On March 9, 2022, after reviewing the parties' arguments, the Third Court of Appeals concluded that the TRO was neither an implied ruling on Defendants' jurisdictional plea nor an appealable temporary injunction. *Doe v. Abbott*, No. 03-22-00107-CV, 2022 WL 710093, at *2-3 (Tex. App.—Austin, Mar. 9, 2022) (mem. op.).

89. On March 11, 2022, the trial court held a temporary injunction hearing to consider the *Doe v. Abbott* Plaintiffs' request for statewide relief. The substantial record before the trial court showed that the new DFPS ule and unauthorized actions by Defendants have caused severe

and ongoing harms to transgender youth and those who care for them by triggering unwarranted investigations into families, threatening providers and mandatory reporters with criminal prosecution, cutting off medically necessary health care to adolescents who rely on it, and infringing upon the fundamental rights of parents to direct the custody and care of their minor children.

90. Based on the evidence presented, the trial court entered a temporary injunction and denied Defendants' plea to the jurisdiction. The trial court found that the *Doe v. Abbott* Plaintiffs had met their burden of showing a probable right of relief. The trial court specifically found that "there is substantial likelihood that [the *Doe v. Abbott* Plaintiffs] will prevail after a trial on the merits because the Governor's directive is ultra vires, beyond the scope of his authority, and unconstitutional." *Doe v. Abbott*, No. D-1-GN-22-000977, 2022 WL 831383 *1 (353rd Dist. Ct., Travis Cty., Mar. 11, 2022). The trial court also found that "gender-affirming care was not investigated as child abuse by DFPS until after February 22, 2022." *Id.* As a result, "[t]he series of directives and decisions by the Governor, the [Commissioner], and other decision-makers at DFPS, changed the status quo for transgender children and their families, as well as professionals who offer treatment, throughout the State of Texas." *Id.* Therefore, the trial court found "[t]he Governor's Directive was given the effect of a new law or new agency rule, despite no new legislation, regulation or even stated agency policy" and that "Governor Abbott and Commissioner Masters' actions violate separation of powers by impermissibly encroaching into the legislative domain." *Id.*

91. Immediately following the entry of the orders granting the temporary injunction and denying Defendants' plea to the jurisdiction, Defendants filed a notice of accelerated interlocutory appeal, wherein they asserted that by perfecting the appeal, the temporary injunction

had been superseded pursuant to Texas Civil Practice and Remedies Code § 6.001(b) and Texas Rule of Appellate Procedure 29.1(b).

92. The *Doe v. Abbott* Plaintiffs then moved for temporary relief under Rule 29.3. On March 21, 2022, finding it "necessary to maintain the status quo and preserve the rights of all parties," the Third Court of Appeals reinstated the temporary injunction. *Abbott v. Doe*, No. 03-22-00126-CV, 2022 WL 837956, at *2 (Tex. App.—Austin, Mar. 21, 2022).

93. On March 23, 2022, Defendants petitioned the Texas Supreme Court for a writ of mandamus directing that the Third Court of Appeals vacate its Rule 29.3 order reinstating the temporary injunction entered by the district court.

94. On May 13, 2022, the Texas Supreme Court denied mandamus relief as to the portion of the order applicable to the *Doe v. Abbott* Plaintiffs while the appeal remains pending. *In re Abbott*, No. 22-0229, 2022 WL 1510326, at *4 (Tex. May 13, 2022). However, the Texas Supreme Court found that given Rule 29.3's specific language referencing "the parties' rights," the Third Court of Appeals abused its discretion by affording relief to nonparties throughout the state. Without opining on the District Court's authority to issue a statewide injunction, the Texas Supreme Court held that the Defendants were entitled to mandamus relief as to the portions of the Third Court of Appeals' order that purport to have statewide application. Further, the Court conditionally granted relief with respect to the order's injunction against the Governor because the Governor lacks the authority to undertake—and has not threatened or attempted to undertake—the enforcement actions the order enjoins.

95. In denying further mandamus relief, the Texas Supreme Court upheld the appeals court's order finding that the *Doe v. Abbott* Plaintiffs had established a probable right to recovery on their claims and that "allowing appellants to follow the Governor's directive pending the

outcome of this litigation would result in irreparable harm." *Abbott v. Doe*, No. 03-22-00126-CV, 2022 WL 837956, at *3 (Tex. App.—Austin, Mar. 21, 2022). Declining to reach Defendants' jurisdictional arguments, the Texas Supreme Court also noted that "DFPS's press statement [] suggests that DFPS may have considered itself bound by either the Governor's letter, the Attorney General's Opinion, or both . . . but neither the Governor nor the Attorney General has statutory authority to directly control DFPS's investigatory decisions." *In re Abbott*, No. 22-0229, 2022 WL 1510326, at *3 (Tex. May 13, 2022).

96. On May 25, 2022, Defendants submitted their brief on the merits of their appeal of the trial court's issuance of the temporary injunction and denial of Defendants' plea to jurisdiction to the Third Court of Appeals. The *Doe v. Abbott* Plaintiffs will file their response brief in the coming weeks.

97. At present, there is no injunction or temporary relief for Plaintiffs in this action, and the *Doe v. Abbott* Litigation is currently stayed in the trial court pending resolution of the appeal.

VII. PLAINTIFFS

A. PFLAG

98. Founded in 1973, Plaintiff PFLAG is the first and largest organization for LGBTQ+ people, their parents and families, and allies. Ex. 4, Decl. of Brian K. Bond.

99. PFLAG is a 501(c)(3) nonprofit membership organization whose mission is "to create a caring, just, and affirming world for LGBTQ+ people and those who love them." PFLAG has chapters in every state and the District of Columbia.

100. Supporting LGBTQ+ young people and strengthening their families has been central to PFLAG's work since its founding, and that objective includes encouraging and

supporting parents and families of transgender and gender expansive people in affirming their children and helping them access the social, psychological, and medical supports they need.

101. PFLAG carries out that commitment through supporting the development and work of PFLAG's chapter network, engaging in policy advocacy, forming coalitions with organizations who share PFLAG's goals, developing trainings and educational materials, and engaging with the media. More specifically, it includes working with PFLAG families to encourage love for and support of their transgender and gender expansive children and to help them ensure that the children's needs are met.

102. PFLAG has seventeen chapters across the state of Texas with over 600 members. Those members include parents of transgender adolescents who are directly impacted by the Governor Abbott's Letter and DFPS's new rule and resulting changes in policy and practice.

103. The issuance of the Paxton Opinion caused immediate harm to PFLAG members and constituents, which was only exacerbated by Governor Abbott's Letter and DFPS's new rule as announced in the DFPS Statement and resulting substantive change in its policies and practices. The order to investigate parents for child abuse based solely on helping their children access medically necessary care turned the very thing PFLAG has long held up as critical for LGBTQ+ children—supporting and loving your child for who they are and ensuring they receive care they need to thrive—into a reason to be reported and subjected to an intrusive and traumatic investigation, or worse.

104. In response, PFLAG provided its members with information and support about the opinion and directive. Local PFLAG chapters heard from members who were parents of transgender children and wondered if they would soon be investigated, and these members asked PFLAG for assistance and about their rights as parents. Members of PFLAG had their children's

appointments and access to health care cut off, as providers mistakenly viewed Abbott's Letter and DFPS's new rule as criminalizing medically necessary health care in Texas. Other PFLAG members have left the state, or contemplated leaving Texas, so as not to risk family separation or criminal penalties for providing their children access to the prescribed, medically necessary care they need.

105. PFLAG, its chapters, and its members have experienced the ebb and flow of fear as the *Doe v. Abbott* Litigation resulted in the investigations being halted, only to have the statewide injunction narrowed by the Texas Supreme Court. PFLAG chapters heard from members that the investigations of parent members that had been paused were suddenly restarted and are being pushed forward contrary to Texas law and longstanding DFPS policies. Members who are parents of transgender children who had not yet been investigated live in fear that they soon could be investigated and have their privacy invaded at home and in their children's schools. Members also worry that their right as parents to provide the best possible health care for their children has been usurped by the state and that their children could lose access to lifesaving health care that they need.

106. Given the scope of the Governor's directive, the breadth of DFPS's investigations, and the current lack of a statewide injunction preventing their pursuit, every one of PFLAG's Texas members with a transgender child, or those with children still learning who they are, is at substantial risk of harm. PFLAG has members who are being harmed right now by these actions and have standing to assert claims in their own right, including the Voe, Roe, and Briggle Plaintiffs and the Poe and Stanton families (*see* Ex. 1, Decl. of Samantha Poe; Ex. 2, Aff. of Lisa Stanton), whether because they are facing active investigations, have had their medically necessary health care disrupted, or were otherwise forced to alter their interactions with schools, care

providers, supportive services, or others in order to avoid being reported for child abuse by mandated reporters, all solely because they are or are suspected of seeking the established course of medically necessary care for their transgender children.

107. Other current and future PFLAG members with transgender or nonbinary children face a substantial risk of being harmed by the directive and its implementation because their care for and affirmation of their children may include seeking gender affirming care for them.

108. Abbott's Letter and DFPS's new rule are contrary to PFLAG's mission, subjecting those who affirm their child's gender identity by seeking the established medically necessary care that has been prescribed for them to the peril and stigma of being labeled a "child abuser" and having the child removed from the parent's care. Defendants' actions threaten drastic penalties on PFLAG members for doing the very things PFLAG encourages as in the best interests of transgender and nonbinary children.

109. PFLAG seeks to vindicate these members' interests in challenging Defendants' actions. The directive and its implementation create a default equation of gender-affirming care with child abuse in a manner that harms all of PFLAG's members who affirm their transgender and nonbinary children, no matter the particular circumstances of those members.

B. The Voe Family

110. Plaintiff Mirabel Voe is the proud parent of Plaintiff Antonio Voe, a 16-year-adolescent. Ex. 5, Decl. of Mirabel Voe. The Voe family are members of PFLAG.

111. Texas is the only home Plaintiffs Mirabel and Antonio have ever known. They reside in Texas along with Antonio's older and younger siblings.

112. Antonio is a kind and empathetic young man who enjoys reading, drawing, and running. Before February 2022, he was a straight-A student and a leader in student government.

113. Antonio is transgender. When he was born, his sex was designated as "female," but he is a boy.

114. Growing up, Antonio presented as a tomboy. Indeed, throughout his childhood, Antonio expressed himself and behaved in a manner that did not conform with the stereotypes associated with the sex he was assigned at birth.

115. When Antonio began puberty, physical changes began causing him intense distress.

116. In 2020, Antonio informed his mom that he was transgender.

117. Thereafter, Mirabel and Antonio did research as a family and decided as an initial step that Antonio would socially transition. Antonio began to socially transition by using a name, pronouns, and gender expression that matched his gender identity.

118. After a year of living as his true and authentic self, Antonio felt happier, but the onset of puberty still caused him significant stress.

119. In the summer of 2021, the Voe family began consulting a physician. The physician diagnosed Antonio with gender dysphoria and determined that it was medically necessary for Antonio to begin puberty blockers to help alleviate some of Antonio's symptoms.

120. Then, in January 2022, after six months of sessions with a therapist, Antonio's physician recommended he be provided with additional medical care to treat and alleviate his gender dysphoria.

121. In consultation with Antonio's therapist and physician, and after extensive discussions about the benefits and potential side effects of hormone therapy, this treatment was prescribed by Antonio's doctor in accordance with medical best practices and standards of care.

122. As Antonio was prescribed this medical treatment, his mood and anxiety improved, and he looked forward to a brighter future. Being able to be affirmed as his true self promised Antonio significant relief.

123. DFPS's new rule to investigate medically necessary gender-affirming care as child abuse, following the issuance of Paxton's Opinion and Abbott's Letter, has upended the Voe family's lives.

124. On February 22, the same day as Abbott's Letter, Antonio attempted to die by suicide by ingesting a bottle of aspirin. Antonio said that the political environment, including Abbott's Letter, and being misgendered at school, led him to take these actions.

125. Following the attempt, Antonio was admitted to a local hospital, which referred him to an outpatient psychiatric facility. He was transported to that facility on February 24.

126. While at that outpatient facility, the staff there learned that Antonio had been prescribed hormone therapy for the treatment of gender dysphoria. During a family therapy session, staff at the facility told Antonio and his mom that their family might be reported for "child abuse" because of Abbott's Letter and DFPS's new rule.

127. Antonio was discharged from the psychiatric facility on March 5.

128. On March 11, an investigator from CPS visited the family's home to interview Antonio and Mirabel.

129. Mirabel assumed the investigator was there for the suicide attempt. But the investigator told her that she was only there because Mirabel was an "alleged perpetrator" of child abuse as the parent of a transgender adolescent who had been reported for allegedly providing her son with treatment for gender dysphoria.

130. Being called an "alleged perpetrator" in her own living room was a shock for Mirabel and imposed immense harm and stigma upon Mirabel to know that she had been accused of harming her own child simply for providing him with medically necessary health care.

131. The investigator told her that the report of "child abuse" originated from the outpatient psychiatric facility where Antonio had been seeking help.

132. The investigator interviewed both Antonio and Mirabel and asked them private, intimate, and invasive questions about Antonio's medical treatment for gender dysphoria. The investigator also took pictures of Antonio's arms, torso, back, and legs to see if he had any injuries.

133. The CPS investigator asked Mirabel to sign a release to obtain Antonio's medical records. Mirabel initially signed the release.

134. On March 14, Mirabel received a call from the investigator, who told her that the medical release form was deficient and needed to be signed again. The investigator had tried to send the release to Antonio's health care provider to obtain all of Antonio's private and confidential medical records, but that provider sent it back because of problems with the form. The investigator called Mirabel multiple times and visited her home unannounced, but only Mirabel's oldest child was home at the time.

135. On March 21, the investigator called Mirabel again and asked that she re-sign the form so that DFPS could obtain all of Antonio's medical records. Mirabel said that she would not re-sign the form and was seeking legal counsel.

136. As of today, DFPS's investigation of Mirabel for child abuse remains open.

137. Antonio is receiving mental health care and is recovering from the attempt, but these events have devastated his life. He has been forced to drop out of in-person school and

stay at home so that Mirabel can more closely monitor his health and wellbeing, but she is a single mom who works two jobs. Mirabel loves her son unconditionally, and she can think of nothing worse than losing him.

138. Should DFPS incorrectly issue a finding that Mirabel has committed "child abuse" due to DFPS's new rule based on Abbott's Letter and Paxton's Opinion, Mirabel could be placed on a child abuse registry, have Antonio taken away from her, and be barred from volunteering or participating in her children's activities.

139. Antonio also faces a grave threat to his mental health, and he and his family live in fear that they will face further interrogations and invasions of privacy from DFPS—or be split apart—due to DFPS's new rule following Paxton's Opinion and Abbott's Letter.

140. Threatening or forcing Antonio to forego the ability to obtain the medically necessary medical treatment that he has been prescribed is also life-threatening. Mirabel's only wish is to ensure the health, safety, and wellbeing of her son, and to ensure that he lives to become a happy and successful adult.

C. The Roe Family

141. Plaintiff Wanda Roe is the proud parent of Plaintiff Tommy Roe, a 16-year-adolescent. Ex. 6, Decl. of Wanda Roe; Ex. 7, Decl. of Tommy Roe.

142. For over 12 years, Plaintiffs Wanda and Tommy have called Texas their home. They reside in Texas along with Tommy's three older brothers and stepdad, Wanda's husband.

143. Plaintiff Wanda Roe and the Roe family are members of PFLAG.

144. Tommy is transgender. When he was born, his sex was designated as "female," even though he is a boy.

145. Growing up, Tommy presented as a tomboy. Indeed, throughout his childhood, Tommy expressed himself and behaved in a manner that did not conform with the stereotypes associated with the sex he was assigned at birth.

146. As he got closer to puberty, Tommy started to wonder if everyone felt the same panic and revulsion that he did when he looked at his changing body, a body that seemed wrong and inconsistent with who he is.

147. Researching online, he discovered the term "gender dysphoria," which he realized described the discomfort and distress that he felt.

148. While Tommy knew he was not a girl, he also felt cautious and apprehensive about learning that he was transgender.

149. Tommy worried about the judgment he would face and was aware that states, like his home state of Texas, were seeking to pass laws and policies to take away the rights from transgender people. Tommy had read stories about people getting kicked out of their homes, losing their friends, and facing stigma in their communities.

150. In the end, Tommy could not ignore how right it felt when he thought of himself living as the boy that he is.

151. For Tommy, it brought him a great sense of relief to be able to live as his true self—a boy—and so he became more comfortable telling close friends and one of his older brothers that he was transgender.

152. On or about mid-2020, Tommy informed his mom, Plaintiff Wanda Roe, that he was transgender. Upon learning of this, Wanda hugged Tommy, told him she loved him, and cried. After telling his mom, Tommy told the rest of his brothers and his stepdad.

153. Because she was unfamiliar with what being transgender meant, Wanda sought to become more informed. Wanda sought guidance from a counselor and Tommy's doctor on the best way to support Tommy and ensure his wellbeing.

154. Thereafter, Tommy began to socially transition by presenting as male publicly beyond the few people to whom he had disclosed he was transgender.

155. The Roe family also began consulting medical professionals and Tommy began working with a therapist. Tommy's doctors diagnosed him with gender dysphoria and recommended as appropriate and medically necessary for Tommy to start undergoing gender-affirming hormone therapy.

156. In consultation with these doctors and after extensive discussions about the benefits and potential side effects of this treatment, Plaintiffs Wanda and Tommy Roe jointly decided they should initiate treatment for Tommy's gender dysphoria. The treatment has been prescribed by Tommy's doctors in accordance with what they believe are best medical practices and what the Roe family understands will be the best course of action to protect Tommy's physical and mental health.

157. As Tommy moved further into puberty, he felt even more distressed and anxious about the conflict between his body and who he is. In public, Tommy would hide behind his mom, worried that someone would misgender him as a girl. Tommy would also worry about whether he was walking femininely or whether his breathing sounded masculine enough. Tommy avoided speaking in class and hid from his family and friends, staying alone in his bedroom, because his voice felt wrong. Even in his room, however, Tommy would still feel uncomfortable, a constant feeling he describes as horrible.

158. Plaintiff Wanda Roe observed the distress and anxiety that Tommy exhibited as he began undergoing puberty.

159. When sophomore year started, Tommy attended high school presenting and living as the boy that he is. This was Tommy's first year of high school that was in-person, as his entire freshman year was virtual due to the COVID-19 pandemic.

160. Being able to present and live as a boy allowed Tommy to thrive, both academically and socially. He felt more confident in his everyday life. Wanda also witnessed Tommy's transformation; being able to present and be perceived as the boy that he is allowed Tommy to go from an uncomfortable, fearful child to a confident, self-assured young man.

161. DFPS's new rule to investigate medically necessary gender-affirming care as a child abuse based on the Paxton Opinion and Abbott Letter has wreaked havoc on the Roe family.

162. Tommy first learned of the Paxton Opinion and Abbott's Letter online. When he first learned of them, Tommy was shocked and upset as he felt this was an attack on him and others like him.

163. On February 24, 2022, Tommy was pulled out of class and called to the school administration's office to meet with a CPS investigator. Coincidentally, earlier that same day, Tommy had texted Wanda about the Paxton Opinion and Abbott Letter.

164. When he was called out of class, Tommy was not told whom he would be speaking with but was simply sent to the office as if he were in trouble. When he arrived, a CPS investigator was waiting for him. Tommy was shocked and confused by what was happening. The only people in the room were Tommy and the CPS investigator.

165. The investigator proceeded to interview Tommy and asked him a series of deeply personal questions. He was told the interview was related to his home life but was not told the reason a call to CPS was made.

166. The questions were very personal and asked about Tommy's family and medical history.

167. Tommy sought to answer the investigator's questions as best he could, but he was nervous and scared. Tommy suspected the investigator was there because of the Paxton Opinion and Abbott Letter, and Tommy did not want it to seem like his family had actually done anything to him because they had not. Tommy also worried that the investigator might try to twist his words.

168. After the interview, Tommy was shaking and upset. He had missed close to half an hour of class time and did not know what to tell others about why he had been called to the office. Tommy texted Wanda that he needed to talk with her but did not text her what had happened because he felt it should be discussed in person.

169. Later that afternoon, Wanda picked Tommy and several of his friends up from school. Before Tommy could tell Wanda what had occurred at school, Wanda received a call from one of her other sons that there was someone waiting outside their home.

170. After dropping off Tommy's friends, Wanda and Tommy arrived at their home. When they arrived, a CPS investigator, who upon information and belief was the same investigator who had interviewed Tommy at school, was waiting outside and asked to speak with Wanda. Wanda and Tommy's stepdad decided to let them into the house.

171. The investigator told Wanda that DFPS had been instructed to prioritize investigations into parents who provide gender-affirming medical care to their children over all other child abuse and neglect cases.

172. The investigator interviewed Wanda, Tommy's stepdad, and Tommy's brothers. Tommy was not present for these interviews, as he was so upset by what was going on that he had to go to his room.

173. The questions related to the Roe family's treatment of Tommy and probed whether they had ever abused him (they have not), forced him to transition (they did not), or forced him to take any drugs in support of his transition (they have not).

174. The investigator also asked about Tommy's medical history. Understanding she had done nothing but be loving and supportive of Tommy, as well as consulted with and relied upon the advice from medical and health professionals, Wanda signed a release to allow DFPS to collect and review Tommy's medical records.

175. The interview lasted for approximately an hour.

176. Following the interview, Wanda secured legal representation and days later revoked the release to allow DFPS to collect and review Tommy's medical records.

177. DFPS's new rule to investigate medically necessary gender-affirming care as a "child abuse" based on the Paxton Opinion and Governor Abbott's Letter has caused the Roe family a significant amount of stress, fear, and anxiety. For example, Tommy has been traumatized by the prospect that he may be separated from his family, while Wanda, Tommy's stepdad, and Tommy's brothers are also filled with anxiety and worry.

178. Since the interview, Wanda has noticed that Tommy appears to be anxious and nervous more often than previously. He now worries that his statements to the investigator

may be used as a pretext to take him away from his family, used to otherwise punish Wanda or his siblings, or that he will not have access to the care his doctors have recommended as medically necessary and that would enable him to live more authentically as himself.

179. Following the interview, Tommy's performance at school took a dive and he became more reserved.

180. Tommy has had difficulty focusing during school and tests, and his grades deteriorated significantly since the investigation. He struggled not only to focus on studying but also struggled in general to pay attention to his surroundings as a direct result of the stress he has experienced because of this investigation.

181. The Roe family found a measure of solace knowing that DFPS's investigation had been stopped as a result of the temporary orders issued in the *Doe v. Abbott* Litigation. However, when the appellate court's order was narrowed to not protect their family, Wanda and Tommy began to fear the worst again.

182. Indeed, in May 2022, DFPS contacted Wanda's attorney again and indicated that it is continuing with its investigation, asking for access to Tommy's doctors and medical records and, consistent with the erroneous framing from the Paxton Opinion, seeking assurances that any form of treatment be reversible.

183. Both Wanda and Tommy feel that the investigation has violated the privacy of their family. The investigation intruded upon Tommy at his school, entered the Roe family's home, and has made Tommy fear that harm may befall his family.

184. The implementation of DFPS's new rule to investigate medically necessary gender-affirming care as a child abuse based on the Paxton Opinion and Abbott Letter has terrorized the Roe family and inflicted ongoing and irreparable harm.

185. Should DFPS incorrectly issue a finding that there is reason to believe that Wanda or the Roe family have committed "child abuse" due to DFPS's new rule as announced in the DFPS Statement based on Governor Abbott's and Attorney General Paxton's erroneous and misguided missives and understanding of medical treatment for gender dysphoria, they would automatically be placed on a child abuse registry and be improperly subject to all of the effects that flow from such placement.

186. The implementation of DFPS's new rule to investigate medically necessary gender-affirming care as child abuse based on the Paxton Opinion and Abbott Letter has caused a significant amount of stress, anxiety, and fear for the Roe family.

187. The Roe family is living in constant fear about what will happen to them due to the actions by DFPS, the Governor, and the Attorney General.

188. Not providing Tommy with the medically necessary health care that he needs is not an option for Wanda, as her utmost desire is to ensure the health, safety, and wellbeing of Tommy, whom she loves and supports.

D. The Briggle Family

189. Plaintiffs Adam and Amber Briggle are the proud parents of Plaintiff M.B., a 14-year-old adolescent. Ex. 8, Aff. of Adam Briggle. Both Briggle parents are members of PFLAG.

190. The Briggles have called Texas their home for nearly 13 years, and Texas is the only home M.B. has ever really known. M.B. is shy, a good student, and is well-liked among his peers. M.B. is also a gifted musician.

191. M.B. is transgender. When he was born, his sex was designated as "female," even though he is a boy.

192. From a very young age, M.B. expressed himself and behaved in a manner that does not conform with the stereotypes associated with the sex he was assigned at birth.

193. M.B.'s parents have been supportive and accepting of him, giving him the space to express himself and explore who he is.

194. When M.B. told his parents that he was a boy, they began to educate themselves about what it means to be transgender, when a person's gender identity differs from the sex they were designated at birth.

195. The Briggles also consulted with doctors and mental health providers about the best way they could support M.B. M.B.'s doctors diagnosed him with gender dysphoria around the age of seven. At that time, M.B.'s doctors did not recommend any medical treatment. However, M.B. is still being seen by his doctors and the Briggles are following the doctors' advice, as any loving and supportive parent would, to ensure their adolescent's health, safety, and well-being.

196. In addition to taking steps to affirm M.B. personally, the Briggles have become very involved in efforts to fight legislative and other government actions that would harm M.B. and other LGBTQ+ youth and to support measures that would protect them. They have been vocal advocates for their son and have worked to help others understand the experiences of transgender youth, including by inviting Texas Attorney General Ken Paxton into their home to share a meal with their family.

197. Following the issuance of the Paxton Opinion, Abbott Letter, and the new rule announced in DFPS's Statement, the Briggles' lives were turned upside down.

198. Within forty-eight (48) hours of Abbott's directive that DFPS begin investigating families, the Briggles were contacted by a CPS investigator. They were terrified at the prospect of their son being taken away from his family, his friends, and the life that he loves.

199. The CPS investigator came to the Briggles' home and asked them very intimate, personal, and invasive questions to determine if the parents had committed "abuse" by affirming M.B.'s identity and following the advice of his medical and mental health care professionals. During her visit, the CPS investigator disclosed to the Briggles that the sole allegation against them is that they have a transgender son and that they allowed their son to undergo "treatment for gender transition."

200. After the CPS investigator left, the Briggle family was shaken, including M.B. Adam Briggle has found it difficult to concentrate at work, has trouble sleeping, and can hardly eat without getting sick to his stomach. Adam and Amber worry about keeping their family intact and keeping M.B. safe and healthy.

201. For over three months, the CPS investigation into the Briggles has been open and is still ongoing. After the Texas Supreme Court's decision limiting the temporary injunction to only those plaintiffs named in the *Doe v. Abbott* Litigation, DFPS has continued its investigation into the Briggles. This is despite the Briggles having been public about M.B.'s transgender identity since 2016 and having never been investigated by DFPS until its change in policy in response to Abbott's Letter.

202. The issuance of the Paxton Opinion and the Abbott Letter, along with DFPS's new rule and substantive policy changes based on the Paxton Opinion and the Abbott Letter, has terrorized the Briggle family and inflicted ongoing and irreparable harm.

203. The implementation of DFPS's new rule to investigate medically necessary gender-affirming care as child abuse based on the Paxton Opinion and Abbott Letter has caused a significant amount of stress, anxiety, and fear for the Briggle family.

204. The Briggles are terrified for M.B.'s physical and mental health, safety, and well-being, and for their family. They live in constant fear every day that one or both of our children will be taken away from them. They are also worried that if M.B. is taken away from them, being separated from his sibling would cause him significant harm.

205. Before the CPS investigation into the Briggle family, M.B. was typically playful, joyful, and happy. Now M.B. is scared, anxious, and worried that he will be removed from his home, taken away from his parents, his sibling, his friends, his school, and the life and activities he loves. M.B. has also had a hard time sleeping, is moodier now, and has stayed home from school. His grades have suffered, which has never before been an issue.

206. In addition, since the Paxton Opinion and Abbott Letter, and the investigation into their family, both M.B. and his sibling have been in therapy to help them cope with the stress of thinking that they will be taken away from their parents.

207. The Briggles further worry about the potential short-term and long-term physical and mental health consequences if they were to not follow the advice, guidance, and counseling of M.B.'s physicians and mental health professionals with respect to medically necessary treatment as is appropriate for his gender dysphoria. They do not want to risk M.B.'s health, safety, or well-being and instead want to make sure that he continues to thrive.

208. The Briggle family is living in constant fear about what will happen to them due to the actions by DFPS, the Governor, and the Attorney General.

209. Since the Paxton Opinion and the Abbott Letter, the Briggles have been called criminals, child abusers, and "groomers" on social media. For the first time, they have installed cameras outside of their home. And since the Governor's Directive, they have been followed in their car, and yelled at by a person in another vehicle.

210. Should DFPS incorrectly issue a finding that the Briggle parents committed "abuse" due to the new rule announced in the DFPS Statement based on Governor Abbott's and Attorney General Paxton's erroneous and misguided missives and understanding of medical treatment for gender dysphoria, they would automatically be placed on a child abuse registry and be improperly subject to all of the effects that flow from such placement.

211. Not providing M.B. with the medically necessary health care that he needs is not an option for the Briggle parents, as their utmost desire is to ensure the health, safety, and wellbeing of M.B., whom they love and support.

VIII. CAUSES OF ACTION

A. Request for Declaratory Relief Under the Texas Administrative Procedure Act – By All Plaintiffs Against Defendants Commissioner Masters and DFPS

212. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

213. Plaintiffs request declaratory relief under the Texas Administrative Procedure Act ("APA"). *See* Tex. Gov't Code § 2001.038(a) ("The validity or applicability of a rule, including an emergency rule adopted under Section 2001.034, may be determined in an action for declaratory judgment if it is alleged that the rule or its threatened application interferes with or impairs, or *threatens to interfere with or impair, a legal right or privilege of the plaintiff*.") (emphasis added).

214. The APA contains a waiver of sovereign immunity to the extent of creating a cause of action for declaratory relief regarding the validity or applicability of a "rule." *Id.*

The DFPS Statement Constitutes a Rule, and Commissioner Masters Bypassed Mandatory APA Procedures for Rule Promulgation.

215. Under the APA, a rule

> (A) means a state agency statement of general applicability that: (i) implements, interprets, or prescribes law or policy; or (ii) describes the procedure or practice requirements of a state agency; (B) includes the amendment or repeal of a prior rule; and (C) does not include a statement regarding only the internal management or organization of a state agency and not affecting private rights or procedures.

Id. § 2001.003(6) (line breaks omitted).

216. As DFPS Commissioner, Commissioner Masters is statutorily authorized to "provide protective services for children" and "develop and adopt standards for persons who investigate suspected child abuse or neglect at the state or local level" via rulemaking. Tex. Hum. Res. Code § 40.002(b); Tex. Fam. Code § 261.310(a).

217. As a state agency, DFPS is required to follow APA rulemaking procedures when adopting or changing rules. The APA's procedural requirements for promulgating agency rules, including public notice, comment, and a reasoned justification for the rule, are mandatory. *See* Tex. Gov't Code §§ 2001.023, .029, .033. To be valid, a rule must be adopted in substantial compliance with these procedures. *See id.* § 2001.035. The February 22, 2022, DFPS Statement conveys the Department's official position with respect to the investigation of gender-affirming care as child abuse. The DFPS Statement, issued in accordance with Abbott's Letter, is a statement of general applicability that is (1) directed at a class of all persons similarly situated and (2) affects the interests of the public at large. The statement sets forth a new rule and provides that DFPS *will* implement Abbott's "directive" and *will* investigate allegations relating to gender-affirming medical care as "child abuse" according to the new definition formulated by the Paxton Opinion. The DFPS Statement thus applies to and affects the private rights of a class of persons—all parents

of transgender children—as well as members of the general public. *El Paso Hosp. Dist. v. Tex. Health & Human Servs. Comm'n*, 247 S.W. 3d 709, 714 (Tex. 2008) (holding that statement of Health and Human Services Commission had "general applicability" because it applied to "all hospitals"); *Combs v. Entm't Publ'ns, Inc.*, 292 S.W.3d 712, 721-22 (Tex. App.—Austin 2009, no pet.) (holding that Comptroller's statements constituted "rule" under the APA because it applied to all persons and entities similarly situated"); *see also Teladoc, Inc. v. Tex. Med. Bd.*, 453 S.W.3d 606, 615 (Tex. App.—Austin 2014, pet. denied) ("Agency statements of 'general applicability' refer to those 'that affect the interest of the public at large such that they cannot be given the effect of law without public comment,' as contrasted with statements 'made in determining individual rights.'" (citation omitted)).

