No. 23-477

In the Supreme Court of the United States

UNITED STATES OF AMERICA, PETITIONER

v.

JONATHAN SKRMETTI, ATTORNEY GENERAL AND REPORTER FOR TENNESSEE, *ET AL.*, RESPONDENTS

and

L.W., BY AND THROUGH HER PARENTS AND NEXT FRIENDS, SAMANTHA WILLIAMS AND BRIAN WILLIAMS, *ET AL.*, RESPONDENTS IN SUPPORT OF PETITIONER

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE STATE OF TEXAS AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

Table of Authorities II
Interest of Amicus Curiae 1
Summary of Argument 3
Argument 4
I. The Court Should Not Declare, As A Legislative Fact, That The Prohibited Procedures Are Effective Treatments of Gender Dysphoria In Minors. 4
A. The district court did not determine any legislative facts about the prohibited procedures. 4
B. In defending its statute in a different case, Texas produced substantial evidence that there is no evidence for the efficacy of the prohibited procedures. 8
1. There are two and only two biological sexes. 8
2. There is no physical test for gender dysphoria. It is purely a mental condition. 9
3. Gender identity can change over time. 11
4. Adolescent onset gender dysphoria is so new that it is not in the DSM-V. 11
5. Gender dysphoria is a social contagion. 12

6. Treatment of adolescent onset gender dysphoria is a developing field. The prohibited treatments are experimental, and no scientific evidence supports their supposed benefits....14
7. The risks of the prohibited procedures outweigh the benefits....19
8. Minors cannot give informed consent to the prohibited procedures. 20
9. Therapy is effective. 20

Conclusion 22

TABLE OF AUTHORITIES

Page(s)

Cases:

Brown v. Chote,
411 U.S. 452 (1973) 7

Kincaid v. Williams,
143 S. Ct. 2414 (2023) (Alito, J., dissenting from the denial of certiorari) 10

Loe v. State,
692 S.W.3d 215 (Tex. 2024)....1

Lyng v. Castillo,
477 U.S. 635 (1986) 11

Trump v. In'l Refugee Assistance Project,
582 U.S. 571 (2017) 7

United States v. Gould,
536 F.2d 216 (8th Cir. 1976) 5, 20-21

Cases—Continued: Page(s)

United States v. Virginia,
518 U.S. 515 (1996) 3

Univ. of Tex. v. Camenisch,
451 U.S. 390 (1981) 7

Constitutional Provision and Statutes:

U.S. Const. amend. XIV 1

29 U.S.C. § 705(20)(F)(i) 10

42 U.S.C.:
§ 12102(1)(A) 10
§ 12211(b)(1) 10

Tex. Health & Safety Code §§ 161.701-.706 1

Other Authorities:

Hilary Cass, M.D., Independent Review of Gender Identity Services for Children and Young Adults, National Health Services England (Apr. 2024) (the "Cass Report"), available at https://tinyurl.com/mw4s3arn 18, 19

Gary Lawson, EVIDENCE OF THE LAW: PROVING LEGAL CLAIMS (2017) 6

Haley N. Proctor, *Rethinking Legislative Facts*, 99 Notre Dame L. Rev. 955 (2024) 2, 5, 6

https://www.texasattorneygeneral.gov/state-vs-loe 2, 8

INTEREST OF AMICUS CURIAE[1]

Texas has an interest in defending SB1 because Texas has a similar statute prohibiting certain medical procedures to treat gender dysphoria in minors. Texas Health & Safety Code §§ 161.701-.706 (statute); Pet. Br. at 7 n.3 (acknowledging the similarity). Texas has successfully defended its statute against challenges brought under the Texas Constitution. *Loe v. State*, 692 S.W.3d 215 (Tex. 2024).

Texas agrees with Tennessee that the Equal Protection Clause does not prohibit states from enacting such statutes. They are appropriate responses to harmful ideas that are not evidence-based about how to treat the unprecedented recent outbreak of gender dysphoria among a small number of adolescents, many of whom have comorbidities, who report feeling unhappy about their biological sex. The States' traditional police powers have always included the power to regulate medical procedures for minors, and the Fourteenth Amendment did not change that.

