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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et al.,

Defendants.

Case No. 1:23-cv-00269-CWD

MOTION FOR A PRELIMINARY INJUNCTION

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The Plaintiffs move this Court, under Federal Rule of Civil Procedure 65, for a preliminary injunction prohibiting the Defendants, as well as their officers, agents, employees, attorneys, and any person who is in active concert or participation with them, from enforcing any of the provisions of House Bill 71, as passed by the Sixty-seventh Idaho Legislature in its Regular Session and enacted on March 30, 2023. The bill is to be codified at Idaho Code §§ 18-1506C and 19-5307 and will also be published at 2023 Idaho Session Laws ch. 292. A copy of the bill is attached to the Complaint for Declaratory and Injunctive Relief (Dkt. 1) and to the memorandum of law supporting this motion. The Plaintiffs also move this Court for an order waiving the requirement for bond or security from them.

This motion is based on the memorandum of law in its support and the declarations filed with it, as well as the Complaint (Dkt. 1). Plaintiffs make this motion on the grounds that the provisions of House Bill 71 are unconstitutional, as set out in the accompanying memorandum of law.

Date: July 21, 2023

Respectfully submitted,

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MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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INTRODUCTION

Idaho has enacted a law that, if it goes into effect on January 1, 2024, would make it a felony, punishable by up to 10 years in prison, to provide medical care to transgender minors with gender dysphoria that those minors, their parents, and their doctors all agree is medically necessary for them, and is care that is supported by every major medical association in the United States. Plaintiffs are two Idaho transgender teenagers who are receiving care that the law would ban, and their parents. The care has alleviated the distress of gender dysphoria and significantly improved their mental health. The parents have seen their children go from dark places to becoming happy, thriving teens, and they fear for their children's well-being if they are forced to discontinue care. This is these youths' and their parents' motion for a preliminary injunction.

The Idaho law is House Bill 71, referred to in this brief as H.B. 71, the "Healthcare Ban," or simply the "Ban." *See* H.B. 71 (engrossed) § 1, 67th Leg., 1st Sess. (Idaho 2023). A copy is attached to the brief as Exhibit 1. It is part of a raft of laws passed in the last year across the country that prohibit gender-affirming medical care for transgender minors. H.B. 71 specifically prohibits medical providers from providing treatment "for the purpose of "alter[ing] the appearance of or affirm[ing] the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." The law bans medications and treatments only when provided to affirm the gender identity of transgender youth; the same medications and treatments are allowed if provided to non-transgender youth for other purposes.

Numerous courts have enjoined similar laws, either preliminarily or permanently, finding that they are, or likely are, unconstitutional. *See Brandt* v. *Rutledge*, --- F. Supp. 3d ---, 2023 WL 4073727 (E.D. Ark. June 20, 2023) (Arkansas: permanent injunction); *Brandt* v. *Rutledge*, 47 F.4th 661, 672 (8th Cir. 2022) (Arkansas: affirming district court's grant of preliminary injunction),

reh'g en banc denied, 2022 WL 16957734 (8th Cir. Nov. 16, 2022); *Eknes-Tucker* v. *Marshall*, 603 F. Supp. 3d 1131, 1151 (M.D. Ala. 2022) (Alabama: preliminary injunction), *appeal filed*, No. 22-11707 (11th Cir. May 18, 2022); *Doe* v. *Ladapo*, No. 4:23cv114-RH-MAF, 2023 WL 3833848, (N.D. Fla. June 6, 2023) (Florida: preliminary injunction); *K. C.* v. *Individual Members of the Med. Licensing Bd. of Ind.*, No. 1:23-cv-00595-JPH-KMB, 2023 WL 4054086 (S.D. Ind. June 16, 2023) (Indiana: preliminary injunction). Only a motions panel of the Sixth Circuit has held otherwise, in a tentative ruling expressing "initial views" that the court acknowledged might be wrong, and which relied on precedent in conflict with controlling Ninth Circuit law. *See L.W.* v. *Skrmetti*, No. 23-5600, 2023 WL 4410576 (6th Cir. July 8, 2023) (Tennessee: staying the district court's preliminary injunction pending expedited appeal).

Plaintiffs respectfully request that this Court preliminarily enjoin the Idaho Healthcare Ban because it, too, is unconstitutional. There is no constitutionally sufficient justification for singling out for prohibition only gender-affirming medical care provided to transgender youth. If the law takes effect it will cause irreparable harm to plaintiffs and many other families across Idaho. This Court should grant a preliminary injunction against H.B. 71.

STATEMENT OF FACTS

I. MEDICAL PROTOCOLS FOR THE TREATMENT OF TRANSGENDER ADOLESCENTS WITH GENDER DYSPHORIA

"Gender identity" refers to a person's core sense of belonging to a particular gender. Declaration of Dr. Christine Brady ("Brady Decl.") ¶ 13. Everyone has a gender identity, and it is a fundamental aspect of human development for all people. *Id.* A person's gender identity cannot be changed voluntarily, by external forces, or through medical or mental health intervention. *Id.* ¶¶ 14–15. People whose gender identity matches the sex they were designated at birth are cisgender. *Id.* ¶ 12. People whose gender identity differs from their sex designated at birth are transgender.

Id. Some transgender people recognize this misalignment in early childhood. For others, it can become apparent with the onset of puberty and the resulting physical changes, or later into adulthood. *Id.* ¶ 32. Being transgender is not itself a condition to be cured, *id.* ¶ 23, but it is common for clinically significant distress—called "gender dysphoria"—to arise from the incongruence transgender people experience between their gender identity and their assigned sex. *Id.* ¶¶ 23–25. To meet the criteria for gender dysphoria in the Diagnostic and Statistical Manual of Mental Disorders (5th Ed.), the incongruence must be present for at least six months, and be causing clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Id.* ¶¶ 18–19.

Gender dysphoria is a serious medical condition that, if left untreated, can result in severe anxiety and depression, self-harm, and suicidality. *Id.* ¶ 24. Treatment for gender dysphoria is provided in accordance with evidence-based clinical guidelines. The Endocrine Society and the World Professional Association for Transgender Health ("WPATH") have published widely accepted clinical guidelines for treating gender dysphoria.[1] Declaration of Dr. Kara Connelly ("Connelly Decl.") ¶¶ 15–16; Brady Decl. ¶¶ 26–27. These guidelines are recognized as authoritative by all of the major medical organizations in the United States. Connelly Decl. ¶ 19; Brady Decl. ¶ 29.

Treatment options for gender dysphoria depend on a patient's stage of pubertal development. Under the WPATH and Endocrine Society guidelines, no medical treatments are indicated or provided before the onset of puberty. Connelly Decl. ¶ 17; Brady Decl. ¶ 31. For

[1] *See* E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23(1) Int'l J Transgender Health (Supplement 1) S1 (2022); Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11) The J. of Clinical Endocrinology & Metabolism 3869 (2017).

adolescents with gender dysphoria who have started puberty, if medically indicated, puberty-delaying medications (called GnRH agonists) may be prescribed to prevent the distress of developing permanent, physical characteristics that do not align with their gender identity. Brady Decl. ¶ 32. Pubertal suppression is reversible, and if the treatment is discontinued, endogenous puberty will resume. Connelly Decl. ¶¶ 21, 46. Thus, puberty-delaying medications can provide patients time to better understand their gender identity before considering less reversible treatments. Brady Decl. ¶ 32.

In some cases, it may be medically necessary for an adolescent patient to be treated with gender-affirming hormone therapy. Brady Decl. ¶ 32. These treatments—testosterone for adolescent transgender boys and testosterone suppression and estrogen for adolescent transgender girls—alleviate the distress of gender dysphoria by allowing the patient to go through puberty consistent with their gender identity. *Id.*

Under the guidelines, before providing any gender-affirming medical care to minors, they should undergo a comprehensive psychosocial assessment. Brady Decl. ¶¶ 30, 33–34. The assessment explores the patient's gender dysphoria and any co-occurring mental health conditions, as well as their ability to understand the potential risks, benefits, and long-term consequences of treatment. *Id.* ¶¶ 35–37.

Gender-affirming medical care is recommended for minors with gender dysphoria only when a patient has: (i) gender incongruence that is marked and sustained over time; (ii) sufficient emotional and cognitive maturity to understand and provide informed assent; (iii) any other mental health conditions that do not interfere with diagnostic clarity or ability to consent; and (iv) the patient and their family is fully informed of potential risks—including the potential impact of some

treatments on fertility—and fertility preservation options. *Id.* ¶ 33. For minors, parental consent—in addition to the minor's assent—is required to prescribe these medical treatments. *Id.* ¶ 37.

Gender-affirming medical treatments can significantly alleviate gender dysphoria by bringing a patient's body into alignment with their gender identity. Brady Decl. ¶¶ 38–41. In addition to addressing the distress the adolescent is experiencing, providing treatment during adolescence can significantly minimize dysphoria later in life by preventing permanent physical changes and may eliminate the need for future surgery. *Id.* A delay in treatment, on the other hand, can result in significant distress, including anxiety and escalating suicidality, as well as permanent physical changes from puberty that can require surgical treatment to reverse later in life. Connelly Decl. ¶¶ 33, 60–63; Brady Decl. ¶¶ 42–44.

The efficacy of gender-affirming medical care in improving mental health outcomes for adolescents suffering from gender dysphoria is supported by decades of clinical experience and scientific research. Connelly Decl. ¶¶ 32–35, 43, 55–57; Brady Decl. ¶ 39. Clinical experience and research regarding the use of these medications to treat gender dysphoria and other conditions has shown that they are safe when provided under the supervision of a medical provider. Connelly Decl. ¶ 49. Like all medications, they have potential risks, which exist whether used to treat transgender adolescents with gender dysphoria or cisgender adolescents for a range of other conditions. *Id.* ¶¶ 36–57. As is the case with other medical treatments patients and their families may undertake, some—but not all—treatments for gender dysphoria can potentially impact fertility. And, as with other medical treatments that can affect fertility, patients and their families are provided information to be able to make a fully informed decision about care. *Id.* ¶¶ 51–54.

II. THE HEALTHCARE BAN

H.B. 71 prohibits medical providers from providing medications or certain surgical treatments to a minor "for the purpose of attempting to alter the appearance of or affirm the child's

perception of the child's sex if that perception is inconsistent with the child's biological sex." H.B. 71 § 1. The law defines "sex" based on "chromosomes and internal and external reproductive anatomy." H.B. 71 § 1. The law specifies that it is prohibited to "administer[] or supply[] . . . [p]uberty blocking medication," "testosterone to a female," or "estrogen to a male," provide surgeries which create "the appearance of genitalia that differs from the child's biological sex" or "mastectom[ies]." *Id.* A child is defined as anyone under 18 years of age. *Id.*

Notably, the Healthcare Ban makes it a felony for Idaho medical providers to provide these medical treatments to minors *only* where it is "for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." *Id.* The same medical treatments are not banned if they are provided for any other purposes, including to affirm a minor's gender if it is *consistent* with the child's "biological sex." For example, cisgender adolescent boys with gynecomastia—enlargement of the breast tissue—may undergo a mastectomy because of the distress related to being a boy with breasts. Connelly Decl. ¶¶ 40–41. Similarly, cisgender girls with polycystic ovarian syndrome—a condition that can cause increased testosterone and, as a result, symptoms including facial hair—may receive testosterone suppressants to address the distress of having facial hair. *Id.* Additionally, the Ban expressly allows physicians to perform permanent and irreversible cosmetic genital surgeries on children with intersex conditions, including newborns, despite their incapacity to assent, and despite the fact that major medical organizations like the American Academy of Family Physicians have said that such surgeries on intersex infants and youth are harmful. H.B. 71 § 1.

There is no exception for treatment that is necessary for the adolescent's health—regardless of their prior course of treatment, individual circumstances, or degree of distress—if the treatment's purpose is to affirm a minor's gender "inconsistent with [their] biological sex." H.B.

71 § 1 (to become Idaho Code § 18-1506C(4)(a)). The Healthcare Ban treats the provision of gender-affirming medical care to minors as a "crime[ ] of violence," *id.* § 2, and imposes on medical providers a penalty of imprisonment up to 10 years. *Id.* § 1. This is equivalent to the prison penalty for involuntary or vehicular manslaughter. H.B. 71 § 2; Idaho Code § 18-4007.

III. THE HEALTHCARE BAN INFLICTS SEVERE AND IRREPARABLE HARMS

By cutting off access to treatment on which transgender adolescents with gender dysphoria in Idaho rely for their health and well-being and prohibiting future access to that treatment, the Ban would cause immediate, severe, and irreparable harm to all Plaintiffs.

The Poe Family: Pam Poe is a 15-year-old rising 10th grader and a lifelong Idaho resident. Pam is transgender: she is a girl with a female gender identity, but when she was born, she was designated as male. Penny Poe Decl. ¶¶ 5–6; Pam Poe Decl. ¶ 3. Pam began to realize she was transgender when she was in seventh grade and changes to her body made her feel less and less like herself. She began to suffer from severe depression and anxiety and engaged in self-injurious acts. Pam Poe Decl. at ¶¶ 4, 9. She began wearing more feminine clothing and makeup, and growing out her hair, which helped her feel more like herself, but she continued to suffer. *Id.* at ¶¶ 16–18.

Despite weekly counseling, Pam's mental health reached a crisis point in early 2022 when she told her mom that she did not want to be alive anymore. With her parents' support, she entered inpatient residential treatment. There, Pam was diagnosed with gender dysphoria. *Id.* at ¶¶ 10–11; Penny Poe Decl. ¶¶ 11–12.

After Pam came home, her parents began taking her to a doctor experienced in treating gender dysphoria. After thorough evaluation of Pam, and discussions with Pam and her parents about the benefits and potential risks of pubertal suppression, the doctor prescribed puberty blockers for Pam in June 2022. By pausing the physical changes that were exacerbating her gender

dysphoria, the puberty blockers improved Pam's mental health. Pam Poe Decl. ¶¶ 12–14; Penny Poe Decl. ¶¶ 13–14, 16–17. When Pam started high school in August 2022, she did so living as a girl and being treated as a girl. Pam Poe Decl. ¶ 17. Her mental health continued to improve, though she still had distress about her body. *Id.* at ¶¶ 14, 18.

In April 2023, when Pam was 15 years old and had been on puberty blockers for roughly a year, her family and her doctor discussed the possibility of Pam beginning estrogen treatment. After the doctor performed bloodwork, discussed the risks and benefits as well as options for fertility preservation, and confirmed Pam's ongoing therapy and mental health support, Pam and her parents, in consultation with her doctor, decided that this was the appropriate treatment plan for Pam. She began estrogen therapy, which she continues to this day. *Id.* at ¶ 19; Penny Poe Decl. ¶ 18.

Gender-affirming medical care has caused a dramatic improvement in Pam's mental health; she is happy, confident, and can see a future for herself. Pam Poe Decl. ¶¶ 20–21; Penny Poe Decl. ¶ 19. She and her family are afraid of the impact the Healthcare Ban will have on them if it goes into effect. Pam is scared of losing access to her medication and her body undergoing unwanted, permanent changes that are inconsistent with her gender identity. Pam and her parents worry about the severe stress, anxiety, and depression associated with Pam's gender dysphoria returning if that happens. The Poe family has considered what they would do if the Healthcare Ban goes into effect, including traveling regularly out of state for care, or uprooting their settled lives and moving out of Idaho. Both options would cause significant hardships to the family, but they do not see any other choices. Pam Poe Decl. ¶¶ 22–23; Penny Poe Decl. ¶¶ 20–23.

The Doe Family: Jane Doe is a 16-year-old rising senior in high school and has lived in Idaho her entire life. Jane Doe Decl. ¶ 2. Jane is transgender. She is a girl with a female gender

identity. Her birth certificate, passport, and school records now all list her as female, but when she was born, she was designated as male. *Id.* at ¶¶ 3, 19–20; Joan Doe Decl. ¶¶ 3, 5.

Growing up, Jane never really felt like a boy. When playing video games or "make believe," she was almost always a girl character. Jane Doe Decl. ¶¶ 5–6; Joan Doe Decl. ¶ 7. In 2018, as she started puberty, Jane was devastated by the way her body was changing, and her mental health deteriorated. She avoided having her picture taken, and there are few photos of her from this time. Jane knew "something felt off" and experienced a great deal of pain moving through the world as a boy. She frequently secluded herself because she did not think she could be herself in social settings, her schoolwork suffered, and she sometimes wished she did not even exist. Jane Doe Decl. ¶¶ 5, 9; Joan Doe Decl. ¶ 8.

Jane came out to some of her friends as transgender in June 2020 and told her parents three months later. Her parents were supportive and loving. Jane Doe Decl. ¶ 10; Joan Doe Decl. ¶¶ 5–6. Around October 2020, Jane began socially transitioning. She dressed in more traditionally feminine clothing, asked her mom to teach her how to wear makeup, and began using a new name consistent with her female gender identity. Jane Doe Decl. ¶ 11; Joan Doe Decl. ¶ 11.

In mid-October 2020, Jane's pediatrician referred her to a doctor who specializes in treating gender dysphoria, and she began seeing a therapist. Jane Doe Decl. ¶ 12; Joan Doe Decl. ¶¶ 9–10. The next month, Jane met with her new doctor who, after evaluating her, diagnosed her with gender dysphoria. Jane Doe Decl. ¶¶ 4, 13. Jane and her parents had conversations with the doctor in which the doctor provided them with information about gender dysphoria and counseled them on the risks and benefits of gender-affirming medical care and fertility preservation. *Id.* at ¶ 13; Joan Doe Decl. ¶¶ 13–14. After several months of therapy, an additional visit with Jane's doctor, and lab work, the doctor prescribed her a puberty blocker in January 2021. Jane Doe Decl. ¶ 14; Joan

Doe Decl. ¶ 16. Knowing that the pubertal changes to her body were not going to get worse was a huge relief to Jane. Jane Doe Decl. ¶ 15; Joan Doe Decl. ¶ 16.

The family began to discuss amongst themselves the possibility of Jane starting estrogen therapy and later discussed this with her doctor. The doctor advised them again on the risks and benefits, further counseled them on fertility preservation, and conducted additional lab work, ultimately finding hormone therapy to address her gender dysphoria to be appropriate. In April 2021, at age 14, Jane started hormone therapy at a very low dose. Jane Doe Decl. ¶ 16; Joan Doe Decl. ¶ 17. Her doctor has been monitoring Jane and her bloodwork since then, adjusting her medications as needed. Jane Doe Decl. ¶ 17; Joan Doe Decl. ¶ 18.

Gender-affirming medical care has transformed Jane's life, and she feels like a brand-new person. Since receiving gender-affirming medical care, Jane's mental health has significantly improved. She no longer feels isolated and is able to go out into the world. She experiences happiness when she looks in the mirror. Her grades in school have improved as well. Jane Doe Decl. ¶¶ 21–22; Joan Doe Decl. ¶ 19.

The debate over H.B. 71 brought back depressive and harmful thoughts for Jane that she had not had since socially and medically transitioning. When the bill passed, Jane was so emotionally devastated that her parents had to come and take her home from school. Joan Doe Decl. at ¶ 22. Jane and her family are scared about what would happen to Jane if she had to stop care. They do not know what they will do if H.B. 71 takes effect; they are grappling with the options of regular travel out of state or selling their home and leaving Idaho, either of which would cause significant hardship to the family. Jane Doe Decl. ¶¶ 23–25; Joan Doe Decl. ¶¶ 23–27.

ARGUMENT

I. PRELIMINARY INJUNCTION STANDARD

"The purpose of a preliminary injunction is to preserve rights pending resolution of the merits of the case by the trial." *E. & J. Gallo Winery* v. *Andina Licores S.A.*, 446 F.3d 984, 990 (9th Cir. 2006) (quoting *Big Country Foods, Inc*. v. *Bd. of Educ*., 868 F.2d 1085, 1087 (9th Cir.1989) (internal quotation marks omitted)). The Court considers whether (1) the plaintiffs show "(1) a likelihood of success on the merits; (2) likely irreparable harm in the absence of a preliminary injunction; (3) that the balance of equities weighs in favor of an injunction; and (4) that an injunction is in the public interest." *Hecox* v. *Little*, 479 F. Supp. 3d 930, 971 (D. Idaho 2020), *aff'd*, 2023 WL 1097255 (9th Cir. Jan. 30, 2023) (quoting *Winter* v. *Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (internal quotation marks omitted)); *see* Fed. R. Civ. P. 65(a). "Where, as here, 'the government is a party, these last two factors merge.'" *Hecox*, 479 F. Supp. 3d at 971 (quoting *Drakes Bay Oyster Co.* v. *Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014)). And where, as here, the ultimate burden to justify H.B. 71 under the Equal Protection Clause "rests entirely on the State," *United States* v. *Virginia*, 518 U.S. 515, 533 (1996) [hereinafter "*VMI*"], the burden to justify H.B. 71 shifts to Defendants at the preliminary injunction stage as well. *See, e.g., Gonzales* v. *O Centro Espírita Beneficente União do Vegetal*, 546 U.S. 418, 429 (2006) ("The point remains that the burdens at the preliminary injunction stage track the burdens at trial."). Furthermore, where, as here (*see* section IV(B), *infra*), the balance of hardships tips sharply towards the plaintiff, a preliminary injunction is appropriate so long as there are serious questions going to the merits. *Roman* v. *Wolf*, 977 F.3d 935, 941 (9th Cir. 2020).

II. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR EQUAL PROTECTION CLAIM

H.B. 71 prohibits, and makes it a crime for medical providers to provide, gender-affirming

medical care to transgender adolescents. The Ban classifies based on transgender status and sex, thereby triggering heightened equal protection scrutiny. The Ban cannot survive this "exacting" test. *VMI*, 518 U.S. at 555. Indeed, it would fail under even the most deferential constitutional scrutiny.

A. The Healthcare Ban Is Subject to Heightened Equal Protection Scrutiny Because It Discriminates Based on Transgender Status and Sex.

Under the Equal Protection Clause, heightened scrutiny applies to classifications based on transgender status and sex. *Karnoski* v. *Trump*, 926 F.3d 1180, 1200–01 (9th Cir. 2019) (applying heightened scrutiny to discrimination based on transgender status); *VMI*, 518 U.S. at 555 (all sex-based classifications are subject to heightened scrutiny); *see also Grimm* v. *Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 611–13 (4th Cir. 2020) (applying heightened scrutiny to discrimination based on sex and transgender status); *Ray* v. *McCloud*, 507 F. Supp. 3d 925, 937–38 (S.D. Ohio 2020) (collecting cases); *Hecox*, 479 F. Supp. 3d at 973–74 (finding that discrimination against transgender people is discrimination on the basis of sex); *F.V.* v. *Barron*, 286 F. Supp. 3d 1131, 1144–45 (D. Idaho Mar. 5, 2018) (finding "transgender people bear all of the characteristics of a quasi-suspect class" and applying heightened scrutiny).[2] To survive heightened scrutiny, such classifications must be "substantially related to an important government interest." *Latta* v. *Otter*, 19 F. Supp. 3d 1054, 1073 (D. Idaho May 13, 2014), *aff'd*, 771 F.3d 456 (9th Cir. 2014) (quoting

[2] As this Court detailed in *F.V.*, "(1) transgender people have been the subject of a long history of discrimination that continues to this day; (2) transgender status as a defining characteristic bears no relation to ability to perform or contribute to society; (3) transgender status and gender identity have been found to be obvious, immutable, or distinguishing characteristics; and (4) transgender people are unarguably a politically vulnerable minority." 286 F. Supp. 3d at 1145 (cleaned up). These realities are "especially true in Idaho," this Court has noted, "where transgender people have no state constitutional protections from discrimination based on their transgender status in relation to employment decisions, housing, and other services." *Id.* Thus, people who are transgender are a quasi-suspect class and H.B. 71 must withstand heightened scrutiny review to be constitutionally sound. *Id.*

Miss. Univ. for Women v. *Hogan*, 458 U.S. 718, 724 (1982)). Because the Ban facially discriminates based on transgender status and sex, it is subject to heightened scrutiny.

1. The Ban Discriminates Based on Transgender Status.

The Ban expressly classifies based on transgender status. A transgender person is, by definition, someone whose sex designated at birth is different from their gender identity. Brady Decl. ¶ 12, *see also Karnoski*, 926 F.3d at 1187 n.1 (transgender people have a "gender identity [that] does not match their birth-assigned sex"). H.B. 71 explicitly bans healthcare for minors *only* when provided "for the purpose of attempting to alter the appearance of or affirm the [minor's] perception of the [minor's] sex" where the minor's "perception of the [minor's] sex is inconsistent with the [minor's] biological sex." H.B. 71 § 1(3). Sex is defined in the statute as "chromosomes and internal and external reproductive anatomy, genetically determined at conception and generally recognizable at birth." H.B. 71, § 1(2)(b). In banning medical care that affirms a minor's gender *only where* it is different from their sex assigned at birth—the defining trait of being transgender—the law necessarily classifies based on transgender status. *See Brandt*, 2023 WL 4073727, at *31 (prohibiting medical care that only transgender people choose to undergo constitutes discrimination against transgender people). Moreover, under the Ban, the medications and treatments that are prohibited for transgender adolescents to affirm their gender identity remain available to cisgender adolescents. *See Fain* v. *Crouch*, 618 F. Supp. 3d 313, 327 (S.D. W. Va. 2022), *appeal filed*, No. 22-1927, 2022 WL 16708468 (4th Cir. 2022); *Toomey* v. *Arizona*, No. CV-19-00035-TUC-RM (LAB), 2019 WL 7172144, at *6 (D. Ariz. Dec. 23, 2019); *Flack* v. *Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 950 (W.D. Wis. 2018).

2. The Ban Discriminates Based on Sex.

In addition to classifying based on transgender status, the Ban draws a classification based on sex in three distinct ways.

First, the Ban speaks in explicit gendered terms, proffers its own definition of the term "sex," and facially discriminates based on that definition. If the legislature cannot "writ[e] out instructions" for determining whether treatment is permitted "without using the words man, woman, or sex (or some synonym)," the law classifies based on sex. *Bostock* v. *Clayton Cnty.*, 140 S. Ct. 1731, 1746 (2020); *see Grabowski* v. *Arizona Board of Regents*, 69 F.4th 1110, 1116 (9th Cir. 2023) (applying *Bostock* outside of context of Title VII). Here, the Ban prohibits medical care when the care is provided in a manner the state deems "inconsistent with the child's biological sex." H.B. 71 § 1(3). Because it is not possible to determine if a practice is permitted or forbidden under H.B. 71 without referring to sex, it draws a classification on the basis of sex.

Second, the Ban discriminates based on stereotypes relating to a person's sex assigned at birth. "By definition, a transgender individual does not conform to the sex-based stereotypes of the sex that he or she was assigned at birth." *Whitaker by Whitaker* v. *Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1048 (7th Cir. 2017), *abrogated on other grounds as recognized by Ill. Republican Party* v. *Pritzker*, 973 F.3d 760, 762 (7th Cir. 2020); *accord Glenn* v. *Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011). "Sex stereotyping based on a person's gender non-conforming behavior"—including a person's "fail[ure] to act and/or identify with his or her" sex designated at birth—"is impermissible discrimination." *Dodds* v. *U.S. Dep't of Educ.*, 845 F.3d 217, 221 (6th Cir. 2016) (*per curiam*) (quoting *Smith* v. *City of Salem*, 378 F.3d 566, 575 (6th Cir. 2004) (internal quotation marks omitted)). When the government "penalizes a person identified as male at birth for traits or actions that it tolerates in" people "identified as female at birth,"—here, for example, receiving medical treatment to live in accordance with a female gender identity—the person's "sex plays an unmistakable and impermissible role." *Bostock*, 140 S. Ct. at 1741–42.

Here, the Ban explicitly enforces sex stereotypes and gender conformity by targeting

medical care for exclusion only if the purpose of the care is to "attempt[] to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex." H.B. 71 § 1(3). Conversely, the Ban does not prohibit a cisgender boy with gynecomastia from having a mastectomy so that his chest will conform to his male gender; nor does it prohibit cisgender girls who have unwanted facial hair due to polycystic ovarian syndrome from being treated with testosterone suppressants to address this unwanted masculinization of their appearance. The same medications that are banned when used to affirm a gender that is inconsistent with one's birth-assigned sex are permitted to affirm a gender that matches their birth-assigned sex. By allowing and disallowing care based on sex designated at birth, the Ban is an impermissible "form of sex stereotyping where an individual is required effectively to maintain [their] natal sex characteristics." *Boyden* v. *Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018); *see also Latta* v. *Otter*, 771 F.3d 456, 484 (9th Cir. 2014) ("Laws that strip *individuals* of their rights or restrict personal choices or opportunities solely on the basis of the individuals' gender are sex discriminatory.") (Berzon, J. concurring). The Ban "tethers Plaintiffs to sex stereotypes which, as a matter of medical necessity, they seek to reject." *Kadel* v. *Folwell*, 446 F. Supp. 3d 1, 14 (M.D.N.C. 2020).

Third, the Ban discriminates based on sex because, as articulated above, it discriminates based on transgender status, which necessarily discriminates based on sex. As the Supreme Court explained in *Bostock*, "it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex." 140 S. Ct. at 1741. By "discriminating against transgender persons," the Ban "unavoidably discriminates against persons with one sex identified at birth and another today." *Id.* at 1746; *see also Brandt*, 47 F.4th at 669 (by relying on "the minor's sex at birth," Arkansas' ban on gender-affirming care for minors

"discriminates on the basis of sex"). The Ninth Circuit and District of Idaho have likewise recognized that discrimination "because of sex" includes discrimination based on transgender status. *See, e.g.*, *Grabowski*, 69 F.4th at 1116 (observing that in *Bostock*, the Supreme Court held "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex.") (internal quotation marks and citations omitted); *F.V.*, 286 F. Supp. 3d at 1142. And as explained above, the Ban discriminates based on transgender status.

B. The Healthcare Ban Fails Heightened Equal Protection Scrutiny.

To survive heightened scrutiny, Idaho must provide an "exceedingly persuasive justification" for the Ban's classifications and a "close means-end fit." *Sessions* v. *Morales-Santana*, 582 U.S. 47, 58, 68 (2017); *see also VMI*, 518 U.S. at 531. Neither exists here. At the preliminary injunction stage and beyond, this Court "(1) looks to the Defendants to justify the Act [here, the Ban]; (2) must consider the Act's actual purposes; (3) need not accept hypothetical, *post hoc* justifications for the Act; and (4) must decide whether Defendants' proffered justifications overcome the injury and indignity inflicted on Plaintiffs and others like them." *Hecox*, 479 F. Supp. 3d at 976. The "burden of justification is demanding"—not "deferential"—and "rests entirely on the State." *VMI*, 518 U.S. at 533, 555. Defendants cannot meet this demanding burden.

Gender dysphoria is a serious medical condition, and all the major medical groups recognize that gender-affirming medical care—the care banned by H.B. 71—is necessary to alleviate the significant distress and other effects of gender dysphoria for many adolescents. There is no justification for singling out gender-affirming medical care for minors and taking this medical decision away from parents. Further, even if Defendants could show an "exceedingly persuasive justification" to restrict care for some minors, the categorical denial of care under the Ban would still be an unconstitutionally restrictive means of achieving the interest. *See K. C.*, 2023 WL

4054086, at *11–12 (finding that Indiana's ban on gender-affirming medical care does not have the necessary "close means-end fit").

Although H.B. 71 is titled the "Vulnerable Child Protection Act," the Ban does nothing to protect children. On the contrary, it will cause them significant harm. If left untreated, gender dysphoria can result in severe anxiety and depression, self-harm, and suicidality. Brady Decl. ¶¶ 24, 36. Gender-affirming medical care is well-accepted in the medical field as appropriate treatment for gender dysphoria in adolescents. Connelly Decl. ¶¶ 19–20; Brady Decl. ¶ 29; *see also Brandt*, 2023 WL 4073727, at *33 ("[B]ased on the decades of clinical experience and scientific research, it is widely recognized in both the medical and mental health fields—including by major medical and mental health professional associations—that gender-affirming medical care can relieve the clinically significant distress associated with gender dysphoria in adolescents."); *Ladapo*, 2023 WL 3833848, at *4 ("The overwhelming weight of medical authority supports treatment of transgender patients with [puberty-delaying medication] and cross-sex hormones in appropriate circumstances.").

Gender-affirming medical care can greatly improve the health and well-being of adolescent patients with gender dysphoria. Connelly Decl. ¶ 31; Brady Decl. ¶ 39. Practitioners' clinical experience observing the benefits of treatment is bolstered by nearly two decades of research demonstrating that gender-affirming care improves health outcomes for adolescent patients and reduces symptoms of anxiety, depression, and suicidality. Connelly Decl. ¶ 32; Brady Decl. ¶ 39.

The personal experiences of the minor Plaintiffs illustrate how this treatment can positively transform the lives of the adolescents who need it. Gender-affirming care has not harmed them; it has enabled them to thrive. It is the denial of this care that will harm the minor Plaintiffs, and transgender minors across Idaho.

There is nothing about gender-affirming medical care for adolescents that justifies singling out for prohibition *only* gender-affirming medical care—and *all* gender-affirming medical care—and taking these medical decisions away from transgender adolescents and their parents.

Gender-affirming medical care is supported by substantial clinical and research evidence demonstrating its effectiveness. The quality of evidence supporting this care is comparable to the quality of evidence supporting other medical treatments that may be provided to minors. Connelly Decl. ¶¶ 55–57.

Gender-affirming care is not uniquely risky, and instead raises the same types of risks as other types of healthcare that families are free to pursue for their minor children. Connelly Decl. ¶¶ 44–48; *Brandt*, 2023 WL 4073727, at *17–18 ("[T]he risks associated with the treatments prohibited by [the Arkansas Ban] are comparable to the risks associated with many other medical treatments that parents are free to choose for their adolescent children after weighing the risks and benefits.").

Moreover, the same medications and treatments that are used in gender-affirming medical care—puberty blockers, testosterone, testosterone suppression, estrogen, and mastectomy—are widely used to treat cisgender adolescents for other purposes, and pose the same potential risks. Connelly Decl. ¶¶ 36–40. For example, GnRHa medications are widely used to treat precocious puberty; testosterone is used to treat cisgender boys with delayed puberty; estrogen is used to treat cisgender girls for ovarian failure, regulation of menstruation, and contraception; and mastectomy is used to treat cisgender boys with gynecomastia. *Id.* ¶¶ 37–40. The potential health risks associated with these medications or surgery are the same whether used for these purposes, or to treat transgender adolescents with gender dysphoria. *Id.* ¶¶ 45, 47, 48. The only difference is that some types of gender-affirming medical care may impair fertility. But as with other medical

treatments that can impact fertility, this is discussed in the informed consent process. *Id.* ¶¶ 50–51. And there are ways to adjust the treatment to protect fertility if that is important to the patient and their family. *Id.* ¶ 50.

Gender-affirming medical care is well-supported by evidence and, thus, widely accepted in the medical field. The fact that the medications used in gender-affirming medical care are used "off-label"—that is, without FDA approval for this specific indication—does not make the care experimental or mean that the FDA does not support this care. Indeed, the medications used off-label to treat gender dysphoria are also commonly used off-label for many other purposes. For example, GnRHa medications are regularly prescribed for minors for a variety of non-FDA-approved indications, including ovarian cancer, premenstrual syndrome, fertility preservation in women, and as an adjunct to growth hormone therapy in youth with idiopathic short stature. Connelly Decl. ¶ 59. Once the FDA approves a drug for one indication, doctors are free to prescribe it for other purposes, and off-label use is extremely common in medicine. Connelly Decl. ¶ 59. Once a pharmaceutical company gets FDA approval for one indication, they often do not consider it worth the cost to pursue approval for additional indications since there is no need. *Id.*; *see also Brandt*, 2023 WL 4073727, at *5 ("Transgender care is not experimental care.").

In sum, the scientific and medical evidence robustly supports the safety and efficacy of gender-affirming care for transgender adolescents. The evidence supporting that care and the potential risks associated with it are comparable to many other medical treatments adolescents and their families are free to seek. Indeed, the Ban does not target the medical treatments; puberty-delaying medication, hormone therapy, and mastectomies are permitted, as long as they are given for some reason other than gender-affirming medical care for transgender adolescents. There is no justification—much less the "exceedingly persuasive justification" that the Constitution would

require—for treating gender-affirming medical care differently than all other medical treatment for minors.

Moreover, the Ban would be unconstitutional even if there were such an exceedingly persuasive justification for restricting care in some circumstances because the legislation *categorically bans* gender-affirming medical care when given to a transgender minor, regardless of the circumstances. A categorical denial of care is an unconstitutionally restrictive means of achieving the interest. *See K. C.*, 2023 WL 4054086, at *11–12 (noting less-restrictive means of regulating gender-affirming care that are available and finding that Indiana's ban does not have the necessary "close means-end fit").

C. The Healthcare Ban Fails Any Level of Review.

Heightened scrutiny is appropriate here for the reasons described above. But the Ban would fail *any* level of scrutiny, including rational basis review, because it "is so far removed from" the purported goal of protecting children, "it [is] impossible to credit" it. *Romer* v. *Evans*, 517 U.S. 620, 635 (1996). The Ban does nothing to protect youth; it simply harms transgender youth. Moreover, there is no rational basis to conclude that allowing minors with gender dysphoria to receive gender-affirming medical care that they, their parents, and their doctors agree is medically necessary "would threaten [Idaho's] legitimate interests in a way that" allowing other types of medical care "would not." *City of Cleburne* v. *Cleburne Living Ctr.*, 473 U.S. 432, 448 (1985). There is nothing unique about gender-affirming medical care that explains the State's decision to override parents' medical decisions for their children for only gender-affirming medical care. Indeed, the Ban's permission of the *same treatments* for non-transgender minors for different medical conditions only underscores the lack of any rational basis for the State to draw the distinctions here. *See Bd. of Trs. of Univ. of Ala.* v. *Garrett*, 531 U.S. 356, 366 n.4 (2001) ("The

Court's reasoning [in *Cleburne*] was that the city's purported justifications . . . *made no sense* in light of how the city treated other groups similarly situated in relevant respects.") (emphasis added).

That the State has banned these medical treatments only for gender dysphoria, while permitting the same treatments when given to affirm an adolescent's gender assigned at birth, confirms that the Ban fails rational-basis review. In *Eisenstadt* v. *Baird*, the Supreme Court held that a state could not rationally ban birth control for unmarried people based on the supposed health risks of the pills, while allowing married people to use the same pills. 405 U.S. 438, 451–52 (1972).

The Supreme Court has also made clear that animus is not a rational basis, *see Romer*, 517 U.S. at 632, and that "a legislative 'desire to harm a politically unpopular group cannot constitute a legitimate governmental interest.'" *Olson* v. *California*, 62 F.4th 1206, 1220 (9th Cir. 2023) (quoting *U.S. Dep't of Ag.* v. *Moreno*, 413 U.S. 528, 534 (1973)). While the Ban purports to protect "vulnerable" children, the facts surrounding its enactment show that its real purpose was to express disapproval of transgender people. The Ban was just part of a larger legislative strategy to discriminate against transgender people, including by prohibiting transgender people of all ages from changing the gender recorded on their birth certificate. *See* Declaration of Ariella Barel (Barel Decl.), Ex. A, B & C. Indeed, a co-sponsor of the bill referred to identifying as LGBTQ as an "epidemic" of which "States need to help stop the spread," and called gender-affirming medical care "Frankenstein Practices." *See* Barel Decl. Ex. D, E. "[D]isfavor with which the architect of the legislation view[s]" the targets of a law—here, transgender people—can belie the articulated purposes of the legislation framed in the language of "protection" of the same individuals. *Olson*, 62 F.4th at 1219. Even where a State's targeting of a particular group does not rise to the level of malice, an improper motive for legislation can also arise due to "insensitivity caused by simple want of careful, rational reflection or some instinctive mechanism to guard against people who

appear to be different in some respects from ourselves." *Garrett*, 531 U.S. at 374 (Kennedy, J., concurring). There is no rational basis to ban accepted gender-affirming care for transgender adolescents. In the absence of a rational relationship to a legitimate state interest, the Ban must fail. *Id.* at 377; *Olson*, 62 F.4th at 1219; *accord, e.g.*, *Ladapo*, 2023 WL 3833848, at *10 (concluding a similar Florida ban on gender-affirming care fails rational basis review).

III. THE PARENT PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIM THAT THE HEALTHCARE BAN VIOLATES PARENTS' FUNDAMENTAL RIGHT TO PARENTAL AUTONOMY.

Idaho's Healthcare Ban triggers strict scrutiny because it burdens the parent Plaintiffs' fundamental right to seek appropriate medical care for their children under the Fourteenth Amendment's substantive due process clause. As explained above, the Healthcare Ban cannot survive any level of constitutional scrutiny, let alone strict scrutiny. *See Brandt*, 2023 WL 4073727, *36 (holding ban on gender-affirming healthcare for minors violates parents' substantive Due Process rights "to seek medical care for their children and, in conjunction with their adolescent child's consent and their doctor's recommendation, make a judgment that medical care is necessary."); *Ladapo*, 2023 WL 3833848, *11 (holding parent plaintiffs challenging a similar healthcare ban likely to prevail on their substantive due process parental-rights claim); *Eknes-Tucker*, 603 F. Supp. 3d at 1146 (holding that parent plaintiffs challenging a similar healthcare ban in Alabama "have a fundamental right to direct the medical care of their children" and were "substantially likely to succeed on their Substantive Due Process claim.")

A. Strict Scrutiny Applies to the Parent Plaintiffs' Due Process Claims.

The Due Process Clause protects "against government interference with certain fundamental rights and liberty interests." *Washington* v. *Glucksberg*, 521 U.S. 702, 719–20 (1997). The government cannot "infringe certain 'fundamental' liberty interests at *all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state

interest." *Brach* v. *Newsom*, 6 F.4th 904, 922 (9th Cir. 2021) (emphasis in original) (quoting *Reno* v. *Flores*, 507 U.S. 292, 302 (1993)), *vacated as moot*, 38 F.4th 6 (9th Cir. 2022) (en banc).

Fundamental liberty interests include parents' rights to make decisions "concerning the care, custody, and control of their children," based on a "presumption" that "fit parents act in the best interests of their children." *Troxel* v. *Granville*, 530 U.S. 57, 66, 68 (2000). This right is "perhaps the oldest of the fundamental liberty interests recognized by [the] Court." *Id.* at 65; *see also Parham* v. *J.R.*, 442 U.S. 584, 602 (1979) (collecting cases). Any substantial infringement of a fundamental right is subject to strict scrutiny. *Halet* v. *Wend Inv. Co.*, 672 F.2d 1305, 1310 (9th Cir. 1982).

