STATE OF NORTH DAKOTA | IN DISTRICT COURT
COUNTY OF BURLEIGH | SOUTH CENTRAL JUDICIAL DISTRICT

T.D., by and through his parents, Devon Dolney and Robert Dolney, et al., Plaintiffs, v. DREW H. WRIGLEY, in his official capacity as Attorney General for the State of North Dakota, et al., Defendants.	Case No. 08-2023-CV-02189 BRIEF OF AMICI CURIAE AMERICAN ACADEMY OF PEDIATRICS AND ADDITIONAL MEDICAL AND MENTAL HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Brenda L. Blazer (#04155)
VOGEL LAW FIRM
200 North 3rd St.
Bismarck, ND 58501
Phone: (701) 258-7889
bblazer@vogellaw.com

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

Cortlin Lannin (clannin@cov.com)
COVINGTON & BURLING LLP
Salesforce Tower
415 Mission St., Suite 5400
San Francisco, CA 94105
Phone: (415) 591-6000

Counsel for Amici Curiae

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STATEMENT OF INTEREST OF AMICI CURIAE

[¶1] Amici curiae are the American Academy of Pediatrics, the Academic Pediatric Association, the American Academy of Child & Adolescent Psychiatry, the American Academy of Family Physicians, the American Academy of Nursing, the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality, the American College of Obstetricians and Gynecologists, the American College of Osteopathic Pediatricians, the American College of Physicians, the American Medical Association, the American Pediatric Society, the Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, Inc., the Endocrine Society, the National Association of Pediatric Nurse Practitioners, the Pediatric Endocrine Society, the Societies for Pediatric Urology, the Society for Adolescent Health and Medicine, the Society for Pediatric Research, the Society of Pediatric Nurses, and the World Professional Association for Transgender Health (collectively, "amici").[1]

[¶2] Amici are professional medical and mental health organizations seeking to ensure that all adolescents, including those with gender dysphoria, receive the optimal medical and mental health care they need and deserve. Amici represent thousands of health care providers who have specific expertise with the issues raised in this brief. The Court should consider amici's brief because it provides important expertise and addresses misstatements about the treatment of transgender adolescents.

[1] Amici affirm that no counsel for a party authored this brief in whole or in part and that no person other than amici or their counsel made any monetary contributions intended to fund the preparation or submission of this brief.

SUMMARY OF ARGUMENT

[¶3] Chapter 12.1-36.1 of the North Dakota Century Code (the "Healthcare Ban") prohibits healthcare providers from providing patients under 18 with critical, medically necessary, evidence-based treatments for gender dysphoria.[2] Denying such evidence-based medical care to adolescents who meet the requisite medical criteria puts them at risk of significant harm. Below, *amici* provide the Court with an accurate description of the relevant treatment guidelines and summarize the scientific evidence supporting the medical interventions prohibited by the Healthcare Ban for adolescents.[3]

[¶4] Gender dysphoria is a clinical condition that is marked by distress due to an incongruence between the patient's gender identity (*i.e.*, the innate sense of oneself as being a particular gender) and sex assigned at birth. This incongruence can lead to clinically significant distress and impair functioning in many aspects of the patient's life.[4] If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with higher rates of suicide. As such, the effective treatment of gender dysphoria saves lives.

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[2] Subsection 12.1-36.1-02(1)(c) prohibits medical treatments that are administered for the purpose of treating gender dysphoria, including "puberty-blocking medication to stop normal puberty," "supraphysiologic doses of testosterone to females," and "supraphysiologic doses of estrogen to males." As discussed in this brief, these treatments are medically necessary care for certain adolescents with gender dysphoria. The law provides that a health care provider who "willfully" provides such care is "guilty of a class A misdemeanor." Chapter 12.1-36.1-02(2)(b). A legacy clause provides that the penalty

[¶5] The widely accepted recommendation of the medical community, including that of the respected professional organizations participating here as *amici*, is that the standard of care for treating gender dysphoria is "gender-affirming care."[5] Gender-affirming care is care that supports an adolescent with gender dysphoria as they explore their gender identity—in contrast with efforts to change the individual's gender identity to match their sex assigned at birth, which are known to be ineffective and harmful.[6] For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical interventions to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including gender-affirming

describes the professionally-accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that supports the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief explains how the Healthcare Ban would irreparably harm adolescents with gender dysphoria by denying crucial care to those who need it.