In its petition for certiorari, the United States claimed that "overwhelming evidence establishes that appropriate gender-affirming treatment with puberty blockers and hormones directly and substantially improves the physical and psychological wellbeing of transgender adolescents with gender dysphoria." Cert. Pet. at 7. That assertion is false. *See part* I.B.6, *infra*. Similarly, in its merits brief, the United States claims that "[m]edical evidence and clinical experience demonstrate that [the prohibited medical procedures], provided

[1] No counsel for any party authored this brief, in whole or in part. No person or entity other than amici contributed monetarily to its preparation or submission.

in appropriate cases, meaningfully improves the health and wellbeing of transgender adolescents with gender dysphoria." Pet. Br. at 5–6 (citing App. 194a–197a). The citation is to the district court's opinion at the preliminary-injunction stage: "Plaintiffs contend that the medical procedures banned by SB1 confer important benefits on patients. (Doc. No. 33 at 12). Based on its review of the record, the Court agrees." App. 194a–195a.

Although the district court's statement is limited to "this record" at a preliminary-injunction stage, the United States presents the supposed "fact" that the prohibited procedures "meaningfully improve[] the health and wellbeing of transgender adolescents with gender dysphoria" as an always-and-everywhere settled, undisputed fact about the world. This type of fact is a "legislative fact" because it is "not unique to the parties and may give shape to legal rules that bind the world." Haley N. Proctor, *Rethinking Legislative Facts*, 99 Notre Dame L. Rev. 955, 957 (2024). If the Court accepts the United States' assertion, then other courts and non-parties will be bound by it.

But the evidence set about the efficacy of the prohibited procedures should not yet be closed. In Texas's defense of its statute in state court, Texas presented a great deal of evidence calling the United States' supposedly undisputed legislative fact into question.[2] For instance, treatment of adolescent onset gender dysphoria is a developing field. The prohibited treatments are experimental, and no scientific evidence supports their supposed benefits there are two and only two biological sexes. Moreover, there is no physical test for gender dysphoria. It is purely a mental condition. Gender

[2] Available at https://www.texasattorneygeneral.gov/state-vs-loe.

identity can change over time. Adolescent onset gender dysphoria is so new that it is not in the DSM-V. Gender dysphoria is a social contagion. The risks of the prohibited procedures outweigh the benefits. Minors cannot give informed consent to the prohibited procedures. And therapy is effective.

Texas therefore has an interest in not having the Court announce a settled, undisputed legislative fact, based only on the preliminary-injunction record in this case, which could then be used to challenge Texas's statute in future litigation.

SUMMARY OF ARGUMENT

Texas agrees with Tennessee that the Equal Protection Clause does not prohibit states from enacting statutes like SB1 because such statutes do not discriminate based on sex, do not discriminate against any quasi-suspect class, and are subject to rational-basis review, which they survive. Texas will not add anything to Tennessee's excellent argument.

But if the Court were to view such statutes as discriminating on the basis of sex, or as classifying based on "transgender" status and that "transgender" status is a quasi-suspect class, then such statues would be subject to intermediate scrutiny and would be declared unconstitutional unless they serve important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives. *United States v. Virginia*, 518 U.S. 515, 532–33 (1996).

Whether the prohibited medical procedures "meaningfully improve[] the health and wellbeing of transgender adolescents with gender dysphoria" is relevant to whether SB1 and similar statutes serve important governmental interests. The Court should not

answer that question, as a matter of always-and-everywhere settled, undisputed legislative fact, because the evidence set should not be considered closed—especially in the light of the record Texas developed in its case defending its similar statute.

ARGUMENT

I. The Court Should Not Declare, As A Legislative Fact, That The Prohibited Procedures Are Effective Treatments of Gender Dysphoria In Minors.

