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IN THE FOURTH JUDICIAL DISTRICT COURT
MISSOULA COUNTY

PHOEBE CROSS, a minor by and through his guardians Molly Cross and Paul Cross, et al. **Plaintiffs,** **v.** **STATE OF MONTANA et al.,** **Defendants.**	**Case No. DV-23-541** **Judge: Hon. Jason Marks** **PLAINTIFFS' BRIEF IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

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INTRODUCTION

Defendants' motion for summary judgment rests on a paradox: it relies on largely the same factual material and legal arguments that were presented in opposition to the preliminary injunction—and that this Court found inadequate—to argue that they now warrant a final ruling in Defendants' favor. That is a logical impossibility. This Court already found that Plaintiffs had shown a likelihood of success on the merits, and the Montana Supreme Court unequivocally upheld this Court's decision. Armed with nothing new, there is no universe in which Defendants can make the showing necessary to prevail on their motion. Indeed, Defendants do not even make a good-faith effort to overcome the Montana Supreme Court opinion. Instead, they mostly ignore it in favor of criticizing this Court's earlier reasoning, argue for the lowest level of review in contravention of the strict scrutiny required, and wholly fail to satisfy their burden of demonstrating that SB 99 is narrowly tailored under that demanding standard.

Defendants' motion for summary judgment is an attempt to distract the Court from the straightforward grounds for granting Plaintiffs' motion for summary judgment. While Defendants falsely present disputed facts as undisputed, and thus fail to satisfy their burden on summary judgment, Plaintiffs' motion shows that there *are* undisputed facts warranting summary judgment in Plaintiffs' favor. With respect to every single claim at issue in this litigation, SB 99 fails strict scrutiny if for no other reason than that it flunks the narrow tailoring requirement.

SB 99 imposes a complete ban on gender-affirming medical care for all minors under all circumstances, without exception. None of the justifications proffered in the law's defense can justify that sweeping scope. Under SB 99, it does not matter how many years such care has already benefited a particular minor since the start of their adolescence. It does not matter how much irreparable harm will be unleashed by the sudden development of sex characteristics in visible

opposition to the minor's gender—even if those changes previously drove the minor to the brink of death. It does not matter whether every other purported alternative to such care has been attempted but failed. It does not matter how carefully medical providers weighed risks against benefits for a particular minor, or how painstakingly the minor's parents deliberated before providing their informed consent. The State simply does not care about any of these individualized considerations, flouting the obligations of narrow tailoring many times over. That constitutional deficiency is further highlighted by the stark contrast between SB 99, which bans all care, and the State's right-to-try law, which embraces with open arms experimental treatment that has not been approved for any purpose and where the sky is the limit for unknown dangers. On the basis of the narrow tailoring requirement alone, Defendants' motion must be denied.

Defendants also cannot obtain summary judgment for additional reasons. With respect to the privacy claim, Defendants cannot "clearly" make the threshold showing of a medically acknowledged bona fide health risk required to justify SB 99. Pointing to mere disagreement with guidelines governing the treatment of gender dysphoria that have been endorsed by America's major medical organizations does not present that clarity. Plaintiffs' equal protection claim reinforces the point, because the State permits medical treatment for minors who are not transgender even where largely the same purported risks are presented in other contexts. Any one of Plaintiffs' claims presents a sufficient basis for this Court to deny Defendants' motion and to grant Plaintiffs' motion.

STANDARD

"Summary judgment is appropriate when the moving party demonstrates both the absence of any genuine issues of material fact and entitlement to judgment as a matter of law." *Planned Parenthood of Mont. v. State*, 2024 MT 178, ¶ 14, 417 Mont. 457, 554 P.3d 153, *appeal filed*, 24-745 (U.S. Jan. 14, 2025). While Montana courts

presume the constitutionality of statutes, "'legislation infringing [on fundamental constitutional rights] must be reviewed under a strict-scrutiny analysis,' which necessarily shifts the burden to the State to demonstrate that the legislation is 'justified by a compelling state interest and [is] narrowly tailored to effectuate only that compelling interest.'" *Id.* ¶ 16 (quoting *Weems v. State ex rel. Knudsen*, 2023 MT 82, ¶ 34, 412 Mont. 132, 529 P.3d 798)).

ARGUMENT

I. SB 99 Is Subject to Strict Scrutiny, Including Where the Government Burdens the Fundamental Rights of Minors.

As this Court already recognized, SB 99 is subject to strict scrutiny. Order Granting Pls.' Mot. for Prelim. Inj. ("PI Order"), Dkt. No. 131, at 28. That holds true across Plaintiffs' claims. The Montana Supreme Court affirmed that strict scrutiny is required because of the law's intrusion on Plaintiffs' constitutional right to privacy, which "reflects Montanans' historical abhorrence and distrust of excessive governmental interference in their personal lives." *Cross ex rel. Cross v. State*, 2024 MT 303, ¶ 22, 560 P.3d 637 (quoting *Gryczan v. State*, 283 Mont. 433, 455, 942 P.2d 112, 125 (1997)). In addition, SB 99 is subject to strict scrutiny review because it infringes on the constitutional guarantee of equal protection. *See infra* pp. 25-32. And strict scrutiny is similarly required because of the law's infringement upon parental rights, the right to seek health, the right to dignity, and the right to freedom of expression, as detailed below and in Plaintiffs' motion for summary judgment, all of which is incorporated by reference. *See infra* pp. 32-37; Pls.' Br. in Support of Mot. for Summ. J. ("Pls. Br."), Dkt. No. 185.

Defendants attempt to sidestep their burden under strict scrutiny by wrongly claiming that Section 15 of Article II of the Montana Constitution ("Section 15") dilutes the strictures of strict scrutiny when a law burdens the fundamental rights of minors. *See, e.g.*, Defs.' Br. in Support of Mot. for Summ. J ("Defs. Br."), Dkt. No.

190 at 25 (arguing that strict scrutiny "is not the proper level of review" because "Section 15 controls this case"). Section 15 states: "The rights of persons under 18 years of age shall include, but not be limited to, all the fundamental rights of this Article unless specifically precluded by laws which enhance the protection of such persons." Mont. Const. art. II, § 15. The Montana Supreme Court has explained that Section 15 requires the State to show that a law infringing on minors' rights will "enhance the[ir] protection" (which, for all the reasons set forth below, the State cannot satisfy, much less on summary judgment). *Planned Parenthood*, ¶ 21.

That requirement of minor-protection enhancement, however, is *in addition* to the conventional requirements of strict scrutiny that apply where the rights of adults are at issue, thus raising—rather than lowering—the State's burden. Those requirements include that (1) "the legislation must be justified by a compelling state interest" and (2) it "must be narrowly tailored to effectuate only that compelling interest." *Id.* ¶ 25 (quoting *Armstrong v. State*, 1999 MT 261, ¶ 34, 296 Mont. 361, 989 P.2d 364). In other words, the duty to show that the law enhances the protection of minors is not some free-standing inquiry that displaces or lightens the State's ordinary burden under strict scrutiny. At various points, Defendants admit as much, contradicting their own arguments elsewhere. Defs. Br. 13 (recognizing that under Section 15, "the Legislature must clearly show[,]" among other things, "a compelling state interest").

The Montana Supreme Court was undoubtedly aware of Section 15 when it held that SB 99 needed to satisfy strict scrutiny in affirming this Court's preliminary injunction. *Cross*, ¶ 37 (requiring the State to show both a compelling interest and narrow tailoring). Months before its decision, it similarly recognized that a law conditioning a minor's right to abortion on parental consent also needed to satisfy strict scrutiny—while specifically addressing the import of Section 15 on

the right to privacy. *Planned Parenthood*, ¶ 21. In sum, nothing about the fact that SB 99 infringes on minors' rights changes the rigors of strict scrutiny for the State.

Notably, Defendants misunderstand who has the burden of proof under strict scrutiny, suggesting that the burden falls on Plaintiffs. *See, e.g.*, Defs. Br. 12, 27, 40. Under strict scrutiny, "the burden shift[s] to the State." *Planned Parenthood*, ¶ 25. As the Montana Supreme Court's ruling affirming the preliminary injunction makes clear, strict scrutiny applies here, and thus the burden falls on the State to justify the law.

II. Defendants Fail to "Clearly" Show a Medically Acknowledged, Bona Fide Health Risk to Obtain Summary Judgment on the Privacy Claim.

Defendants fall short of "clearly and convincingly" making the threshold showing of a "medically acknowledged, bona fide health risk" posed by the proscribed medical care that would be required to grant Defendants summary judgment on Plaintiffs' privacy claim. *Cross*, ¶¶ 21, 28. Because the undisputed facts—and even the disputed facts asserted by Defendants—fail to satisfy this demanding standard, Defendants' motion should be denied (and, for the same reasons, Plaintiffs' motion should be granted) with respect to the privacy claim.

Medical Community Acknowledgment. Defendants' argument fails at the outset: there has not been an acknowledgment by the medical community of a bona fide health risk that warrants banning gender-affirming medical care. Defendants agree that "[s]uch a determination must be made by the medical community" itself rather than the courts. Defs. Br. 35.

In assessing whether a medical community acknowledgment exists, the Montana Supreme Court has looked to the positions adopted by major medical organizations in America as the touchstone. For instance, in deciding whether there was a bona fide health risk that justified conditioning minors' right to an abortion on parental consent, the Montana Supreme Court recognized that "[t]he American

Medical Association and the American Academy of Pediatrics, and other medical organizations, are opposed to parental consent laws." *Planned Parenthood*, ¶ 38. Similarly, the Montana Supreme Court recognized here that the evidence demonstrates "that leading United States medical organizations, including the American Medical Association, the American Psychological Association, and the American Academy of Pediatrics, endorse and cite the WPATH standard of care as authoritative for treating gender dysphoria." *Cross*, ¶ 35.

Nothing cited by Defendants can overcome the foregoing and establish a bona fide health risk acknowledged by the medical community. For instance, Defendants cite to the testimony of Plaintiffs' experts—and, indeed, to the clinical practice guidelines issued by WPATH and the Endocrine Society—to argue that there are some risks associated with gender-affirming medical care. Defs. Br. 17-19. But *all* medical treatment can entail risk, *see, e.g.*, SA.004,[1] and the very purpose of informed consent is to provide information about that risk. As this Court previously recognized, "[r]isk is a factor inherent in the field of medicine." PI Order 31. And the Montana Constitution safeguards an individual's relationship with their chosen health care provider precisely because the individual "may consent to the most risky and intimate invasions of body and psyche, largely upon her or his personal trust in the education, training, experience, advice, and professional integrity of the health care provider he or she has chosen."[2]

[1] Citations to SA.001-096 refer to the supplemental appendix filed concurrently with Plaintiffs' opposition to Defendants' motion for summary judgment. Citations to A.001-504 refer to the appendix filed with Plaintiffs' motion for summary judgment.

[2] In light of this protection, it is perhaps unsurprising that Montana courts have yet to identify a treatment presenting a bona fide health risk acknowledged by the medical community to warrant its wholesale prohibition. Defendants fail to show that the treatment banned by SB 99 is acknowledged by the medical community to be so uniquely dangerous that it should be the first and only treatment deprived of the constitutional protection afforded to medical decision-making.

Armstrong, ¶58. Defendants fail to show that there is a medical community acknowledgment of a bona fide risk *that justifies banning the treatment at issue*.

None of Defendants' other arguments are sufficient to establish the requisite medical community acknowledgment. With the major medical organizations in the United States supporting gender-affirming medical care, Defendants instead pivot to reliance on the positions purportedly adopted in select foreign countries. But none of the foreign countries that Defendants rely upon have banned gender-affirming medical care as SB 99 does, *see infra* pp. 23-25, and in any event, none of the major medical organizations in America have adopted the positions of these foreign countries. The opinions of the expert witnesses that Defendants selected for this litigation cannot change that basic reality either, even if they may *disagree* with the medical community here. *See, e.g.*, Defs. Br. 7 (asserting that "gender ideology" drives gender-affirming medical care). A mere showing of disagreement by some medical providers does "not clearly and convincingly demonstrate that the proscribed treatments present a bona fide health risk to minors." *Cross*, ¶ 21. Otherwise, any medical treatment could be deemed to present a bona fide health risk so long as any medical provider expressed the view it should be barred. And the mere fact that a drug is not approved for a particular indication does not demonstrate a medical community acknowledgment of such a risk. Defs. Br. 19-20. Otherwise, *most* therapies provided to children could be banned, because it is commonplace for medications to be used for off-label purposes, especially in pediatrics. A.077.

Similar Risks for Other Treatment. Defendants cannot meet the high bar of a bona fide health risk warranting interfering with medical decisions for additional reasons as well. Where the risks associated with the banned treatment also exist for other treatment that has not been banned, the standard is not satisfied. *See, e.g.*, *Weems*, ¶¶ 47-48 (noting that complication rates from abortion are similar to other

permitted outpatient procedures in affirming the absence of a bona fide health risk). Here, many of the purported risks cited by Defendants are also present when the medications at issue are used for cisgender patients. *See infra* pp. 16-17; *see, e.g.*, A.075 (risks from hormones and puberty blockers exist for both cisgender and transgender people), A.034 (risks from puberty blockers are similar for cisgender and transgender people), SA.042 (use of estrogen can increase risk of blood clots, stroke, and heart attack for both cisgender and transgender people).

Likewise, the possibility of regret from medical treatment is not unique to gender-affirming medical care, and both sides acknowledge evidence that rates of regret with respect to such care is low. A.244-46, 384, 408-10. The existence of "detransitioners" does not negate that. In other contexts, some individual patients may also regret receiving particular medical treatment, whether because it proved unnecessary, led to complications, or did not yield the expected benefits. But it does not follow that regret by some individuals means that the treatment poses a bona fide health risk to warrant its prohibition. *See* A.118 ("There is no space in medicine where we would prioritize a false positive by discontinuing care for all of the true positives.").

Risk Reducing Measures. The availability of measures to reduce risk, and to mitigate problems when risks materialize, further negates the existence of a bona fide health risk. *See Planned Parenthood*, ¶ 31 (noting, in holding that a bona fide health concern did not exist, that when complications of abortion care arise, they can be treated). Those risk reducing measures similarly exist with respect to risks identified by Defendants. *See, e.g.*, A.076 (explaining that "the risks [of gender-affirming medical care] … are well-managed under appropriate care" but that they are elevated if patients turn to black markets and resort to self-treatment), SA.043 (explaining that cardiovascular risks from hormone therapy can be managed through bloodwork monitoring), A.166 (explaining fertility preservation

measures). Similarly, Defendants point to an individual who did not undergo "any kind of psychological evaluation or other history" before beginning hormone therapy and subsequently detransitioned—but that risk can be addressed through requiring such psychological assessment, which is consistent with clinical practice guidelines. Defs. Br., Ex. D. Likewise, any purported medical malpractice based on care that is not provided in accordance with clinical guidelines, Defs. Br. 22-23, does not demonstrate a bona fide health risk for care that *is* provided in accordance with such guidelines. All of the foregoing concerns can be managed.

Benefits of Care. The points discussed above provide a sufficient basis for finding the absence of a bona fide health risk, but Defendants additionally fail to show that the medical community has determined that the risks of care outweigh its benefits for all patients. Defendants recognize that the assessment of both risks and benefits is integral to medicine. For instance, adolescents can be prescribed antidepressants like Prozac—even though clinicians including Defendants' own experts are aware that some percentage of patients will experience suicidality, a risk that warrants a black box warning—because of the countervailing benefits in treating depression. SA.026-27; *see also* SA.028-29, 093-96 (mood stabilizer can be used in minors, despite possibility of "fatal" reactions that are "not always possible to predict"). Likewise, in finding no bona fide health risk posed by advanced practice registered nurses providing abortion care, the Montana Supreme Court observed that a ban on such care would reduce the pool of providers and force patients to seek later-term abortion care, thereby risking worse outcomes as a result of the delay. *Weems*, ¶ 50.

Here, Defendants do not seriously claim, and certainly fail to show, that no transgender adolescent derives any benefit from gender-affirming medical care. This Court's preliminary injunction ruling alone would preclude such a conclusion. As this Court observed, "Plaintiffs have demonstrated that Youth Plaintiffs—and

other minors in Montana experiencing gender dysphoria—are at risk of facing severe psychological distress if they are blocked from receiving such care." PI Order 41 (citing declarations of Dr. Hodax, Dr. Mistretta, Mr. Cross, and Ms. van Garderen). Indeed, the record "clearly" demonstrated irreparable harm from SB 99. PI Order 42. While Defendants fixate on attacking one particular benefit—reduction of suicidality (which is addressed below)—they fail to show that such care does not yield any other benefit, including the reduction of distress associated with gender dysphoria. The significance of that benefit can be enormous. Mr. Cross, for example, described such distress as "agony" that drove him to tears an "uncountable number of times" but that after gender-affirming medical care, he can look in the mirror and "finally see my real self, someone that I actually recognize." A.003, 006.

Defendants assert that "there is no genuine dispute that no medical consensus exists on the benefits of [gender-affirming medical care]." Defs. Br. 15. That statement is not only false but it turns the relevant legal inquiry on its head. As discussed above, to establish a bona fide health risk, Defendants would first need to show a consensus that the care is harmful. Defendants point to no authority that any treatment can be banned so long as there is no consensus on efficacy,[3] which would be inconsistent with the high bar required for a bona fide health risk. In any event, it is undisputed that the major medical organizations in the United States support gender-affirming medical care as an effective and safe treatment for adolescents with gender dysphoria. *See, e.g.*, A.242 (Plaintiffs' expert witness discussing "the strong medical consensus across organizations and the overwhelming support for gender-affirming medical care"). And Defendants'

[3] And such an assertion directly conflicts with the mandates of HB 422, the State's right-to-try law, which prohibits the State from interfering with access to medications that have not been found to be effective at all.

reliance on the existence of dissenters on the efficacy of care certainly does not establish that the existence of a consensus that the care is *not* effective.

With respect to suicidality in particular, Defendants' various attacks all miss the mark in establishing a bona fide health risk. They first focus on the efficacy of puberty-suppressing medication in mitigating suicidality when used to treat gender dysphoria in minors. Defs. Br. 3. But reducing suicidality is not the only or even the primary treatment goal of puberty-suppressing medications; rather, their purpose is primarily to "*stop* further development of physical characteristics inconsistent with the adolescent's identity, [and] they therefore are meant to *prevent* (not improve) the worsening of dysphoria." A.147; *see also* SA.030.

With respect to gender-affirming medical care more broadly, Plaintiffs' expert witnesses have testified to the efficacy of such care in reducing suicidality. *See, e.g.,* A.138-39, 200-01, 204-05 (Plaintiffs' experts discussing efficacy as to suicidality). Even Defendants' own representatives admitted that banning treatment would lead to an increase in depression, anxiety, and suicidality.[4] SA.033. Defendants' reliance on a statement made at oral argument in another case in another state reveals a basic misunderstanding. Defs. Br. 16. That statement referenced studies of "completed suicide," which is difficult to study and distinct from *suicidality* or *suicidal ideation,* which are well-studied. Defendants' assertion that gender-affirming medical care does not reduce suicidality is, at the very least, disputed, *see, e.g.*, A.204-05, and thus cannot support Defendant's motion for summary judgment.

[4] Defendants' factual assertions about suicide also come overwhelmingly from the opinions of James Cantor, who submitted a declaration at the preliminary injunction stage but whom Defendants did not choose to disclose as an expert witness for trial. *See* Defs. Br. 5 (references to "Doc. 79"). His opinions are thus outside the summary judgment record because they could not be considered at trial. Defendants' motion similarly cites the opinions of Michael Laidlaw and Daniel Weiss (references to "Doc. 78" and "Doc. 92") for various other assertions, but Defendants likewise abandoned them as trial witnesses by not disclosing them.

Finally, Defendants' statement that Plaintiffs "present no valid or reliable evidence" of the benefits of gender-affirming medical care is nonsense. Defs. Br. 16. That evidence is readily apparent from Plaintiffs' expert witness reports and deposition testimony. *See, e.g.*, A.233-35 (discussing at length the evidence of efficacy). To the extent Defendants mean to criticize the *quality* of the evidence offered, they make no specific criticism. And as explained more fully in Plaintiffs' motion for summary judgment, it is undisputed that the evidence underlying gender-affirming medical care is of the same kind and quality as the evidence underlying most other medical interventions (which are not banned by SB 99). *See* Pls. Br. 24-25.

III. Defendants Fail to Meet Their Burden of Showing Undisputed Facts that SB 99 is Narrowly Tailored to Further Any Purported Interest.

Even if Defendants *had* met their threshold burden of demonstrating that gender-affirming medical care constitutes a "bona fide, medically acknowledged health risk," they have not met their burden of demonstrating that SB 99's categorical ban is narrowly tailored to effectuate any purported governmental interest. Strict scrutiny—whether it is triggered by Plaintiffs' privacy claim or by any of their other claims—"requires that the State demonstrate the challenged law is narrowly tailored to serve a compelling government interest and only that interest." *Cross*, ¶ 22. The State must show that it has taken the "least onerous path that can be taken to achieve the state objective" such that it is "closely tailored to effectuate only that compelling state interest." *Wadsworth v. State*, 275 Mont. 287, 302, 911 P.2d 1165, 1174 (1996) (emphasis added). SB 99 cannot withstand strict scrutiny because it is both extremely over- and under-inclusive with respect to any asserted government interest.

To be sure, Defendants' brief puts forward a number of factual assertions regarding supposed harms associated with gender-affirming medical care (many of

which are unsupported by reference to any material in the record), but in fact are disputed, in many cases by Defendants' own expert witnesses. It is unnecessary, however, to set forth a painstaking account of each disputed fact upon which Defendants rely, because even if all of Defendants' factual assertions of harm *were* undisputed, none of them explains why a *categorical ban* is constitutionally justified, nor why gender-affirming medical care is prohibited while other forms of care with comparable risks and evidence bases is expressly permitted. Rather, the undisputed facts establish that SB 99 is *not* narrowly tailored to *any* potential governmental interest set forth by Defendants.

A. Defendants Fail to Present Undisputed Evidence Substantiating Any Interest in Addressing "Pressure" to Receive Care, and SB 99 Is Not Narrowly Tailored to Any Such Interest.

First, Defendants point to the sole governmental interest identified by the Montana Legislature in enacting SB 99—"the protection of minors and their families . . . from any form of pressure to receive harmful, experimental puberty blockers and cross-sex hormones and to undergo irreversible, life-altering surgical procedures prior to attaining the age of majority." Mont. Code Ann. § 50-4-1002. But Defendants have not substantiated this interest with reference to any undisputed facts. This alone precludes summary judgment. Though they point to the legislative testimony surrounding SB 99 and various witness affidavits, none of these establishes the existence of any "pressure to receive" gender-affirming medical care in Montana. Defendants' vague reference to the testimony of a parent that they claim is "assuring this is happening in this state" (without clarifying what "this" means) is no exception. *See* Defs. Br. 5. That parent's testimony—about his 18-year-old estranged child using a different name at school—does not indicate that the child ever even received any gender-affirming medical care, much less that they received any "pressure" to do so. *See* Defs. Br. 5 & n.5.

Neither does Defendants' reference to the legislative or affidavit testimony of some individuals who have detransitioned establish the presence of any "pressure" in Montana to receive gender-affirming care, as *none* of these detransitioner affidavits relied on by Defendants testify that they received care in Montana.[5] Indeed, other of Defendants' witnesses disclaim the possibility of medical providers exerting such pressure. A.445-46 (Defendants' Rule 30(b)(6) designee disclaiming any knowledge of complaints of pressure to receive gender-affirming medical care). And though Defendants point to a number of allegations made in complaints filed in other states, "[u]nsupported allegations and speculation do not demonstrate . . . entitlement to summary judgment." *Rivera-Colon v. Mills*, 635 F.3d 9, 12 (1st Cir. 2011); *see also* Mont. R. Civ. P. 56(e)(1) ("A supporting or opposing affidavit must be made on personal knowledge, set out facts that would be admissible in evidence, and show that the affiant is competent to testify on the matters stated.").

More importantly, even if it *were* undisputed that "pressure" to receive gender-affirming care exists in Montana, Defendants point to no material undisputed facts explaining why *a categorical ban* is the least restrictive means to address it. For example, it is undisputed that existing state mechanisms that regulate the practice of medicine (like investigation and discipline by licensing bodies, and medical malpractice and informed consent actions) can be used to address any "pressure" to receive gender-affirming medical care. A.455-56 (Defendants' Rule 30(b)(6) designee testifying that a healthcare professional pressuring a patient could constitute unprofessional conduct that licensing bodies could investigate).

[5] Elle Palmer, identified as a "Montanan" by Defendants, does not indicate whether she received care in Montana. Defs. Br., Ex. D. Moreover, her affidavit evinces no evidence of being "pressured" to receive gender-affirming care. *Id.*

And no undisputed fact explains why Montana could not address any purported concerns about pressure by simply directly prohibiting coercion or interference with a patient's medical decision-making across all areas of medicine, or use existing, generally-applicable means to address any such concern (as discussed more fully above). Rather than attempt to address this, Defendants state simply that SB 99 "prevents susceptible youth and their families from medical providers' pressure to receive experimental treatments and procedures." Defs. Br. 21. But this is not an accurate characterization of what SB 99 *does*. The statute does not institute legal protections for youth and their families against being pressured to make medical decisions; rather, it outlaws an entire category of medical treatment for minors—whether or not they are pressured to receive it.[6] And rather than attempt to address "pressure" generally in the practice of medicine, it applies *only* to medical care that is provided to "address [a] minor's perception that [their] gender or sex" is something other than the minor's sex assigned at birth. Mont. Code Ann. § 50-4-1004(1)(a). Thus, SB 99 is both over- and underinclusive with respect to any interest in addressing "pressure."

B. SB 99's Categorical Ban Is Not Justified By Any Undisputed Facts Regarding the Risks of Gender-Affirming Medical Care.

Any constitutional justification asserted in defense of SB 99 apart from addressing "pressure" to receive gender-affirming care is "hypothesized or invented post hoc in response to litigation" and is therefore an insufficient basis for Defendants' motion. *United States v. Virginia*, 518 U.S. 515, 533 (1996). "Because post-hoc rationalizations provide an insufficient basis to find a compelling governmental interest, the court must look to the compelling interest asserted by [the State] at the time of" SB 99's enactment. *Native Am. Council of Tribes v.*

[6] Defendants' assertion that the banned care is "experimental" is addressed more fully bellow.

Weber, 897 F. Supp. 2d 828, 849 (D.S.D. 2012), *aff'd*, 750 F.3d 742 (8th Cir. 2014). Though Defendants make no explicit reference to additional state interests, they present a highly disputed narrative of purportedly "undisputed" facts that they argue justifies SB 99's categorical ban.

1. Undisputed Facts Show that SB 99 is *Not* Narrowly Tailored to Any Interest Regarding the Medical Risks of Treatment.

Defendants seek to justify SB 99 by pointing to potential medical risks associated with the various medical interventions that comprise gender-affirming medical care. As discussed above, it is undisputed that every medical intervention presents risks of adverse effects. Thus, the mere fact that gender-affirming medical treatment carries some risks does not differentiate it in character from other forms of medical intervention and justify singling it out for categorical prohibition. *See, e.g.*, A.162; *see also* Pls. Br. 14, 15. And the State has made no showing (let alone through undisputed facts) that gender-affirming medical care is uniquely risky such that it should be treated differently from any other form of medical care that carries risk. Neither has the State offered any authority to support the notion that it possesses a compelling interest in prohibiting treatments if they are not categorically free of medical risk.[7]

To the extent Defendants claim that any of the specific potential adverse effects associated with gender-affirming care justifies the categorical ban reflected in SB 99, that argument necessarily fails. With respect to any of the risks identified by Defendants, it is undisputed that (a) the same medications or interventions used to treat other conditions also pose the same risk, and/or (b) other medical

[7] Defendants make the wildly speculative, incorrect, and unsupported claim that minor patients receiving gender-affirming medical care are "all but certain to suffer any number of . . . harms." Defs. Br. 17. Defendants make no attempt to support or justify this extraordinarily bold claim that the degree of risk is anywhere *near* "all but certain," and this claim is clearly disputed. *See, e.g.*, A.076.

treatments offered for minors (but not banned by SB 99) pose the same medical risks. *See* A.075-76, 162-63, 427-31, 352 (undisputed that risks of puberty blockers, estrogen, and testosterone are not limited to treatment of gender dysphoria), A.380-82, 383, A.348 (undisputed that the risks posed by the interventions, including any potential risk to fertility or sexual response, are also posed by other treatments not banned by SB 99).

SB 99 does not ban the medications at issue outright, nor does it ban all medications which carry any particular risk when prescribed for minors. Rather, SB 99 bans medical treatment when, and only when, it is provided to "address the minor's perception that her gender or sex" is something other than the minor's sex assigned at birth; meanwhile, the State expressly permits the same medications (carrying essentially the same risks) when used to treat other conditions and allows other treatments to be provided to minors despite posing the same risks with which the State purports to be concerned. Mont. Code Ann. § 50-4-1004(1)(a). State law also permits Montanans, including minors, to access investigational medications that have not been approved by the FDA for any purpose and that carry all manner of potential risks. *See* S.B. 422. Thus, SB 99 is extremely underinclusive with respect to any of these identified risks, and is accordingly not narrowly tailored to any interest in preventing harm from adverse effects.[8]

[8] The unremarkable fact that WPATH acknowledges the potential risks does nothing explain why those risks necessitate a categorical ban. Defendants' selective quoting from the Standards of Care in fact demonstrates SB 99's fatal underinclusiveness. The passage from the Standards of Care quoted in Defendants' brief discussing risks and that "[s]ystemic long-term studies" that are "urgently needed" does not refer to the treatments banned by SB 99, but in fact refers to surgeries conducted on intersex patients (as the context makes clear), which are explicitly permitted by SB 99. *See* SA.085-92. Defendants' emphasis on the risks and research base underlying these treatments—without explanation as to why a policy permitting them but not permitting interventions to treat gender dysphoria—only highlights that SB 99 is underinclusive with respect to these justifications.

Finally, Defendants assert that the "alternative treatments" of "watchful waiting" or psychotherapy alone are safer alternatives to gender-affirming medical care. Defs. Br. 8. First, this claim is not only disputed and incorrect, SA.022, 021, it is immaterial: Defendants have offered no authority establishing that the legislature is free to ban medical treatments whenever it can point to an alternative treatment with a purportedly more favorable side effect profile (even when, as here, it is undisputed that in at least some cases, that alternative treatment will and does fail to address the medical condition at issue, and thus leads to greater consequential harms). SA.021 (Defendants' designated expert acknowledging that she has had patients for whom psychotherapy failed to address gender dysphoria and who proceeded to transition). Under Plaintiffs' privacy and other claims, the burden of constitutional justification is on the State to establish why banning *this* treatment withstands heightened scrutiny—not why it might prefer another path.

Moreover, Defendants fail to show that it is undisputed that watchful waiting or psychotherapy is effective in treating gender dysphoria or the attendant harms to mental health. To the contrary, their own representative testified that banning medical treatment would likely lead to increases in anxiety, depression, and suicidality. SA.033. Nor do Defendants present any evidence or undisputed facts demonstrating that psychotherapy causes adolescents with gender dysphoria to "desist" or no longer identify as transgender—nor could they, as their own expert acknowledges that the scientific literature suggests that gender dysphoria present in adolescence is unlikely to desist, and that gender identity is resistant to voluntary change. A.362; *see also* A.482; SA.023. And even if it *were* undisputed that psychotherapy alone may cause some young people to no longer identify as transgender, it certainly is undisputed that this would not be the case for *every* young person with gender dysphoria, and thus SB 99 is overinclusive and not narrowly tailored. SA.021.

2. SB 99 Is Not Narrowly Tailored to Any Other State Interest.

Finally, Defendants raise several additional purported justifications for SB 99's categorical ban separate from medical risks. But Defendants do not substantiate these justifications with undisputed facts; rather, the undisputed facts undermine these asserted interests. Nonetheless, even assuming that each interest offered by Defendants is legitimate, or even compelling, none of them justifies a categorical ban, and Defendants ignore less restrictive alternatives at every turn.

Off-Label Use. First, Defendants argue that SB 99 is justified because the banned medications are used "off-label" (meaning they are FDA-approved for some indications but not the specific indication for which they are being prescribed) when used to treat gender dysphoria. Defs. Br. 19, 20. Once again, Defendants fail to support their assertion that off-label use of a medication equates to unsafe or risky medical treatment with reference to any undisputed facts. *See, e.g.*, A.265-66 (Plaintiffs' expert Dr. Antommaria explaining that off-label use does not equate to a lack of evidence of safety or efficacy). To the contrary, it is undisputed that off-label use is common, particularly in pediatrics. A.265-66, 351, 379, 385-86, 401. And Defendants' own designated experts testify that they prescribe medications off-label in their own practices, or that they see no issue with doing so in other medical contexts. A.351, 379, 385, 401, 425.

Moreover, Defendants do not even attempt to demonstrate that SB 99 is narrowly tailored to any interest in prohibiting off-label use of medications. SB 99 does not ban off-label prescription generally, and Montana's right-to-try law expressly permits medical care that is *not even approved for any purpose* by the FDA (which both sides agree means that it lacks clinical data to support its general use) and that is explicitly deemed "investigational." *See* A.265, SA.024-25, A.356, 471-72. Defendants make no attempt to justify this extreme underinclusiveness.

Misdiagnosis/Regret. Next, Defendants rely on the possibility of regret,[9] by pointing to individual "detransitioners" who are witnesses for the State or who have filed lawsuits in other states, to justify SB 99.[10] But it is undisputed that regret accompanies virtually every area of medicine, and Defendants make no attempt to establish that regret is at all a common or likely outcome compared to other medical treatments not banned by SB 99. Nor could they, as their own experts acknowledge that the medical literature establishes that the regret rate for gender-affirming medical care is generally low. A.384; *see also* A.205. If Montana were concerned with eliminating medical regret, it could have enacted a law banning all forms of medical care giving rise to any medical malpractice actions—but it did not do so (perhaps because such a law would ban virtually all forms of medical care). Because SB 99 bans the medical interventions at issue, but does not ban other medical care that may carry the same or much higher likelihood of medical regret, it is highly underinclusive and not narrowly tailored to any interest in preventing medical regret.[11]

Additionally, even taking Defendants' claims about regret and detransition at face value, the affidavits attached by Defendants fail to justify a categorical ban because they confirm that less restrictive alternatives are available. For example, it is undisputed that the clinical practice guidelines provide for a biopsychosocial

[9] Defendants also claim that the possibility of regret or misdiagnosis means that the benefits of gender-affirming medical care—specifically, the changes to secondary sex characteristics that contributes to a reduction in gender dysphoria—are actually risks.

[10] As discussed above, none of these witnesses indicate that they received gender-affirming medical care in Montana.

[11] Defendants reference a complaint filed against one of Plaintiffs' experts and a news article about a study in which the same expert's research is discussed. The allegations in the referenced complaint are clearly disputed, and that expert has disputed the claims made in the news article when asked at her deposition and in other cases. SA.044-061; *see also* Decl. of Johanna Olson-Kennedy, M.D., M.S., *Misanin v. Wilson*, 2:24-CV-04734 (D.S.C. Nov. 18, 2024), Dkt. 51-5 (SA.066-69).

assessment before initiating care. SA.083-84. But both affiants cited by Defendants as having regretted treatment state in no uncertain terms that they did not receive a mental health assessment prior to initiating treatment. Defs. Br., Ex. C ¶6, Ex. D ¶8. Defendants make no effort to show why the State could not impose a less restrictive alternative to address the circumstances reflected in these anecdotes, such as a law mandating that care be provided consistent with the clinical practice guidelines, or a law instituting enhanced assessment requirements.[12]

Nor does Defendants' concern with a purported "sudden rise" in gender dysphoria among young people explain why a categorical ban would be justified. Defendants do not attempt to reference undisputed facts establishing that any purported increase in prevalence of gender dysphoria diagnoses is a result of misdiagnosis, or is accompanied by a higher likelihood of regret. And, as discussed above, far less restrictive means are available to address any purported concern with misdiagnosis. At best, Defendants imply that there is a causal connection between social media use and increases in diagnosis of gender dysphoria, but this claim is plainly disputed. A.119-23 (explaining flaws in the "social contagion" hypothesis). There are also other reasons for increases in diagnosis or presentation, including, for example, decreases in stigmatization or increased insurance coverage leading to more families being able to afford care and seek evaluations. A.121-22.

Even if it *were* undisputed that some fraction of transgender adolescents come to identify as transgender as a result of social influence, Defendants' own experts acknowledge that this concern would not apply across the board, and thus

[12] Defendants also reference declarations submitted in opposition to the preliminary injunction, but as with their two affiants, none of these witnesses indicate that they received care as a minor in Montana. Two of the affidavits concern patients who were adults when they initiated gender-affirming medical care. *See* Dkt. 106 ¶5; Dkt. 105. The other two, as with Defendants' two new affiants, do not indicate that the relevant patient received the biopsychosocial assessment. *See* Dkt. 108 ¶12; Dkt. 107 ¶7.

would not justify a categorical ban. A.365-66. For example, one of Defendants' experts acknowledged that the scientific literature underlying this hypothesis would not apply to adolescents assigned male at birth, but SB 99 bans medical care even as to those adolescents. *Id.* Similarly, another of Defendants' experts acknowledged that his concern applied only to a proportion of transgender adolescents which he was unable to quantify, and that "a certain proportion of children with gender dysphoria have it permanently." SA.036-37. Rather than institute less restrictive means to address this concern, like mandating that care be provided according to the clinical practice guidelines, or mandating some form of enhanced assessment, SB 99 bans care across the board. Thus, it is not narrowly tailored to any interest in reducing misdiagnosis of gender dysphoria.

The confused reference in Defendants' briefing to the rate of "desistance" among pre-pubertal transgender children is both misplaced and irrelevant. The figures and sources cited by Defendants refers to studies of the proportion of *pre-pubertal children* who will go on to identify as transgender in adulthood. *See* A.244-45. But no medical interventions are offered to pre-pubertal children, and the scientific literature is clear: when gender dysphoria persist into *adolescence,* it is overwhelmingly likely to persist. A.243-44. On this point, both sides agree—Defendants' own designated expert acknowledges that "there's a good bit of literature that indicates that adolescent gender dysphoria continues into adulthood." A.362; *see also* A.482 ("[W]hen gender variance with the desire to be the other sex is present in adolescent, this desire usually does persist through adulthood.").[13]

Informed Consent. Next, Defendants assert that it is "unclear" how informed consent can be achieved in the context of a minor patient with gender

[13] Defendants' subsidiary argument that "social transitioning encourages full medical transition," Defs. Br. 9, is both disputed and immaterial as a purported justification for SB 99, which does not ban or attempt to regulate social transition.

dysphoria, because the relevant information cannot be conveyed in an age-appropriate way. Defs. Br. 9. But parental informed consent is the generally applicable mechanism through which minors are able to receive medical care (to which they provide their assent). A.376-77. And both sides agree that this mechanism is a sufficient ethical basis for minors to receive care in other contexts, including ones with similar risks and consequences. SA.024-25, A.383, SA.012, 005-008, 003. If Montana were concerned with the ability of minors to provide assent (and for their parents to provide consent) to treatments that may affect a minor's future, that does not explain why it banned only these treatments rather than declare that minors are simply unable to assent to medical care. Because it did not, SB 99 is underinclusive with respect to this purported concern. More specifically, SB 99 is not narrowly tailored with respect to Defendants' assertion that a child who "has not gone through puberty" cannot adequately consent to care that may carry certain risks, given that (1) as discussed above, medical interventions are not available for pre-pubertal children; and (2) SB 99 bans care for *all* minors, whether or not they have entered puberty for some duration of time. Defs. Br. 9. And, as discussed immediately above, SB 99 permits care in other areas of medicine that carry the same risks.

Europe. Finally, Defendants point to various purported actions by some European governmental health agencies that they claim support SB 99. In each case, Defendants' portrayal of what these agencies have done is disputed, sometimes by the statements and admissions of Defendants' own experts; and crucially, it is undisputed that *none* of these countries have instituted a ban on care like SB 99. Defendants claim that "Sweden does not offer gender transitioning outside of research settings," Defs. Br. 3, but as Defendants' own expert witness and Swedish psychiatrist Sven Román testified, this is not true: under the Swedish criteria, gender-affirming medical care is widely available to minors outside

research contexts in Sweden. A.404; *see also* SA.012-015 (acknowledging that care is available in Sweden and that statement in his report that the Swedish policy was "essentially a ban" was incorrect). In fact, the Swedish guidelines are in some ways far more permissive than the clinical practice guidelines that apply in the U.S. SA.016 (Defendants' expert acknowledging that the Swedish guidelines allow treatment in certain cases when parents do not provide consent). Similarly, any suggestion that gender-affirming care has been banned or severely restricted in Finland, Norway, or Denmark, is incorrect. *See* A.277 (discussing review of EU countries, including Finland, Norway, and Denmark, which found that "[a]ll services routinely offer interventions to suppress puberty and masculinising/ feminising hormone interventions" or referred to a national service); *see also* SA.017-18.

As for the United Kingdom,[14] Defendants' own experts acknowledge that the U.K. policy currently in effect is not a categorical ban—it allows hormones to be prescribed in adolescence and allows puberty blockers in the context of clinical trials. A.152, 386-87. Finally, to the extent Defendants rely on the Cass review (and quoted portions of the *TransActual* decision from the United Kingdom which are summarizing the report's findings), their own experts acknowledge that the Cass report does not support banning care and in fact acknowledges that care is appropriate for some minors. Defs. Br. 4; A.386-87, 436.

If anything, "[t]hese countries' approaches to gender-affirming medical care highlight that [the State's] chosen 'means'—a sweeping ban on such care—fails to properly account for the 'close means-end fit' heightened scrutiny requires." *Poe ex rel. Poe v. Labrador*, 709 F. Supp. 3d 1169, 1194 (D. Idaho 2023) (quoting

[14] Defendants assert that the United Kingdom is "not alone" in part because "Scotland and Wales" implemented similar restrictions. Defs. Br. 3. Of course, Scotland and Wales are part of the United Kingdom.

S*essions v. Morales-Santana*, 582 U.S. 47, 68 (2017), *appeal filed*, No. 24-142 (9th Cir. Jan. 9, 2024).

IV. SB 99 Violates Equal Protection, Which Independently Requires Strict Scrutiny.

The Montana Constitution's "guarantee of equal protection is a fundamental right . . . that extends to minors[.]" *Planned Parenthood* ¶ 26. It provides even more individual protection than the United States Constitution's Equal Protection Clause. *Snetsinger v. Mont. Univ. Sys.*, 2004 MT 390, ¶ 15, 325 Mont. 148, 104 P.3d 445. "When analyzing an equal protection claim, the [c]ourt follows a three-step process: (1) identify the classes involved and determine if they are similarly situated; (2) determine the appropriate level of scrutiny to apply to the challenged legislation; and (3) apply the appropriate level of scrutiny to the challenged statute." *Planned Parenthood*, ¶ 26 (citing *Goble v. Mont. State Fund*, 2014 MT 99, ¶ 28, 374 Mont. 453, 325 P.3d 1211).

In granting Plaintiffs' motion for a preliminary injunction, this Court already determined that SB 99 classifies based on sex and on transgender status and that such a classification must be subject to strict scrutiny. PI Order 19-27; *see also Cross*, ¶ 64 (McKinnon, J., concurring). Defendants offer no basis to revisit these sound conclusions or for this Court to reach a different result.

A. SB 99 Classifies on the Basis of Sex.

On its face, SB 99's prohibition against the provision of medical care "to a male minor to address the minor's perception that his gender or sex is not male[,]" and "to a female minor to address the minor's perception that her gender or sex is not female[,]" classifies based on sex. Mont. Code Ann. § 50-4-1004(1)(a)-(b). As this Court and others have held, laws like SB99 on their face impose differential treatment based on the sex an individual is assigned at birth "[b]ecause the minor's sex at birth determines whether or not the minor can receive certain types of

medical care under the law." *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022); *Kadel v. Folwell*, 100 F.4th 122, 153 (4th Cir. 2024) ("This is textbook sex discrimination . . . . For one, we can determine whether some patients will be eliminated from candidacy for these surgeries solely from knowing their sex assigned at birth.") (en banc), *petition for cert. filed*, No. 24-90 (July 29, 2024), and *petition for cert. filed*, No. 24-99 (July 30, 2024).

Separate and independently, SB 99 receives strict scrutiny because under its plain terms, its language imposes differential treatment based on whether the treatment is inconsistent with each individual's sex assigned at birth. 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., Georgia*, 590 U.S. 644, 668-69 (2020). Thus, the law prohibits testosterone from being prescribed to masculinize the bodies of birth-assigned females because such masculinization is deemed inconsistent with a female birth sex. Conversely, the law prohibits estrogen from being prescribed to feminize the bodies of birth-assigned males because Montana deems such feminization inconsistent with a male birth sex. The same is true for puberty-delaying medication. Birth-assigned males can receive puberty delaying medication to bring their bodies into alignment with a typical male puberty, but birth-assigned females cannot. Birth-assigned females can receive puberty-delaying medication to bring their bodies into alignment with a typical female puberty, but birth-assigned males cannot. By "discriminating against transgender persons," the Act "unavoidably discriminates against persons with one sex identified at birth and another today." *Bostock*, 590 U.S. at 669.

As this Court has already found, "[t]ransgender minors . . . [and t]heir cisgender counterparts seek these treatments for *medical* reasons . . . and on the advice of their healthcare providers." PI Order 22. Thus, "they are similarly

situated." PI Order 21. Under SB 99, minors who conform with the State's expectations about sex and gender conformity are permitted to access the medications, while those who fail to conform are denied access.

Relying on nonbinding and unpersuasive decisions from the Sixth and Eleventh Circuits, Defendants argue only that this Court should ignore the U.S. Supreme Court's recognition in *Bostock* that "it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex." *Bostock*, 590 U.S. at 698.

This argument has already been expressly rejected by another Montana district court that relied on *Bostock*'s reasoning to hold that "[i]f the challenged state actions discriminate against transgender individuals on the basis of their transgender status, they also necessarily discriminate on the basis of sex." Order Granting Pls.' Mot. for Prelim. Inj. at 10, *Kalarchik v. State*, No. ADV-2024-261 (Mont. First Jud. Dist. Ct. Dec. 16, 2024) (attached at SA.070-84).

Defendants also ignore the holdings of the Fourth, Ninth, and Tenth Circuits recognizing that *Bostock*'s fundamental interpretive holding applies in the equal protection context. *See Kadel*, 100 F.4th at 153-154; *Hecox v. Little*, 104 F.4th 1061, 1080 (9th Cir. 2024), *petition for cert. filed*, No. 24-38 (July 15, 2024); *Fowler v. Stitt*, 104 F.4th 770, 793-94 (10th Cir. 2024), *petition for cert. filed*, No. 24-801 (Jan. 28, 2025). Similarly relying on *Bostock*, the Eighth Circuit has found that a ban on gender-affirming care necessarily "discriminates on the basis of sex." *Brandt*, 47 F.4th at 669.

Defendants' assertion that SB 99 does not discriminate on the basis of sex because it applies equally to males and females similarly must fail. SB 99 constitutes a facial sex classification whether or not it applies "equally" to both sexes—just as a ban on marriage for interracial couples that applies equally to people of different races classifies based on race, or a ban on religious conversion

that applies equally to people of all religions classifies based on religion. "It is axiomatic" that classifications "do not become legitimate on the assumption that all persons suffer them in equal degree." *Powers v. Ohio*, 499 U.S. 400, 410 (1991). A statute that classifies based on sex is subject to heightened scrutiny even if applied even-handedly to both sexes. *See J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127, 141 (1994) (equal protection right to a jury selection process free of sex discrimination "extends to both men and women"); *cf. Powers*, 499 U.S. at 410 ("The suggestion that racial classifications may survive when visited upon all persons . . . has no place in our modern equal protection jurisprudence."). To illustrate the point, imagine a law that prohibits hairdressers from providing clients gender non-conforming haircuts—men could only receive typically masculine haircuts and women could be given typically feminine haircuts. Such a law would undoubtedly impose a classification based on sex, even though it applies to both men and women.

Defendants' next argument—that SB 99 discriminates on the basis of the purpose of the treatment rather than on sex, Defs. Br. 28-29—confirms rather than disproves that SB 99 classifies based on sex. The only purpose for which any of the medications or procedures are prohibited is when prescribed "to address the minor's perception that [their] gender or sex is not [the sex they were assigned at birth]." That the statute "allows children to have these treatments—but only so long as they are used for any reason other than as gender-affirming medical care," makes it clear that "'[t]he State's goal in passing [the challenged Act] was not to ban a treatment. It was to ban an outcome that the State deems undesirable.'" *Poe*, 709 F. Supp. 3d at 1193 (quoting *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 891 (E.D. Ark. 2021), *aff'd*, 47 F.4th 661 (8th Cir. 2022)). This purpose of preventing affirmation of a gender that is different from one's birth-assigned sex is, as discussed above, a clear sex classification.

Defendants' argument that the regulation of a medical procedure that only one sex can undergo is not necessarily a sex classification has no application here. Defs. Br. 31-32 (arguing that a restriction on abortion does not constitute a sex-based classification absent evidence of pretext). SB 99 is not a restriction on a medical procedure that is limited to one sex. Rather, it restricts medical treatment, such as hormone therapy, that all individuals can otherwise receive, regardless of their sex. But, on its face, SB 99 uses an individual's sex assigned at birth to determine when treatment is prohibited and when it is permitted. Defendants also rely on *Geduldig v. Aiello*, 417 U.S. 484 (1974). "*Geduldig* is best understood as standing for the simple proposition that pregnancy is an insufficiently close proxy for sex. The same cannot be said for the inextricable categories of gender dysphoria and transgender status." *Kadel*, 100 F.4th at 146. "[G]ender dysphoria is so intimately related to transgender status as to be virtually indistinguishable from it. The excluded treatments aim at addressing incongruity between sex assigned at birth and gender identity, the very heart of transgender status." *Id.*

Defendants' claim that SB 99 imposes an age classification rather than a sex classification, *e.g.*, Defs. Br. 32, assumes that a law cannot do both or that an age classification can somehow cancel out SB 99's sex classification. Both assumptions are wrong. A law that discriminates on the basis of sex on its face, as SB 99 does, cannot escape heightened scrutiny by also imposing an age classification. *See Craig v. Boren*, 429 U.S. 190, 197-99 (1976) (applying heightened scrutiny to law that classified based on sex and age).

Defendants also assert that the "same treatment" is not used for cisgender and transgender adolescents, because one treatment is "correcting an abnormality" whereas another is "creating an abnormality." Defs. Br. 29. Likewise, Defendants argue that there is a distinction between treating a physical condition and a psychological condition. *Id.* All of that is simply another way of arguing that the

groups are not similarly situated—a point that this Court already correctly rejected. PI Order 21 ("Both are medical conditions."). What matters is that both groups can have a medical need for the treatment at issue. Attempting to affix labels about "abnormality" does not change that need. And psychological conditions can and often do require medical intervention including, for instance, medications to treat depression.

Additionally, any attempt to use differences between men and women as a justification for a classification goes not to whether the statute *receives* heightened scrutiny, but whether it *survives* it. Courts consider alleged differences between the two classes "to decide whether the governmental interest for discrimination is *justified*." *Kadel*, 100 F.4th at 155 (emphasis added); *see also Tuan Anh Nguyen v. INS*, 533 U.S. 53, 62-68 (2001) (different citizenship rules that depend on whether the citizen parent is a mother or father warranted heightened scrutiny, but analysis of whether rules were justified depended on the question whether biological mother and father are similarly situated with regard to proof of biological parenthood). Such differences do not negate the fact that SB 99, on its face, treats minors differently based on whether or not medical treatment is consistent or inconsistent with their sex-assigned at birth. Whether that unequal treatment is justified by biological differences is a question to be addressed when determining whether SB 99 survives strict scrutiny, and as discussed more fully above, Defendants fail to meet their burden.

B. SB 99 Classifies on the Basis of Transgender Status.

SB 99 also classifies on the basis of transgender status by classifying based on an incongruence between a person's sex designation at birth and their gender identity. PI Order 21 ("Given the definition of 'transgender,' a person whose gender identity is not congruent with their sex assigned at birth, the language of SB 99 classifies based directly on transgender status."). And while the text of SB 99

may not contain the word "transgender," that is immaterial where the law's terms accomplish the exact same objective. *See, e.g.*, *Hecox*, 104 F.4th at 1077 (recognizing that statutes need not use "the word 'transgender'" to discriminate against transgender people). Indeed, proponents of SB 99 in the Montana Legislature also made no effort to conceal their intent to target transgender people. In fact, SB 99's primary sponsor, Senator Fuller, stated during a Senate floor session that "transgender ideology" is a "spiritual dogma" and that "medicine cannot make a man into a woman or a woman into a man." *See* 2/7/23 Senate Floor Session, 13:14:33, *available at* http://sg001-harmony.sliq.net/00309/Harmony/en/PowerBrowser/PowerBrowserV2/20230207/-1/46207#agenda.

As this Court has also previously recognized, transgender status itself is a suspect classification. PI Order 25 n.7 (noting that "the Court believes that transgender persons comprise a suspect class"). This is consistent with the law of the Ninth Circuit. *Karnoski v. Trump*, 926 F.3d 1180, 1199-1201 (9th Cir. 2019); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015). Other federal courts across the country have reached the same conclusion.[15]

C. Classifications Based on Sex or Transgender Status Are Subject to Strict Scrutiny.

After identifying the classifications imposed by the challenged statute, the Court must determine which level of scrutiny it must apply. *Planned Parenthood*, ¶ 29. Montana courts apply strict scrutiny "where the legislation at issue infringes

[15] Courts across the country have held that transgender people constitute at least a quasi-suspect class. *See*, *e.g.*, *Doe v. Horne*, 115 F.4th 1083, 1102 (9th Cir. 2024) ("[H]eightened scrutiny applies to laws that discriminate based on transgender status."); *Hecox*, 104 F.4th at 1079 (same); *Kadel*, 100 F.4th at 143 ("[T]ransgender people constitute a quasi-suspect class . . . ."); *Dekker v. Weida*, 679 F. Supp. 3d 1271, 1291-92 (N.D. Fla. 2023), *appeal filed*, No. 23-12155 (11th Cir. June 27, 2023); *Brandt v. Rutledge*, 677 F. Supp. 3d 877, 917-18 (E.D. Ark. 2023); *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 607 (4th Cir. 2020), *as amended* (Aug. 28, 2020); *Karnoski*, 926 F.3d at 1200-01; *Ray v. McCloud*, 507 F. Supp. 3d 925, 937-38 (S.D. Ohio 2020) (collecting cases); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017).

upon a fundamental right or discriminates against a suspect class." *Powell v. State Comp. Ins. Fund*, 2000 MT 321, ¶ 17, 302 Mont. 518, 15 P.3d 877. In addition to triggering strict scrutiny because it burdens the fundamental right to privacy, SB 99 must also be subjected to strict scrutiny because it imposes a suspect classification by discriminating on the basis of sex and transgender status.

As this Court previously recognized, sex is a suspect classification that warrants strict scrutiny. PI Order 25-27; *see also Cross*, ¶ 64 (McKinnon, J., concurring) ("[S]trict scrutiny is the appropriate standard of review . . . because Article II, Section 4 is unequivocal in its intolerance for discrimination, which includes discrimination based on sex."). While Defendants argue that SB 99 does not classify on the basis of sex, they do not argue that sex itself is not a suspect classification warranting strict scrutiny. This Court correctly concluded as a matter of law that sex classifications must be subjected to strict scrutiny. PI Order 25-27 ("To the degree strict scrutiny imposes a higher burden than [the federal courts'] heightened scrutiny, that higher burden is justified by Montana citizens' heightened protection under Article II, § 4"). Defendants offer no basis for the Court to revisit this well-reasoned conclusion. And as discussed more fully above, discrimination against transgender people constitutes discrimination against a suspect class; thus SB 99 independently receives strict scrutiny for that reason. For both of these reasons, SB 99 must be subjected to strict scrutiny.

V. SB 99 Also Violates Numerous Other Fundamental Rights.

The State wrongly asserts that SB 99 does not violate any other constitutional rights. Defs. Br. 35. However, for all of the reasons previously briefed in support of Plaintiffs' motion for preliminary injunction, SB 99 infringes upon Montanan's fundamental rights to parental autonomy, to seek health care, to dignity, and to freedom of speech and expression. *See* Pls. Br. 32-41. Infringement

of fundamental rights is reviewed under strict scrutiny, which SB 99 fails for the aforementioned reasons. *See supra* pp. 12-25.

A. Parental Rights

The Montana Constitution protects "the fundamental right of a parent to make decisions regarding the care of their children, including, among other things, the upbringing, education, health care, and mental health of their children." *Stand Up Mont. v. Missoula Cnty. Pub. Sch.*, 2022 MT 153, ¶ 28, 409 Mont. 330, 514 P.3d 1062. The Montana Legislature underscored the importance of this fundamental right by statute, explicitly prohibiting the government from interfering unless it "furthers a compelling government interest [and] is narrowly tailored and is the least restrictive means available." Mont. Code Ann. § 40-6-701(1); *Stand Up Mont.*, ¶ 27. Defendants' response that a more specific statute, SB 99, controls over this more general statute only confirms that SB 99 cannot satisfy the conventional requirements of strict scrutiny. Defs. Br. 36.

The State attempts to evade the requirements of strict scrutiny by mischaracterizing gender-affirming medical care as a "bona fide health risk" to justify, and even necessitate, legislature interference with parental rights. Defs. Br. 36. However, as discussed above, gender-affirming medical care does *not* create a bona fide health risk, and the State cannot baldly assert that it does to sidestep a parent's fundamental right to make medical decisions for their children, particularly where the parents, the minor, and the doctor all agree upon the appropriate course of treatment. *See supra* pp. 5-12; *see Stand Up Mont.*, ¶ 27 (finding that the legislature's "intent of [Section 40-6-701] is clear from a plain reading: it prohibits the government from interfering with the fundamental parental rights" unless the government can pass strict scrutiny).

B. Right to Seek Health Care

Montanans also have a fundamental and inalienable right to "seek[] their safety, health and happiness in all lawful ways," Mont. Const. art. II, § 3, including the right to "seek and obtain medical care from a chosen health care provider and to make personal judgments affecting one's own health and bodily integrity without government interference," *Armstrong*, ¶ 72.

The State conflates SB 99's categorical ban on gender-affirming medical care for minors with a ban on a particular drug or a single medical treatment by relying upon *Montana Cannabis Industry Ass'n v. State* ("*MCIA*"), 2012 MT 201, ¶ 24, 366 Mont. 224, 286 P.3d 1161 (analyzing legislation limiting access to medical marijuana); Defs. Br. 37. However, as the Montana Supreme Court already held when distinguishing that authority, "the law at issue [in *MCIA*] restricted a single drug for all uses" whereas "SB 99 prohibits a host of procedures and medications, but only if used to treat gender dysphoria." *Cross*, ¶ 31. SB 99's wholesale ban sweeps in "a broad swath of medical treatments" needed by transgender adolescents. *Id.* ¶ 32. Further, the State's reliance upon *MCIA* fails to address another distinction, that "the procedures and medications prescribed by SB 99 are not 'unequivocally illegal,' as was medical marijuana when [*MCIA* was] decided." *Id.* ¶ 31; *see also* A.336-37. Yet SB 99 prohibits minors from obtaining FDA-approved gender-affirming medical care as treatment for their gender dysphoria, rendering them unable to "seek and obtain medical care" to ensure their own health as is their fundamental right under the Montana Constitution. *See* Mont. Const. art. II, § 3.

C. Right to Dignity

The Montana Constitution provides that "[t]he dignity of the human being is inviolable." Mont. Const. art. II, § 4. The Montana Supreme Court has recognized that the right to dignity is a fundamental right and that "[t]reatment which degrades

or demeans persons, that is, treatment which deliberately reduces the value of persons, and which fails to acknowledge their worth as persons, directly violates" this right. *Walker v. State*, 2003 MT 134, ¶ 81, 316 Mont. 103, 68 P.3d 872.

In an effort to minimize the harm caused by SB 99, the State highlights the dire living conditions at issue in *Walker v. State*. *See* Defs. Br. 38. In fact, *Walker* actually supports Plaintiffs arguments because there is no genuine dispute that gender dysphoria can cause serious harms when left untreated. Both sides—including the State's expert witnesses—agree that, without treatment, gender dysphoria can lead to "very adverse long-term mental health consequences, including suicide." A.375; *see also* A.200-01. The life-altering and potentially life-threatening impact of depriving transgender adolescents of the care they need cannot be set aside so easily. This Court already recognized the severity of the harms at stake when detailing SB 99's irreparable harms, PI Order 40-43, a holding that the Montana Supreme Court affirmed, *Cross*, ¶¶ 48-51.

SB 99 violates transgender minors' right to dignity by threatening and demeaning their humanity and identity. A person's ability to live as their true self, consistent with their core identity, and—specifically to the point here—to align their body with their gender identity, is protected from government intrusion. Here, the intrusion on dignity is stark. SB 99 would, for example, seek to forcibly "detransition" a transgender boy like Mr. Cross, causing him to develop female-typical secondary sex characteristics in visible opposition to his male gender—and contrary to the boy he currently sees when he "look[s] in the mirror" and contrary to what his family, peers, and others in his life have seen for years. A.006. SB 99 infringes upon the fundamental right to dignity by drastically limiting the ability of transgender minors to seek potentially life-saving care that would allow them to live in alignment with their gender identity.

D. Right to Speech and Expression

"No law shall be passed impairing the freedom of speech or expression. Every person shall be free to speak or publish whatever he will on any subject, being responsible for all abuse of that liberty." Mont. Const. art. II, § 7. The Montana Constitution protects the "vast majority" of speech, and these protections extend to the right to receive information as an indispensable component of the free exchange of ideas. *State v. Dugan*, 2013 MT 38, ¶¶ 18, 79, 369 Mont. 39, 303 P.3d 755 (citation omitted); *see State ex rel. Missoulian v. Mont. Twenty-First Jud. Dist. Ct.*, 281 Mont. 285, 301, 933 P.2d 829, 839 (1997).

SB 99 infringes upon this right. At a minimum, according to the State's representatives, SB 99 prohibits health care providers from even referring any adolescent out-of-state for gender-affirming medical care. SA.034; *see Brandt*, 677 F. Supp. 3d at 924 (finding Arkansas regulation restricting "healthcare professionals from making referrals for 'gender transition procedures'" violated the First Amendment as a content and viewpoint-based restriction on speech). Thus, Defendants view SB 99 as not only banning the provision of gender-affirming medical care but also banning speech that may lead to a minor being provided such care. And that speech prohibition would exist regardless of whether a particular patient is on Medicaid or any public funding is implicated. *Cf.* Defs. Br. 39.

The State draws a false equivalency between the requirements at issue in *Planned Parenthood of Southeast Pennsylvania v. Casey*, 505 U.S. 833, 884 (1992), and SB 99's prohibition against speech. Defs. Br. 39. The law in *Casey* required physicians to disclose the risks associated with abortion to ensure informed consent. 505 U.S. at 840. The Court found that there was no free speech issue with requiring physicians to provide the risks and alternatives associated with a procedure before administering that procedure because it is "part of the practice of medicine, subject to reasonable licensing and regulation by the State." *Id.* at

884. In contrast, here, SB 99 does not simply require physicians to provide patients with information about the risks associated with a specific treatment option, a step that gender-affirming medical care providers already take under the clinical practice guidelines.

Instead, according to Defendants, SB 99 prohibits speech causing a minor to obtain gender-affirming care at all, including through a referral to a provider in a state where there is no prohibition on such care. This restricts speech based upon its content and viewpoint, infringing upon Montana's fundamental right to speech and expression. *State v. Lamoureux*, 2021 MT 94, ¶ 21, 404 Mont. 61, 485 P.3d 192 ("[R]egulation is content-based if the law 'on its face, draws distinctions based on the message a speaker conveys,' such as 'the topic discussed or the idea or message expressed.'"); *see also Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 585 U.S. 755, 756 766-68 (2018) (addressing arguments based on purported speech-conduct distinction and holding that "[s]peech is not unprotected merely because it is uttered by 'professionals'").

CONCLUSION

For the foregoing reasons, Defendants' motion should be denied.

Dated: February 19, 2025

Respectfully submitted,

By: /s/ Alex Rate
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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 3(G) of the Court's Local Rules of Practice and the Court's order of February 19, 2025, *see* Dkt. No. 202, the undersigned certifies that this brief was prepared using a proportionally spaced typeface of 14 points and does not exceed forty (40) pages in length, excluding the brief's title page, table of contents, table of authorities, certificate of compliance, and certificate of service.

Dated: February 19, 2025 By: /s/ Alex Rate
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CERTIFICATE OF SERVICE

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PHOEBE CROSS, a minor by and through his guardians Molly Cross and Paul Cross, et al.	)	
	)	**Case No. DV-23-541**
	)	
Plaintiffs,	)	**Judge: Hon. Jason Marks**
	)	
v.	)	
	)	
STATE OF MONTANA et al.,	)	
	)	
Defendants.	)	
	)	
	)	

PLAINTIFFS' SUPPLEMENTAL APPENDIX TO PLAINTIFFS' BRIEF IN OPPOSITION TO DEFENDANTS' MOTION IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

Phoebe Cross, et al. v. State of Montana
Case No. DV-23-541, Hon. Jason Marks

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Defendants' Motion for Summary Judgement

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SA.009 to SA.018	Defendants' Deposition	2024-10-22 Sven Roman, M.D. Deposition (Excerpts)
SA.019 to SA.030	Defendants' Deposition	2024-10-29 Geeta Nangia Deposition (Excerpts)
SA.031 to SA.034	Defendants' Deposition	2025-01-10 David Ortley Deposition (Excerpts)
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SA.039 to SA.061	Plaintiffs' Deposition	2024-10-28 Johanna Olson-Kennedy, M.D. Deposition (Excerpts)
SA.062 to SA.065	Defendants' Expert Report	2025-05-15 Expert Report of Geeta Nangia (Dep. Exh. 543)
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SA.070 to SA.084	Other Case Filings	2024-13-16 Order Granting Motion for Preliminary Injunction in *Kalarchik v. State of Montana,* ADV-2024-261 (First Judicial DC, Lewis and Clark County), Dkt. 61
SA.085 to SA.092	Documents	Standards of Care 8 - S101 - S102 SB99-PLAINTIFFS_0000548 - 553; 0000650 - 651
SA.093 to SA.096	Documents	DEF 0740 - 743

MONTANA FOURTH JUDICIAL DISTRICT COURT

MISSOULA COUNTY

PHOEBE CROSS, et al.,

Plaintiffs,

vs. Cause No. DV-23-541

STATE OF MONTANA, et al.,

Defendants.

VIDEO DEPOSITION UPON ORAL EXAMINATION OF

FARR A. CURLIN, M.D.

BE IT REMEMBERED, that the video deposition upon oral examination of FARR A. CURLIN, M.D., appearing at the insistence of the Defendants, was taken via Zoom, on September 16, 2024, beginning at 9:00 a.m., MST, pursuant to Montana Rules of Civil Procedure, before Robyn Ori English, Court Reporter - Notary Public.

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notwithstanding those things that we experience.

So the science of medicine is really not influenced by Christianity either now or in the past in the sense that the Christian tradition doesn't offer a particular science of medicine, but the vision of why we do medicine and how to really care well for another is certainly shaped by Christian tradition.

Q. Okay. