

IN THE UNITED STATES DISTRICT COURT FOR  
THE SOUTHERN DISTRICT OF FLORIDA

ROBERT W. OTTO, PH.D. LMFT, )  
individually and on behalf of his patients, )  
and JULIE H. HAMILTON, PH.D., LMFT, )  
individually and on behalf of her patients, ) Civil Action No. 9:18-cv-80771-RLR  
)  
Plaintiffs, )  
)  
v. )  
)  
CITY OF BOCA RATON, FLORIDA, and )  
COUNTY OF PALM BEACH, FLORIDA, )  
)  
Defendants. )

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**[PLAINTIFFS' PROPOSED]  
FINDINGS OF FACT AND CONCLUSIONS OF LAW  
ON PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

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**I. FINDINGS OF FACT.**

**A. Defendants’ Ordinances Banning “Conversion Therapy.”**

1. The County began considering its ordinance banning “conversion therapy” on June 20, 2016, at the prompting of Rand Hoch, the President and Co-Founder of the Palm Beach County Human Rights Council (PBCHRC). (Hvzd Dep., 21:22–23:19, 94:9–98:9; Pls.’ Ex. 6.) In the same manner, Hoch prompted the City’s consideration of its “conversion therapy” ordinance in July 2017. (Woika Dep., 12:24–13:24.) Defendants enacted their respective ordinances banning “conversion therapy” (collectively, the “Ordinances”) in the Fall of 2017. (City of Boca Raton Ordinance 5407, DE 1-4 (Oct. 10, 2017); Palm Beach County Ordinance 2017-46, DE 85-2, (Dec. 19, 2017).)

2. The operative language of the Ordinances is identical, as are the practices prohibited. Both Ordinances provide that “[i]t shall be unlawful for any provider to practice conversion therapy on any individual who is a minor regardless of whether the provider receives monetary compensation . . . .” (City Ord., Sec. 1 (9-106); Cnty. Ord., Sec. 5.). The Ordinances’ prohibitions are only applicable to licensed practitioners, including licensed marriage and family therapists. (City Ord., Sec. 1 (9-105(c)); Cnty. Ord., Sec. 4.).

3. The Ordinances’ define “conversion therapy” in nearly identical terms:

“Conversion therapy” . . . means . . . any counseling, practice, or treatment performed with the goal of changing an individual’s sexual orientation or gender identity, including but not limited to, efforts to change behaviors, gender identity, or gender expression, or to eliminate or reduce sexual or romantic attractions towards individuals of the same gender or sex.

(City Ord., Sec. 1 (9-105(a)); Cnty. Ord., Sec. 4 (“the practice of seeking to change”).)

4. Both Ordinances exclude from their definitions of “conversion therapy”:

counseling that provides support and assistance to a person undergoing gender transition or counseling that provides acceptance, support, and understanding of a person or facilitates a person’s coping, social support, and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, **as long as such counseling does not seek to change sexual orientation or gender identity.**

(City Ord., Sec. 1 (9-105(a)) (emphasis added); Cnty. Ord., Sec. 4 (substituting “identity exploration and development” for “development” and other minor variations).)

5. Licensed practitioners who violate the Ordinances are subject to financial penalties. (City Ord., Sec. 1 (9-107); Cnty. Ord., Sec. 6.)

6. Neither Ordinance defines “sexual orientation,” “gender identity,” “gender expression,” or “gender transition.”

7. According to the County’s 30(b)(6) witness, the same therapy content can be both allowed and prohibited by the County’s Ordinance, depending on whether the **intent** is to change a minor’s sexual orientation or gender identity. (Hvizd Dep., 260:11–262:12, 266:14–267:18.) If an adolescent born female, but who identifies as a male for a time, seeks therapeutic help to change her gender identity back to female to align with her biological body, the County Ordinance prohibits licensed therapists from helping her. (Hvizd Dep., 268:15–25.) Indeed, according to the County, if a minor desires and intends to change gender identity and presents that goal to a licensed therapist, the therapist is prohibited by the Ordinance from assisting with the minor’s goal, **regardless of whether the therapist also intends to change the minor’s gender identity.** (Hvizd Dep., 269:2–270:2.)

8. The City interprets its Ordinance the same way, as explained by its 30(b)(6) witness: “[I]f the therapist treats—if the practice is gender identity conversion or sexual orientation conversion, **whether or not it's prompted by the parents, by the therapist, by the child, themselves, that is banned by the ordinance.**” (Woika Dep., 154:23–158:13 (emphasis added).)

**B. Defendants’ Ordinances are Not Justified by “Overwhelming Research.”**

**1. The “Overwhelming Research” Recited by the Ordinances Contains No Empirical Evidence of Harm.**

9. The Ordinances identically claim justification in “overwhelming research,” which refers exclusively to ten sources appearing in the Ordinances’ respective recitals. (City Ord., DE 1-4, at 1–5; Cnty. Ord., DE 85-5, at ECF 9–12; Hvizd Decl., DE 85-1; DE 85-2 – 85-13; Hvizd Dep., 253:16–254:21; Woika Dep., 146:12–24.) Neither the “overwhelming research” language nor the cited sources were original to Defendants, however, having been copied from Rand Hoch’s model ordinance proposal. (Hvizd Dep., 247:14–249:23; Woika Dep., 12:24–13:24.)

10. The ten sources cited in the Ordinances (collectively, the “Sources,” DE 85-2 through 85-13) comprise various reports, statements, and position papers, centering on the 2009 Report of American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (DE 85-5, the “APA Report”). All of the other Sources either cite to the APA

Report, or cite to no authorities at all for their positions. (*See, e.g.*, DE 85-12, Substance Abuse and Mental Health Services Administration (SAMHSA), *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* (2015); DE 85-13 American College of Physicians Position Paper, *Lesbian, Gay, Bisexual, and Transgender Health Disparities* (2015); DE 85-11, American School Counselor Association Position Paper (2014).)

11. The APA Report does not use the term “conversion therapy.” Rather, the APA Report uses “the term sexual orientation change efforts (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a person’s same-sex sexual orientation to other-sex, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.” (APA Rep., DE 85-5, at 2 n.\*\*.)

12. The APA Report discloses up front, and repeatedly throughout, that there is no empirical or other research supporting **any conclusions** regarding either efficacy **or harm** from SOCE, especially in children and adolescents. (APA Rep. at 3 (“[T]he recent SOCE research **cannot provide conclusions** regarding efficacy or safety . . .”), 7 (“The research on SOCE **has not adequately assessed** efficacy and safety.”), 37 (“These [recent] studies all use designs that **do not permit cause-and-effect attributions to be made.**”), 42 (“[T]he recent studies **do not provide valid causal evidence** of the efficacy of SOCE **or of its harm . . .**”), 42 (“[T]he nature of these studies **precludes causal attributions** for harm or benefit to SOCE . . .”), 42 (“Thus, we **cannot conclude how likely it is that harm will occur from SOCE.**”), 72 (“**There is a lack of published research on SOCE among children.**”), 73 (“**We found no empirical research on adolescents who request SOCE . . .**”), 91 (“**We concluded that research on SOCE . . . has not answered basic questions of whether it is safe or effective and for whom.**”), 91 (“**[S]exual orientation issues in children are virtually unexamined.**”) (all emphases added).) None of the other Sources adds anything to the empirical record unequivocally found to be lacking in the APA Report.

13. Despite the “overwhelming research” language in the Ordinances, both Defendants confirmed through their Rule 30(b)(6) witnesses that the Ordinances are not justified by any empirical research. (Ginsburg Dep., 40:11-21; Woika Dep, 26:13–28:13.)

**2. The APA Report Discloses Anecdotal Evidence of Benefits from SOCE at Least Equivalent to Anecdotal Evidence of Harm, and More Benefits Perceived by Religious Individuals.**

14. Given the lack of empirical research on the outcomes of SOCE, the Task Force looked to participants' perceptions of SOCE, "in order to examine what may be perceived as being helpful or detrimental by such individuals, distinct from a scientific evaluation of the efficacy or harm . . . ." (APA Rep. at 49.) The review did not show evidence of one outcome over the other. "[S]ome recent studies document that there are people who perceive that they have been harmed through SOCE, just as other recent studies document that there are people who perceive that they have benefited from it." (APA Rep. at 42 (citations omitted).)

15. Nonetheless, the Task Force found several reported benefits of SOCE perceived by participants: "(a) a place to discuss their conflicts; (b) cognitive frameworks that **permitted them to reevaluate their sexual orientation identity, attractions, and selves in ways that lessened shame and distress and increased self-esteem**; (c) social support and role models; and (d) **strategies for living consistently with their religious faith and community**." (APA Rep. at 49 (emphasis added) (citations omitted).) "Participants described the social support aspects of SOCE positively." (*Id.*)

16. The Task Force also observed that perceptions of harm may correlate specifically to "aversion techniques." (APA Rep. at 41 ("Early research on efforts to change sexual orientation focused heavily on interventions that include **aversion** techniques. Many of these Studies did not set out to investigate harm. Nonetheless, these studies provide some suggestion that harm can occur from **aversive** efforts to change sexual orientation." (emphasis added)).) To illustrate, the Report gives some examples of aversion treatments:

Behavior therapists tried a variety of aversion treatments, such as inducing nausea, vomiting, or paralysis; providing electric shocks; or having the individual snap an elastic band around the wrist when the individual became aroused to same-sex erotic images or thoughts.

