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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **DEFENDANTS' REPLY IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT** [ORAL ARGUMENT REQUESTED]

INTRODUCTION

In their emotional polemic against common sense, Plaintiffs lose sight of the central issue here: subjecting children with gender dysphoria to medically unnecessary and inappropriate, life-altering, unproven, and irreversible drugs and surgery is wrong. This case is not about all access to puberty blockers, cross-sex hormones, and surgery—those are still available to consenting adults and children

who need them as appropriate treatment for medical conditions. This case is about protecting children from likely devastating treatments pushed on them by medical providers worried not about their patients' health and well-being, but their bottom lines or ideological agendas. SB 99 protects children and their families from pressure to receive puberty blockers, cross-sex hormones, and surgery—medicalized gender transition ("MGT") treatments for a temporary psychological disorder. A child's life—growing comfortable with themselves, having children themselves, building new relationships, and experiencing new sensations—should not be denied because of an imprudent, immature decision to deal with the short-term emotional discomfort of mental health issues. Accordingly, this Court should grant Defendants' (collectively, "the State") Motion for Summary Judgment.

ARGUMENT

I. SB 99 IS CONSTITUTIONAL UNDER ARTICLE II, SECTION 15.

To defeat the State's Motion, Plaintiffs must "set forth specific facts, not merely denials, speculation, or conclusory statements, in order to establish that a genuine issue of material fact does indeed exist." *Lorang v. Fortis Ins.*, 2008 MT 252, ¶ 39, 345 Mont. 12, 192 P.3d 186 (citing Mont. R. Civ. P. 56(e)). Plaintiffs' argument is entirely lacking in this regard. Instead, Plaintiffs offer conclusory statements, immaterial anecdotes, and baseless denials to try to undermine the State's common-sense analysis. The Court rightfully should reject Plaintiffs' arguments and grant summary judgment for the State.

"The rights of persons under 18 years of age shall include, but not be limited to, all the fundamental rights of this Article *unless* specifically precluded by laws which enhances the protections of such persons." Mont. Const. art. II, § 15 (emphasis added). In other words, the Constitution permits the Legislature to limit minors' fundamental rights if doing so enhances their protection. *See In re C.H.*, 210 Mont. 184, 202, 683 P.2d 931 (1984). To determine whether a law fits into this exception, the Montana Supreme Court developed a standard—different from strict scrutiny—to evaluate that law: the State must clearly show it has a compelling state interest and that the law enhances minors' protections. *Planned Parenthood v. State*, 2024 MT 178, ¶ 21, 417 Mont. 457, 554 P.3d 153. The State has done so, and Plaintiffs present no material facts to dispute this.

A. Plaintiffs' Section 15 argument is nonsensical.

Plaintiffs insert what is not there and then insist the State does not "clearly" show SB 99 enhances minors' protections under Section 15. This argument, however, does not make sense. The State, Plaintiffs, the Court, and the Montana Supreme Court all agree that the State has a compelling interest in protecting minors' "physical and psychosocial well-being." (Doc. 131 at 29). So the next step for the State is to clearly show SB 99 enhances minors' protections. Because the State easily meets this standard, Plaintiffs instead demand the State meet a higher standard of their own devise. But that demand lacks legal and logical basis.

First, Plaintiffs conflate the more rigorous *Armstrong* standard for *Planned Parenthood*'s requirement that the law "enhance the *protection* of [minors]." Mont. Const. art. II, § 15 (emphasis added). *Armstrong* does not contemplate Section 15 and, different from Section 15, requires the State make a clear and convincing showing that SB 99 regulates a "medically-acknowledged, *bona fide* health risk." *Armstrong v. State*, 1999 MT 261, ¶ 59, 296 Mont. 361, 989 P.2d 354. Section 15, as explained in *Planned Parenthood*, imposes a lesser standard on the State: "[the State] must not only show a compelling state interest but must also show that the exception is designed to enhance the protections of minors." *Planned Parenthood v. State*, 2024 MT 178, ¶ 29, 417 Mont. 457, 554 P.3d 153. These standards are not the same, and under Article II, Section 15, the State need only show SB 99 enhances the protection of minors—which the State has easily done. And that makes sense. Minors sometimes need heightened protection dissimilar to adults. Indeed, "SB 99 provides minors with the opportunity to reach their full potential without being denied freedoms or autonomy later in life because of their rash decisions as children." (Doc. 190 at 20). *Armstrong* merely provides a more rigorous framework to *further prove* the State's argument, not establish the standard the State must meet for SB 99 to prevail under Article II, Section 15.

Plaintiffs, however, woefully misapprehend the law. They incorrectly posit that the State must, to show SB 99 enhances minors' protection, clearly and convincingly prove *Armstrong*'s medically acknowledged, bona fide health risk.

(Doc. 204 at 5) (citing *Cross*, ¶¶ 21, 28). But this is not what either Section 15 requires, what the drafters contemplated, or what the Montana Supreme Court has articulated. Indeed, the State offered its *Armstrong* analysis to *further show* that SB 99 enhances minors' protection. The State never conceded—nor have courts asserted—that Section 15 demands the State also satisfy the *Armstrong* standard. Indeed, Plaintiffs are the first to ever argue that the State must make such a showing. The Court should reject this.

Plaintiffs also make up out of whole cloth a standard more stringent than strict scrutiny. They argue, "[Section 15's] requirement of minor-protection enhancement, however, is *in addition* to the conventional requirements of strict scrutiny." (Doc. 204 at 4). That does not make any sense. Plaintiffs do not—and cannot—cite any caselaw to support this absurd super-strict scrutiny standard. Indeed, *Planned Parenthood* stands for the opposite conclusion: Section 15 creates a different and independent standard from strict scrutiny. It makes no sense that Section 15 imposes a super-strict scrutiny. Strict scrutiny is already an exacting standard under which few (if any) laws have ever survived judicial review in Montana. Plaintiffs' argument betrays the Montana Constitution's plain text. No one besides Plaintiffs believe this super-strict scrutiny standard to be the applicable Section 15 standard. Plaintiffs' argument, therefore, does not make sense and lacks any supporting caselaw for this absurd assertion. The Court must reject Plaintiffs' super-strict scrutiny standard for a Section 15 claim.

To bolster this fiction, Plaintiffs take the Montana Supreme Court's decision on the preliminary injunction as supporting their imagined super-strict scrutiny standard. This is a curious assertion given that the Montana Supreme Court never once mentioned Article II, Section 15 in that decision, nor did either party substantially argue that point prior to the current summary judgment briefing. Indeed, not even the dissent touched Section 15. That the Montana Supreme Court did not mention Section 15 somehow means it imposes a super-strict scrutiny standard of review is baseless and nonsensical.

The Montana Supreme Court has never gone beyond the two-step Section 15 standard: "[Minors] have all the fundamental rights of the Declaration of Rights. The only exceptions permitted to this recognition are in cases in which rights are infringed by laws designed and operating to enhance the protection for such persons. That, in turn, requires a clear showing that such protection is being enhanced." *Planned Parenthood*, ¶ 21 (cleaned up).[1] So under Article II, Section 15, SB 99 survives.

B. SB 99 clearly enhances minors' protections.

The State has a compelling interest in protecting the mental and physical health of minors. Everyone agrees. The State achieves this interest with SB 99,

[1] The Montana Supreme Court unequivocally confirmed this when it said, "Thus, if the legislature seeks to carve out exceptions to the guarantee of equal protection, it must not only show a compelling state interest but must also show that the exception is designed to enhance the protections of minors." *Planned Parenthood*, ¶ 29. This does not—and cannot—amount to super-strict scrutiny for Section 15 claims.

protecting minors and their families from medical providers' pressure to undergo unproven, risky, and irreversible treatments on vulnerable children.

The State has brought up Elle Palmer many times in briefing because her story proves MGT not only causes harm but that medical providers pressure minors and their parents to proceed on the conveyor belt of MGT. This tracks with testimony the Legislature heard when considering SB 99. (Doc. 190 at 5–6). That extensive testimony underscores SB 99's purpose in protecting minors. Elle put it best when she said SB 99 "is a necessary law *that will protect* vulnerable children and teens" like Elle "and their parents from the tremendous regret and irreversible physical changes that" Elle and many more "have experienced after receiving medical treatments that promised to 'transition'" them. (Doc. 190, Ex. B. ¶ 2) (emphasis added). In Montana, medical providers subjected Elle and her mother to pressure to undergo life-altering treatment for a mental condition that eventually resolved. (*Id.*, ¶¶ 3–19). As Elle said,

> Children are not able to fully understand the life-changing consequences that hormones will have on their bodies and their futures as adults. These hormones will have lifelong effects on their bodies, their minds, their future romantic relationships, and their social interactions. Parents cannot predict how hormonal interventions will affect their children's future or what decisions their children will want to make as adults regarding their fertility and sexual relationships. Therefore, they should not be put in the place of making those decisions or being pressured by their child or health care provider to make those decisions on behalf of the child.