The Ninth Circuit has held that the Fourteenth Amendment right to direct the upbringing of one's children includes "the right of parents to make important medical decisions for their children, and of children to have those decisions made by their parents rather than the state." *Wallis* v. *Spencer*, 202 F.3d 1126, 1141 (9th Cir. 2000) (citing *Parham*, 442 U.S. at 602); *see also Kanuszewski* v. *Mich. Dep't of Health & Hum. Servs.*, 927 F.3d 396, 419 (6th Cir. 2019) (strict scrutiny applies to "parents' substantive due process right . . . to direct their children's medical care."); *Troxel*, 530 U.S. at 68–69 ("[T]here is normally no reason for the State to inject itself into the private realm of the family to further question fit parents' ability to make the best decisions regarding their children."). Accordingly, parents "retain plenary authority to seek such [medical] care for their children, subject to a physician's independent examination and medical judgment." *Parham*, 442 U.S. at 604.

When the parents' and child's liberty interests in pursuing a course of medical care align, the strength of those interests against state interference is at its apex. *Cf. Santosky* v. *Kramer*, 455 U.S. 745, 760–61 (1982) (heightened evidentiary standards required where the "vital interest" of

the parent and child in preserving their relationship "coincide"). Idaho's Healthcare Ban deprives the parents of the right to seek care for their children that every major U.S. medical association has recognized as safe, effective, and medically necessary care. "Parents, pediatricians, and psychologists—not the State or this Court—are best qualified to determine whether [gender-affirming] medications are in a child's best interest on a case-by-case basis." *Eknes-Tucker*, 603 F. Supp. 3d at 1146.

B. The Healthcare Ban Cannot Survive Strict Scrutiny.

Idaho's Healthcare Ban cannot survive any level of constitutional scrutiny, and thus necessarily fails to satisfy the strict scrutiny applied to governmental intrusions into fundamental rights. In addition to the reasons discussed above, Idaho's Healthcare Ban fails strict scrutiny because the means chosen by Idaho to address any purported concerns about gender-affirming healthcare are nowhere near the "least restrictive." *See Bernal* v. *Fainter*, 467 U.S. 216, 219 (1984).

Nothing about Idaho's Healthcare Ban is narrowly tailored to *any* interest. Rather than address any particularized concerns, the Ban simply rules out *all* medical treatments if the purpose is to affirm the gender identity of transgender youth. There is no rationale that explains why this fundamental right of medical decision-making must be stripped from parents for *every* type of gender-affirming medical care and in all circumstances. *See Brandt*, 2023 WL 4073727 at *36 (finding the ban on "all gender transition procedures" not to be narrowly tailored, but rather, violative of the parents' substantive due process rights). The parent Plaintiffs are acting in the best interests of their children, and the State's interference in their decision-making does not survive strict scrutiny, let alone any basis of review.

IV. THE REMAINING PRELIMINARY INJUNCTION FACTORS SUPPORT GRANTING A PRELIMINARY INJUNCTION

A. Plaintiffs Will Suffer Immediate and Irreparable Harm If the Healthcare Ban Is Not Blocked.

If the Ban is not blocked, Plaintiffs will suffer serious and irreparable harm for which there is no adequate remedy at law. *See Brandt*, 47 F.4th at 672. As discussed above, the Ban violates the constitutional rights of both adolescents and their parents, which is, in and of itself, irreparable harm. *See, e.g.*, *Hernandez* v. *Sessions*, 872 F.3d 976, 994–95 (9th Cir. 2017); *Monterey Mech. Co.* v. *Wilson*, 125 F.3d 702, 715 (9th Cir. 1997).

The irreparable harm here is far greater than just the deprivation of Plaintiffs' constitutional rights. The Ban would strip the minor Plaintiffs and other Idaho youth of medically necessary care, forcing them to suffer the pain of gender dysphoria and jeopardizing their mental health and well-being. And the Ban would force parents to watch their children suffer—or, if they have the resources, incur the significant expense of regular travel or uproot their lives to relocate out of state to access care.

Minor Plaintiffs: As a result of the Ban, Pam Poe and Jane Doe are at risk of losing the medical treatment that has allowed them to thrive. They are already experiencing severe anxiety and distress at the prospect of losing care, and the harm from this loss of care will be immediate.

For Pam Poe, if the Ban takes effect, she would be forced to stop hormone therapy that is enabling her to go through puberty consistent with her gender identity, and force her into endogenous puberty, causing her to develop physiological traits inconsistent with her gender identity, at great risk to her mental health. *See* Pam Poe Decl. ¶¶ 14, 19; Penny Poe Decl. ¶¶ 16–19. Pam has already experienced significant distress related to her endogenous puberty, and she has engaged in self-harm and didn't want to live prior to receiving gender-affirming medical care. *See* Pam Poe Decl. ¶¶ 9–11; Penny Poe Decl. ¶¶ 11–13. Pam is terrified of losing access to the

medication that has saved her life and made her feel like a future is possible. Pam Poe Decl. ¶¶ 20–22; Penny Poe Decl. ¶¶ 20–23. She has already lived through the extreme despair of not receiving treatment and cannot go back to that. Pam Poe Decl. ¶ 22.

For Jane Doe, the Ban would mean disrupting her hormone therapy that she has been receiving for over two years. *See* Jane Doe Decl. ¶ 24; Joan Doe Decl. ¶ 17, 21. This care has alleviated her gender dysphoria and turned her life around. *See* Jane Doe Decl. at ¶¶ 18, 21; Joan Doe Decl. ¶¶ 19–20. The prospect of H.B. 71 has already brought back pain and mental health struggles that Jane has not had since starting gender-affirming medical care, affecting her daily life and her grades. Jane Doe Decl. ¶¶ 23–24; Joan Doe Decl. ¶¶ 21–22.

Parent Plaintiffs: If the Ban is not blocked, the parent Plaintiffs will have their parental decision-making displaced by the State, forcing them either to watch their minor children suffer immense pain and worry about a resumption of isolation, self-harm, or worse, or—if they are able to manage it financially—regularly travel out of state for care or disrupt their lives, families, and careers to move out of state.

Both the Poes and the Does are grappling with how to get their children care if the Ban takes effect because discontinuing care is not an option. Penny Poe remembers the fear of possibly losing her daughter before she and her husband could get Pam the gender-affirming care she needed, and they are terrified of the potential consequences on Pam's health if care is stopped—they "do not even have to guess what will happen to her mental health" because they have been through it. Penny Poe Decl. ¶¶ 20–22. For both families, they are facing an impossible decision because both regular travel out of state for care and moving would cause significant financial and personal hardships to their families. Joan Doe Decl. ¶¶ 23–27.

A preliminary injunction is necessary to prevent these severe and irreparable harms.

B. The Balance of Equities Weigh in Plaintiffs' Favor and Issuance of the Preliminary Injunction Is in the Public Interest.

Because state government officials are Defendants here, this Court considers the "balance of the equities" and "public interest" components of the preliminary injunction test together, as one inquiry. *Porretti* v. *Dzurenda*, 11 F.4th 1037, 1047 (9th Cir. 2021). The threat of harm to Plaintiffs far outweighs Defendants' interests in immediately enforcing the Ban, and preserving Plaintiffs' constitutional rights is in the public interest. *See Melendres* v. *Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) ("[I]t is always in the public interest to prevent the violation of a party's constitutional rights" (citation omitted)).

The balance of equities decidedly warrants a preliminary injunction here and the court should preserve the status quo until the case can be decided on the merits.

The harm to Plaintiffs from allowing the Ban to go into effect would be tangible, immediate, and irreparable. Whatever interest the State may have in enforcing the Ban during the pendency of this case pales in comparison to Plaintiffs' certain and severe harm. In stark contrast to the deeply personal and irreparable harms Pam, Jane, and their families face, a preliminary injunction would not harm Defendants at all, but merely maintain the status quo while Plaintiffs pursue their claims. Gender-affirming medical care has been provided safely in Idaho for many years. No problems have been reported from the treatment that either family has undertaken, nor does H.B. 71's legislative history identify any harm to the State of Idaho from the medical care H.B. 71 would criminalize.

And so, "by establishing a likelihood that [the government's] policy violates the U.S. Constitution," as Plaintiffs have here, they "have also established that both the public interest and the balance of the equities favor a preliminary injunction." *Ariz. Dream Act Coalition* v. *Brewer*, 757 F.3d 1053, 1069 (9th Cir. 2014).

V. A FACIAL STATEWIDE INJUNCTION IS NECESSARY

Plaintiffs have met all of the factors for a preliminary injunction, and a facial statewide injunction is "necessary to give [Plaintiffs] the relief to which they are entitled." *See Bresgal* v. *Brock*, 843 F.2d 1163, 1170–71 (9th Cir. 1987) (finding a nationwide mandatory injunction not "overbroad" because limiting enforcement of the law to a particular group would not give the prevailing parties relief); *see also Easyriders Freedom F.I.G.H.T.* v. *Hannigan*, 92 F.3d 1486, 1501–02 (9th Cir. 1996) (affirming a statewide injunction prohibiting enforcement of California's motorcycle helmet law, even though there were just 14 named plaintiffs and was no class certification, because plaintiffs could not otherwise "receive the complete relief to which they are entitled").

An injunction applicable to only the Plaintiffs would not allow them to obtain the relief they urgently need and to which they are entitled. It is not clear how any medical provider or pharmacist in Idaho from whom plaintiffs might seek care or medication would be able to verify that they are the plaintiffs in this case (even if they were not proceeding under pseudonyms) and, thus, feel secure that they will not face severe criminal penalties if they provide them with care or medications. *See Easyriders*, 92 F.3d at 1502 (granting statewide preliminary injunction enjoining a highway patrol policy regarding enforcement of a motorcycle helmet mandate because patrol officers could not know which motorcyclists were plaintiffs). Moreover, even if a doctor or pharmacist is willing to provide care or medications to Plaintiffs, the institutions where they work may implement policies prohibiting the care if H.B. 71 goes into effect.

Additionally, the Ninth Circuit has held that courts may deny class certification in prospective constitutional challenges to state statutes, such as the present challenge, because "the relief sought will, as a practical matter, produce the same result as formal class-wide relief." *James* v. *Ball*, 613 F.2d 180, 186 (9th Cir. 1979), *rev'd on other grounds*, 451 U.S. 355 (1981); *see also*

DiFrancesco v. *Fox*, No. CV 17-66-BU-SEH, 2019 WL 145627, at *2 (D. Mont. Jan. 9, 2019) (denying class certification because "[a]ny judgment implicating the constitutionality of [the state statute] would be binding on all Defendants and to the benefit of all potential class members"). In other words, the Ninth Circuit recognizes that statewide relief is an appropriate remedy where there is a challenge to the constitutionality of a state statute. And Courts in this district have granted statewide relief in cases similar to this one. *See, e.g.*, *F.V.*, 286 F. Supp. at 1146.

VI. BOND SHOULD BE WAIVED

Plaintiffs seek an injunction of unconstitutional conduct by a governmental entity, and because there is no risk of monetary harm to Defendants if they are eventually found to be wrongfully enjoined, the FRCP 65(c) bond is neither appropriate nor necessary in this case and should be waived. *See Diaz* v. *Brewer*, 656 F.3d 1008, 1015 (9th Cir. 2011); *Baca* v. *Moreno Valley Unified Sch. Dist.*, 936 F. Supp. 719, 738 (C.D. Cal. 1996).

VII. CONCLUSION

Plaintiffs respectfully request the Court grant this Motion and enjoin the enforcement of H.B. 71 pending a decision on the merits of Plaintiffs' claims and grant such other relief that the Court deems just and proper. Given the Ban's grave harms, Plaintiffs request a hearing as soon as practicable. Defendants are being served with the motion papers immediately.

Date: July 21, 2023

Respectfully submitted,

/s/ *Alexia D. Korberg*
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Leslie Cooper
Taylor Brown
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Exhibit 1

LEGISLATURE OF THE STATE OF IDAHO
Sixty-seventh Legislature First Regular Session - 2023

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 71, As Amended in the Senate

BY JUDICIARY, RULES AND ADMINISTRATION COMMITTEE

AN ACT

RELATING TO THE VULNERABLE CHILD PROTECTION ACT; AMENDING CHAPTER 15, TITLE 18, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 18-1506C, IDAHO CODE, TO PROVIDE A SHORT TITLE, TO DEFINE TERMS, TO PROHIBIT CERTAIN PRACTICES UPON A CHILD, TO PROVIDE CERTAIN EXEMPTIONS, TO PROVIDE A PENALTY, AND TO PROVIDE SEVERABILITY; AMENDING SECTION 19-5307, IDAHO CODE, TO PROVIDE A CODE REFERENCE; AND PROVIDING AN EFFECTIVE DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Chapter 15, Title 18, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 18-1506C, Idaho Code, and to read as follows:

18-1506C. VULNERABLE CHILD PROTECTION. (1) This section shall be known and may be cited as the "Vulnerable Child Protection Act."

(2) As used in this section:

(a) "Child" means any person under eighteen (18) years of age; and

(b) "Sex" means the immutable biological and physiological characteristics, specifically the chromosomes and internal and external reproductive anatomy, genetically determined at conception and generally recognizable at birth, that define an individual as male or female.

(3) A medical provider shall not engage in any of the following practices upon a child for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex:

(a) Performing surgeries that sterilize or mutilate, or artificially construct tissue with the appearance of genitalia that differs from the child's biological sex, including castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, clitoroplasty, vaginoplasty, vulvoplasty, ovariectomy, or reconstruction of the fixed part of the urethra with or without metoidioplasty, phalloplasty, scrotoplasty, or the implantation of erection or testicular prostheses;

(b) Performing a mastectomy;

(c) Administering or supplying the following medications that induce profound morphologic changes in the genitals of a child or induce transient or permanent infertility:

(i) Puberty-blocking medication to stop or delay normal puberty;

(ii) Supraphysiological doses of testosterone to a female; or

(iii) Supraphysiological doses of estrogen to a male; or

(d) Removing any otherwise healthy or nondiseased body part or tissue.

(4) A surgical operation or medical intervention shall not be a violation of this section if the operation or intervention is:

(a) Necessary to the health of the person on whom it is performed and is performed by a person licensed in the place of its performance as a medical practitioner, except that a surgical operation or medical intervention is never necessary to the health of the child on whom it is performed if it is for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex;

(b) For the treatment of any infection, injury, disease, or disorder that has been caused or exacerbated by the performance of gender transition procedures, whether or not the procedures were performed in accordance with state and federal law; or

(c) Performed in accordance with the good faith medical decision of a parent or guardian of a child born with a medically verifiable genetic disorder of sex development, including:

(i) A child with external biological sex characteristics that are ambiguous and irresolvable, such as a child born having 46, XX chromosomes with virilization, 46, XY chromosomes with undervirilization, or with both ovarian and testicular tissue; or

(ii) When a physician has otherwise diagnosed a disorder of sexual development in which the physician has determined through genetic testing that the child does not have the normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a male or female.

(5) Any medical professional convicted of a violation of this section shall be guilty of a felony and shall be imprisoned in the state prison for a term of not more than ten (10) years.

(6) The provisions of this act are hereby declared to be severable, and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this section.

SECTION 2. That Section 19-5307, Idaho Code, be, and the same is hereby amended to read as follows:

19-5307. FINES IN CASES OF CRIMES OF VIOLENCE. (1) Irrespective of any penalties set forth under state law, and in addition thereto, the court, at the time of sentencing or such later date as deemed necessary by the court, may impose a fine not to exceed five thousand dollars ($5,000) against any defendant found guilty of any felony listed in subsections (2) and (3) of this section.

The fine shall operate as a civil judgment against the defendant and shall be entered on behalf of the victim named in the indictment or information, or the family of the victim in cases of homicide or crimes against children, and shall not be subject to any distribution otherwise required in section 19-4705, Idaho Code. The clerk of the district court may collect the fine in the same manner as other fines imposed in criminal cases are collected and shall remit any money collected in payment of the fine to the victim named in the indictment or information or to the family of the victim in a case of homicide or crimes against minor children, provided that none of the provisions of this section shall be construed as modifying the provisions of chapter 6, title 11, Idaho Code, chapter 10, title 55, Idaho Code, or

section 72-802, Idaho Code. A fine created under this section shall be a separate written order in addition to any other sentence the court may impose.

The fine contemplated in this section shall be ordered solely as a punitive measure against the defendant and shall not be based upon any requirement of showing of need by the victim. The fine shall not be used as a substitute for an order of restitution as contemplated in section 19-5304, Idaho Code, nor shall such an order of restitution or order of compensation entered in accordance with section 72-1018, Idaho Code, be offset by the entry of such fine.

A defendant may appeal a fine created under this section in the same manner as any other aspect of a sentence imposed by the court. The imposition of a fine created under this section shall not preclude the victim from seeking any other legal remedy; provided that in any civil action brought by or on behalf of the victim, the defendant shall be entitled to offset the amount of any fine imposed pursuant to this section against any award of punitive damages.

(2) The felonies for which a fine created under this section may be imposed are those described in:

Section 18-805, Idaho Code (Aggravated arson);
Section 18-905, Idaho Code (Aggravated assault);
Section 18-907, Idaho Code (Aggravated battery);
Section 18-909, Idaho Code (Assault with intent to commit a serious felony);
Section 18-911, Idaho Code (Battery with intent to commit a serious felony);
Section 18-913, Idaho Code (Felonious administration of drugs);
Section 18-918, Idaho Code (Felony domestic violence);
Section 18-923, Idaho Code (Attempted strangulation);
Section 18-1501, Idaho Code (Felony injury to children);
Section 18-1506, Idaho Code (Sexual abuse of a child under the age of sixteen);
Section 18-1506A, Idaho Code (Ritualized abuse of a child);
Section 18-1506B, Idaho Code (Female genital mutilation of a child);
Section 18-1506C, Idaho Code (Vulnerable child protection);
Section 18-1507, Idaho Code (Sexual exploitation of a child);
Section 18-1508, Idaho Code (Lewd conduct with a child under the age of sixteen);
Section 18-1508A, Idaho Code (Sexual battery of a minor child sixteen or seventeen years of age);
Section 18-4001, Idaho Code (Murder);
Section 18-4006, Idaho Code (Felony manslaughter);
Section 18-4014, Idaho Code (Administering poison with intent to kill);
Section 18-4015, Idaho Code (Assault with intent to murder);
Section 18-4502, Idaho Code (First degree kidnapping);
Section 18-5001, Idaho Code (Mayhem);
Section 18-5501, Idaho Code (Poisoning food, medicine or wells);
Section 18-6101, Idaho Code (Rape);
Section 18-6501, Idaho Code (Robbery).

(3) Notwithstanding the provisions of section 18-306(4) and (5), Idaho Code, the fine created under this section may also be imposed up to five thousand dollars ($5,000) for attempts of the felonies described in:
Section 18-4001, Idaho Code (Murder);
Section 18-6101, Idaho Code (Rape).

SECTION 3. This act shall be in full force and effect on and after January 1, 2024.

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IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

PAM POE, *by and through her parents and next friends, Penny and Peter Poe*; **PENNY POE**; **PETER POE**, *et al.*,

v.

Plaintiffs,

RAÚL LABRADOR, *in his official capacity as Attorney General of Idaho, et al.*,

Defendants.

Case No. 1:23-cv-00269-CWD

DECLARATION OF PAM POE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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DECLARATION OF PAM POE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Pam Poe, hereby declare as follows:

1. I am a fifteen-year-old transgender girl, living with my mom, dad, and sibling in Meridian, Idaho. I am a Plaintiff in this lawsuit and call myself "Pam Poe." Our counsel have explained to me and my family what a preliminary injunction is, and we eagerly join the other Plaintiffs in seeking an injunction. Our lawyers have helped me prepare this Declaration, but the story below is mine. I have personal knowledge of the facts I explain below, and I would testify to them if called as a witness.

2. I have lived in Meridian, Idaho my entire life. I will be a sophomore in high school beginning in August 2023. I am interested in engineering, programming, and math. During the summer, I have a part-time job. This year is my second year working there.

3. While I am a girl, I was designated male at birth. Growing up, I always felt different, like I was not really a boy, but I did not know how to describe those feelings. I also did not know how to describe the mental and emotional distress I began experiencing as I got older because I knew that my gender was wrong. I know that I am a girl, not a boy. I just want to live and be treated like any other girl.

4. Around the time I was in 7th grade, as I began to experience puberty, I noticed how heavily I was struggling with depression, anxiety, and thoughts of self-harm. I started engaging in acts of self-injury. I did not really understand why exactly, but I was in a very dark place. During that time, there were times I felt like I did not want to exist anymore because I was so unhappy with what was happening to my body, feeling trapped and not like myself, and because people saw me as a boy and addressed me as one.

5. Eventually, these feelings became so overwhelming that I finally told my mom what I was feeling in August 2021.

6. I remember that moment clearly. We had a bunch of family over at the house, but I was feeling uncomfortable with myself, so I stayed in my room for most of the evening. As it got late that night, I realized that I could not wait any longer. I had to tell my mom my truth. I had been wanting to tell her for so long, but I was scared. I decided to text her and come out. I told her that I was non-binary (I was still exploring my gender identity and knew I was not a boy, but did not yet understand that I am a girl), that I wanted to be called "Pam," and that I wanted people to use different pronouns in referring to me. I was not sure how or if she was going to respond, because it was so late and she was entertaining family. But she did respond. She used my new name and told me that she loved me, and that we would talk about it in the morning, when things were quieter and we would have more privacy.