(APA Rep. at 22.)

17. The Task Force also found that individuals' religious beliefs shape their experiences and outcomes:

[P]eople whose motivation to change was strongly influenced by their Christian beliefs and convictions were **more likely to perceive**

**themselves as having a heterosexual sexual orientation after their efforts.** [T]hose who were less religious were more likely to perceive themselves as having an LGB sexual orientation after the intervention. **Some . . . concluded that they had altered their sexual orientation, although they continued to have same-sex sexual attractions.**

(APA Rep. at 50 (emphasis added) (citations omitted).) “The participants had multiple endpoints, including LGB identity, ‘ex-gay’ identity, no sexual orientation identity, and a unique self-identity.” (*Id.*) “Further, the findings suggest that some participants may have reconceptualized their *sexual orientation identity* as heterosexual . . . .” (*Id.* at 50.)

### **3. The APA Report Excludes Gender Identity Change Efforts.**

18. The APA Report addressed only sexual orientation: “Due to our charge, we limited our review to sexual orientation and **did not address gender identity . . . .**” (APA Rep. at 9 (emphasis added).)

19. Another Source cited by the Ordinances, however, points to the same lack of empirical research on the outcomes of gender identity change efforts:

Different clinical approaches have been advocated for childhood gender discordance. Proposed goals of treatment include reducing the desire to be the other sex, decreasing social ostracism, and reducing psychiatric comorbidity. **There have been no randomized controlled trials of any treatment. . . .**

(DE 85-8, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51(9) J. Am. Acad. Child and Adolescent Psychiatry 957 (2012) (footnote omitted) (hereinafter, “AACAP Statement”).)

20. As with the APA Report, the AACAP Statement leaves discretion with licensed professionals to make an informed decision, with the patient, about the most appropriate treatment. (AACAP Statement at 969 (“As an ethical guide to treatment, ‘the clinician has an obligation to inform parents about the state of the empiric database’ . . . .” (footnote omitted), 971 (“The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and that patient’s family, the diagnostic and treatment options available, and other available resources.”).)

21. The APA itself more recently addressed issues of gender identity and minors which were not included in the APA Report. *Guidelines for Psychological Practice with Transgender*

*and Gender Nonconforming People*, 70(9) *Am. Psychologist* 832 (2015), <https://www.apa.org/practice/guidelines/transgender.pdf> (hereinafter, “APA TGNC Guidelines”). As a discussion separate from SOCE, the Guidelines make the point that “[t]he constructs of gender identity and sexual orientation are theoretically and clinically distinct, even though professionals and nonprofessionals frequently conflate them.” (*Id.* at 835.) Nonetheless, the APA recognized the same absence of research on gender identity change in children: “Due to the evidence that not all children persist in a TGNC identity into adolescence or adulthood, and because no approach to working with TGNC children has been adequately, empirically validated, consensus does not exist regarding best practice with prepubertal children.” (*Id.* at 842.) One distinct approach recognized by the APA “to address gender identity concerns in children” is an approach where “children are encouraged to embrace their given bodies and to align with their assigned gender roles.” (*Id.*) And again, calling for more research, the APA concludes, “It is hoped that future research will offer improved guidance in this area of practice.” (*Id.* (citation omitted).)

22. Notwithstanding the APA’s call for future research, however, the APA expressly sanctioned as **imperative** allowing a minor who has selected a gender identity different from his or her biological sex to choose to return:

Emphasizing to parents the importance of allowing their child the freedom **to return to a gender identity that aligns with sex assigned at birth** or another gender identity at any point **cannot be overstated**, particularly given the research that suggests that not all young gender nonconforming children will ultimately express a gender identity different from that assigned at birth.

(APA TGNC Guidelines at 843 (emphasis added).)

23. Other literature by a research scientist favorably cited in the AACAP Statement positively advances treatment to assist children in fading “cross-gender identity” by the time they reach adolescence. Heino F. L. Meyer-Bahlburg, *Gender Identity Disorder in Young Boys: A Parent- and Peer-Based Treatment Protocol*, 7 *Clinical Psychol. And Psychiatry* 360, 361 (2002) (cited by AACAP Statement at 969 (n.100)) (“We expect that we can diminish these problems if we are able to speed up the fading of the cross-gender identity which will typically happen in any case.”); *see also id.* at 365 (“The specific goals we have for the boy are to develop a positive relationship with the father (or a father figure), positive relationships with other boys, gender-typical skills and habits, to fit into the male peer group or at least into a part of it, and to feel good about being a boy.”).)

**4. The APA Report Commends a Client-Directed Approach to Therapy for Clients with Unwanted Same-Sex Attractions, Commends More Research on Voluntary SOCE, and Condemns Only Coercive Therapies.**

24. For adults desiring “**to change their sexual orientation** or their behavioral expression of their sexual orientation, or both,” the APA reported that “adults perceive a benefit when they are provided with **client-centered** . . . approaches” involving “identity exploration and development,” “**respect for the client’s values, beliefs, and needs,**” and “permission and opportunity to explore a wide range of options . . . **without prioritizing a particular outcome.**” (APA Report, DE 85-5, at 4.) The Task Force elaborated:

Given that there is diversity in how individuals define and express their sexual orientation identity, **an affirmative approach is supportive of clients’ identity development without an a priori treatment goal concerning how clients identify or live out their sexual orientation or spiritual beliefs.** This type of therapy . . . can be helpful to those who accept, reject, or are ambivalent about their same-sex attractions. **The treatment does not differ, although the outcome of the client’s pathway to a sexual orientation identity does.**

(APA Rep. at 5 (emphasis added).) “For instance, the existing research indicates that possible outcomes of sexual orientation identity exploration **for those distressed by their sexual orientation** may be: LGB identities[,], **Heterosexual sexual orientation identity**[,], Disidentifying from LGB identities[, or] Not specifying an identity.” (*Id.* at 60 (emphasis added) (citations omitted).)<sup>1</sup>

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<sup>1</sup> In connection with its SOCE review and recommendations, the APA Report highlighted a problem with the sexual orientation terminology in the academic research:

Recent studies of participants who have sought SOCE **do not adequately distinguish between sexual orientation and sexual orientation identity.** We concluded that the failure to distinguish these aspects of human sexuality has led SOCE research to obscure what actually can or cannot change in human sexuality. . . . **[S]ome individuals modified their sexual orientation identity** (e.g., individual or group membership and affiliation, self-labeling) **and other aspects of sexuality** (e.g., values and behavior). . . . **[I]ndividuals, through participating in SOCE, became skilled in**

25. A key finding from the Task Force’s review “is that those who participate in SOCE, **regardless of the intentions of these treatments**, and those who resolve their distress through other means, **may evolve during the course of their treatment in such areas as self awareness, self-concept, and identity.**” (APA Rep. at 66 (emphasis added); *id.* at 61 (“Given . . . that many scholars have found that **both religious identity and sexual orientation identity evolve**, it is important for LMHP to explore the development of religious identity and sexual orientation identity.” (emphasis added) (citations omitted).))

26. The Task Force identifies the **same essential framework** “for children and adolescents who present a desire to change either their sexual orientation or the behavioral expression of their sexual orientation, or both, or whose parent or guardian expresses a desire for the minor to change.”<sup>2</sup> (APA Rep. at 5.) Specifically, for children and youth, “[s]ervices . . . should support and respect age-appropriate issues of **self-determination**; services should also be provided in the least restrictive setting that is clinically possible and should maximize self-determination. At a minimum, **the assent of the youth should be obtained, including whenever possible a developmentally appropriate informed consent to treatment.**” (*Id.* (emphasis added).))

27. The Task Force also highlighted the ethical importance of client self-determination, encompassing “the ability to seek treatment, consent to treatment, and refuse treatment. **The informed consent process is one of the ways by which self-determination is maximized in psychotherapy.**” (APA Rep. at 68 (emphasis added); *see also id.* at 6 (“LMHP **maximize self-determination** by . . . providing effective psychotherapy that explores the client’s assumptions and goals, without preconditions on the outcome [and] **permitting the client to decide the ultimate goal of how to self-identify and live out her or his sexual orientation.** . . . [T]herapy that increases the client’s ability to cope, understand, acknowledge, and integrate sexual orientation concerns into **a self-chosen life** is the measured approach.”).))

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**ignoring or tolerating their same-sex attractions. Some individuals reported that they went on to lead outwardly heterosexual lives, developing a sexual relationship with an other-sex partner, and adopting a heterosexual identity.**

(APA Rep. at 3–4 (emphasis added).))

<sup>2</sup> The APA Report defines “*adolescents* as individuals between the ages of 12 and 18 and children as individuals under age 12.” (APA Rep. at 71 n.58.)

28. The Task Force viewed the concept of self-determination as equally important for minors: “It is now recognized that **adolescents are cognitively able to participate in some health care treatment decisions**, and such participation is helpful. [The APA] encourage[s] professionals to seek the assent of minor clients for treatment.” (APA Rep. at 74 (emphasis added) (citations omitted); *see also id.* at 77 (“The ethical issues outlined [for adults] are also relevant to children and adolescents . . . .”))