218. The DFPS Statement prescribes a new DFPS rule and enforcement policy with respect to the investigation of gender-affirming care to minors as child abuse, which changes DFPS policy and constitutes a rule for purposes of the APA. *See Texas Alcoholic Beverage Comm'n v. Amusement & Music Operators of Texas, Inc.*, 997 S.W.2d 651, 657-58 (Tex. App.—Austin 1999, writ dism'd w.o.j.) (holding that memoranda constituted a "rule" because they "set out binding practice requirements" that "substantially changed previous enforcement policy" with respect to eight-liner machines).

219. Prior to the DFPS Statement, DFPS had not promulgated any rule pertaining to the investigation of gender-affirming care as child abuse.[40] The DFPS Commissioner explicitly disavowed pursuing these investigations last September, stating "I will await the opinion issued by the Attorney General's office before I reach any final decisions" relating to investigations of gender-affirming care as child abuse. The agency has now adopted a new rule that it *will* conduct

[40] Even if DFPS had previously promulgated a rule providing for the investigation of gender-affirming medical care as "child abuse," such a rule would have exceeded the bounds of DFPS's authority. *See infra* ¶¶ 223-229.

investigations in accordance with the Paxton Opinion, while stating that there were "no pending investigations of child abuse involving the procedures described in [the Paxton Opinion]" when DFPS announced this policy change on February 22. Before the Commissioner's announcement, there were *no* pending investigations being pursued by DFPS. But now there are investigations targeting Plaintiffs and the Commissioner's statement prescribed a new rule and policy that greatly expands DFPS's scope of enforcement. *See John Gannon, Inc. v. Tex. Dep't of Transp.*, No. 03-18-00696-CV, 2020 WL 6018646, at *5 (Tex. App.—Austin Oct. 9, 2020, pet. denied) (mem. op.) (agency statements that "advise third parties regarding applicable legal requirements" may "constitute 'rules' under the APA" (quoting *LMV-AL Ventures, LLC v. Texas Dep't of Aging & Disability Servs.*, 520 S.W.3d 113, 121 (Tex. App.—Austin 2017, pet. denied))).

220. In addition, DFPS's actions since the Statement evidence a new rule and substantive change in policy. Prior to DFPS's Statement, DFPS had refused to investigate reports regarding the provision of gender-affirming medical treatment as child abuse. *See Doe v. Abbott*, 2022 WL 831383, at *1; *see also* Ex. 2, Aff. of Lisa Stanton. In fact, such reports were treated as "priority none" and closed without further investigation. Now, however, following DFPS's Statement, DFPS has opened investigations into the Voe, Roe, and Briggle families in this suit, the Doe family in the *Doe v. Abbott* Litigation, and at least five other families based on allegations that just a few months before would have been treated as "priority none" and not investigated. Moreover, CPS investigators and supervisors have been told to pursue these cases in a manner that departs from longstanding agency procedures and lacks transparency. For example, upon information and belief, DFPS has instructed CPS investigators and supervisors to not put anything about these specific cases in writing. And despite the *Doe v. Abbott* court's finding that these actions are likely unlawful, DFPS has now resumed investigations into Plaintiffs in this case.

221. In declaring that investigations would be initiated based on a non-binding opinion from the Attorney General and an unauthorized directive from the Governor, and now having resumed them, the Commissioner has entirely bypassed the APA's mandatory procedural requirements for promulgating agency rules. The Commissioner did not provide public notice or an opportunity for and full consideration of comments from the public. Additionally, the Commissioner provided no reasoned justification for the new rule announced in the DFPS Statement, nor for the implementation of the Abbott Letter, which goes even further than Paxton's Opinion by making no mention of medical necessity. Neither the non-binding Paxton Opinion nor the Abbott Letter—both of which conflict with well-established medical standards of care—are a legitimate basis for the rule and drastic change in DFPS policies. This agency action, therefore, is arbitrary and capricious.

222. A rule that is not properly promulgated under mandatory APA procedures is invalid. *El Paso Hosp. Dist.*, 247 S.W.3d at 715. As such, the DFPS Statement is invalid and should not be given effect, and DFPS enforcement activity implementing the DFPS Statement should be enjoined.

The DFPS Statement Conflicts with DFPS's Enabling Statute, Exceeding its Authority.

223. DFPS's new rule, based on Abbott's Letter and the Paxton Opinion, and as announced on the DFPS Statement, is also invalid because it stands in direct conflict with DFPS's enabling statute and, as such, is an overreach of DFPS's power as established by the legislature.

224. "To establish the rule's facial invalidity, a challenger must show that the rule: (1) contravenes specific statutory language; (2) runs counter to the general objectives of the statute; or (3) imposes burdens, conditions, or restrictions in excess of or inconsistent with the relevant statutory provisions." *Gulf Coast Coal. Of Cities v. Pub. Util. Comm'n*, 161 S.W.3d 706, 712 (Tex. App.—Austin 2005, no pet.).

225. The new rule announced in the DFPS Statement contravenes specific language in DFPS's enabling statute. Section 40.002 of the Texas Human Resources Code specifies that DFPS "*shall* . . . provide family support and family preservation services *that respect the fundamental right of parents to control the education and upbringing of their children*." Tex. Hum. Res. Code § 40.002 (emphasis added). As demonstrated herein, the new rule announced in the DFPS Statement infringes on the rights of parents to direct the custody and care of their children, including by providing them with needed medical care. *See infra*, Section VIII.E. The new DFPS rule thus conflicts with the obligations imposed on DFPS by its enabling statute and, therefore, is invalid.

226. In addition to conflicting with specific statutory language, the new rule announced in the DFPS Statement also conflicts with the general objectives of DFPS's enabling statute. *See Gulf Coast Coal. Of Cities*, 161 S.W.3d at 711-12. These general objectives are informed by the specific duties imposed on DFPS by the Legislature and encompass the objective of protecting children against abuse while respecting parents' fundamental right to control the upbringing of their children. *See* Tex. Hum. Res. Code § 40.002(b). Not only does the new rule announced in the DFPS Statement infringe on parents' fundamental rights, it also *causes* immense harm to minor children with gender dysphoria who have a medical need for treatment that is now considered "child abuse" under the new agency rule.

227. Pursuant to the new rule announced in the DFPS Statement and implementation thereof, the Voe, Roe, and Briggle parents, as well as other parents who are members of PFLAG (together, "Plaintiff Parents"), cannot provide medically necessary and doctor-recommended medical treatment to their adolescent children without exposing themselves to criminal liability. Precisely because this medical treatment is necessary, if the Plaintiff Parents

ceased providing this care, their children will be greatly and irreparably harmed, including by being forced to undergo endogenous puberty with the permanent physical changes that can result. The new DFPS rule, though cloaked under the guise of protecting children, actually *causes* harm where none existed in the first place. Furthermore, the mere *threat* of enforcement has already impacted Antonio Voe, Tommy Roe, and M.B., as well as other transgender youth whose families are members of PFLAG, by causing them immeasurable anxiety and distress. These young people are now forced to choose between the medical care that they need and exposing their parents to criminal liability and potentially being removed from their care or, alternatively, abstaining from such medically necessary care and suffering the physical and mental consequences, all in order to protect their families from DFPS investigation. As such, the new DFPS rule cannot be harmonized with DFPS's general objectives as set forth in its enabling statute. *See R.R. Comm'n of Tex. v. Lone Star Gas Co.*, 844 S.W.2d 679, 685 (Tex.1992); *Gerst v. Oak Cliff Sav. & Loan Ass'n*, 432 S.W.2d 702, 706 (Tex. 1968).

228. Every major medical organization in the United States considers the treatment now effectively banned and criminalized by DFPS to be medically necessary. And none of the alleged concerns about the now-prohibited gender dysphoria treatment is unique to the prescribed treatments but is rather targeted only at families who are seeking this care for the treatment of gender dysphoria. Transgender young people and their families are therefore uniquely singled out and threatened by Texas officials. Such a radical disregard of medical science and the medical needs of a subset of minors in Texas cannot be squared with the agency's authority as prescribed by Statute.

229. Finally, nothing in DFPS's enabling statute authorizes it to expand the scope of statutory definitions established by the Legislature. The definition of "child abuse" is provided

by statute and is not within DFPS's jurisdiction. Because the DFPS Statement is not rooted in any rulemaking authority provided by the Legislature, it is invalid. *See Williams v. Tex. State Bd. Of Orthotics & Prosthetics*, 150 S.W.3d 563, 568 (Tex. App.—Austin 2004, no pet.) ("An agency rule is invalid if [] the agency had no statutory authority to promulgate it . . . .").

Implementation of the DFPS Statement Interferes with Plaintiffs' Constitutional Rights.

230. Separate and apart from the procedural and substantive defects set forth above, the new DFPS rule is also invalid because its application interferes with Plaintiffs' fundamental parental rights and other equality and due process guarantees of the Texas Constitution.

231. Under the APA, an action for declaratory judgment can be sustained if a "rule or its threatened application interferes with or impairs, or threatens to interfere with or impair, a legal right." Tex. Gov't Code § 2001.038(a). Agency rules that are unconstitutional can be invalidated through declaratory judgment. *See Williams*, 150 S.W.3d at 568.

232. The new rule announced in the DFPS Statement and DFPS's implementation thereof interferes with Plaintiff Parents' fundamental right to care for their children guaranteed by the Texas State Constitution. *Wiley v. Spratlan*, 543 S.W.2d 349, 352 (Tex. 1976). The Texas Legislature has codified its acknowledgement that parents possess fundamental, constitutional rights beyond those expressly provided for by statute. Tex. Fam. Code § 151.001(a)(11) (concluding enumerated list of parental rights and obligations by stating that a parent has "any other right or duty existing between a parent and child by virtue of law").

233. A parent's right to control the care of their child is one of the most ancient and natural of all fundamental rights. *See Holick v. Smith*, 685 S.W.2d 18, 20 (Tex. 1985) ("This natural parental right has been characterized as essential, a basic civil right of man, and far more precious than property rights." (citation and quotations omitted)).

234. By, in effect, cutting off the ability of parents to treat their minor adolescent children in accordance with doctor-recommended and clinically appropriate care, the agency's new rule infringes on the parental rights of Plaintiff Parents. The agency's new rule substitutes parents' judgment as to what medical care is in the best interests of their children for the judgment of the government. There is no justification—let alone one that is compelling—to warrant such a gross and arbitrary invasion of parental rights. The new DFPS rule creates a presumption that certain medical treatments must be uniquely denied to transgender youth, even where those treatments are medically necessary and commonly prescribed for diagnoses other than gender dysphoria. This political interference with essential health care "run[s] roughshod over the important interests of both parent and child." *Stanley v. Illinois*, 405 U.S. 645, 657 (1972).

235. As such, the new DFPS rule must be declared invalid because it conflicts with Plaintiff Parents' fundamental rights as parents under the Texas Constitution, as well as other equality and due process guarantees of the Texas Constitution.

B. *Ultra Vires* Claims – By All Plaintiffs Against Defendants Governor Abbott and Commissioner Masters

236. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

237. Plaintiffs request declaratory relief under the Uniform Declaratory Judgments Act ("UDJA").

238. The UDJA is remedial and intended to settle and afford relief from uncertainty and insecurity with respect to rights under state law and must be liberally construed to achieve that purpose. Tex. Civ. Prac. & Rem. Code. § 37.002. The UDJA waives the sovereign immunity of the State and its officials in actions that challenge the constitutionality of government actions and that seek only equitable relief.

239. Pursuant to the UDJA, Plaintiffs seek a declaratory judgment of the Court that Abbott's Letter, the DFPS Statement directing DFPS to investigate families for providing their children with medically necessary health care, and DFPS's new rule and substantive change in policy regarding the investigation of gender-affirming care as child abuse:

a. Is *ultra vires* and exceeds the Governor's and the Commissioner's authority under the Texas Family Code; and

b. Contravenes separation of powers established by Article II of the Texas Constitution.

240. A government official commits an *ultra vires* act when the officer "act[s] without legal authority or fail[s] to perform a purely ministerial act." *City of El Paso v. Heinrich*, 284 S.W.3d 366, 372 (Tex. 2009). An officer acts without legal authority "if he exceeds the bounds of his granted authority or if his acts conflict with the law itself." *Houston Belt & Terminal Ry. Co. v. City of Houston*, 487 S.W.3d 154, 158 (Tex. 2016).

241. In this case, both Governor Abbott and Commissioner Masters have acted without legal authority in directing DFPS to initiate investigations for any reported instances of the enumerated medical procedures in the Abbott Letter. For the reasons discussed below, there is a "probable right to relief" here on the *ultra vires* claims. *See Abbott v. Harris Cty.*, No. 03-21-00429-CV, 2022 WL 92027, at *10 (Tex. App.—Austin Jan. 6, 2022, pet. filed) (finding that plaintiffs had established "a probable right to relief on their claim that the Governor's issuance of [an executive order] constitutes an ultra vires act" in granting injunctive relief).

Governor Abbott Has Exceeded His Authority.

242. Governor Abbott has exceeded his authority by unilaterally redefining child abuse and then ordering "prompt and thorough investigation[s]" based on his redefinition.[41]

243. In contrast to the Governor's past executive orders, *see, e.g.*, Executive Order GA-38 (citing Tex. Gov't Code. § 418.016), Governor Abbott issued this directive without citing any gubernatorial authority.

244. Instead, the Abbott Letter cites only to the Texas Family Code. The Texas Family Code, however, does not give Governor Abbott any authority to define the contours of "child abuse" or to "direct the agency to "conduct . . . investigation[s]," as he attempted to do in his letter.[42] The Texas Family Code itself defines child abuse and outlines DFPS's investigatory authority. *See* Tex. Fam. Code §§ 261.001, 261.301. These laws also specifically task the DFPS Commissioner with establishing procedures for investigating abuse and neglect, based on the definitions of abuse and neglect under Texas law and in accordance with the APA. Thus, the Governor has no authority to define the contours of what constitutes child abuse under Texas law or to unilaterally change any DFPS procedures. Indeed, even the Paxton Opinion merely identified what *could* be considered "child abuse." Governor Abbott then took that non-binding analysis and directed DFPS to presume, in all cases, that a minor adolescent with gender dysphoria with medical treatment consistent with well-established medical guidelines amounted to abuse.

245. Furthermore, the Texas Constitution makes clear that the Governor only administers the law pursuant to the general grant to "cause the laws to be faithfully executed." Tex. Const. art. 4, § 10. The Governor neither makes the law nor possesses the authority to suspend

[41] Greg Abbott, Letter to Hon. Jaime Masters, Commissioner, Tex. Dep't of Fam. & Protective Servs. (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf.
[42] *Id.*

laws under the Texas Constitution. *See* Tex. Const. art. 1, § 28 ("No power of suspending laws in this State shall be exercised except by the Legislature.").

246. Even where a state agency like DFPS has been delegated the power to make rules, the Governor cannot lawfully order the Commissioner to adopt a particular rule, much less order her to do so without following the proper rulemaking process. *See* Tex. Hum. Res. Code § 40.027(c)(3) (tasking the Commissioner, not the Governor, with "oversee[ing] the development of rules relating to the matters within the department's jurisdiction").

247. In the *Doe v. Abbott* Litigation, the Texas Supreme Court held that "neither the Governor nor the Attorney General has statutory authority to directly control DFPS's investigatory decisions." *In re Abbott*, 2022 WL 1510326 at *3. However, the Court also acknowledged that there are "many informal mechanisms by which a governor or an attorney general may validly seek to influence the behavior of state agencies as part of the normal give-and-take between departments of state government." *Id*. at *2, n. 3.

248. Governor Abbott's Letter went beyond these "informal mechanisms" by which a governor may seek to influence the behavior of a state agency. Indeed, Governor Abbott very clearly stated: "I hereby ***direct*** [DFPS] to conduct a prompt and thorough investigation of any reported instances of [minors being provided gender-affirming care] in the State of Texas."[43] By the plain meaning of the language he used, Governor Abbott sought to directly control DFPS despite having no authority to do so.

249. In addition, the Governor's directive must be viewed within the context that Commissioner Masters's appointment as Commissioner expired in late 2021, and the continuation of her tenure is entirely at the Governor's discretion. Abbott's Letter set forth his clear expectation

[43] Greg Abbott, Letter to Hon. Jaime Masters, Commissioner, Tex. Dep't of Fam. & Protective Servs. (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf (emphasis added).

of what the Commissioner should do going forward, and given her expired term, left her with limited options.

250. And so, despite the Governor's lack of authority, Commissioner Masters and DFPS nonetheless heeded his instruction. The Texas Supreme Court observed that the statement issued by DFPS in response to Abbott's Letter "suggests that DFPS may have considered itself bound by either the Governor's letter, the Attorney General's Opinion, or both." *In re Abbott*, 2022 WL 1510326 at *3. In its response, DFPS referred to Abbott's Letter as a "directive," implying that DFPS was acting solely at the behest of Governor Abbott.

251. Regardless of whether DFPS was statutorily or legally bound by Abbott's Letter, the end result is still the same: Governor Abbott "directed" DFPS to investigate the families of transgender adolescents, and DFPS complied with that "directive." Abbott's Letter thus constituted an *ultra vires* act because, as the Texas Supreme Court has noted, the Governor does not have authority to "direct" DFPS.

Commissioner Masters Has Exceeded Her Authority.

252. Commissioner Masters has also exceeded her authority and acted *ultra vires* by implementing Governor Abbott's unlawful redefinition of child abuse. In accordance with the DFPS Statement issued soon after the Abbott Letter, Commissioner Masters has already directed her department to investigate any reports of minors who have undergone the medical procedures outlined in the Abbott Letter. Although DFPS is not, in fact, bound by Abbott's Letter—which has no legal force or effect—Commissioner Masters continues to press forward with the investigation of families of transgender adolescents.

253. These actions contravene Commissioner Masters's limited statutory authority to "adopt rules and policies for the operation of and the provision of services by the department." Tex. Hum. Res. Code § 40.027(e). As set forth in Section VIIII.A. above,

Commissioner Masters has completely ignored the APA's mandatory rulemaking process. Therefore, the issuance and implementation of DFPS's new rule is *ultra vires* of the Commissioner's statutory rulemaking authority. *See City of El Paso v. Public Util. Comm'n,* 839 S.W.2d 895, 910 (Tex. App.—Austin 1992) ("[I]f there is no specific express authority for a challenged [agency] action, and if the action is inconsistent with a statutory provision or ascertainable legislative intent, we must conclude that, by performing the act, the agency has exceeded its grant of statutory authority."), *aff'd in part & rev'd in part,* 883 S.W.2d 179 (Tex. 1994). Furthermore, the Commissioner lacked authority to issue the new rule announced in the DFPS Statement as new law or policy because it is the Legislature's constitutional mandate to "provide for revising, digesting and publishing the laws." Tex. Const. art. 3, § 43.

254. Moreover, the new DFPS rule contradicts DFPS's enabling statute, which requires the department to "provide protective services for children" and "provide family support and family preservation services that respect the fundamental right of parents to control the education and upbringing of their children." Tex. Hum. Res. Code § 40.002(b). Rather than support children and respect the right of parents to raise their children and the rights of transgender minors to receive medically necessary treatment available to similarly situated non-transgender minors, Commissioner Masters's actions has already directly caused harm to loving families across Texas. This harm will become even more irreparable as investigations turn into family separations and medically necessary treatments are terminated.

255. Finally, this sequence of events, in which a Commissioner agrees to follow a Governor's unlawful directive—issued not as an executive order but as a letter—has never before been recognized by a court as a proper execution of government authority, further underscoring the *ultra vires* nature of both officials' actions here.

C. Separation of Powers Claims – By All Plaintiffs Against Defendants Governor Abbott and Commissioner Masters

256. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

257. Defendants' actions violate the separation of powers established by Article II of the Texas Constitution. Defendants' actions run afoul of Article II in two ways:

258. *First*, the Governor's directive, which criminalizes conduct by adding a new definition of "child abuse" under Section 261.001 of the Texas Family Code, unduly interferes with the functions of the state Legislature, which possesses *sole* authority to establish criminal offenses and designate applicable penalties. *See Martinez v. State*, 323 S.W.3d 493, 501 (Tex. Crim. App. 2010).

259. *Second*, all Defendants seek to adopt and enforce an overbroad interpretation of "child abuse." They do this in contravention of the plain meaning of the statute, and despite the state Legislature's recent decision not to adopt such a definition. This too represents an overreach by the executive branch into the legislative function.

260. The Texas Constitution prohibits one branch of state government from exercising power inherently belonging to another branch. Tex. Const. art. II, § 1; *see also Gen Servs. Comm'n v. Little-Tex. Insulation Co.*, 39 S.W.3d 591, 600 (Tex. 2001) (superseded by statute on other grounds).

261. A separation of powers constitutional violation occurs when: (1) one branch of government has assumed or has been delegated a power more "properly attached" to another branch, or (2) one branch has unduly interfered with another branch so that the other branch cannot effectively exercise its constitutionally assigned powers. *Jones v. State*, 803 S.W.2d 712, 715 (Tex. Crim. App. 1991) (citing *Rose v. State*, 752 S.W.2d 529, 535 (Tex. Crim. App. 1987)).

262. The "power to make, alter, and repeal laws" lies with the state Legislature, and such power is plenary, "limited only by the express or clearly implied restrictions thereon contained in or necessarily arising from the Constitution." *Diaz v. State*, 68 S.W.3d 680, 685 (Tex. App.—El Paso 2000, pet. denied) (citations omitted).

263. In particular, the Legislature possesses the *sole* authority to establish criminal offenses and designate applicable penalties. *See Martinez*, 323 S.W.3d at 501; *see also Matchett v. State*, 941 S.W.2d 922, 932 (Tex. Crim. App. 1996) (en banc) (the authority to define crimes and prescribe penalties for those crimes is vested exclusively with the Legislature).

264. Governor Abbott's directive unduly interferes with the state Legislature's sole authority to establish criminal offenses and penalties. First, the Abbott Letter outright claims that "a number of so-called 'sex change' procedures constitute child abuse under existing Texas law," despite the fact that the Legislature has failed to pass nearly identical legislation.

265. The Abbott Letter also violates separation of powers by inventing a separate crime when it directs, under the threat of *criminal prosecution*, "all licensed professionals who have direct contact with children" as well as "members of the general public" to report instances of minors who have undergone the medical procedures outlined in the Letter and the Paxton Opinion. This, too, is without legislative approval and represents an overreach by the executive into the core legislative function of establishing crimes and criminal penalties.

266. Second, separate and apart from the criminalization of conduct that has heretofore been legal, all Defendants violate separation of powers by seeking to adopt and enforce an overbroad interpretation of "child abuse" under the Family Code.

267. Texas law mandates that the executive branch and the courts must, in construing statutes, take them as they find them. *See Tex. Highway Comm'n v. El Paso Bldg. &*

Const. Trades Council, 234 S.W.2d 857, 863 (Tex. 1950); *Simmons v. Arnim*, 220 S.W. 66, 70 (Tex. 1920); *City of Port Arthur v. Tillman*, 398 S.W.2d 750, 752 (Tex. 1965). In particular, the other branches are not empowered to "substitute what [they] believe is right or fair for what the legislature has written," *Vandyke v. State*, 538 S.W.3d 561, 569 (Tex. Crim. App. 2017) (citations omitted), or to give meanings to statutory language that contravene their plain meaning or clear legislative intent. *See Burton v. Rogers*, 492 S.W.2d 695 (Tex. Civ. App.—Beaumont 1973, writ granted), *judgment rev'd on other grounds*, 504 S.W.2d 404 (Tex. 1973) (finding that words employed by the Legislature must be taken in their ordinary and popular acceptation). To do otherwise would once again violate the core legislative power to make, alter, and repeal laws.

268. Defendants violate separation of powers when they attempt to create new and novel definitions for "child abuse" under the Family Code. Defendants endeavored to redefine "child abuse" in spite of the state legislature's recent refusal to adopt Senate Bill 1646, which would have included certain treatments for gender dysphoria in adolescents under the definition of child abuse, and bills like it, such as House Bills 68 and 1339. In expanding the definition of child abuse beyond the limits permitted by the plain meaning of the Family Code, and in clear defiance of legislative intent, the Defendants impermissibly invade the legislative field. *See Brazos River Auth. v. City of Graham*, 354 S.W.2d 99, 109 (Tex. 1961).

269. Finally, there has been no delegation of powers from the state Legislature to the executive that would in any way cure the separation of powers violation. While the Legislature may not generally delegate its law-making power to another branch, it may designate some agency to carry out legislation for the purposes of practicality or efficiency. *See Tex. Boll Weevil Eradication Found., Inc. v. Lewellen*, 952 S.W.2d 454, 466 (Tex. 1997). Separation of powers requires that in statutes delegating such power, the Legislature must provide definite

guidelines and prescribe sufficient standards to circumscribe the discretion conferred. *See State v. Rhine*, 255 S.W.3d 745, 749 (Tex. App.—Fort Worth 2008, pet. granted), *aff'd*, 297 S.W.3d 301. Such standards must be reasonably clear and acceptable as standards of measurement. Tex. Const. art. II § 1.

270. In the instant case, the Texas Family Code provides no such delegation in any way from the state Legislature to the executive of the power to expand—unilaterally and without legislative approval—the definition of "child abuse." Recent decisions by the state Legislature in fact signal that the Legislature does not intend and has explicitly declined to expand the definition of child abuse to include certain gender-affirming care for minors.

271. For the foregoing reasons, Defendants' actions violate state constitutional separation of powers.

D. Due Process Vagueness Claims – By All Plaintiffs Against Defendants Governor Abbott and Commissioner Masters

272. Article 1, Section 19 of the Texas Constitution states: "No citizen of this State shall be deprived of life, liberty, property, privileges or immunities, or in any manner disfranchised, except by the due course of the law of the land." Under this guarantee, a governmental enactment is unconstitutionally vague if it fails to provide a person of ordinary intelligence fair notice of what is prohibited or is so standardless that it authorizes or encourages seriously discriminatory enforcement. *See Ex parte Jarreau*, 623 S.W.3d 468, 472 (Tex. App.—San Antonio 2020, pet. ref'd) (quoting *Sessions v. Dimaya*, 138 S. Ct. 1204, 1212 (2018)). Governmental enactments are unconstitutionally void for vagueness when their prohibitions are not clearly defined.

273. Criminal enactments are subject to an even stricter vagueness standard because "the consequences of imprecision are . . . severe." *Vill. of Hoffman Estates v. Flipside,*

Hoffman Estates, Inc., 455 U.S. 489, 498-99 (1982). Each ground—a lack of fair notice and a lack of standards for enforcement—provides an independent basis for a facial vagueness challenge. *Ex parte Jarreau*, 623 S.W.3d at 472.

274. The Abbott Letter and the DFPS Statement announcing a new rule adopting and enforcing an overbroad interpretation of "child abuse" under the Family Code create precisely this type of unconstitutional vagueness. These vague prohibitions leave parents of transgender youth like Plaintiffs Mirabel Voe, Wanda Roe, Adam and Amber Briggle, and those who are members of PFLAG, uncertain how to avoid criminal penalty in their efforts to provide for the medical needs of the children they love. Under the text of the Family Code itself, a parent is liable for neglect for "failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting an immediate danger of death, disfigurement, or bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child." Tex. Fam. Code § 261.001(4)(A)(ii)(b). Failing to seek medically necessary treatment for an adolescent's gender dysphoria would seemingly fall within this statutory definition. But if parents pursue the medical care necessary for their transgender adolescent's growth, development, and functioning, Defendants' recent actions make them liable for abuse. These parents are left without fair notice of how their actions will be assessed and what standards will apply.

E. Deprivation of Parental Rights Due Process Claims – By Plaintiff Parents Against Defendants Governor Abbott and Commissioner Masters

275. Plaintiffs incorporate the foregoing paragraphs in support of the following causes of action.

276. Plaintiff Parents' right to care for their children is a fundamental liberty interest protected by the Texas Constitution and acknowledged by the Legislature. *See Wiley*, 543 S.W.2d at 352; *see also* Tex. Fam. Code § 151.001(a)(11).

277. Under substantive due process, the government may not infringe parental rights unless there exist exceptional circumstances capable of withstanding strict scrutiny. *See Wiley*, 543 S.W.2d at 352. The state must have a compelling state interest, and the state action in question "*must* be narrowly drawn to express *only* the legitimate state interests at stake." *Gibson v. J.W.T.*, 815 S.W.2d 863, 868 (Tex. App.—Beaumont 1991, writ granted), *aff'd and remanded In re J.W.T.*, 872 S.W.2d 189 (Tex. 1994) (citations omitted).

278. In the present case, there are no exceptional circumstances that would justify Defendants' complete negation of Plaintiff Parents' fundamental liberty interests in parental autonomy. There is perhaps no right more fundamental than the right of parents to care for their children. *See Holick v. Smith*, 685 S.W.2d 18, 20 (Tex. 1985). Defendants have trampled on Plaintiff Parents' right to care for their children by effectively criminalizing the act of providing medically necessary care to their children in consultation with medical professionals in accordance with applicable standards of care. Defendants' actions cause immeasurable harm to both parents and young people, threaten family separation, and lack any legitimate justification at all, let alone a constitutionally adequate one. This is not a "narrowly drawn" policy that respects Plaintiff Parents' fundamental due process rights to parent their children.

F. Violation of the Guarantee of Equal Rights and Equality Under the Law – By Minor Plaintiffs Against Defendants Governor Abbott and Commissioner Masters

279. The Abbott Letter, DFPS's Statement, and DFPS's implementation of these through its new rule violate the Texas Constitution by denying transgender youth equal protection under law. Under the Texas Constitution, all persons "have equal rights," Tex. Const. art. I, § 3,

and "[e]quality under the law shall not be denied or abridged because of sex." Tex. Const. art. I, § 3a.

280. The Abbott Letter, incorporated into the DFPS Statement, classifies based on both transgender status and sex. The Abbott Letter specifically designates "*gender*-transitioning procedures" to be abusive and refers to the Paxton Opinion by noting that it deems "'*sex* change' procedures [to] constitute child abuse." The Abbott Letter, incorporated into the DFPS Statement, explicitly uses sex-based terms, making plain that the discrimination at issue here is based on sex, including failure to conform to sex stereotypes. Moreover, it discriminates against transgender youth, like Antonio Voe, Tommy Roe, M.B., and the children of PFLAG members, because they are transgender. By definition, transgender people undergo "gender transition" and by targeting medical care related to gender transition, Texas officials are discriminating against transgender people as such.

281. As the United States Supreme Court has explained, "discrimination based on . . . transgender status necessarily entails discrimination based on sex." *Bostock v. Clayton Cty., Georgia*, 140 S. Ct. 1731, 1747 (2020); *cf. Tarrant Cty. Coll. Dist. v. Sims*, 621 S.W.3d 323, 329 (Tex. App.—Dallas 2021, no pet.) ("[W]e conclude we must follow Bostock and read the TCHRA's prohibition on discrimination 'because of ... sex' as prohibiting discrimination based on an individual's status as a . . . transgender person.") (citing *Bostock*, 140 S. Ct. at 1738-43). Likewise, discrimination based on transgender status is independently unconstitutional. *See Brandt*, 551 F. Supp. 3d at 889 ("The Court concludes that heightened scrutiny applies to Plaintiffs' Equal Protection claims because Act 626 rests on sex-based classifications and because 'transgender people constitute at least a quasi-suspect class.'" (quoting *Grimm v. Gloucester Cty.*

Sch. Bd., 972 F.3d 586, 607 (4th Cir. 2020))); *Eknes-Tucker v. Marshall*, 2022 WL 1521889, at *1.

282. The Abbott Letter, DFPS Statement, and DFPS's implementation of these directives therefore unlawfully discriminate against transgender youth by deeming the medically necessary care for the treatment of their gender dysphoria as presumptively abuse because they are transgender when the same treatment is permitted for non-transgender youth. The law also singles out for prohibition only medical treatment for gender dysphoria when many other forms of care carry the same or comparable risk and are supported by the same or less evidence of efficacy. In so doing, the Abbott Letter, DFPS Statement, and DFPS's implementation of these directives through its new rule place a stigma and scarlet letter upon transgender youth and subject them to immense harms. Defendants' actions do nothing to protect transgender youth, yet subject them to invasive investigations simply because of who they are, while triggering an unimaginable choice between being forced to forego medically necessary care or being separated from their families or having their loving parents criminalized.