7. The next morning my mom came into my room. She sat by me on the floor and hugged me. She told me that she loved me. It was very emotional, but I was so happy that she accepted me. Because we still had family in town and some staying with us, we also talked about who knew, who did not know, and who we should avoid finding out for now. My mom was already trying to protect me, and that also made me feel very happy, safe, and loved.

8. I continued to try to understand my gender identity and who I am. Not long after coming out, I told my parents I was more comfortable with she/her pronouns. I knew I didn't feel like a boy and was coming to realize I didn't have to force a masculine presence on myself. I was still exploring whether nonbinary, transgender, or no gender felt like the right label for how I was feeling. I stopped trying to be the boy that society told me to be, and I focused on presenting my true self.

9. My parents found a counselor, who I started seeing weekly. He diagnosed me with depression. Even with counseling, I continued to struggle. Due to puberty, my body was still changing in ways that were making me feel miserable, because with every change, I became more and more physically a boy, and I just knew that was not who I was.

10. One day in early 2022, I sent my mom a text at 2am because I did not want to wake her, asking for admission to hospitalized care. I told her that I did not want to be alive anymore. It was hard to describe to her how I was feeling at the time. I decided that an inpatient stay at a residential treatment facility would help me and provide me with greater support. With my parents' support, I entered residential treatment at the end of February 2022 and stayed there for one week. During my time in inpatient treatment, I opened up more to one of the providers I was seeing about my gender identity and the distress, depression, and anxiety around my body. That provider diagnosed me with gender dysphoria, in addition to my depression and anxiety.

11. Before, when I thought about the possibility of being diagnosed with gender dysphoria, I had assumed it would be something negative and that I would feel shame about the diagnosis. However, when I received the diagnosis, I felt relief and validation. I felt like I had permission to stop fighting my identity and pretending to be someone I wasn't. My body and its developments were causing me severe dysphoria, because I was unable to be seen by others as a girl, or even a feminine human being

12. After I left the residential treatment facility, I was referred to a doctor who is an expert in treating gender dysphoria. Unfortunately, the next available appointment was not until a few weeks later, in May 2022.

13. At the appointment, my doctor evaluated me, talked with my parents and me about the possibility of me being treated with puberty blockers, and discussed with us the benefits of

treatment and the risks. I also had blood drawn to figure out where my body was, in terms of puberty. I remember leaving that first appointment with a huge smile and feeling just overwhelmed with relief . Learning that puberty blockers were possible and that they would stop the changes happening to my body took a huge weight off my shoulders and helped my mental health.

14. At my next visit with the doctor, after again discussing everything we discussed at the first meeting, my parents and I, along with the doctor, decided that puberty blockers were the right treatment for me. I began puberty blockers in June 2022. I just felt so happy and relieved because I knew that it was going to stop what was happening to me. My mental health started to improve and only continued to improve over the next few months.

15. A counselor had been recommended to us as someone with experience caring for people with gender dysphoria, and after several months on the waitlist, I began therapy with her in July 2022.

16. With my parents' support, I had begun socially transitioning after coming out to them. I started wearing more feminine clothing, wearing makeup, and dying my hair and growing it out. Making these changes made me feel more like myself. Seeing that that my family saw me, accepted me, and treated me as who I really am also made me feel more like myself.

17. Being able to be myself, because of the puberty blockers and socially transitioning, I became more confident. I was already out to my close friends and family, and I realized I was ready to reintroduce myself, my real self, to other people in my life. When I started high school in August 2022, I entered as a girl and have been treated as a girl since day one.

18. Socially transitioning helped me feel like I wasn't hiding when I was in public. I felt more confident that people were seeing *me*, not the masculine role I was assigned. It didn't alleviate all of my distress though. I still constantly worried about people seeing certain parts of

me that are not in line with my gender identity and expression. Puberty blockers paused more changes to my body that did not align with my gender identity, and I was still having a lot of gender dysphoria about the ways my body didn't align with my gender identity.

19. In April 2023, after being on puberty blockers for almost a year, my parents and I had a conversation with my doctor about starting estrogen therapy. My doctor performed more bloodwork, talked to us about the potential risks and benefits of estrogen therapy, discussed options for fertility preservation, and confirmed my ongoing therapy and mental health support. My parents and I, in talking with my doctor, decided that estrogen therapy was the best and appropriate treatment for my gender dysphoria. I started treatment and I have been on estrogen ever since. Just like with the puberty blockers, the estrogen therapy has made such a difference in my life. My mental health is the best it has ever been. I am feeling more confident, happy, and excited that I am developing as a girl.

20. Before I began gender-affirming medical treatment, I was in a very dark place. I struggled so hard, with anxiety, depression, hiding away by myself, thoughts of self-harm, and even harming myself to cope with it all. The changes because of male puberty were making me miserable and causing all of those bad symptoms. I could not see a future for myself and did not want to exist. Gender-affirming medical care saved my life. When I think back to that time, it makes me sad. I know it really scared my parents. It scared me too. I did not want to die, I just wanted to be myself, my true self. I am so glad that I told my parents about what I was struggling with. I wish I had told them sooner.

21. It is hard for me to find the words to explain the difference in my life now that I am receiving gender-affirming medical care and living as the girl that I know I am. I am happy and confident. I am excited about the future I see for myself.

22. That is also why I am incredibly anxious and scared about H.B. 71. My entire family is very scared. If H.B. 71 becomes law, I would have to stop receiving the medical treatment that has saved me. I have already lived through the extreme mental health symptoms of not receiving treatment and I never want to experience that again. I cannot go back to that.

23. If H.B. 71 becomes law, my parents have talked about moving out of Idaho when my sister graduates from high school next year. We also talked about traveling to get care, but that would be a significant financial burden for my family. If we move, I will leave the only home I have ever known, my close community of friends, and my healthcare providers, who I trust, who have supported me, and who have changed my life for the better. I do not want to leave. I want to stay in Idaho, in my home, and continue receiving the healthcare I need. Please, please do not let this law take effect.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Idaho, on this 18th day of July, 2023

Pam Poe

Pam Poe

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, *by and through her parents and next friends, Penny and Peter Poe*; **PENNY POE**; **PETER POE**, *et al.*,

v.

Plaintiffs,

RAÚL LABRADOR, *in his official capacity as Attorney General of Idaho, et al.*,

Defendants.

Case No. 1:23-cv-00269-CWD

DECLARATION OF PENNY POE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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DECLARATION OF PENNY POE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Penny Poe, hereby declare as follow:

1. I offer this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth herein, and could and would testify competently to these facts if called as a witness. I am a Plaintiff in this Action, and call myself "Penny Poe." I am the parent and next friend of my minor child, Pam Poe, who is also a Plaintiff. My husband, "Peter Poe," is the father of Pam Poe and is also a Plaintiff.

2. My husband and I reside in Meridian, Idaho, with our daughter Pam and her sibling. We have an adult daughter who also lives in Idaho. We are all lifelong Idahoans. We have lived in Meridian for the last fifteen years and before that, we resided in Boise.

3. I work as a data coordinator for an Idaho agency. My husband is employed in the operations division of a warehouse.

4. Our daughter, Pam Poe, is fifteen years old.

5. Pam is a girl.

6. Pam is transgender.

7. Pam first told me that she was transgender in August 2021. My husband and I were hosting family one evening at our home. I received a text from Pam telling me that she was nonbinary, that her name was now "Pam," and the pronouns she would like to use. I realized it was a big moment for her and that she likely had a lot of fear. I can admit that in the moment I felt overwhelmed when I first read the text. Having so many family members over and not being able to go and comfort Pam in the moment made it harder. I texted her back and told her that I loved her and that we would talk more in the morning. I eventually told my husband late in the evening about what Pam had texted me.

8. The next morning, after much of my family had left, I went to Pam's room. I sat next to her on the floor, gave her a big hug, and just told her repeatedly how much I loved her. I asked her who else she had told, who does not know, and who she wanted to avoid knowing at that time.

9. As parents, there was not a question in our minds about supporting our daughter, but when she first told me, I did not know anything about being nonbinary or transgender, or what it would look like to support her. I just knew I wanted the best for her, and I wanted her to be happy and healthy. It took me some time to learn through self-education. I also learned a lot from Pam and her healthcare providers, as we have embarked on this journey.

10. Although I sensed that telling me was a huge relief for Pam, I saw her struggling with her mental health in late 2021. She was depressed and anxious, but most concerning was that Pam was having thoughts of self-harm and was actually engaging in self-harm. I believe that this behavior was being driven by the overwhelming emotions that she had been and was continuing to deal with, including what we later learned was gender dysphoria. It scared us a lot, as a family. I never want to lose my daughter.

11. We quickly got her into weekly counseling, so that she would have a professional to talk to and another person to receive support from. Despite the counseling, Pam continued to have severe mental health issues and thoughts of self-harm, and she was engaging in self-injurious behavior. Thankfully, around the last week in February 2022, Pam was brave enough to come to me and tell me how severe her symptoms were and she said that she needed more support. As a family we decided that Pam would benefit from inpatient residential treatment. That way we would know she was safe, in the care of trained professionals around the clock, and she could get the care we all agreed she needed.

12. Pam spent one week at the inpatient residential treatment facility. She was diagnosed with gender dysphoria, depression, and anxiety by one of her treating providers at the facility.

13. My husband and I immediately started seeking out providers who had experience in treating gender dysphoria. It took longer than we would have liked because of waiting lists, but Pam was finally able to start seeing a doctor who specialized in treating gender dysphoria about two months later, around May 2022.

14. During the first visit, my husband and I were both there with Pam. We learned a lot during that appointment. Pam's doctor went through a long questionnaire with Pam. In evaluating Pam and discussing treatment options for gender dysphoria, he considered that she was already seeing a mental health professional, had already been diagnosed with gender dysphoria, and that we had received a referral for treatment following her time in inpatient residential treatment. He also drew blood to perform lab work to establish where Pam was in terms of her puberty. The doctor discussed the risks of puberty blocking medication, the expected results from treatment, and potential effects on Pam's fertility if she were to later receive estrogen therapy.

15. I will never forget the huge smile on Pam's face after we left that first appointment. She looked the happiest I had seen her in over a year. While it was still very early in the process, I had such a huge sense of relief. I knew we were on the right track. I was happy that we knew why Pam was experiencing the feelings she was, and that we had a doctor who could provide the treatment and support that she needed.

16. Pam's doctor prescribed puberty blockers and she began taking them in June 2022. Pam was 14 years old at the time. The change in Pam was almost overnight. Her mental health

improved significantly just knowing that the changes that were happening to her body, which had been causing her such severe distress, were no longer going to happen or progress.

17. For the next year, Pam was a different person. She started feeling more confident and happier without having to experience the distress that male puberty caused for her. We told more and more people that her name was now Pam and that she used female pronouns. She was herself, happy, and thriving. She saw her doctor regularly for check-ins and lab work, to monitor the effectiveness and dosage of the puberty blockers, and to make sure she was happy and otherwise healthy. When Pam started high school in August 2022, she went to school as Pam because it was important for her to start these next four years living authentically. Everything at school has been great for Pam regarding her being transgender. She was treated as the girl that she is from day one.

18. In April 2023, when Pam was 15 years old, we raised with her doctor the possibility of beginning estrogen therapy as the next step in treatment for her gender dysphoria. Again, after careful consideration, evaluation by her doctor, discussion with her doctor of the potential risks and benefits of estrogen therapy and fertility preservation, and talks as a family, Pam, her father and I, along with her doctor, agreed that estrogen therapy was an appropriate medical treatment for her gender dysphoria. We signed the informed consent paperwork and her doctor prescribed her estrogen therapy. She has now been on estrogen therapy since April 2023

19. Pam's mental health has continued to improve with treatment, as she continues to develop into the person she knows herself to be. As parents, my husband and I could honestly not be happier. We have our child back and she is flourishing. She is a wonderful, talented, and beautiful young woman, who we are so proud of.

20. Like any person these days who watches or reads the news, we started seeing the legislation banning gender-affirming medical care popping up all over the country. I do not think we ever thought it would come to Idaho. When the H.B. 71 legislation was introduced in the Idaho legislature, we were terrified. After everything that we had been through with Pam, including the fear of losing our daughter before we were able to get her the care that she needed, we just could not believe that Pam was now at risk of being taken off her medication. It was inconceivable that we, as her parents, and in consultation with her doctor, had no say in the decision.

21. Around the time H.B. 71 was being debated, my husband and I noticed that Pam's mental health seemed to be negatively impacted. When the legislation passed, Pam was visibly devastated. As were we. Gender-affirming medical care saved our daughter. Now, we live every day knowing that in a few short months, Pam may no longer be able to receive the care she needs anywhere in Idaho, our home.

22. The stress and fear have impacted our entire family. We are lifelong Idahoans. We never imagined a time when we would leave Idaho, and especially not during the middle of Pam's high school years. This is where our home is, our community, our lives, our family, our friends, our jobs, our children's schools, and their friends. We do not want to uproot our lives, but Pam's health, safety, and ability to access the healthcare she needs is and has to be a top priority. We are terrified of the potential consequences on Pam's health if her medical care is banned, because we do not even have to guess what will happen to her mental health and to her body, because we have been through it. The thought of my child going back to feeling like she does not want to live or wants to hurt herself is just something I cannot even think about.

23. My husband and I would never put her through that because we would be forcing her to live as someone she is not and placing her in danger because of the effects on her mental

health. We have explored the possibility of regularly traveling to another state for care, and the time, logistics, and costs would be very difficult for our family. If we had to move, it would mean giving up our jobs, our home, our financial security, disrupting our two youngest children's educations and lives, and leaving everything we have ever known behind. Both of these options would result in significant hardship on everyone in our family, but these are our only options if H.B. 71 goes into effect.

24. H.B. 71 will be devastating for our family. We ask the Court please not to let H.B. 71 take effect.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Idaho, on this 18th day of July, 2023.

Penny Poe

Penny Poe

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IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

PAM POE, *by and through her parents and next friends, Penny and Peter Poe*; **PENNY POE**; **PETER POE**, *et al.*,

v.

Plaintiffs,

RAÚL LABRADOR, *in his official capacity as Attorney General of Idaho*, *et al.*,

Defendants.

Case No. 1:23-cv-00269-CWD

DECLARATION OF JANE DOE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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DECLARATION OF JANE DOE IN SUPPORT OF
PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Jane Doe, hereby declare as follows:

1. I am a Plaintiff in this action, and refer to myself here as "Jane Doe." I make this Declaration in support of my and the other Plaintiffs' Motion for a Preliminary Injunction. My lawyers have helped me prepare this Declaration because I am not a lawyer and I have no experience with Declarations. The facts I describe below are about my own experience, however. I have personal knowledge of them, and would testify competently to them if called as a witness.

2. I am a sixteen-year old girl. I live with my mom, dad, and siblings in Boise, Idaho, where I have lived my entire life. This fall, I will be a high school senior. After high school, I plan to attend college. I am in interested in majors related to computer coding, cybersecurity, or videogame development.

3. I am transgender. I have a female gender identity, but I was designated as male at birth.

4. I have gender dysphoria, and was diagnosed with gender dysphoria by my doctor in November 2020.

5. For as long as I can remember, I knew that something felt off about my being a boy. I have always naturally related to other girls, felt the most like myself around other girls, and had similar interests as other girls. When I was younger, I did not have the words to express my feelings related to my gender identity or being transgender. But I knew it even before I knew the words for it.

6. In school, when we would be divided into girls' teams and boys' teams, I always wanted to be and felt like I belonged on the girls' team. When I would play "make believe" with my friends, I was always a girl character. When I would play video games, I would almost always

choose a girl avatar. My mom and dad have told me that when I was little and my mom was pregnant with my younger sibling, I would lay down and place a doll on my stomach and tell them that I wanted to be a mom.

7. While I always felt like I was not a boy, it was difficult and scary for me to address these feelings. That distress became severe with puberty. I now understand this to be gender dysphoria. But I never tried to tell my parents about my feelings when I was young, out of my own fear of rejection from friends and the community.

8. I did not meet a transgender person, or at least someone I knew was transgender, until I was about 10 years old and met a transgender woman who was friends with my parents. My parents explained to me that their friend was transgender, that she had been born a boy but was a woman on the inside, and was now living her life as a woman. It was like hearing them describe my own life to me. Before that, I did not know that transitioning was even possible. I was immediately excited about the possibility that I could do the same one day.

9. In 2018, my body started changing as I entered puberty. It became increasingly devastating to me, and my mental health began to deteriorate. The changes to my body made me look like a boy. I remember that I would often refuse to allow my photograph to be taken during that time because of the pain it caused me seeing myself as someone I was not. I could not hide all of the physical changes, and I would often self-isolate and avoid social settings. I wanted to be social, but the pain of being perceived as a boy and seeing myself with male features was too much to bear. I also began to suffer academically at school because I could not focus on my schoolwork due to the severe mental health issues my gender dysphoria was causing me. There were times that I simply just did not want to exist because the physical changes to my body were trapping me in an existence that was not me and caused me so much pain, on a constant basis.

10. In June 2020, my gender dysphoria had intensified so badly that I needed to tell someone. I told one friend in July and then a couple more in September. In late September 2020, I finally found the courage to tell my parents that I am transgender, that I am a girl, that I was suffering, and that I needed help. My parents did not hesitate. They told me they loved me, they would support me in anything, and they just wanted me to be happy and healthy.

11. With my parents' support, I began socially transitioning in October 2020. I began going by a female first name and using feminine pronouns. I wore a feminine hairstyle and I started wearing girls' clothes. I told my mom I wanted to wear makeup and, as part of all of the ways in which she supported me when I asked for her help, she taught me about makeup and how to apply it. All of this helped my gender dysphoria, but I was still experiencing male puberty, which was causing significant physical changes to my body that I could not hide or cover up with makeup or clothes. And I knew that some of these unwanted changes would be permanent. My gender dysphoria was still causing me significant pain.

12. In mid-October 2020, my parents and I had a visit with my pediatrician to discuss what I was experiencing. My pediatrician referred me to a doctor who specializes in the treatment of gender dysphoria. My parents also found a therapist for me.

13. We had our first visit with the doctor in November 2020. The doctor examined me, asked me about my experience regarding my gender over the years, took blood for tests, and talked to me about the options for treating gender dysphoria based on my age, the risks and benefits of treatment, and things we could do to preserve my ability to have children.

14. After several months of therapy, an additional visit with the doctor, and much discussion with my parents, we decided to start on puberty blockers. I began receiving that treatment in January 2021.

15. The puberty blockers stopped any new changes from happening to my body and prevented my gender dysphoria from getting worse. Knowing that further changes would not happen was a big relief to me and improved my mental health.

16. After a few successful months on puberty blockers, we began talking about starting gender-affirming estrogen therapy. I spoke to my parents about it and during one of our visits with my doctor, he talked to my parents and me about the risks and benefits of estrogen therapy and fertility preservation, and he drew more blood for tests. Eventually, my parents and I agreed that gender-affirming estrogen therapy was appropriate for me. The doctor agreed. In April 2021, at the age of 14, I began a low dose of gender-affirming estrogen therapy.

17. Since April 2021, I see my doctor regularly for lab work, so that he can make sure I remain healthy and so he can check my hormone levels and change my estrogen dosage if needed to remain in target ranges for my age.

18. Estrogen has been amazing. It has changed my body in more feminine ways that I am so happy with. Seeing these bodily changes has helped my gender dysphoria a lot, and I feel like my body more accurately reflects who I am.

19. With the help of my parents, I began legally transitioning in 2023. My parents and I first obtained a court-ordered name change in Idaho. We then had my Idaho birth certificate corrected with my new legal name and we corrected the gender marker, changing it from male to female. My parents also helped me update my information with the United States Social Security Office and helped me obtain a United States passport with my new legal name and a female gender marker.

20. My parents and I also spoke to the administrators at my school, who were great about everything. They readily corrected my name and gender marker in my digital school records,

so that my teachers and any substitute teachers would not use the wrong name for me or the wrong pronouns and gender. This is really important to me, and I am so glad that the administrators at my school are supportive of me.

21. Being able to medically transition and see myself, and be seen by others, as the girl I am absolutely saved my life. Before I told my parents I was transgender and about the feelings of my gender dysphoria, I was not me. I was isolating myself, depressed, anxious, and I felt trapped and scared almost daily. I could not see a future for myself and did not want to exist. I am so grateful that when I told my parents about what I was experiencing, they listened to me, trusted me, and took me to providers who could give me the gender-affirming health care that I needed to be who I am.

22. My whole life has turned around. I am confident in who I am. My academics have improved. My mental health has improved substantially. I no longer feel the need to isolate, and I can live my life more fully and authentically. I am excited about what comes next in my life and everything I hope to do in the future.

23. Now all of that is at risk because of H.B. 71 and I am really scared. My parents and siblings are scared, and the others who love and care about me are scared, too. The anxiety from H.B. 71 and the possibility of my healthcare being taken away and having to go back to life as it was before I began receiving gender-affirming medical care is very stressful and harmful to my mental health. It caused me to miss a lot of school while the law was being debated. As a result, my grades suffered last semester.