29. In light of this strong self-determination ethic regarding youth, the Task Force “recommend[ed] that when it comes to treatment that purports to have an impact on sexual orientation, LMHP assess the adolescent’s ability to understand treatment options, provide developmentally appropriate informed consent to treatment, and, at a minimum, obtain the youth’s assent to treatment.” (*Id.* at 79.) “[F]or children and adolescents who present a desire to change their sexual orientation or their behavioral expression of their sexual orientation, or both, or whose guardian expresses a desire for the minor to change,” the Task Force recommended “approaches [that] support children and youth in identity exploration and development without seeking predetermined outcomes.” (*Id.* at 79–80.) “LMHP should strive to maximize autonomous decision making and self-determination and avoid coercive and involuntary treatments.”<sup>3</sup> (APA Rep. at 76.) “The use of inpatient and residential treatments for SOCE is inconsistent with the recommendations of the field.” (APA Rep. at 74–75.)

30. Apart from recommending against coercive, involuntary, and residential treatments, the Task Force **did not recommend the end of SOCE**. Rather, without empirical evidence of SOCE efficacy or harm, the Task Force merely recommended that clients not be lead to **expect** a change in sexual orientation through SOCE. (APA Rep. at 66.) Indeed, The Task Force cited literature expressly cautioning **against declining SOCE** therapy for a client who requests it.

LMHP who turn down a client’s request for SOCE at the onset of treatment without exploring and understanding the many reasons why the client may wish to change may instill hopelessness in the client, who already may feel at a loss about viable options. . . .  
**[B]efore coming to a conclusion regarding treatment goals,**

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<sup>3</sup> The APA Report defines “*coercive treatments* as practices that compel or manipulate a child or adolescent to submit to treatment through the use of threats, intimidation, trickery, or some other form of pressure or force.” (APA Rep. at 71 n.59.) It defines “*involuntary treatment* as that which is performed without the individual’s consent or assent and which may be contrary to his or her expressed wishes.” (*Id.* at 71 n.60.)

**LMHP should seek to validate the client’s wish to reduce suffering and normalize the conflicts at the root of distress**, as well as create a therapeutic alliance that recognizes the issues important to the client.

(APA Rep. at 56 (emphasis added) (citation omitted).)

31. The Task Force also called for more research on SOCE. (APA Rep. at 91 (“Any future research should conform to best-practice standards for the design of efficacy research. Additionally, **research into harm and safety is essential.**”), 91 (“**Future research** will have to better account for the motivations and beliefs of participants in SOCE.”), 91 (“**This line of research should be continued and expanded to include conservatively religious youth and their families.**”) (all emphases added).)

32. The Task Force also noted, “The debate surrounding SOCE has become mired in ideological disputes and competing political agendas.” (APA Rep. at 92 (citation omitted).) One policy recommendation “urges the APA to: . . . Encourage **advocacy groups, elected officials**, policymakers, religious leaders, and other organizations to seek accurate information and avoid promulgating inaccurate information.” (*Id.* (emphasis added).) The Task Force’s call for future research implicitly rejected the suggestion by some that “SOCE should not be investigated or practiced until safety issues have been resolved.” (*Id.* at 91.)

33. Given the absence of empirical evidence on SOCE outcomes, and the emphasis on client-centered approaches, the Task Force recommended that choosing SOCE counseling be given to the discretion of licensed mental health providers (LMHP):

[The APA Ethics Code] establishes that psychologists aspire to provide services that maximize benefit and minimize harm. . . . When applying this principle in the context of providing interventions, **LMHP assess the risk of harm, weigh that risk with the potential benefits, and communicate this to clients through informed consent procedures** that aspire to provide the client with an understanding of potential risks and benefits that are accurate and unbiased. . . .

In weighing the harm and benefit of SOCE, LMHP can review with clients the evidence presented in this report. Research on harm from SOCE is limited, and some of the research that exists suffers from methodological limitations that make broad and definitive conclusions difficult. . . .

(APA Rep. at 67 (emphasis added) (citations omitted); *see also id.* at 6 (“LMHP reduce potential harm and increase potential benefits by basing their scientific and professional judgments and

actions on the most current and valid scientific evidence, such as the evidence provided in this report.”.)<sup>4</sup>

**5. The APA Report Specifically Calls for Therapists to Respect and Consider the Religious Values of Individuals Desiring Therapy.**

34. The APA Task Force highlighted the particular stress experienced by individuals of conservative religious faiths who “struggle to live life congruently with their religious beliefs,” and that this stress “had mental health consequences.” (APA Rep. at 46–47.) “Some conservatively religious individuals felt a need to change their sexual orientation because of the positive benefits that some individuals found from religion . . . .” (*Id.* at 47.) Thus, the Task Force “proposed an approach that respects religious values and welcomes all of the client’s actual and potential identities by exploring conflicts and identities without preconceived outcomes. This approach does not prioritize one identity over another and may aide a client in creating a sexual orientation identity consistent with religious values.” (APA Rep. at 67 (citation omitted).) “Although there are tensions between religious and scientific perspectives, the task force and other scholars do not view these perspectives as mutually exclusive.” (APA Rep. at 67 (citations omitted).)

**C. Defendants Received No Complaints or Evidence of Harm by SOCE When Considering Their Ordinances.**

35. In Rand Hoch’s e-mailed memorandum which prompted the County to take up the therapy ban, Hoch represented that “[c]onversion therapy’ (also known as ‘reparative therapy,’) is counseling based on the erroneous assumption that gay, lesbian, bisexual and transgender (LGBT) identities are mental disorders that can be cured through **aversion treatment**.” (Pls.’ Ex. 6 at PBC 007643 (emphasis added).) Hoch also represented that “conversion therapy . . . **is most often forced upon minors** by their parents or guardians [and] is extremely harmful.” (Pls.’ Ex. 6 at PBC 007644 (emphasis added).) Upon receiving Hoch’s request, however, the County did not direct any investigation as to whether anyone in the County had been harmed by “conversion

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<sup>4</sup> The AAMFT, which sets ethical standards for marriage and family therapists such as Plaintiffs, agrees with the APA Task Force’s permissive approach for licensed providers: “AAMFT expects its members to practice based on the best research and clinical evidence available,” and, “treatment of those clients who present feeling confused about or wanting to change their sexual orientation should be undertaken with great care, knowledge, and openness.” (DE 86-1 at 3, 5.)

therapy,” voluntary, aversive, or otherwise. (Hvizd Dep., 26:21–27:19.) Nonetheless, Attorney Hvizd was assigned the task of drafting the ordinance requested by Hoch, and she undertook her own informal investigation in connection with her drafting assignment. (Hvizd Dep., 27:20–28:3, 31:1–33:25.) Hvizd found no reports of any person harmed by “conversion therapy” in Palm Beach County, or in Florida. (*Id.*; Ginsburg, 12:5–25.)

36. At the December 5, 2017 County Commission meeting at which the County Ordinance was considered, Hoch represented to the Board, “we’ve heard from two individuals, minors who have been required to go to conversion therapy by their parents.” (Hvizd Dep., 34:1–13, 36:9–37:18; Pls.’ Ex. 2, 65:10–17.) Hoch did not describe what the “conversion therapy” consisted of, including whether it was aversive or non-aversive, or voluntary or forced. (*Id.*) No Commissioner asked Hoch what kind of therapy was involved, or what kind of harm was claimed. (Hvizd Dep., 50:5–51:20.) At the second Commission meeting where the County Ordinance was considered, on December 19, 2017, Hoch clarified that the complaints were “from the mothers of gay people because their friends, the gay children’s friends who also identified as gay, were being subjected to conversion therapy.” (Hvizd Dep., 55:2–58:21; Pls.’ Ex. 3, 80:10–13.) And, according to Hoch, the friends of the complainants’ children were being forced to go. (Hvizd Dep., 61:20–62:12; Pls.’ Ex. 3, 80:15–18.) But the Commissioners did not undertake to find out, from Hoch or anyone else, the type of therapy or the nature of harm allegedly experienced by the unnamed friends of the children of the mothers who complained to Hoch. (Hvizd Dep., 65:2–66:7.)

37. The County may or may not have considered an additional complaint e-mailed to the Commissioners by Nick Sofoul on December 18 at 10:16 PM, the night before the second and final Commission Meeting where the County Ordinance was considered and ultimately voted on. (Hvizd Dep., 73:2–78:20; Pls.’ Ex. 4 at PBC 002849.) The Sofoul e-mail represented that Sofoul “[had] personally heard and been moved by the horrific stories of friends that have been subject [sic] to these cruel and inhumane methods.” (Hvizd Dep., 78:21–79:2.; Pls.’ Ex. 4 at PBC 002849.) Even if the Commissioners were aware of the e-mail prior to voting on the County Ordinance, however, they did not undertake to determine what “friends” Sofoul was writing about, whether they were minors, whether they were residents of Palm Beach County (or Florida), what “methods” Sofoul heard about, and whether the “friends” were forced. (Hvizd Dep., 79:3–82:4.)