IX. APPLICATION FOR EMERGENCY TEMPORARY RESTRAINING ORDER, TEMPORARY INJUNCTION AND PERMANENT INJUNCTION

283. In addition to the above-requested relief, Plaintiffs seek: (1) a temporary restraining order and a temporary injunction against Commissioner Masters and DFPS (not Governor Abbott) solely on the grounds that DFPS's new rule, expanding the definition of "child abuse" violates the APA; and (2) a permanent injunction against Commissioner Masters and DFPS (not Governor Abbott) on each of the grounds asserted by Plaintiffs herein.

284. The purpose of a temporary restraining order and temporary injunction is to maintain the status quo pending trial. The status quo is "the last actual, peaceable, non-contested status which preceded the pending controversy." *In re Newton*, 146 S.W.3d 648, 651 (Tex. 2004)

(quoting *Janus Films, Inc. v. City of Fort Worth*, 358 S.W.2d 589, 589 (Tex. 1962) (per curiam) (citation omitted)). Until a permanent injunction can be decided on the merits, Plaintiffs are entitled to a temporary restraining order and a temporary injunction pursuant to Texas Civil Practice and Remedies Code section 65.011 and Texas Rules of Civil Procedure 680 *et seq.* to preserve the status quo before the unconstitutional enactment of Abbott's Letter and the DFPS Statement, which incorporate and reference the Paxton Opinion.

285. As determined by the Court in *Doe v. Abbott*, "gender-affirming care was not investigated as child abuse by DFPS until after February 22, 2022" and "[t]he series of directives and decisions by the Governor, the [Commissioner], and other decision-makers at DFPS, changed the *status quo* for transgender children and their families, as well as professionals who offer treatment, throughout the State of Texas." *Doe v. Abbott*, 2022 WL 831383, at *1.

286. Moreover, as a result of temporary orders from the Travis County District Court and the Third Court of Appeals, DFPS and Commissioner Masters were "enjoined from investigating reports of child abuse by persons, providers or organizations facilitating or providing gender-affirming care to transgender minors where the only grounds for the purported abuse or neglect are either the facilitation or provision of gender-affirming medical treatment or the fact that the minors are transgender, gender transitioning, or receiving or being prescribed gender-affirming medical treatment; prosecuting or referring for prosecution such reports" until at least mid-May 2022.

287. The Commissioner's and DFPS's actions since the Texas Supreme Court's decision narrowing the Third Court of Appeals' order demonstrate that the agency is continuing to conduct investigations based solely on the suspected provision of gender affirming care for adolescent minors with gender dysphoria, as directed by Abbott's Letter and explained in Paxton's

Opinion. DFPS never conducted these investigations before February 22 but is now violating Plaintiffs' rights and threatening medically necessary health care for transgender youth based on an invalid agency rule.

288. Plaintiffs meet all the elements necessary for temporary injunctive relief with respect to their APA claims. Plaintiffs state a valid cause of action against the Commissioner and DFPS and have a probable right to the relief sought. For the reasons detailed above, a bona fide issue exists as to Plaintiffs' right to ultimate relief because the Commissioner and DFPS violated the APA by adopting and enforcing a new rule, namely a significant expansion of the definition of "child abuse", without following the statutorily required procedures. Plaintiffs have already been injured by these actions and will continue to experience imminent and irreparable harm without injunctive relief.

289. Plaintiffs in this suit have suffered and will continue to suffer probable, imminent, and irreparable harms before a trial on the merits, absent intervention by the Court. Antonio Voe, Tommy Roe, M.B., and transgender youth whose parents are members of PFLAG have already had their lives upended by the Commissioner and DFPS's actions.

290. Antonio Voe attempted death by suicide in response to Texas leaders targeting transgender youth. Following that attempt, he faced intrusive invasions of his and his family's privacy from DFPS. Antonio was questioned and photographed by an investigator at home and his mom was called an "alleged perpetrator" of child abuse, interrogated, and asked to turn over private and confidential medical records for her son. Because of the trauma and harm caused by Defendants' actions, Antonio has stopped going to school in-person and is seeking additional mental health care.

291. Tommy Roe felt his world cave in when he was pulled out of class and questioned by a CPS investigator at school about his medically necessary health care. He suffered the trauma and anxiety of seeing CPS question his mother, stepdad, and brothers in their home. M.B. also suffered this same invasion of his privacy, as his family was questioned by CPS in their home based solely on allegations relating to the medically necessary health care. PFLAG members across Texas have suffered these same harms and are living in fear, anxiety, and apprehension that CPS could at any moment knock on their door or pull their kids out of class to interrogate them about the medically necessary health care that they receive.

292. Plaintiffs who are parents of PFLAG, Mirabel Voe, Wanda Roe, and Adam and Amber Briggle also face lasting harm—the prospect of losing their children. Commissioner Masters and DFPS's efforts to continue investigations into families that love and support their children by providing them with medically necessary care threaten to rip families apart and trample on Plaintiffs' parental rights. Because DFPS is pursuing these investigations contrary to law and in flagrant violation of the APA, Plaintiffs live in fear that their children could be taken away from them with little or no notice. Even an investigation that does not result in a removal can still stay on a parent's record and curtail a parent's rights and freedom. And the worst harm of all is that Plaintiffs fear that their children could attempt to take their own lives because Defendants' actions have baselessly portrayed gender-affirming care as a crime and transgender youth as a burden on their families.

293. Defendants' unlawful actions have also threatened the availability of medically necessary health care for gender dysphoria that Plaintiffs need, which if abruptly discontinued can cause severe physical and emotional harms, including anxiety, depression, and suicidality. If placed on the child abuse registry, Plaintiff Parents like Mirabel Voe, Wanda Roe,

Adam and Amber Briggle, and PFLAG members would be barred from ever working with children, including as volunteers in their community. Plaintiffs also face the prospect of criminal penalties, as threatened in Abbott's Letter.

294. For the reasons above, Plaintiffs request the Court issue a temporary restraining order now and a temporary injunction following a hearing within 14 days and a permanent injunction after a trial on the merits. Since there is no adequate remedy at law that is complete, practical, and efficient to the prompt administration of justice in this case, equitable relief is necessary to enjoin the enforcement of the Commissioner's and DFPS's unlawful new rule, preserve the status quo, and ensure justice.

295. In balancing the equities between Plaintiffs and the Commissioner and DFPS, Plaintiffs will suffer probable, imminent, irreparable, and ongoing harm including the deprivation of their medical treatment and their constitutional rights, whereas the injury to the Commissioner and DFPS is nominal pending the outcome of this suit. In fact, enjoining the Commissioner and DFPS's unlawful implementation of Paxton's Opinion and Abbott's Letter will simply allow the agency to follow existing Texas law and longstanding DFPS policies and practices, while not diverting resources to unlawfully investigate loving families for the provision of medically necessary health care.[44]

296. Plaintiffs are willing to post a bond for any temporary injunction if ordered to do so by the Court, but request that the bond be minimal because the Commissioner and DFPS are acting in a governmental capacity, have no pecuniary interest in the suit, and no monetary damages can be shown. Tex. R. Civ. P. 684.

[44] Reese Oxner & Neelam Bohra, *Texas foster care crisis worsens, with fast-growing numbers of children sleeping in offices, hotels, churches*, Tex. Trib. (July 19, 2021), https://www.texastribune.org/2021/07/19/texas-foster-care-crisis/.

X. CONDITIONS PRECEDENT

297. All conditions precedent have been performed or have occurred.

XI. RELIEF REQUESTED

298. For the foregoing reasons, Plaintiffs request the Court grant the following relief:

a. A temporary restraining order prohibiting Commissioner Masters and DFPS from implementing or enforcing the new rule announced in the DFPS Statement, implementing the Abbott Letter and the Paxton Opinion, or otherwise investigating for possible child abuse or taking any actions against Plaintiffs and other members of PFLAG solely based on allegations that they have a child that is transgender or that they have a minor child with gender dysphoria who is being treated with medically prescribed treatment for that condition;

b. Upon hearing, a temporary injunction prohibiting Commissioner Masters and DFPS from implementing or enforcing the new rule announced in the DFPS Statement, implementing the Abbott Letter and the Paxton Opinion, or otherwise investigating for possible child abuse or taking any actions against Plaintiffs and other members of PFLAG solely based on allegations that they have a child that is transgender or that they have a minor child with gender dysphoria who is being treated with medically prescribed treatment for that condition;

c. After trial, a permanent injunction prohibiting Commissioner Masters and DFPS from implementing or enforcing the new rule announced in the DFPS Statement, implementing the Abbott Letter and the Paxton Opinion as

announced in the DFPS Statement, or otherwise investigating for possible child abuse or taking any actions against any person, including Plaintiffs and other members of PFLAG, solely based on allegations that they have a child that is transgender or that they have a minor child with gender dysphoria who is being treated with medically prescribed treatment for that condition;

d. Declaratory judgment that the Commissioner's and DFPS's new rule, as announced in the DFPS Statement and subsequent actions implementing it, violates the Texas Administrative Procedure Act;

e. Declaratory judgment that Abbott's Letter and the Commissioner's and DFPS's new rule, as announced in the DFPS Statement and subsequent actions implementing it, are *ultra vires* and unconstitutional;

f. Reasonable and necessary attorneys' fees and costs as are equitable and just under Texas Civil Practice and Remedies Code section 37.009; and

g. All other relief, general and special, at law and in equity, as the Court may deem necessary and proper.

[Signature Page Follows]

Dated: June 8, 2022

Respectfully submitted:

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**Pro hac vice* forthcoming

CERTIFICATE OF CONFERENCE

I certify that Plaintiffs have notified Defendants pursuant to the Local Rules of the District Courts of Travis County and will file the certification for requested temporary restraining order hearing.

/s/ Paul D. Castillo
Paul D. Castillo

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

AUGUST DEKKER, legally known as KORI DEKKER; BRIT ROTHSTEIN; SUSAN DOE, a minor, by and through her parents and next friends, JANE DOE and JOHN DOE; and K.F., a minor, by and through his parent and next friend, JADE LADUE, *Plaintiffs*, v. SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration; and FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *Defendants*.	Civil Action No. **COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND OTHER RELIEF**

Plaintiffs AUGUST DEKKER, legally known as KORI DEKKER;[1] BRIT ROTHSTEIN; SUSAN DOE, a minor, by and through her parents and next friends, JANE DOE and JOHN DOE;[2] and K.F., a minor, by and through his parent and next

[1] Although Plaintiff's legal name is Kori Dekker, he is known by and uses the name August Dekker in accordance with his male gender identity. Accordingly, this Complaint refers to Plaintiff as August and uses male pronouns to refer to him.

[2] As set forth in the motion to proceed pseudonymously, Plaintiff Susan Doe, and her parents and next friends, Jane Doe and John Doe, seek to proceed pseudonymously in order to protect Susan Doe's right to privacy given that she is a

friend JADE LADUE,[3] by and through the undersigned counsel, bring this lawsuit against Defendants SIMONE MARSTILLER, in her official capacity as Secretary of the Florida Agency for Health Care Administration, and the FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION ("AHCA") to challenge the adoption of a rule, Florida Administrative Code 59G-1.050(7), prohibiting Medicaid coverage of services for the treatment of gender dysphoria and to seek declaratory and injunctive relief.

INTRODUCTION

1. A person's access to health care should not be contingent on their sex, gender identity, or whether they are transgender. Yet, that is exactly the situation in Florida. AHCA has made access to medically necessary health care for Medicaid beneficiaries contingent on whether they are transgender.

2. Empirical evidence and decades of clinical experience demonstrate that medical care for the treatment of gender dysphoria, also known as gender-affirming care, is medically necessary, safe, and effective for both transgender adolescents and adults with gender dysphoria. Gender-affirming care is neither experimental nor

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minor and the disclosure of her identity "would reveal matters of a highly sensitive and personal nature, specifically [Susan Doe]'s transgender status and [her] diagnosed medical condition—gender dysphoria." *Foster v. Andersen*, No. 18-2552-DDC-KGG, 2019 WL 329548, at *2 (D. Kan. Jan. 25, 2019).

[3] Because he is a minor, Plaintiff K.F. is proceeding under his initials pursuant to Federal Rule of Civil Procedure 5.2(a).

investigational; it is the prevailing standard of care, accepted and supported by every major medical organization in the United States.

3. Under newly adopted Rule 59G-1.050(7) of the Florida Administrative Code (the "Challenged Exclusion"), transgender Medicaid beneficiaries are denied coverage for gender-affirming care to treat gender dysphoria, without regard to the actual generally accepted professional medical standards that govern such care or the particular medical needs of any Medicaid beneficiary. Specifically, any health care service that "alter[s] primary or secondary sexual characteristics" is ineligible for Medicaid coverage, though only when that service is being used to treat gender dysphoria. These same health care services, however, are routinely covered by Medicaid when they are for medically necessary purposes other than the treatment of gender dysphoria.

4. The Challenged Exclusion represents dangerous governmental action that threatens the health and wellbeing of transgender Medicaid beneficiaries.

5. The purpose of Medicaid is to provide health care coverage to individuals who have low income and cannot otherwise afford the costs of necessary medical care. By denying coverage for gender-affirming care, Defendants effectively *categorically* deny access to medically necessary care to thousands of Floridians who lack other means to pay for such care.

6. Defendants' actions not only come within the context of a series of measures the State has adopted targeting transgender people for discrimination, but they stand in sharp contrast not just to the well-established evidence and widely accepted view of the medical and scientific community in the United States, but also to the policies of the vast majority of states, which provide Medicaid coverage for gender-affirming care.

7. If allowed to remain in effect, the Challenged Exclusion will have immediate dire physical, emotional, and psychological consequences for transgender Medicaid beneficiaries.

8. These consequences need not occur, however, as the Challenged Exclusion is unlawful in multiple respects and therefore should be preliminarily and permanently enjoined.[4]

9. First, the Challenged Exclusion, which Defendant Marstiller enforces, violates the United States Constitution's guarantee of equal protection of the laws. Under the Fourteenth Amendment's Equal Protection Clause, Defendants are prohibited from discriminating against persons based on sex and transgender status.

[4] Blanket bans like the Challenged Exclusion have been repeatedly found to be unlawful and unconstitutional forms of discrimination. *See, e.g.*, *Fain v. Crouch*, 3:20-cv-00740, Dkt. #271 (S.D.W.V. Aug. 2, 2022) (granting summary judgment in favor of plaintiffs on causes of action also brought in this Complaint); *Flack v. Wis. Dep't. of Health Services*, 3:18-cv-00309-wmc, Dkt. #217 (W.D. Wis. Aug. 16, 2019) (same).

10. Second, the Challenged Exclusion violates Section 1557 of the Patient Protection and Affordable Care Act (the "ACA"), 42 U.S.C. § 18116, which prohibits discrimination on the basis of sex by health programs or activities, any part of which receives federal funding, such as Medicaid.

11. Third, the Challenged Exclusion violates the Medicaid Act's Early and Periodic Screening, Diagnostic, and Treatment provisions, which require Defendants to affirmatively arrange for services that are necessary to "correct or ameliorate" a health condition for Medicaid beneficiaries under 21 years of age, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r) ("EPSDT Requirements"), as well as the Medicaid Act's requirement for Defendants to ensure comparable coverage to every Medicaid beneficiary, 42 U.S.C. § 1396a(a)(10)(B)(i) ("Comparability Requirements").

12. Accordingly, Plaintiffs seek relief related to Defendants' adoption and enforcement of the Challenged Exclusion, including declaratory and preliminary and permanent injunctive relief, as well as compensatory damages, attorney's fees, and costs.

PARTIES

A. Plaintiffs

Plaintiff August Dekker

13. Plaintiff August Dekker is a 28-year-old transgender man. August, who has been diagnosed with gender dysphoria, is enrolled in and receives his health care coverage through Florida's Medicaid program. At the recommendation of his health care providers, August receives medically necessary hormone therapy to treat his gender dysphoria, which Florida's Medicaid program has covered until now. August has been enrolled in Medicaid at all times relevant to this complaint. August lives in Hernando County, Florida.

Plaintiff Brit Rothstein

14. Plaintiff Brit Rothstein is a 20-year-old transgender man. Brit, who has been diagnosed with gender dysphoria, is enrolled in and receives his health care coverage through Florida's Medicaid program. At the recommendation of his health care providers, Brit receives medically necessary hormone therapy to treat his gender dysphoria, which Florida's Medicaid program has covered until now, and is scheduled to obtain chest surgery as treatment for his gender dysphoria in December 2022, which Medicaid had pre-authorized. Brit has been enrolled in Medicaid at all times relevant to this complaint. As he is college student, Brit lives in Orange

County, Florida while he is in school, and lives in Broward County, Florida, along with his family, when he is out of school.

Plaintiff Susan Doe

15. Plaintiff Susan Doe is a 12-year-old transgender adolescent girl. Susan Doe sues pursuant to Federal Rule of Civil Procedure 17(c) by and through her next friends and parents, Jane Doe and John Doe. Susan, who has been diagnosed with gender dysphoria, is enrolled in and receives her health care coverage through Florida's Medicaid program. At the recommendation of her health care providers, Susan receives medically necessary puberty delaying medication to treat her gender dysphoria, which Florida's Medicaid program has covered until now. Susan has been enrolled in Medicaid at all times relevant to this complaint. Susan, Jane, and John live in Brevard County, Florida.

Plaintiff K.F.

16. Plaintiff K.F. is a 12-year-old transgender adolescent boy. K.F. sues pursuant to Federal Rule of Civil Procedure 17(c) by and through his next friend and parent, Jade Ladue. K.F., who has been diagnosed with gender dysphoria, is enrolled in and receives his health care coverage through Florida's Medicaid program. At the recommendation of his health care providers, K.F. receives medically necessary puberty delaying medication to treat his gender dysphoria, which Florida's Medicaid

program has covered until now. K.F. has been enrolled in Medicaid at all times relevant to this complaint. Jade and K.F. live in Sarasota County, Florida.

B. Defendants

17. Defendant Simone Marstiller is sued in her official capacity as Secretary of AHCA, the "single state agency authorized to manage, operate, and make payments for medical assistance and related services under Title XIX of the Social Security Act [Medicaid]." Fla. Stat. §§ 409.902, 409.963 (2022); *see also* 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10. Defendant Marstiller is responsible for the enforcement of the Challenged Exclusion. Defendant Marstiller is responsible for ensuring that the operation of Florida's Medicaid program complies with the United States Constitution and the Medicaid Act and its implementing regulations. Defendant Marstiller's official place of business is located in Tallahassee, Leon County, Florida.

18. Defendant AHCA is the "single state agency authorized to manage, operate, and make payments for medical assistance and related services under Title XIX of the Social Security Act [Medicaid]." Fla. Stat. §§ 409.902, 409.963 (2022). As such, AHCA receives federal funding to support the Florida Medicaid Program. AHCA uses the funds it receives from the federal government in part to cover health care services for persons enrolled in the Florida Medicaid Program. Moreover, AHCA oversees the promulgation of all Medicaid rules, fee schedules, and coverage

policies into the Florida Administrative Code. Fla. Stat. § 409.919 (2022). Defendant AHCA is based and headquartered in Tallahassee, Leon County, Florida.

JURISDICTION AND VENUE

19. The Court has jurisdiction over the claims asserted herein pursuant to 28 U.S.C. §§ 1331, 1343(a)(3)-(4).

20. Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201, 2202, 42 U.S.C. § 1983, and Rules 57 and 65 of the Federal Rules of Civil Procedure.

21. Under 28 U.S.C. § 1391(b), venue is proper in the U.S. District Court for the Northern District of Florida because all Defendants reside within this District and a substantial part of the events or omissions giving rise to the claims alleged herein occurred in this District. Venue is proper in the Tallahassee Division of the Northern District of Florida under N.D. Fla. Loc. R. 3.1(B) because it is where the Defendants reside and where a substantial portion of the acts or omissions complained of herein occurred.

22. This Court has personal jurisdiction over Defendants because they are domiciled in Florida and/or have otherwise made and established contacts with Florida sufficient to permit the exercise of personal jurisdiction over them.

FACTUAL BACKGROUND

A. Gender Identity and Gender Dysphoria

23. A person's sex is multifaceted, and comprised of a number of characteristics, including but not limited to chromosomal makeup, hormones, internal and external reproductive organs, secondary sex characteristics, and most importantly, gender identity.

24. Gender identity is a person's internal sense of their sex. It is an essential element of human identity that everyone possesses, and a well-established concept in medicine. Gender identity is innate; immutable; has significant biological underpinnings, such as the sex differentiation of the brain that takes place during prenatal development; and cannot be altered.

25. Gender identity is the most important determinant of a person's sex. Everyone has a gender identity.

26. A person's sex is generally assigned at birth based solely on a visual assessment of external genitalia. External genitalia, however, are only one of several sex-related characteristics that comprise a person's sex, and as a result, are not always indicative of a person's sex.

27. For most people, their sex-related characteristics are aligned, and the visual assessment performed at birth serves as an accurate proxy for that person's sex.

28. The term "sex assigned at birth" is the most precise terms to use because not all of the physiological aspects of a person's sex are always in alignment with each other as typically male or typically female.

29. For these reasons, the Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, warns practitioners that the terms "biological sex" and "biological male or female" are imprecise and should be avoided.[5]

30. When a person's gender identity does not match that person's sex assigned at birth, gender identity is the critical determinant of that person's sex.

31. Individuals whose sex assigned at birth aligns with their gender identity are referred to as cisgender. Transgender people, on the other hand, have a gender identity that differs from the sex assigned to them at birth. A transgender boy or man is someone who was assigned a female sex at birth but has a male gender identity. A transgender girl or woman is someone who was assigned a male sex at birth but has a female gender identity.

[5] *See* Wylie C. Hembree, *et al*., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3875 (2017), https://perma.cc/FM96-L228 (hereinafter "Endocrine Society Guidelines").

32. The health and wellbeing of all people, including those who are transgender, depends on their ability to live in a manner consistent with their gender identity.

33. Scientific and medical consensus recognizes that attempts to change an individual's gender identity to bring their gender identity into alignment with their sex assigned at birth are ineffective and harmful. Attempts to force transgender people to live in accordance with their sex assigned at birth, a practice often described as "conversion," or "reparative" therapy, is universally known to cause profound harm and is widely considered unethical and, in some places, unlawful.

34. For transgender people, the incongruence between their gender identity and sex assigned at birth can result in clinically significant stress and discomfort known as gender dysphoria.

35. Gender dysphoria is a serious medical condition recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. The World Health Organization's International Classification of Diseases, which is the diagnostic and coding compendia used by medical professionals, refers to the condition as "gender incongruence." Gender dysphoria is also recognized by the leading medical and mental health professional groups in the United States, including the American Academy of Pediatrics,

American Medical Association, the American Psychological Association, American Psychiatric Association, and the Endocrine Society, among others.

36. If left untreated, gender dysphoria can result in debilitating anxiety, severe depression, self-harm, and even suicidality. Untreated gender dysphoria often intensifies with time. The longer an individual goes without or is denied adequate treatment for gender dysphoria, the greater the risk of severe harms to the person's health.

37. The World Professional Association for Transgender Health ("WPATH") and the Endocrine Society have published widely accepted guidelines for treating gender dysphoria.[6] The goal of medical treatment for gender dysphoria is to eliminate clinically significant distress by helping a transgender person live in accordance with their gender identity. This treatment is sometimes referred to as "gender transition," "transition related care," or "gender-affirming care."

38. WPATH is an international and multidisciplinary association whose mission is to promote evidence-based health care protocols for transgender people. WPATH publishes the Standards of Care based on the best available science and expert professional consensus.

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[6] Endocrine Society Guidelines; World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (7th Version, 2012), https://perma.cc/62K5-N5SX (hereinafter, "WPATH Standards of Care").

39. The WPATH Standards of Care and Endocrine Society Guidelines are widely accepted as best practices guidelines for the treatment of adolescents and adults diagnosed with gender dysphoria and have been recognized as authoritative by the leading medical organizations.

40. The WPATH Standards of Care and Endocrine Society Guidelines recognize that puberty delaying medication, hormone therapy, and surgery to align a person's primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring) with their gender identity are medically necessary services for many people with gender dysphoria.

41. The precise treatment of gender dysphoria for any individual depends on that person's individualized needs. The guidelines for medical treatment of gender dysphoria differ depending on whether the treatment is for an adolescent (minors who have entered puberty) or an adult. No pharmaceutical or surgical intervention is recommended or necessary prior to the onset of puberty, however. The individualized steps that many transgender people take to live in a manner consistent with their gender identity are known as "a transition" or "transitioning." The precise steps involved in transitioning are particular to the individual but may include social, medical, and legal transition. Determinations regarding medically necessary care are made on an individualized basis between by the medical professional and the patient.

42. Social transition entails a transgender individual living in accordance with their gender identity in all aspects of life. Social transition can include wearing attire, following grooming practices, and using pronouns consistent with that person's gender identity. The steps a transgender person can take as part of their social transition help align their gender identity with all aspects of everyday life.

43. Many transgender individuals also pursue legal transition, which involves taking steps to formally amend their legal identification documents to align with their gender identity, such as changing one's name through a court ordered legal name change and updating the name and gender marker on their driver's license, birth certificate, and other identification documents.

44. Medical transition, a critical part of transitioning for many transgender people, includes gender-affirming care that brings the sex-specific characteristics of a transgender person's body into alignment with their identity.

45. Gender-affirming care can involve counseling, hormone therapy, surgery, or other medically necessary treatments for gender dysphoria.

46. The most effective treatment for transgender adolescents and adults with gender dysphoria, in terms of both their mental and medical health, contemplates an individualized approach. Medical and surgical treatment interventions are determined by the health care team (usually involving medical and

mental health professionals) in collaboration with the patient, and the patient's parents/guardians, if the patient is an adolescent.

47. Under the WPATH Standards of Care, medical interventions may become medically necessary and appropriate after transgender youth reach puberty. In providing medical treatments to adolescents, pediatric physicians and endocrinologists work in close consultation with qualified mental health professionals experienced in diagnosing and treating gender dysphoria.

48. For many transgender adolescents, going through puberty as the sex assigned to them at birth can cause extreme distress. Puberty delaying medication allows transgender adolescents to pause puberty, thus minimizing and potentially preventing the heightened gender dysphoria and permanent physical changes that puberty would cause.

49. Puberty delaying treatment is reversible. When the adolescent discontinues treatment, puberty will resume. Puberty delaying treatment does not cause infertility.

50. For some transgender adolescents and adults, it is necessary to undergo hormone therapy, which involves taking hormones for the purpose of bringing their secondary sex characteristics into alignment with their gender identity (testosterone for transgender males, and estrogen and testosterone suppression for transgender females). Secondary sex characteristics are bodily features not associated with

external and internal reproductive genitalia (primary sex characteristics). Secondary sex characteristics include, for example, hair growth patterns, body fat distribution, and muscle mass development. Hormone therapy can have significant masculinizing or feminizing effects and can assist in bringing transgender people's secondary sex characteristics into alignment with their gender identity, and therefore is medically necessary care for transgender people who need it to treat their gender dysphoria.

51. Gender-affirming surgery might be sought by transgender people after puberty to treat symptoms of gender dysphoria by better aligning their primary or secondary sex characteristics with their gender identity. Though not all transgender people require or seek gender-affirming surgical care, such care can be medically necessary when determined to be in the best interests of the patient and supported by empirical evidence.

52. Gender-affirming medical care can be lifesaving treatment and has been shown to positively impact the short and long-term health outcomes for transgender people of all ages.

53. All of the treatments used to treat gender dysphoria are also used to treat other diagnoses or conditions. These treatments are not excluded from Medicaid coverage under the Challenged Exclusion when used to treat any diagnosis or condition other than gender dysphoria, yet they carry comparable risks and side

effects to those that can be present when treating gender dysphoria. Thus, the use of these treatments for gender dysphoria are not any more risky than for other conditions and diagnoses for which the same treatments are regularly used.

54. The consequences of untreated, or inadequately treated, gender dysphoria, however, are dire, as untreated gender dysphoria is associated with both clinically significant anxiety, depression, self-harm, and suicidality and higher levels of stigmatization, discrimination, and victimization, contributing to negative self-image and the inability to function effectively in daily life.

55. When transgender people are provided with access to appropriate and individualized gender-affirming care in connection with treatment of gender dysphoria, its symptoms can be alleviated and even prevented.

56. As such, the American Medical Association, American Psychological Association, American Psychiatric Association, Endocrine Society, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Family Physicians, and other major medical organizations have recognized that gender-affirming care is medically necessary, safe, and effective treatment for gender dysphoria, and that access to such treatment improves the health and well-being of transgender people. These groups and others have explicitly advocated against blanket bans on gender-affirming care like the Challenged Exclusion.

57. The medical procedures for the treatment of gender dysphoria are not "cosmetic" or "elective" or for the mere convenience of the patient, but instead are medically necessary for the treatment of the diagnosed medical condition. They are not experimental or investigational, because decades of both clinical experience and medical research show that they are essential to achieving well-being for transgender patients with gender dysphoria.

B. The Medicaid Act and Florida's Medicaid Program

i. Medicaid Coverage

58. The Medicaid Act, Title XIX of the Social Security Act of 1965, 42 U.S.C. §§ 1396-1396w-6, creates a joint federal-state program that provides health care services to specified categories of low-income individuals.

59. Medicaid is designed to "enabl[e] each State, as far as practicable...to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence and self-care...." 42 U.S.C. § 1396-1.

60. States are not required to participate in the Medicaid program—but all states do. States that choose to participate must comply with the Medicaid Act and its implementing regulations. In return, the federal government reimburses each

participating state for a substantial portion of the cost of providing medical assistance. *See id.* §§ 1396b(a), 1396d(b), 1396(c).

61. The Medicaid Act requires each participating state to designate a single state agency charged with administering or supervising the state's Medicaid program. *Id*. § 1396a(a)(5). While a state may delegate certain responsibilities to other entities, such as local agencies or Medicaid managed care plans, the single state agency is ultimately responsible for ensuring compliance with all aspects of the Medicaid Act. *See, e.g.*, 42 C.F.R. §§ 438.100(a)(2), 438.100(d).

62. Each participating state must maintain a comprehensive state plan for medical assistance, approved by the Secretary of the U.S. Department of Health and Human Services. 42 U.S.C. § 1396a.

63. The state plan must describe how the state will administer its Medicaid program and affirm the state's commitment to comply with the Medicaid Act and its implementing regulations. *Id.*

64. Under the Medicaid Act, a participating state must provide medical assistance to certain eligibility groups. *Id*. § 1396a(a)(10)(A)(i). One such group is children and adolescents under age 18 whose household income is below 133% of the federal poverty level. *Id*. §§ 1396a(a)(10)(A)(i)(VI)-(VII), 1396a(l). Another mandatory eligibility category is individuals with a disability who receive Supplemental Security Income or meet separate disability and financial eligibility

standards established by the state. *Id*. §§ 1396a(a)(10)(A)(i)(II), 1396a(f). States have the option to cover additional eligibility groups. *Id*. §§ 1396a(a)(10)(A)(ii).

65. States must administer Medicaid in "the best interests of recipients." 42 U.S.C. § 1396a(a)(19).

ii. The Medicaid EPSDT Requirements

66. The Medicaid Act requires each participating state to cover certain health care services, including inpatient and out-patient hospital services and physician services, when medically necessary. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d. States have the option to cover additional services, including prescription drugs, when medically necessary. *Id*.

67. One mandatory benefit under Medicaid is Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for beneficiaries under age 21. *Id.* §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

68. The fundamental purpose of the EPSDT Requirements is to "[a]ssure that health problems are diagnosed and treated early, before they become more complex and their treatment more costly." Ctrs. for Medicare & Medicaid Servs., State Medicaid Manual § 5010.B.

69. Pursuant to the EPSDT requirements, states must cover four specific, separate categories of screening services: medical, vision, dental, and hearing. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B), 1396d(r)(1)-(4).

70. States also must cover "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in [1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." *Id.* § 1396d(r)(5). In other words, states participating in Medicaid must cover all medically necessary services for beneficiaries under age 21, even when those services are not covered for adults.