24. If H.B. 71 becomes law, I would no longer be able to receive the estrogen therapy that I have been on for over two years that treats my gender dysphoria. I fear what would happen

to my mental, emotional, and physical health if my medication is cut off because of H.B. 71 and I have to resume male puberty. I have already lived that pain.

25. My parents have talked to my siblings and me about trying to find care for me out of state or selling our house and leaving Idaho—the only home I've ever known—because of H.B. 71. I don't know if we can find care out of state or what it would look like to have to regularly travel for healthcare. Having to move would mean losing my friends, my family, my home, my community, my school, and everything that I have always known. It would mean the same for my parents and siblings. My oldest sibling is starting college in Idaho in the fall. I worry about what impact moving will have on him, his college plans, and our relationship. I do not want to move to a different state far away from him. I do not want any of this. I just want to stay in Idaho, my home, and continue receiving the healthcare I have been receiving that has made the life I am now living possible. But if H.B. 71 goes into effect, my family understands that this healthcare is so central to my wellbeing that we will likely have no other choice but to move out of Idaho.

26. I ask that the Court please help me. Please do not let my healthcare be taken away.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Idaho, on this 18th day of July, 2023

Jane Doe

Jane Doe

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, *by and through her parents and next friends, Penny and Peter Poe*; **PENNY POE**; **PETER POE**, *et al.*,

v.

Plaintiffs,

RAÚL LABRADOR, *in his official capacity as Attorney General of Idaho*, *et al.*,

Defendants.

Case No. 1:23-cv-00269-CWD

DECLARATION OF JOAN DOE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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DECLARATION OF JOAN DOE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Joan Doe, hereby declare as follow:

I offer this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I have personal knowledge of the facts set forth herein and could and would testify competently to these facts if called as a witness.

1. I am a Plaintiff in this action, and refer to myself here as "Joan Doe." I am the mother and next friend of Plaintiff Jane Doe, my minor child. Plaintiff John Doe is my husband, and Jane Doe's father. I make this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I am over the age of 18, of sound mind, and in all respects competent to testify. I have personal knowledge of the information contained in this Declaration and would testify completely to these facts if called to do so.

2. My husband and I, with our three children, have resided in Boise for seventeen years. I work part-time at an elementary school. My husband is an engineering director at a technology company.

3. Our daughter Jane Doe is sixteen years old, is a girl, and is transgender.

4. My husband and I love Jane unconditionally, exactly as we do our other two children. As parents, we have always done what we know and believe to be best for her, to ensure that she is happy and healthy. That is all we have ever wanted for all of our children.

5. Jane was assigned the sex male at birth, and we gave her a traditionally male name. Around September 2020, when she was 14 years old, Jane told my husband and me that she is transgender. She told us that she had known she was a girl for much longer, but that she had been afraid to tell us and unsure how to do so. But she told us that she could not put off telling us any

longer because she was in so much pain because of changes that were happening to her body. Like any mother whose child tells them that they are in pain, this broke my heart more than I could ever express. No mother ever wants their child to be in any kind of pain, let alone to struggle in silence.

6. My husband and I have friends who are transgender, and we felt we understood at some level what it means to be transgender and how difficult it can be in this world. And like any parents confronting something new with their child, we had concerns because we just did not know how to get Jane the right help. Our main concern was and continues to be Jane's health and happiness.

7. As a child, Jane had naturally gravitated towards things considered to be for little girls. For example, when Jane played video games, which she enjoys, she would always choose to be a female character. Jane would also often choose clothes in the girls' section of the store.

8. Before Jane told us she is transgender, I saw her struggle immensely with her mental health, especially as puberty started. At the time, I was not sure what was causing it, but I saw her withdrawing and closing off from her normal self. In retrospect, I realize this was stemming from her gender dysphoria.

9. After Jane told us what was going on and that she is transgender, we immediately wanted to educate ourselves and to get her help. We first took her to her long-time pediatrician. We explained to the pediatrician what Jane had told us, and Jane herself explained how she felt and what she was experiencing. While our pediatrician had no personal experience treating gender dysphoria, and therefore referred us to someone with expertise in the area, I will never forget what she said to Jane that day: "from the moment you were born my job has been to make sure you're healthy and happy, and this doesn't change anything." It meant so much to us that she knew instinctually to support us and to do so overtly.

10. With our pediatrician's help, we found a therapist with experience working with transgender patients and made appointments for Jane, and we found a doctor who had experience caring for youth with gender dysphoria. We reached out and set up an appointment.

11. While we waited for the appointment, Jane began to socially transition and we educated ourselves about that. She chose her new name, and she started styling her hair more femininely and wearing makeup.

12. We noticed some improvements in Jane's mental health and confidence, just from calling her by her chosen name and pronouns, supporting her in dressing and grooming herself how she wanted, and in finally being free to live as herself. But she remained distressed about the changes that puberty was bringing to her body.

13. When the time finally came for Jane's first appointment with the doctor in November 2020, she was very excited. During that appointment, several things happened. We provided Jane's past medical history, which was quite limited because she had never had any medical issues. The doctor evaluated her, asking her a lot of questions about her experiences, understanding of herself, and mental health history. Separately, he and I talked about what I had seen with regard to Jane's gender identity, experiences, and mental health. He also requested contact information for Jane's primary care doctor and therapist. Next, he went over the treatment options for gender dysphoria, such as puberty blockers, and later, potentially gender-affirming estrogen therapy. He explained what to expect regarding timelines, and risks associated with each type of treatment, and he also did bloodwork.

14. After the first appointment with her doctor, Jane continued seeing her therapist, which went really well. She also continued to see her doctor during this time so he could see how she was progressing in therapy, and to continue to discuss the potential risks and benefits of

treatment and to discuss fertility preservation options should she proceed with gender affirming medical care.

15. During this time, we also continued to discuss everything we were learning with Jane, privately as a family. Jane still struggled with the changes that were happening to her body as male puberty continued, and she was hopeful knowing that she had options and a competent doctor who could provide the care she needed. But she wanted the process to move faster.

16. In January, 2021, with the support of her therapist and doctor, as a family we decided that Jane would start puberty blockers. I know that this was a huge relief for Jane. Even though the effects were not immediate, just knowing that she was finally getting the care to stop the changes to her body that were causing her so much pain really impacted her mental health in a positive way. I was just so happy to see her happy and getting what she needed to be herself.

17. In April 2021, Jane was nearly 15 and there were no doubts about the stability of Jane's female gender identity, so in consultation with Jane's doctor and after again discussing what to expect from estrogen therapy, the potential risks and benefits, and fertility preservation options, we all agreed that it was appropriate for Jane to start estrogen therapy for the continued treatment of her gender dysphoria.

18. Jane remains on estrogen therapy for the treatment of her gender dysphoria, under the care and supervision of her doctor.

19. Gender-affirming medical care has changed Jane's life, and the life of our family, for the better. She has never been happier. She has never been more herself. As a parent, to see where she started, in so much pain, in comparison to where she is today, a vibrant, happy, outgoing, beautiful young woman, has been lifechanging for me and my family as well. Her mental health

has significantly improved. Her grades in school have improved. And this is all because she was able to access the healthcare that she needed.

20. As a family, when we first heard about H.B. 71, we were naturally concerned and confused. We have seen how beneficial gender affirming medical care had been for Jane.

21. Leading up to H.B. 71 being passed, my husband and I witnessed Jane's mental health begin to decline, out of anxiety about what was happening in the state legislature and out of fear of having to stop gender-affirming medical care. Her mental health deteriorated to a state that we had not seen since before she came out to us and began treatment. It terrified all of us. Jane's anxiety around potentially losing care intensified to such debilitating levels that her grades began to slip again. She started missing school because her anxiety was so bad that she could not get out of bed or leave her room. She was scared to go outside. I was heartbroken to see my child, this beautiful flower that had blossomed so much and was finally thriving, start to wither away.

22. On the day H.B. 71 passed into law, Jane was so emotionally devastated that my husband and I had to pick her up from school and bring her home for the day.

23. This is the medical care that we want for our child. This is the medical care for which we sought out experienced, competent providers for. My husband, Jane's siblings, and I, are all so scared about what will happen to Jane if she is forced to stop treatment. We do not know what to do. We have thought about trying to find care in another state, but do not know if we can make it work with out-of-state providers, insurance, time off for travel, and the additional financial burden. My husband and I are also seriously considering uprooting our lives and our

children's lives by leaving Idaho, so that Jane can continue to receive the gender-affirming medical care she needs.

24. We do not want to leave Idaho. Jane does not want to leave Idaho. Her siblings do not want to leave Idaho. They have lived here their entire lives. This is where we have built our lives, it is our community, it is where they go to school, and it is where our friends and family are. I love my job and care deeply about the students that I work with. The reality that I might have to quit my job because of H.B. 71 makes me incredibly sad.

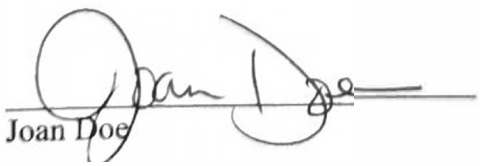
25. Our oldest child committed to attending Boise State University before any of this happened, because he wanted to remain close to us and we wanted to be close to him.

26. As each day passes, our fear grows and we are still grappling with what we must do if H.B. 71 goes into effect in a few months. Jane's health is our priority, and we know that we have done what is best for her. The fear and uncertainty is affecting all of us, and threatens to upend all of our lives. All that we want is for Jane to be able to continue receiving the care that we agree she needs, her providers agree that she needs, and that we have seen, firsthand, as necessary for our daughter to thrive.

27. But as parents who have seen what it means when their child is not receiving care, we understand how serious Jane's gender dysphoria is, and how harmful it would be if her treatment is cut off and all her progress is lost.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Idaho, on this 18th day of July, 2023.



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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, by and through her parents and next friends, Penny and Peter Poe; **PENNY POE**; **PETER POE**; **JANE DOE**, by and through her parents and next friends, Joan and John Doe; **JOAN DOE**; **JOHN DOE**,

Plaintiffs,

v.

RAÚL LABRADOR, in his official capacity as Attorney General of the State of Idaho; **JAN M. BENNETTS**, in her official capacity as County Prosecuting Attorney for Ada, Idaho; and the **INDIVIDUAL MEMBERS OF THE IDAHO CODE COMMISSION**, in their official capacities,

Defendants.

Case No. 1:23-cv-00269-CWD

EXPERT DECLARATION OF CHRISTINE BRADY, PhD

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Attorneys for Plaintiffs

I, Christine Brady, PhD, hereby declare and state as follows:

1. I am over 18 years of age and competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. The opinions expressed herein are my own and do not necessarily express the views or opinions of my employer.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinions.

4. In preparing this declaration, I reviewed Idaho State Legislature House Bill 71 (hereafter "Ban"). My opinions contained in this declaration are based on my training as a psychologist; my clinical experience as a pediatric psychologist, including my experience treating youth and young adults up to age 23 with gender dysphoria; my knowledge of peer reviewed research relevant to the treatment of gender dysphoria; my knowledge of the clinical best practice guidelines set forth by professional organizations for the treatment of gender dysphoria including the World Professional Association for Transgender Health ("WPATH") Standards of Care for the Health of Transgender and Gender Diverse People Version 8 ("SOC 8"), Endocrine Society's the Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline ("Endocrine Society Guideline"), and the American Psychological Association ("APA") Guidelines for Psychological Practice With Transgender and Gender Nonconforming People.

BACKGROUND AND QUALIFICATIONS

5. I am a Clinical Assistant Professor in the Department of Pediatric Endocrinology and Diabetes, and (by courtesy) Psychiatry and Behavioral Sciences at Stanford University School of Medicine. I am the full-time psychologist at the Pediatric and Adolescent Gender

Clinic at Stanford Medicine Children's Health. I provide direct therapeutic service to patients (average of 350 families per year), clinical supervision/training to the psychology graduate program and psychiatry fellowship program, and lectures on gender affirming care to psychology students, residents, and fellows and psychiatry fellows. I also conduct research on cultural considerations related to Asian American Native Hawaii Pacific Islander (AANHPI) gender diverse youth.

6. I received my Bachelor of Science and Master of Arts in Psychology from James Madison University, Harrisonburg, VA. I completed my Ph.D. in Clinical Psychology at Ohio University, Athens, OH in 2014. I completed a year-long Pre-Doctoral Internship at the University of Washington/Seattle Children's Hospital as well as a year-long Post-Doctoral Fellowship at the University of Louisville/Norton Children's Hospital.

7. In 2015, I co-founded and was Co-Director of the Gender Clinic at Hennepin Healthcare in Minneapolis, MN. After a year in Minnesota, I became Co-Director of the Pediatric Gender Clinic at the University of Louisville and was there for three years before coming to Stanford, where I have been working for almost three years. In the eight years I have been working with individuals with gender dysphoria, I have treated over 1,000 youth and families. Currently, 100 percent of my clinical practice are transgender youth. In previous positions, I provided therapy to a wide range of presenting problems including ADHD, depression, anxiety, trauma, and coping with medical illness such as cancer. Thus, I have extensive experience and strong therapeutic skills in working with patients with gender dysphoria as well as other common diagnoses in adolescents and young adults.

8. I am a licensed psychologist in the state of California.

9. I have been a member of WPATH since 2017.

10. Further information about my professional background and experience is outlined in my curriculum vitae, a true and accurate copy of which is attached as **Exhibit A** to this report.

11. I am being compensated at an hourly rate of $250 per hour for preparation of expert declarations and reports, and $400 per hour for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

EXPERT OPINIONS

A. Gender Identity

12. A person's sex is typically assigned at birth based upon the external genitalia observed. A person's assigned or designated sex may or may not align with their gender identity. Transgender or gender diverse individuals have a gender identity that does not align with their assigned sex. Cisgender individuals have a gender identity that does align with their assigned sex.

13. Gender identity is a person's core, internal sense of gender, such as male or female. Every person has a gender identity.

14. Gender identity is not a choice. It is an essential part of one's identity and being. Moreover, gender identity is not something that can be voluntarily changed.

15. Efforts to try to change a person's gender identity through therapy have been shown to be ineffective and harmful. For example, in a survey of transgender adults, those who reported receiving talk therapy aimed at changing their gender identity to match their sex assigned at birth (sometimes referred to as conversion therapy) indicated a lack of effectiveness

of that treatment, higher psychological distress, and increased odds of suicide attempts.[1] The survey found that conversion efforts in children under the age of 10 correlated with a 4-fold increase in attempted suicides.[2] Major U.S. professional medical organizations have therefore published statements warning against the dangers of conversion therapy and their recommendations that it should not be used with transgender individuals (e.g., American Psychological Association, American Medical Association, and American Academy of Child and Adolescent Psychiatry).[3]

B. Diagnosing Gender Dysphoria

16. Gender dysphoria is a clinical diagnosis given to an individual who is experiencing significant symptoms and impairment of function due to the incongruence between their assigned sex and their gender identity. Gender dysphoria (and past iterations of gender dysphoria) was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) in the 1980s (version 3). The diagnosis and its criteria have changed over time to reflect the most current research regarding the presentation of this diagnosis.

17. The current version of the DSM (DSM-5 published in 2013 and DSM-5-TR published in 2022) define gender dysphoria as a "marked difference between the individual's

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[1] Jack L. Turban et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, 77 JAMA PSYCHIATRY 68, 69 (2019).
[2] *Id*. at 68.
[3] AMERICAN PSYCHOLOGICAL ASSOCIATION, APA RESOLUTION ON GENDER IDENTITY CHANGE EFFORTS 1-2 (2021), https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf; AMERICAN MEDICAL ASSOCIATION & GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, SEXUAL ORIENTATION AND GENDER IDENTITY CHANGE EFFORTS (SO-CALLED "CONVERSION THERAPY") 4 (2022), https://www.ama-assn.org/system/files/conversion-therapy-issue-brief.pdf; American Academy of Child & Adolescent Psychiatry, *Conversion Therapy Policy Statement* (Feb. 2018), https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

expressed/experienced gender and the gender others would assign him or her." Symptoms must be present for at least six months, be verbalized externally, and be causing significant impairment in various domains of functioning such as peer relationships, school, or home life. There are different diagnostic criteria for children than there are for adolescents and adults.

18. For pre-pubertal children, DSM-5 diagnostic criteria are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or insistence that one is the other gender (or some alternative gender different from one's assigned gender).

2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire, or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

3. A strong preference for cross-gender roles in make-believe play or fantasy play.

4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

5. A strong preference for playmates of the other gender.

6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, game and activities.

7. A strong dislike of one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social circles, school, or other important areas of functioning.

19. For adolescents and adults, DSM-5 diagnostic criteria are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

20. For adolescents and adults whose gender identity differs from their sex assigned at birth, it is very unlikely that they will later come to identify with their birth-assigned sex. In my experience with over 900 transgender adolescent patients who met the criteria for gender dysphoria, only 6 have later come to identify with their sex assigned at birth (4 had not engaged in medical interventions; 2 had received puberty delaying medications, stopped those medications, and their endogenous puberty resumed; none expressed regret around their gender exploration or care).

21. There is some research on pre-pubertal children that has been described as showing high rates of "desistance" of transgender identity among pre-pubertal children.[4] Because that research included gender-non-conforming children who did not necessarily identify as a sex different than their birth-assigned sex, it can be misleading when used to talk about desistance of transgender identity. In other words, many of these youth did not identify as transgender, would not meet the criteria of gender dysphoria under the current DSM 5 standards, and would not be included in studies of transgender youth today. A more recent study of pre-pubertal transgender children who had socially transitioned (mean age of 8-years-old) reports 2.5% of participants identified with their designated sex at birth five years later (mean age of 13-years-old at follow-up).[5] Moreover, there is no evidence that transgender adolescents are likely to "desist" at high rates. One study found that only 3.5% of adolescents stopped taking puberty blockers because they no longer wished to have gender affirming treatment.[6]

22. Some patients with gender dysphoria may discontinue gender-affirming medical interventions for a variety of reasons, including having achieved their transition goals (e.g., voice deepening, facial hair growth), barriers to accessing care such as lack of insurance, or family or social pressure. Discontinuing care should not be interpreted to mean that the patient has "detransitioned" in the sense of coming to identify with one's birth-assigned sex[7] and there are

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[4] *See, e.g.*, Madeleine S.C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual Outcome of Gender-Dysphoric Children*, 47 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1413, 1413-23 (2008) (investigating which childhood measures of gender behavior related to "desistance").
[5] Kristina R. Olson et. al., *Gender Identity 5 Years After Social Transition*, 150 PEDIATRICS 1, 3 (2022).
[6] Tessa Brik et al., *Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*, 49 ARCHIVES SEXUAL BEHAV. 2611, 2615 (2020).
[7] Jack L. Turban et al., *Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis*, 8 LGBT HEALTH 273, 273-80 (2021).

no studies that have found that such an experience is common among those who receive gender affirming medical care.

C. The Treatment of Gender Dysphoria

23. Being transgender or gender diverse alone is not pathological; a person's gender identity is not a medical condition or the target of treatment. DSM-5 states that treatments for the diagnosis of gender dysphoria should be focused on alleviating the distress/impairment of function stemming from the incongruence between the patient's gender identity and birth-assigned sex, not trying to change the patient's gender identity.

24. Gender dysphoria can be debilitating and cause significant impairment in function. It is well recognized that transgender adolescents and young adults are a vulnerable population at higher risk for depression/anxiety, suicidal ideation and suicide attempts. The Youth Risk and Behavior Survey (YRBS) is an ongoing study conducted by the Center for Disease Control that obtains data on variables relevant to adolescents in the United States. Data from states that ask about and can analyze variables related to gender identity found that adolescents who are gender diverse, when compared to cisgender peers, had higher rates of consideration of suicide (45% vs 10-20%) and attempted suicide (35% vs. less than 10%).[8]

25. Without treatment, adolescents and young adults with gender dysphoria can experience symptoms that make very basic tasks feel impossible such as showering, eating, attending school, or socializing. Clinically, many of my patients report not participating in class due to discomfort with their voice, avoiding the use of bathrooms throughout the school day,

[8] Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students–19 States and Large Urban School Districts, 2017*, MORBIDITY & MORTALITY WKLY. REP., Jan. 25, 2019, at 67, 69.

avoiding physical activity due to body discomfort, as well as discomfort leaving the house in general. Delays in treatment can exacerbate symptoms, creating more impairment and psychological distress. A recent study of adults showed that longer wait times to establish care at a gender clinic resulted in low mood, worsening suicidal ideation and poorer quality of life.[9]

26. The World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People are the most widely adopted clinical practice guidelines for the treatment of transgender and gender diverse individuals. The Standards of Care (SOC) were first published in 1979 and the most recent iteration (SOC 8) was published in 2022.[10] Per the methodology described by WPATH "SOC-8 is based on the best available science and expert professional consensus in transgender health. International professionals and stakeholders were selected to serve on the SOC-8 committee. Recommendation statements were developed based on data derived from independent systematic literature reviews, where available, background reviews and expert opinions."[11] SOC 8 provides detailed guidance for evaluation of gender dysphoria and criteria for medical intervention, as well as procedures for hormone treatment and surgery when indicated.[12]

27. The Endocrine Society has also published a widely adopted clinical practice guideline for the treatment of gender dysphoria (Endocrine Society Guideline) to help guide

[9] N. Henderson et al., *The Impact of Gender Identity Clinic Waiting Times on the Mental Health of Transitioning Individuals*, 65 EUR. PSYCHIATRY S851 (2022)
[10] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH S1 (2022).
[11] *Id.* at S3.
[12] *Id.*

providers working with gender diverse adolescents and adults.[13] The SOC 8 and Endocrine Society Guideline have a high degree of overlap and consensus regarding best practices.