38. In sum, the County received no evidence of harm suffered by any minor in its jurisdiction as a result of voluntary SOCE or “conversion therapy.” (Ginsburg, 15:11–22.) The

only “evidence” of harm attributed to SOCE was the anecdotal, multi-layered hearsay communicated by Hoch, which he in turn claims to have heard from the mothers of friends of the supposed victims, and possibly the hearsay e-mail of Sofoul, regarding unnamed “friends” subjected to unidentified “methods” in unidentified jurisdictions. (Ginsburg, 10:9–12:4.)

39. Hoch was also the originator of the City Ordinance, and he made the same unsubstantiated representations of harm to the City Council. (Woika Dep., 12:24–14:10.) Prior to enacting its Ordinance, the City had never received a complaint about harm from “conversion therapy,” and the City never investigated whether any of its citizens had been harmed by “conversion therapy.” (Woika Dep., 16:19–18:9.) The City based its determination of need for the Ordinance entirely on Hoch’s request. (Woika Dep., 16:19–20:11; Pls.’ Ex. 23.) Thus, the City likewise considered no evidence of harm in its jurisdiction before enacting its Ordinance, and considered no empirical evidence of harm from “conversion therapy” elsewhere. (Woika Dep., 26:13–28:13.)

**D. Defendants Did Not Consider Any Less Restrictive Alternatives to Their Outright Therapy Bans.**

40. There is no evidence that the County seriously considered any alternative to the outright therapy ban in its Ordinance. For example, there is no evidence that the County considered banning only the “aversion treatment” or “therapy . . . forced upon minors” complained of by Hoch in his memorandum to the County Commissioners setting the Ordinance in motion. (Pls.’ Ex. 6 at PBC 007643–44.) There is no evidence that, for example, Plaintiff Hamilton’s suggested revision to the draft County Ordinance to prohibit only “coercive counseling . . . against the individual’s will” ever made it to the Commissioners for consideration. (Hvizd Dep., 273:2–279:23; Pls.’ Ex. 21 at PBC 006034–35.) And, while the Board received public comment asking it to consider alternatives, such as banning shock therapy, there is no evidence that the Board gave the requests any consideration whatsoever. (Hvizd Dep., 39:20–30:11.)

41. Though it could have, the City did not consider any alternative to the blanket ban contained in its Ordinance. (Woika Dep., 28:16–32:10 (“I think the Council had really the option of passing the ordinance, which is a total ban. And the only other alternate they considered was no ban.”).) Thus, the City never considered banning only aversive therapy, or only coercive or forced therapy. (*Id.*) In fact, during the three City Council meetings covering the Ordinance’s conception,

introduction, and enactment, the Council spent **less than five minutes** considering it. (Woika Dep., 52:12–63:20; Pls.’ Ex. 24.)

**E. Defendants Knew Their Ordinances Were Not Enforceable by Their Code Enforcement Officials.**

42. In her September 7 “definite-no-to-maybe” e-mail to Commissioners (Pls.’ Ex. 16), Nieman expressed her legal reservations about tailoring the proposed Ordinance to the supposed problems to be remedied, namely conversion therapies by religious organizations that the Ordinance would not touch, and the inability of the County to enforce the Ordinance against licensed therapists in any event:

In addition to the legal issues, after researching the history of conversion therapy, I felt it important to bring to your attention some general observations, as well as some practical concerns. **Most of the universal complaints seem to be about religious organizations that the ordinance would not legally be able to address.** Further, all of the six therapists who have been identified to us as practicing conversion therapy in PBC are located in the incorporated areas of the County, which I suppose is a plus because **one of the main concerns is enforcement. It's difficult to imagine how a County Code Enforcement Officer would be able to issue a citation for a violation. How would an officer determine if a violation occurred?** The ordinances play more of a deterrent role.

(Pls.’ Ex. 16 at PBC 00800 (emphasis added).)

43. Prior to enactment of the City Ordinance, Deputy City Manager George Brown, who was the direct supervisor of code compliance at the time, cautioned the City Attorney Diana Grub Frieser about enforcement in a July 18, 2017 e-mail:

While I find so-called “conversion therapy” inherently wrong and totally abhorrent, **a local ordinance banning such practice would be extremely difficult, if not impossible, to enforce.** Proving a violation (before the special magistrate) would necessarily require public disclosure by a patient or credible witness that the “treatment” had been administered in violation of the ordinance. **The City has not adopted ordinances limiting or regulating professions otherwise regulated by the state.**<sup>5</sup>

(Woika Dep., 104:7–107:16, Pls.’ Ex. 25 (emphasis added).)

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<sup>5</sup> This concern for the City’s competence to enforce a therapy ban no doubt informed the City Attorney’s preemption concerns in her communication to the City Council. (*See infra* § I.F; Pls.’ Ex. 23 at City - 00870.)

44. Brown's concerns about enforceability caused him to inquire with city managers of other cities where similar therapy ban ordinances had been adopted in a July 21, 2017 e-mail:

Each of your cities has adopted a conversion therapy prohibition ordinance . . . . Have any of you established specific enforcement procedures? What methods of investigation are utilized to determine if a violation is occurring/has occurred? Have any cases been prosecuted?

(Woika Dep., 112:17–114:18; Pls.' Ex. 26 at City - 00993.) A response from Boynton Beach City Manager Lori LaVerriere prompted this follow-up from Brown:

I have recommended we adopt a resolution stating our position against it, rather than an ordinance making it an offense, because we would not want to get between a family and its child based on a complaint from the child or a third party. We are in the early stages of considering the matter. **I consider it a more or less unenforceable ordinance and a matter that is not something our local government should take up.**

(Woika Dep., 119:5–21; Pls.' Ex. 26 at City - 00992 (emphasis added).) There is no evidence that either Brown's recommendation that a resolution be passed instead of an ordinance, or his concern that an ordinance would be unenforceable, was ever communicated to the City Council before enactment. (Woika Dep., 120:15–121:5, 122:8–123:3.) A likely explanation for the City Council's disregard of the enforcement (and preemption) concerns raised by the City Attorney and staff is revealed in the subsequent exchange between LaVerriere and Brown, wherein LaVerriere wrote, **"Agreed. Electeds received a lot of pressure from Rand Hoch,"** to which Brown replied, **"As are ours."** (Pls.' Ex. 26 at City - 00992 (emphasis added).)

45. The Village Manager of the Village of Wellington, Paul Schofield, also commiserated with Brown regarding unenforceability:

[W]e do not have a specific enforcement mechanism and **I don't have any clear idea how we could train either our Code Enforcement staff of [sic] law enforcement staff to actually enforce it.** If we receive a complaint will deal with it individually and **most likely referee [sic] it to one for the state governing bodies. The M.D.'s, D.O.'s and clinicians all have their own state boards.**

(Pls.' Ex. 26 at City - 00991 (emphasis added).) Neither LaVerriere's nor Schofield's concurrences with Brown's enforcement doubts were shared with the Boca Raton City Council. (Woika Dep., 135:5–9.)

46. Council Member Rodgers also had doubts about enforcement, which he raised with the Council and City staff at the meeting where the Ordinance was enacted, prompting responses from both Deputy City Manager Brown and City Attorney Frieser:

MR. RODGERS: Madam Chair?

MAYOR HAYNIE: Mr. Rodgers.

MR. RODGERS: Question for our City Manager. How -- and I've looked through this, and I have some concerns of language licensed practice versus unlicensed. **How would we enforce this?** Would this be like a code violation that we'd bring it forward or...

DEPUTY CITY MANAGER BROWN: It would be. **I'm not sure how we would enforce it.** But it would be in the code-related area.

[MR. RODGERS:] Any other thoughts from the attorney? I don't...

MAYOR HAYNIE: Ms. Frieser?

MS. FRIESER: That was a -- it's a Code Enforcement process. **I concede that it's -- there may be difficulties in actual practical enforcement issue.** But it is a Code Enforcement process.

(Woika Dep., 59:12–18, 61:5–21, 62:23–63:3.) Suffice it to say, at the time of enactment, enforcement of the City Ordinance had not been clearly delineated or even thought out. (Woika Dep., 65:5–16.)

47. As with other ordinances, complaints of violations of the therapy ban Ordinances would be investigated by code enforcement officials and decided by special masters, neither of whom would be required to be licensed mental health professionals, or trained to interpret scientific literature such as the APA Report, or otherwise knowledgeable about ethical or recommended therapeutic practices. (Hvizd Dep., 208:3–15, 214:18–215:8; Woika 67:10–69:12.) In each case, an untrained code official would make an initial determination as to whether a complained of therapy violates the applicable Ordinance, and then issue a notice of violation if so. (Woika Dep., 90:12–91:1.) In any case prosecuted before a special master, the special master acts as the finder of fact, and would be allowed or required to question witnesses, including children seeking mental health therapy and their licensed mental health professionals. (Hvizd Dep., 264:13–266:13.)

48. According to an unwritten, internal policy, the County's Ordinance will be enforced by any of five senior code enforcement officers. (Hvizd Dep., 219:20–221:18.) The only

educational requirement for senior code enforcement officers is a high school diploma or equivalent, and there is no evidence that any of the County's current five have more, or hold any professional licenses. (Hvzd Dep., 223:21–225:14; Pls.' Ex. 18.) None of the code officials has been trained on enforcing the Ordinance in the ten months since enactment; no training materials have been developed, and there is no plan to develop any. (Hvzd Dep., 225:15–228:9.) These code officials would not only determine whether to issue notice of a violation of the County Ordinance but would also prosecute any noticed violations in front of the special master. (Pls.' Ex. 18.) There is no evidence that any of the five senior code officials has any experience enforcing regulations of licensed mental health professionals. (Hvzd Dep., 232:3–233:11.)