(*Id.*, ¶ 20). SB 99 protects children from a life of suffering, regret, and pain because of immature decisions their parents agreed to.

Plaintiffs try to ignore Elle's experience: "Though [the State] point[s] to the legislative testimony surrounding SB 99 and various affidavits, none of these establishes the existence of any 'pressure to receive' gender-affirming medical care in Montana." (Doc. 204 at 13). Not only is this patently false, but Plaintiffs' denial of Elle's experience is despicable. Montanan medical providers subjected her to MGT, resulting in great suffering. (Doc. 190, Ex. D ¶ 7) ("After a year of fighting with my parents, at age 16, they agreed to take me to Planned Parenthood."). Because that truth is inconvenient to Plaintiffs' argument, they simply try to ignore it as if that would make it go away. But they can't undo what Elle went through.

Nor can they deny the existence of and experience of other Montanan detransitioners and families. The Legislature heard testimony and evidence establishing there was a problem needing a solution in Montana. Consistent with Section 15, the Legislature enacted SB 99 to enhance minors' protections against pressure to receive MGT.

Unsurprisingly, Plaintiffs gloss over Article II, Section 15 and instead attempt to direct the Court's attention elsewhere—precisely because Section 15 resolves this case. That is because the evidence proves SB 99 protects children and their families from pressure to receive puberty blockers, cross-sex hormones, and surgery that causes biological abnormalities in children's bodies that would not exist otherwise.

And Plaintiffs have failed to present any facts to the contrary. Indeed, SB 99 achieves the commonsense goal that medical providers should not push life-altering, unproven, and irreversible treatments on unknowing children and their families—providing enhanced protection for minors as Section 15 *explicitly* contemplates. SB 99 shuts down the ideological rather than evidence-based agenda the medical providers pursue.

II. SB 99 NONETHELESS SURVIVES UNDER ANY LEVEL OF SCRUTINY.

Plaintiffs fumbled their Article II, Section 15 analysis. They conjured from thin air inconsistent standards and then argued that no facts support the State under those standards. Not only does SB 99 prevail under the Section 15 standard, but it also prevails even if Plaintiffs' fabricated, mix-and-match standard was valid and applicable. Plaintiffs begin by claiming that strict scrutiny is the correct standard of review and then work backwards to explain why. (*See generally* Doc. 204 at 3–31). But that is wrong. Despite Plaintiffs' privacy and equal protection claims, SB 99 is constitutional, and the State is entitled to summary judgment.

A. SB 99 regulates a medically acknowledged, bona fide health risk.

For SB 99 to survive under *Armstrong*'s standard, the State need only make a clear and convincing showing that there is a "medically-acknowledged, *bona fide* health risk." *Armstrong*, ¶ 59. This means the State just has to show there is such risk, which the undisputed facts prove. SB 99 therefore prevails under *Armstrong*.

Both parties' medical experts agree that MGT presents medically acknowledged, bona fide health risks. (Doc. 190 at 2–13; Doc. 205 at 11–15). Through informed consent forms, WPATH's Standards of Care, Endocrine Society guidelines, and other guidelines, plaintiff medical providers and others highlight the significant risks associated with MGT. If MGT does not present medically acknowledged, bona fide health risks, why would the various informed consent forms, standards of care, and other guidance specifically list those exact risks? Dr. Mistretta, for example, uses an informed consent document which relies on the 2015 Fenway Health guidelines. (Doc. 205, Ex. Q). Those guidelines specifically require hormone therapy only for 18-year-olds. (Doc. 205, Ex. R). Yet she still provides hormone therapy for minors. If risk to minors was not real, why would Fenway Health guidelines specifically not allow hormone treatment for minors? Plaintiffs present no specific facts to dispute that MGT presents medically acknowledged, bona fide health risks. That all "medical treatment can entail risk," (Doc. 204 at 6), is no argument that this potentially catastrophic treatment cannot be limited to adults who are better able to understand the risks and can provide actual informed consent. For children, the vast amount of risk is not worth whatever meager benefits Plaintiffs can conjure.[2] The facts could not be clearer.

[2] Although irrelevant to the *Armstrong* analysis, there is no medical consensus on the benefits of MGT. *See*, *e.g.*, Doc. 190 at 15-17; *K.C. v. Individual Members of Med. Licensing Bd. of Indiana*, 121 F.4th 604, 611-12 (7th Cir. 2024) ("There is no medical consensus that sex reassignment surgery is a necessary or even effective treatment for gender dysphoria.") (alteration and quotation omitted).

Here again, Plaintiffs make up standards and declare victory. They posit *Armstrong* requires "an acknowledgment by the medical community of a bona fide health risk *that warrants banning gender-affirming care*." (Doc. 204 at 5) (emphasis added). But that is not what *Armstrong* requires. *Armstrong* does not require anything beyond bona fide risk, yet Plaintiffs unilaterally insert an implied degree of risk requirement. They have added what is not there and then say the State failed to meet its burden. But under the unadulterated *Armstrong* standard, the evidence proves MGT presents medically acknowledged, bona fide health risks.

There can be no clearer indication of medically acknowledged risk than the many countries (and their medical associations) are reevaluating, banning, or restricting MGT to clinical studies: Finland, Sweden, England, Scotland, Wales, Denmark, Norway, Australia, Italy, Germany, France, Belgium, and the Netherlands (home to the Dutch protocol). (Doc. 205 at 3–4). Any of this proves there is medical acknowledgment of MGT's risks. Yet Plaintiffs believe none of what these countries are doing is appropriate—they want no regulation of MGT, let alone to restrict it to clinical study settings.

These countries do not show only "mere disagreement" in the medical community, as Plaintiffs claim. Plaintiffs also assert, "Nothing cited by Defendants can overcome the foregoing and establish a bona fide health risk acknowledged by the medical community." (Doc. 204 at 6). Plaintiffs aren't ignorant; they are in denial of the medical communities' vast consensus on MGT's risks. These are countries

rejecting what Plaintiffs posit as gospel—that MGT is safe and the standard of care for minors. But the Court must reject Plaintiffs' attempt to constitutionalize a standard of care.

Plaintiffs' blind reliance on limited cherry-picked American institutions betrays their point here. As the international community walks back MGT, only a few American institutions stonewall and refuse to accept reality. That is not "mere disagreement." Plaintiffs present no specific facts to support their denial of the obvious: these countries—the innovators and old guard of MGT—now acknowledge MGT presents so much risk that it should not be readily available to children.

Plaintiffs make the confusing point that, while other countries restrict the public's access to MGT, "none of the major medical organizations in America have." (Doc. 204 at 7). Why? Because those American organizations are apparently unconcerned with patient health in this context. They are concerned with their bottom lines and ideological agendas. "That means this lawsuit is not about adjudicating between various facts and their interpretations. It is about choosing between a worldview in which facts matter and one in which facts do not matter except insofar as they further an ideological cause." (Doc. 190, Ex. G, ¶ 18). Just like Plaintiffs' expert Dr. Johana Olson-Kennedy, because the facts contradict the ideology the facts must be ignored (Dr. Olson-Kennedy still has not published her $10 million study on puberty blockers). The irony of Plaintiffs' argument is that it was the Europeans that pioneered MGT (e.g., the Dutch protocol). These other

countries now see MGT for what it is: too risky to be unregulated and widely available to children.

This risk is not going away and only continues to compound as more research comes out, placing MGT's risk in greater focus. For example, the Journal of Sexual Medicine very recently published an American study on MGT where the researchers concluded, "both male and female patients with gender dysphoria who undergo gender-affirming surgery *are at significantly higher risk for adverse mental health outcomes*, including depression, anxiety, suicidal ideation, and substance use disorder." (Joshua E. Lewis, et al., *Examining gender-specific mental health risks after gender-affirming surgery: a national database study*, The Journal of Sexual Medicine (Feb. 4, 2025), **attached as Exhibit K**, at 6) (emphasis added).

Trying to resuscitate their losing position, Plaintiffs try to pivot away from medically acknowledged, bona fide health risk and distract from the point with tangential arguments about risk reduction, similar risks from other treatments, and "benefits" of care. None of this is material to *Armstrong*, however, and should be disregarded. *Armstrong* requires a clear and convincing showing of a medically acknowledged, bona fide health risk. The State presented more than sufficient evidence to meet this burden. Plaintiffs fail to show specific material facts to the contrary. The Court should therefore grant summary judgment for the State.