28. The American Psychological Association (APA) also released guidelines specific to the provision of mental health care to gender diverse individuals.[14] The APA defines gender affirming care to be "care that is respectful, aware, and supportive of the identities and life experiences of [transgender and gender non-conforming] people."[15] Gender affirming care is creating a safe, therapeutic space where individuals can grow, evolve and understand themselves more completely, wherever their path may lead.

29. As stated above, these guidelines are widely accepted in the professional community. They have analyzed all available scientific research, and are widely referenced and endorsed by all major U.S. medical and mental health associations.

30. The SOC 8 and Endocrine Society Guideline described above emphasize the importance of mental health assessments and evaluations in the treatment of gender diverse adolescents. Beyond assessing eligibility criteria for medical interventions (puberty-delay, hormones, or surgery), which will be discussed below, mental health providers can facilitate exploration and deepen understanding of an individual's gender, help manage anxiety/depression or other mental health diagnoses related to gender dysphoria, provide support related to social transition (e.g. dressing and using names and pronouns that accord with one's gender identity), provide education to caregivers to increase support and positive communication, and enhance

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[13] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (2017).
[14] American Psychological Association, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, AM. PSYCH. 832 (2015).
[15] *Id.* at 832-33.

coping skills to manage discrimination/minority stress. For some, non-medical interventions such as social transition, creating gender congruent expression, and getting social support of their identity is sufficient to manage gender dysphoria. For many others, medical intervention is clinically indicated.

31. Under the WPATH SOC 8 and the Endocrine Society Guideline, no medical interventions are recommended or indicated for the treatment of gender dysphoria prior to the onset of puberty (otherwise referred to as Tanner Stage 2). Prior to Tanner Stage 2, the recommended care is to help youth in their gender exploration, and provide support to youth and families as described above.

32. Once puberty begins, many adolescents with gender dysphoria will experience great distress related to the changes in their bodies that do not match their gender identity. For some of these youth, medical interventions may be deemed necessary. They may include puberty blockers (GnRH agonists) to pause puberty, hormone therapy in accordance with one's gender identity (e.g. testosterone for transgender boys and estrogen and anti-androgens for transgender girls), and sometimes surgery. Pausing puberty with blockers can help prevent the distress associated with physical changes inconsistent with an adolescent's gender identity and also provide the adolescent more time to understand their gender identity before considering less reversible treatments. Hormone therapy and surgery can alleviate the distress of gender dysphoria by helping align the adolescent's body with their gender identity.

33. The WPATH SOC and the Endocrine Society Guideline outline criteria for eligibility for medical interventions for adolescents with gender dysphoria including a) significant duration of gender incongruity, b) the diagnostic criteria for gender dysphoria are met, c) the adolescent has the emotional and cognitive capacity to provide informed consent

regarding the treatment they are seeking; d) any other mental health conditions do not interfere with diagnostic clarity or ability to consent and e) the patient and their family is fully informed of potential risks and fertility preservation options.

34. To determine if the eligibility criteria are met and if medical interventions are appropriate for an adolescent patient, the SOC 8 and Endocrine Society Guideline recommend a comprehensive psychosocial assessment. Assessment procedures can vary based on the practice setting, discipline of the provider conducting the assessment, presence of neurodiversity, or other individual patient considerations/needs.

35. During the assessment, a thorough history and diagnosis of gender dysphoria (evolution of identity, onset of symptoms, types of symptoms experienced, disclosure of identity, impairment experienced) is obtained. It is important to understand fully how identity has developed over time and how their gender dysphoria manifests. Some patients who are evaluated do not meet the criteria for gender dysphoria (either due to symptom length or lack of symptoms), in which case a treatment plan may include non-medical support and intervention to address symptoms/distress.

36. Evaluation of co-occurring mental health disorders is also obtained. If other conditions are present, it is important to understand how/if other diagnoses are related to gender dysphoria and ensure that other mental health needs are getting adequate support and are addressed. Further assessment or testing may be needed to fully understand more complex presentations (e.g., challenging psychopathology, co-occurring neurodiversity) prior to initiating medical intervention. The presence of co-occurring disorders does not preclude eligibility for medical intervention. Gender dysphoria can contribute to symptoms of depression, anxiety, eating disorder, etc., thus we often cannot expect symptoms to improve or be in remission until

the gender dysphoria is treated. Any co-occurring mental health issue should be managed enough so that it is not interfering in the diagnostic picture or impairing one's judgment or ability to make informed decisions. In some cases, further testing or therapy may be needed to address this criterion prior to recommending medical intervention.

37. The assessment should also include an evaluation of an adolescent's ability to understand the potential risks, benefits, and long-term consequences of treatment. Treatment options should be discussed thoroughly, including changes (both reversible and permanent), timeline for when changes occur, realistic expectations of physical changes, medical risks and side effects, and potential implications for fertility and fertility preservation options. As with all medicine, information should be presented in a developmentally appropriate manner to both the adolescent and caregivers. Information should be presented using the current evidence available. Once an adolescent has been provided all the information necessary to make an informed choice, if they want to proceed with the treatment, they must provide assent and their parent or guardian must provide consent.

D. Efficacy of Medical Treatment for Gender Dysphoria

38. In the years that I have been seeing patients with gender dysphoria, I have clinically seen the life-changing—and sometimes life-saving—benefits of gender-affirming medical interventions. Not only do I see improvements in depression, anxiety, and suicidal ideation, but I have seen significant improvements in overall daily functioning in adolescents after receiving gender-affirming medical care. Adolescents who were previously too anxious to attend school in person are now going to school and thriving academically. They are now able to make friends, date, and work, and do so with confidence. Caregivers have often commented on

the weight that has been lifted from their child or how happy they are to see their child thriving again.

39. Research conducted in this area echoes what I have seen clinically. A substantial body of evidence shows the efficacy of gender affirming medical care. Studies have demonstrated improvements in mental health following gender-affirming medical interventions.[16] Many of these studies demonstrate improvement in depression and anxiety symptoms, quality of life indicators, as well as reductions in suicidal ideation and attempts.

40. Moreover, as I have seen in my experience as a clinician the use of hormone blockers and cross-sex hormone therapy during adolescence can prevent the need for future medical treatments (such as surgeries to remove or alter secondary sex characteristics) and allow for more favorable future outcomes. This, in turn, reduces the gender dysphoria associated with one's body failing to align with one's gender identity.

41. There are no scientific studies demonstrating that non-medical treatments alone (such as therapy only) are effective in the treatment of gender dysphoria.

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[16] *See e.g.*, Diane Chen et al., *Psychological Functioning in Transgender Youth After 2 Years of Hormones*, 388 NEW ENG. J. MED. 240, 245-247 (2023) (demonstrating increased mental health benefits from gender affirming care for transgender people); Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643, 647-48 (2022) (same); Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 PEDIATRICS 1, 3 (2020) (same); Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8 J. SEXUAL MED. 2276, 2281-90 (2011) (same); Rosalia Costa et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12 J. SEXUAL MED. 2206, 2212-13 (2015) (same); Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 PEDIATRICS 696, 701-03 (2014) (same).

E. Harm to Transgender Youth if Care is Restricted

42. Withholding or discontinuing widely accepted, effective medical care from adolescents with gender dysphoria will cause serious harm. Having seen the significant distress and limitations on function experienced by adolescent patients with gender dysphoria, and the transformative effects of gender affirming medical treatments, the thought of withholding this care from those who need it is deeply concerning. Doing so will predictably result in adolescents unnecessarily suffering distress, withdrawing from life activities and, for some, hurting themselves. It will deny many adolescents with gender dysphoria the opportunity to be healthy and thrive. In a large survey of transgender adolescents and young adults, those who had access to medical interventions reported lower depression and suicidal ideation compared to adolescents and young adults who sought medical interventions but were not receiving them.[17] Restricting access will increase depression and suicidal ideation within an already vulnerable population.

43. For youth entering puberty, access to puberty blockers prior to the onset of irreversible secondary sex characteristics (e.g., deep voice, chest development) bypasses much of the dysphoria, distress and psychological harm that going through misaligned puberty can cause, as well as prevent more invasive and costly procedures in adolescence and adulthood such as surgery.

44. Clinically, I have had cases where patients are not able to receive gender affirming medical care for various reasons and are forced to wait until they turn 18. While waiting, there is often increased psychological distress impairing their daily life and functioning. For example, individuals may become so dysphoric with their bodies that they are not able to

[17] Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643, 647-48 (2022).

leave the house to attend school, participate in extra-curricular activities, or continue working or obtain employment. Those who are forced to wait can decompensate. I have had several cases where depression related to gender dysphoria increased to such a degree that inpatient hospitalization was needed for stabilization following significant self-harm, suicidal ideation or a suicide attempt. In some cases, adolescent patients become desperate and have explored or obtained hormones online or from other countries. Doing so without appropriate dosing and monitoring places them at risk for physical harm.

45. Our clinic has recently had around ten families come to us from other states where bans on gender-affirming medical care for minors have been enacted. With some families, they come to us every 3-6 months for follow-up. This places significant financial strain on families as well as disrupts daily life every 3-6 months. Some families have made the difficult decision to move to California, leaving a state that they loved and leaving their support systems behind in order to care for their child.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: 7/19/2023

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION

PAM POE, by and through her parents and next friends, Penny and Peter Poe; **PENNY POE**; **PETER POE**; **JANE DOE**, by and through her parents and next friends, Joan and John Doe; **JOAN DOE**; **JOHN DOE**,

Plaintiffs,

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RAÚL LABRADOR, in his official capacity as Attorney General of the State of Idaho; **JAN M. BENNETTS**, in her official capacity as County Prosecuting Attorney for Ada, Idaho; and the **INDIVIDUAL MEMBERS OF THE IDAHO CODE COMMISSION**, in their official capacities,

Defendants.

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EXPERT DECLARATION OF KARA CONNELLY, MD

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Attorneys for Plaintiffs

I, Kara Connelly, MD, hereby declare and state as follows:

1. I am over 18 years of age and competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinions.

4. In preparing this declaration, I reviewed Idaho State Legislature House Bill 71 (hereinafter, "Ban"). My opinions contained in this declaration are based on my training as a pediatric endocrinologist; my clinical experience as a pediatric endocrinologist, including my experience treating youth and young adults with hormonal therapies for a variety of conditions, including gender dysphoria; my knowledge of peer-reviewed research relevant to the treatment of gender dysphoria and other medical conditions for which hormonal therapies are provided; and my knowledge of the clinical practice guidelines for the treatment of gender dysphoria set forth by professional organizations including the World Professional Association for Transgender Health ("WPATH") and the Endocrine Society, as well as clinical practice guidelines for the treatment of a wide range of conditions within the field of endocrinology.

5. I am being compensated at a rate of $350 per hour for the time I spend on this case. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

6. In the past four years, I have not given expert testimony at trial or deposition in any cases.

I. BACKGROUND AND QUALIFICATIONS

7. I received my medical doctor degree from the University of Texas Health Science Center at San Antonio in 2007. I completed my residency in pediatrics and fellowship in pediatric endocrinology at Oregon Health and Science University ("OHSU").

8. Since completing my fellowship in 2013, I have been a pediatric endocrinologist at OHSU, holding faculty appointments in the Division of Pediatric Endocrinology in the Department of Pediatrics (I am currently an Associate Professor of Pediatrics) and serving as an attending physician in Doernbecher Children's Hospital at OHSU. I am currently the medical director of the Doernbecher Gender Clinic and co-founder of the Doernbecher Sexual Development Program.

9. I have extensive experience treating a variety of endocrine conditions in children and adolescents and special expertise in treating youth with differences in sex differentiation as well as youth with gender dysphoria. I have attended specialized training sessions on these topics and routinely review the literature to remain knowledgeable of and familiar with all emerging research.

10. I have been providing medical care for youth with gender dysphoria since 2014. In 2015, I founded the Doernbecher Gender Clinic, which has grown over the years to an interdisciplinary team providing comprehensive medical and mental health care for youth with gender dysphoria and their families. In 2022, our team cared for 993 youth and their families. I have personally delivered care to over 700 patients with gender dysphoria.

11. I have been providing medical care for children and adolescents with intersex traits since 2010. In 2016, I co-founded the Doernbecher Sexual Development program. I have personally cared for nearly 100 intersex youth through this program.

12. I have published research on a variety of pediatric endocrine issues, including the treatment of gender dysphoria, in peer-reviewed scholarly journals. I also serve as a reviewer for scholarly journals in my field.

13. I am an active member of the Oregon Pediatric Society, American Academy of Pediatrics, Pediatric Endocrine Society, World Professional Association of Transgender Health (WPATH), and the United States Association of Transgender Health. I've also served as a faculty member for WPATH's General Education Initiative and have been an invited speaker on gender-affirming care for the Pediatric Endocrine Society. I have given numerous lectures on the treatment of gender dysphoria and other endocrine issues at meetings of medical professional associations.

14. Further information about my professional background and experience is outlined in my curriculum vitae, a true and accurate copy of which is attached as **Exhibit A** to this declaration.

II. TREATMENT PROTOCOLS FOR GENDER DYSPHORIA

15. The Endocrine Society, in partnership with the Pediatric Endocrine Society, and WPATH have published clinical practice guidelines for the treatment of gender dysphoria that are based on systematic reviews of research and the expert opinions of clinicians in the field. The first version of the WPATH guidelines, known as the Standards of Care, was published in 1979, and the most recent version—version 8—was released in 2022.[1] The first clinical practice

[1] Coleman, E., et al. (2022). Standards of Care for Health of Transgender and Gender Diverse People, Version 8. *Int J Transgender Health*. 23:S1–S258. *Available at* https://doi.org/10.1080/26895269.2022.2100644 (hereinafter, "WPATH guideline").

guideline for the treatment of gender dysphoria issued by the Endocrine Society was published in 2009, and the most recent update was released in 2017.[2]

16. Like other clinical practice guidelines issued by the Endocrine Society and other professional medical organizations regarding the treatment of other medical conditions, the WPATH and Endocrine Society guidelines on the treatment of gender dysphoria provide recommendations to healthcare providers about how to approach treatment of a condition based on the best available evidence.

17. Under the WPATH and Endocrine Society guidelines, prior to onset of puberty, there are no medical interventions that are indicated or recommended for children with gender dysphoria.

18. For adolescents—youth who have started puberty—and adults, medical interventions may be appropriate to treat gender dysphoria depending on the patient's individual needs. These interventions may include medication to delay puberty, hormone therapy (e.g., testosterone for transgender boys and testosterone suppression and estrogen for transgender girls), and surgeries. These interventions are often collectively referred to as gender-affirming medical care.

19. The WPATH and Endocrine Society guidelines on the treatment of gender dysphoria are recognized as authoritative by the major medical and mental health professional organizations in the United States, including the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, the American Psychological Association, the American Academy of Child & Adolescent Psychiatry, the American Academy

[2] Hembree, W.C., et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *JCEM*. 102(11):3869–3903. *Available at* https://doi.org/10.1210/jc.2017-01658 (hereinafter, "Endocrine Society Guideline").

of Family Physicians, and the American College of Obstetricians and Gynecologists. These organizations all support the provision of gender-affirming medical care to adolescent patients with gender dysphoria when indicated.[3]

20. Gender-affirming medical care is provided to adolescents with gender dysphoria in many other countries. While some European national health authorities have issued guidelines recommending caution about providing such care, or providing that such care should occur in clinical research settings, care is provided when deemed appropriate for adolescents.

21. Gonadotropin releasing hormone agonists (GnRHa) can be used to suppress puberty and delay the development of secondary sex characteristics that are not in alignment with the individual's gender identity. These medications have been used successfully to delay pubertal changes in youth with central precocious puberty. If treatment is stopped, endogenous puberty resumes.

22. Under the Endocrine Society Guideline, adolescents with gender dysphoria may be eligible for pubertal suppression if they meet the following criteria:

1. A qualified mental health professional has confirmed that:
    a. the adolescent has demonstrated a long-standing pattern of gender nonconformity, gender incongruence or gender dysphoria (whether suppressed or expressed),
    b. gender dysphoria worsened with the onset of puberty,

[3] In contrast with the broad support of the medical community for gender-affirming medical care for adolescents with gender dysphoria, cosmetic genital surgeries on infants with intersex traits, which are permitted under the Ban, are highly controversial and many children's hospitals and major medical organizations such as the American Medical Academy have recommended that these surgeries be deferred until children are old enough to assent to these procedures. *See* Mulkey, N., Streed, C.G., & Chubak, B.M. (2021). A Call to Update Standard of Care for Children with Differences in Sex Development, AMA J Ethics. 23(7):E550–556.

c. any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,

d. the adolescent has sufficient emotional capacity and maturity to give informed consent to this (reversible) treatment,

2. And the adolescent:

a. has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,

b. has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment:

a. agrees with the indication for GnRH agonist treatment,

b. has confirmed that puberty has started in the adolescent, and

c. has confirmed that there are no medical contraindications to GnRH agonist treatment.[4]

[4] Endocrine Society Guideline at 3878.

23. Hormone therapy—testosterone for transgender males and estrogen and anti-androgens (to suppress testosterone) for transgender females—can be used to initiate puberty consistent with a patient's gender identity.

24. Under the Endocrine Society Guideline, adolescents may be eligible for gender-affirming hormone therapy if they meet the following criteria:

1. A qualified mental health professional has confirmed:
    a. the persistence of gender dysphoria,
    b. any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
    c. the adolescent has sufficient mental capacity to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
2. And the adolescent:
    a. has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
    b. has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:

a. agrees with the indication for sex hormone treatment, and

b. has confirmed that there are no medical contraindications to sex hormone treatment.[5]

25. The WPATH standards of care have similar recommendations concerning eligibility of adolescents for pubertal suppression and gender-affirming hormone therapy.

26. Surgical care for gender dysphoria is rarely provided to youth under 18. If surgical services are offered, they are almost always gender-affirming chest surgeries for youth assigned female at birth—also known as gender-affirming mastectomy.[6] Under the Endocrine Society Guideline, genital surgery is not recommended to patients under age 18. The WPATH standards of care do not provide an age delineation for vaginoplasty, but strongly caution about the need to ensure that the patient has the maturity to make this decision.

27. Both the WPATH and Endocrine Society guidelines emphasize the importance of a comprehensive mental health evaluation prior to the initiation of gender-affirming medical care for adolescents. This evaluation should include an assessment of the youth's gender identity development; the presence of any co-occurring mental health conditions and whether symptoms may interfere with diagnosis or functioning to the extent that decision-making is compromised; and emotional maturity and decision-making capacity.

28. Gender-affirming medical interventions are not indicated for all individuals who present for care. Overall, about one-third of our patient population continues to see our team for support without accessing medical interventions.

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[5] *Id.*

[6] Surgery is not offered before an individual has reached their final adult height, and only after other attempts to relieve dysphoria are pursued.

29. The WPATH and Endocrine Society guidelines also highlight the importance of informing the patient and their parents of the potential risks and benefits of treatment, including the potential risk to fertility and options for fertility preservation, and obtaining informed consent from the parents or legal guardians. The WPATH guideline also recommends that doctors inform families of the limitations of the research and the possibility that some patients will come to experience their gender differently.

III. GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS IS EFFECTIVE

30. Gender-affirming medical care has been provided to adolescents for decades, and clinicians have seen the significant benefits of such treatment to patients.

31. In our clinic, when adolescents present for care, they often present with high degrees of anxiety, depression, and suicidal ideation. Most of our patients also come in experiencing challenges with social isolation, school attendance, and lack of desire to engage in relationships with family and peers. Most of these mental health and social challenges are linked to gender dysphoria and experiences of minority stress. While the social and political environment may continue to negatively impact a patient's mental health, we see dramatic improvements in our patients after they begin gender-affirming medical care. Depression, anxiety, self-harm, and suicidal ideation are significantly reduced, based on the screening tools, PHQ-9 and GAD-7, which patients complete at every visit. Patients routinely comment about finally feeling like themselves and being able to engage with the rest of their world. Parents regularly tell our clinical team that gender-affirming medical care has resulted in great improvement in their children's psychological well-being, school performance, and relationships. As treatment helps address their gender dysphoria, our patients feel motivated to apply for

college, join the military, and pursue employment and creative outlets. Many become leaders in their schools and communities.

32. Research conducted by investigators in the United States and around the world has evaluated a variety of mental health outcomes for minors with gender dysphoria who have been treated with puberty blockers, hormone therapy, or both, and their findings are consistent with what we experience in clinic—that treatment is associated with improvement in mental health.[7]

33. Research also demonstrates the negative impacts of not receiving treatment, or having to delay treatment into adulthood. For example, a study of 20,619 transgender adults found that access to pubertal suppression during adolescence resulted in lower odds of lifetime suicidal ideation (Turban 2020). Another survey of 11,914 transgender and nonbinary youth demonstrated that individuals who had access to gender-affirming hormones had lower odds of depression and suicidality (Green 2022).