The United States claims that the district court determined that the prohibited procedures are effective to treat gender dysphoria in minors, and that the question is forever settled. But the court did not and could not do that, and in fact the question is hardly settled. To the contrary, Texas compiled a great deal of evidence challenging the United States' claim in its parallel state-law challenge.

A. The district court did not determine any legislative facts about the prohibited procedures.

Citing the trial court's preliminary injunction order, the United States claims that the district court determined, without qualification, that "Medical evidence and clinical experience demonstrate that [the prohibited procedures], provided in appropriate cases, meaningfully improves the health and wellbeing of transgender adolescents with gender dysphoria." Pet. Br. at 5–6 (citing App. 194a–197a). But in its ruling at the preliminary-injunction phase, the district court specified that it was only "concerned with the relative persuasiveness of the two sides' experts based on the current record, and not with declaring which side's experts ultimately are in the

right." App. 176a n.39. The United States mischaracterizes the district court's ruling as establishing settled, undisputed legislative facts about the efficacy of the prohibited procedures to treat gender dysphoria in minors. In so doing, the United States confuses legislative facts for adjudicative facts.

"Legislative facts are established truths, facts, or pronouncements that do not change from case to case but apply universally, while adjudicative facts are those developed in a particular case." *United States v. Gould*, 536 F.2d 216, 220 (8th Cir. 1976). Legislative facts are "not unique to the parties and may give shape to legal rules that bind the world." Proctor, *supra*, at 957. They "are facts about the broader world, while adjudicative facts are facts about the parties and their dispute," *id.* at 977, and "call for exercises of conjecture, prediction, or opinion, while adjudicative facts do not," *id.* at 978.

Courts have never developed a systematic method for determining legislative facts. "Judges, litigants, legislators, and scholars have grappled with legislative facts for nigh on a century, yet repeated invocations of the concept have yet to mature into administrable rules about what they are and who should find them." Proctor, *supra*, at 957–58.

But, as Professor Gary Lawson has argued, any "formal structure for proof of facts in the law" must involve five principles:

- Admissibility (what counts towards establishing a claim)
- Principles of weight or significance (how much the admissible evidence counts towards establishing a claim)
- Standards of proof (how much total admissible evidence one must have in order to establish a claim)

- Burdens of proof (how one makes decisions in the face of uncertainty)
- Principles of closure (when one can stop looking for more information and declare the evidence set closed)

Gary Lawson, EVIDENCE OF THE LAW: PROVING LEGAL CLAIMS 9 (2017); *see also id.* at 16–44.

Whether or not Professor Lawson is entirely correct about the nature of proof, *any* method of proving legislative facts *must* have a closure principle. However courts should decide legislative facts about the efficacy of the prohibited procedures, the evidence set should not be closed based on a single preliminary-injunction hearing which did not even result in a final ruling. The district court itself recognized that it was only making a preliminary ruling and was not purporting to establish a legislative fact.

"[C]ourts finding legislative facts are conducting complex, empirical inquiries." Proctor, *supra*, at 972. The complex, empirical inquiry into the efficacy of the prohibited procedures for minors should not cease with the district court's ruling on a preliminary injunction in a single case that happened to be the first to reach this Court.

Although the United States claims that the trial court determined, without qualification, that "Medical evidence and clinical experience demonstrate that [the prohibited procedures], provided in appropriate cases, meaningfully improves the health and wellbeing of transgender adolescents with gender dysphoria (citing A00.194a–197a)," it cited the trial court's opinion at the preliminary-injunction stage: "Plaintiffs contend that the medical procedures banned by SB1 confer important benefits on patients. (Doc. No. 33 at 12). *Based on its*

review of the record, the Court agrees." App. 194a–195a (emphasis added). The district court thus never said that the prohibited procedures had been finally demonstrated as good for adolescents with gender dysphoria as a matter of legislative fact.

Similarly, the United States asserts, "[t]he [district] court found that 'the benefits of the medical procedures banned by SB1 are well-established (citing App. 197a).'" In fact, the district court found "that the benefits of the medical procedures banned by SB1 are well-established *by the existing record*." App. 197a (emphasis added).