49. City Code officials likewise only need a high school diploma or equivalent. (Woika Dep., 72:3–73:4.) And like the County, the City has no written policies or procedures for enforcing its Ordinance, and no plans for any. (Woika Dep., 74:19–75:9, 78:2–5.) No current City code compliance officials have experience enforcing ordinances against licensed professionals concerning their professional standards. (Woika Dep., 110:5–111:8.)

**F. Defendants' Knew Their Ordinances Regulated a Field Preempted to the State.**

50. Palm Beach County Attorney, Denise Marie Nieman, stated unequivocally to the Ordinance originator Hoch in an August 26, 2016 e-mail that the State of Florida had preempted the entire field of therapy regulation. (Hvzd Dep., 111:25–115:6; Pls.' Ex. 9 at PBC 014666 (“On a very basic level, how can we say [conversion therapy] is a local issue?”) (“This is a classic non-localized issue in my view.”).) In a subsequent e-mail to Hoch from Hvzd on August 29, 2016, Hvzd endorsed Nieman's preemption position with a more formal analysis:

In follow-up to your email of Friday, I offer the following synopsis of legal research conducted on the question of whether a County may enact a conversion therapy ban. The dual considerations a local government must address when determining whether it is able to enact legislation in a particular area are preemption and conflict. **The Florida Legislature's scheme of licensing and regulating businesses and professions is pervasive . . . evidencing an intent that this area be preserved to the Legislature. Neither county nor municipal governments license counselors, and there is no support in the law for a conclusion that regulating counselors is a “local issue” as addressed in *Browning*. To the contrary, every indication is that regulation of businesses and professions, including counselors, is a state issue.**

**As to conflict, a local ordinance regulating the treatment available to patients would conflict with Florida's broad Patients' Bill of Rights**, section 38 I.026(4)(d), and section 456.41 of the Florida Statutes. Counties are prohibited from enacting an ordinance that conflicts with general law.

The Federal Courts addressing conversion therapy bans in California and New Jersey have examined state statutes, and upheld them, in part, on the basis that those laws were rationally related to a legitimate state interest. **The state is charged with regulating and licensing businesses and professions, including counselors**, thus they are more readily able to satisfy this test than the County would be. **The County plays no part in regulating counselors.**

(Hvizd Dep., 126:4–127:12; Pls.' Ex. 11 at PBC 014677 (emphasis added).) Nieman adopted Hvizd's analysis without reservation: "Rand, that sums it up." (Pls.' Ex. 11 at PBC 014677.)

51. Anticipating issuing an adverse legal opinion against the proposed County Ordinance, based on preemption, Nieman advised Hoch in a March 5, 2017 e-mail, "We'll keep it in 'still researching' mode, but know that **nothing will change just because more cities enact ordinances, unless one is tested and upheld on issues of concern to us.**" (Hvizd Dep., 147:5–15, 156:22–157:19; Pls.' Ex. 13 at PBC 014706 (emphasis added).) Nieman repeated this point emphatically in an April 12, 2017 e-mail to Hoch: "Let me know when you want [the opinion] to go, keeping in mind that **nothing that happens with cities holds much persuasive value unless a court rules on the exact issues I'm concerned about.**" (Hvizd Dep., 158:21–159:6, 163:3–9; Pls.' Ex. 14 at PBC 007914 (emphasis added).)

52. In an August 28, 2017 e-mail, Hoch asked Nieman to proceed with issuing a legal opinion to the County Commissioners on the proposed County Ordinance. (Hvizd Dep., 164:25–165:12; Pls.' Ex. 15 at PBC 008017.) On September 7, 2017, Nieman sent her definite-no-to-maybe e-mail to the County Commissioners expressing several legal concerns with enacting a County therapy ban, specifically highlighting the preemption and conflict issues: "**We strongly believe that this area should be regulated by the state since it is the state who licenses and otherwise governs therapists.**" (Hvizd Dep., 177:16–178:19; Pls.' Ex. 16 at PBC 008000 (emphasis added) "[W]e still have legal concerns including, but not limited to, **implied preemption, the Florida Patients' Bill of Rights . . . .**" (*Id.*))

53. Despite the County Attorney's steadfast opinion that the field of therapist regulation is preempted to the state, and repeated admonitions that the passage of ordinances by other cities

would not change that opinion, the only thing that changed legally between her last such admonition to Hoch on April 12, 2017, and her definite-no-to-maybe e-mail to the Commissioners on September 7, 2017, was the passage of ordinances in other cities. (Pls.’ Ex. 16 at PBC 008000 (“As Mr. Hoch pointed out in his recent email, a number of cities did adopt ordinances.”).) Without any change in the law that could have changed Nieman’s opinion (Hvzd Dep., 185:17–196:6)—the one condition Nieman had imposed—only a change in the political calculus can account for the change of opinion, apparently prompted by Hoch’s August 28 e-mail. (Pls.’ Ex. 15 at PBC 008017 (“On behalf of . . . PBCHRC, I want to thank you for delaying moving forward . . . . At this time, PBCHRC would like you to move forward with providing your office’s opinion . . .”).)

54. Like the Palm Beach County Attorney, Boca Raton’s City Attorney raised the preemption issue in her first communication to the City Council introducing the draft City Ordinance on August 17, 2017:

It is worth noting that although regulation of health professions occurs through licensure at the state level, there is no express statutory preemption regarding the state’s regulation of licensed health professions . . . . However, **given the extensive regulation of health professions by the state, it is possible a court may, in the future, find the regulatory field has been impliedly preempted to the state (thereby prohibiting local regulation).**

(Pls.’ Ex. 23 at City - 00871 (emphasis added).)

## **G. Plaintiffs’ and Their Therapy Practices.**

### **1. Plaintiff Robert W. Otto, Ph.D., LMFT.**

55. Plaintiff, Robert W. Otto, Ph.D, LMFT, is a licensed marriage and family therapist and is licensed to practice mental health counseling in Florida. (DE 1, Verified Complaint (“VC”), ¶ 122<sup>6</sup>). Dr. Otto maintains a counseling practice in the City of Boca Raton and in other parts of Palm Beach County, which included prior to the Ordinances voluntary SOCE counseling of minors who are experiencing unwanted same-sex attractions, behaviors, and identity. (*Id.*, ¶¶125-26).

56. Dr. Otto does not call his SOCE counseling “conversion therapy,” and does not know anyone who does. (Otto Dep., 176:4–22, 190:17–191:9.) Rather, “this is client-centered and

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<sup>6</sup> The City expressly **accepts as true** the allegations of Plaintiffs’ Verified Complaint for preliminary injunction purposes. (City Opp’n, DE 83, at 2 n.2.) The County offers no evidence to the contrary either.

client-directed with clients' goals. So when you ask me about trying to change somebody, I am not trying to change anybody on anything. **These are client issues that clients want to seek change on, and they come asking for assistance** as they walk through that journey, and we talk about that process in speech.” (Otto Dep., 44:13–20 (emphasis added).)

57. Prior to engaging in SOCE counseling with any client, Dr. Otto provides them with an extensive informed consent form and requires them to review and sign it prior to commencing SOCE counseling. (*Id.*, ¶ 128). Many of Dr. Otto’s clients who desire SOCE counseling profess to be Christians with sincerely held religious beliefs conflicting with homosexuality and seek SOCE counseling in order to live a lifestyle that is in congruence with their faith and to conform their identity, concept of self, attractions, and behaviors to their sincerely held religious beliefs. (*Id.*, ¶ 129). Dr. Otto has never received any complaint or report of harm from any of his clients seeking and receiving SOCE counseling, including the many minors that he has counseled. (*Id.*, ¶ 130).

58. Dr. Otto has minor clients who have experienced unwanted same-sex attractions, behaviors, and identity. (*Id.*, ¶¶ 132-35). Some of Dr. Otto’s clients have experienced anxiety, confusion, depression, and even suicide ideation and attempts as a result of their unwanted same-sex attractions. (*Id.*). Those clients seek to engage in SOCE counseling with Dr. Otto, but are unable to engage in such counseling because of the Ordinances. (*Id.*, ¶ 137). Dr. Otto is prohibited from engaging in SOCE counseling with his minor clients or must discontinue ongoing SOCE counseling despite the clients’ and parents’ consent and requests to continue, or face penalties under the Ordinances. (*Id.*, ¶ 139).

## **2. Plaintiff Julie H. Hamilton, Ph.D, LMFT.**

59. Plaintiff, Julie H. Hamilton, Ph.D., LMFT, is a licensed marriage and family therapist and is licensed to practice mental health counseling in Florida. (*Id.*, ¶ 140). Hamilton practices throughout Palm Beach County, including in the City of Boca Raton. (Hamilton Dep., 329:3–335:15; Hamilton Decl., DE 96-1.) In her current practice, Dr. Hamilton provides individual, marital, and family therapy for a wide variety of issues, including the issues of unwanted same-sex attractions and gender identity confusion. (*Id.*, ¶ 142).