[7] *See, e.g.*, de Vries, A.L., et al. (2011). Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study. *J Sex Med*. 8(8):2276–2283; de Vries, A.L., et al. (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics*. 134(4):696–704; Turban, J., et al. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 145(2):e20191725; van der Miesen, A.I., et al. Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *J Adolesc Health*. 66(6):699–704; Achille, C., et al. (2020). Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Health and Well-Being of Transgender Youths: Preliminary Results. *Int J Pediatr Endocrinol*. 2020:8; Chen, D., et al. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England J Med*. 388:240–250; Allen, L.R., et al. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clin Pract Ped Psychol*. 7(3):302–311; de Lara, D.L., et al. (2020). Psychosocial Assessment in Transgender Adolescents. *Anales de Pediatría (Eng Ed)*. 93(1):41–48; Green, A.E., et al. (2022). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *J Adol Health*. 70(4):643–649.

34. Research also shows the benefit of access to care during adolescence as opposed to waiting until adulthood. A study of 27,715 transgender and nonbinary adults revealed lower lifetime odds of suicidality for those who were able to access gender-affirming care during adolescence compared to those who could not access care until adulthood.[8]

35. The findings of the research on adolescents who receive gender-affirming hormone therapy are consistent with findings of the body of research on treatment of adults. Numerous studies have found that hormone therapy is effective at alleviating gender dysphoria and improving mental health in adults.[9]

IV. GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS IS SAFE

36. Pubertal suppression with GnRHa medications, hormone therapy, and mastectomy are treatments that have been used for many years for a range of conditions in adolescents.

37. GnRHa medications have been used for 40 years to treat central precocious puberty (CPP), a condition that causes early pubertal development in children. The medications pause pubertal development until the child reaches the typical age for puberty, at which point the medication is stopped, endogenous hormone production resumes, and typical secondary sex characteristics develop. GnRHa medications are also used to treat endometriosis, uterine

[8] Turban, J.L., et al. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS ONE* 17(1):e0261039.

[9] *See, e.g.*, van Leerdam, T.R., Zajac, J.D., & Cheung, A.S. (2023). The Effect of Gender-Affirming Hormones on Gender Dysphoria, Quality of Life, and Psychological Functioning in Transgender Individuals: A Systematic Review, *Transgender Health*. 8(1); Colizzi, M., Costa, R., & Todarello., O. (2014). Transsexual patients' psychiatric comorbidity and positive effect of cross-sex hormonal treatment on mental health: results from a longitudinal study. *Psychoneuroendocrinology*. 39:65–73.

leiomyoma, ovarian cancer, fertility preservation in women with cancer, premenstrual syndrome, and as an adjunct to growth hormone therapy in youth with idiopathic short stature.

38. Some adolescents have medical conditions (i.e., ovarian failure, Turner syndrome, hypogonadotropic hypogonadism, Klinefelter syndrome, or constitutional delay of puberty) which require the use of sex steroid hormone therapy. Cisgender girls also utilize estrogen-containing medications to manage menstrual cycles and prevent pregnancy.

39. Cisgender girls with polycystic ovarian syndrome ("PCOS") utilize spironolactone—an anti-androgen medication—to manage the increased facial and body hair that is often associated with that condition.

40. Mastectomy is a commonly performed and widely accepted surgical procedure to treat gynecomastia in adolescent cisgender boys. Gynecomastia is enlargement of the breast tissue in cisgender boys or men.

41. In some cases, these medications or surgical treatments are aimed at bringing cisgender adolescent patients' bodies into alignment with their gender. For example, mastectomy is often provided to cisgender boys with gynecomastia to address the distress related to being a boy with breasts. And for some cisgender girls with PCOS, treatment with spironolactone addresses distress related to being a girl with facial hair.

42. Children and adolescents of all gender identities often need the assistance of medicine when their bodies start puberty too early, they are delayed in starting puberty or not able to start puberty at all, they experience the development of secondary sex characteristics that do not accord with their cisgender identity, or they start a puberty that causes secondary sex characteristics causing or exacerbating gender dysphoria.

43. GnRHa medications for pubertal suppression, testosterone, estrogen, and anti-androgens have all been demonstrated to be safe in clinical experience and research studies. The same is true of mastectomies.

44. There are risks and benefits to any medical treatment; gender-affirming medical treatments are not an exception.

45. The risks of puberty blockers are decreased bone density with prolonged use, sterile abscess at an injection site, and, very rarely, prolonged cardiac QT and increased intercranial hypertension. These risks are the same for youth receiving treatment for gender dysphoria as those being treated for central precocious puberty and other conditions.

46. Pubertal suppression does not result in any permanent changes to the body and has no permanent impact on fertility as a stand-alone medication.

47. Risks of estrogen therapy include blood clots, elevated blood pressure, diabetes, and migraine headaches. These risks are not higher than for the general population in the absence of individual or family history, or the use of nicotine. These risks exist whether the treatment is for transgender girls with gender dysphoria or for cisgender girls with ovarian failure, or any other hypogonadal condition.

48. Risks of testosterone therapy include increased red blood cells, liver inflammation (research studies show that risk of liver inflammation is very low), high cholesterol, high blood pressure, and heart disease, especially with a positive family history. These same risks exist whether the treatment is for transgender boys with gender dysphoria or for cisgender boys with testicular failure or any other hypogonadal condition.

49. For all of these medications, the risks are well-managed when care is provided and monitored by a healthcare provider. The risks become more significant when patients resort

to self-treatment. There are well-documented stories, including those we have witnessed in our own clinic, where adolescents were unable to access this care through a doctor and instead turned to black markets or took medications from friends/family to self-treat. Self-treatment can result in non-therapeutic hormone levels, which can negatively impact mood and increase several health risks, such as blood clots, cardiovascular problems, and liver and kidney dysfunction.

50. Gender-affirming hormone therapy may have an impact on future fertility potential,[10] although treatment can be tailored to minimize that risk if maintaining fertility is important to the family and there are options for fertility preservation. Impairment of fertility is not unique to gender-affirming hormone therapy. For example, treatments for some pediatric cancers cause likely loss of fertility. Some youth with intersex traits have their gonads surgically removed if they are at high risk of developing gonadal cancer.

51. As with all medical treatments, doctors are expected to fully inform patients and their parents, based on the available evidence, of the potential risks, benefits, and alternatives to treatment so that the families can weigh them and make an informed decision about whether to pursue treatment. The informed consent process is the hallmark of medical decision-making. Patients—and if minors, their parents—make the decision after being provided the information necessary to make an informed decision. The informed consent process for gender-affirming

[10] Many individuals assigned female at birth who take testosterone are able to achieve pregnancy or use assisted reproductive technology to conceive after discontinuing testosterone. *See, e.g.*, Light, A.D., et al. (2014). Transgender Men Who Experienced Pregnancy after Female to Male Gender Transitioning, *Obstetrics & Gynecology*, 124(6):1120–1127. In addition, testosterone is not an effective form of contraception and some transgender men have conceived while taking testosterone. *See, e.g.*, Thornton, K.G. & Mattatall, F. (2021). Pregnancy in transgender men. *CMAJ*. 193(33):E1303. Some transgender women may elect to use only anti-androgen medications without estrogen to preserve sperm production and fertility potential. Sperm production may resume in some transgender women. *See, e.g.*, Jiang, D.D., et al. (2019). Effects of Estrogen on Spermatogenesis in Transgender Women. *Urology*. 132:117–122.

medical care for minors is no different than how medical decision-making for minors occurs in other areas of medicine.

52. As discussed above, the WPATH and Endocrine Society guidelines offer recommendations about information that should be provided to families regarding gender-affirming medical care, including information about limitations in research—what is known and unknown; the potential impacts of some gender-affirming medical interventions on fertility; and the rare but potential possibility of returning to living consistently with their birth-assigned gender.[11]

53. Informed consent is a dynamic process; frequent assessment of the benefits of medications, and whether they continue to align with the individual's goals and outweigh risks, occurs in both medical and behavioral health follow-up visits.

54. There is nothing unique about gender-affirming medical care that warrants departing from the normal principles of medical decision-making for youth that parents make the decision after being informed of the risks, benefits, and alternatives by physicians.

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[11] Both clinical experience and research show that adolescents and adults who have received gender-affirming medical care rarely later come to identify with their sex assigned at birth and/or regret the care. For example, a prospective longitudinal study by de Vries, et al. found that none of the 55 adults who had initiated puberty blockers and hormones in adolescence reported regret with any of their treatment (de Vries 2014). Wiepjes, et al. (2018) found that 0.6% of transgender women and 0.3% of transgender men experienced regret (n=6793) related to gender-affirming medical interventions. Their study also noted that in many of those cases, the regret was "social regret"—regret related to rejection, loss of community, or threats of violence. *See* Wiepjes, C.M., et al. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets. *J Sexual Med*. 15(4):582–590. *See also* Brik, T., et al. (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. *Archives of Sexual Behavior*. 49(7):2611–2618 (finding that 3.5% of study cohort discontinued GnRHa and did not go on to hormone therapy because they no longer wished gender-affirming treatment); Wiepjes, et al. (2018) (finding 1.9% of cohort discontinued GnRHa but reasons not provided); Olson, K.R., et al. (2022). Gender Identity 5 Years After Social Transition. *Pediatrics*. 150(2) (2.5% of study cohort returned to cisgender identity by five years after their initial social transition).

V. THE EVIDENCE SUPPORTING GENDER-AFFIRMING CARE IS COMPARABLE TO EVIDENCE SUPPORTING MANY OTHER MEDICAL TREATMENTS

55. The studies on gender-affirming medical care for adolescents (and adults) use a variety of commonly used research methods including prospective observational and retrospective cross-sectional studies comparing individuals who receive treatment to those who do not, and longitudinal studies that follow individuals over a period of time. These research methods are widely used in the field of medicine to evaluate the efficacy of treatment.

56. While randomized controlled clinical trials ("RCTs") can provide especially strong evidence in medical research by limiting confounding variables, given that such studies require that outcomes of a particular treatment are compared to outcomes of patients not receiving the treatment, it is frequently not feasible or ethical to rely on RCTs. Thus, many medications used to treat medical conditions in both pediatrics and adults are used based only on observational and retrospective research studies—or clinical experience alone—without randomized controlled clinical trials. For example, insulin, the hormone discovered in the 1920s as a treatment for type 1 diabetes mellitus, was used successfully to prevent death in several patients with diabetic ketoacidosis. Based on the outcomes of these clinical experiences, insulin became widely accepted as the standard treatment for type 1 diabetes mellitus; a randomized controlled trial would have been unethical given the high rate of death associated with other earlier attempted treatments.[12] Because pubertal suppression and gender-affirming hormones to treat gender dysphoria are now widely accepted in the medical field based on decades of clinical experience and research studies demonstrating efficacy, denying this care for a population of youth to serve as the "control," or comparison, group for an RCT would be unethical.

[12] Rosenfeld, L. (2002). Insulin: discovery and controversy. *Clin Chem.* 48:2270–2288.

57. While the body of research on gender-affirming medical care for adolescents continues to grow, we presently have sufficient clinical and research evidence in both youth and adult populations that shows the risks and benefits of providing this care, in addition to the risks of not providing care. The evidence is comparable in quantity and quality to evidence we have in support of many other medical interventions.

58. Some who oppose gender-affirming medical care have asserted that this care is "experimental," suggesting this is an area of medicine where there is no clear understanding of the impact of an intervention. Here, we have decades of experience providing care and a growing body of research also supporting the efficacy and safety of this care, in addition to substantial evidence about the use of these medications in other areas of medicine.

59. Once the Food and Drug Administration ("FDA") has approved a medication as safe and effective for an indication, prescribers are generally free to prescribe it for other indications. The fact that the FDA has not approved puberty blockers, testosterone, or estrogen specifically for the treatment of gender dysphoria does not mean that the treatment is experimental or unproven. The use of medication for indications that have not received FDA approval—often called "off-label use"—is a widely accepted practice in medicine. This practice is legal, ethical, and common. The Agency for Healthcare Research and Quality estimates that one in five medications prescribed is prescribed off-label. Off-label use is even more common in pediatrics: 45% of pediatric outpatient prescriptions are off-label, and nearly 80% of hospitalized children receive at least one drug off-label.[13] Off-label use is so common because it is often not worth the cost to pharmaceutical companies to pursue approval for additional indications once a

[13] Antoon, J.W., et al. (2023). . Advancing pediatric medication safety using real-world data: Current problems and potential solutions. *J Hosp Med*. doi:10.1002/jhm.13068. Epub ahead of print. PMID: 36855275.

medication has been approved by the FDA. For example, Gabapentin has an FDA indication for treating seizures and fibromyalgia, but is often (more than 80% of the time) used off-label to treat bipolar disorder, subacute low back pain, neuropathy, as migraine prophylaxis, and for additional indications.[14] Some of the same medications used off-label in gender-affirming medical care are also widely used off-label for other purposes. Spironolactone, which was approved by the FDA for controlling blood pressure, is used in cisgender women and girls off-label to control side effects of PCOS. And GnRHa medications have been approved for the treatment of precocious puberty but not for many other indications for which they are commonly used, including ovarian cancer, premenstrual syndrome, fertility preservation in women and adolescent girls with cancer, and as an adjunct to growth hormone therapy in youth with idiopathic short stature.

VI. HARM TO ADOLESCENTS WITH GENDER DYSPHORIA AND THEIR FAMILIES IF THE BAN TAKES EFFECT

60. We know from clinical experience and research that delaying or denying patients gender-affirming medical care when needed comes with an increase in emotional harm. Social transition can offer many benefits, but social transition alone does not prevent an adolescent from experiencing the trauma of seeing their body change in ways that do not align with their gender identity. Additionally, many of these body changes would require major surgical interventions in the future to address, and some are not fully treatable by future medical intervention. For example, once vocal cords are exposed to testosterone, only vocal training can potentially shift the deepening of the voice, but this treatment has mixed success. Pubertal

[14] *See* Fukada C., et al. (2012). Prescribing gabapentin off label: perspectives from psychiatry, pain and neurology specialists. *Can Pharm J (Ott)*. 145:280–284.e1.

suppression prevents this psychological trauma and the need for more invasive medical interventions in the future.

61. As previously discussed, clinical experience and research have shown that gender-affirming medical care improves mental health outcomes; the converse is also true—that being unable to access care increases mental health distress. We see a marked difference in the social functioning, emotional wellness, and psychological stability of our patients after they are able to access pubertal suppression and hormone therapy when indicated.

62. Additionally, our older adolescent patients who have experienced at least some secondary sex characteristics not aligned with their identity report higher levels of depression and anxiety, lower participation in school, and less ability to engage in social relationships.

63. Adolescents in Idaho who are already receiving gender-affirming medical care will be forced to medically detransition by the Ban. Abruptly discontinuing hormone therapy can result in emotional instability and dysregulation as well as adverse medical outcomes such as profound fatigue, hot flashes, and difficulty concentrating.

64. If this Ban takes effect, patients who have had the benefit of pubertal suppression and/or hormone therapy will see their bodies change in ways that will cause profound distress. And for some, discontinuing care will not return their body to match their assigned sex but will leave them with a mix of typically male and female phenotype. Adolescents assigned male at birth who have been treated with pubertal suppression and estrogen will have had permanent breast development from the estrogen and suppression of testosterone. Once these medications are stopped, endogenous testosterone becomes the dominant hormone, leading to masculinizing physical changes. Patients assigned female at birth who have taken testosterone may have experienced permanent voice deepening, masculinized facial structure, and facial and body hair

growth. Discontinuing care would be followed by breast development and resumption of menses, which often cause significant distress.

65. Psychologically, adolescents who have been receiving care for years and have to discontinue treatment will see a return of, or dramatic increase in, distress related to gender dysphoria. Based on what we know about patients' experiences prior to receiving care, if care is cut off or denied, we will see increased rates of depression, anxiety, suicidal ideation, and hospitalizations for suicide attempts. We also will likely see the tragedy of lives ended by suicide.

66. Patients may be the most directly and seriously harmed by these care bans, but their families are also suffering. At our clinic in Oregon, we are already seeing the impact on families who have already or are planning to leave their states because of healthcare bans; there are also families deciding to attempt to seek care in states where the care is available. Our clinic has already received inquiries from Idaho families wanting to travel for care. We do not yet have a clear answer of whether or how we will have the capacity to be able to meet the care needs of these patients. Idaho parents and providers are calling in states of desperation and hopelessness, unable to confirm that they will have access to care in Oregon.

67. Parents are having to make the difficult decision to relocate the family so that their children can continue to access care. In some cases, it is more financially viable to relocate, rather than to regularly travel. In others, the families are afraid that traveling for care and bringing medications back to a state with a ban may put their providers or their family at risk. The need to relocate removes patients and families from their support systems at a time when direct emotional and material support is most needed. Financial resources are drained and family units are split up. For example, in one family from another state that we see in the clinic, one

parent was able to secure a job in Oregon, but the other parent has not yet and has stayed behind with the cisgender sibling. The family is paying for a mortgage, plus the cost of relocation and temporary housing. Another clinic family that came to Oregon from a state with a ban does not have the means to afford housing and is living in a camper van in a city where they are at risk of being ticketed and towed.

68. Parents of families from out of state are often in a state of grief, unable to believe that the state that they've called home, many for generations, is harming their children. The emotional and logistical burden for parents is high, and the areas that they are moving to do not have the infrastructure or resources to absorb the increasing demand and severity of mental health issues. Many existing clinics are challenged in getting patients in on a timeline that will not result in a gap in treatment. As parental stress increases, we've seen parental mental health declines and the overall health of the family system decrease.

69. Adolescents are painfully aware of the sacrifices their families are making to get them care and many see this as evidence that they are a burden; belief of the adolescent that they are a burden is an intrusive thought that drives suicidal ideation and attempts.[15]

70. We are seeing these scenarios unfold as families move to Oregon from Texas, Tennessee, Arkansas, Iowa, Florida, Alabama, and Idaho. Others are exploring traveling to Oregon for care. Our clinic wait-times continue to increase, which increases patient distress (for both existing Oregonians and those relocating to Oregon) and risk for psychological harm.

71. Idaho families that have reached out to our clinic are already suffering and feeling the impact of this Ban, even before it goes into effect. We are receiving an increasing number of

[15] *See, e.g.*, Chu, C., et al. (2017). The interpersonal theory of suicide: A systematic review and meta-analysis of a decade of cross-national research, *Psychol Bull*. 143(12):1313–1345.

calls and emails requesting care from families and providers in Idaho and other states who are desperate to continue the care their adolescents need. Providers are distraught because they will be forced to abandon their patients and/or force them to medically detransition, which directly violates their code of medical ethics—to do no harm.

72. It is often the most well-connected and resourced families that are able to relocate. If the Ban goes into effect, Idaho families will feel the pain more deeply and Idaho will continue to lose medical providers and other front-line healthcare staff, business owners, teachers, first responders, and individuals in the hospitality industry, to name a few of the occupations held by parents who are seeking to relocate.

73. For those families that are less resourced and unable to move or travel out of state for care, they will have to watch as their children are withdrawn from treatment that has enabled them to flourish and see them return to the suffering that brought them to care. We know that gender diverse people from communities of color and families living in poverty have significantly worse mental health outcomes than their white and financially resourced peers.[16]

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: _7/14/2023_

Kara Connelly MD

Kara Connelly, MD

[16] James, S.E., et al. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et al.,

Defendants.

Case No. 1:23-cv-00269-CWD

DECLARATION OF ARIELLA BAREL IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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I, Ariella Barel, declare under penalty of perjury of the laws of the United States of America that the following is true and correct, and state:

1. I am an attorney with the law firm Groombridge, Wu, Baughman and Stone LLP, counsel of record for Plaintiffs Pam Poe, Penny Poe, Peter Poe, Jane Doe, Joan Doe, and John Doe. I have been admitted *pro hac vice* in this Court for this action. I make the following statements of my own personal knowledge, and, if called as a witness, I would and could testify competently thereto.

2. Attached hereto as Exhibit A is a true and correct copy of Idaho House Bill 509 of the 65th Legislature, introduced during the Second Regular Session of 2020, as published on the Idaho Legislature's official website.

3. Attached hereto as Exhibit B is a true and correct copy of the engrossed version of Idaho House Bill 500 of the 65th Legislature, introduced during the Second Regular Session of 2020, as published on the Idaho Legislature's official website.

4. Attached hereto as Exhibit C is a true and correct copy of the engrossed version of Idaho Senate Bill 1100 of the 67th Legislature, introduced during the First Regular Session of 2023, as published on the Idaho Legislature's official website.

5. Attached hereto as Exhibit D is a true and correct copy of a Tweet from Tammy Nichols' official Twitter account, dated April 30, 2023.

6. Attached hereto as Exhibit E is a true and correct copy of a Tweet from Tammy Nichols' official Twitter account, dated April 28, 2023.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: July 21, 2023

Ariella Barel, Esq.

EXHIBIT A

LEGISLATURE OF THE STATE OF IDAHO
Sixty-fifth Legislature Second Regular Session - 2020

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 509

BY STATE AFFAIRS COMMITTEE

AN ACT

RELATING TO VITAL STATISTICS; AMENDING SECTION 39-240, IDAHO CODE, TO PROVIDE LEGISLATIVE FINDINGS AND TO MAKE A TECHNICAL CORRECTION; AMENDING CHAPTER 2, TITLE 39, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 39-245A, IDAHO CODE, TO ESTABLISH PROVISIONS REGARDING CERTAIN FACTS INCLUDED IN AND AMENDMENTS TO BIRTH CERTIFICATES; AND AMENDING CHAPTER 2, TITLE 39, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 39-279, IDAHO CODE, TO PROVIDE SEVERABILITY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 39-240, Idaho Code, be, and the same is hereby amended to read as follows:

39-240. SHORT TITLE -- LEGISLATIVE FINDINGS. (1) This act shall be known and may be cited as the "Idaho Vital Statistics Act."

(2) The legislature finds:

(a) As early as 1632, government officials began tracking vital statistics, specifically births, deaths, and marriages;

(b) Today, state and local vital records offices record over eleven million (11,000,000) vital events annually in the United States;

(c) Material facts included in vital records include the date of birth, the individual's sex, the location of birth, the parents' identities, and the date of death;

(d) The purpose of documenting factual information on vital records is to help the government fulfill one of its most basic duties: protecting the health and safety of its citizens;

(e) Numerous courts have recognized that the purpose of vital records is to maintain an accurate database of factual information regarding births, deaths, and other vital events in a given jurisdiction. See Sea v. U.S. Citizenship & Immigration Servs., 2015 WL 5092509, at *4 (D. Minn. Aug. 28, 2015) ("The public does have an interest in having accurate records on vital statistics…"); Ampadu v. U.S. Citizenship & Immigration Servs., Dist. Dir., 944 F. Supp. 2d 648, 655 (C.D. Ill. 2013) (acknowledging "the public's interest in having accurate records on vital statistics"); Boiko v. Holder, 2013 WL 709047, at *2 (D. Colo. Feb. 26, 2013) ("[T]he government, and the public at large, would appear to benefit from having the most accurate vital statistics records possible."); J.R. v. Utah, 261 F. Supp. 2d 1268, 1294 (D. Utah 2002) ("The State also has a significant interest in the accuracy of the records it keeps, particularly vital records like birth certificates.");

(f) According to the national research council committee on national statistics, factual information contained in vital records is used to help diagnose and solve problems that impact national health, including tracking and diagnosing disparities in mortality rates based on age and

sex, identifying factors that account for the significant differences in life expectancy between males and females, measuring and seeking solutions to socioeconomic inequalities in health based on sex and age, and studying infant death rates based on sex, location, birth weight, and other information collected from vital records;

(g) Factual information from vital records is also necessary for national security. It is used to identify potential disease epidemics, such as the zika virus, that may disproportionately impact one sex over the other; expose covert bioterrorist attacks, such as determining whether a sudden increase in certain symptoms in a population is due to random chance or should be further investigated; and identify criminals and terrorists, where vital records can be used to uncover fraudulently obtained driver's licenses or passports; and

(h) Allowing individuals to alter their vital records, including birth certificates, based upon subjective feelings or experiences undermines the government's interest in having accurate vital records.

SECTION 2. That Chapter 2, Title 39, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 39-245A, Idaho Code, and to read as follows:

39-245A. CERTIFICATES OF BIRTH -- MATERIAL FACTS INCLUDED -- AMENDMENTS.

(1)(a) The legislature finds that:

(i) There is a compelling interest in maintaining accurate, quantitative, biology-based material facts on Idaho certificates of birth that provide material facts fundamental to the performance of government functions that secure the public health and safety, including but not limited to identifying public health trends, assessing risks, conducting criminal investigations, and helping individuals determine their biological lineage, citizenship, or susceptibility to genetic disorders;

(ii) The equal protection clause of the fourteenth amendment to the United States constitution prohibits purposeful discrimination, not facially neutral laws of general applicability, such as a biology-based definition of sex that has been consistently applied since our nation's founding;

(iii) Decades of court opinion have upheld the argument that biological distinctions between male and female are a matter of scientific fact, and biological sex is an objectively defined category that has obvious, immutable, and distinguishable characteristics;

(iv) Identification of biological sex on a birth certificate impacts the health and safety of all individuals. For example, the society for evidence based gender medicine has declared that the conflation of sex and gender in health care is alarming, subjects hundreds of thousands of individuals to the risk of unintended medical harm, and will greatly impede medical research;

(v) Vital statistics are defined in section 39-241(21), Idaho Code, as data, being the plural of datum, which is a known fact;

(vi) Idaho certificates of birth are of an evidentiary character and prima facie evidence of the facts recited therein, according to section 39-274, Idaho Code;

(vii) Age and sex, unlike the names of natural parents whose rights have been terminated, are legally applicable facts fundamental to the performance of public and private policies and contracts;

(viii) The failure to maintain accurate, quantitative vital statistics and legal definitions upon which the government and others may with confidence rely constitutes a breach of the public trust; and

(ix) The government has a compelling interest in maintaining the public trust and confidence and a duty to fulfill, to the best of its ability, those functions that rely on accurate vital statistics.

(b) Based on the findings in paragraph (a) of this subsection, the legislature directs that an Idaho certificate of birth shall document specific quantitative, material facts at the time of birth, as provided in subsection (2) of this section.

(2) Any certificate of birth issued under the provisions of this chapter shall include the following quantitative statistics and material facts specific to that birth: time of birth, date of birth, sex, birth weight, birth length, and place of birth.

(3) For purposes of this chapter, "sex" means the immutable biological and physiological characteristics, specifically the chromosomes and internal and external reproductive anatomy, genetically determined at conception and generally recognizable at birth, that define an individual as male or female.

(4) The quantitative statistics and material facts identified in subsection (2) of this section may be amended within one (1) year of the filing of the certificate by submitting to the registrar a notarized affidavit of correction that:

(a) Is on a form prescribed by the registrar;

(b) Is signed by:

(i) The parents identified on the certificate of birth; or

(ii) The child's legal guardian;

(c) Is signed by the physician or other person in attendance who provided the medical information and certified to the facts of birth; and

(d) Declares that the information contained on the certificate of birth incorrectly represents a material fact at the time of birth.

After one (1) year, the quantitative statistics and material facts identified in subsection (2) of this section may be challenged in court only on the basis of fraud, duress, or material mistake of fact, with the burden of proof upon the party challenging the acknowledgment.

(5) In those instances in which an individual suffers from a physiological disorder of sexual development and the individual's biological sex cannot be recognized at birth as male or female based upon externally observable reproductive anatomy, the physician shall make a presumptive determination of the individual's sex, which may thereafter be amended based on the appropriate combination of genetic analysis and evaluation of the individual's

naturally occurring internal and external reproductive anatomy as provided in section (4) of this section.

(6) Notwithstanding any provision of this section to the contrary, a hospital may correct a birth certificate for a clerical or data entry error at any time by submitting a notarized affidavit on a form specified by the registrar with any appropriate supporting documentation.

SECTION 3. That Chapter 2, Title 39, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 39-279, Idaho Code, and to read as follows:

39-279. SEVERABILITY. The provisions of this chapter are hereby declared to be severable, and if any provision of this chapter or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this chapter.

EXHIBIT B

LEGISLATURE OF THE STATE OF IDAHO
Sixty-fifth Legislature Second Regular Session - 2020

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 500, As Amended in the Senate

BY EDUCATION COMMITTEE

AN ACT

RELATING TO THE FAIRNESS IN WOMEN'S SPORTS ACT; AMENDING TITLE 33, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 62, TITLE 33, IDAHO CODE, TO PROVIDE A SHORT TITLE, TO PROVIDE LEGISLATIVE FINDINGS AND PURPOSE, TO PROVIDE FOR THE DESIGNATION OF ATHLETIC TEAMS, TO PROVIDE PROTECTION FOR EDUCATIONAL INSTITUTIONS, TO PROVIDE FOR A CAUSE OF ACTION, AND TO PROVIDE SEVERABILITY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Title 33, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW CHAPTER, to be known and designated as Chapter 62, Title 33, Idaho Code, and to read as follows:

CHAPTER 62
FAIRNESS IN WOMEN'S SPORTS ACT

33-6201. SHORT TITLE. This chapter shall be known and may be cited as the "Fairness in Women's Sports Act."

33-6202. LEGISLATIVE FINDINGS AND PURPOSE. (1) The legislature finds that there are "inherent differences between men and women," and that these differences "remain cause for celebration, but not for denigration of the members of either sex or for artificial constraints on an individual's opportunity," United States v. Virginia, 518 U.S. 515, 533 (1996);

(2) These "inherent differences" range from chromosomal and hormonal differences to physiological differences;

(3) Men generally have "denser, stronger bones, tendons, and ligaments" and "larger hearts, greater lung volume per body mass, a higher red blood cell count, and higher haemoglobin," Neel Burton, The Battle of the Sexes, Psychology Today (July 2, 2012);

(4) Men also have higher natural levels of testosterone, which affects traits such as hemoglobin levels, body fat content, the storage and use of carbohydrates, and the development of type 2 muscle fibers, all of which result in men being able to generate higher speed and power during physical activity, Doriane Lambelet Coleman, Sex in Sport, 80 Law and Contemporary Problems 63, 74 (2017) (quoting Gina Kolata, Men, Women and Speed. 2 Words: Got Testosterone?, N.Y. Times (Aug. 21, 2008));

(5) The biological differences between females and males, especially as it relates to natural levels of testosterone, "explain the male and female secondary sex characteristics which develop during puberty and have lifelong effects, including those most important for success in sport: categorically different strength, speed, and endurance," Doriane Lambelet Coleman and Wickliffe Shreve, "Comparing Athletic Performances: The Best Elite Women to Boys and Men," Duke Law Center for Sports Law and Policy;

(6) While classifications based on sex are generally disfavored, the Supreme Court has recognized that "sex classifications may be used to compensate women for particular economic disabilities [they have] suffered, to promote equal employment opportunity, [and] to advance full development of the talent and capacities of our Nation's people," United States v. Virginia, 518 U.S. 515, 533 (1996);

(7) One place where sex classifications allow for the "full development of the talent and capacities of our Nation's people" is in the context of sports and athletics;

(8) Courts have recognized that the inherent, physiological differences between males and females result in different athletic capabilities. See e.g. Kleczek v. Rhode Island Interscholastic League, Inc., 612 A.2d 734, 738 (R.I. 1992) ("Because of innate physiological differences, boys and girls are not similarly situated as they enter athletic competition."); Petrie v. Ill. High Sch. Ass'n, 394 N.E.2d 855, 861 (Ill. App. Ct. 1979) (noting that "high school boys [generally possess physiological advantages over] their girl counterparts" and that those advantages give them an unfair lead over girls in some sports like "high school track");

(9) A recent study of female and male Olympic performances since 1983 found that, although athletes from both sexes improved over the time span, the "gender gap" between female and male performances remained stable. "These suggest that women's performances at the high level will never match those of men." Valerie Thibault et al., Women and men in sport performance: The gender gap has not evolved since 1983, 9 Journal of Sports Science and Medicine 214, 219 (2010);

(10) As Duke Law professor and All-American track athlete Doriane Coleman, tennis champion Martina Navratilova, and Olympic track gold medalist Sanya Richards-Ross recently wrote: "The evidence is unequivocal that starting in puberty, in every sport except sailing, shooting, and riding, there will always be significant numbers of boys and men who would beat the best girls and women in head-to-head competition. Claims to the contrary are simply a denial of science," Doriane Coleman, Martina Navratilova, et al., Pass the Equality Act, But Don't Abandon Title IX, Washington Post (Apr. 29, 2019);

(11) The benefits that natural testosterone provides to male athletes is not diminished through the use of puberty blockers and cross-sex hormones. A recent study on the impact of such treatments found that even "after 12 months of hormonal therapy," a man who identifies as a woman and is taking cross-sex hormones "had an absolute advantage" over female athletes and "will still likely have performance benefits" over women, Tommy Lundberg et al., "Muscle strength, size and composition following 12 months of gender-affirming treatment in transgender individuals: retained advantage for the transwomen," Karolinksa Institutet (Sept. 26, 2019); and

(12) Having separate sex-specific teams furthers efforts to promote sex equality. Sex-specific teams accomplish this by providing opportunities for female athletes to demonstrate their skill, strength, and athletic abilities while also providing them with opportunities to obtain recognition and accolades, college scholarships, and the numerous other long-term benefits that flow from success in athletic endeavors.

33-6203. DESIGNATION OF ATHLETIC TEAMS. (1) Interscholastic, intercollegiate, intramural, or club athletic teams or sports that are sponsored by a public primary or secondary school, a public institution of higher education, or any school or institution whose students or teams compete against a public school or institution of higher education shall be expressly designated as one (1) of the following based on biological sex:

(a) Males, men, or boys;

(b) Females, women, or girls; or

(c) Coed or mixed.

(2) Athletic teams or sports designated for females, women, or girls shall not be open to students of the male sex.

(3) A dispute regarding a student's sex shall be resolved by the school or institution by requesting that the student provide a health examination and consent form or other statement signed by the student's personal health care provider that shall verify the student's biological sex. The health care provider may verify the student's biological sex as part of a routine sports physical examination relying only on one (1) or more of the following: the student's reproductive anatomy, genetic makeup, or normal endogenously produced testosterone levels. The state board of education shall promulgate rules for schools and institutions to follow regarding the receipt and timely resolution of such disputes consistent with this subsection.

33-6204. PROTECTION FOR EDUCATIONAL INSTITUTIONS. A government entity, any licensing or accrediting organization, or any athletic association or organization shall not entertain a complaint, open an investigation, or take any other adverse action against a school or an institution of higher education for maintaining separate interscholastic, intercollegiate, intramural, or club athletic teams or sports for students of the female sex.

33-6205. CAUSE OF ACTION. (1) Any student who is deprived of an athletic opportunity or suffers any direct or indirect harm as a result of a violation of this chapter shall have a private cause of action for injunctive relief, damages, and any other relief available under law against the school or institution of higher education.

(2) Any student who is subject to retaliation or other adverse action by a school, institution of higher education, or athletic association or organization as a result of reporting a violation of this chapter to an employee or representative of the school, institution, or athletic association or organization, or to any state or federal agency with oversight of schools or institutions of higher education in the state, shall have a private cause of action for injunctive relief, damages, and any other relief available under law against the school, institution, or athletic association or organization.

(3) Any school or institution of higher education that suffers any direct or indirect harm as a result of a violation of this chapter shall have a private cause of action for injunctive relief, damages, and any other relief available under law against the government entity, licensing or accrediting organization, or athletic association or organization.

(4) All civil actions must be initiated within two (2) years after the harm occurred. Persons or organizations who prevail on a claim brought pur-

suant to this section shall be entitled to monetary damages, including for any psychological, emotional, and physical harm suffered, reasonable attorney's fees and costs, and any other appropriate relief.

33-6206. SEVERABILITY. The provisions of this chapter are hereby declared to be severable and if any provision of this chapter or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this chapter.

EXHIBIT C

LEGISLATURE OF THE STATE OF IDAHO
Sixty-seventh Legislature First Regular Session - 2023

IN THE SENATE

SENATE BILL NO. 1100, As Amended

BY EDUCATION COMMITTEE

AN ACT

RELATING TO PROTECTING THE PRIVACY AND SAFETY OF STUDENTS IN PUBLIC SCHOOLS; AMENDING TITLE 33, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 66, TITLE 33, IDAHO CODE, TO PROVIDE LEGISLATIVE FINDINGS, TO DEFINE TERMS, TO ESTABLISH PROVISIONS REGARDING SCHOOL RESTROOMS, TO PROVIDE EXEMPTIONS, TO PROVIDE FOR REASONABLE ACCOMMODATION IN CERTAIN INSTANCES, TO PROVIDE FOR A CIVIL CAUSE OF ACTION, AND TO PROVIDE FOR PREEMPTION; PROVIDING SEVERABILITY; AND DECLARING AN EMERGENCY AND PROVIDING AN EFFECTIVE DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Title 33, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW CHAPTER, to be known and designated as Chapter 66, Title 33, Idaho Code, and to read as follows:

CHAPTER 66
PROTECTING THE PRIVACY AND SAFETY OF STUDENTS IN PUBLIC SCHOOLS

33-6601. LEGISLATIVE FINDINGS. The legislature finds that:

(1) There are real and inherent physical differences between men and women;

(2) Every person has a natural right to privacy and safety in restrooms and changing facilities where such person might be in a partial or full state of undress in the presence of others;

(3) This natural right especially applies to students using public school restrooms and changing facilities where student privacy and safety is essential to providing a safe learning environment for all students;

(4) Requiring students to share restrooms and changing facilities with members of the opposite biological sex generates potential embarrassment, shame, and psychological injury to students, as well as increasing the likelihood of sexual assault, molestation, rape, voyeurism, and exhibitionism;

(5) Providing separate public school restrooms and changing facilities for the different biological sexes is a long-standing and widespread practice protected by federal law, state law, and case law;

(6) Federal legislative action, federal executive action, and federal court judgments that prevent public schools from maintaining separate restrooms and changing facilities for different biological sexes are inconsistent with the United States constitution and violate the privacy and safety rights of students; and

(7) A statewide policy ensuring separate school restrooms and changing facilities on the basis of biological sex is substantially related to the important governmental interest in protecting the privacy and safety of all students.

33-6602. DEFINITIONS. For the purposes of this chapter:

(1) "Changing facility" means a facility in which a person may be in a state of undress in the presence of others, including a locker room, changing room, or shower room.

(2) "Public school" means any public school teaching K-12 students within an Idaho school district or charter school.

(3) "Sex" means the immutable biological and physiological characteristics, specifically the chromosomes and internal and external reproductive anatomy, genetically determined at conception and generally recognizable at birth, that define an individual as male or female.

33-6603. SCHOOL RESTROOMS. (1) Every public school restroom or changing facility accessible by multiple persons at the same time must be:

(a) Designated for use by male persons only or female persons only; and

(b) Used only by members of that sex.

(2) No person shall enter a multi-occupancy restroom or changing facility that is designated for one sex unless such person is a member of that sex. The public school with authority over the building shall ensure that all restrooms and changing facilities provide its users with privacy from members of the opposite sex.

(3) In any other public school setting where a person may be in a state of undress in the presence of others, school personnel must provide separate and private areas designated for use by persons based on their sex, and no person may enter these private areas unless such person is a member of the designated sex.

(4) During any school authorized activity or event where persons share overnight lodging, school personnel must provide separate sleeping quarters for members of each sex. No person shall share sleeping quarters, a restroom, or a changing facility with a person of the opposite sex, unless the persons are members of the same family.

33-6604. EXEMPTIONS. This chapter shall not apply:

(1) To single-occupancy restrooms and changing facilities or restrooms and changing facilities that are conspicuously designated for unisex or family use;

(2) To restrooms and changing facilities that have been temporarily designated for use by that person's biological sex;

(3) To a person of one sex who uses a single-sex facility designated for the opposite sex, if such single-sex facility is the only facility reasonably available at the time of the person's use of the facility;

(4) To a person employed to clean, maintain, or inspect a restroom or single-sex facility;

(5) To a person who enters a restroom or facility to render medical assistance;

(6) To a person who is in need of assistance and, for the purposes of receiving that assistance, is accompanied by a family member, a legal guardian, or the person's designee who is a member of the designated sex for the single-sex restroom or changing facility;

(7) To coaching staff and personnel during athletic events; or

(8) During an ongoing natural disaster or emergency, or when necessary to prevent a serious threat to good order or student safety.

33-6605. REASONABLE ACCOMMODATION. (1) A public school shall provide a reasonable accommodation to a student who:

(a) For any reason, is unwilling or unable to use a multi-occupancy restroom or changing facility designated for the person's sex and located within a public school building, or multi-occupancy sleeping quarters while attending a public school-sponsored activity; and

(b) Provides a written request for reasonable accommodation to the public school.

(2) A reasonable accommodation does not include access to a restroom, changing facility, or sleeping quarter that is designated for use by members of the opposite sex while persons of the opposite sex are present or could be present.

33-6606. CIVIL CAUSE OF ACTION. (1) Any student who, while accessing a public school restroom, changing facility, or sleeping quarters designated for use by the student's sex, encounters a person of the opposite sex has a private cause of action against the school if:

(a) The school gave that person permission to use facilities of the opposite sex; or

(b) The school failed to take reasonable steps to prohibit that person from using facilities of the opposite sex.

(2) Any civil action arising under this chapter must be commenced within four (4) years after the cause of action has occurred.

(3) Any student who prevails in an action brought under this chapter may recover from the defendant public school five thousand dollars ($5,000) for each instance that the student encountered a person of the opposite sex while accessing a public school restroom, changing facility, or sleeping quarters designated for use by aggrieved student's sex. The student may also recover monetary damages from the defendant public school for all psychological, emotional, and physical harm suffered.

(4) Any student who prevails in action brought under this chapter is entitled to recover reasonable attorney's fees and costs from the defendant public school.

(5) Nothing in this chapter limits other remedies at law or equity available to the aggrieved student against the school.

33-6607. PREEMPTION. This chapter preempts any law, regulation, policy, or decree enacted or adopted by any city, county, municipality, or other political subdivision within the state that purports to permit or require public schools to allow persons to use facilities designated for the other sex.

SECTION 2. SEVERABILITY. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

SECTION 3. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after July 1, 2023.

EXHIBIT D

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Nichols For Idaho
@nicholsforidaho

Frankenstein procedures on children are barbaric and people who do this should go to jail.

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EXHIBIT E

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This is clearly an epidemic running in America because of a variety of reasons including indoctrination, social media, wokeism, mental health and more. States need to help stop the spread.
#stopthespread

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