The district court made a preliminary ruling at a preliminary-injunction stage based on the record before it. In that posture, the court's order did "not [] conclusively determine the rights of the parties, but" instead "balance[d] the equities as the litigation moves forward." *Trump v. In'l Refugee Assistance Project*, 582 U.S. 571, 580 (2017) (citation omitted). It is not "any sense intended as a final decision." *Brown v. Chote*, 411 U.S. 452, 456 (1973). Indeed, "findings of fact and conclusions of law made by a court granting a preliminary injunction are not binding at trial on the merits." *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 395 (1981).

Thus, the district court never purported to conclusively establish that the prohibited procedures "meaningfully improve[] the health and wellbeing of transgender adolescents with gender dysphoria." That is reason enough for the Court to decline the United States' invitation to declare that as a settled, established, undisputed legislative fact that binds future courts when determining the constitutionality of similar statutes.

B. In defending its statute in a different case, Texas produced substantial evidence that there is no evidence for the efficacy of the prohibited procedures.

In Texas's ultimately successful defense of its statute that is similar to SB1, Texas produced substantial evidence contrary to the United States' proposed legislative fact that the prohibited procedures "meaningfully improve[] the health and wellbeing of transgender adolescents with gender dysphoria,"[3] detailed below. This evidence should preclude a finding of legislative fact about the efficacy and safety of the prohibited procedures at this time. The question is still open.

1. There are two and only two biological sexes.

Dr. Colin Wright, Ph.D., an evolutionary behavioral ecologist, testified as an expert for Texas on biological sex. 2.RR.229-40. He explained that "biological sex refers to the type of reproductive strategy that an individual has," and it cannot be changed. 2.RR.228-29. In anisogamous species—including humans—biological sex is defined by the type of gamete that individual can produce—an individual who produces the larger gamete is called the female, while one "who produce[] the smaller gamete or sperm is called the male." 2.RR.229-30.

[3] Available at https://www.texasattorneygeneral.gov/state-vs-loe. This webpage has hyperlinks to Volumes 1–4 of the Reporter's Record, documenting the testimony and evidence presented at the temporary injunction hearing in trial court, and Volumes 1–7 of the Clerk's Record, containing the papers submitted in the trial court. Citations to the Reporter's Record will be in the form [Vol.X].RR.[Page Y-Z]. Citations to the Clerk's Record will be in the form [Vol.X].CR.[Page Y-Z].

Because there are “only two gamete types” for a species, there are only two biological sexes. 2.RR.230.

Dr. Wright explained that in human beings, the type of gamete an individual can produce (sperm and ovum, respectively) is determined by his or her chromosomes (typically XY for males and XX for females); one’s type of gamete, in turn, results in the production of relatively greater testosterone (males) and estrogen (females), which in turn result in secondary sex-related characteristics such as facial hair (males) or breasts (females). 2.RR.235-40. These secondary characteristics do not “define the sex of an individual,” but “are downstream consequences of an individual’s sex.” 2.RR.235.

Dr. Michael Laidlaw, M.D., an endocrinologist, testified as an expert for Texas that it is not medically possible for anyone to change their biological sex. 3.RR.63.

Plaintiffs produced no contradicting evidence.

2. There is no physical test for gender dysphoria. It is purely a mental condition.

Dr. Johanna Olson-Kennedy testified as an expert for plaintiffs on “the study, research, and treatment of gender dysphoria.” 2.RR.112. Regarding the process of diagnosing gender dysphoria, Dr. Olson-Kennedy acknowledged that the condition has no physical manifestation, and that there is no “physical test to prove or disprove” a person’s “experience of having an incongruent gender identity.” 2.RR.135.