71. Services that fall under 42 U.S.C. § 1396d(a) include inpatient and outpatient hospital services, physician services, and prescription drugs. *Id*. § 1396d(a)(1), (2), (5)(A), (12).

72. Gender-affirming medical treatments, including puberty delaying medication, hormone therapy, and surgery come within the services described in section § 1396d(a) and, thus, are EPSDT services when they are necessary to correct or ameliorate gender dysphoria. *Id*. § 1396d(r)(5) (incorporating services listed in § 1396d(a)).

73. States must "arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by" screening services. *Id*. § 1396a(a)(43)(C).

74. States must initiate EPSDT services in a timely manner, as appropriate to the individual needs of the beneficiary, and absolutely no later than 6 months from the date of the request. 42 C.F.R. § 441.56(e).

iii. The Medicaid Comparability Requirements

75. Under the Medicaid Act, "the medical assistance made available to any individual ... shall not be less in amount, duration or scope than the medical assistance made available to any other such individual." 42 U.S.C. § 1396a(a)(10)(B)(i).

76. "Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b).

77. A state "Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service ... to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c).

iv. Florida's Medicaid Program

78. The State of Florida participates in the federal Medicaid program. Fla. Stat. §§ 409.901-409.9205. AHCA is the single state agency in Florida that is responsible for administering and implementing Florida's Medicaid program consistent with the requirements of federal law. *See* Fla. Stat. § 409.902; 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.

79. AHCA contracts with private managed care plans to provide health care services to most Medicaid beneficiaries. Fla. Stat. § 409.964.

80. The federal government reimburses Florida for approximately 60% of the cost of providing medical assistance through its Medicaid program. *See* U.S. Dep't of Health & Hum. Servs., Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2022 Through September 30, 2023, 86 Fed. Reg. 67479, 67481 (Nov. 26, 2021).

81. Florida regulations require AHCA to cover health care services that are medically necessary within the scope of Fla. Admin. Code R. 59G-1.035(6), 59G-1.010. To qualify as medically necessary, a service must meet several conditions. *See* Fla. Admin. Code R. 59G-1.010, incorporating by reference AHCA, Definitions Policy at 2.83 (2017) (defining medically necessary care).

82. For one, the service must be consistent with generally accepted professional medical standards and not experimental or investigational. *Id*.; Fla. Admin. Code R. 59G-1.035. To determine whether a particular service is consistent with generally accepted professional medical standards, AHCA must consider: "(a) Evidence-based clinical practice guidelines. (b) Published reports and articles in the authoritative medical and scientific literature related to the health service (published in peer-reviewed scientific literature generally recognized by the relevant medical

community or practitioner specialty associations). (c) Effectiveness of the health service in improving the individual's prognosis or health outcomes. (d) Utilization trends. (e) Coverage policies by other creditable insurance payor sources. (f) Recommendations or assessments by clinical or technical experts on the subject or field." *Id*. § 59G-1.035(4).

83. After considering those factors, AHCA must submit a report with recommendations to the Deputy Secretary for Medicaid for review, and the Deputy Secretary makes a final determination as to whether the health service is consistent with generally accepted professional medical standards and not experimental or investigational. *Id*. § 59G-1.035(5).

84. Until August 21, 2022, Florida Medicaid covered the full range of gender-affirming treatments, including puberty delaying medication, hormone therapy, and surgical care.

85. Effective August 21, 2022, Florida excluded the coverage without any intervening change in federal Medicaid laws or the standard of care for gender dysphoria, as recognized by the medical community.

C. Defendants Adopt the Challenged Exclusion and Target Transgender Medicaid Beneficiaries for Discrimination.

86. On April 20, 2022, Florida's Department of Health ("FDOH") issued a misleading and factually inaccurate set of guidelines titled "Treatment of Gender

Dysphoria for Children and Adults" (hereinafter "FDOH Guidelines").[7] FDOH issued the FDOH Guidelines in direct response to the fact sheet from the U.S. Department of Health & Human Services regarding "Gender-Affirming Care and Young People."[8]

87. The FDOH Guidelines, which are non-binding in nature, directly contradicted the guidance from HHS, as well as the established medical guidelines supported by the country's largest and leading medical organizations.

88. The FDOH Guidelines stated that:

- Social gender transition should not be a treatment option for children or adolescents.
- Anyone under 18 should not be prescribed puberty delaying medication or hormone therapy.
- Gender reassignment surgery should not be a treatment option for children or adolescents.

89. Under the WPATH Standards of Care and Endocrine Society Guidelines, no one is provided pharmaceutical treatment for gender dysphoria until *after* the onset of puberty. No surgical interventions are recommended for

[7] *See Treatment of Gender Dysphoria for Children and Adults*, FLORIDA DEP'T OF HEALTH (April 20, 2022), https://perma.cc/W33H-6P5Q.

[8] *See Gender-Affirming Care and Young People*, U.S. Dep't of Health & Human Servs. (March 2022), https://perma.cc/399W-T6AC.

transgender adolescents prior to the age of 18, *except* for limited reconstructive surgery for adolescents who have reached Tanner Stage 5 and for whom it is deemed medically necessary by qualified mental and medical health care professionals.

90. The FDOH Guidelines were criticized by, among others, a group of more than 300 Florida health care professionals who care for transgender and gender diverse youth. This group denounced the FDOH Guidelines for citing "a selective and non-representative sample of small studies and reviews, editorials, opinion pieces and commentary to support several of their substantial claims" and misrepresenting "high-quality studies" by making "conclusions that are not supported by the authors of the articles."[9]

91. The 300 Florida health care professionals further stated that the FDOH Guidelines "contradict[] existing guidelines from the American Academy of Pediatrics, the Endocrine Society, the American Academy of Child and Adolescent Psychiatry and the World Professional Association for Transgender Health," and that "[t]hese national and international guidelines are the result of careful deliberation and examination of the evidence by experts including pediatricians, endocrinologists, psychologists and psychiatrists."

[9] Brittany S. Bruggeman, *et al*., *Opinion: We 300 Florida health care professionals say the state gets transgender guidance wrong | Open letter*, TAMPA BAY TIMES (Apr. 27, 2022), https://perma.cc/5UWE-LURH.

92. On April 20, 2022, based on the publication of the FDOH Guidelines, Secretary Marstiller sent a letter to Tom Wallace, AHCA's Deputy Secretary for Medicaid, requesting that AHCA determine if the treatments addressed in the FDOH Guidelines "are consistent with generally accepted professional medical standards and not experimental or investigational."[10]

93. The request from Secretary Marstiller to Deputy Secretary Wallace was highly unusual, as AHCA does not generally draft a GAPMS report for services that it is already covering.

94. While AHCA purported to go through its required rule-making process, it was clear the outcome was predetermined: to restrict access to medically necessary gender-affirming care for transgender people in Florida.

95. On June 2, 2022, Defendants published their report, "Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria" (hereinafter "GAPMS Memo").[11] The publication of the GAPMS Memo was accompanied by the publication of a political webpage within AHCA's website titled "Let Kids Be Kids"

[10] *Letter from AHCA Secretary Marstiller to Deputy Secretary Wallace* (April 20, 2022), https://perma.cc/YS7S-DFAX.

[11] AHCA, *Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria* (June 2, 2022), https://perma.cc/SUB9-V7DW.

(https://ahca.myflorida.com/letkidsbekids/) that included graphics, misleading "fact-checking" of HHS's guidance, and false assertions about social media's alleged influence on experiences of gender dysphoria.

96. The GAPMS Memo wrongly concluded that gender-affirming medical treatments, including puberty blockers, hormone therapy, and surgery, "do not conform to GAPMS [("generally accepted professional medical standards")] and are experimental and investigational." Deputy Secretary Wallace signed the GAPMS Memo and noted his concurrence.

97. To support this conclusion, the GAPMS Memo cited to, and relied upon, five non-peer-reviewed, unpublished "assessments" that Defendants commissioned. The "assessments" are the following:

- Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence. 16 May 2022.
- James Cantor, PhD: Science of Gender Dysphoria and Transsexualism. 17 May 2022.
- Quentin Van Meter, MD: Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent. 17 May 2022.

- Patrick Lappert, MD: Surgical Procedures and Gender Dysphoria. 17 May 2022.
- Kevin Donovan, MD: Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children. 16 May 2022.

98. These "assessments" illustrate how the GAPMS Memo is the product of bias and was engineered to achieve a particular result.

99. For example, although the GAPMS Memo presents Dr. Quentin van Meter as an expert in medical treatment for gender dysphoria, at least one court in Texas barred him from providing expert testimony on the on the "question of whether an adolescent transgender child should be administered puberty blockers and whether affirmation of an incongruent gender in a child is harmful or not."[12] Dr. Van Meter is the president of the American College of Pediatricians (not to be confused with the American Academy of Pediatrics). The American College of Pediatricians is not a professional association but instead a political group that, among other things, opposes marriage equality for same-sex couples, supports the

[12] Stephen Caruso, *A Texas judge ruled this doctor was not an expert. A Pennsylvania Republican invited him to testify on trans health care*, PENNSYLVANIA CAPITOL-STAR (Sept. 15, 2020), https://perma.cc/P8AU-3RFC.

provision of conversion therapy, and describes childhood gender dysphoria as "confusion."

100. The GAPMS Memo also cites to Dr. James Cantor as an expert on gender dysphoria. However, Dr. Cantor admitted in court to having no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving medical or surgical treatments for gender dysphoria.[13]

101. AHCA's GAPMS Memo also cites to an "assessment" authored by Dr. Romina Brignardello-Petersen and a post-doctoral fellow purporting to review the scientific literature regarding gender dysphoria and its treatment. Dr. Brignardello-Petersen has no particular expertise regarding gender dysphoria and is a member of the Society for Evidence Based Gender Medicine ("SEGM"), a group that opposes standard medical care for gender dysphoria, has no publications or conferences, and, upon information and belief, consists solely of a website created by a small group of people.

102. AHCA cites to an "assessment" by Dr. Patrick Lappert, a non-board-certified plastic surgeon. A federal court recently noted that there is evidence that calls Dr. Lappert's "bias and reliability [to testify regarding gender dysphoria] into

[13] In *Eknes-Tucker v. Marshall*, No. 2:22-CV-184-LCB, 2022 WL 1521889, at *5 (M.D. Ala. May 13, 2022), based on Dr. Cantor's lack of experience in providing this type of care, "the Court gave his testimony regarding the treatment of gender dysphoria in minors very little weight."

serious question" and that Dr. Lappert "is not qualified to render opinions about the diagnosis of gender dysphoria, its possible causes, … the efficacy of puberty blocking medication or hormone treatments, the appropriate standard of informed consent for mental health professionals or endocrinologists, or any opinion on [] non-surgical treatments," and that his views "do not justify the exclusion" of gender-affirming medical care.[14]

103. On June 17, 2022, AHCA issued a Notice of Proposed Rule seeking to amend Florida Administrative Code 59G-1.050 to prohibit Florida Medicaid from covering "services for the treatment of gender dysphoria," including: "1. Puberty blockers; 2. Hormones and hormone antagonists; 3. Sex reassignment surgeries; and 4. Any other procedures that alter primary or secondary sexual characteristics." The Proposed Rule also stated that, "For the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)," the aforementioned services "do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C."[15]

[14] *Kadel v. Folwell*, No. 1:19CV272, 2022 WL 3226731, at *12-13, 32 (M.D.N.C. Aug. 10, 2022).

[15] https://www.flrules.org/gateway/View_Notice.asp?id=25979915.

104. The Proposed Rule sought to prohibit Medicaid coverage of medical treatment for gender dysphoria for both transgender adolescents and adults, going beyond the FDOH Guidance.

105. During the 21 days following the issuance of the Proposed Rule, from June 17, 2022 to July 8, 2022, thousands of comments were submitted by individuals, organizations, and medical professionals across Florida in opposition to the rule.

106. On July 8, 2022, AHCA held a public hearing on the proposed rule.

107. The hearing, which was set for 3:00pm on a Friday afternoon, featured a "panel of doctors," none of whom had any clinical experience treating gender dysphoria, to respond to any substantive comments from the audience. The panel of doctors included: Dr. Andre Van Mol; Dr. Quentin Van Meter; and Dr. Miriam Grossman.

108. The panel highlighted AHCA's singular focus on prohibiting coverage of and access to medically necessary gender-affirming care.

109. Dr. Andre Van Mol is a board member of Moral Revolution (https://www.moralrevolution.com/), an organization that believes that "[t]he multitude of possible gender identities and the normalization of same-sex sexual behavior points to a society that has abandoned the desire to accurately define and socialize humanity as a reflection of God's image," and that "[s]ome people

experience same-sex attraction and gender dysphoria … not because they were 'born that way,' but because they were born human into a fallen world, and because society has disrupted and confused how we teach children who they are."

110. In reference to transgender youth, Dr. Miriam Grossman has stated that "conditioning children into believing that a lifetime of impersonating someone of the opposite sex, achievable only through chemical and surgical interventions, is harmful to youths."

111. The public hearing was also characterized by participants who were flown in from out of state, who did not profess to be Florida Medicaid participants, or who were opponents of transgender rights bussed in to testify in support of the rule. Many of them were carrying signs and shirts reflecting the "Let Kids Be Kids" slogan that appears on AHCA's webpage regarding the GAPMS Memo. AHCA allowed stickers containing their slogan to be passed out at the front door and at the sign-in table as attendees entered.

112. Notwithstanding the seemingly biased nature of the proceedings, thousands of commenters submitted written comments and many testified at the hearing in opposition to the Proposed Rule. The range of comments highlighted, among other things: the significant and immediate harms that transgender Medicaid beneficiaries in Florida would suffer; the flaws of the GAPMS Memo; the well-documented evidence base for gender-affirming care, including that it is safe and

effective for the treatment of gender dysphoria; and that the Proposed Rule was unlawful.

113. Among the comments submitted to Defendants in opposition to the Proposed Rule was a comment by a team of legal and medical experts from Yale Law School, the Yale School of Medicine's Child Study Center and Departments of Psychiatry and Pediatrics, University of Texas Southwestern, and University of Alabama at Birmingham that identifies and refutes the many unscientific claims behind the GAPMS Memo.[16]

114. The comment by the team of experts indicated that:

- **The GAPMS Memo falsely claims that the scientific evidence does not support medical treatment for gender dysphoria.** In fact, medical care for gender dysphoria is supported by a robust scientific consensus. The specific medical services at issue have been used worldwide for decades, meet generally accepted medical standards, and are not experimental.
- **The GAPMS Memo urges a discriminatory policy that violates the federal and state constitutions and federal and state law.** AHCA offered the report to justify the denial of Medicaid coverage for medical

[16] *Letter from Anne L. Alstott et al. to AHCA Secretary Marstiller* (July 8, 2022), https://perma.cc/E432-YUQ7.

care for gender dysphoria. But this discriminatory policy illegally targets transgender people. Neither the June 2 GAPMS Memo nor the AHCA proposal would apply to similar treatments routinely offered to cisgender people.

- **The GAPMS Memo repeatedly and erroneously dismisses solid medical research studies as "low quality," demonstrating a faulty understanding of statistics, medical regulation, and scientific research.** The GAPMS Memo makes unfounded criticisms of robust and well-regarded clinical research, while disregarding other relevant studies altogether. If Florida's Medicaid program applied the June 2 GAPMS Memo's approach to all medical procedures equally, it would have to deny coverage for widely used medications like statins (cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.
- **The GAPMS Memo cites sources that have no scientific merit.** The GAPMS Memo relies on pseudo-science, particularly purported expert "assessments" that are biased and full of errors. The "assessments" are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups. The GAPMS

Memo's unfounded claims come from unqualified sources, which include a blog entry, letters to the editor, and opinion pieces.

115. The comment by the team of experts was accompanied by the publication of a report, "A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria," that represents the first comprehensive examination of Florida's GAPMS Memo. The authors of this report contend that the GAPMS Memo is a misleading document intended to justify denying Florida Medicaid coverage for gender dysphoria treatment.[17]

116. In its comment, the American Academy of Pediatrics noted: "[T]he mental and physical health and well-being of transgender children and adolescents often rely on their abilities to access much needed mental and physical health care—care that is in keeping with the widely recognized evidence-based standards of care for gender dysphoria. In proposing this rule, Florida ignores broad consensus among the medical community as to what those evidence-based standards of care are, and instead seeks, for its own discriminatory reasons, to impose alternate standards and

[17] *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria* (July 8, 2022), https://perma.cc/XZV3-PBEA.

an outright ban of specific treatments for transgender adolescents in the state's Medicaid program."[18]

117. Similarly, the Endocrine Society submitted a comment stating: "The proposed rule would deny Medicaid beneficiaries with gender dysphoria access to medical interventions that alleviate suffering, are grounded in science, and are endorsed by the medical community. The medical treatments prohibited by the proposed rule can be a crucial part of treatment for people with gender dysphoria and necessary to preserve their health. … [R]esearch shows that people 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. In light of this evidence supporting the connection between lack of access to gender-affirming care and lifetime suicide risk, banning such care can put patients' lives at risk."[19]

118. In addition, interviews with researchers whose studies were cited within the FDOH Guidelines and GAPMS Memo have expressed alarm at how Defendants

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[18] *Letter from the American Academy of Pediatrics and the Florida Chapter of the AAP to AHCA Deputy Secretary Tom Wallace* (July 7, 2022), https://perma.cc/ND5M-TGYJ.

[19] *Letter from the Endocrine Society to AHCA* (July 8, 2022), https://perma.cc/F5TX-J3JY.

have misinterpreted and misrepresented their studies to justify the Challenged Exclusion.[20]

119. Notwithstanding the thousands of comments submitted to AHCA in opposition to the Proposed Rule, as well as the substantive evidence and extensive commentary submitted by leading medical and legal experts and organizations, Defendants filed the Challenged Exclusion as a final rule for adoption on August 1, 2022, a mere three weeks after the close of the public comment period and without having responded in writing to material or timely written comments, as required by Fla. Stat. § 120.54(3)(e)(4).

120. Notice of the Final Adopted Version of the Challenged Exclusion was published on FLRules.com on August 10, 2022 and stated that the Challenged Exclusion would become effective on August 21, 2022.[21]

121. The Challenged Exclusion, in its final adopted form within Florida Administrative Code 59G-1.050, states as follows:

> (7) Gender Dysphoria.
>
> (a) Florida Medicaid does not cover the following services for the treatment of gender dysphoria:

[20] Sam Greenspan, *How Florida Twisted Science to Deny Healthcare to Trans Kids*, VICE NEWS (Aug. 3, 2022), https://perma.cc/GZ6P-W2WN.

[21] https://www.flrules.org/gateway/View_Notice.asp?id=26157328.

1. Puberty blockers;

2. Hormones and hormone antagonists;

3. Sex reassignment surgeries; and

4. Any other procedures that alter primary or secondary sexual characteristics.

(b) For the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the services listed in subparagraph (7)(a) do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

122. Coverage for the four services listed within the Challenged Exclusion is still available when those services are medically necessary for the treatment of conditions other than gender dysphoria.

123. The Challenged Exclusion ignores the established scientific and medical consensus that the four specified services are frequently medically necessary, safe, and effective for treating gender dysphoria.

124. The Challenged Exclusion results in AHCA refusing to cover medically necessary treatments for gender dysphoria.

125. In addition, the Challenged Exclusion is one of a series of measures the State has taken targeting transgender people, and LGBTQ people more broadly, for discrimination.

126. For example, surrounding the GAPMS Memo's release and the adoption of the Challenged Exclusion:

a. The FDOH issued its factually inaccurate April 2022 guidelines titled "Treatment of Gender Dysphoria for Children and Adults";[22]

b. Florida enacted its infamous "Don't Say Gay" law, Fla. Stat. § 1001.42(8)(c) (2022);[23]

c. Governor DeSantis removed a state attorney from office for, in part, saying he would refuse to enforce any laws criminalizing gender-affirming care;[24]

d. The FDOH sent the Florida Board of Medicine ("FBOM") a "Petition to Initiate Rulemaking," asking it to, among other things, adopt a categorical ban on the provision of gender-affirming medical care to people under 18 years of age and, with respect to adults, to adopt a 24-hour waiting period;[25]

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[22] *Treatment of Gender Dysphoria for Children and Adults*, FLORIDA DEP'T OF HEALTH (April 20, 2022), https://perma.cc/W33H-6P5Q.

[23] Enacted July 1, 2022, the law seeks to erase LGBTQ people and related content from Florida public schools. The widely used "Don't Say Gay" moniker fails to recognize the harms this law intentionally inflicts upon transgender people and others who identify as members of the LGBTQ community.

[24] Florida Executive Order No. 22-176 (Aug. 4, 2022), https://perma.cc/VSG9-2SUJ.

[25] *Petition to Initiate Rulemaking Setting the Standard of Care for Treatment of Gender Dysphoria* (July 28, 2022), https://perma.cc/3PP7-N6WW.

e. The FBOM initiated a rulemaking process for a proposed rule to, among other things, ban gender-affirming care for people under the age of 18;[26]

f. The Florida Department of Business and Professional Regulation lodged a public nuisance complaint against a bar catering to transgender people when that bar had a drag queen reading event;[27] and

g. Florida officials and their spokespersons made a litany of statements denigrating transgender people.[28]

127. The discriminatory animus by Defendants toward transgender people is clearly evident by their actions, as the adoption of the Challenged Exclusion deliberately targets transgender people for discrimination in Florida.

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[26] *Meeting Minutes*, FLORIDA BOARD OF MED. (Aug. 5, 2022), https://perma.cc/52A3-2E5V.

[27] *Fla. Dep't of Bus. and Prof. Reg., Div. of Alcoholic Beverages and Tobacco v. R House, Inc.*, Case No. 2022-035976, Admin. Complaint (July 26, 2022), https://perma.cc/8DRL-KVWY.

[28] Jeremy Redfern (@JeremyRedfernFL), Twitter (Aug. 14, 2022), https://tinyurl.com/2p8vajvw; Governor Ron DeSantis (@GovRonDeSantis), Twitter (Aug. 16, 2022), https://tinyurl.com/yckkuh32; Christina Pushaw (@ChristinaPushaw), Twitter (Aug. 19, 2022), https://tinyurl.com/2p8r5r6c.

D. The Plaintiffs

Plaintiff August Dekker

128. August Dekker is a 28-year-old transgender man.

129. August is unemployed and receives Supplemental Security Income due to disability, as he lives with debilitating rheumatoid arthritis. He has been a Medicaid beneficiary in Florida since 2014.

130. August experiences and has been diagnosed with gender dysphoria.

131. As a child, even as early as 5 years of age, August felt uncomfortable being perceived as a girl. For example, he would always choose to play a male character when he was roleplaying with his brothers and would also play male characters when he would play "house."

132. Around the age of 13, August was extremely distraught when he got his first period. He ran to his mom crying and wondering what was happening because he did not feel that he was a girl.

133. However, because of his family's religious beliefs, August felt forced to suppress his gender identity as a child and adolescent, which caused him great distress and anxiety.

134. Once he graduated high school, August felt freer to explore his gender expression and come to terms with his gender identity as a man. By 2015, August began to socially transition and live openly as the man that he is.

135. Not long after, August decided to seek out medical care. It took him a while to find a provider who would be qualified and with whom he felt comfortable. Once he found a provider at Metro Inclusive Health in Tampa, August began working with a therapist before starting hormone therapy. The therapist diagnosed August with gender dysphoria in 2017.

136. Following the diagnosis of gender dysphoria and working with and under the care of his medical and mental health providers, August began undergoing hormone therapy as medically necessary treatment for his gender dysphoria in 2017.

137. August has since worked with different medical and mental health providers, who continue to recommend hormone therapy as medically necessary treatment for his gender dysphoria. He now sees a therapist at Solace Behavioral Health in Tampa and receives his hormone therapy through Planned Parenthood in Tampa.

138. At present, at the recommendation of his medical and mental health providers, August is being prescribed testosterone hormone therapy as treatment for his gender dysphoria. The prescription must be written every month. Up until now, Medicaid has covered August's testosterone hormone therapy.

139. In addition, in consultation with and under the care of his medical and mental health providers, August obtained chest surgery as treatment for his gender dysphoria in April 2022. This surgical treatment, which was covered by Medicaid,

was recommended by his providers as medically necessary treatment for August's gender dysphoria. And it was covered by Medicaid.

140. Medicaid has always covered August's medically necessary gender-affirming medical care as recommended by his medical and mental health providers to treat his gender dysphoria.

141. Being able to receive hormone therapy in the form of testosterone injections and to have chest surgery has allowed August to bring his body into alignment with who he is, provided a great deal of relief to August, and relieved some of the clinically significant distress underlying his gender dysphoria. It has given August the ability to not hate himself or his body and has brought great comfort to his life.

142. Having access to this medically necessary care has allowed August to be the version of himself that he pictured growing up. For August, it feels natural and normal to be able to live as the man that he is.

143. Following his chest surgery, August was able to celebrate his birthday with some friends outdoors in a state park. Having a more masculine chest that conformed with his identity allowed August to be shirtless in public for the first time ever, just like any other man. It was an afternoon full of joy and laughter for August, and he had never felt more euphoric about his body than he did in that moment.

144. AHCA's adoption of the Challenged Exclusion has caused August a great deal of distress and anxiety. When August first learned of the new regulation, he felt a great sense of dread. August is now fearful of the future.

145. August's only source of income is his monthly Supplemental Security Income payments of $841. He uses this limited income to pay for rent, food, and necessities, and simply cannot afford his medically necessary hormone therapy without Medicaid, which would cost $60-65 per month.

146. While August could ask some family and friends for money in order to afford his medically necessary care, that is neither guaranteed nor sustainable. It also feels dehumanizing and shameful to August to have to ask for help all the time, especially when his hormone therapy is medically necessary health care recommended by his doctors and which Medicaid has covered until now.

147. August also has experienced the physical effects of having to stop hormone therapy for a period of time. That experience caused him to lose muscle mass, have a higher pitched voice, and lose some of his body and facial hair such that it caused him distress and to a degree that people started perceiving him as a woman instead of the man that he is. It caused August great discomfort and anguish to be perceived as such, and he does not want to ever have to experience that again.

148. The adoption of the Challenged Exclusion, along with other actions taken by Florida's current administration targeting transgender people, have shaken

August and caused him to lose hope. August no longer feels safe to be an out transgender person in Florida. Because of the discrimination he sees stoked by Florida's policy decisions to target transgender people, August often worries that someone will perceive him as transgender and decide they want to hurt him. He is frightened about the possibility that losing access to his medically necessary gender-affirming care will cause physical changes that will make it more likely for someone to perceive him as transgender or more feminine. If someone perceives him as transgender or more feminine, August is afraid that they will verbally or physically assault him.

149. It is incredibly stressful and debilitating for August to have to worry about whether he will be able to get the medical care that he needs, or whether in its absence, he will be incorrectly perceived as female.

150. The Challenged Exclusion threatens the health and wellbeing of transgender Medicaid beneficiaries like August.

Plaintiff Brit Rothstein

151. Brit Rothstein is a 20-year-old transgender man.

152. Brit is a junior in at the University of Central Florida (UCF), where he is studying digital media and minoring in information technology. Brit has a full scholarship to attend UCF, which is the only way that he is able to go to college as his family is low-income and could not otherwise afford tuition and living expenses.

Brit worked hard to obtain a Florida Bright Futures scholarship so that he would be able to attend college. He also received a Top Ten Knights Scholarship from the UCF. In addition, Brit participates in a federal work study program, which provides part-time jobs for students with financial need, while taking 15 credits this semester.

153. Given his and his family's very limited income, as well as his age, Brit receives his health care coverage through Florida's Medicaid program, as administered through Sunshine Health.

154. A transgender man, Brit was incorrectly assigned the sex female at birth, but his gender identity is male.

155. Brit experiences gender dysphoria in relation to the disconnect between his sex assigned at birth and his gender identity.

156. Since the third grade, Brit has been aware of his male gender identity. When he was younger, Brit's mom would try to force him to wear dresses to church but he hated dresses and would only want to wear slacks. He also did not understand why he could not have short hair. Even as a child, stereotypical assumptions and expectations regarding his sex assigned at birth did not make sense to him.

157. In the sixth grade, as he approached puberty, Brit's anxiety and depression surrounding his sex assigned at birth was exacerbated, and he would become physically ill when he had to go into the girls' locker room for P.E. Fortunately, there was a guidance counselor who understood the discomfort that Brit

experienced in the locker room and the manifesting anxiety and distress it caused him, so she helped him transfer out of P.E.

158. While he was in the seventh grade, Brit was seeing a therapist due to unrelated issues. His therapist saw how much Brit was struggling with not being able to live his life as a boy and, through his sessions with his therapist, Brit became more comfortable with how he was feeling and came to understand that he was a boy. Brit's therapist also helped Brit navigate how to talk to others about his gender identity.

159. After a lot of research about how to explain to his family how he felt and that he was transgender, Brit came out to his dad in 2015, at age 13, and asked that he be treated in accordance with his male gender identity. Brit's parents are divorced, and he came out only to his dad at first. Brit's dad was very supportive and allowed Brit to wear a binder (a garment that helps to give the appearance of a flatter chest) at his house and live as his true authentic self when he was there.

160. Unfortunately, Brit was not able to do the same at his mother's house because she disapproved of him. For example, when Brit came out to his mother as transgender in 2016, she called him an "abomination" and disowned him. Brit has not had any contact with his mother or her side of the family since then.

161. Around July 2015, when Brit was 14 years old, Brit began seeing a psychologist, and continued therapy with her until he went to college. Brit's

psychologist diagnosed him with gender dysphoria and, after a couple of years of counseling, the psychologist referred Brit to Joe DiMaggio Children's Hospital to meet with a pediatric endocrinologist.

162. Because Brit's mother objected to the medical care for Brit's gender dysphoria recommended by Brit's mental health and medical providers, Brit's dad had to go to court, where he was granted by the court sole decision-making authority as it related to issues involving Brit's gender identity.

163. Thereafter, when Brit was 17 years old, he began to see a pediatric endocrinologist at Joe DiMaggio. By then, Brit had been diagnosed with gender dysphoria approximately four years prior and had been in consistent and regular counseling since that time. Brit was also living in accordance with his male gender identity to the maximum extent possible, given his family situation.

164. Brit's pediatric endocrinologist determined that it was medically necessary for Brit to begin hormone blockers, which she prescribed for him, and oversaw his treatment. Months later, Brit also began testosterone hormone therapy as medically necessary treatment for his gender dysphoria at his pediatric endocrinologist's recommendation. Medicaid has covered Brit's gender-affirming health care needs, including therapy, blood tests, office visits, and his prescriptions for hormone blockers and testosterone.

165. Hormone therapy, in the form of testosterone, has impacted Brit's life in many positive ways, including the changes to his physical body, his mental and emotional health, and even the self-confidence he has gained through existing in a body that feels more like his own.

166. When he was 18, Brit was able to obtain a court order for legal name change, changing his legal name to Brit Andrew Rothstein, which aligned with his gender identity and who he knows himself to be. Brit also amended his legal government-issued identification documents to reflect his new legal name and correct gender marker as male.

167. Still, however, Brit continues to experience significant dysphoria related to his chest. Ever since his chest developed, Brit has hated the way it looks and feels, and has long known that he needs to have chest surgery to bring his body into alignment with who he is.

168. Brit wears a binder almost every day, usually for 10-12 hours per day, depending on his schedule. His binder causes him discomfort, leaves skin indentations, and sometimes causes bruising on his ribcage. In 2018, Brit had to go to the emergency room for chest contusions caused by wearing his binder for too long. Having top surgery would allow Brit to no longer wear a restrictive binder just to navigate his daily life. Unfortunately, there are very few medical providers in

Florida who are both competent in performing gender-affirming chest surgery, and even fewer who also take Medicaid.

169. Brit finally found a surgeon at the University of Miami who accepts Medicaid for chest surgeries in January 2022. Brit had his consultation with the surgeon in May and the surgeon recommended that Brit undergo gender-affirming chest surgery, which was pre-authorized by Medicaid. When Brit received his pre-authorization on August 11, 2022, he felt blessed to finally have the chance to obtain the gender-affirming care he needed.

170. Brit was elated to learn that he would finally be getting the surgery that he needed and had long awaited, and he even had a date scheduled: December 22, 2022. For Brit, it would be an understatement to say that he was looking forward to the surgery. The surgery would allow Brit to bring his body into alignment with who he is. It would also eliminate the need for Brit to wear a restrictive and painful binder to hide that part of his body.