60. Prior to engaging in therapy for any issue, Dr. Hamilton provides all of her clients with informed consent, in which she explains that, because there are many variables in psychotherapy, there is no guarantee that by pursuing therapy clients will be happier; that no

particular treatment method can be guaranteed to be effective; and that therapy can be uncomfortable as clients talk about unresolved life experiences. (*Id.*, ¶ 143).

61. Many of Dr. Hamilton's clients are referred through churches or word of mouth, and hold a Biblical worldview. (*Id.*, ¶ 145). Dr. Hamilton's clients with same-sex attractions, behaviors, or identity or gender identity confusion who adhere to a Biblical worldview believe that embracing a gay identity is not in accordance with God's plan for their lives, nor is adopting a gender identity that is different from their biological sex. (*Id.*). Many such clients who have same-sex attractions or gender identity confusion, who also prioritize their faith above their feelings, seek out therapy to clear up gender identity confusion, reduce same-sex attractions, change same-sex behaviors, and/or simply live a life consistent with their faith. (*Id.*, ¶ 146). Clients who have been living lives inconsistent with their faith often present with internal conflicts, depression, anxiety, substance abuse and so forth; therefore, they are seeking resolution to such turmoil. (*Id.*). Dr. Hamilton currently has clients seeking to engage in what would be considered SOCE counseling, but she is prohibited from engaging in such counseling because of the Ordinances. (*Id.*, ¶¶ 148-61).

### **3. Plaintiffs' Voluntary SOCE Counseling.**

62. Plaintiffs do not begin counseling with any predetermined goals other than those that their clients themselves identify and set, including client goals to change sexual orientation or gender identity. This is consistent with the clients' fundamental right of self-determination. (VC, ¶ 75.)

63. In their practices, Plaintiffs help clients with their unwanted same-sex attractions, behaviors, and identity by talking with them about root causes, about gender roles and identities, and about their anxieties and confusion that arises from these attractions. (*Id.*, ¶ 73). Speech is the only tool that Plaintiffs use in their counseling with minors seeking to reduce or eliminate their unwanted same-sex attractions, behaviors, or identity. (*Id.*, ¶ 74). The only thing that happens in their counseling sessions is speech. (*Id.*). Plaintiffs employ speech to help clients understand and identify their anxiety or confusion regarding their attractions, behaviors, or identity and then to help the client formulate the method of counseling that will most benefit that particular client. (*Id.*, ¶ 76).

64. Plaintiffs do not engage in aversive or coercive techniques, nor are they aware of any practitioner who engages in such practices with clients seeking to reduce or eliminate their

unwanted same-sex attractions, behaviors, or identity. (VC, ¶ 72). Plaintiffs do not coerce their clients into any form of counseling, only engage in SOCE counseling with those clients who desire and consent to it, and always permit the clients to set the goals of any form of counseling they offer. (*Id.*, ¶¶ 77, 131, 144).

## II. CONCLUSIONS OF LAW.

### A. Plaintiffs' Talk Therapy is Speech.

65. Plaintiffs' talk therapy, whether or not it involves SOCE, is speech. The government cannot label the **speech** of professionals as **conduct** in order to restrain it without scrutiny. *See, e.g., Nat'l Inst. for Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2371–72 (2018) (hereinafter, "*NIFLA*") ("[T]his Court has not recognized 'professional speech' as a separate category of speech. Speech is not unprotected merely because it is uttered by professionals."); *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2229 (2015) (same); *Holder v. Humanitarian Law Project*, 561 U.S. 1, 27 (2010) (holding government may not apply alternative label to protected speech to evade First Amendment review, when only "conduct" at issue is speech); *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533 (2001) (same); *NAACP v. Button*, 371 U.S. 415, 438 (1963) ("[A] state may not, under the guise of prohibiting professional misconduct, ignore constitutional rights.").

66. Indeed, as the *NIFLA* Court recently reiterated, permitting the government to label a professional's speech as unprotected conduct would eviscerate the protections afforded to doctors, lawyers, nurses, mental health professionals, and many others:

All that is required to make something a profession . . . is that it involves personalized services and requires a professional license from the State. But that gives the States unfettered power to reduce a group's First Amendment rights by simply imposing a licensing requirement. **States cannot choose the protection that speech receives under the First Amendment**, as that would give them a powerful tool to impose invidious discrimination on disfavored subjects.

*NIFLA*, 138 S. Ct. at 2372.

67. The en banc Eleventh Circuit decision in *Wollschlaeger v. Florida* compels the conclusion that the Ordinances ban speech. There, the entire Eleventh Circuit rejected, **word-for-word**, what Defendants proffer here, because "**characterizing speech as conduct is a dubious constitutional enterprise.**" 848 F.3d 1293, 1309 (11th Cir. 2017) (en banc) (emphasis added).

Defendants’ arguments entirely ignore this development, and continue instead their rote reliance on the contrary holding of *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014), even though, in the same breath, the en banc Eleventh Circuit relegated *Pickup* to the dustbin of constitutional history: “There are serious doubts about whether *Pickup* was correctly decided.” *Wollschlaeger*, 848 F.3d at 1309.

68. In *Wollschlaeger*, much like Defendants here, the government argued that “the First Amendment is not implicated because any effect on speech is merely incidental to the regulation of professional conduct.” *Id.* at 1308. But, as do the Ordinances here, the law in question “expressly limit[ed] the ability of certain speakers—doctors and medical professionals—to write and speak about a certain topic—the ownership of firearms—and thereby restrict[ed] their ability to communicate and/or convey a message.” *Id.* The Eleventh Circuit had no doubt these restrictions “trigger First Amendment scrutiny. **‘[S]peech is speech, and it must be analyzed as such for the purposes of the First Amendment.’**” *Id.* at 1308 (emphasis added) (quoting *King v. Governor of New Jersey*, 767 F.3d 216, 229 (3d Cir. 2014)). Indeed, “[w]hat the Supreme Court said in concluding its analysis in *Button* seems to **fit like a glove here**: A state may not, under the guise of prohibiting professional misconduct, ignore constitutional rights.” *Id.* (quoting *Button*, 372 U.S. at 439 (emphasis added)). As was true in *NIFLA* and *Wollschlaeger*, Plaintiffs here have demonstrated that their practices involve only speech.

#### **B. The Ordinances Ban Speech as Speech and Must Satisfy Strict Scrutiny.**

69. As was true in *King*, the Ordinances here ban speech on the basis of content. Like the Third Circuit, this Court has “little doubt” in concluding that the Ordinances ban speech on the basis of content. *See* 767 F.3d at 236 n.20; *see also id.* at 236 (“we agree with Plaintiffs that A3371 discriminates on the basis of content”). Indeed, the Ordinances “on [their] face, prohibit licensed counselors from speaking words with a particular content, *i.e.*, words that ‘seek to change a person’s sexual orientation’ [VC, ¶¶ 26, 33]. Thus, as in *Humanitarian Law Project*, Plaintiffs want to speak to minor clients, and whether they may do so under [the Ordinances] depends on what they want to say.” That is textbook content discrimination.

70. Because this Court finds that the Ordinances ban speech on the basis of content, unequivocal Supreme Court precedent requires the Ordinances to survive strict scrutiny to be upheld. Indeed, in *Reed v. Town of Gilbert*, the Supreme Court issued its firm rule: all content-

based restrictions on speech must receive strict scrutiny. 135 S. Ct. at 227 (“[A] law that is content based on its face is subject to strict scrutiny regardless of the government’s benign motive, content-neutral justification, or lack of animus towards the ideas contained in the regulated speech.”). In handing down that firm rule, the Supreme Court unequivocally stated that it applied equally to any content-based regulation of the speech of licensed professionals. *Id.* at 2229 (“it is no answer to say that the purpose of these regulations was merely to insure high professional standards”).

71. *NIFLA* also confirmed that regulations on the speech of licensed professionals is no exception to this rule. In *NIFLA*, the Supreme Court affirmed *Reed*’s firm rule mandating strict scrutiny for all content-based restrictions on speech, expressly abrogated *King*’s and *Pickup*’s erroneous conclusion that content-based regulations of so-called professional speech do not receive strict scrutiny, and condemned the invidious discrimination inherent in bans on the speech of licensed professionals. *NIFLA*, 138 S. Ct. at 2371 (all content-based restrictions on speech receive strict scrutiny). Indeed, gutting *King* and *Pickup* by name, *NIFLA* stated that “[s]o defined, these courts except professional speech from the rule that content-based regulations of speech are subject to strict scrutiny . . . . But, this Court has not recognized professional speech as a separate category of speech. Speech is not unprotected merely because it is uttered by professionals.” *Id.* at 2371-72 (emphasis added). And, confirming that content-based restrictions on the speech of licensed professionals receive strict scrutiny, *NIFLA* held that “States cannot choose the protection that speech receives under the First Amendment, as that would give them a powerful tool to impose invidious discrimination of disfavored subjects,” *id.* at 2375, such as any counseling that seeks to help a minor reduce or eliminate their unwanted same-sex attractions, behaviors, and identity. Thus, binding precedent requires this Court to subject the Ordinances to strict scrutiny.

### C. Defendants Have the Burden of Proof on Strict Scrutiny.

72. Defendants bear the burden of demonstrating that the Ordinance satisfies strict scrutiny. As the Supreme Court has held: “the burdens at the preliminary injunction stage track the burdens at trial.” *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 429 (2006). As such, on a preliminary injunction motion, **the government**—not the movant—bears the burden of proof on narrow tailoring, because **the government** bears that burden at trial. *Ashcroft v. ACLU*, 542 U.S. 656, 665 (2004) (holding, on preliminary injunction motion, “**the burden is on the government** to prove that the proposed alternatives will not be as effective as the challenged statute.” (emphasis added)). Defendants indisputably bear the burden of proving

narrow tailoring at trial. *See, e.g., United States v. Playboy Entm't Grp., Inc.*, 529 U.S. 803, 816 (2000) (“When the Government restricts speech, the Government bears the burden of proving the constitutionality of its actions.”); *id.* at 2540 (“To meet the requirement of narrow tailoring, **the government must demonstrate** that alternative measures that burden substantially less speech would fail to achieve the government’s interests, not simply that the chosen route is easier” (emphasis added)). Thus, Defendants also bear—and fall woefully short of meeting—the burden of proving narrow tailoring here. *Gonzales*, 546 U.S. at 429; *Ashcroft*, 542 U.S. at 665.

### 1. Defendants Must Show Empirical or Concrete Evidence of Harm.

73. In the First Amendment context, the government is not entitled to deference in making speech-restrictive determinations. When “[a] speech-restrictive law with widespread impact” is at issue, “the government must shoulder a correspondingly heavier burden and is entitled to considerably less deference in its assessment that a predicted harm justifies a particular impingement on First Amendment rights.” *Janus v. Am. Fed’n of State, Cnty. & Mun. Emps., Council 31*, 138 S. Ct. 2448, 2472 (2018) (emphasis added). Here, because the Ordinances infringe upon the free speech rights of licensed medical professionals, the government “must do more than simply posit the existence of the disease sought to be cured. It must demonstrate that the recited harms are real, not merely conjectural.” *Turner Broad. Sys., Inc. v. FCC*, 512 U.S. 622, 664 (1994); *see also Edenfield v. Fane*, 507 U.S. 761, 770 (1993) (regulation of professional speech must still demonstrate that the alleged harm is not “mere speculation or conjecture”); *Landmark Commc’ns, Inc. v. Virginia*, 435 U.S. 829, 841 (1978) (same). This is so because “[d]eference to legislative findings cannot limit judicial inquiry when First Amendment rights are at stake.” *Landmark Commc’ns*, 435 U.S. 843.

74. Courts have not hesitated to invalidate ordinances that impose restrictions on speech based on supposition and conjecture, rather than empirical evidence. In *Edenfield*, where the government sought to restrict the speech of licensed accountants, the government “presented no studies” and relied upon a record that “contain[ed] nothing more than a series of conclusory statements that add little if anything” to the government’s effort to regulate certain speech. 507 U.S. at 771. Also, the government relied upon a report of an independent organization to bolster its claims of harm, but—exactly as the APA Report does in this case—the report there admitted that it was “unaware of the existence of **any empirical data supporting the theories**” of alleged

harm. *Id.* at 772 (emphasis added). Because of the lack of evidence of harm, the Supreme Court invalidated the restriction as a violation of the accountants' First Amendment rights. In *Sable Commc'ns of Cal., Inc. v. FCC*, 492 U.S. 115 (1989), the Supreme Court again confronted a record (like here) where there was nothing more than anecdote and suspicion of harm behind a total prohibition on the targeted speech. 492 U.S. at 129. There was no record evidence "aside from conclusory statements during the debates by proponents of the bill" and the record "contain[ed] no evidence" concerning the alleged effectiveness of other alternatives. *Id.* Because of that failure, the Supreme Court invalidated the ban. *Id.*

75. The Eleventh Circuit, too, has invalidated laws regulating professional speech when the alleged harm purportedly being addressed was unsupported by concrete evidence. In *Mason v. Florida Bar*, 208 F.3d 952 (11th Cir. 2000), the government attempted to regulate the speech of attorneys, but "presented no studies, nor empirical evidence of any sort to suggest" that the harm they were positing was real, rather than merely conjectural. *Id.* at 957 (emphasis added). The Eleventh Circuit held that, to survive scrutiny, the government "has the burden . . . of producing **concrete evidence**" of the alleged harm prior to restricting the protected speech of licensed professionals. *Id.* at 958 (emphasis added). Indeed, it held that when there are "**glaring omissions in the record of identifiable harm,**" the government has not satisfied "its burden to identify a genuine threat of danger." *Id.* (emphasis added)

## 2. Defendants Must Show that the Ordinances Are the Least Restrictive Means.

76. Under strict scrutiny, Defendants must also demonstrate that the Ordinances are the least restrictive means of remedying their claimed governmental interests. *See Boos v. Berry*, 485 U.S. 312, 329 (1988) (when content-based restrictions on speech are analyzed under strict scrutiny, an ordinance "is not narrowly tailored [where] a less restrictive alternative is readily available"); *Ward v. Rock Against Racism*, 491 U.S. 781, 798 n.6 (1989) (noting that under "the most exacting scrutiny" applicable to content-based restrictions on speech, the government must employ the least restrictive alternative to pass narrow tailoring). Plaintiffs "must be deemed likely to prevail unless the government has shown that [Plaintiffs'] proposed less restrictive alternatives are less effective than enforcing the act." *Ashcroft*, 542 U.S. at 666 (emphasis added).

**D. Defendants' Ordinances Are Unconstitutional Because They Fail Strict Scrutiny.**

**1. Defendants Have No Compelling or Other Sufficient Governmental Interest to Ban Voluntary SOCE Talk Therapy.**

77. As shown in the Court's findings of fact above, Defendants never received or considered any evidence that any person was harmed, or complained of harm by any SOCE counseling in their respective jurisdictions, let alone voluntary SOCE counseling that minors request and want to receive. Moreover, despite claiming "overwhelming research" justifying their Ordinances, the "research" cited by Defendants justifies no conclusions regarding harmful outcomes from SOCE. Thus, like in *Mason and Edenfield*, Defendants have conducted no independent inquiry into the alleged harm and have proffered no substantial or concrete evidence demonstrating that the actual harm exists. Because of their failures, the Ordinances fail strict scrutiny. *See, e.g., Comcast Cablevision of Broward Cnty., Inc. v. Broward Cnty.*, 124 F. Supp. 2d 685, 697-98 (S.D. Fla. 2000) (providing where government's alleged harm "appears to be non-existent," where government "conducted no inquiry" and "proffered no substantial evidence demonstrating that actual harm exists," government fails its burden and regulation of speech cannot survive First Amendment scrutiny). Defendants cannot satisfy strict scrutiny by pointing to empirical or concrete evidence of harm justifying their Ordinances.

78. Furthermore, Defendants' Ordinances undermine several specific admonitions from the APA Report and related Sources, such as the APA imperative that minors be allowed to return to their biological gender, even after identifying as the other gender for a period of time. The Ordinances also require therapists such as Plaintiffs to cut off counseling with clients who express a desire to change their sexual orientation or gender identity, which directly contradicts the APA Report's admonition to explore a client's identity issues instead of declining them outright. Thus, the Ordinances prohibit therapists from assisting minors with change decisions the APA expressly endorses, and otherwise create harm identified by the APA rather than reducing any.

**2. Defendants' Ordinances Are Not the Least Restrictive Means or Otherwise Narrowly Tailored.**

79. Under strict scrutiny, Defendants are required to demonstrate that the Ordinances are the least restrictive means available. *See Boos v. Berry*, 485 U.S. 312, 329 (1988) (when

content-based restrictions on speech are analyzed under strict scrutiny, an ordinance “is not narrowly tailored [where] a less restrictive alternative is readily available”); *Ward v. Rock Against Racism*, 491 U.S. 781, 798 n.6 (1989) (noting that under “the most exacting scrutiny” applicable to content-based restrictions on speech, the government must employ the least restrictive alternative to pass narrow tailoring). Plaintiffs “must be deemed likely to prevail unless the government has shown that [Plaintiffs’] proposed less restrictive alternatives are less effective than enforcing the act.” *Ashcroft*, 542 U.S. at 666 (emphasis added). Defendants cannot do so.

80. To satisfy the narrow tailoring prong of their strict scrutiny burden, Defendants must show that they “**seriously** undertook to address the problem with less intrusive tools readily available to [them],” meaning that they “**considered different methods that other jurisdictions have found effective.**” *McCullen v. Coakley*, 134 S. Ct. 2518, 2539 (2014) (emphasis added). “To meet the requirement of narrow tailoring, the government must demonstrate that alternative measures that burden substantially less speech would fail to achieve the government’s interests, not simply that the chosen route is easier.” *Id.* at 2540. Thus, Defendants “would have to show either that **substantially less-restrictive alternatives were tried and failed**, or that the **alternatives were closely examined and ruled out for good reason.**” *Bruni v. City of Pittsburgh*, 824 F.3d 353, 370 (3d Cir. 2016) (emphasis added). Defendants have done neither.