Dr. Laidlaw, expert for Texas, testified that “there is no brain study, there is no imaging, there is no blood test, there is no chromosome test, there is no genetic test which can definitively show diagnostically the gender identity of a given person. So there is no biological physical method to confirm the gender identity.” 3.RR.66. He also testified that in the DSM-V, “gender identity is a

social psychological concept distinct from biologic sex, which has to do with a person's internal feeling of being male or female or on a spectrum of male to female or some other gender identity." *Id*. As one of Plaintiffs' experts testified, the DSM-V is "published by the American Psychiatric Association. It's the primary guide by which we use to make diagnoses in the field of mental health." 2.RR.39. Dr. Laidlaw also testified, "Endocrinology is the study of glands and hormones, diagnosing disorders with those, looking at hormone imbalances or structural problems with glands…. Gender dysphoria is not an endocrine disorder. It is a psychological disorder found in the Diagnostic and Statistical Manual of Mental Health Disorders V." 3.RR.28–29.

Katrina Taylor, a psychologist, testified as an expert for Texas: "Gender identity, it's not an empirical statement. We have no proof that there's such a thing as a gender identity. I have come to see it as a personal or spiritual belief about the self. Therefore, I don't agree that one can have a gender identity that is fundamentally different from one's sexed body. What is possible are feelings of hatred, of revulsion for one's own body, whether it has to do with sex and the sexed body or whether it has to do, you know, with weight like we see in eating disorders." 3.RR.144.[4]

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[4] Incidentally, if gender dysphoria is purely a mental condition, and not a physical condition, as was undisputed in the case against Texas's statute, then gender dysphoria is not a "disability" under federal law. "Disability … shall not include … gender identity disorders not resulting from physical impairments." 42 U.S.C. § 12211(b)(1); 29 U.S.C. § 705(20)(F)(i). The Americans with Disabilities Act recognizes "physical impairments" as a distinct category from "mental impairment[s]." *Id.* §§ 12102(1)(A), 12211(b)(1); *Kincaid v. Williams*, 143 S. Ct. 2414, 2417–18 (2023) (Alito, J., dissenting from the denial of certiorari).

3. Gender identity can change over time.

Dr. Laidlaw, expert for Texas, testified that one's gender identity can change over time. 3.RR.67–68. Likewise, Dr. Olson-Kennedy, expert for plaintiffs, testified that gender identity "unfolds," and that some people "realized their gender was different than their sex" later in life. 2.RR.134–35.

Incidentally, this cuts against the idea that "transgenderism" is an immutable characteristic, and thus cuts against the idea that "transgenderism" is a quasi-suspect class. After all, one of the factors the Court has used to determine whether to recognize a quasi-suspect class is whether members of the class have "obvious, immutable, or distinguishing characteristics that define them as a discrete group," *Lyng v. Castillo*, 477 U.S. 635, 638 (1986).

4. Adolescent onset gender dysphoria is so new that it is not in the DSM-V.

Dr. James Cantor, Ph.D., testified as an expert for Texas on the scientific research related to treating gender dysphoria in minors. He testified that there are two "major types [of gender dysphoria] that have been well-known for decades … childhood onset gender dysphoria [and] … adult onset dysphoria." 3.RR.105. The former "are kids who feel like they're the opposite sex pretty much from the get-go. They start reporting it prepubertally really since childhood." 3.RR.106. The latter "almost always are in men…. These are men who are attracted to women…. But usually by middle age, you know, they've decided that they've lived a heterosexual life and that it's just not working for them. They experience a sexual interest pattern that we call autoandrophilia where they actually experience sexual arousal to the image of themselves as female." 3.RR.105–06.

But

> in the past ten years or so, really coinciding almost identically with the advent of social media, a third group has started coming to clinics, and these are completely unlike either of the first two clinics. They do not report childhood gender dysphoria like the childhood onset types. They're majority female, and they have a completely different mental health pattern, again, unlike the other two groups. This is the group who now is the large, large majority of people coming into clinics saying that they feel unhappy with their gender and want to live in some other way. Also unlike the other two types, they're very frequently picking some neologism or some ambiguous status such as being fluid or non-binary, unlike the other two groups.

3.RR.107–08.