171. However, the very next day after Brit learned his surgery had been pre-authorized, Brit learned that AHCA adopted a rule that prohibited Medicaid coverage for Brit's medically necessary gender-affirming chest surgery. To Brit, it was a punch to the gut to learn that the state of Florida had decided to strip coverage for medically necessary medical care from him and other transgender Floridians on Medicaid. It was the highest of highs followed by the lowest of lows.

172. What is worse, without Medicaid, Brit cannot afford to pay for his testosterone prescription or for his surgery, which is still scheduled for December 22, 2022. Because of the Challenged Exclusion, Brit is unable to access to the medical care for his gender dysphoria that his medical providers have determined is medically necessary for his health and wellbeing.

173. Brit's family is also of very limited income, and he does not have family members who can pay for his care. Brit's dad is a single parent, who has arranged his entire life around being the sole-caretaker for Brit's twin sister, who lives with cerebral palsy and other disabilities. Brit's dad needs to have the same schedule as his sister because she requires around the clock care and attention. As such, Brit's has worked as a teachers' assistant for students with special education needs in the Broward County School District, a job which pays approximately $21,000 per year. Brit's dad is thus barely able to make ends meet and cannot afford to financially help Brit access the medical care he needs.

174. Brit has spent a long time fighting to become the man that he knows himself to be. He has overcome obstacles and worked hard to get an education and have access to the medical care his providers have deemed medically necessary to treat his gender dysphoria, yet Defendants have created an unnecessary additional barrier blocking Brit from the medical care that he needs, and which would allow him to feel like his body is in alignment with who he truly is.

175. Even though Brit is legally male in the eyes of the state and federal government, has testosterone circulating through his body, and has grown facial hair, Brit still lives in fear every day that he will be misperceived as female or perceived as transgender due to his chest.

176. In high school, Brit recognized how fortunate he was to have a supportive parent who loved him for who he is. Not everyone has that. There were multiple students at Brit's high school who attempted or died by suicide, so Brit decided that he needed to advocate for those who did not have the support that he had from his dad. As a result, Brit was invited to join the Broward County Superintendent's LGBTQ+ Advisory Council, and Brit was the President of his school's Gay/Straight Alliance (GSA) Club. Brit supported his fellow transgender classmates the best that he could, because Brit believes that everyone deserves to feel accepted for who they are.

177. For Brit, the State's decision to deny transgender people, like himself, of access to medically necessary health care and being treated differently than others solely for being transgender is unthinkable and wrong.

Plaintiff Susan Doe

178. Susan Doe is the daughter of Jane and John Doe.

179. Jane Doe is a full-time mom and homemaker. John Doe works for the federal government. He has worked there for 19 years.

180. Along with their two children, Jane and John live in Brevard County, Florida.

181. Jane and John adopted Susan, their 12-year-old daughter, out of medical foster care in Florida when she was 2 years old.

182. Susan is transgender.

183. When Jane and John adopted Susan out of foster care, Susan had several medical issues. She was originally placed in regular foster care and was then moved into the medical foster care program after an incident where she stopped breathing as an infant. At the time she came into the Does' care, she had severe acid reflux that needed treatment and was barely meeting developmental milestones.

184. Because Jane and John adopted Susan out of foster care, she is eligible for Medicaid coverage until she turns 18. Susan has thus been eligible for and enrolled in Florida's Medicaid program since she entered Florida's foster care system as an infant. Jane and John have kept Susan on Medicaid in order to ensure continuity of care with her existing providers and to ensure that her medical needs are properly met.

185. Although Susan was assigned male at birth, she has known that she is a girl from a very young age. When she was 3 years old, Susan first told her parents that she was a girl. Jane and John allowed Susan to explore her gender expression in deliberate and gradual steps. For example, Susan liked to wear ribbons in her hair

and pink bracelets to school, even when she still wore typical boy clothes and had not yet grown out her hair. Jane and John kept princess dresses for Susan at home, and she would often change into a dress as soon as she came home from school.

186. When Susan was in first grade, she became extremely unhappy with her assigned gender. Before that time, she had mostly been a very happy-go-lucky child, but starting in first grade she began getting angry and frustrated easily, and then would become incredibly sad, often crying for 20 minutes or more.

187. Jane and John consulted resources online and researched gender dysphoria in children, and as Susan's parents, had to acknowledge that the discrepancy between Susan's sex assigned at birth and how she felt inside was causing her to suffer.

188. The Does looked for a therapist for Susan. Ultimately, Susan and Jane were able to go to one session with a therapist when Susan was 6, and the therapist advised Jane on how to best support Susan. The therapist told Jane to keep listening to Susan and to allow her to express herself, as Jane and John had been doing. The therapist also suggested buying clothes from the girls' department that were gender neutral so Susan could wear them to school without attracting attention about her gender presentation.

189. Susan had her last short haircut when she was 6 years old, and when she saw how it looked, she started crying because she felt like the short haircut did not reflect her identity. After that, she started growing out her hair.

190. Around the same time, Jane found out that Susan had started to introduce herself to people with her chosen name, which has since become her legal name, and is more typically feminine.

191. During the summer of 2017, which was the summer before Susan started second grade, Susan told Jane and John unequivocally: "I need to be a girl." To ensure that they were properly supporting Susan, Jane and John took Susan to see a therapist as a family. The therapist diagnosed Susan with gender dysphoria. The therapist also made clear to the Does that Susan knows exactly who she is and that any problems stemmed from when people question Susan's identity. The therapist thus recommended Jane and John continue to support Susan in her social transition.

192. Following the therapist's advice, Jane and John followed Susan's lead and bought her more traditionally feminine clothes, including dresses and skirts to wear to school. Jane and John also worked with the principal and teachers at Susan's school to try to make sure that they used the appropriate name and pronouns for Susan. In addition, the therapist shared with Jane and John, and the Does in turn

shared with Susan's school, the latest research on helping children with gender dysphoria adjust well at school, in addition to in the home.

193. After Susan was able to socially transition and live in accordance with her firmly asserted female gender identity, Jane and John observed Susan feeling a sense of joy. Susan was happy and comfortable in her own skin.

194. In addition, the therapist further recommended that Susan see a pediatric endocrinologist, who could monitor her hormone levels for the onset of puberty and assist with any future medical needs.

195. Jane and John looked for a pediatric endocrinologist that was close to them, but ultimately began working with a pediatric endocrinologist at Joe DiMaggio Children's Hospital in south Florida. Susan has been seeing her pediatric endocrinologist since 2019. The Does drive three hours there and three hours back for every appointment. Initially, the pediatric endocrinologist closely monitored Susan's hormone levels to determine the onset of puberty. Susan had visits approximately every three months.

196. Jane and John have been very deliberate in their approach to supporting Susan. Their goal has always been to support their daughter while following the advice and recommendations of medical and health professionals experienced in dealing with gender identity and gender dysphoria.

197. In July 2020, after Susan began the onset of puberty, the pediatric endocrinologist started Susan on a puberty delaying medication called Lupron as medically necessary treatment for Susan's gender dysphoria. The medication, which Medicaid has been covering, prevents Susan from developing secondary sex characteristics consistent with male puberty. According to the pediatric endocrinologist, it is medically necessary for Susan to receive a Lupron injection every three months in order for her to live authentically in a manner consistent with her gender identity and to treat her gender dysphoria. By preventing the physical manifestations that accompany male puberty, Susan is also able to avoid negative social and emotional consequences associated with her being forced to develop the characteristics aligned with a gender with which she does not identify.

198. When Susan learned that the puberty delaying medication was necessary to suppress male puberty, she was happy at the prospect. There is nothing worse in Susan's mind than male puberty; she describes it as a "nightmare."

199. Susan's pediatric endocrinologist is currently monitoring Susan to determine when it would be medically appropriate for her to begin hormone therapy. Susan is very eager to go through female puberty. At this point, the pediatric endocrinologist thinks that Susan could be ready to start hormone therapy in a year or two.

200. In August 2021, the Does' therapist retired from her practice. In November 2021, Susan began seeing another therapist, who is a Licensed Clinical Social Worker. Like the first therapist, the second therapist diagnosed Susan with gender dysphoria. The second therapist has further supported Susan in managing the symptoms of her dysphoria.

201. In light of Defendants' adoption of the Challenged Exclusion, the Does understand that Florida's Medicaid program will no longer cover Lupron for Susan as treatment for her gender dysphoria. The Challenged Exclusion will also prohibit Medicaid from covering hormone therapy as treatment for Susan's gender dysphoria when Susan is ready to begin the treatment, per the medical guidance of her pediatric endocrinologist.

202. Susan is due to have her next Lupron injection on October 3, 2022. Due to the Challenged Exclusion, Medicaid will refuse to pay for the medically necessary Lupron injection when it is needed.

203. Jane and John worry about the potential physical and mental health consequences of depriving Susan of the medically necessary treatment recommended by her doctors. Not providing such treatment is not an option for them. For Jane and John, providing Susan with the medical treatment for gender dysphoria that she requires is necessary to ensure her health and well-being.

204. If Susan had to stop taking Lupron and go through male puberty as a result of the Challenged Exclusion, she would be devastated. Susan has been living as a girl in every aspect of her life since 2017. Her legal name was changed to her current affirmed name in 2018, and in 2020, her birth certificate was amended to reflect that she is female.

205. If Susan were no longer able to access the medical care that she needs to align her body with her gender identity, Susan's mental health would suffer tremendously. Susan would not want to leave the house, and Jane and John fear that she might engage in self-harm. Going through male puberty would be torture for Susan. It would also be agony for Jane and John to watch Susan suffer needlessly when this could be easily eliminated with what they understand to be effective medical care for treating their daughter's gender dysphoria.

206. Through their experience with Susan's medical treatment and extensive conversations with her medical providers over the past five years, Jane and John understand that gender-affirming treatment is medically necessary, safe, and effective treatment for Susan's gender dysphoria.

207. Unlike Susan, Jane and John receive their health coverage through John's employer-provided health plan.

208. While the Does can add Susan to John's health plan, they cannot do so until the open enrollment period near the end of the year, and Susan's coverage

would not start before January 1, 2023. Thus, given her need for her next Lupron shot in early October 2022, this is not a feasible solution.

209. In any event, as a child adopted out of foster care, Susan is entitled to have her medical needs covered by Medicaid and Jane and John should not have to move Susan to John's employer-provided health plan in order for her to continue receiving medically necessary care.

210. With Medicaid no longer covering Susan's Lupron treatment, Jane and John will have no choice but to try to pay for her upcoming three-month Lupron injection out of pocket. Based on their research, the retail price for a single Lupron shot is roughly $11,000. As the parents of two children with only one income, Jane and John do not have sufficient resources to provide this care without sacrifice. Jane and John would have to take on debt to pay for Susan's puberty delaying medication and it would be a hardship for them.

211. Even if the Does are able to add Susan to John's health plan, Susan's health care would be more expensive for them, as they would have a $300 annual deductible for Susan and higher cost-sharing for Susan's gender-affirming care. These are costs they did not have prior to the Challenged Exclusion due to Medicaid's coverage of the medical treatment for Susan's gender dysphoria.

212. Jane and John not only worry about the multitude of harms that would be imposed on their family by the Challenged Exclusion, but also about the effect that Defendants' actions will have on other transgender people and their families.

213. The Does have begun considering moving out of state in order to protect their daughter from state-sponsored discrimination. Jane and John do not wish to move if it can be avoided, as, among other things, it could mean John having to switch jobs and separating Susan and their son from their long-term health care providers, friends, and family. That said, the health and wellbeing of their adolescent children are paramount to them.

214. The Does consider Defendants' decision to stop covering medically necessary gender-affirming medical care through Medicaid to be tragic and dehumanizing. They are concerned about the message the State of Florida is sending by excluding transgender people from Medicaid coverage to which they otherwise would be entitled simply because they are transgender.

215. Jane and John keep in touch with other families in the LGBTQ+ affirming foster care community and are concerned for the ability of some children to find foster and adoptive families because of the state's hostility toward LGBTQ+ people and concerns about being able to meet the health care needs of those children through Medicaid.

Plaintiff K.F.

216. K.F. is the 12-year-old son of Jade Ladue and stepson of Joshua Ladue.

217. Joshua has raised K.F. since he was three years old and K.F. considers and calls Joshua "dad."

218. Jade is a patient coordinator at a dental office, while Joshua receives Social Security Disability Insurance because he is diagnosed with venous malformation, a type of vascular condition that results from the veins in his leg having developed abnormally.

219. K.F., Jade, and Joshua all live in Sarasota County along with K.F.'s four siblings, ranging in age from five to sixteen years old. They moved to Florida from Massachusetts as a family in August 2020.

220. K.F. is transgender.

221. Because of K.F.'s age and the Ladue family's income, he is eligible for Medicaid. He has been eligible for and enrolled in the program since he and his family moved to Florida. Prior to the Ladue family's move, K.F. was enrolled in Massachusetts's Medicaid program.

222. Although K.F. was assigned female at birth, he has known he was a boy from a very young age. When he was 7 years old, he came out to his grandparents during a camping trip, telling them that he has known since he was four years old that he is a boy and was born in the wrong body. In looking back on K.F.'s

childhood, both Jade and Joshua see that K.F. was showing them that he was a boy well before that conversation K.F. had with his grandparents. K.F. always wanted to wear traditional boy clothes (no dresses or skirts), insisted on his hair being kept short, and loved to play shirtless with other boys in their neighborhood.

223. K.F. has never wavered about his gender identity.

224. As with all of their children before their pre-teen years, Joshua and Jade established strict limitations on K.F.'s consumption of television, movies, videos, and video games. At the age of seven, when K.F. came out as transgender, he had never heard of the concept of gender dysphoria, or transgender people, beyond his own experience, which he described first to his grandparents, and then to Jade and Joshua, as simply "being a boy."

225. After K.F. confided in his parents, Jade decided the next best step would be to locate a therapist who specializes in gender dysphoria. Soon after, K.F. had his first appointment with a Licensed Mental Health Counselor. After thorough evaluation, the therapist was the first to diagnose K.F. with gender dysphoria and made sure that Jade and Joshua understood K.F.'s diagnosis and walked them carefully through what they should expect as K.F. got older.

226. After K.F. began therapy, Jade joined a local PFLAG group, an organization which is dedicated to supporting, educating, and advocating for

LGBTQ+ people and their families. She joined the group because it was important to her and Joshua that they demonstrate to K.F. their commitment to supporting him.

227. K.F. was living fully in accordance with his male gender identity in every aspect of his home life and he wanted to be treated accordingly at school. Thus, when K.F. entered the second grade, K.F.'s therapist helped facilitate a meeting between Jade and his school administrators and teachers to talk about K.F.'s gender identity and what actions the school should take to ensure he was fully affirmed and supported as a boy with his classmates in the school environment.

228. Once K.F.'s licensed mental health provider gave her professional recommendation that it was appropriate for K.F. to begin seeing a pediatric endocrinologist, she referred K.F. to the Gender Multispecialty Service (GeMS) Program at Boston Children's Hospital, the first pediatric and adolescent transgender health program in the United States. K.F. had his first appointment with the GeMS Program on September 13, 2015. That first appointment was incredibly thorough, lasting over two hours, and was overall a very happy occasion. It was clear to Jade that K.F. would be receiving the best possible care and the team of providers confirmed everything that K.F.'s therapist had told them: that K.F. is a transgender boy and that his parents and extended family supporting him in his affirmation of his male gender identity was the best decision for his health and well-being.

229. GeMS continued K.F.'s therapy and started him with pediatric nurse practitioner. The nurse practitioner's role was to monitor K.F.'s hormone levels for the onset of puberty and assist with any future gender-affirming health care needs. K.F.'s care with GeMS continued until the family moved to Florida in August 2020.

230. Before the Ladue family moved, in the summer of 2020, K.F.'s medical providers determined that based on the onset of K.F.'s puberty, it was medically necessary for K.F. to receive his first puberty delaying medication. At the recommendation of K.F.'s medical providers, K.F. received a Supprelin implant, a form of puberty delaying medication which would prevent the onset of secondary sex characteristics typical of girls and women. K.F. received the implant on August 8, 2020, and it was fully covered by Massachusetts' Medicaid program.

231. According to K.F.'s former and current medical providers, it is medically necessary for K.F. to receive puberty delaying medication so that K.F. can live authentically in a manner consistent with his gender identity and to treat his gender dysphoria. By preventing the physical manifestations that would accompany the puberty of his sex assigned at birth, K.F. is also able to avoid negative social and emotional consequences associated with his being forced to develop secondary sex characteristics that do not align with his male gender identity.

232. As his parent, it is also important to Jade and Joshua that K.F. be able to choose with whom to disclose this deeply personal, private information about

himself. Because of the puberty delaying medication, K.F. has that option, and the inherent protection and privacy that it provides.

233. When Jade and Joshua decided to move their family to Florida, Jade researched programs in the state that offered the same or similar level of care afforded by GeMS. Finding a program that offers high quality gender-affirming care and that accepts Medicaid can be challenging. Fortunately, through that research, Jade found the Emerge Gender & Sexuality Clinic for Children, Adolescents and Young Adults based at Johns Hopkins All Children's Hospital (Johns Hopkins Gender Clinic) located in St. Petersburg, Florida.

234. Once they moved, K.F. initiated care with a doctoral-level pediatric nurse practitioner specializing in endocrinology at the Johns Hopkins Gender Clinic. In April 2022, K.F. received his second Supprelin implant which was fully covered by his Florida Medicaid plan.

235. K.F. typically visits the Johns Hopkins Gender Clinic every six months. Recently, however, K.F. has had more frequent visits because his medical provider is monitoring whether K.F.'s second implant is adequately suppressing puberty and there is a possibility that K.F. may need a different type of puberty delaying medication to suppress puberty and successfully continue his medical transition. K.F. has another appointment scheduled at the end of October 2022 to check in with K.F.'s medical provider.

236. K.F. is adamant that he does not want breasts and would eventually like to have facial hair and muscles. The idea of developing typically female secondary sex characteristics makes K.F. extremely anxious; he prays every night that his puberty delaying medication will be successful. Since K.F. came to understand and express the dysphoria he experienced resulting from his sex assigned at birth at an early age, Jade and Joshua were able to get him the mental health and medical treatment that was necessary, and as a result K.F. is perceived as and accepted by other people as male and very few people know he is transgender. Developing secondary sex characteristics typically associated with girls and women, instead of those aligned with his male gender identity, would be tremendously emotionally and physically painful for K.F.

237. In the event K.F.'s current implant is not effective, and because Florida Medicaid now excludes coverage of puberty delaying medication when used to treat gender dysphoria, the Ladues would have to pay out of pocket for Lupron Depot shots, the treatment K.F.'s medical provider has indicated would be the next step for K.F. Those monthly shots would cost between $1,000 to $2,000 per shot out of pocket. The Ladue family has limited income, and they are very worried because they would not be able to afford these treatments without Medicaid coverage.

238. K.F.'s medical providers have also told the Ladues that likely within the next year, when K.F. is fourteen years old, that it will be medically indicated for

him to begin hormone therapy (testosterone) at a dose appropriate to his age and body composition. K.F. is very excited about starting testosterone therapy. K.F. usually hates receiving shots but he told Jade he would be happy to take a monthly shot if it meant that he would experience the male puberty that is aligned with his gender identity, such as his voice deepening and growing facial hair.

239. Jade and Joshua are so grateful that K.F. was confident enough and felt safe to come out to them at such a young age. His identifying his gender dysphoria at a young age combined with a loving and supportive immediate and extended family means that they were able to ensure that K.F. received the health care appropriate for him as soon as possible. As a result, his gender dysphoria has been well managed.

240. While K.F. has always dealt with anxiety, before he came out, it was much worse. He experienced what Jade would describe as "night terrors" and had a persistent stomachache. The Ladues would get calls from K.F.'s school that he was not doing well and was often in the nurse's office. The Ladues went to doctors to determine the source of K.F.'s distress, but no one could identify what was causing the problem. After he had firmly established gender-affirming care with GeMS, K.F. became a completely different child; it was like night and day. He had a smile on his face, a light in his eye, and even a glow about him. His performance and

attendance in school improved, as did his peer relationships. Like any parent, Jade and Joshua were relieved to see their child happy and thriving.

241. K.F. has also begun the process of legal transition. He has legally changed his name and the family is currently in the process of having his gender marker changed on his birth certificate and records with the Social Security Administration.

242. Under the Challenged Exclusion, Medicaid will no longer cover puberty delaying medications for K.F. as treatment for his gender dysphoria. The Challenged Exclusion will also prohibit Medicaid from covering hormone therapy as a medically necessary treatment for K.F.'s gender dysphoria when K.F., pursuant to the medical expertise and recommendations of his physicians, is ready to begin that treatment.

243. Jade and Joshua are incredibly worried about the potential physical and mental health consequences of depriving K.F. the medically necessary treatment recommended by his health care providers. K.F. has been living as a boy in every aspect of his life--medically, legally, and socially--since 2016.

244. If he were no longer able to access the medication that aligns his body with his gender identity, K.F.'s mental health would suffer tremendously, and he would be devastated. Jade and Joshua fear that K.F., and the whole family with him, would go down a dark and scary road fast. For example, they fear that K.F. would

not leave his bedroom and he would refuse to go to school, or that he would cut off his communications with his friends, teammates, and teachers. Given how much his gender-affirming care has improved his life and mental health, Jade and Joshua can only assume that reversing that course of treatment would result in the unthinkable happening.

245. Because of these concerns, K.F. going without treatment is simply not an option for the Ladue family. They believe providing K.F. with the medical treatment for gender dysphoria that he requires is necessary to ensure his health and well-being.

246. The Ladue family is under 138% of the federal poverty limit; that is why their children, including K.F., qualify for Florida's Medicaid program. Whether it be paying for a different puberty delaying medication if K.F.'s provider determines the current implant is not working or beginning K.F.'s course of hormone therapy in the next year, the Ladue family simply does not have sufficient resources to provide K.F. the gender-affirming care he requires. They simply could not pay out of pocket for the cost of K.F.'s care.

247. Joshua receives his health insurance through Medicare. He cannot add K.F. to his health insurance. Jade has access to health care coverage for family members because of her job, but the cost of adding K.F. is unaffordable for their family.

248. While Florida is their home, ultimately, the Ladue family will be forced to move if necessary to protect their son's access to medication that is necessary for his health and well-being. Doing so would mean Jade would have to find a new job, Joshua would have to establish his Social Security payment through a new field office, and the kids would be uprooted and forced to start at new schools and make new friends.

249. In addition, the Ladues are Christian and just joined a church that they attend every Sunday. So far, they have felt very welcome and would be sad to break a tie with this faith community and the other communities and relationships they have established in South Florida.

250. For K.F., this would be a particularly difficult and painful transition. K.F. is doing well academically, socially, and athletically. He is on the golf team at his school and he is looking forward to upcoming tryouts out for the basketball team in their town. It is awful for Jade and Joshua to even think that K.F. would have to end this participation and leave his teammates because Florida refuses to provide him with coverage for the medical treatment that he needs to live and thrive, medical treatment that is available to many other cisgender young people, simply because K.F. is transgender.

CLAIMS FOR RELIEF

COUNT I
Deprivation of Equal Protection in Violation of the Fourteenth Amendment of the U.S. Constitution

(All Plaintiffs Against Defendant Simone Marstiller)

251. Plaintiffs reallege and incorporate by reference paragraphs 1 to 250 of this Complaint as though fully set forth herein.

252. The Fourteenth Amendment to the United States Constitution, enforceable pursuant to 42 U.S.C. § 1983, provides that no state shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. Amend. XIV, § 1.

253. Plaintiffs state this cause of action against Defendant Marstiller, in her official capacity, for purposes of seeking declaratory and injunctive relief, and to challenge her adoption and enforcement of the discriminatory Exclusion both facially and as applied to Plaintiffs.

254. Defendant Marstiller is a person acting under color of state law for purposes of 42 U.S.C. § 1983 and has acted intentionally in denying Plaintiffs equal protection of the law.

255. Under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, discrimination based on sex is presumptively unconstitutional and subject to heightened scrutiny.

256. Discrimination on the basis of nonconformity with sex stereotypes, transgender status, gender, gender identity, gender transition, and sex characteristics are all forms of discrimination on the basis of sex.

257. A person is defined as transgender precisely because of the perception that they contradict gender stereotypes associated with the sex they were assigned at birth. When a transgender person affirms their authentic gender, it inherently contradicts standard gender stereotypes expected of the individual based on their sex assigned at birth.

258. In addition, under the Equal Protection Clause of the Fourteenth Amendment, discrimination based on transgender status is presumptively unconstitutional and subject to strict, or at least heightened, scrutiny. Indeed, transgender people have suffered a long history of discrimination in Florida and across the country and continue to suffer such discrimination to this day; they are a discrete and insular group and lack the political power to protect their rights through the legislative process; they have largely been unable to secure explicit state and federal protections to protect them against discrimination; their transgender status bears no relation to their ability to contribute to society; and gender identity is a core, defining trait so fundamental to one's identity and conscience that a person cannot be required to abandon it as a condition of equal treatment.

259. By adopting and enforcing the Challenged Exclusion categorically excluding "services for the treatment of *gender* dysphoria," including "*[s]ex* reassignment surgeries" and any "procedures that alter primary or secondary *sexual* characteristics," Defendant Marstiller is engaging in constitutionally impermissible discrimination based on sex, including, *inter alia*, discrimination based on nonconformity with sex stereotypes and transgender status.

260. Through her duties and actions to design, administer, and implement the Challenged Exclusion, Defendant Marstiller has unlawfully discriminated—and continues to unlawfully discriminate—against Plaintiffs based on sex-related considerations.

261. The Challenged Exclusion treats Plaintiffs differently from other persons who are similarly situated.

262. Under the Challenged Exclusion, transgender Medicaid beneficiaries who require gender-affirming care are denied coverage for that medically necessary care, while other Medicaid participants can access the same care as long as it is not required for the treatment of gender dysphoria, i.e., gender transition.

263. The Challenged Exclusion on its face and as applied to Plaintiffs deprives transgender Medicaid beneficiaries of their right to equal protection of the laws and stigmatizes them as second-class citizens, in violation of the Equal Protection Clause of the Fourteenth Amendment.

264. Defendants' promulgation and continued enforcement of the Challenged Exclusion did not, and does not, serve any rational, legitimate, important, or compelling state interest. Rather, the Challenged Exclusion serves only to prevent Plaintiffs and other transgender Medicaid beneficiaries from obtaining medically necessary medical care and services to treat their gender dysphoria, complete their gender transition, and live as their authentic selves.

265. As a direct and proximate result of the discrimination described above, Plaintiffs have suffered injury and damages, including mental pain and suffering and emotional distress. Without injunctive relief from Defendants' discriminatory Challenged Exclusion of coverage for gender-affirming care, Plaintiffs will continue to suffer irreparable harm in the future.

COUNT II
Discrimination on the Basis of Sex in Violation of Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116
(All Plaintiffs Against AHCA)

266. Plaintiffs reallege and incorporate by reference paragraphs 1 to 250 of this Complaint as though fully set forth herein.

267. Section 1557 of the ACA, 42 U.S.C. § 18116, provides, in relevant part that, "an individual shall not, on the ground prohibited under … title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681, et seq.)"—which prohibits discrimination "on the basis of sex"—"be excluded from participation in, be denied

the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance."

268. Discrimination on the basis of nonconformity with sex stereotypes, transgender status, gender, gender identity, gender transition, and sex characteristics are all forms of discrimination encompassed by the prohibition of discrimination on the basis of sex under Section 1557.

269. Defendant AHCA receives federal financial assistance such that it is a "covered entity" for purposes of Section 1557 of the ACA. The Centers for Medicare & Medicaid Services ("CMS"), operating within HHS, provide federal financial assistance to AHCA for the state's participation in the Medicaid program. Indeed, Defendant AHCA has a published Notice of Nondiscrimination Policy on its website, stating that the "This Notice is provided as required by … Section 1557 of the Affordable Care Act and implementing regulations."

270. A covered entity, such as Defendant AHCA, cannot provide or administer health care coverage which contains a categorical exclusion of coverage for gender-affirming health care, or otherwise impose limitations or restrictions on coverage for specific health services related to gender transition if such limitation or restriction results in discrimination on the basis of sex.

271. Plaintiffs have a right under Section 1557 to receive Medicaid coverage through AHCA free from discrimination on the basis of sex, sex characteristics, gender, nonconformity with sex stereotypes, transgender status, or gender transition.

272. By categorically excluding "services for the treatment of *gender* dysphoria," including "*[s]ex* reassignment surgeries" and any "procedures that alter primary or secondary *sexual* characteristics," Defendant AHCA has discriminated against Plaintiffs on the basis of sex in violation of Section 1557 and has thereby denied Plaintiffs the full and equal participation in, benefits of, and right to be free from discrimination in a health program or activity.

273. As a result of the Challenged Exclusion, Plaintiffs have and will continue to suffer harm. By knowingly and intentionally offering coverage to Plaintiffs that discriminates on the basis of sex, Defendant AHCA has intentionally violated the ACA, for which Plaintiffs are entitled to injunctive relief, compensatory and consequential damages, and other relief.

274. Without injunctive relief from Defendants' discriminatory Challenged Exclusion of coverage for gender-affirming care, Plaintiffs will continue to suffer irreparable harm in the future.

COUNT III
Violation of the Medicaid Act's EPSDT Requirements,
42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5)
(Plaintiffs Brit Rothstein, Susan Doe, and K.F. Against Defendant Marstiller)

275. Plaintiffs reallege and incorporate by reference paragraphs 1 to 250 of this Complaint as though fully set forth herein.

276. The Medicaid Act mandates that states provide Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") services, which include all services necessary to "correct or ameliorate" a physical or mental health condition, to Medicaid beneficiaries under age 21. 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), 1396d(r)(5).

277. The Challenged Exclusion, and Defendants' refusal, based on the Challenged Exclusion, to provide coverage for services for the treatment of gender dysphoria to Plaintiffs Brit Rothstein, Susan Doe, and K.F., and transgender Medicaid beneficiaries under age 21, violates the Medicaid Act's EPSDT requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5), which are enforceable by Plaintiffs under 42 U.S.C. § 1983.

COUNT IV
Violation of the Medicaid Act's Comparability Requirements,
42 U.S.C. § 1396a(a)(10)(B)(i)

(All Plaintiffs Against Defendant Marstiller)

278. Plaintiffs reallege and incorporate by reference paragraphs 1 to 250 of this Complaint as though fully set forth herein.

279. The Medicaid Act's Comparability Requirements, 42 U.S.C. § 1396a(a)(10)(B)(i), require that the "medical assistance made available to [eligible individuals] shall not be less in amount, duration, or scope than the medical assistance made available to" other eligible individuals.

280. The Challenged Exclusion, and Defendants' refusal, based on the Challenged Exclusion, to provide coverage for services for the treatment of gender dysphoria to Plaintiffs and other transgender Medicaid beneficiaries, while covering the same services for other Florida Medicaid beneficiaries with different diagnoses, violate the Medicaid Act's Comparability Requirements, 42 U.S.C. § 1396a(a)(10)(B)(i), which is enforceable by Plaintiffs under 42 U.S.C. § 1983.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court enter judgment in their favor and against Defendants on all claims, as follows:

A. Issue preliminary and permanent injunctions prohibiting Defendants from any further enforcement or application of the Challenged Exclusion and directing Defendants and their agents to provide Medicaid coverage for the medically necessary care for the treatment of gender dysphoria without regard to the Challenged Exclusion;

B. Enter a declaratory judgment that the Challenged Exclusion, which categorically excludes coverage for medically necessary care for the treatment of gender dysphoria, both on its face and as applied to Plaintiffs:

i. Violates the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution by discriminating against Plaintiffs and all similarly situated individuals on the basis of sex, including transgender status, nonconformity with sex stereotypes, sex characteristics, gender, gender identity, sex assigned at birth, and gender transition;

ii. Violates Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116, by discriminating against Plaintiffs and all similarly situated individuals on the basis of sex (including transgender status, nonconformity with sex stereotypes, sex characteristics, gender, gender identity, sex assigned at birth, and gender transition);

iii. Violates the Medicaid Act's EPSDT Requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(C), 1396d(a)(4)(B), and 1396d(r)(5); and

iv. Violates the Medicaid Act's Comparability Requirements, 42 U.S.C. § 1396a(a)(10)(B)(i);

C. Waive the requirement for the posting of a bond of security for the entry of temporary and preliminary relief;

D. Award the declaratory and injunctive relief requested in this action against Defendants' officers, agents, servants, employees, and attorneys, as well as any other persons who are in active concert or participation with them;

E. Award compensatory and consequential damages to Plaintiffs in an amount that would fully compensate each of them for: (1) the harms to their short- and long-term health and well-being from being denied access to medically necessary health care as a result of the Challenged Exclusion and its application to them; (2) their economic losses; and (3) all other injuries that have been caused by Defendants' acts and omissions alleged in this Complaint;

F. Award Plaintiffs their reasonable attorneys' fees, costs, and expenses under 42 U.S.C. § 1988 or other applicable statutes; and

G. Award such other and further relief as the Court may deem just and proper.

* * * * *

Respectfully submitted this 7th day of September 2022.