B. SB 99 does not facially classify on sex or transgender status.

Plaintiffs yet again make up the law and then operate under that legal fiction, declaring victory under this imagined legal regime. But this is not Calvinball, where players make up the rules as they play along. Yet that is exactly what Plaintiffs do with their equal protection argument.

Plaintiffs' incoherent argument seems to be that because SB 99 uses "male" and "female," it imposes a sex-based classification. (Doc. 204 at 25). They argue, "SB 99 … impose[s] differential treatment based on … '[sex because sex] determines whether or not the minor can receive certain types of medical care under the law.'" (*Id.* at 25–26) (quoting *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022). That is false[3].

SB 99 imposes the same treatment upon every minor regardless of sex. Indeed, the only difference between subsections (a) and (b) is the use of "female" and "her" instead of "male" and "his." As Plaintiffs readily admit, SB 99 "restricts medical treatment, such as hormone therapy, *that all individuals can otherwise receive, regardless of their sex.*" (Doc. 204 at 29) (emphasis added). The State agrees: SB 99 does not treat male and female minors differently.

Just because a law references or relates to sex does not mean it classifies people because of sex. SB 99 affords neither sex—male or female, man or woman—

[3] The Eight Circuit is currently reconsidering this reasoning in *Brandt v. Griffin*, No. 23-2681. (Doc. 205, Ex. B).

a benefit or a burden because of sex. Rather, SB 99 denies every *minor* certain medical services because of the *purpose* of those medical services. There is no difference in treatment of males or females.

This is neither new nor controversial. Take for example a hysterectomy—surgical removal of the uterus—to treat uterine cancer. Under SB 99, this procedure for a minor is permitted because it is medically necessary. Not removing an unhealthy uterus is worse than keeping it. But if a minor desires a hysterectomy to address her subjective feelings of identity (meaning it is a non-medically necessary surgery and therefore removing a healthy organ without a medical need), that surgery is prohibited until she reaches the age of majority. SB 99 is, on its face, an age-based restriction. The patient's sex has nothing to do with the availability of that procedure. Giving a female minor a hysterectomy to address fleeting and subjective feelings of gender identity is not healing; that is harming.

Any minor, male or female, regardless of "gender identity" or transgender status can receive puberty blockers, cross-sex hormones, or surgery for any reason *other than those SB 99 expressly prohibits*—"to address the minor's perception" that his or her gender or sex is not male or female. Plaintiffs' real concern here is that they (wrongly) believe under SB 99 a male cannot receive certain drugs or treatments that a female can (like estrogen) or that a female cannot receive drugs or treatments that a male can (like testosterone).

Not so. Male and female minors may receive puberty blockers, cross-sex hormones, or surgery to correct *biological* abnormalities. For example, a female may need testosterone to correct biologically abnormal hormonal levels. This is, however, *different* from giving a female minor testosterone so she develops more masculine secondary sex characteristics. Plaintiffs present no evidence showing a male or female minor cannot receive puberty blockers or cross-sex hormones *in all circumstances*. But neither male nor female minors may receive, for example, testosterone or estrogen *to address his or her subjective feelings about identity*. Just like a male cannot receive estrogen to make himself feel or appear more feminine, he cannot receive testosterone to make himself feel or appear more masculine (absent a medical necessity). Something else, not related to subjective feelings about gender identity, must be the reason for the treatment.

Take as another example, a patient seeks a vaginoplasty—surgical creation of an artificial vagina. That patient can be either male or female. But it is the reason for the surgery that matters. When a female seeks a vaginoplasty, that is to *correct* a biological abnormality (such as a congenital absence of a vagina). When a male seeks a vaginoplasty, that is to *create* a biological abnormality (giving a man a new, vagina-like orifice). "Affirming" a subjective gender identity that can change on a whim is categorically different from correcting congenital absence of a vagina. Plaintiffs simply seek to displace the medical reason—or lack thereof—for the medical procedure. But this is wrong. The only way for Plaintiffs to reach their

conclusion is to assume two people, a male and a female, seeking the same procedure, a vaginoplasty, do so for the same reason. This is false—the female seeks to *correct* a biological abnormality while the male seeks to affirm his subjective feelings about identity—*creating* a biological abnormality in the process.

Plaintiffs also present a completely incomprehensible, non-sequitur argument about puberty blockers. They argue, "Birth-assigned males can receive puberty delaying medication to bring their bodies into alignment with a typical male puberty, but birth-assigned females cannot." (Doc. 204 at 26). A female taking puberty blockers does not—and cannot—assume a typical male puberty path; she simply does not proceed with female puberty. A female, regardless of taking puberty blockers, can never bring herself into alignment with typical male puberty. And even when taking cross-sex hormones with puberty blockers, the female still does not go through male puberty. She merely develops masculine secondary sex characteristics. A female on puberty blockers is a pre-pubescent female while a male on puberty blockers is a pre-pubescent male; they don't change sex. Plaintiffs' nonsensical argument on this point only serves to highlight the weakness of their equal protection analysis. They can't get science right. And so they can't get the law right.

The fundamental shortcoming of Plaintiffs' equal protection argument is that they cannot show that SB 99 imposes differential treatment on males and females. Their argument "speaks the language of Equal Protection yet departs wholly from its established principles." *Kadel v. Folwell*, 100 F.4th 122, 164 (4th Cir. 2024)

(dissent). For example, Plaintiffs try (and fail) to analogize SB 99 to a ban on interracial marriages. Although they do no analysis, a ban on interracial couples violates equal protections because, for example, an Asian man cannot marry a Hispanic woman while a Hispanic man could. Thus, two men, otherwise alike (choosing to marry a Hispanic woman), are treated differently because of their race. This reasoning can be extended to gay marriage ban, where a man can marry a woman, but a woman cannot marry that same woman. Because she is a woman, such hypothetical law prohibits conduct otherwise permitted for a man. That is not the case here. Plaintiffs' absurd haircut hypothetical highlights their error in reasoning.[4] Regardless of being male or female, minors cannot receive these treatments for improper purposes. And the treatments are not age restricted because of sex. As Plaintiffs incorrectly argue, "SB 99 uses an individual's sex … to determine when treatment is prohibited and when it is permitted." (Doc. 204 at 29). Nowhere does SB 99 do this. SB 99 never looks at the minor's sex to determine permissible versus impermissible treatment. A male minor, for example, cannot receive surgery to address his subjective identity just as a female minor cannot receive surgery for that same reason. The minor's sex is immaterial to SB 99's age restrictions. Plaintiffs' half-baked analysis here shows how SB 99 does not violate equal protections.

[4] As an aside, the military imposes sex-specific regulations for soldiers' haircuts. For example, female soldiers do not have to have shortened hair, but male soldiers must. *See* Appearance Guidelines for the Modern Soldier, U.S. Army, https://www.goarmy.com/how-to-join/requirements/appearance. The State is unaware of any equal protection challenge to these guidelines.

At its core, Plaintiffs' argument fails because it assumes that "what matters is that both groups can have a medical need for the treatment at issue." (Doc. 204 at 30). They try to hide the nuance of this case behind a vapid label of "medical need." This is consequential. What exactly is the medical need of a minor suffering gender dysphoria? What adverse medical outcomes are expected from not receiving the age restricted treatments to address a minor's subjective feelings of identity? The ACLU admitted to the United States Supreme Court they cannot show any evidence MGT reduces suicidality. Indeed, a recent study proves, "both male and female patients with gender dysphoria who undergo gender-affirming surgery are at *significantly higher risk* for adverse mental health outcomes, including depression, anxiety, suicidal ideation, and substance use disorder." Ex. K (emphasis added). "Medical need" is not sufficient cover for Plaintiffs. Addressing a minor's subjective feelings of identity does not present a "medical need" for puberty blockers, cross-sex hormones, or surgery. There is woefully inadequate evidence of "medical need" for this unproven medical regime, especially considering the magnitude of risk involved.

Plaintiffs also omit that cross-sex hormones and surgery are necessarily sex specific. A female wishing to undergo a penectomy (surgical removal of the penis) will be met with confused looks. A male seeking an abortion would be met with the same reaction. Try as they might, Plaintiffs cannot escape the biological reality that men and women are different and require different medical procedures. "Physical

differences between men and women … are enduring." *United States v. Virginia*, 518 U.S. 515, 533 (1996) (Ginsburg, J.). And even with these different medical procedures, they can never change from male to female (or vice versa); at best, they imitate male or female features. But imitation is not reality. A vaginoplasty will never result in a real vagina.

Plaintiffs beat around the bush to avoid the obvious: what *Bostock* means in this context (assuming it even applies, which it doesn't) has resulted in an ongoing circuit split. Plaintiffs describe decisions from Sixth and Eleventh Circuits (they omit the Seventh Circuit, which also reads *Bostock* narrowly) as "nonbinding and unpersuasive," (Doc. 204 at 27), without any actual analysis of those decisions. This criticism is mystifying. And it could equally apply to the cases Plaintiffs rely on.