I. Understanding Gender Identity and Gender Dysphoria.

[¶8] A person's gender identity is a person's deep internal sense of belonging to a particular gender.[8]

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

[¶10] Adolescents with gender dysphoria are not expected to identify later as their sex assigned at birth.[16] Instead, “[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult.”[17]

[¶11] If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.[18] Indeed, over 60% of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75% reported symptoms of generalized anxiety disorder in the preceding two weeks.[19] Even more troubling, more than

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[14] AAP Policy Statement, *supra* note 4, at 3.

[15] *See* Am. Psychiatric Ass’n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022).

[16] *See, e.g.*, Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/22917211 (“In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood”).

[17] Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist’s View*, 17(10) NATURE REV. ENDOCRINOLOGY 581, 585 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/34376826.

[18] *See* Brayden N. Kameg & Donna G. Nativio, *Gender Dysphoria In Youth: An Overview For Primary Care Providers*, 30(9) J. AM. ASSOC. NURSE PRAC. 493 (2018), https://pubmed.ncbi.nlm.nih.gov/30095668.

[19] *See* Amit Paley, *The Trevor Project 2020 National Survey*, at 1, https://www.thetrevorproject.org/wp-content/uploads/2020/07/The-Trevor-Project-National-Survey-Results-2020.pdf.

have worked with patients with gender dysphoria for many years.

[¶14]

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

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

[¶17] For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family.[29] The Guidelines do not recommend that any medical interventions (such as medications or surgery) be provided to prepubertal children with gender dysphoria.[30]

a sustained and persistent pattern of gender nonconformity or gender dysphoria; (3) the adolescent has demonstrated the emotional and cognitive maturity required to provide informed consent for treatment; (4) any coexisting psychological, medical, or social problems that could interfere with diagnosis, treatment, or the adolescent's ability to consent have been addressed; (5) the adolescent has been informed of the reproductive effects of treatment in the context of their stage in pubertal development and discussed fertility preservation options; and (6) the adolescent has reached Tanner stage 2 of puberty to initiate pubertal suppression.[32] Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (7) agree with the indication for treatment, (8) confirm the patient has started puberty, and (9) confirm that there are no medical contraindications.[33]

[¶19] If all of the above criteria are met, and the patient and their parents provide informed consent, gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," may be offered beginning at the onset of puberty.[34] The purpose of puberty blockers is to delay pubertal development until adolescents are old enough and have sufficient time to make more informed decisions about whether to pursue further treatments.[35] Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible bodily changes such as protrusion of the Adam's apple or breast growth.[36] Puberty blockers have well-known efficacy and side-

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[32] WPATH Guidelines, *supra* note 24, at S59–65.

[33] Endocrine Soc'y Guidelines, *supra* note 24, at 3878 tbl.5.

[34] WPATH Guidelines, *supra* note 24, at S61–62, S64; Endocrine Soc'y Guidelines, *supra* note 24, at 3878 tbl.5; Martin, *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, *supra* note 7.

[35] WPATH Guidelines, *supra* note 24, at S112.

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

effect profiles,[37] and their effects are generally reversible.[38] In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.[39] The risks of any serious adverse effects from these treatments are exceedingly rare when provided under clinical supervision.[40]

[¶20] Later in adolescence—and if the criteria below are met—hormone therapy may be used to initiate puberty consistent with the patient's gender identity.[41] Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.[42] Hormone therapy is only prescribed when a qualified mental health professional has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity to consent to the treatment, and that any coexisting problems have been addressed.[43] A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, and the patient and their parents or guardians must be informed of the potential effects and side effects and give their informed consent.[44] Although some of the

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[37] See Martin, supra note 7, at 2.

[38] See id.

[39] See F. Comite et al., Short-Term Treatment of Idiopathic Precocious Puberty with a Long-Acting Analogue of Luteinizing Hormone-Releasing Hormone — A Preliminary Report, 305 NEW ENG. J. MED. 1546 (1981).

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

[41] Martin, supra note 7, at 2.

[42] See AAP Policy Statement, supra note 4, at 6.

[43] Endocrine Soc'y Guidelines, supra note 24, at 3878 tbl.5.

[44] See id

changes caused by hormone therapy become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones.[45]

[¶21] The Guidelines contemplate that the provision of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and close monitoring to mitigate any potential risks.[46] Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents or guardians, and the medical and mental health care team. There is "no one-size-fits-all approach to this kind of care."[47]

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process, Employing the Same Scientific Rigor That Underpins Other Medical Guidelines.

[¶22] The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous requirements—as other guidelines promulgated by *amici* and other medical organizations.

[¶23] For example, the Endocrine Society's Guidelines were developed following a 26-step, 26-month drafting, comment, and review process.[48] The Endocrine Society imposes strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.[49] That GRADE assessment is then reviewed, re-

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[45] *See* AAP Policy Statement, *supra* note 4, at 5–6.

[46] *See* Endocrine Soc'y Guidelines, *supra* note 24, at 3871, 3876.

[47] Martin, *supra* note 7, at 1.

[48] *See, e.g.*, Endocrine Soc'y Guidelines, *supra* note 24, at 3872–73 (high-level overview of methodology).

[49] *See* Gordon Guyatt et al., *GRADE Guidelines: 1. Introduction—GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. CLINICAL EPIDEMIOLOGY 383 (2011),

reviewed, and reviewed again by multiple, independent groups of professionals.[50] Reviewers are subject to strict conflict of interest rules, and there is ample opportunity for feedback and debate through the years-long review process.[51] Further, the Endocrine Society continually reviews its own guidelines and recently determined that the 2017 transgender care guidelines continue to reflect the best, most up-to-date available evidence.

[¶24] First published in 1979, the WPATH Standards of Care are currently in their 8th Edition. The current Standards of Care are the result of a robust drafting, comment, and review process that collectively took five years.[52] The draft guidelines went through rigorous review and were publicly available for discussion and debate, receiving a total of 2,688 comments.[53] 119 authors were ultimately involved in the final draft, including feedback from experts in the field as well as from transgender individuals and their families.[54]

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published that investigated the use of puberty blockers on adolescents with gender dysphoria,[56] and nine studies have been published that investigated the use of hormone therapy to treat adolescents with gender dysphoria.[57] These studies find positive mental health outcomes for those

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[56] See, e.g., Christal Achille et al., Longitudinal Impact of Gender-Affirming Endocrine Intervention on The Mental Health and Well-being of Transgender Youths: Preliminary Results, 8 INT'L J

adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.[58]

[¶26] For example, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not.[59] The study found that those who received puberty blocking treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.[60] Approximately nine in ten transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.[61] Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically significant degree after receiving gender-affirming hormone treatment.[62] A study published in January 2023, following 315 participants age 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated with decreased symptoms of depression and anxiety.[63]

[¶27] As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with

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Transgender Adults

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

[¶29] The Healthcare Ban denies adolescents with gender dysphoria in North Dakota access to medical interventions that are designed to improve health outcomes and alleviate suffering and that are grounded in science and endorsed by the medical community. The medical treatments prohibited by the Healthcare Ban can be a crucial part of treatment for adolescents with gender dysphoria and necessary to preserve their health.

[¶30] As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life.[68] 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.

CONCLUSION

[¶31] For the foregoing reasons, the court should grant Plaintiffs' motion for a temporary restraining order and preliminary injunction.

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[68] *See* M. Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) CLINICAL ENDOCRINOLOGY 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; *see also* Turban, *Pubertal Suppression For Transgender Youth And Risk of Suicidal Ideation*, *supra* note 56.

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Respectfully submitted,

/s/ Brenda L. Blazer

Brenda L. Blazer (#04155)
VOGEL LAW FIRM
200 North 3rd St. Bismarck,
ND 58501 Phone: (701)
258-7889
bblazer@vogellaw.com

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

Cortlin H. Lannin
COVINGTON & BURLING LLP
Salesforce Tower
415 Mission St., Suite 5400
San Francisco, CA 94105
Phone: (415) 591-6000
clannin@cov.com

Counsel for Amici Curiae

SUR KDF YLFH PRWLRQV IRUWKFR