On cross-examination, Dr. Cantor testified that the DSM-V has only two diagnoses for gender dysphoria: gender dysphoria in children and gender dysphoria is adolescents and adults. It does not have a diagnosis for adolescent onset gender dysphoria. 3.RR.132.

Plaintiffs produced no contradicting evidence.

5. Gender dysphoria is a social contagion.

Dr. Sven Román, a child and adolescent psychiatrist, testified by declaration as an expert for Texas:

> In psychiatry, it is very common for syndromes to be socially transmitted, especially among teenage and young adult females. Those who have similar problems are in contact or socialize and in these subcultures there can be a kind of competition to go the furthest.

> One example is anorexia, and experience has shown that it is often directly counterproductive to admit these patients to inpatient care, because then these girls and young women are inspired by the other anorexia patients, and a very destructive desire to extremes. Another example of social contagion is self-harm. It emerged as an epidemic in the early 1990s and has since escalated. Even for this group of patients, inpatient care is often counterproductive. It is not uncommon for patients with self-harm to post pictures and videos of self-harm on social media and, while in hospital, to contact likeminded people and ask when they will be admitted to the clinic.
>
> My view is that gender dysphoria in children and young adults is largely explained as a social contagion. A slight increase in prevalence started in 2007, when the first smartphone was launched. However, it took a few years before the majority of teenagers had a smartphone, and this coincides quite well with the sharp increase in the diagnosis of gender dysphoria in young people. American journalist Abigail Schrier's book *Irreversible Damage: The Transgender Craze Seducing Our Daughters* (2020) provides a vivid and detailed account of the social contagion of gender dysphoria.

4.CR.1630–31.

6. Treatment of adolescent onset gender dysphoria is a developing field. The prohibited treatments are experimental, and no scientific evidence supports their supposed benefits.

Dr. Cantor, expert for Texas, testified that although "we have outcome studies on the childhood onset type and we have outcome studies on the adult onset type, we have absolutely no data, we have no outcome studies on this -- what I'll call the adolescent onset type even though they are now suddenly the large majority of people coming into clinics." 3.RR.108.

He also testified that there are "various levels of evidence going from low-quality evidence that are relatively uncertain or ambiguous up through high-quality evidence that is highly reliable and worth generalizing to other people." 3.RR.83. "[L]ow-quality studies are very numerous in the research literature exactly because or as a side effect of their being easy to perform, but they're less reliable. The more systematic and the more reliable studies are harder to perform, take more time to perform, and take much more thorough analysis, so there are fewer of them." 3.RR.86. The highest-quality studies are "systematic reviews which review all the other studies beneath it assessing them according to their relative qualities." *Id.*

Dr. Cantor testified that the "great majority of the studies [relied on by the plaintiffs' experts] were surveys." Surveys "are very, very common because it's so easy to conduct a survey, for example, on the Internet. Surveys can, you know, help us give, you know -- help us produce hypotheses, can help give us ideas, but they don't represent evidence at all.... [T]hey can give us a good idea of questions to look at, but they don't represent

any kind of outcomes evidence." 3.RR.95. Surveys "don't count as medical evidence, they don't count as outcome evidence, but the conclusions of the [plaintiffs'] experts depended largely on what doesn't count as evidence." 3.RR.96.

The lowest-quality evidence comes from "case studies and reports," which "are generally retrospective studies where somebody would go through hospital records, for example, pull out cases of specific diagnoses and see what happened amongst those people. It gives -- it can give some idea of what to expect if nothing is done, but because these are not systematic, they're not yet ready for any kind of generalization to other cases." 3.RR.90. "[T]here have been a handful [of case studies about the prohibited procedures on minors] published over the years. But again, they generally came out with ambiguous -- with ambiguous results but results that, again, suggested that it was at least worth looking at more systematically." 3.RR.97–98.

Higher quality evidence comes from "case-controlled studies," which are "looking for patterns of what happens in different groups of people or what makes different groups of people different from each other." 3.RR.90–91. Dr. Cantor is only aware of one such study, which was "a particularly low-quality study because we can't tell, you know, what changes, you know, what improvements and, you know, what got worse amongst these people" and "[t]hey were in a poor mental health status to begin with." 3.RR.98.