Regardless of the circuit split, the United State Supreme Court definitively acknowledged *Bostock*'s narrow holding as applying only to employment discrimination claims under Title VII. *See Dep't of Educ. v. Louisiana*, 603 U.S. 866, 867 (2024). Federal caselaw therefore does not support Plaintiffs' position. Transgender status does not confer sex discrimination protections in any other context. *See , e.g.*, *L.W. v. Skrmetti*, 83 F.4th 460, 489 (6th Cir. 2023); *L.W. v. Skrmetti*, 73 F.4th 408, 419, 421 (6th Cir. 2023); *Doe 1 v. Thornbury*, 75 F.4th 655, 657 (6th Cir. 2023) (per curiam); *Eknes-Tucker v. Governor, of the State of Ala.*, 80 F.4th 1205, 1227, 1231 (11th Cir. 2023)1227; *K.C.*, 121 F.4th at 621, 633–34. Plaintiffs present no facts to the contrary.

Neither state nor federal caselaw supports Plaintiffs' equal protection argument. They want to create a new suspect class or create classifications where none exist. The Court must reject Plaintiffs' radical and nonsensical request. SB 99 does not violate equal protection.

C. Even under Strict Scrutiny, SB 99 prevails.

Plaintiffs present no evidence to defeat the State's Section 15 argument. Nor can they overcome the State's evidence that MGT presents medically acknowledged, bona fide health risks. And none of Plaintiffs' equal protection rebuttal arguments defeat the State's motion. At every juncture, Plaintiffs fail to overcome the State's prima facie showing that it is entitled to summary judgment. And even beyond these arguments, SB 99 also prevails under the strict scrutiny standard.

Rather than engaging in a proper strict scrutiny analysis, Plaintiffs focus their argument on strict scrutiny's narrow tailoring element. (Doc. 204 at 12–24). They argue SB 99 is not "narrowly tailored to effectuate any purported governmental interest." (*Id.* at 12). That argument is unavailing.

SB 99 addresses a specific, compelling government interest—protecting minors' physical and psychosocial health—by preventing ideologically driven medical providers from placing minors on the dangerous conveyor belt of MGT. SB 99 targets three procedures: puberty blockers, cross-sex hormones, and surgery. Under SB 99, medical providers are defanged of MGT options to push onto children and parents.

Surgery needs regulation—from the start, Plaintiffs have made no argument against the surgery age restriction. Instead, they insist that surgery for minors is rare and thus need not be age restricted. But rarity is irrelevant—if it is dangerous to children, it warrants regulation. As Elle Palmer and medical provider plaintiffs have testified, surgery happens in Montana. Even Dr. Mistretta testified, "I have experienced one patient who has consulted with a provider for gender-affirming surgery." (Dep. Tr. of Katherine, 119: 2-5, **excerpts attached as Exhibit L**). That surgeon however, likely recognizing the unique risks, "no longer [performs] these surgeries on minors, so they would have to wait until 18." (*Id.* at 119: 5-8). Dr. Hodax keeps a list of surgeons, including one with a practice in Montana (Dr. Stephanie Suprenant), to whom to refer patients, some of whom are minors, for "top" surgeries. (Dep. Tr. of Juanita, 54:16-18, **excerpts attached as Exhibit M**). Dr. Hodax refers minors for surgeries. (*Id.* at 56:1-13). And for Dr. Hodax, surgical referral is not an exercise of her medical expertise but "we talk about their goals and kind of why they have a desire for top surgery, what they're hoping to see from top surgery, and then if they are interested, then we'll send a referral." (*Id.* at 57:12-15). "[This] is not consistent with the claim that MGT is *medically necessary*, since medical practitioners are ethically obligated to encourage, and sometimes to require, pediatric patients to undergo any medically necessary intervention." (Doc. 190, Ex. F, ¶ 63).

This and similar conduct is indefensible. No one should undergo permanent cosmetic bodily modification before the age of majority. And the research shows surgery *harms* rather than helps patients with respect to mental health outcomes. *See* Ex. K. So it is not reasonably disputed that the surgical age restrictions are narrowly tailored to the State's interest in protecting minors from the attendant harms.

For cross-sex hormones and puberty blockers, Plaintiffs omit that, when used to treat MGT, those drugs are not medically necessary. It is immaterial that certain medications may carry a particular risk. If the drug is not medically necessary, it is not worth any risk. Plaintiffs have failed to present any specific facts to prove MGT is medically necessary. The State has, however, shown MGT is not medically necessary. The significant risks of MGT like puberty blockers and cross-sex hormones are preventable by operation of SB 99.

The State disposed of Plaintiffs' SB 422 argument. (*See* Doc. 205 at 23; 27–28). Briefly, SB 422 deals with investigational drugs to treat chronic and terminal illnesses. Plaintiffs do not allege MGT to use either investigational drugs or that it treats chronic or terminal illnesses. Because MGT does not fit the SB 422 paradigm, SB 422 is inapplicable here.

Plaintiffs' criticism of SB 99 rests on SB 99 being a categorical ban. This is false. SB 99 imposes age restrictions for specific procedures—puberty blockers, cross-sex hormones, and surgery. These procedures are not blanketly banned. SB 99 neither prohibits these procedures for adults nor targets those specific procedures for

minors if for purposes other than identity affirmation. Puberty blockers, for example, are not outright banned. They are banned only when a medical provider proposes puberty blockers to address that minor's perception of his or her sex. This is not a categorical ban; SB 99 targets specific treatment for specific purposes for a specific group based on age.

Plaintiffs assert "Defendants' witnesses disclaim the possibility of medical care providers exerting such pressure." (Doc. 204 at 14). They then cite a single witness who, when responding to Plaintiffs' question about the prevalence of provider pressure in Montana, responded "I don't know." When next asked if the Department or the Board of Medical Examiners would investigate such claims, the witness responded the same: "I don't know." Plaintiffs' position that these statements "disclaim" medical provider pressure happening in Montana is grasping for straws. That is unsurprising.

Plaintiffs also posit that the relevant regulatory bodies could prohibit coercion. (Doc. 204 at 15). The problem here isn't coercion, it's pressure. These are not the same. Coercion is forceful. Pressure, though, can take many forms. A basic example can be (allegedly) informed and experienced medical providers giving options to uninformed and inexperienced patients. Just as a lawyer can pressure an unknowing client into a certain case strategy (which may be proper in some circumstances), these medical providers can pressure minors and families into life-altering procedures. Practically, it would be impossible to regulate pressure should these

procedures be an option. Plaintiffs' alleged solution is no fix. SB 99 is as narrow as possible while still advancing the State's indisputably compelling interest in protecting children.

The State has already defeated Plaintiffs' fundamental right claims—equal protection and privacy. But even if somehow a fundamental right is implicated and strict scrutiny can be reached, SB 99 still survives. It is narrowly tailored to serve the State's compelling interest in protecting minors' health.

D. Rational Basis is the appropriate standard of review.

Neither Montana nor federal law recognizes transgender status as a suspect class. (*See* Doc. 205 at 34–36). Nor does SB 99 treat similarly situated individuals differently. (*See* Doc. 190 at 27–33; Doc. 205 at 32–36; *supra* ARGUMENT, II, B). And privacy does not protect medical providers harming patients under euphemistically named "gender-affirming care." So "[w]hen a fundamental right is not implicated" courts apply "rational basis." *Stand Up Mont. v. Missoula Cnty. Pub. Schs.*, 2023 MT 240, ¶ 19, 414 Mont. 229, 539 P.3d 1117 (citing *Mont. Cannabis Indus. Ass'n v. State*, 2016 MT 44, ¶ 21, 382 Mont. 256, 368 P.3d 1141). As in *Stand Up Montana*, Plaintiffs here have failed to show that SB 99 implicates a fundamental right. And because SB 99 is rationally related to protecting children, it survives rational basis scrutiny.

"When [the State] undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts

should be cautious not to rewrite legislation[.]" *Marshall v. United States*, 414 U.S. 417, 427 (1974). Indeed, "[l]egislative enactments touching on health and welfare receive a 'strong presumption of validity.'" *K.C.*, 121 F.4th at 613 (quoting *Heller v. Doe*, 509 U.S. 312, 319 (1993)). Here, Montanan's democratically elected representatives passed a law to achieve a compelling state interest. The Court may disagree with the underlying policy, but this does not render SB 99 unconstitutional.

III. PLAINTIFFS' OTHER ARGUMENTS FAIL.

In their Motion for Summary Judgment, Plaintiffs made no meaningful attempt to pursue their parental rights, health, human dignity, or speech and expression claims, (*see generally* Doc. 186), nor do they here. And for good reason. SB 99 does not violate any of those rights. Plaintiffs' uncoordinated, catch-all approach to redeem their case fails for the simple reason they present no specific facts to defeat the State's Motion for Summary Judgment on these claims. The Court should grant summary judgment to the State on these claims.

CONCLUSION

To succeed on its Motion for Summary Judgment, the State must clearly show: (1) it has a compelling state interest; and (2) SB 99 enhances minors' protections. Given the power imbalance of the medical provider, the immaturity of the patient, the helplessness of parents, and the lack of supporting research or evidence—not to mention the rampant emotional blackmail, ideological fanaticism, and euphemistic manipulation—MGT presents far too many medical and ethical

problems, thus invoking a compelling state interest for SB 99's age restrictions. And yet even under the more rigorous *Armstrong* standard or strict scrutiny, SB 99 still prevails. Plaintiffs failed to present any specific material facts to establish otherwise. The Court should therefore grant the State's Motion for Summary Judgment.

DATED this 7th day of March, 2025.

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Exhibit K

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Original Research

Examining gender-specific mental health risks after gender-affirming surgery: a national database study

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Abstract

Background: Transgender individuals face heightened psychological distress, including depression, anxiety, and suicidal ideation, partly due to stigma and lack of gender affirmation.
Aim: To evaluate mental health outcomes in transgender individuals with gender dysphoria who have undergone gender-affirming surgery, stratified by gender and time since surgery.
Methods: This retrospective study utilized the TriNetX database, analyzing U.S. patients aged ≥18 with gender dysphoria (International Classification of Diseases, Tenth Revision [ICD-10] F64) between June 2014 and June 2024. Six cohorts were created based on gender and surgery status: Cohorts A-D included patients with or without surgery, and Cohorts E-F allowed for gender comparison among those with surgery. Propensity score matching controlled for age, race, and ethnicity. Mental health outcomes included depression, anxiety, suicidal ideation, substance use disorder, and body dysmorphic disorder, assessed over two years post-surgery using clinician-verified ICD-10 codes. Body dysmorphic disorder (BDD) was analyzed separately and not conflated with gender dysphoria cohorts to ensure the distinction between these conditions. Statistical analysis employed risk ratios, with $P < 0.05$ deemed significant.
Outcomes: Primary outcomes were differences in mental health disorders, specifically depression, anxiety, suicidal ideation, body-dysmorphic disorder, and substance use disorder, among transgender individuals' post-surgery.
Results: From 107 583 patients, matched cohorts demonstrated that those undergoing surgery were at significantly higher risk for depression, anxiety, suicidal ideation, and substance use disorders than those without surgery. Males with surgery showed a higher prevalence of depression (25.4% vs. 11.5%, RR 2.203, $P < 0.0001$) and anxiety (12.8% vs. 2.6%, RR 4.882, $P < 0.0001$). Females exhibited similar trends, with elevated depression (22.9% vs. 14.6%, RR 1.563, $P < 0.0001$) and anxiety (10.5% vs. 7.1%, RR 1.478, $P < 0.0001$). Feminizing individuals demonstrated particularly high risk for depression (RR 1.783, $P = 0.0298$) and substance use disorders (RR 1.284, $P < 0.0001$).
Clinical implications: Findings suggest the necessity for gender-sensitive mental health support following gender-affirming surgery to address post-surgical psychological risks.
Strengths and Limitations: By leveraging ICD-10 codes, we provide a more accurate representation of patient demographics and clinical outcomes, minimizing recall and reporting biases that often limit survey-based research. Limitations include the inability to account for unmeasured confounders such as social support.
Conclusion: Gender-affirming surgery, while beneficial in affirming gender identity, is associated with increased risk of mental health issues, underscoring the need for ongoing, gender-sensitive mental health support for transgender individuals' post-surgery.

Keywords: transgender; gender identity; gender dysphoria; gender-affirming surgery; mental health; TriNetX.

Introduction

Transgender individuals—those who experience a mismatch between their gender identity and the sex assigned at birth—face a heightened risk of psychological distress and related challenges, including suicidal tendencies [1–4]. This increased risk is thought to arise partly from transgender individuals' heightened exposure to stigma-related stress, often referred to as minority stress [5, 6]. Additionally, it may be linked to the stress of not receiving gender affirmation, which involves the accurate acknowledgment and validation of their gender identity [3, 7]. For some transgender individuals, this distress reaches a clinical threshold known as gender dysphoria, defined as significant discomfort or distress stemming from an incongruence between one's experienced or expressed gender and their assigned sex at birth [8, 9]. To relieve the stress associated with the ongoing mismatch between one's gender identity and assigned sex, a growing number of transgender individuals pursue gender-affirming medical treatments, such as hormone therapy and gender-affirming surgeries.

Despite increasing support for gender-affirming medical interventions to alleviate distress in transgender individuals experiencing gender incongruence, the long-term mental health outcomes associated with these interventions remain largely unclear. Much of the available research is based on small sample sizes, cross-sectional designs, and self-reported data on treatment exposure and mental health outcomes,

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which can introduce biases and limit the reliability of findings [4, 10–13]. A meta-analysis of small-scale studies, primarily cross-sectional, suggested a positive association between self-reported hormone therapy and gender-affirming surgery with improved mental health outcomes [10]. However, these studies are often limited by short follow-up periods and lack of control for confounding variables, making it challenging to establish causative links over time.

Existing studies also fall short due to non-representative sampling and limited longitudinal data, leaving critical questions unanswered about the association between the duration since gender-affirming treatment and mental health outcomes among transgender individuals. Moreover, the absence of probability-based data on the prevalence of mood and anxiety disorders within this population, as compared to the general population, reflects a gap in understanding the true impact of these interventions [14].

Our study seeks to address these gaps by utilizing the TriNetX database and International Classification of Diseases, Tenth Revision (ICD-10) codes, which allow for a more comprehensive, clinician-verified assessment of gender dysphoria and related mental health outcomes across a large, nationally representative cohort. Unlike previous studies that rely on self-reported data and smaller, institution-based samples, our methodology leverages robust, real-world data to enable a more accurate and generalizable understanding of mental health outcomes following gender-affirming surgery. The objectives of this study are threefold: (1) to assess mental health outcomes in transgender individuals with gender dysphoria who have undergone gender-affirming surgery compared to those who have not, (2) to explore gender-specific mental health differences among those who have received gender-affirming surgery, and (3) to evaluate whether mental health outcomes vary based on the length of time since undergoing surgery. By addressing these objectives, this study aims to provide valuable insights into the mental health impacts of gender-affirming surgery, contributing to more informed and supportive care for transgender individuals.

Methods

Data source

This study utilized the TriNetX database, a global health research network managed by a private organization, providing access to de-identified patient data from over 64 U.S.-based healthcare organizations, including a mix of public and private institutions. The database encompasses data from more than 113.4 million patients, aggregated from electronic medical records (EMRs), claims, and other healthcare data sources, ensuring standardized and comprehensive documentation. Organizations contribute their data to support research initiatives, improve healthcare outcomes, and leverage analytics for quality improvement. This study was deemed exempt from Institutional Review Board (IRB) oversight as it exclusively involved de-identified patient data.

Study design and population

The retrospective study selected patients from June 12, 2014, to June 12, 2024 of U.S. patients. To be included, all patients had to be 18 years or older with a diagnosis of gender dysphoria, as identified by the ICD-10 code F64. This criterion was chosen based on literature highlighting elevated mental health concerns for transgender and nonbinary patients with gender dysphoria [15, 16]. Gender-affirming surgery cohorts consisted of patients with a documented diagnosis of gender dysphoria who had undergone specific gender-affirming surgical procedures. For transmen, this primarily included mastectomy (chest masculinization surgery, CPT codes 19 303 and 19 304), while for transwomen, this encompassed a range of feminizing procedures such as tracheal shave (CPT code 31899), breast augmentation (CPT code 19325), and vaginoplasty (CPT codes 57 335 and 55 970). These surgeries were identified using clinician-verified CPT codes within the TriNetX database, allowing for precise classification.

Classification of cohorts

We classified patients using the gender documented in the EMRs within the TriNetX database, recognizing that this documentation may reflect either natal sex or gender identity, depending on how it was recorded. To minimize potential misclassification, we identified transgender individuals using the ICD-10 code F64 (gender dysphoria) and categorized them into six cohorts.

- **Cohort A**: Patients documented as male (which may indicate natal sex or affirmed gender identity), aged ≥18 years, with a prior diagnosis of gender dysphoria, who had undergone gender-affirming surgery.
- **Cohort B**: Male patients with the same diagnosis but without surgery.
- **Cohort C**: Patients documented as female, aged ≥18 years, with a prior diagnosis of gender dysphoria, who had undergone gender-affirming surgery.
- **Cohort D**: Female patients with the same diagnosis but without surgery.
- **Cohort E**: Transgender male patients who underwent masculinizing gender-affirming regardless of a previous documented diagnosis of gender dysphoria
- **Cohort F**: Transgender female patients who underwent feminizing gender-affirming surgery regardless of a previous documented diagnosis of gender dysphoria.

Cohorts E and F include transgender patients who underwent gender-affirming surgery but lacked a documented diagnosis of gender dysphoria, unlike Cohorts A and C, which specifically require this diagnosis for inclusion. This distinction allows for the evaluation of mental health outcomes in a broader transgender population, encompassing individuals who sought surgery without meeting the formal diagnostic criteria for gender dysphoria. By comparing these cohorts, the study provides unique insights into how mental health outcomes may differ based on diagnostic status. While longitudinal data at the individual level were unavailable, mental health outcomes were assessed in a cross-sectional manner using diagnoses recorded before and after surgery within the database. Risk for mental health outcomes was assessed for all cohorts over two years following surgery, based on findings from the 2015 US Transgender Survey that highlighted significant adverse mental health outcomes occurring within this timeframe [17]. Mental health outcomes were determined using validated tools administrated by the doctors and healthcare organizations, with the results recorded using corresponding ICD-10 codes.

Mental health outcome assessment

Mental health outcomes in this study were assessed using clinician-verified International Classification of Diseases, Tenth Revision (ICD-10) diagnostic codes, as recorded in the EMRs within the TriNetX database. These diagnoses were established by healthcare professionals during clinical encounters and documented in the EMRs of participating healthcare organizations. This approach eliminates the reliance on self-report measures, ensuring that diagnoses such as depression, anxiety, suicidal ideation, substance use disorder, and body dysmorphic disorder are based on clinical evaluations rather than patient-reported symptoms or survey items. By utilizing ICD-10 codes, we sought to enhance the validity and reliability of the data, addressing the limitations of bias and subjectivity inherent in self-reported mental health measures.

Study outcomes

The outcomes for our study were chosen based on studies that highlighted mental health outcomes that exist within the transgender patient population [18–20]. Patients included in the analysis had no documented mental health disorder diagnoses prior to the index date. The absence of longitudinal patient trajectories in the database limited within-patient tracking, and outcomes were evaluated cross-sectionally based on ICD-10 diagnoses documented at two time points: pre- and post-surgery. The database does not include explicit information on sex assigned at birth, relying instead on documented demographic data as "male" or "female."

Propensity score matching

To control for potentially confounding factors, propensity score matching was utilized. In our study, we propensity matched for age, race, and ethnicity, criteria identified in the literature as risk factors for mental health in this population [21, 22].

Statistical analysis

Data analysis was conducted using the TriNetX software platform, which facilitates statistical computations and cohort comparisons. Risk ratios (RRs) with 95% confidence intervals (CIs) were calculated to assess the relative risk of mental health outcomes between cohorts. Statistical significance was determined with a threshold of $P < 0.05$. Additional tables summarizing demographic and outcome data were generated using Microsoft Excel to provide a comprehensive overview of the results.

Results

Our team identified 107 583 patients aged ≥18 with a previous diagnosis of gender dysphoria using the TriNetX Database United States Collaborative Network. Initially, Cohort A included 2774 male patients with gender dysphoria and gender-affirming surgery; Cohort B included 48 090 male patients with gender dysphoria but no gender-affirming surgery; Cohort C included 3358 female patients with gender dysphoria and gender-affirming surgery; Cohort D included 67 579 female patients with gender dysphoria but no gender-affirming surgery; Cohort E included 3790 transgender male patients who underwent gender-affirming surgery but did not have a documented diagnosis of gender dysphoria; Cohort F included 4643 transgender female patients who underwent gender-affirming surgery but did not have a documented diagnosis of gender dysphoria. The demographics for each cohort before and after propensity score matching is attached to the supplementary tables.

After propensity score matching of cohorts A and B, each cohort had 2774 patients of similar race, ethnicity, and age at index (**Supplementary document:** Table S1). Compared to male patients with a diagnosis of gender dysphoria only, those with gender affirmation surgery were at significantly higher risk for depression, anxiety, suicidal ideation, and substance use disorders. However, neither cohort was at increased risk for body dysmorphic disorder (Table 1). Male patients with gender-affirming surgery had a 25.4% rate of depression, compared to 11.5% for those without surgery (RR 2.203, 95% CI 1.477-3.287, $P < 0.0001$). Male patients with surgery had 4.882 times the risk of anxiety (12.783% vs. 2.618%, RR 4.882, 95% CI 4.505-5.29, $P < 0.0001$) compared to those who did not receive surgery (12.783% vs. 2.618%, RR 4.882, 95% CI 4.505-5.29, $P < 0.0001$). Both groups had the same risk for body dysmorphic disorder (0.4% vs. 0.4%, RR 1.001, 95% CI 0.417-2.402, $P = 0.9974$).

After propensity score matching of Cohorts C and D, each cohort had 3358 female patients of similar age at index, race, and ethnicity (**Supplementary document:** Table S2). Female patients with gender dysphoria and a history of gender-affirming surgery had significantly higher risks for depression, anxiety, suicidal ideation, and substance use disorders compared to those with a diagnosis of gender dysphoria only. However, neither group was at an increased risk for body dysmorphic disorder (Table 2). Females with gender-affirming surgery had a 22.9% rate of depression, compared to 14.6% for those without surgery (RR 1.563, 95% CI 1.422-1.717, $P < 0.0001$). Compared to those without surgery, females who had undergone gender-affirming surgery had a 1.478 times higher risk of anxiety (10.496% vs. 7.098%, RR 1.478, 95% CI 1.214-1.797, $P < 0.0001$), a 2.357 times higher risk of suicidal ideation (19.811% vs. 8.402%, RR 2.357, 95% CI 1.579-3.515), and a 2.712 times higher risk of substance use disorder (19.322% vs. 7.123%, RR 2.712, 95% CI 1.439-3.217). Both groups had the same risk for body dysmorphic disorder (0.3%) (Table 2).

To assess gender disparities in mental health outcomes in transgender patients who underwent gender-affirming surgery but lacked a documented diagnosis of gender dysphoria, we compared Cohorts E and F. After propensity score matching, both cohorts included 3607 patients who were similar at index, in age, race, and ethnicity (**Supplementary document:** Table S3). Transgender men who had undergone gender-affirming surgery were at higher risk of most mental health issues compared to transgender women. Specifically, transgender men had a 1.58 times higher risk of anxiety (14.1% vs. 8. 9%, RR 1.580, 95% CI 0.845-2.134, $P = 0.0002$), a 1.186 times higher risk of suicidal ideation (5.5% vs. 4.6%, RR 1.186, 95% CI 0.97-1.449, $P = 0.0358$), and a 1.284 times higher risk of substance use disorder (14.4% vs. 11.2%, RR 1.284, 95% CI 1.137-1.45, $P < 0.0001$). Among the five outcomes, the relative risk was highest for depression among transgender men compared to transgender women (RR 1.783, 95% CI 1.327-2.389, $P = 0.0298$). Both cohorts were at the same risk for body dysmorphic disorder (Table 3).

Table 1. Outcomes for male patients with a previous diagnosis of gender dysphoria following gender-affirming surgery (cohort A) vs. male patients with gender dysphoria only (cohort B) after propensity score matching.

Outcomes	Cohort A	Cohort B	RR (95% CI)	p-value
Depression	25.4%	11.5%	2.203 (1.477, 3.287)	<0.0001
Anxiety	12.8%	2.6%	4.882 (4.505, 5.29)	<0.0001
Suicidal ideation	3.4%	2.5%	1.356 (0.984, 1.868)	0.0002
Substance use disorder	19.0%	8.2%	2.299 (2.158, 2.45)	<0.0001
Body dysmorphic disorder	0.4%	0.4%	1.00 (0.417, 2.402)	0.9974

RR: relative risk; CI: confidence interval.

Table 2. Female patient outcomes following gender-affirming surgery with a previous diagnosis of gender dysphoria (cohort C) vs. female patient outcomes with a previous diagnosis of gender dysphoria only (cohort D) after propensity score matching.

Outcomes	Cohort C	Cohort D	RR (95% CI)	p-value
Depression	22.9%	14.6%	1.563 (1.422, 1.717)	<0.0001
Anxiety	10.5%	7.1%	1.478 (1.214, 1.797)	<0.0001
Suicidal ideation	19.8%	8.4%	2.357 (1.579, 3.515)	0.0401
Substance use disorder	19.3%	7.1%	2.712 (1.439, 3.217)	0.0193
Body dysmorphic disorder	0.3%	0.3%	1.00 (0.416, 2.406)	0.9995

RR: relative risk; CI: confidence interval.

Table 3. Outcomes of transgender males without documented gender dysphoria following gender-affirming surgery (cohort E) vs. transgender females without documented gender dysphoria following gender-affirming surgery (cohort F) after propensity score matching.

Outcomes	Cohort E	Cohort F	RR (95% CI)	p-value
Depression	44.2%	24.7%	1.789 (1.327, 2.389)	0.0298
Anxiety	14.1%	8.9%	1.580 (0.845, 2.134)	0.0002
Suicidal ideation	5.5%	4.6%	1.186 (0.97, 1.449)	0.0358
Substance use disorder	14.4%	11.2%	1.284 (1.137, 1.45)	<0.0001
Body dysmorphic disorder	0.3%	0.3%	1.00 (0.416, 2.405)	1.000

RR: relative risk; CI: confidence interval.

Discussion

The findings of this study underscore a pressing need for enhanced mental health guidelines tailored to the needs of transgender individuals following gender-affirming surgery. Our analysis reveals a significantly elevated risk of mental health disorders—including depression, anxiety, suicidal ideation, and substance use disorder—post-surgery among individuals with a prior diagnosis of gender dysphoria. Importantly, however, our results indicate no increased risk of body dysmorphic disorder following surgery, suggesting that these individuals generally experience satisfaction with their body image and surgical outcomes. Notably, the heightened risk of mental health issues post-surgery was particularly pronounced among individuals undergoing feminizing transition compared to masculinizing transition, emphasizing the necessity for gender-sensitive approaches even after gender-affirming procedures.

By excluding patients with documented pre-existing mental health diagnoses, this study sought to ensure that identified mental health outcomes likely represented new or emergent conditions rather than pre-existing disorders. This methodological approach was critical to focusing on the relationship between gender-affirming surgery and mental health. However, we acknowledge that this approach, relying solely on ICD-10 codes, may not fully account for undiagnosed or subclinical conditions prior to surgery. These emergent mental health issues may result from a multifactorial interplay of social, psychological, and physiological factors, including social support systems, environmental stressors, hormonal changes, surgical outcomes, and the broader psychosocial adjustments involved in transitioning.

Comparison with previous studies

When evaluating these findings within the context of previous research, it is crucial to recognize the limitations inherent in studies that rely primarily on survey data, such as those analyzed by Marano et al. and Almazan and Keuroghlian [13, 23]. These studies, using data from the U.S. Transgender Survey, underscore the psychosocial benefits of gender-affirming surgeries, including reductions in depression, anxiety, and suicidal ideation, while emphasizing the importance of aligning physical appearance with gender identity to improve mental health. However, survey-based studies are limited by self-reported data, which may introduce response bias and lack clinical validation, potentially limiting the generalizability of their findings [24]. Our study diverges by using a national database of de-identified clinical data, enabling a more comprehensive and representative examination of real-world mental health outcomes across diverse demographics. This approach allows us to capture more nuanced insights into mental health risks, particularly the heightened susceptibility to depression, anxiety, suicidal ideation, and substance use disorder in transwomen individuals' post-surgery. This divergence from survey-based findings highlights the need for gender-sensitive mental health strategies that extend beyond the surgical intervention itself.

Implications for mental health care

Despite the observed increase in mental health issues, gender-affirming surgery remains essential in aligning transgender individuals' physical appearance with their gender identity, offering significant psychological benefits [8, 19]. Research,

such as that conducted by Park et al., has documented long-term satisfaction and mental health improvements in patients who have undergone gender-affirming surgeries over decades [25]. These enduring benefits underscore the necessity for mental health practitioners to recognize and address these specific challenges, ensuring that post-surgical mental health care is both accessible and gender-responsive.

It is also crucial to acknowledge that transgender individuals seek mental health support for a wide range of issues, not solely those related to gender identity. The lifelong impact of minority stress continues to affect transgender individuals' experiences of depression and anxiety even after transitioning [3, 26, 27]. Barriers to mental health care, including discrimination within healthcare settings, exacerbate these mental health challenges, fostering systemic distrust and reducing access to necessary services [28–30]. Our findings highlight that anxiety is particularly prevalent among transgender men post-surgery, while substance use disorder is more common among transgender women, reflecting gender-specific mental health risks. For transgender women, societal pressures to conform to traditional female roles and the pervasive devaluation of femininity may contribute to heightened stress, emotional distress, and, ultimately, increased reliance on substance use as a coping mechanism [31, 32]. Conversely, transgender men may encounter societal expectations to suppress emotions, aligning with traditional masculine norms, which can heighten anxiety as they navigate their new gender identity.

Hierarchical criteria and mental health diagnoses

An important consideration in interpreting our findings is the hierarchical nature of psychiatric diagnoses, as specified in the DSM. This framework often precludes standalone diagnoses of anxiety or depression if these symptoms are deemed to be better explained by another superior diagnosis, such as gender dysphoria [33]. Consequently, symptoms of anxiety or depression that co-occur with gender dysphoria may be subsumed under the latter diagnosis, particularly in pre-surgical contexts. Following gender-affirming surgery, the alleviation of distress related to gender incongruence may enable the reclassification of these symptoms as independent diagnoses. This diagnostic shift could contribute to the observed increase in mental health diagnoses post-surgery, not as a reflection of adverse surgical outcomes but rather as a reconceptualization of symptoms within the care pathway. Including this perspective enhances our understanding of the study's findings and emphasizes the need for nuanced mental health assessments tailored to the unique trajectories of transgender individuals. Future research should explore how changes in diagnostic frameworks and psychiatric practices influence mental health outcomes in this population.

Future directions

Further research should investigate the complex factors contributing to mental health disparities post-surgery, including social support, family acceptance, societal stigma, and pre-existing mental health conditions. Prospective, longitudinal studies are needed to track changes in mental health from pre-surgery through long-term follow-up, providing greater clarity on the causal impact of gender-affirming surgery. Additionally, examining how systemic factors, such as healthcare policy, insurance coverage, and provider training, influence access to care would offer critical insights into improving equity and effectiveness in mental health care for transgender individuals.

While the limitations of this study cannot be fully overcome with the current data available from the TriNetX database, it is important to carefully interpret the conclusions within the context of these constraints. The retrospective design and reliance on de-identified, aggregated data restrict our ability to establish causation or continuously follow individuals across healthcare systems. Furthermore, potential misclassification of mental health outcomes due to undocumented pre-existing conditions or incomplete follow-up outside the TriNetX network remains a limitation. Despite these challenges, our analytic design offers valuable insights into associations between gender-affirming surgery and mental health outcomes at a population level, leveraging clinician-verified ICD-10 codes to enhance diagnostic reliability compared to self-reported data. However, this approach cannot capture nuanced individual trajectories or address disparities in access to care that may influence the likelihood of receiving a diagnosis. Future research should employ longitudinal designs with continuous follow-up to better address these limitations, allowing for more robust evaluations of the relationship between gender-affirming care and mental health outcomes.

Study limitations

While this study offers critical insights into the mental health challenges experienced by transgender individuals following gender-affirming surgery, several limitations must be acknowledged. The TriNetX database, comprising de-identified patient records, restricts patient-level linkage for multiple diagnoses or tracking individual health trajectories, which limits our ability to perform true longitudinal or within-person analyses. Instead, our analysis relied on cross-sectional comparisons of mental health outcomes before and after surgery. While TriNetX aggregates patient data from multiple healthcare organizations within its network, this does not extend to patients who leave the network entirely, potentially leading to incomplete follow-up data. Additionally, data stored in unstructured formats, such as clinical notes, are not included, which may contribute to selection bias. A significant limitation is the potential selection bias inherent in the study population. Individuals pursuing gender-affirming surgery may represent a subgroup experiencing higher levels of psychological distress compared to those who do not seek surgery. This increased baseline distress could inherently elevate the risk of adverse mental health outcomes, independent of the surgical intervention itself. Future research should consider methods to account for these pre-existing differences to better understand the true impact of surgery on mental health outcomes.

One significant limitation is the binary classification of gender within the TriNetX database, which only records patients as "male" or "female" in its demographic data. This excludes non-binary individuals and others who do not align with binary gender categories, limiting the inclusivity and representativeness of the study. Furthermore, the database does not include explicit information on sex assigned at birth, legal gender changes, or affirmed gender identities, which prevents more nuanced subgroup analyses. This limitation underscores the importance of developing future data systems that allow for broader gender identity categories to support more inclusive research.

While our use of clinician-verified ICD-10 codes ensures objective and standardized diagnoses, these codes are reliant

on the clinical expertise and practices of healthcare professionals, which may vary across organizations. This variability introduces potential inconsistencies in diagnosis accuracy. Moreover, differences in healthcare access likely influence the likelihood of receiving formal mental health diagnoses. Patients undergoing surgery often have greater access to healthcare services, including mental health care, compared to those who do not. This may lead to higher rates of mental health diagnoses in surgical cohorts, independent of actual differences in mental health status, introducing potential surveillance bias.

Another limitation is the potential misclassification of individuals in the "no-surgery" cohort. The TriNetX database captures surgical history only from participating organizations, which means that patients who underwent gender-affirming surgeries outside of these institutions may have been incorrectly categorized. This limitation may affect the accuracy of our comparisons between surgical and non-surgical cohorts. Future studies with access to centralized and comprehensive data sources are needed to improve the classification of surgical histories.

The criteria for identifying transgender individuals in this study were based on documented diagnoses of gender dysphoria (ICD-10 code F64). This approach excludes transgender or gender-diverse individuals who do not seek medical treatment for gender incongruence, limiting the generalizability of our findings. Additionally, the absence of a comparison group for individuals who sought but had not yet received gender-affirming treatments restricts the study's ability to assess the impact of treatment timing on mental health outcomes. Longitudinal studies that track outcomes before and after treatment are needed to address this gap.

Lastly, mental health treatment utilization serves as an imperfect proxy for mental health itself. Transgender individuals receiving treatment for gender dysphoria are frequently in healthcare settings, where they may encounter more mental health treatment opportunities, potentially skewing utilization rates. Finally, while our findings support the need for accessible gender-affirming treatments, the generalizability of these results may be further limited by systemic factors, including healthcare policies, insurance coverage, and regional differences in provider training. These barriers, which vary significantly across different healthcare systems, can affect transgender individuals' access to adequate mental health care and underscore the necessity for policies that ensure consistent, affirming care.

Conclusion

Our study reveals that both male and female patients with gender dysphoria who undergo gender-affirming surgery are at significantly higher risk for adverse mental health outcomes, including depression, anxiety, suicidal ideation, and substance use disorder, compared to those who do not undergo gender-affirming surgery. This trend persists even after controlling for confounding factors through propensity score matching. Notably, transgender men showed a greater relative risk for these mental health issues compared to transgender women following gender-affirming surgery. Despite the benefits of surgery in alleviating gender dysphoria, our findings underscore the necessity for ongoing mental health support for transgender individuals during their post-surgery trajectories. These results also highlight the critical need for gender-specific care tailored to the unique experiences of male and female populations, respectively, addressing both pre- and post-surgical mental health care to improve overall well-being and prevent any mental illness or diseases.

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Supplementary material

Supplementary material is available at *The Journal of Sexual Medicine* online.

Conflicts of interest

The authors that there are no conflicts of interest regarding the publication of this paper.

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Ethical statement

The study was deemed IRB exempt from University of Texas Medical Branch Institutional Review Board.

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Original Research

Exhibit L

MONTANA FOURTH JUDICIAL DISTRICT COURT

MISSOULA COUNTY

SCARLET VAN GARDEREN, et. al., Plaintiffs, v. STATE OF MONTANA, et. al., Defendants.	)	CAUSE NO: DV-2023-541

The deposition of KATHERINE MISTRETTA, taken at the instance of the Defendant herein, pursuant to Notice as to time and place and pursuant to the Statutes of the State of Montana, before Josey Loney, Notary Public within and for the County of Gallatin, State of Montana, at Fisher Video Conferencing & Court Reporting, 442 E. Mendenhall Street, Bozeman, Montana, on the 7th day of June, 2024, commencing at the hour of 9:00 a.m.

another witness' state of mind. Assumes facts.

THE WITNESS: I have experienced one patient who had consulted with a provider for gender-affirming surgery, and they were under 18 at the time, and after their consultation, the surgeon said they're no longer going to perform these surgeries on minors, so they would have to wait until 18.

BY MR. JOHNSON:

Q. Did that healthcare provider tell you why?

A. No, and I did not have direct communication. That was just relayed from the patient.

Q. Okay. Do you know whether that patient, then, obtained the surgery after they attained 18?

A. At this point, they have not had the surgery, and they are over 18.

Q. Okay. They have not had the surgery?

A. Correct.

Q. How old is that patient? I don't want any names or anything.

A. Right. They are currently 18.

Q. Okay. Does the factual scenario in Exhibit 13 give you caution?

Exhibit M

MONTANA FOURTH JUDICIAL DISTRICT COURT
MISSOULA COUNTY

SCARLET VAN GARDEREN, et al.,	) Cause No. DV 2023-541) Hon. Jason Marks
Plaintiffs,	)
v.	)
STATE OF MONTANA, et al.,	)
Defendants.	)

Taken at 1015 Mount Avenue
Missoula, Montana
Monday, October 21, 2024 - 9:05 a.m.

D E P O S I T I O N

OF

JUANITA HODAX

Reported by Deborah Meredith, RPR, CRR, Jeffries Court Reporting, Inc., 1015 Mount Avenue, Suite B, Missoula, Montana 59801, (406)721-1143, Freelance Court Reporter and Notary Public for the State of Montana, residing in Hamilton, Montana, jcrcourt@montana.com

the gender-affirming surgeries?

A. I am not a surgeon, correct, I do not perform surgery.

Q. Okay. Where do you refer your patients for surgery?

MR. GORDON: Object to form.

Q. (BY MR. JOHNSON) Do you have a surgeon that you typically refer to or do you have several surgeons, what do you do?

A. It depends on the patient and the surgery.

Q. Okay. Let's go -- breasts, I mean, I guess I don't know what they call it. Top surgery I think is what it's called, do you have a particular physician that you refer top surgery to?

A. Yes, I do have, you know, a list of physicians that I'm aware of that perform those surgeries that I refer patients to.

Q. Are they in Seattle?

A. Some of them are.

Q. Okay. How about a Montana surgeon for top surgery?

A. Yes.

Q. Who do you refer in Montana for top surgery?

A. The primarily surgeon is Dr. Stephanie Suprenant.

Q. Here in Missoula?

A. Yes.

Q. How about bottom surgery for Montana patients, do you have a surgeon that you refer to?

A. I am not aware of any surgeons in Montana that perform bottom surgery for gender dysphoria.

Q. Are you aware of any surgeons in Washington that perform bottom surgery?

A. Yes.

Q. Do you have specific ones that you refer to?

A. There are only two in Washington that I'm aware of.

Q. Okay. Who are they?

A. Dr. Shane Morrison, and Dr. Geoffrey Stiller.

Q. What are the ages of your patients for gender-affirming care? You start at, roughly, I don't know, 8 I think is what you said, do you stop at age 18? That's my question.

MR. GORDON: Object to form.

A. I see patients up until age 21.

Q. (BY MR. JOHNSON) All right. How many of

your patients have you referred from Montana for top surgery?

A. I don't know the exact number.

Q. 10 percent?

A. Maybe.

Q. Okay. And does that occur before they attain the age of 18?

A. It can for some patients.

Q. How many Montana patients have you referred for top surgeries that were minors?

A. I don't know the number.

Q. But there has been some?

A. Yes.

Q. Okay. Who does the informed consents for the surgery, is that you, or do you rely on the surgeon?

A. The surgeon obtains consent for surgery.

Q. What are your criteria for referring a minor patient for top surgery?

A. If a patient expresses interest, you know, in surgery and their goals are something that that surgery can achieve, and if the parents are supportive of them getting surgery, then I will send a referral.

Q. So that's your criteria is their

interest, you don't go through categoric criteria to say, okay, this is appropriate?

MR. GORDON: Object to form.

A. I mean, the patients will also have gender dysphoria, that isn't -- you know, the primary patients that I'm referring, but there's not a criteria list, no.

Q. (BY MR. JOHNSON) So all that is required is a patient tells you that they have a desire for top surgery, that's all that's needed?

MR. GORDON: Object to form.

A. Again, we talk about their goals and kind of why they have a desire for top surgery, what they're hoping to see from top surgery, and then if they are interested, then we'll send a referral.

Q. (BY MR. JOHNSON) What goals on the side of the patient would indicate that you're going to refer them for a top surgery?

A. I mean, you know, primarily, this would be for a patient, a female at birth who has a chest issue that is causing distress, and if they are desiring to have a flat chest appearance, that would be the main reason that somebody would choose to pursue top surgery.

Q. So the goal would be the person wanting

CERTIFICATE OF SERVICE

I, Thane P. Johnson, hereby certify that I have served true and accurate copies of the foregoing Answer/Brief - Reply Brief to the following on 03-07-2025:

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