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** Application for admission pro hac vice forthcoming.*
*** Application for admission to the Northern District Court forthcoming.*

Lambda Legal
making the case for equality

House Bill 454 – WRITTEN-ONLY OPPONENT TESTIMONY

November 14, 2022

Rep. Susan Manchester, Chair
Rep. Al Cutrona, Vice-Chair
Rep. Sedrick Denson, Ranking Member
Members of the Families, Aging, and Human Services Committee

Ohio House of Representatives
77 S. High St. #12
Columbus, OH 43215

Re: House Bill 454, the Save Adolescents from Experimentation Act – WRITTEN-ONLY OPPONENT TESTIMONY

Chair Manchester, Vice-Chair Cutrona, Ranking Member Denson, and Members of the Families, Aging, and Human Services Committee:

Lambda Legal Defense and Education Fund respectfully submits the following written comments in opposition to H.B. 454, the "Save Adolescents from Experimentation Act." Founded in 1973, Lambda Legal is the oldest and largest national legal organization dedicated to achieving full recognition of the civil rights of lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people and people living with HIV through impact litigation, education, and public policy work. Lambda Legal's Midwestern Regional Office in Chicago leads cases in the Midwest, including in Ohio and the rest of the nation concerning issues of anti-LGBTQ and HIV discrimination in all areas of law including health care, identity documents, employment discrimination, students' rights, family law, and marriage equality.

We write to express our deep concern and opposition to H.B 454 which harmfully and unlawfully targets some of Ohio's most vulnerable young people by categorically banning clinically effective and lifesaving health care treatment, disincentivizing health care providers from providing such care in the absence of liability insurance coverage, and interferes with the relationships between school counselors and vulnerable students by forcing counselors and educators to "out" transgender students to their parents. If enacted, the legislation would cause serious, immediate, and irreparable harm to transgender youth, who already experience well-documented stigma and discrimination, and who already experience significant challenges when seeking competent gender affirming health care services.[1]

We urge you to be guided by well-established science, and not stigma, when advancing public policy. Underlying H.B. 454 is the dangerous and incorrect assumption that treatment for gender

[1] *See* Centers for Disease Control and Prevention, Resilience and Transgender Youth, *available at* https://www.cdc.gov/healthyyouth/disparities/ryt.htm

dysphoria is not clinically effective or medically necessary for transgender children, an assumption roundly contradicted by peer-reviewed science and medicine. The American Academy of Pediatrics ("AAP"), comprised of over 67,000 pediatricians committed to the well-being of children and young adults, has long supported affirming care for transgender children.[2] In addition, the AAP has expressly opposed legislation like H.B. 454 and "recommends that youth who identify as transgender have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space."[3]

Likewise, the Endocrine Society, which establishes the Clinical Practice Guidelines[4] for transgender care, opposes legislative efforts to exclude such care, and has emphasized the importance of transgender people having access to appropriate treatment and care to ensure their health and well-being and that the "diagnosis and treatment of transgender individuals should be based on science, not politics."[5] In addition, many medical organizations have examined the science and have recognized the clinical effectiveness and medical necessity for gender affirming care for gender dysphoria, including the American Medical Association (AMA), the American Psychiatric Association and the American Psychological Association.[6] In an April 26, 2021 letter to the National Governors Association, the AMA urged governors to oppose legislation like H.B. 454, citing evidence that "trans and non-binary gender identities are normal variations of human identity and expression," and that the failure to provide "gender-affirming care can have tragic health consequences, both mental and physical."[7]

Scientific research demonstrates that care for gender dysphoria improves the well-being of transgender people, including children.[8] Such research shows that supporting transgender youth in living according to their internal sense of gender is associated with better mental health and

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[2] Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, Pediatrics (Oct. 2018), *available at* https://pediatrics.aappublications.org/content/142/4/e20182162

[3] American Academy of Pediatrics, *American Academy of Pediatrics Speaks Out Against Bills Harming Transgender Youth*, *available at* https://services.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-speaks-out-against-bills-harming-transgender-youth/.

[4] Wylie C. Hembree, *Endocrine Treatment of Gender-Dysphoric/Gender-Icongruent Persons: An Endocrine Society*, Clinical Practice Guidelines, https://academic.oup.com/jcem/article/102/11/3869/4157558.

[5] Endocrine Society, *Endocrine Society Urges Policymakers to Follow Science on Transgender Health*, (Oct. 28, 2019), *available at* https://www.endocrine.org/news-and-advocacy/news-room/2019/transgender-custody-statement.

[6] Transgender Legal Defense & Education Fund, Medical Organization Statements, *available at* https://transhealthproject.org/resources/medical-organization-statements/.

[7] See American Medical Association, "AMA to states: Stop interfering in health care of transgender children," *available at* https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children.

[8] Cornell University, *What Does the Scholarly Research say about the effect of gender transition on transgender well-being? available at* https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/

that efforts to change the gender identity of transgender people are associated with suicidality.[9] Not only would H.B. 454 interfere with the ability of transgender students to be supported by appropriate mental health treatment, it would destroy the trust that is crucial to their relationships with school counselors and educators by forcing those counselors and educators to betray the confidences of the very students most at risk of harm. Put simply, H.B. 454 is contrary to well-settled medical standards of care.

The legislation also violates the Constitution. H.B. 454 deprives transgender youth of treatment available to other Ohio residents simply because they are transgender. In fact, the legislation takes great pains to clarify that the same exact treatments should be provided for other serious medical conditions but treats differently – that is, discriminates against – transgender children.[10] The legislation would prevent medical providers from administering proven and lifesaving care to their transgender patients, even where those providers would be able to provide the same exact care for other patients. Singling out transgender people for such unequal treatment violates the Equal Protection Clause of the Constitution.[11]

The Equal Protection Clause prohibits state entities from advancing legislation intended to target a specific population.[12] Discrimination based on transgender status triggers heightened scrutiny under the Equal Protection Clause.[13] Transgender children are the only people who need such treatments to treat gender dysphoria and they will be the only class of people harmed by the legislation.[14] Moreover, the section of the bill setting out exceptions for certain categories of care for intersex or cisgender people makes explicit that this is its intended purpose as well as its

[9] Turban, J. L., King, D., Reisner, S. L., & Keuroghlian, A. S. (2019) *Psychological attempts to change a person's gender identity from transgender to cisgender: Estimated prevalence across US States, 2015*. American Journal of Public Health, 109, 1452-1454. https://doi.org/10.2105/AJPH.2019.305237.

[10] *See* H.B. 454, Section 3129.03, setting out exceptions for certain categories of care when performed on intersex people or to treat a medical concern other than gender dysphoria.

[11] See *Carcano v. Cooper*, 350 F. Supp. 3d 388 (M.D.N.C. 2018) (finding that HB2 in North Carolina was enacted with discriminatory intent). *See also Evancho v. Pine-Richland Sch. Dist*., 237 F. Supp. 3d 267 (W.D. Pa. 2017) (enjoining school district's policy of targeting transgender students regarding facilities access).

[12] See *Romer v. Evans*, 517 U.S. 620, 632 (1996) (declaring unconstitutional a law designed solely to deny LGB people protections under the law).

[13] *See Karnoski v. Trump*, 926 F.3d 1180 (9th Cir. 2019); *Evancho v. Pine-Richland Sch. Dist*., 237 F. Supp. 3d 267, 287 (W.D. Pa. 2017). *See also Bostock v. Clayton County, Georgia,* 140 S. Ct. 1731, 1749 (2020) (discrimination based on transgender status is sex discrimination); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011) (same).

[14] *See Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270, 113 S. Ct. 753, 760 (1993) ("Some activities may be such an irrational object of disfavor that, if they are targeted, and if they also happen to be engaged in exclusively or predominantly by a particular class of people, an intent to disfavor that class can readily be presumed. A tax on wearing yarmulkes is a tax on Jews.")

obvious effect. Under any standard of constitutional review, given the governing medical standards for young people with gender dysphoria, the bill would be indefensible in court.[15]

In addition, the legislation also infringes upon other constitutional rights of transgender youth and their parents and guardians by denying young people the ability to transition when their health care providers advise that course of care, and by eliminating their parents' right to care for their children without undue, medically contraindicated interference from the state.[16]

Indeed, two similar laws enacted by the states of Arkansas and Alabama have both already been enjoined by federal courts, and the only federal Court of Appeals to rule on such state laws has upheld a ruling enjoining the law in question. In invalidating the Arkansas law, a federal district court held that it violated the Equal Protection and Due Process clauses of the Fourteenth Amendment and the First Amendment.[17] That court found that the State's goal "was not to ban a treatment. It was to ban an outcome that the State deems undesirable."[18] In August, the Court of Appeals for the Eighth Circuit upheld the lower court's injunction of the Arkansas law.[19] Separately, in May, a federal district court in Alabama invalidated a similar Alabama law,[20] also on Equal Protection and Due Process grounds.[21]

H.B. 454 flouts science and medicine and invites harm to all trans youth, and invites the contentiousness and expense of litigation for the state, merely to inscribe discrimination into statute—at least until the courts enjoin it—with no persuasive justification. It is important for elected leaders to uphold the statutory and constitutional guarantees that protect everyone in this State, especially including marginalized populations like those who would be impacted by this bill.

We appreciate your consideration of the above submission and hope that it informs your decision to vote against H.B. 454. Thank you for your kind attention to these matters. Please do not hesitate to contact us at nhuppert@lambdalegal.org should you have questions or if additional information about these matters would be helpful.

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[15] *See Brandt v. Rutledge*, No. 4:21-CV-0045, (E.D. Ark. Aug. 2, 2021) (enjoining a similar Arkansas law because it banned treatments for transgender people but not for cisgender people).
[16] *See Troxel v. Granville*, 530 U.S. 57, 65 (2000); *Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Meyer v. Nebraska*, 262 U.S. 390 (1923).
[17] *Brandt v. Rutledge*, No. 4:21-CV-0045 (E.D. Ark. Aug. 2, 2021).
[18] *Id.* at 2.
[19] *Brandt v. Rutledge*, 47 F.4th 661 (8th Cir. 2022).
[20] *Eknes-Tucker v. Marshall*, No. 2:22-CV-184-LCB (M.D. Ala. May 13, 2022).
[21] In doing so, that court gave the testimony of Dr. James Cantor—whose name appears in some of the testimony already offered in support of H.B. 454—"very little weight" because he admitted on cross examination that "his patients are, on average, thirty years old" and that he "has never provided care to a transgender minor" and had "no personal experience" nor "personal knowledge" of the relevant patient population and methodologies. *Id.* at 12.

Sincerely,

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Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims

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Introduction and Summary

On February 18, 2022, Texas Attorney General Ken Paxton issued an interpretation of Texas state law (the "AG Opinion"), taking the position that certain medical procedures constitute child abuse as defined in the Texas Family Code.[1] Texas Governor Greg Abbott cited the AG Opinion as authority for his February 22, 2022 directive requiring the Texas Department of Family and Protective Services to "conduct a prompt and thorough investigation of any reported instances of these abusive procedures" (the "Governor's Directive").[2]

[*] We would like to thank Dr. Sundes Kazmir, M.D., FAAP, who provided helpful information on medical research on child abuse investigations. Calleigh Higgins, Christina Lepore, and Henry Robinson provided excellent research assistance.

[1] Tex. Op. Att'y. Gen. No. KP-0401 (Feb. 18, 2022) (hereinafter, "AG Opinion").

[2] Letter from Greg Abbott, Governor of Texas, to Jaime Masters, Commissioner, Texas Department of Family and Protective Services, Feb. 22, 2022, at https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf

On April 7, 2022, Governor Kay Ivey of Alabama signed S.B. 184 (the "Alabama Law"), which imposes felony penalties on anyone providing certain medical care to any child, adolescent, or young adult under age 19.[3]

We are a group of six scientists and one law professor. Among the scientists, three of us are M.D.s., three are PhD's, and all treat transgender children and adolescents in daily clinical practice. We all hold academic appointments at major medical schools, including the University of Texas Southwestern and Yale University. In this report, we examine in depth the scientific claims made in the AG Opinion and the text of the Alabama Law about medical care for transgender children and adolescents. Note that, although we reject the AG's assertion that gender-affirming care constitutes child abuse and we oppose the Alabama Law's criminalization of such care, we do not address, in this report, the legal validity of either.[4] In accordance with our expertise, our focus is on the science.

After examining the AG Opinion and the findings of "fact" in the Alabama Law in detail, we conclude that their medical claims are not grounded in reputable science and are full of errors of omission and inclusion. These errors, taken together, thoroughly discredit the AG Opinion's claim that standard medical care for transgender children and adolescents constitutes child abuse. The Alabama Law contains similar assertions of scientific fact, and these too are riddled with errors, calling into question the scientific foundations of the law.

In this report, we focus closely on the AG Opinion, because it contains a full explanation of its reasoning, while the Alabama law presents a list of purported scientific findings without argument or citation. We note, throughout, when the purported findings in the Alabama law echo the claims made in the AG Opinion.

The Texas Attorney General either misunderstands or deliberately misstates medical protocols and scientific evidence. The AG Opinion and the Alabama Law make exaggerated and unsupported claims about the course of treatment for gender dysphoria, specifically claiming that standard medical care for pediatric patients includes surgery on genitals and reproductive organs. In fact, the authoritative protocols for medical care for transgender children and adolescents, which define what we term "gender-affirming care," specifically state that individuals must be over the age of majority before they can undergo such surgery. The AG Opinion and the Alabama Law also ignore the mainstream scientific evidence showing the significant benefits of gender-affirming care and exaggerate potential risks.

These are not close calls or areas of reasonable disagreement. The AG Opinion and the Alabama Law's findings ignore established medical authorities and repeat discredited, outdated, and poor-quality information. The AG Opinion also mischaracterizes reputable sources and repeatedly cites a fringe group whose listed advisors have limited (or no) scientific and medical credentials and include well-known anti-trans activists.

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[3] Vulnerable Child Compassion and Protection Act, 2022 Ala. Laws 289 (hereinafter, "Alabama Law").
[4] For legal analysis, see Plaintiffs' Original Petition and Application for Temporary Restraining Order, Temporary Injunction, Permanent Injunction, and Request for Declaratory Relief, Doe v. Abbott, March 1, 2022, at https://www.aclu.org/legal-document/doe-v-abbott-petition.

The AG Opinion falsely implies that puberty blockers and hormones are administered to prepubertal children, when, in fact, the standard medical protocols recommend drug treatments only for adolescents (and not prepubertal children). For purposes of this report, we use the term "adolescent" to refer to a child under the age of majority in whom pubertal development has begun.

The AG Opinion also omits mention of the extensive safeguards established by the standard protocols to ensure that medication is needed and that adolescents and their parents give informed assent and consent, respectively, to treatment when it is determined to be essential care. There is no rush to treatment: the course of gender-affirming care is tailored to each individual, and standard protocols mandate a process of consultation involving an interdisciplinary team including mental health professionals, medical providers, and parents.

By omitting the evidence demonstrating the substantial benefits of treatment for gender dysphoria, and by focusing on invented and exaggerated harms, the AG Opinion and the Alabama Law portray a warped picture of the scientific evidence. Contrary to their claims, a solid body of reputable evidence shows that gender-affirming care can be lifesaving and significantly improves mental health and reduces suicide attempts. The standard medical protocols were crafted by bodies of international experts based on a solid scientific foundation and have been in use for decades. Thus, treating gender dysphoria is considered not only ethical but also the clinically and medically recommended standard of care. Indeed, it would be considered unethical to *withhold* medical care from patients with gender dysphoria, just as it would be unethical to withhold potentially lifesaving care for patients with any other serious medical condition.

The repeated errors and omissions in the AG Opinion are so consistent and so extensive that it is difficult to believe that the opinion represents a good-faith effort to draw legal conclusions based on the best scientific evidence. It seems apparent that the AG Opinion is, rather, motivated by bias and crafted to achieve a preordained goal: to deny gender-affirming care to transgender youth. The same is true of the scientific claims made in the Alabama Law.

Many reputable scientific and professional organizations have issued statements opposing the Texas action,[5] but to our knowledge, none have conducted the in-depth, point-by-point review that we provide here.

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[5] See APA President Condemns Texas Governor's Directive to Report Parents of Transgender Minors [Internet]. Washington, D.C.: American Psychological Association; 2022 Feb 24 [cited 2022 Apr 15]. Available from: https://www.apa.org/news/press/releases/2022/02/report-parents-transgender-children; American Academy of Pediatrics, AAP, Texas Pediatric Society Oppose Actions in Texas Threatening Health of Transgender Youth [Internet]. Itasca (IL): American Academy of Pediatrics; 2022 Feb 24 [cited 2022 Apr 15]. Available from: https://www.aap.org/en/news-room/news-releases/aap/2022/aap-texas-pediatric-society-oppose-actions-in-texas-threatening-health-of-transgender-youth/; AACAP Statement Opposing Actions in Texas Threatening the Health, Mental Health and Well-Being of Transgender and Gender Diverse Youth and Their Families [Internet]. Washington, D.C.: American Academy of Child & Adolescent Psychiatry; 2022 March 1 [cited 2022 Apr 22]. Available from: https://www.aacap.org/AACAP/zLatest_News/AACAP_Statement_Opposing_Actions_in_Texas.aspx.
See also Letter from James L. Madara, CEO and Executive Vice President of the American Medical Association, to Bill McBride, Executive Director of the National Governors Association, April 26, 2021 (opposing legislation in

Throughout this report, we use the highest-quality scientific evidence available. In this context, large-scale, randomized controlled trials would be inappropriate for ethical reasons: when medical care has been shown (by other methods) to reduce gender dysphoria and improve mental health, as is the case for gender-affirming care for individuals with gender dysphoria, it would be unethical to deny that care to a control group of patients. This is true in many areas of medicine. In such cases, physicians instead rely on studies using other scientific methods, and they judge the relative quality of evidence based on several factors, including whether the study is peer-reviewed, published in a high-impact journal, up to date, and conducted by reputable investigators.

In this report, we cite studies that are peer-reviewed, up to date, conducted by respected investigators, and published in high-impact journals that are widely read. This represents the highest-quality evidence available to physicians making treatment decisions in this context. By contrast, the AG Opinion relies on very poor-quality evidence. Only two of its sources are peer-reviewed scientific studies. Of these, one is badly out-of-date, and the other is cited for a proposition that is irrelevant to the treatment of transgender children and adolescents.[6]

To summarize, we find that:

1. The AG Opinion and the Alabama Law falsely claim that current medical standards authorize the surgical sterilization of transgender children and adolescents. In fact, present medical standards state that individuals must be the age of majority or older before undergoing surgery on genitals or reproductive organs.

> Current medical protocols do not allow for either surgery or drug therapy for prepubertal children and specifically state that genital surgery should not be carried out before patients reach the legal age of majority. The standards of care do permit the careful use of drug therapies for adolescents (but not prepubertal children) and caution that drug therapies should be undertaken only after a careful, staged process of psychological and medical counseling. The AG Opinion's and Alabama Law's lists of "sex change procedures" and the claims that doctors are routinely sterilizing children and teenagers do not reflect current medical practice.

Arkansas and other states that would deny gender-affirming care), at https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children; Clarke M, Farnan A, Barba A, Giovanni K, Brymer M, Julian J. Gender-Affirming Care Is Trauma-Informed Care [Internet]. Los Angeles (CA) and Durham (NC): National Child Traumatic Stress Network; 2022 [cited 2022 Apr 15]. Available from: https://www.nctsn.org/sites/default/files/resources/fact-sheet/gender-affirming-care-is-trauma-informed-care.pdf.

[6] One study is Dhejne C, Lichtenstein P, Boman M, Johansson AL, Langstrom N, Landen M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. PLoS One 2011 Feb 22;6(2):e16885. We discuss in Section 2 why Dhejne et al. is out of date and unsupportive of the AG's claims. The AG Opinion also cites one study for the proposition that "hysterectomy, oophorectomy, and orchiectomy result in permanent sterility." The cited study is Cheng PJ, Pastuszak AW, Myers JB, Goodwin IA, Hotaling JM. Fertility concerns of the transgender patient. Transl Androl Urol. 2019 Jun;8(3):209-218. As we explain in Section 1, current medical protocols do not authorize surgery on genitals or reproductive organs for anyone under the age of majority, and so the reference is irrelevant to the treatment of minors.

2. The AG Opinion and the Alabama Law ignore the substantial benefits of medical care for transgender children and adolescents, care which has consistently been shown to reduce gender dysphoria and improve mental health. The best scientific evidence shows that gender dysphoria is real, that untreated gender dysphoria leads predictably to serious, negative medical consequences, and that gender-affirming care significantly improves mental health outcomes, including reducing rates of suicide.

The AG Opinion and the Alabama Law omit any discussion of the demonstrated benefits of gender-affirming care as recognized by established medical science. The AG Opinion and the Alabama Law also greatly exaggerate the percentage of adolescents whose diagnosed gender dysphoria dissipates without gender-affirming care. And the AG Opinion repeats discredited evidence claiming that there is a wave of so-called "rapid-onset" gender dysphoria among U.S. adolescents.

3. The AG Opinion and the Alabama Law greatly exaggerate the risks of gender-affirming drug therapy.

The AG Opinion exhibits a poor understanding of medicine and consistently misstates medical protocols and scientific evidence. Contrary to the AG Opinion's statements, gender-affirming drug therapy (including puberty blockers and hormonal treatments) is safe and effective and has been approved by the major medical authorities. Puberty blockers are fully reversible; when discontinued, puberty begins, and fertility develops normally.

Gender-affirming hormone treatments can reduce fertility to some degree while ongoing, but the evidence suggests that these effects are reversible when hormone therapy is discontinued. Standard medical protocols manage these risks in the way any medical risks should be managed: by weighing the benefits of treatment against potential harms and by a careful and individualized process of consultation and consent. Indeed, the informed consent procedures for gender-affirming drug treatment are at least as rigorous as the consent required for any other drug treatment.

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Section 1. The AG Opinion and the Alabama Law falsely claim that current medical standards authorize the surgical sterilization of transgender children and adolescents. In fact, present medical standards state that individuals must be the age of majority or older before undergoing surgery on genitals or reproductive organs.

The AG Opinion asserts that the medical treatments for transgender children include a list of surgical procedures including "sterilization through castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty."[7] The AG Opinion also claims that physicians dispense "drugs to children that induce transient or permanent infertility," including "(1) puberty-suppression or puberty-blocking drugs, (2) supraphysiologic doses of testosterone to females; and (3) supraphysiologic doses of estrogen to males."[8] The AG Opinion asserts that "[t] he novel trend of providing these elective sex changes to minors often has the effect of permanently sterilizing those minor children."[9] The Alabama Law contains similar statements.[10]

These statements are incorrect. Current medical protocols state that genital surgery should not be carried out before patients reach the legal age of majority. To make the distinction clear, we refer to the AG Opinion's list of procedures as the "AG Opinion claims." We refer to the standard medical protocols issued by the World Professional Association for Transgender Health ("WPATH") and the Endocrine Society as "gender-affirming care."[11]

The AG Opinion fails to engage with the WPATH and Endocrine Society guidelines (or any other recognized set of medical guidelines), even though these are well-known, widely viewed as authoritative, and readily available to the public.[12] These standards are explicitly

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[7] AG Opinion, p. 1. The AG Opinion also includes "(2) mastectomies; and (3) removing from children otherwise healthy or non-diseased body part or tissue." These procedures do not affect fertility, which is the opinion's stated concern, and they are common among cisgender adolescents (e.g., rhinoplasty and breast reduction). We do not address these procedures in this report.

[8] AG Opinion, p. 1.

[9] AG Opinion, pp. 2-3.

[10] Alabama Law, Section 2(6).

[11] See Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, Fraser L, Green J, Knudson G, Meyer WJ, Monstrey S, Adler RK, Brown GR, Devor AH, Ehrbar R, Ettner R, Eyler E, Garofalo R, Karasic DH, Lev AI, Mayer G, Meyer-Bahlburg H, Hall BP, Pfafflin F, Rachlin K, Robinson B, Schechter LS, Tangpricha V, van Trotsenburg M, Vitale A, Winter S, Whittle S, Wylie KR, Zucker K. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version [Internet]. East Dundee (IL): World Professional Association for Transgender Health; 2012 [cited 2022 Apr 17]. Available from: https://www.wpath.org/publications/soc (hereinafter, "WPATH (2012)"); Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2017 Sept 13;102(11):3869-3903 (hereinafter, "Endocrine Society (2017)").

[12] The AG Opinion quotes the WPATH standards once, but the opinion mischaracterizes the source material and persists in its repeated claims that gender-affirming care involves genital surgery on children. At page 4, the AG Opinion quotes WPATH (2012) to the effect that genital surgery should not be carried out before patients reach the age of majority. See AG Opinion, p. 4. The AG Opinion misleadingly uses the WPATH quotation as evidence that there is no benefit from gender-affirming care; in fact, WPATH (2012), pp. 10-21, acknowledges the benefits of psychotherapy and, in the case of adolescents, puberty blockers and hormone therapy. Apart from the isolated and misleading citation to WPATH (2012) at p. 4, the AG Opinion does not otherwise discuss the WPATH standards or correct its repeated assertion that children and adolescents are undergoing "sex change" procedures.

followed by major gender clinics in the United States.[13] We address the AG Opinion's misstatements in turn.

a. The medical standards of care for transgender children specifically state that individuals must be the age of majority or older before undergoing surgery on genitals or reproductive organs.

Gender dysphoria is a recognized medical condition[14] that merits medical treatment, and the evidence shows that treatment improves mental health outcomes, including reducing rates of suicidal ideation and suicide attempts. (See Section 2 of this report.)

Individuals with gender dysphoria seek care at a wide variety of ages, which depends on sociocultural and environmental factors, including parental support, socioeconomic status, and access to care. In the early phases of treatment, gender-affirming care consists of using the individual's preferred pronouns, psychosocial support, and education about the next stages of transition if desired. Medical professionals draw an important distinction between hormonal treatment and gender-affirming surgery. Hormonal transition is an established practice in older adolescents experiencing gender dysphoria, but current standards for gender-affirming care set the age of majority as the threshold for considering surgery on genitals and reproductive organs.

Two of the leading guidelines for the medical treatment of transgender children and adolescents are those published by WPATH and by the Endocrine Society. WPATH is a leading international organization of scientists, which has issued standards of care for transgender adults and children since 1979.[15] Several revisions have been made as scientific evidence drives changes in standards. The current version, WPATH Standards of Care, version 7, is viewed as authoritative in the medical community and is widely consulted by physicians and other clinicians. The WPATH standards explicitly state that genital surgery should not be carried out until the patient reaches the age of majority. Further, WPATH advises that "the age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention."[16]

The Endocrine Society is the leading international organization of endocrinologists, i.e., physicians specializing in the study and treatment of the human endocrine system, including hormonal treatment.[17] In 2017, the Endocrine Society issued clinical practice guidelines for the

[13] See Kuper LE, Stewart S, Preston S, Lau M, Lopez X. Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. Pediatrics 2020 Apr;145(4):e20193006. doi: 10.1542/peds.2019-3006 (stating that Endocrine Society guidelines are followed). The same is true of the Greenwich Center for Gender & Sexuality. The Yale Pediatric Gender Clinic generally follows WPATH standards.

[14] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth edition. 2013.

[15] The current version is WPATH (2012). According to WPATH, the first six versions were published in 1979, 1980, 1981, 1990, 1998, and 2001.

[16] WPATH (2012), at p. 21: "Genital surgery should not be carried out until (i) patients reach the legal age of majority to give consent for medical procedures in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention."

[17] Who We Are [Internet]. Washington, D.C.: The Endocrine Society; c2022 [cited 2022 Apr 15]. Available from: https://www.endocrine.org/about-us.

treatment of gender dysphoria.[18] Like WPATH, the Endocrine Society does not authorize surgery on the genitals or reproductive organs of transgender children or adolescents.[19]

Both WPATH and Endocrine Society guidelines are based on reviews of the best available science conducted by panels of experts across medical disciplines. These guidelines are updated periodically to ensure that they reflect a current understanding of scientific knowledge and clinical practice. The statements in this report refer to current WPATH and Endocrine Society standards, i.e., those in force as of the date of publication of this report.

b. The standards of care do not recommend drug treatments (puberty blockers or hormones) for prepubertal children.

The AG Opinion wrongly conflates treatments available to adolescents with those offered to children.[20] In fact, current medical protocols for gender-affirming care do not recommend either surgery or drug treatments (puberty blockers and hormones) for prepubertal children.

The WPATH standards state clearly that physical interventions, including drug therapy, are recommended only for adolescents and only after an in-depth process of mental health and medical counseling, described below. The WPATH standards state that social transition, which is entirely reversible, may be considered by the parents of prepubertal children.[21] (Social transition consists of, e.g., wearing clothes and using a name that are consistent with the child's gender identity.) The Endocrine Society also "recommend[s] against puberty blocking and gender-affirming hormone treatment in prepubertal children."[22] (There is, of course, no need for such medication in children who have not reached puberty.)

c. Present standards of care recommend drug treatments for adolescents (youth who have developed pubertal changes) only for those with puberty-induced worsening gender dysphoria and only after a careful protocol that begins with psychological and medical counseling to ensure valid consent.

The AG Opinion claims that "[c]hildren and adolescents are promised relief and asked to 'consent' to life-altering, irreversible treatment—and to do so in the midst of reported psychological distress, when they cannot weigh long-term risks the way adults do."[23] The Alabama Law contains a similar statement.[24]

This statement misdescribes both medical practice and the consent procedures used for the treatment of adolescents. Legally, a parent or guardian must consent to the medical treatment of a minor, and so the AG Opinion is incorrect in implying that medical treatment depends on a

[18] Endocrine Society (2017).
[19] Id. (Guideline 5.5).
[20] AG Opinion, p. 2 (claiming that there is a "novel trend of providing these elective sex changes to minors," with "sex changes" previously defined to include surgery and drug therapies).
[21] WPATH (2012), p. 17.
[22] Endocrine Society (2017) (Guideline 1.4).
[23] AG Opinion, p. 4.
[24] Alabama Law, Section 2(15).

child or teenager's consent alone. [25] As noted above, medical protocols do not recommend drug therapy for prepubertal children, and so consent by young children is never an issue. For adolescents, the standard medical protocols provide for gender-affirming drug therapy only when medically necessary and after a comprehensive process that includes specialist medical consultation and assessment, parent consent and youth assent, and mental health evaluation.

A key feature of both the WPATH Standards of Care and the Endocrine Society Clinical Practice Guidelines is the central role of mental health professionals in assessing gender dysphoria and appropriate modes of medical treatment. The Endocrine Society notes, for example, that, "because of the psychological vulnerability of many individuals with [gender dysphoria], it is important that mental health care is available before, during, and sometimes also after transitioning."[26] Both WPATH and the Endocrine Society provide extensive guidance on how to provide psychosocial support to youth experiencing gender dysphoria, as well as a definition of what constitutes a properly trained mental health professional.