81. As shown in the Court’s findings of fact, Defendants failed to try, discuss, or even consider any less restrictive alternatives to their blanket therapy bans. Even the anecdotal hearsay brought to Defendants by the Ordinances’ chief advocate, Rand Hoch, complained of alleged “aversive” and “coercive” therapies, happening to someone somewhere, and not voluntary SOCE as practiced by Plaintiffs; but Defendants did not consider banning only aversive or coercive therapies, or even imposing specific informed consent requirements consistent with the APA Report’s recommendations. Instead, Defendants acted contrary to the APA Report recommendations and banned SOCE outright, foreclosing the further development of the scientific record on SOCE sought by the APA, and usurping for politicians and activists the discretionary judgment that the APA deemed appropriate for licensed mental health professionals. Defendants’ failure to consider any alternatives cannot satisfy the demanding narrow tailoring burden placed upon them by the Supreme Court in *McCullen*.

82. Defendants also fail narrow tailoring because their Ordinances cannot, as a practical matter, be enforced to remedy any purported harms Defendants claim to have in view. This

inability to enforce the Ordinances through their respective code officials is admitted by both City and County senior officials in their unfiltered pre-Ordinance correspondence. Defendants' code officials are objectively ill-equipped to investigate and make determinations about appropriate mental health therapeutic practices, as are the special masters who would be required to rule on violations. Such a fatally flawed process could never satisfy narrow tailoring.

83. Furthermore, if the purpose of the Ordinances is to protect children and youth from the purported harms of SOCE counseling, they are “wildly underinclusive,” further undermining any notion of narrow tailoring. *See NIFLA*, 138 S. Ct. at 2376 (quoting *Brown v. Entertainment Merchants Assn.*, 564 U.S. 786, 802 (2011)). Both ordinances regulate only licensed professionals, and expressly exclude conversion therapy offered by unlicensed religious counselors and clergy. (City Ord., DE 1-4, at 6:26–7:3; Cnty. Ord., DE 1-5, at ECF 13:16–19.) The Palm Beach County Attorney, however, expressly advised the County Commissioners that “[m]ost of the universal complaints seem to be about religious organizations that the ordinance would not legally be able to address.” (Pls.’ Ex. 16 at PBC 008000.) If Defendants genuinely believe all “conversion therapy” is harmful to minors, then exempting unlicensed religious counselors and clergy from regulation makes no sense, especially if they are the source of the “universal complaints.” Given the County’s supposition of the prevalence of religious conversion therapy perpetrators, its 30(b)(6) witness could offer no justification for exempting religious persons where the ostensible government interest is regulating harmful conduct directed at children. (Hvzd Dep., 200:14–18, 202:5–9.) The City likewise has the authority to regulate behavior by adults that is considered harmful to children, whether or not those adults are religious or part of a religious institution, but did not consider doing so in its Ordinance. (Woika Dep., 48:7–49:8.) The APA Report is also relevant here because, not only does it fail to present empirical evidence of harm from **any** kind of SOCE counselling, its non-empirical, anecdotal reporting of harm does not differentiate between SOCE from licensed professionals and SOCE from religious organizations or persons. Thus, Defendants cannot justify the underinclusivity of their Ordinances on any claimed difference in harm between licensed SOCE and unlicensed religious SOCE, still further undermining any notion of narrow tailoring.

**E. Defendants' Ordinances are *Ultra Vires* Because They Purport to Regulate a Field Preempted to the State.**

84. As shown above, Defendants' most senior in-house lawyers sounded the alarm on preemption to their respective legislative bodies prior to their enactment of the Ordinances. Defendants' lawyers were correct then, and nothing has changed legally to remove the State's preemption of the field of regulating the practices of licensed mental health professionals. Defendants Ordinances are *ultra vires* and unenforceable.

85. In determining whether the State's regulation impliedly preempts local governments from regulating mental health professionals licensed by the State, the court must look at the provisions of the policy as a whole, the nature of power exercised by the legislature, the object sought to be attained by the statute, and the character of the obligations imposed by the statute. *Classy Cycles, Inc. v. Bay Cnty.*, 201 So.3d 779, 784 (Fla. 2016). The proper inquiry under Article VIII, § 2(b), is whether the State has "preempted **a particular subject area**," not one discrete form of counseling. *Sarasota Alliance For Fair Elections, Inc. v. Browning*, 28 So.3d 880, 886 (Fla. 2010) (emphasis added). The subject area in this matter is regulation of mental health professionals, not one subset of an entire course of counseling for one subset of a particular issue relating to that course of counseling. Were the rule otherwise, a municipality would be empowered to enact any regulation it desires if the State has not passed discrete legislation prohibiting a specific act, regardless of whether the statutory scheme regulating a particular **area** is overwhelmingly pervasive.

86. It is axiomatic that the regulation of licensed professionals, including medical and mental health professionals, has always been a matter of **state concern**. *See, e.g., Watson v. Maryland*, 218 U.S. 173, 176 (1910) ("It is too well settled to require discussion at this day that the police power of the **states** extends to the regulation of certain trades and callings, particularly those which closely concern the public health." (emphasis added)); *Dent v. West Virginia*, 129 U.S. 114, 122 (1889) ("it has been the practice of different **states**, from time immemorial, to exact in many pursuits a certain degree of skill and learning" to practice a profession (emphasis added)); *McNaughton v. Johnson*, 242 U.S. 344, 348-49 (1917) ("It is established that **a state** may regulate the practice of medicine." (emphasis added); *see also Betancur v. Fla. Dep't of Health*, 296 F. App'x 761, 763 (11th Cir. 2008) ("**States** retain the police power to regulate professions, such as the practice of medicine." (emphasis added)). Thus, Defendants' contention that the regulation of

mental health professionals is primarily a local concern is historically, legally, and logically incorrect. The State of Florida's regulatory scheme, which covers all licensed medical and mental health professionals in the State, is pervasive and evinces an intent to maintain sole control of licensed professionals in the State.

87. Furthermore, the absence of **any** regulation of professions or professionals in general, and of mental health professions and professionals specifically, by either Defendant, especially when viewed in light of Defendants' purported compelling interests, confirms that Defendants heretofore have submitted to the state's "will to be the sole regulator" of mental health and similarly situated professionals. *See Lake Hamilton Lakeshore Owners Ass'n, Inc. v. Neidlinger*, 182 So. 3d 738, 743 (Fla. 2d DCA2015) (internal quotation marks omitted).

**F. Plaintiffs Have Satisfied the Remaining Preliminary Injunction Elements.**

**1. Plaintiffs Have Demonstrated That They Are Suffering Irreparable Injury.**

88. As shown above, Plaintiffs are likely to succeed on the merits of their constitutional and preemption challenges to the Ordinances. Given their likelihood of success on their First Amendment claims, the irreparable harm prong of the preliminary injunction standard is satisfied as a matter of law: "The loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." *Elrod v. Burns*, 427 U.S. 347, 373 (1976). Indeed, First Amendment violations are **presumed** to impose irreparable injury. *See, e.g., Awad v. Ziriya*, 670 F.3d 1111, 1125 (10th Cir. 2012); *see also* 11A Charles Alan Wright, Arthur R. Miller, & Mary Kay Kane, *Federal Practice & Procedure* §2948.1 (2d ed. 1995) ("When an alleged constitutional right is involved, most courts hold that **no further showing of irreparable injury is necessary.**" (emphasis added)).

**2. Plaintiffs Have Demonstrated That Defendants Suffer No Harm From Injunctive Relief And That The Public Interest Favors An Injunction.**

89. A law that is like unconstitutional for preliminary injunction purposes is not only presumed to cause irreparable injury, but is also *ipso facto* is not in the public interest. *See Scott v. Roberts*, 612 F.3d 1279, 1297 (11th Cir. 2010). Indeed, the inability to punish Plaintiffs and other licensed counselors for engaging in an ethical form of counseling that is desired by their clients

“does not outweigh the serious loss of first amendment freedoms.” *ACLU of Fla., Inc. v. The Florida Bar*, 744 F. Supp. 1094, 1099 (N.D. Fla. 1990).

90. Defendants suffer no harm by being forced to comply with the dictates of the First Amendment. Importantly, Defendants have **never identified a single person being harmed** within their jurisdictions by any SOCE counseling, let alone voluntary SOCE counseling that the person requests and is willing to receive. Defendants have never received any complaints of any SOCE-related harm to their citizens. Accordingly, Defendants will not suffer any harm if their unconstitutional Ordinances are enjoined. Their citizens were not being harmed prior to the enactment of the Ordinances, and they will not be harmed while a preliminary injunction is in effect.

91. Moreover, as show above, the Ordinances are unenforceable by Defendants’ code officials in any event. Defendants cannot be harmed by an injunction against Ordinances that they lack the capacity or competency to enforce.

92. Protection of First Amendment rights is always in the public interest, while violating First Amendment rights at the whim of ideological opponents does not serve the public. *KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 1272 (11th Cir. 2006).

Respectfully submitted,

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**CERTIFICATE OF SERVICE**

I hereby certify that on this October 15, 2018, I caused a true and correct copy of the foregoing to be filed electronically with the Court's CM/ECF system. Service upon all counsel of record will be effectuated by the Court's electronic notification system.

/s/ Roger K. Gannam  
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