To: Utah Legislature's Health & Human Services Interim Committee,

My name is Dr. Shannon C. Metzler and I am submitting this letter in response to the questions sent to me from the Utah Legislature's Health & Human Services Interim Committee (HHSIC). Thank you for the opportunity to be included in this important discussion.

My educational background is primarily in mental health practice with concentrations in childhood and adolescent development, lifespan development, and cognitive neuropsychology. I also have more than a decade of experience working with LGBTQ+ people in clinical settings and primarily work with gender-diverse individuals and families.

I will follow the original order of the HHSIC outline in my responses. Hopefully, this will make the information easier to digest and ensure that I address your questions directly. Many of the questions raised by the HHSIC are complex and can be particularly nuanced. I have made significant efforts to answer these questions as clearly and succinctly as possible within the amount of time available to me to respond to your questions.

PREVALENCE OF CONDITION AND TREATMENT

a. How many Utah minors identify as transgender?

We currently do not know how many Utah minors identify as transgender for several reasons. One of the leading reasons is an ongoing lack of awareness and inclusion within existing data collection systems that could capture such information. This has been particularly problematic in trying to understand several important issues, but none more critical than trying to understand the role of gender diverse youth in Utah's youth suicide epidemic. Research consistently suggests this is a population with high attempted suicide rates that start early in life and often continue throughout the life of many gender-diverse individuals (Grant et al., 2011; NIH, 2016; James et al., 2016).

Research suggests the lifetime attempted suicide rate for transgender individuals is 25 times the rate for the general U.S. population (Grant et al., 2011; James et al., 2016). One in three (30 %) transgender youth report a history of suicide attempt(s), and almost half (42 %) endorse a history of self-harming behaviors (Peterson, Matthews, Copps-Smith, & Conard, 2016). Given these concerning numbers, providing more attention and resources to this population should be our focus to adequately address Utah's youth suicide problem and improve the health and wellbeing of all Utah children and young adults.

The second reason it is difficult to know how many Utah minors identify as transgender is language tends to be an evolving process, especially when it comes to gender diversity. Many gender-diverse people, particularly younger people, do not necessarily identify with the term "transgender" and endorse different language to describe their experiences. For example, Meerwijk and Sevelius (2017) found that participants endorsed genderqueer 1.5 to 2 times more frequently than transgender. To accurately understand this population requires greater awareness around inclusive language and gender-diverse experiences.

Finally, safety is another factor that makes it difficult to calculate the prevalence of this population. Research indicates that many gender-diverse individuals conceal their gender identity to avoid mistreatment (Hendricks & Testa, 2012). Beemyn and Rankin's (2011) survey of gender-diverse individuals revealed that more than half of participants intentionally concealed their gender identity from providers out of fear. In addition to external factors associated with threats to safety, internalized shame and struggles with self-acceptance may be significant driving factors for individuals deciding to conceal their gender identity (Hendricks & Testa, 2012).

More than half of gender-diverse participants in one study exhibited signs of psychological distress and had not accessed mental health support in the last year (Shipherd et al., 2010). Another study found that 28% of gender-diverse individuals were postponing or avoiding needed care due to a fear of being mistreated (Grant et al., 2011).

A recent study on mental health access for gender-diverse people in Utah suggests that most community mental health clinics in Utah exclude and erase the identities and experiences of gender-diverse people as one of the primary steps in accessing mental health treatment (Metzler,

2020). This means institutions that could help us understand the prevalence of transgender minors in Utah are not collecting the data that would provide those answers. Findings also indicate that most social work programs in Utah are not adequately preparing future mental health providers to work with gender-diverse individuals at the most basic level, which is the level of being able to communicate without potentially causing harm (Metzler, 2020). Perhaps it is easier, in light of this information, to understand why so many gender-diverse individuals decide to conceal their experiences.

It is difficult to provide statistical data on a population that continues to be erased through data collection systems and processes that are not typically designed to include such people or experiences. Improving access to care for gender-diverse individuals is a critically important issue. Instead, H.B. 92 would diminish access further and reinforce the stigma and internalized phobia that causes gender-diverse individuals to avoid seeking help. Improving access to care would also improve our ability to accurately understand the prevalence of transgender minors in Utah because it would help to create an environment where families are more likely to know they have resources available to them to access professional support. Most importantly, it may help to create an atmosphere where individuals feel safer being open and honest about their experiences and communicating their needs.

b. How many Utah minors experience gender dysphoria?

Gender dysphoria (GD) is often used to describe the distress some gender-diverse individuals experience around an incongruence between their assigned sex and gender identity. The World Professional Association of Transgender Health (WPATH) describes gender dysphoria as "…distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (Coleman et al., 2012, p. 5). Many people who experience such distress may never seek or need professional support. Moreover, a diagnosis of "gender dysphoria" would not be a reliable predictor of who has or will seek transition-related medical care such as puberty blockers, gender-affirming hormone therapy, or gender-affirming surgical procedures.

A common misconception and stereotype are that transgender people always go through medical transition. This misconception might also be associated with a diagnosis of gender dysphoria. To be clear, having a diagnosis of gender dysphoria would not inform a process of knowing the number of gender-diverse youth who seek medical transition. Each individual will have different needs that may or may not include medical interventions.

The usefulness of the diagnosis may be further diminished when health insurance companies use such information to exclude people from coverage for needed health care. Such dynamics make it necessary to question the usefulness of the diagnosis when excluding it could be in the patient's best interest. This is an area where more attention and discussion are needed and could potentially improve access. Instead, the State maintains a position that allows insurance companies to specifically exclude the medical needs of gender-diverse individuals, including minors. This continues to negatively impact the health and wellbeing of many gender-diverse individuals and families in Utah today.

c. How many Utah minors are treated for gender dysphoria?

I am unable to provide this information as I am unaware of any available system or resource that currently tracks such information on a statewide basis.

d. How many Utah minors are treated for gender dysphoria with:

i. puberty-blocking drugs?

I am unable to provide this information as I am unaware of any available system or resource that currently tracks such information on a statewide basis.

ii. masculinizing or feminizing drugs?

I am unable to provide this information as I am unaware of any available system or resource that currently tracks such information on a statewide basis.

iii. gender affirming/reassignment surgery?

I am unaware of minors accessing reassignment surgery in Utah as part of a medical transition before the age of 18, which is consistent with the WPATH Standards of Care (WPATH, 2012). However, I am aware of instances where minors have attempted to conduct such surgeries on themselves after being unable to access treatment through the health care system. Some have eventually succeeded after numerous attempts. I am also aware of situations where minors bind, cut, and even mutilate their genitalia and body due to severe gender dysphoria.

Given that these situations are taking place in our existing health care environment, perhaps it is easier to understand why I am concerned about the Utah legislature enacting a "one-size-fits-all" law that would complicate these types of situations even more by denying access to available evidence-based treatments. Enacting a law like H.B. 92 would likely cause more individuals to take matters into their own hands and turn to less safe methods for relief.

e. How many Utah minors treated for gender dysphoria with a puberty-blocking drug are subsequently treated with masculinizing or feminizing drugs?

I am unable to provide this information as I am unaware of any available system or resource that currently tracks such information on a statewide basis.

f. How many Utah minors treated for gender dysphoria with puberty-blocking or masculinizing or feminizing drugs are subsequently treated with gender-affirming/reassignment surgery?

I am unable to provide this information as I am unaware of any available system or resource that currently tracks such information on a statewide basis.

g. How are social awareness, population growth, and the evolving understanding of appropriate treatment for gender dysphoria likely to affect the estimates above?

I would expect that as our social understanding, awareness, and inclusion of gender diversity increases, it is also likely that parents will be exposed to more information about gender-diverse

people and be more likely to seek support for their gender-diverse children. Perhaps young people will also feel less compelled to conceal their experiences from other people and feel safer asking for help.

OUTCOMES

a. What are the short- and long-term potential benefits and harms of addressing gender dysphoria in minors with:

i. puberty-blocking drugs

ii. masculinizing or femininizing drugs?

iii. gender affirming/reassignment surgery?

iv. only treatments other than those listed above?

Each individual will have different needs and respond differently to treatment. Successful outcomes generally require good initial and ongoing assessment and clear communication with parents and adolescents. The potential benefits and harms of any intervention often depend on several factors.

The short-term benefits of puberty-blocking drugs include the possibility of alleviating gender dysphoria and improving overall functioning. The WPATH Standards of Care identify two primary benefits, "(i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment" (Coleman et al., 2012, p. 19).

As a clinician, I have repeatedly witnessed what I would describe as significant improvements in mental health and overall functioning after a client starts puberty blockers. This is consistent with findings from a recent systematic review that found similar benefits (Rew, 2021). Early intervention often provides some level of respite from gender dysphoria, which can improve mental health and overall functioning while avoiding the potential negative impacts of sustained distress and eventual mental health decline. My position is consistent with WPATH that "early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would" (Coleman, 2012, p. 19).

The potential long-term harms from puberty suppressing drugs are generally low because it is considered a fully reversible intervention if a decision is made to stop the medication (Ramos, 2020; Coleman et al., 2012). Interventions like HRT are considered partially reversible.

In my experience, adolescents and parents will seek help after social transition has started to some degree. This is often in the form of things like coming out to others, wearing gender-affirming clothing, or the use of an affirming name and pronouns. These types of inventions can provide non-medical interventions for individuals experiencing gender dysphoria. However, assessment should always consider the severity of the distress and the potential for short or long-term harm. This is where I am less clear about the role of the State in this process. H.B. 92 seems

to suggest the severity of an individual's suffering is irrelevant to this process as long as the individual in question is a minor.

Access to puberty blockers not only helps to buy time for adolescents, but it also provides a process that can help to alleviate suffering while a client explores or continues non-medical approaches like social transition. For many providers, including myself, this process informs further assessment for clients who may be considering interventions like gender-affirming hormone treatment in the future.

The potential short and long-term benefits of cross-sex hormone treatment include the possibility of alleviating gender dysphoria and improving overall functioning (Kuper et al., 2020). The process of assessment and treatment would ideally involve a multidisciplinary team of professionals working together with the adolescent and parents to make decisions. Limited resources and scarcity of competent providers can make this type of specialized support very challenging to access, especially in rural communities. However, some local providers and institutions have found ways to combine efforts to overcome these types of challenges. More attention and access to financial resources could improve access to this type of specialized care and ensure that Utah parents have access to treatment that is consistent with medical and mental health standards. This could also help to ensure that appropriate assessment and screening are taking place.

I require minor clients and their parents to fully understand the potential risks associated with gender-affirming hormone treatment as part of an informed consent process (consistent with WPATH guidelines). I also use a therapeutic process to help clients identify and clarify their expectations and goals for what a particular medical intervention will resolve and address unrealistic expectations. Ultimately, it is up to a licensed medical provider to decide to prescribe such medications.

This approach is part of my treatment process for anyone seeking gender-affirming medical interventions, especially before I will provide a letter of support to medical providers who require such letters to start treatment. It is difficult to imagine the State stepping between a multidisciplinary team of providers and preventing individuals in need from accessing interventions that have been shown to provide relief for the majority of people who receive them. Improvement in overall functioning and decreased depressive symptoms were two key findings from research conducted by de Vries, et al., (2011) examining the use of puberty suppressing drugs to treat GD. A recent study that examined outcomes after participants had been on affirming hormone treatment for a year revealed significant reductions in youth body dissatisfaction and improvements in mental health (Kuper et al., 2020).

One of the more obvious benefits of successful treatment is often measurable improvements in overall functioning, which may be more obvious with things like increased ability to maintain focus and improvements in academic performance. The potential implications of these types of benefits are especially consequential to the future success of gender-diverse youth. Improvements in function and mental health are also consequential to the health and wellbeing of these individuals.

Current standards do not recommend access to surgical interventions before the age of 18, except in unique circumstances where early treatment may be indicated. I have already discussed situations where genital mutilation and self-harming behaviors can result from individuals lacking access to treatment. The potential for harm and ongoing suffering requires a need for flexible guidelines that can accommodate such needs and provide humane options for relief.

b. How should potential harms and benefits be weighed in treatment decisions?

- Treatment should always be individualized.
- Potential risks and benefits should be understood and weighed by the individual receiving treatment and their parent(s)/legal guardians as part of an informed decision-making process.
- Final treatment decisions would ideally be made by a multidisciplinary team of professional(s) after assessment has established a potential course of treatment and clear expectations and goals are understood and agreed upon by all involved parties.

c. To what extent have long-term outcomes, including physical health, mental health, satisfaction, and regret, been tracked in individuals receiving various treatments for gender dysphoria? What do those studies indicate?

Several studies have collected this type of data and I have cited some of the more relevant ones in my responses. Additionally, I have included information in the reference section to help readers gain access to the original research and documents used in this response.

Much of the available research in this area tends to be limited in terms of generalizable findings due to small sample sizes, methodology, and limited replicable findings (Chew et al., 2018; Ramos et al., 2020; Rew et al., 2021). The need for quality longitudinal studies was noted by many of the researchers in this field. One such large-scale study launched in 2016 will eventually provide valuable insight into many important questions. More information about this study can be found here: https://www.nature.com/news/largest-ever-study-of-transgender-teenagers-set-to-kick-off-1.19637

Many researchers also noted gaps in the available data including the psychosocial and cognitive impact of treatment (Chew et al., 2018). One peer-reviewed study published in *Pediatrics* suggests that age-appropriate treatment, including puberty blockers, gender-affirming hormone treatment, and gender-reassignment surgery, resulted in notable improvements in psychological functioning and subjective wellbeing. Alleviation of GD symptoms and improvements in psychological functioning was most notable after gender reassignment (de Vries et al., 2014).

3. CLINICAL GUIDELINES

a. **Are the flexible clinical guidelines published by the World Professional Association for Transgender Health, the clinical guidelines published by the Endocrine Society, and other information published to guide providers of transgender healthcare sufficient to protect the interests of minors**?

Scientific methods and the peer review process should be at the forefront of our decision-making when it comes to establishing and amending clinical standards and guidelines. It is also important to incorporate the needs and voices of the people who experience GD into this process. The clinical guidelines established by WPATH and the Endocrine Society are consistent with these principles and continue to evolve as our understanding of how to best treat and support adolescents with GD evolves.

In terms of protecting the interests of minors, guidelines alone do not protect the interests of minors. The current standards and guidelines reflect the prevailing best practice approaches to treatment, despite the number of people who might disagree with this outcome. If we are truly concerned about protecting the interests of minors, we would focus more resources on improving access to competent care.

We can do more to make sure mental health providers are being trained to communicate with gender-diverse adolescents without potentially causing more harm than good; which can derail the therapeutic process before it has a chance to begin (Metzler, 2020). We can require community mental health clinics in Utah that receive government funding to recognize and include the needs of gender-diverse people; such as implementing inclusive intake forms and increased acknowledgment and visibility of gender-diverse people (Metzler, 2020). These actions could help to create safer therapeutic environments and decrease care avoidance and concealment of critical information, especially in rural areas where access is limited (Metzler, 2020).

We can strengthen existing professional guidelines around competency for advanced practice with this population and change policies to ensure families have better access to multidisciplinary treatment, such as changing state health insurance requirements so insurance companies cannot exclude the medical needs of gender-diverse individuals.

There are many things we could be doing to protect the interests of minors but we are talking about potential legislation that would likely have devastating consequences for many of the individuals we are talking about. My hope is this will be the beginning of this discussion and we can continue to explore ways to improve the health, wellbeing, and future success of this population.

The need for more attention and resources to help this population is great. I appreciate that we are having this conversation, which is why I have used the entirety of my holiday weekend and more to respond to the questions submitted to me. I hope this conversation can continue without causing more distress for gender-diverse youth because it comes at the potential threat of restricting access to existing care.

4. UTAH POLICY

a. Should any particular treatments for gender dysphoria be limited to adults and emancipated minors? Why or why not?

Guidelines for surgical interventions to treat GD generally limit access to individuals who are 18 already. I believe flexible guidelines are necessary to address situations where significant and

probable harms could be avoided. Again, a one-size-fits-all approach that ignores suffering is potentially damaging to the short and long-term health and wellbeing of gender-diverse adolescents. Research continues to indicate that treatments involving age-appropriate medications and surgical treatment do provide significant relief from GD and improve mental health and overall functioning (Becker-Hebly et al., 2020; de Vries et al., 2014). Combined with a multidisciplinary team, these medical interventions are likely to be more successful (de Vries et al., 2014; de Vries, et al., 2011).

I would note that despite being considered "off-label," minors in Utah continue to access procedures like breast augmentation and other surgical procedures to modify the body without interference. The proposed legislation reflects what appears to be a double standard that seems only interested in regulating and restricting access to medical care when adherence to gender stereotypes is not maintained. In this case, such policymaking would also disregard the existing guidelines and standards established by professional bodies that conduct and review research, assess, and develop treatments for individuals who experience gender dysphoria.

These same medications and surgical procedures that H.B. 92 seeks to restrict from gender-diverse minors continue to be forced on young children with differences of sex development (DSD) or those who identify as intersex before the child is old enough to make informed decisions about their care or provide consent. This is often in the form of surgical procedures to "normalize" the appearance of genitalia and in some cases, reassign the child's sex. Proponents of H.B. 92 seem to understand this as they have listed several DSD in the bill. It seems disingenuous and cruel to suggest it is all right to force these medical treatments on children when they are too young to participate in their care and restrict access when they voice their needs and seek the same exact medical treatments as adolescents. Puberty blocking medications are frequently used to treat precocious puberty but we are supposed to believe they are dangerous when a gender-diverse adolescent is seeking them. These are examples of a double standard that only seems concerned with access to medical care when adherence to gender stereotypes is not being maintained.

From a policy perspective, it is difficult to ascertain how proponents of H.B. 92 have the best interests of gender-diverse youth in mind as the logic behind this bill seems to be more about gender-nonconformity than the needs of the individuals in question. The language used in this bill also reflects a bias towards gender-nonconforming people and a lack of awareness around the issues and people being discussed. My hope is the needs and potential suffering of the young people we are talking about is central in the minds of decision-makers. I also hope legislators will recognize this as an opportunity to provide meaningful change to improve the health, wellbeing, and success of these individuals.

I would welcome further discussion and any questions committee members might have. Thank you again for this opportunity.

b. Is there statutory, regulatory, or case law you believe the committee should be particularly mindful of?

Equality Utah and/or the ACLU would be a better resource to answer this question.

5. **IS THERE OTHER INFORMATION YOU WISH TO BRING TO THE COMMITTEE'S ATTENTION?**

Supporting documents you wish the committee to be aware of. Brevity will facilitate comparison of viewpoints and identification of areas for further discussion. You are not obligated to answer all questions, but please identify others you may know who would be qualified to address questions you do not wish to answer.

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Link to document: WPATH Standards of Care (version 7)

https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341