Contrary to the AG Opinion's implication, there is no medical rush to prescribe drug treatments to transgender adolescents. The current WPATH and Endocrine Society standards recommend a staged process for physical interventions, one that takes into account the presentation of gender dysphoria in each individual, along with their medical history and psychological functioning. Social transition, puberty blockers, and hormonal treatment may be used in stages, but not all adolescents with gender dysphoria undergo each treatment.[27] As always in medicine, the priority is to treat the patient as an individual and to address their physical and mental health needs holistically. WPATH, for example, expressly states that, "[b]efore any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken …. The duration of this exploration may vary considerably depending on the complexity of the situation."[28]

WPATH and Endocrine Society standards recommend puberty-suppressing medications (GnRH agonist treatment), only for adolescents and only with guardrails to ensure that medication is medically necessary and that adolescents and their parents give informed consent to treatment. These safeguards are worth summarizing in some detail, because they contradict the AG Opinion's claim that gender-affirming care, including drug therapy, is being casually administered.[29]

For puberty-suppressing medications, the standards require the participation of a qualified mental health practitioner, who confirms that the adolescent has demonstrated a long-lasting and intense pattern of gender dysphoria, that gender dysphoria worsened with the onset of

[25] While the law usually grants parents the final decision, bioethicists have found that adolescents can be meaningful participants in the consent process. Clark BA, Virani A. "This Wasn't a Split-Second Decision": An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy. J Bioeth Inq. 2021 Mar;18(1):151-64; Vrouenraets LJJJ, de Vries ALC, de Vries MC, van der Miesen AIR, Hein IM. Assessing Medical Decision-Making Competence in Transgender Youth. Pediatrics 2021 Dec 1;148(6):e2020049643.
[26] Endocrine Society (2017).
[27] WPATH (2012), p. 18; Endocrine Society (2017) (Guidelines 2.1 and 2.2).
[28] WPATH (2012), p. 16.
[29] We quote the Endocrine Society phrasing, but the two protocols are substantively the same.

puberty, and that any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed, so that the adolescent's situation and functioning are stable enough to start treatment. The guidelines also require informed assent by adolescents and (if under the age of majority) informed consent by their parents, and they require the involvement of a pediatric endocrinologist (or another physician versed in gender-affirming treatment) to ensure that puberty-blocking medication is warranted, that puberty has begun in the adolescent patient, and that there are no medical contraindications to puberty-blocking medication. [30]

For those adolescents for whom progression to hormone therapy is medically indicated, WPATH and the Endocrine Society require additional counseling regarding the possible fertility effects of hormone therapy. In addition to parental consent, the guidelines require that a mental health practitioner confirm that the adolescent has "sufficient mental capacity (which most adolescents have by age 16 years)" to evaluate the benefits and risks of treatment.[31]

Section 2. The AG Opinion and the Alabama Law ignore the substantial benefits of medical care for transgender children and adolescents, care which has consistently been shown to reduce gender dysphoria and improve mental health. The best scientific evidence shows that gender dysphoria is real, that untreated gender dysphoria leads predictably to serious, negative medical consequences, and that gender-affirming care significantly improves mental health outcomes, including reducing rates of suicide.

The AG Opinion omits any discussion of the documented benefits of gender-affirming care and vastly overstates potential risks by relying on misrepresented or unreliable studies. The AG Opinion also misstates scientific evidence on the percentage of children and adolescents whose gender dysphoria resolves without treatment (sometimes termed "desistance"), and the opinion repeats discredited evidence on a purported novel trend of so-called rapid-onset gender dysphoria. The Alabama Law contains similar errors.[32]

The AG Opinion falsely states that "The medical evidence does not demonstrate that children and adolescents benefit from engaging in these irreversible sterilization procedures."[33] Contrary to the AG Opinion's statements, scientific studies have demonstrated that gender dysphoria is a well-documented condition for which medical care is essential treatment. The established scientific evidence shows that treatment improves mental health outcomes, including reducing rates of suicidal ideation and suicide attempts.

In this Section, we review the scientific evidence on gender dysphoria and the benefits of gender-affirming treatment, and we correct the AG Opinion's and Alabama Law's erroneous claims.

a. Gender dysphoria is real, and untreated gender dysphoria is harmful.

The American Psychiatric Association explains that

[30] Endocrine Society (2017) (Table 5), citing WPATH (2012), p. 16.
[31] Endocrine Society (2017) (Table 5).
[32] Alabama Law, Section 2 and Section 2(4).
[33] AG Opinion, at 3.

> [T]he term "transgender" refers to a person whose sex assigned at birth (i.e., the sex assigned by a physician at birth, usually based on external genitalia) does not match their gender identity (i.e., one's psychological sense of their gender). Some people who are transgender will experience "gender dysphoria," which refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Though gender dysphoria often begins in childhood, some people may not experience it until after puberty or much later.[34]

In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, the standard reference for the diagnosis of mental health conditions. The DSM-5 recognizes gender dysphoria and sets forth criteria for diagnosis. These criteria include "a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics" and "a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)." To meet diagnostic criteria, an individual must exhibit "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[35]

In other words, individuals who live in a manner that is physically and socially incongruent to their gender identity can experience gender dysphoria – a clinically significant psychological distress that can lead to depressed mood.[36] Suicidal ideation and attempts have been found to be significantly higher among transgender adolescents who cannot obtain or do not receive gender-affirming care than among their cisgender peers. The harm of not providing gender-affirming care is well documented: 40% of trans individuals who do not receive hormones will attempt or complete suicide in their lifetime.[37] Untreated gender dysphoria can also lead to disordered eating. Patients may engage in unsafe eating behaviors (e.g., food restriction or purging) as a body-affirming tool and an effort to align their bodies with their gender identity. These behaviors can impair physical health and development.[38]

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[34] What is Gender Dysphoria? [Internet]. Washington, D.C.: American Psychiatric Association; 2020 Nov [cited 2022 Apr 15]. Available from: https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria.

[35] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, D.C.: American Psychiatric Association; 2013.

[36] Sorbara JC, Chiniara LN, Thompson S, Palmert MR. Mental health and timing of gender-affirming care. Pediatrics 2020 Oct 1;146(4):e20193600 (hereinafter, "Sorbara et al. 2020").

[37] Herman JL, Brown TNT, Haas AP. Suicide Thoughts and Attempts Among Transgender Adults [Internet]. Los Angeles (CA): The Williams Institute, UCLA School of Law; 2019 Sept [cited 2022 Apr 1]. Available from: https://williamsinstitute.law.ucla.edu/publications/suicidality-transgender-adults/. So-called "conversion" therapy (an extreme form of denying gender-affirming care, which attempts to change a person's gender identity to match the sex assigned at birth) has been shown to create psychological distress and prompt suicide. Turban JL, Beckwith N, Reisner SL, Keuroghlian AS. Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. JAMA Psychiatry 2019 Sept 11;77(1):68-76.

[38] Coelho JS, Suen J, Clark BA, Marshall SK, Geller J, Lam PY. Eating Disorder Diagnoses and Symptom Presentation in Transgender Youth: a Scoping Review. Curr Psychiatry Rep. 2019 Oct 15;21(11):107; Kamody RC, Yonkers K, Pluhar EI, Olezeski CL. Disordered Eating Among Trans-Masculine Youth: Considerations Through a Developmental Lens. LGBT Health. 2020 May/Jun;7(4):170-73; Legroux I, Cortet B. Factors influencing bone loss in anorexia nervosa: assessment and therapeutic options. RMD Open. 2019 Nov 13;5(2):e001009.

For all these reasons, the American Academy of Pediatrics, the American Psychological Association, and the American Academy of Child and Adolescent Psychiatry – the three major professional associations of pediatricians, psychologists, and child and adolescent psychiatrists – have endorsed gender-affirming care and condemned efforts to deny medical care to transgender people, as have the Texas Medical Society and the Alabama Psychological Association.[39] These organizations have also condemned so-called "conversion therapy" as ineffective, unethical, and dangerous.[40]

The scientific consensus is clear: denying gender-affirming care harms transgender people and puts their lives at risk.[41]

b. Gender-affirming care has measurable and significant benefits.

The AG Opinion incorrectly states that "There is no evidence that long-term mental health outcomes are improved or that rates of suicide are reduced by hormonal or surgical intervention."[42] The AG's statement that gender-affirming care is not beneficial is contradicted by a significant body of recent scientific evidence.[43]

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[39] Rafferty J, Committee on Psychosocial Aspects of Child and Family Health; Committee on Adolescence; Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Pediatrics. 2018 Oct;142(4):e20182162; American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. American Psychologist 2015 Dec;70(9):832-64 (hereinafter, "American Psychological Association (2015)"); AAP Continues to Support Care of Transgender Youth as More States Push Restrictions [Internet]. Itasca (IL): American Academy of Pediatrics; 2022 Jan 6 [cited 2022 Mar 31]. Available from: https://publications.aap.org/aapnews/news/19021/AAP-continues-to-support-care-of-transgender; Criminalizing Gender Affirmative Care with Minors [Internet]. Washington, D.C.: American Psychological Association; [cited 2022 Mar 30]. Available from: https://www.apa.org/pi/lgbt/resources/policy/issues/gender-affirmative-care; AACAP Statement Opposing Actions in Texas Threatening the Health, Mental Health and Well-Being of Transgender and Gender Diverse Youth and Their Families, Washington, D.C.: American Academy of Child & Adolescent Psychiatry; 2022 March 1 [cited 2022 Apr 22=]. Available from: https://www.aacap.org/AACAP/zLatest_News/AACAP_Statement_Opposing_Actions_in_Texas.aspx; Statement of the Alabama Psychological Association (aPA) Supporting Gender-Affirming Care for Transgender Youth and Urging Opposition to Alabama SB184/HB266 [internet]. Alabama Psychological Association 2022. Available at https://cdn.ymaws.com/www.alapsych.org/resource/resmgr/2022/sb184-hb266_apa_statement_3-.pdf; Sorrel AL, TMA Supports Evidence-Based Gender-Affirming Care in Lawsuit [internet]. Texas Medical Association. March 14, 2022. Available from https://www.texmed.org/TexasMedicineDetail.aspx?id=59040.

[40] APA Resolution on Gender Identity Change Efforts [Internet]. Washington, D.C.: American Psychological Association; 2021 Feb [cited 2022 Mar 31]. Available from: https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

[41] Abreu RL, Sostre JP, Gonzalez KA, Lockett GM, Matsuno E. "I am afraid for those kids who might find death preferable": Parental figures' reactions and coping strategies to bans on gender-affirming care for transgender and gender diverse youth. Psychology of Sexual Orientation and Gender Diversity [Internet]. 2021 Jul 29 [cited 2022 Mar 31]; advance online publication. Available from: https://psycnet.apa.org/record/2021-67997-001; Hughes LD, Kidd KM, Gamarel KE, Operario D, Dowshen N. (2021). "These Laws Will Be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents. Journal of Adolescent Health 2021 Dec;69(6):976-82; Kidd KM, Sequeira GM, Paglisotti T, Katz-Wise SL, Kazmerski TM, Hillier A, Miller E, Dowshen N. "This could mean death for my child": Parent perspectives on laws banning gender-affirming care for transgender adolescents. Journal of Adolescent Health 2021 Jun;68(6):1082-88.

[42] AG Opinion, p. 4.

[43] De Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. The Journal of Sexual Medicine 2011 Aug;8(8):2276-83; De Vries

As explained in Section 1 of this report, social transition is an important first step for adolescents (and is the only medically accepted form of gender-affirming care for prepubertal children). The scientific evidence shows that social transition, including using a child or adolescent's chosen name, reduces depression and suicide risk.[44]

A solid body of reliable research has shown that the potential next steps in gender-affirming care for adolescents with gender dysphoria – puberty-blocking medications and hormone therapy – have major mental-health benefits, including higher levels of general well-being and significantly decreased levels of suicidality.[45] Puberty blockers have been shown to

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AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics 2014 Oct;134(4):696-704; Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. The Journal of Sexual Medicine 2015 Nov;12(11):2206-14 (hereinafter, "Costa et al. 2015"); Allen LR, Watson LB, Egan AM, Moser CN. Well-being and suicidality among transgender youth after gender-affirming hormones. Clinical Practice in Pediatric Psychology 2019 Sept;7(3):302-11 (hereinafter, ("Allen et al 2019"); Kaltiala R, Heino E, Tyolajarvi M, Suomalainen L. Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. Nordic Journal of Psychiatry 2020 Apr;74(3):213-19; de Lara DL, Rodriguez OP, Flores IC, Masa JLP, Campos-Munoz L, Hernandez MC, Amador JTR. Psychosocial assessment in transgender adolescents. Anales de Pediatria (English Edition) 2020 Jul;93(1):41-48; van der Miesen AI, Steensma TD, de Vries AL, Bos H, Popma A. Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. Journal of Adolescent Health 2020 Jun;66(6):699-704; Achille C, Taggart T, Eaton NR, Osipoff J, Tafuri K, Lane A, Wilson TA. Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. International Journal of Pediatric Endocrinology 2020;2020:8; Kuper LE, Stewart S, Preston S, Lau M, Lopez X. Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. Pediatrics 2020 Apr;145(4):e20193006; Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. Pediatrics 2020 Feb;145(2):e20191725; Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, Skageberg EM, Khadr S, Viner RM. 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. PLoS One 2021 Feb 2;16(2):e0243894; Grannis C, Leibowitz SF, Gahn S, Nahata L, Morningstar M, Mattson WI, Chen D, Strang JF, Nelson EE. Testosterone treatment, internalizing symptoms, and body image dissatisfaction in transgender boys. Psychoneuroendocrinology 2021 Oct;132:105358; Hisle-Gorman E, Schvey NA, Adirim TA, Rayne AK, Susi A, Roberts TA, Klein DA. Mental Healthcare Utilization of Transgender Youth Before and After Affirming Treatment. The Journal of Sexual Medicine 2021 Aug;18(8):1444-54; Green AE, DeChants JP, Price MN, Davis CK. Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. Journal of Adolescent Health 2022 Apr;70(4):643-49 (hereinafter, "Green et al. 2022"); Turban JL, King D, Kobe J, Reisner SL, Keuroghlian AS. Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. PLoS One 2022 Jan 12;17(1):e0261039 (hereinafter, "Turban et al. 2022"); Tordoff DM, Wanta JW, Collin A, Stephney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA Network Open 2022 Feb 1;5(2):e220978 (hereinafter, "Tordoff et al. (2022)").

[44] Russell ST, Pollitt AM, Li G, Grossman AH. Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender youth. Journal of Adolescent Health 2018 Oct;63(4):503-05; Durwood L, McLaughlin KA, Olson KR. Mental health and self-worth in socially transitioned transgender youth. Journal of the American Academy of Child & Adolescent Psychiatry 2017 Feb;56(2):116-23.

[45] Allen et al. 2019, cited in note 43; Green et al. (2022), cited in note 43; Connolly MD, Zervos MJ, Barone II CJ, Johnson CC, Joseph CL. The Mental Health of Transgender Youth: Advances in Understanding. Journal of Adolescent Health 2016 Nov;59(5):489-95; Turban et al. 2022, cited in note 43; Costa et al. (2015), cited in note 43; See also Witcomb GL, Bouman WP, Claes L, Brewin N, Crawford JR, Arcelus J. Levels of depression in transgender people and its predictors: Results of a large matched control study with transgender people accessing clinical services. Journal of Affective Disorders 2018 Aug 1; 235:308-15.

decrease suicidality in adulthood and to improve affect and psychosocial functioning as well as social life.[46] Hormone therapy has been shown to reduce suicidality in transgender adolescents when compared to peers with gender dysphoria who did not receive it.[47] Notably, none of the studies has found a worsening of these mental health measures among recipients of gender-affirming care.

Among children and adolescents, patients who present for gender-affirming care at later pubertal stages are more likely to require psychoactive medications and are more likely to have considered or attempted suicide than patients who received gender-affirming care at earlier stages of pubertal development.[48]

As evidence for the proposition that "[t]here is no evidence that long-term mental health outcomes are improved or that rates of suicide are reduced by hormonal or surgical intervention," the AG Opinion cites a 2011 Swedish study by Dhejne et al. that, the AG Opinion claims, "monitored transitioned individuals for 30 years [and] found high rates of post-transition suicide and significantly elevated all-cause mortality, including increased death rates from cardiovascular disease and cancer, although causality could not be established."[49] In fact, the 2011 study by Dhejne is badly out-of-date and does not support the AG Opinion's claim.

The Dhejne study compared post-gender-affirmation transgender individuals with cisgender individuals from the general population, as opposed to transgender individuals who did not receive gender-affirming care. Therefore, as the study's author explicitly cautions in the body of the text, *it is impossible to conclude from this data* that gender-affirming procedures were a causative factor in suicidality among transgender individuals.[50] Rather, the study shows only that transgender adults were more likely to experience suicidal ideation/attempts and risky behavior when compared to the general population in Sweden between 1973 and 2003. Further, the Dhejne study is not generalizable to a modern American population or to adolescents. During the study period, Swedish law required that individuals seeking gender-affirming surgery be

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[46] Rew L, Young CC, Monge M, Bogucka R. Review: Puberty blockers for transgender and gender diverse youth – a critical review of the literature. Child and Adolescent Mental Health 2021 Feb;26(1):3-14; de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J Sex Med. 2011 Aug;8(8):2276-83. Epub 2010 Jul 14 (hereinafter, "de Vries et al. (2011)").

[47] Tordoff et al (2022), cited in note 43; Sorbara et. al. (2020), cited in note 36.

[48] Sorbara JC et. al. (2020), cited in note 36. Studies of adults confirm that gender-affirming treatment has been associated with marked improvement in mental health outcomes in transgender patients. See Almazan AN, Keuroghlian AS. Association Between Gender-Affirming Surgeries and Mental Health Outcomes. JAMA Surgery 2021 Jul 1;156(7):611-18; Marano AA, Louis MR, Coon D. Gender-Affirming Surgeries and Improved Psychosocial Health Outcomes. JAMA Surgery 2021 Jul 1;156(7):685-87; Swan J, Phillips TM, Sanders T, Mullens AB, Debattista J and Bromdal A. Mental health and quality of life outcomes of gender-affirming surgery: A systematic literature review, Journal of Gay & Lesbian Mental Health, 2022.

[49] AG Opinion, at 4, citing Dhejne C, Lichtenstein P, Boman M, Johansson AL, Langstrom N, Landen M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. PLoS One 2011 Feb 22;6(2):e16885 (hereinafter, "Dhejne (2011)").

[50] "It is therefore important to note that the current study is only informative with respect to [transgender] persons' health after sex reassignment; *no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism*. In other words, the results should not be interpreted such as sex reassignment per se increases morbidity and mortality. Things might have been even worse without sex reassignment." Dhejne (2011) at 7 (emphasis added).

sterilized. The presence of this law alone might account for the higher risk of suicide attempts and risky behavior in the transgender population compared to the cisgender population at the time.[51]

The AG Opinion also mischaracterizes an important governmental decision, claiming incorrectly that the Centers for Medicare and Medicaid Services ("CMS") found that gender-affirming care has no benefits. The AG Opinion claims that "there is no scientific consensus that [medical care] even serve[s] to benefit minor children dealing with gender dysphoria," and that "[t]he lack of evidence in this field is why the CMS rejected a nationwide coverage mandate for adult gender transition surgeries during the Obama Administration."[52] Although the CMS did issue a 2016 Decision Memo denying blanket, automatic coverage for gender-affirming surgery, the decision specifically *authorizes* Medicare and Medicaid providers to cover such surgery on a case-by-case basis.[53] Thus, contrary to AG Opinion's claim, the CMS decision memo expressly *permits* state and local decision-makers to authorize coverage for gender-affirming surgery.[54] The federal directive simply declines to authorize automatic coverage in every case. And, in fact, the 2016 CMS decision marks an expansion of the permissibility of gender-affirming treatment: the Decision Memo followed the 2014 revocation of the CMS's 1989 decision to deny nationwide coverage.[55]

Further, the CMS did not reach any negative conclusion on the benefits of gender-affirming care for children and adolescents. The CMS reviewed only studies on the outcomes of surgery (not hormone treatment) for an adult population that is overwhelmingly elderly (over age 65) and has a high prevalence of preexisting medical conditions that can make surgery risky, regardless of its purpose.[56]

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[51] Nelson R. Transgender People in Sweden No Longer Face Forced Sterilization. Time [Internet]. 2013 Jan 14 [cited 2022 Apr 1]; Available from: https://newsfeed/time.com/2013/01/14/transgender-people-in-sweden-no-longer-face-forced-sterilization/. The presence of this law alone might account for the higher risk of suicide attempts and risky behavior in the transgender population at the time.

[52] AG Opinion, at 3-4, citing Jensen TS, Chin J, Rollins J, Koller E, Gousis L. Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N). Baltimore (MD): Centers for Medicare and Medicaid Services; 2016 Aug 30 [cited 2022 Feb 18]. Available from: https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=282.

[53] Id.

[54] Id. ("We acknowledge that [gender reassignment surgery] may be a reasonable and necessary service for certain beneficiaries with gender dysphoria. The current scientific information is not complete for CMS to make a [national coverage decision] that identifies the precise patient population for whom the service would be reasonable and necessary.")

[55] Id.

[56] The CMS Decision Memo notes that "the Medicare population is different from the general population in age (65 years and older) and/or disability as defined by the Social Security Administration. Due to the biology of aging, older adults may respond to health care treatments differently than younger adults. These differences can be due to, for example, multiple health conditions or co-morbidities, longer duration needed for healing, metabolic variances, and impact of reduced mobility. All of these factors can impact health outcomes. The disabled Medicare population, who are younger than age 65, is different from the general population and typical study populations due to the presence of the causes of disability such as psychiatric disorders, musculoskeletal health issues, and cardiovascular issues." Id.

c. The AG Opinion repeats discredited and unreliable evidence on "desistance" and "rapid-onset gender dysphoria."

The AG Opinion greatly exaggerates the extent to which adolescent gender dysphoria abates without treatment, and it repeats discredited claims that there is a novel wave of rapid-onset dysphoria among today's teens.

"Desistance." The AG Opinion asserts that "[c]hildhood-onset gender dysphoria has been shown to have a high rate of natural resolution, with 61-98% of children reidentifying with their biological sex during puberty."[57] The Alabama law makes a parallel statement.[58] The assertion is incorrect.

As authority for the claimed 61-98% figure, the AG Opinion does not cite reputable scientific evidence. Instead, it cites a biased source – the website of the so-called Society for Evidence-Based Gender Medicine ("SEGM"). SEGM is not a recognized scientific organization, and in Appendix A we document the bias that infuses its medical claims. The SEGM website badly mischaracterizes the underlying source that it cites for the 61-98% figure.

The study SEGM cites is Steensma et al. (2013).[59] But the Steensma study was not designed to (and the lead author has acknowledged) does not provide a basis for calculating what percentage of prepubertal children diagnosed with gender dysphoria persist with that diagnosis into adolescence. Rather, the Steensma study was designed only to study the characteristics of those who persisted. [60] Among other limitations, in Steensma (2013), former patients who opted to not participate in the study (either refused to participate or did not respond to an offer to participate) were categorized as "desisters," i.e., patients whose gender dysphoria resolved without transition or treatment. Patients can fail to respond to a study request for many reasons, including having moved away, receiving treatment elsewhere, or being uninterested in participating in a study. Thus, SEGM misuses the Steensma data by counting nonresponding patients as having "desisted" in experiencing gender dysphoria.[61] Indeed, in published correspondence, Steensma emphasizes that the 2013 study should *not* be used to calculate the percentages of "persisters" and "desisters."[62] The misrepresentation of Steensma on the SEGM website constitutes a major violation of the scientific method and the accepted conventions of research.

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[57] AG Opinion, at 4.
[58] Alabama Law, Section 2(4).
[59] Steensma TD, McGuire JK, Kreukels BP, Beekman AJ, Cohen-Kettenis PT. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry. 2013 Jun;52(6):582-90.
[60] Steensma TD, Cohen-Kettenis PT. A critical commentary on follow-up studies and "desistence" theories about transgender and gender non-conforming children. Int J Transgend. 2018 May; 19(2):225-30.
[61] See American Psychological Association (2015), p. 842 (noting that several studies categorized youth who did not return to the clinic after initial assessment as "desisters" who no longer identified with a gender different than sex assigned at birth; "As a result, this research runs a strong risk of inflating estimates of the number of youth who do not persist with a TGNC identity").
[62] Id.

Actual scientific evidence on the course of gender dysphoria emphasizes the importance of distinguishing between prepubertal children and adolescents. The evidence suggests that the course of dysphoria is more diverse for prepubertal children, and so it is critical to recognize them as a distinct population from adolescents. By referring to "children," the AG Opinion creates the misimpression that most or all children *and* teens diagnosed with dysphoria will cease identifying with the gender not assigned at birth. This is false.

The evidence suggests that the vast majority of adolescents who are diagnosed with gender dysphoria will persist in their gender identity and will benefit from gender-affirming medical care.[63] In a Dutch study, among 70 adolescents diagnosed with gender dysphoria and treated with puberty-suppressing hormones, 100% opted to continue with gender-affirming treatment.[64] A recent U.S. study found a consistent pattern. Following a large cohort of U.S. young people who reported some evidence of gender dysphoria but had not yet been formally diagnosed, the study found that adolescents were far more likely than prepubertal children to go on to a formal diagnosis of gender dysphoria and to receive gender-affirming treatment.[65]

The course of gender dysphoria is different in pre-pubertal children. For this group, the percentage of those whose dysphoria resolves without treatment is higher than for adolescents but likely lower than the AG Opinion's claimed 61-98% figure. When prepubertal children experience gender dysphoria, some will find that their dysphoria resolves before adolescence. That is, many of these children will not, as adolescents, identify as transgender or proceed with gender-affirming medical care. Importantly, as we have emphasized, standard medical protocols do not treat prepubertal children with drug therapy or genital surgery, and so there is zero risk that a prepubertal child with dysphoria will have received physical interventions.

Further, the AG Opinion's claim of 98% "desistance" is overstated even for prepubertal children. The Endocrine Society reports that, "[c]ombining all outcome studies to date, the [gender dysphoria]/gender incongruence of a minority of prepubertal children appears to persist

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[63] American Psychological Association (2015), p. 843; WPATH (2012), p. 11; Endocrine Society (2017). See also Turban JL, DeVries ALC, Zucker K. Gender Incongruence & Gender Dysphoria. In Martin A, Bloch MH, Volkmar FR (editors): Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook, Fifth Edition. Philadelphia: Wolters Kluwer 2018, pp. 20-21 ("we must recognize that [the existing studies of persistence] have been quite limited in power and generalizability and should not be misused to create barriers for TGD youth seeking gender-affirming care. The most relevant conclusions from these studies are that insistent cross-gender identification in adolescence most often correlates with persistent TGD identities in adulthood").

[64] de Vries et al. 2011, cited in note 43 ("None of the gender dysphoric adolescents in this study renounced their wish for [gender reassignment] during puberty suppression. This finding supports earlier studies showing that young adolescents who had been carefully diagnosed show persisting gender dysphoria into late adolescence or young adulthood").

[65] Wagner S, Panagiotakopoulos L, Nash R, Bradlyn A, Getahun D, Lash TL, Roblin D, Silverberg MJ, Tangpricha V, Vupputuri S, Goodman M. Progression of Gender Dysphoria in Children and Adolescents: A Longitudinal Study. Pediatrics. 2021 Jul;148(1):e2020027722. doi: 10.1542/peds.2020-027722. Epub 2021 Jun 7. PMID: 34099504; PMCID: PMC8276590. Wagner et. al (2021) studied this cohort for only (on average) 3.5 years; by the end of the study period, roughly 35% of teens but only about 15-18% of prepubertal children received a formal diagnosis of gender dysphoria. Note that these data do *not* establish that only 35% of teens *with gender dysphoria* persist in their diagnosis. This was not a population already diagnosed with dysphoria, and so the persistence rate cannot be calculated. Rather, Wagner et al. (2021) shows that, among a population with some evidence of dysphoria, adolescents are far more likely than young children to continue to a formal diagnosis.

in adolescence."[66] A reasonable summary of the literature would be that around 50% of prepubertal children diagnosed with gender dysphoria (using older, less stringent diagnostic criteria) will not persist in identifying as transgender into adolescence and adulthood.[67]

Recent evidence suggests that the spontaneous resolution of true gender dysphoria among prepubertal children is likely even lower. Earlier studies likely overstate the spontaneous resolution of gender dysphoria among children diagnosed before puberty, because their data incorporated broader diagnostic criteria.[68] That is, the studies likely included prepubertal children with gender variant behavior (e.g., boys with feminine interests or "tomboy" girls) alongside children who would meet today's diagnostic criteria for gender dysphoria – a deeply felt and lasting transgender identity with clinically significant distress and impaired functioning.[69] Consistent with this hypothesis is the recent finding that "the intensity of early dysphoria appears to be an important predictor" of the persistence of dysphoria into adolescence.[70] The evidence thus implies that, had the earlier studies focused on prepubertal children with intense gender dysphoria, the rates of spontaneous resolution of dysphoria would be lower.

To summarize, then, the key to the question of whether gender dysphoria persists over time is whether the patient is diagnosed with gender dysphoria in adolescence. (This might be a new diagnosis or it might be a persistent diagnosis from childhood.) Put plainly: *adolescents with gender dysphoria rarely find that their dysphoria resolves without treatment.*

"Rapid-onset" gender dysphoria. The AG Opinion also asserts that there has been a recent spike in gender dysphoria diagnosis and gender-affirming treatment among U.S. adolescents.[71] The AG insists that this is a "novel cohort" of youth and implies that their gender dysphoria is transient.[72]

As evidence, the AG Opinion again fails to consult reputable science and instead cites the SEGM website, which features a graph showing an increase from 2010 to 2020 in referrals of British adolescents to a specialized gender clinic.[73] The graph is calibrated to look as if the

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[66] Endocrine Society (2017). See Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. J Am Acad Child Adolesc Psychiatry. 2008 Dec;47(12):1413-23. doi: 10.1097/CHI.0b013e31818956b9. PMID: 18981931.

[67] American Psychological Association (2015), pp. 841-2 ("existing research suggests that between 12% and 50% of children diagnosed with gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood").

[68] See Temple Newhook J, Pyne J, Winters K, Feder S, Holmes C, Tosh J, Sinnott ML, Jamieson A, and Pickett S, A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children, International Journal of Transgenderism, vol. 19(2), pp. 212-224 (2018) doi: 10.1080/15532739.2018.1456390.

[69] Endocrine Society (2017).

[70] Steensma TD, McGuire JK, Kreukels BP, Beekman AJ, Cohen-Kettenis PT. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry. 2013 Jun;52(6):582-90 (finding that "children with persistent GID are characterized by more extreme gender dysphoria in childhood than children with desisting gender dysphoria").

[71] AG Opinion, at 3 (stating that "the spike in [surgical and drug] procedures is a relatively recent development").

[72] AG Opinion, at 4.

[73] The AG Opinion cites to the website of the Society for Evidence-Based Gender Medicine (SEGM). SEGM's homepage provides an uncredited and unverifiable graph, which claims to depict referrals to an undefined term,

increase is very large, but in fact, the absolute numbers are small. The information depicted cannot be verified, because SEGM provides no citation. But taking the data at face value, in 2020 about 2600 children and teens sought treatment at the U.K. gender clinic. That is a very small percentage of Britain's child population. Further, the data appear to show only the number of children and adolescents referred for consultation; only a subset of these will ultimately be diagnosed with gender dysphoria and will continue with medical treatment.[74] The claimed "spike" in referrals certainly reflects the reduction in social stigma over the past decade and the expansion of care options.

By contrast, reliable recent data shows that, among high-school students, the percentage who identify as transgender is under 2% (1.8%).[75] These data come from the Centers for Disease Control's Youth Risk Behavior Surveillance System, which is the largest repository of data on self-reported behaviors in the United States. Because not all transgender people seek medical treatment, the percentage seeking medical care would be smaller.

The AG Opinion also repeats a discredited claim that a novel wave of "adolescent-onset gender dysphoria" is sweeping the U.S.[76] This statement echoes (without citing or quoting) a poor-quality study by Lisa Littman.[77] Littman's 2018 article contended that a novel pathology, "rapid-onset gender dysphoria" was leading teenagers to claim a transgender identity because of peer influence. WPATH, among other authorities, has taken a skeptical view of Littman's claim,[78] and the study has been criticized for serious methodological errors, including the use of parent reports instead of clinical data and the recruitment of its sample of parents from anti-transgender websites.[79] The journal of publication required an extensive correction of the

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"GIDS." SEGM [Internet]. c2020 [cited 2022 Apr 1]. Available from: https://segm.org/. Although GIDS is not defined on the SEGM site, it appears to refer to the Gender Identity Development Service, a specialized UK gender clinic for children and adolescents. GIDS [Internet]. c2022 [cited 2022 Apt 1]. Available from: https://gids.nhs.uk/about-us#main-content.

[74] A referral means that a medical provider (or, possibly, the patient) has suggested an appointment with GIDS. A referral does not equate to the receipt of gender-affirming care. See GIDS [internet]. Available from https://gids.nhs.uk/about-us#main-content.

[75] Johns MM, Lowry R, Andrzejewski J, Barrios LC, Demissie Z, McManus T, Rasberry CN, Robin L, Underwood JM. 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. MMWR Morb Mortal Wkly Rep. 2019 Jan 25;68(3):67-71.