The next highest-quality evidence is "cohort studies," in which "we're now checking on a single group of people but over time. We're looking to see what happened, for example, before or after they were exposed to a treatment or exposed to some not just substance. So instead

of just taking a look at them at one point in time, we're taking the same group of people and looking at them over several groups of time." 3.RR.91. "There have been exactly 13 [cohort studies], and these are the 13 that I summarize in my own report. This is the highest level study that so far has been conducted at all for the medical transition of minors." 3.RR.99.

"[F]our of [the cohort studies] showed essentially no improvement at all." 3.RR.100. In "roughly six of them, there were some improvements in some mental health parameters, but we can't conclude that it was the intervention, that it was the medical interventions itself that caused the improvement because the people were getting psychotherapy at the same time." *Id.* "[T]here were two studies which were designed in a way that allowed more direct comparison trying to allocate how much of the improvement was due to the medical interventions versus how much of the improvement was due to the mental health interventions. And both of those demonstrate -- and both of those failed to demonstrate that the medical interventions produced any more benefit than did the mental health -- the psychotherapeutic interventions." 3.RR.100-01. "And there was one other very recent study that just did not indicate whether the people were in psychotherapy at the same time, so the results -- we can't assess whether the medical interventions were superior because we don't know how many were getting psychotherapy at the same time." 3.RR.101.

The next highest level of evidence comes from "randomized controlled trials[, which] are the ones where we take a group of people, randomly assign which ones are going to receive the experimental treatment and which ones are going to receive either no treatment or some other comparison treatment such as treatment as usual,

a placebo treatment, or some other -- some other intervention." 3.RR.92. There have not been any randomized control studies of the prohibited procedures. 3.RR.101.

The highest-level evidence comes from systematic reviews, which "analyze all of the studies and all of the layers that were beneath it. Again, especially in large fields with many people, there are many, many studies, and especially for very busy clinicians, it's not possible to read and integrate every single one. So the purpose of systematic reviews is to get the big picture of what all of the other studies have shown, but as I say, to do it in a systematic way that removes the potential for bias. The biggest bias, as I mentioned, was cherry-picking where people pick out the positive studies but don't mention the studies where the experiment failed." 3.R.93–94. "There have now been several systematic reviews, none conducted in the U.S. They've all been conducted by the national public healthcare systems in Europe." 3.RR.101. Each of them concluded that "there is no evidence to suggest that medicalized interventions provides any benefits superior to the mental health interventions." 3.RR.102. "Each of the systematic reviews came to the same conclusion, that the evidence for benefits are outweighed by the evidence of the risks of harm." 3.RR.104. Those harms include, sterilization, permanent loss of capacity to breast-feed, inability to orgasm and loss of sexual function, interference with neurological and cognitive development, elevated risk of Parkinsonism, and reduced bone density. 4.CR.1220–25.

In short, there is no evidence that the prohibited procedures are safe and effective to treat minors with gender dysphoria. The prohibited procedures have "not yet been tested with experimental studies, so it's necessarily still within the experimental status." 3.RR.116.

Plaintiffs produced no contradicting evidence.

Dr. Cantor's testimony is consistent with the Cass Report,[5] a study recently commissioned by the National Health Service in the United Kingdom to evaluate the safety and efficacy of puberty blockers and cross-sex hormones for children diagnosed with gender dysphoria. The authors of Cass Report spent four years reviewing clinical data, interviewing patients and providers, and conducting six systematic reviews. It concluded, among other things, the following:

- **Gender Dysphoria**: a diagnosis of gender dysphoria is "not reliably predictive of whether that young person will have longstanding gender incongruence in the future, or whether medical intervention will be the best option for them." Cass Report at 29.
- **Social Transition**: there is "no clear evidence that social transition in childhood has any positive or negative mental health outcomes, and relatively weak evidence for any effect in adolescence." *Id.* at 31.
- **Puberty Blockers**: the use of puberty blockers resulted in "no changes in gender dysphoria or body satisfaction" and there is "insufficient/inconsistent evidence about the effects of puberty suppression on psychological or psychosocial wellbeing, cognitive development, cardio-metabolic risk or fertility … there is no evidence that puberty blockers buy time to think, and some concern that

[5] Hilary Cass, M.D., Independent Review of Gender Identity Services for Children and Young Adults, National Health Services England (Apr. 2024) (the "Cass Report"), available at https://tinyurl.com/mw4s3arn.

they may change the trajectory of psychosexual and gender identity development." *Id.* at 32.

- **Cross-Sex Hormones**: "[t]here is a lack of high-quality research assessing the outcomes of hormone interventions in adolescents with gender dysphoria/incongruence, and few studies that undertake long-term follow-up. No conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility [from the use of cross-sex hormones]. Uncertainty remains about the outcomes for height/growth, cardiometabolic and bone health." *Id.* at 33.
- **Suicides**: "It has been suggested that hormone treatment reduces the elevated risk of death by suicide in this population, but the evidence found did not support this conclusion." *Id.*

7. The risks of the prohibited procedures outweigh the benefits.

As noted, Dr. Cantor testified, "Each of the systematic reviews came to the same conclusion, that the evidence for benefits are outweighed by the evidence of the risks of harm." 3.RR.104.

Dr. Román, expert for Texas, testified that the "Swedish National Board of Health and Welfare concluded that 'the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of these treatments.'" 4.CR.1637.

Dr. Laidlaw, expert for Texas, also testified, "The potential benefits [of providing puberty blockers to minors] do not outweigh the risks," 3.RR.37–38, and that "the benefits do not outweigh the risks for cross-sex hormones for adolescents," 3.RR.52.

8. Minors cannot give informed consent to the prohibited procedures.

Dr. Geeta Nangia, a child and adolescent psychiatrist, testified as an expert for Texas. She testified that "minors lack the necessary neurological, psychosocial, and cognitive development to provide informed consent or assent to" the prohibited procedures. 4.CR.1452–85.

Dr. Laidlaw, expert for Texas, testified that minors have very limited capacity to understand the implications of taking potentially life-altering puberty blockers or cross-sex hormones. 3.RR.54–57.

Dr. Alan Hopewell, a clinical psychologist and neuropsychologist, testified as an expert for Texas that minors have limited reasoning ability and cannot give informed consent to the prohibited procedures. 3.RR.186–90.

9. Therapy is effective.

Dr. Nangia, expert for Texas, "treat[s] her patients with exploratory, supportive, and family therapy," and testified that "children with gender dysphoria benefit tremendously from therapy—particularly psychodynamic therapy." 4.CR.1447–49.

Dr. Taylor, expert for Texas, testified that psychotherapy is a safe and effective treatment for minors with gender dysphoria. 3.RR.144. She testified that minors with gender dysphoria or confusion is a symptom of the family dynamic and that dysfunction in the family system needs to be addressed to resolve their feelings of gender dysphoria and confusion. 3.RR.143–44.

* * *

In sum, the district court did not and could not have announced as a matter of legislative fact ("established truths, facts, or pronouncements that do not change from case to case but apply universally," *Gould*, 536 F.2d at

220) that the prohibited treatments "meaningfully improve[] the health and wellbeing of transgender adolescents with gender dysphoria." And the evidence set for this question should not be closed. Evidence such as that presented in Texas's defense of its statute similar to SB1 and the Cass report needs to be considered before the Court can announce any legislative fact about the prohibited procedures.

CONCLUSION

The judgment of the court of appeals should be affirmed. But if the Court remands this case, it should not announce that the prohibited treatments "meaningfully improve[] the health and wellbeing of transgender adolescents with gender dysphoria" as a matter of settled, undisputed legislative fact.

Respectfully submitted.

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OCTOBER 15, 2024