[76] AG Opinion, at 4.

[77] Littman L. Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLoS One. 2018 Aug 16;13(8):1-44; Littman L. Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLoS One. 2019 Mar 19;14(3):1-7.

[78] WPATH Global Board of Directors. WPATH Position on "Rapid-Onset Gender Dysphoria" [Internet]. 2018 Sep 4 [cited 2022 Apr 1]. Available from: https://www.wpath.org/media/cms/Documents/Public%20Policies/2018/9_Sept/WPATH%20Position%20on%20Rapid-Onset%20Gender%20Dysphoria_9-4-2018.pdf (stating that ROGD "constitutes nothing more than an acronym created to describe a proposed clinical phenomenon that may or may not warrant further peer-reviewed scientific investigation").

[79] Restar AJ. Methodological Critique of Littman's (2018) Parental-Respondents Accounts of "Rapid-Onset Gender Dysphoria". Arch Sex Behav. 2020 Jan;49(1):61-66. doi: 10.1007/s10508-019-1453-2 (hereinafter, "Restar 2020"); Temple Newhook, J, Pyne, J, Winters, K, Feder, S, Holmes, C, Tosh, J, and Pickett, S. A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children. *International Journal of Transgenderism*, *19*(2), 212-224. (2018).

original Littman article because of its misstatements.[80] Such a correction in reputable, peer-reviewed academic journals is taken only when a panel of experts, in retrospect, came to recognize the methodological flaws of the original study and concluded that it would be unscientific to allow the originally published findings to stand.

Littman's hypothesis that rapid-onset gender dysphoria exists as a distinct condition has not been supported by studies of clinical data.[81] Neither the American Psychiatric Association nor any other reputable professional organization has recognized rapid-onset gender dysphoria as a distinct clinical condition or diagnosis.[82]

Section 3. The AG Opinion and the Alabama Law greatly exaggerate the risks of gender-affirming drug therapy.

The AG Opinion claims that "sex change procedures," including surgery and drug therapies "often ha[ve] the effect of permanently sterilizing those minor children."[83] The Alabama Law makes similar claims.[84] Section 1 of this report has established that the AG Opinion's claim with respect to surgery is false: current medical protocols state that individuals must be the age of majority or older before undergoing surgery on genitals or reproductive organs. In this Section, we focus on the AG Opinion's (and Alabama Law's) claims regarding the medical effects of drug treatment for transgender adolescents.

a. The AG Opinion and the Alabama Law greatly overstate the risks of puberty-blocking medication and incorrectly state that it results in sterilization.

The Texas Attorney General claims that "[t]here is insufficient medical evidence available to demonstrate that discontinuing [puberty-blocking] medication resumes a normal puberty process."[85] The Alabama Law contains similar statements.[86] The claim is false: puberty-blocking medication has been shown to be safe, effective, and fully reversible.

As noted in Section 1 of this report, puberty-blocking medication (gonadotropin-releasing hormone agonists, or GnRHa's) can be part of a staged approach to gender-affirming care for

[80] Littman L. Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLoS One. 2019 Mar 19;14(3):1-7 (altering the original article to, inter alia, clarify that the article collected no data from adolescents or clinicians and generates only a hypothesis for further exploration).
[81] Bauer GR, Lawson ML, Metzger DL; Trans Youth CAN! Research Team. Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"? J Pediatr. 2022 Apr; 243:224-227. See also Arnoldussen M, Steensma TD, Popma A, van der Miesen AIR, Twisk JWR, de Vries ALC. Re-evaluation of the Dutch approach: are recently referred transgender youth different compared to earlier referrals? Eur Child Adolesc Psychiatry. 2020 Jun;29(6):803-811. Erratum in: Eur Child Adolesc Psychiatry. 2020 Dec 16 (concluding that there has been no marked change in the characteristics of the population of adolescents referred for gender dysphoria from 2000 to 2016; the authors hypothesize that the increase in number of referrals reflects the increasing social acceptability of seeking treatment).
[82] Restar (2018), cited in note 79.
[83] AG Opinion, at 2-3. The AG Opinion repeats its claim about sterilization. Id. at 5 ("The surgical and chemical procedures you ask about can and do cause sterilization.")
[84] Alabama Law, Sections 2(9), 2(11), 2(12), 2(13) and 2(14).
[85] AG Opinion, at 5.
[86] Alabama Law, Sections 2(7), (11), (12) and (13).

adolescents. By stalling pubertal maturation, the medication relieves adolescents of the intense gender dysphoria that can accompany pubertal development along the pathway of their assigned sex. During this pause, the adolescent is given time to confirm their gender identity and to consider the need for appropriate gender-affirming hormone therapy without having had their body mature along pubertal path incongruent with their gender identity. Adolescents who continue to identify as transgender will be able to proceed with gender-affirming hormone therapy when they, their parents, and their providers determine that treatment is medically appropriate. Puberty blockers not only alleviate gender dysphoria in adolescence but have beneficial lifelong effects on dysphoria and can minimize the need for subsequent treatments, including surgery in adulthood. In the unlikely event that a teen realizes that they identify as cisgender, they can discontinue the blocker and spontaneous pubertal maturation will resume.

The scientific evidence clearly shows that treatment with puberty blockers is fully reversible. GnRHa therapy has been used since the 1980's in children with precocious puberty, and a solid body of evidence documents that pubertal progression stops with drug therapy and that spontaneous pubertal development occurs after discontinuation of the medication.[87]

Recent studies suggest that puberty-blocking medication has negligible or small effects on bone development in adolescents, and any negative effects are temporary and reversible. The most recent studies show that puberty-blocking drug therapy either has no effect on bone mineral density (BMD), a proxy measure of bone strength, or is associated with a very small decrease.[88]

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[87] Manasco PK, Pescovitz OH, Feuillan PP, Hench KD, Barnes KM, Jones J, Hill SC, Loriaux DL, Cutler Jr GB. Resumption of puberty after long term luteinizing hormone-releasing hormone agonist treatment of central precocious puberty. J Clin Endocrinol Metab. 1988 Aug 1;67(2):368-72; Heger S, Muller M, Ranke M, Schwarz H, Waldhauser F, Partsch C, Sippell WG. Long-term GnRH agonist treatment for female central precocious puberty does not impair reproductive function. Mol Cell Endocrinol. 2006 Jul 25;254-255:217-220; Feuillan PP, Jones JV, Barnes K, Oerter-Klein K, Cutler Jr GB. Reproductive Axis after Discontinuation of Gonadotropin-Releasing Hormone Analog Treatment of Girls with Precocious Puberty: Long Term Follow-Up Comparing Girls with Hypothalamic Hamartoma to Those with Idiopathic Precocious Puberty. J Clin Endocrinol Metab. 1999 Jan;84(1):44-49; Bertelloni S, Baroncelli GI, Ferdeghini M, Menchini-Fabris F, Saggese G. Final height, gonadal function and bone mineral density of adolescent males with central precocious puberty after therapy with gonadotropin-releasing hormone analogues. Eur J Pediatr. 2000 May;159(5):369-74 (hereinafter, "Bertelloni et al (2000)"); Bertelloni S, Mul D. Treatment of central precocious puberty by GnRH analogs: long-term outcome in men. Asian J Androl. 2008 Jul;10(4):525-34; Luo X, Liang Y, Hou L, Wu W, Ying Y, Ye F. Long-term efficacy and safety of gonadotropin-releasing hormone analog treatment in children with idiopathic central precocious puberty: A systematic review and meta-analysis. Clin Endocrinol. 2021 May; 94(5):786-96.

[88] Klink D, Caris M, Heijboer A, van Trotsenburg M, Rotteveel J. Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. J Clin Endocrinol Metab. 2015 Feb;100(2):E270-75 (hereinafter, "Klink et al. 2015"); Schagen SEE, Wouters FM, Cohen-Kettenis PT, Gooren LJ, Hannema SE. Bone Development in Transgender Adolescents Treated With GnRH Analogues and Subsequent Gender-Affirming Hormones. J Clin Endocrinol Metab. 2020 Dec 1;105(12): e4252-e4263 (hereinafter, Schagen et al. 2020"); Delemarre-van de Waal HA, Cohen-Kettenis PT. Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. Eur J Endocrinol. 2006;155:S131-S137. Studies of children treated for precocious puberty found that BMD was normal at final height attainment. Alessandri SB, Pereira F de A, Villela RA, Antonini SRR, Elias PCL, Martinelli Jr CE, de Castro M, Moreira AC, de Paula FJA. Bone mineral density and body composition in girls with idiopathic central precocious puberty before and after treatment with a gonadotropin-releasing hormone agonist. Clinics (Sao Paulo). 2012;67(6):591-96; Antoniazzi F, Zamboni G, Bertoldo F, Lauriola S, Mengarda F, Pietrobelli A, Tato L. Bone mass at final height in precocious puberty after gonadotropin-releasing hormone agonist with and without calcium supplementation. J Clin Endocrinol Metab. 2003 Mar;88(3):1096-1101 (hereinafter,

Calcium supplementation has been shown to protect patients from bone loss.[89] Critically, any reduction in BMD is recovered when adolescents cease taking puberty-blocking medication, whether or not they continue to gender-affirming hormone therapy.[90]

Tellingly, the AG Opinion does not cite scientific evidence for its claim regarding "insufficient medical evidence"[91] Instead, it cites two legal cases, neither of which contains sound scientific evidence on this subject.[92] One of the cited cases is irrelevant, because it involves legal claims about surgery, not puberty blockers.[93] The other cited case, Bell v. Tavistock and Portman NHS Foundation Trust (2020), was reversed on appeal in the U.K. in 2021 because the decision relied on biased and inexpert scientific testimony.[94]

The AG Opinion also attacks puberty blockers by claiming that their use "is not approved by the federal Food and Drug Administration and is considered an 'off-label' use of the medications."[95] The Alabama Law makes a similar claim.[96] The implication is that off-label use of medication is harmful, but this claim is unfounded.

"Antoniazzi et al. (2003)"); Heger S, Partsch CJ, Sippell WG. Long-term outcome after depot gonadotropin-releasing hormone agonist treatment of central precocious puberty: final height, body proportions, body composition, bone mineral density, and reproductive function. J Clin Endocrinol Metab. 1999 Dec;84(12):4583-90; Neely EK, Bachrach LK, Hintz RL, Habiby RL, Slemenda CW, Feezle L, Pescovitz OH. Bone mineral density during treatment of central precocious puberty. J Pediatr. 1995 Nov;127(5):819-22.

[89] Antoniazzi et al. (2003), cited in note 88.

[90] Klink et al. (2015), cited in note 88; Schagen et al. (2020), cited in note 88. Bertelloni et al. (2000), cited in note 87; Pasquino AM, Pucarelli I, Accardo F, Demiraj V, Segni M, Di Nardo R. Long-term observation of 87 girls with idiopathic central precocious puberty treated with gonadotropin-releasing hormone analogs: impact on adult height, body mass index, bone mineral content, and reproductive function. J Clin Endocrinol Metab. 2008 Jan;93(1):190-195; Magiakou MA, Manousaki D, Papadaki M, Hadjidakis D, Levidou G, Vakaki M, Papaefstathiou A, Lalioti N, Kanaka- Gantenbein C, Piaditis G, Chrousos GP, Dacou-Voutetakis C. The efficacy and safety of gonadotropin-releasing hormone analog treatment in childhood and adolescence: a single center, long-term follow-up study. J Clin Endocrinol Metab. 2010 Jan;95(1):109-17; Bertelloni S, Baroncelli GI, Sorrentino MC, Perri G, Saggese G. Effect of central precocious puberty and gonadotropin-releasing hormone analogue treatment on peak bone mass and final height in females. Eur J Pediatr. 1998 May;157(5):363-67.

[91] AG Opinion, at 5.

[92] The AG Opinion's citation is "see generally Hennessy-Waller v. Snyder, 529 F. Supp. 3d 1031, 1042 (D. Ariz. 2021), citing Bell v. Tavistock and Portman NHS Foundation Trust, 2020 EWHC 3274, para. 134 (Dec. 1, 2020) (referring to Bell's conclusion that a clinic's practice of prescribing puberty-suppressing medication to individuals under age 18 with gender dysphoria and determining such treatment was experimental)." Id. at 5-6.

[93] Hennessy-Waller is a decision that denies a motion for preliminary injunction against an insurance company for failure to cover gender-affirming surgery. The decision involves surgery, not puberty blockers, and it is not a fully-adjudicated factual determination about either surgery or puberty blockers. Hennessy-Waller v. Snyder, 529 F. Supp. 3d 1031 (D. Ariz. 2021).

[94] Bell v. The Tavistock and Portman NHS Foundation Trust [2021] EWCA (Civ) 1363 [38] (Eng.) (noting that the claimant's (plaintiff's) expert evidence was faulty: "None of it complied with the rules regarding expert evidence and a good deal of it is argumentative and adversarial."). For a scientific review of the evidence in the lower court decision, see de Vries ALC, Richards C, Tishelman AC, Motmans J, Hannema SE, Green J, Rosenthal SM. Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing current knowledge and uncertainties in decisions about gender-related treatment for transgender adolescents. Int J Transgend Health. 2021 Apr 5;22(3):217-24.

[95] AG Opinion, at 5.

[96] Alabama Law, Section 2(7).

"Off label" means only that the FDA has not specifically approved a particular medication for a particular use. The off-label use of medications for children is quite common and often necessary, because an "overwhelming number of drugs" have no FDA-approved instructions for use in pediatric patients.[97] This is in part because pharmaceutical companies often lack financial incentives to support research required for FDA approval for specific use in children.[98] Indeed, the American Academy of Pediatrics specifically approves the off-label use of drugs:

> The purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. As such, *the term "off-label" does not imply an improper, illegal, contraindicated, or investigational use*. Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient.[99]

Many common medications, including hormones, are used off-label in adults and minors. In fact, pediatricians prescribe off-label drugs in 20% of patient visits.[100] Estrogen and testosterone are often used off-label to treat adolescents with intersex conditions. Common hormonal medications used off-label include norethindrone, a progesterone analogue used off-label for the treatment of heavy menstrual bleeding in those with polycystic ovarian syndrome, bleeding disorder, and anovulatory bleeding of early puberty. It is also used to treat endometriosis, which is a painful inflammatory condition. Many forms of combined hormonal contraception, as well as a testosterone-blocking medication (spironolactone), are used off-label to treat acne. Other examples include clonidine, a blood pressure medication used off-label for the treatment of ADHD, migraine headaches, disorders of behavioral regulation, and insomnia; and propranolol, a blood pressure medication used off-label for the treatment of performance anxiety.

> <u>b. The AG Opinion and the Alabama Law exaggerate the fertility risks of gender-affirming hormonal treatment.</u>

[97] The quote is from the American Academy of Pediatrics Committee on Drugs. See Frattarelli DA, Galinkin JL, Green TP, Johnson TD, Neville KA, Paul IM, Van Den Anker JN; American Academy of Pediatrics Committee on Drugs. Off-label use of drugs in children. Pediatrics. 2014 Mar;133(3):563-7 (hereinafter, "AAP Committee on Drugs (2014)"); see also Allen HC, Garbe MC, Lees J, Aziz N, Chaaban H, Miller JL, Johnson P, DeLeon S. Off-Label Medication use in Children, More Common than We Think: A Systematic Review of the Literature. J Okla State Med Assoc. 2018 Oct;111(8):776-783.

[98] AAP Committee on Drugs (2014), cited in note 97.

[99] AAP Committee on Drugs (2014), cited in note 97 (emphasis added). See also Schrier L, Hadjipanayis A, Stiris T, Ross-Russell RI, Valiulis A, Turner MA, Zhao W, De Cock P, de Wildt SN, Allegaert K, van den Anker J. Off-label use of medicines in neonates, infants, children, and adolescents: a joint policy statement by the European Academy of Paediatrics and the European society for Developmental Perinatal and Pediatric Pharmacology. Eur J Pediatr. 2020 May;179(5):839-847.

[100] Hoon D, Taylor MT, Kapadia P, Gerhard T, Strom BL, Horton DB. Trends in Off-Label Drug Use in Ambulatory Settings: 2006-2015. Pediatrics. 2019 Oct;144(4):1-10 (emphasis added).

The AG Opinion claims that gender-affirming hormone treatments cause infertility.[101] The Alabama Law contains a similar statement.[102] These are unwarranted exaggerations, which ignore the substantial evidence of reversibility of the fertility effects of hormone therapy.

Treatment with gender-affirming sex hormones impacts fertility while drug therapy is ongoing, but the effect is anticipated to be reversible if medication is discontinued. Importantly, hormone therapy is always individualized, and some transgender and non-binary teens remain on puberty blockers up to the age of majority without proceeding to hormone treatment.

For transgender men (persons assigned female sex at birth who retain ovaries), testosterone treatment can affect ovarian function, inhibiting menses in the majority of those on therapy. The evidence shows that most transgender men who had regular menses before starting testosterone therapy are reported to resume menses if testosterone is discontinued.[103] Some transgender men may retain fertility during hormone treatment: spontaneous pregnancies have occurred in testosterone-treated transgender men, some while still amenorrheic.[104] Further, a number of transgender men have discontinued testosterone therapy prior to undergoing assisted reproductive technology and have carried pregnancies to term with delivery of normal infants.[105]

The effects of gender-affirming estrogen treatment on testicular histology vary among individuals. Reduced spermatogenesis is common while patients remain on estrogen, but fully normal spermatogenic activity has been documented.[106] Importantly, return of spermatogenesis occurred quickly in patients who discontinued hormone treatment.[107] Patients who were treated with puberty blockers (GnRHa's) starting at the onset of pubertal development and estrogen at

[101] AG Opinion, at 3.
[102] Alabama Law, Section 2(13).
[103] Endocrine Society (2017). Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol.* 2014;124(6):1120–1127 (hereinafter, "Light et al. 2014"); Pelusi C, Costantino A, Martelli V, et al. Effects of three different testosterone formulations in female-to-male transsexual persons. *J Sex Med.* 2014;11(12):3002–3011.; Smith KP, Madison CM, Milne NM. Gonadal suppressive and cross-sex hormone therapy for gender dysphoria in adolescents and adults. *Pharmacotherapy.* 2014;34(12):1282–1297.
[104] Light et al. (2014), cited in note 103; Light A, Wang LF, Zeymo A, Gomez-Lobo V. Family planning and contraception use in transgender men. Contraception. 2018 Oct;98(4):266-69.
[105] Leung A, Sakkas D, Pang S, Thornton K, Resetkova N. Assisted reproductive technology outcomes in female-to-male transgender patients compared with cisgender patients: a new frontier in reproductive medicine. Fertil Steril. 2019 Nov;112(5):858-65; Wallace SA, Blough KL, Kondapalli LA. Fertility preservation in the transgender patient: expanding oncofertility care beyond cancer. Gynecol Endocrinol. 2014;30(12):868-71; Maxwell S, Noyes N, Keefe D, Berkeley AS, Goldman KN. Pregnancy outcomes after fertility preservation in transgender men. Obstet Gynecol. 2017 Jun;129(6):1031-34.; Gale J, Magee B, Forsyth-Greig A, Visram H, Jackson A. Oocyte cryopreservation in a transgender man on long-term testosterone therapy: a case report. F S Rep. 2021 Feb 20;2(2):249-51.
[106] Schneider F, Kliesch S, Schlatt S, Neuhaus N. Andrology of male -to-female transsexuals: influence of cross-sex hormone therapy on testicular function. Andrology. 2017 Sept;5(5):873-80.
[107] Schneider F, Neuhaus N, Wistuba J, Zitzmann M, Heß J, Mahler D, van Ahlen H, Schlatt S, Kliesch S. Testicular functions and clinical characterization of patients with gender dysphoria (GD) undergoing sex reassignment surgery (SRS). J Sex Med. 2015 Nov;12(11):2190-2200.

16 years of age were shown to have normal-appearing, immature sperm-producing cells in the testes, suggesting those individuals retained fertility potential.[108]

As with any other medical decision, parents and providers carefully weigh the risks of treating the individual adolescent against the risks of not treating them, including the mental health impact and potential suicide risk of not beginning gender-affirming care.

As the standard protocols summarized in Section 1 of this report demonstrate, there is no push by physicians to proceed to hormone therapy. On the contrary, the decision to proceed with drug therapy and the choice of therapy are determined after assessing each adolescent's medical history as well as their past and ongoing mental health concerns. The standard of care specifically states that any existing mental health issues must be stable prior to moving forward with gender-affirming medical interventions. When counseling transgender adolescents who are considering gender-affirming drug therapy, physicians can also offer sperm or oocyte (egg) cryopreservation.

In addition to its claims about fertility, the AG Opinion offers a list of asserted medical harms without citation to any existing medical authority. The cited source is a healthcare website, and the underlying document has been removed from the site and is not otherwise available on the Internet.[109] The opinion offers no scientific foundation for its claims but seems to conflate long-outdated practice with the current standard of care.[110]

A more accurate perspective begins with an understanding of the role of hormones in the body. Hormones play a role in determining the medical profile of cisgender people. Generally speaking, cisgender women have relatively higher levels of estrogen and lower levels of testosterone, and cisgender men have the reverse. Each hormonal profile carries with it medical benefits and risks. Cisgender women, for example, have lower rates of cardiovascular disease than cisgender men but higher risks of venous thromboembolism. When a transgender individual receives gender-affirming hormone treatment, they take doses of exogenous sex hormones that approximate the physiologic state of their identified gender. Put simply, a transgender female is supplied an amount of estrogen similar to the estrogen that a cisgender woman's ovaries typically produce. Similarly, a transgender male receives a dose of testosterone that approximates what a cisgender male's testicles typically produce. Protocols provide explicit dosage guidelines to approximate the physiology of the patient's identified gender rather than to develop desired physical characteristics.

The medical result is that transgender individuals move toward the typical medical profile of their identified gender. And so transgender women, like cisgender women, have lower risks of

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[108] de Nie I, Mulder CL, Meißner A, Schut Y, Holleman EM, van der Sluis WB, Hannema SE, den Heijer M, Huirne J, van Pelt AMM, van Mello NM. Histological study on the influence of puberty suppression and hormonal treatment on developing germ cells in transgender women. Hum Reprod. 2022 Jan 28;37(1):297-308.

[109] The AG Opinion cites to Timothy Cavanaugh, M.D., Cross-Sex Hormone Therapy, FENWAY HEALTH (2015), https://www.lgbtqiahealtheducation.org/wp-content/uploads/Cross-Sex-Hormone-Therapy1.pdf. A search conducted in March 2022 found that the link was broken and the document could not be found on the Fenway Health website or elsewhere on the Internet.

[110] The iatrogenic (drug-induced) risks of hepatotoxicity, meningioma, and prolactinoma are now zero, because the medication associated with those risks (cyproterone) is no longer in use in the United States. WPATH (2012), p. 48.

cardiovascular disease than cisgender men.[111] Transgender women, like cisgender women, have a slightly higher risk of venous thromboembolism than cisgender men. In fact, transgender women have a *lower* risk of venous thromboembolism than cisgender women, and the overall risk is extremely low (less than 1%) for all transgender individuals, both women and men.[112] The risk of venous thromboembolism in transgender women and non-pregnant cisgender women is less than the risk in pregnancy, which is the highest estrogenic physiologic state known.

It is also critical to note that the medical impact of gender-affirming treatment is generally the same in transgender people as in cisgender people who take the same hormone medications. For example, physicians commonly prescribe hormonal contraceptives containing ethinyl estradiol (a synthetic estrogen) to adolescents for reasons including birth control, management of irregular or painful menstrual periods, and acne. In other words, similar doses of exogenous sex hormones are commonly administered to cisgender individuals for a host of reasons and are well tolerated.

[111] Connelly PJ, Marie Freel E, Perry C, Ewan J, Touyz RM, Currie G, Delles C. Gender-Affirming Hormone Therapy, Vascular Health and Cardiovascular Disease in Transgender Adults. Hypertension. 2019 Dec;74(6):1266-1274. doi: 10.1161/HYPERTENSIONAHA.119.13080. Epub 2019 Oct 28. Erratum in: Hypertension. 2020 Apr;75(4):e10. PMID: 31656099; PMCID: PMC6887638.

[112] Oral estradiol, the preferred estrogen formulation that is given to transgender women in the United States, carries a VTE risk of <1%. T'Sjoen G, Arcelus J, Gooren L, Klink DT, Tangpricha V. Endocrinology of Transgender Medicine. Endocr Rev. 2019 Feb 1;40(1):97-117. In transgender men, the overall risk of VTE ranges from 0% to 0.34%. Maraka S, Singh Ospina N, Rodriguez-Gutierrez R, Davidge-Pitts CJ, Nippoldt TB, Prokop LJ, Murad MH. Sex Steroids and Cardiovascular Outcomes in Transgender Individuals: A Systematic Review and Meta-Analysis. J Clin Endocrinol Metab. 2017 Nov 1;102(11):3914-23.

Appendix A: Additional Information on Biased Sources of Information in the AG Opinion

Here, we address two sources of information mischaracterized by the AG Opinion as authorities on, respectively, science and medical ethics.

a. The Society for Evidence-Based Gender Medicine

The AG Opinion twice cites the Society for Evidence-Based Gender Medicine ("SEGM"). SEGM claims to be "an international group of over 100 clinicians and researchers concerned about the lack of quality evidence for the use of hormonal and surgical interventions as first-line treatment for young people with gender dysphoria."[113]

Despite SEGM's statement, the group appears to be nothing more than a website; it does not appear to hold meetings, screen its members, or publish a journal. The original content on the website includes statements unsupported by any citations. When the content does provide citations, they are often unreliable or misleading. The SEGM website includes a list of citations to more than 100 articles as evidence for the medical risks of gender-affirming care, but we reviewed each article and found the vast majority to be of low quality. The site's content omits mention of the standards of care published by mainstream scientific organizations, and it falsely claims that the standard protocols permit gender-affirming surgery before the age of majority. The long list of citations omits mainstream scientific articles that do not support the SEGM agenda, and the list includes a large number of letters to the editor, which are not peer-reviewed or fact-checked,[114] as well as other sources of little scientific value, including opinion pieces and case studies.

Although the SEGM site claims "over 100 clinicians and researchers" as members, it lists as "clinical and academic advisors" a group of only 14 people, many of whom have limited (or no) scientific qualifications related to the study of medical treatment for transgender people. Of the 14, only eight claim academic credentials above the master's degree level (and, of these, two of the PhD's are in sociology and evolutionary biology). None have academic appointments in pediatric medicine or child psychology; none have published original empirical research on the medical treatment of transgender people in a peer-reviewed publication; and none currently treat patients in a recognized gender clinic.[115]

A contextual examination reveals that SEGM is an ideological organization without apparent ties to mainstream scientific or professional organizations. Its 14 core members are a small group of repeat players in anti-trans activities – a fact that the SEGM website does not disclose. These 14 often write letters to the editor of mainstream scientific publications; these letters appear in the list of publications on the website (even though letters to the editor typically are not peer-reviewed or fact-checked). (Our review shows that the group of 14 has a total of 39 relevant publications and that 75% of these are letters to the editor.)

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[113] All SEGM.org website citations reflect visits to the site in March 2022.
[114] Of the 123 listed papers (some are listed more than once), 49 (or 40%) are letters to the editor or opinion pieces.
[115] These findings are based on the biographical data posted on the SEGM.org website, supplemented with searches of Google (to determine academic appointments and listed publications) and the database PubMed (to determine medical publication records).

The core members of SEGM frequently serve together on the boards of other organizations that oppose gender-affirming treatment and, like SEGM, feature biased and unscientific content. These include Genspect, Gender Identity Challenge (GENID), Gender Health Query, Rethink Identity Medicine Ethics, Sex Matters, Gender Exploratory Therapy Team, Gender Dysphoria Working Group, and the Institute for Comprehensive Gender Dysphoria Research.

b. Purported bioethics experts

The AG Opinion cites two purported ethics experts for the proposition that "it is particularly unethical to radically intervene in the normal physical development of a child to 'affirm' a 'gender identity' that is at odds with bodily sex."[116]

This is an unreliable citation for two reasons. First, the cited item is not published in a peer-reviewed or mainstream legal or ethics journal. It appears, instead, in *Public Discourse*, an online journal on the website of an organization with no clear academic or professional affiliation.[117] Second, the two authors have strong ties to anti-trans activism. The first author, Ryan T. Anderson, is the president of a right-wing, Catholic-identified think tank. [118] (Anderson is also the founder of the publishing journal, *Public Discourse*, further undermining the credibility of the citation.) The second author, Robert George, is a professor at Princeton who has long been engaged in anti-trans political activism. George is the founder of The American Principles Project, which states: "We want to impose a political cost on the Left's anti-family extremism. If they want to attack parental rights [or] confuse young children about their gender…they are going to be punished at the polls."[119]

By contrast, academic experts in bioethics consider gender-affirming treatment to be ethical.[120] They emphasize "the importance of balanced decision making when counseling and

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[116] AG Opinion, at 4 (citing Anderson RT, George RP. Physical Interventions on the Bodies of Children to "Affirm" their "Gender Identity" Violate Sound Medical Ethics and Should Be Prohibited [Internet]. Public Discourse: The Journal of the Witherspoon Institute; 2019 Dec 8 [cited 2022 Mar]. Available from: https://www.thepublicdiscourse.com/2019/12/58839/.

[117] "*Public Discourse* is the online journal of the Witherspoon Institute, a 501(c)3 research center located in Princeton, New Jersey". Our Mission. Public Discourse: The Journal of the Witherspoon Institute; c2022 [cited 2022 Mar]. Available from: https://www.thepublicdiscourse.com/our-mission/.

[118] "Founded in 1976, the Ethics and Public Policy Center" works "to apply the riches of the Judeo-Christian tradition to contemporary questions of law, culture, and politics, in pursuit of America's continued civic and cultural renewal." About. Ethics & Public Policy Center; c2022 [cited 2022 Mar]. Available from: https://eppc.org/about/. The EPPC's programs include "Catholic Studies" and the "Catholic Women's Forum. Programs. Ethics & Public Policy Center; c2022 [cited 2022 Mar]. Available from: https://eppc.org/program/. Anderson is listed as the president. Ryan T. Anderson. Ethics & Public Policy Center; c2022 [cited 2022 Mar]. Available from: https://eppc.org/author/ryan_anderson/.

[119] About. American Principles Project; c2020 [cited 2022 Mar]. Available from: https://americanprinciplesproject.org/about/. On another page, the website states that the American Principles Project was founded in 2009 by George and "veteran political strategist Frank Cannon." History. American Principles Project; c2020 [cited 2022 Mar]. Available from: https://americanprinciplesproject.org/about/history-story/.

[120] For examples, see Kimberly LL, Folkers KM, Friesen P, Sultan D, Quinn GP, Bateman-House A, Parent B, Konnoth C, Janssen A, Shah LD, Bluebond-Langner R, Salas-Humara C. Ethical Issues in Gender-Affirming Care for Youth. Pediatrics. 2018 Dec;142(6):e20181537; Bizic MR, Jeftovic M, Pusica S, Stojanovic B, Duisin D,

treating adolescents with nonconforming gender identities,"[121] and they have evaluated decision-making procedures that can ensure that adolescents and their parents give fully-informed consent to treatment.[122] These considerations align with the consent processes prescribed by standard medical protocols, which we discuss in Section 1.

Vujovic S, Rakic V, Djordjevic ML. Gender Dysphoria: Bioethical Aspects of Medical Treatment. BioMed Res Int. 2018 Jun 13;2018:9652305; Strang JF, Powers MD, Knauss M, Sibarium E, Leibowitz SF, Kenworthy L, Sadikova E, Wyss S, Willing L, Caplan R, Pervez N, Nowak J, Gohari D, Gomez-Lobo V, Call D, Anthony LG. "They Thought It Was an Obsession": Trajectories and Perspectives of Autistic Transgender and Gender-Diverse Adolescents. J Autism Dev Disord. 2018 Dec;48(12):4039-55.

[121] Steensma TD, Wensing-Kruger SA, Klink DT. How Should Physicians Help Gender-Transitioning Adolescents Consider Potential Iatrogenic Harms of Hormone Therapy? AMA J Ethics. 2017 Aug 1;19(8):762-70.

[122] Vrouenraets LJJJ, Hartman LA, Hein IM, de Vries ALC, de Vries MC, Molewijk BAC. Dealing with Moral Challenges in Treatment of Transgender Children and Adolescents: Evaluating the Role of Moral Case Deliberation. Arch Sex Behav. 2020 Oct;49(7):2619-34.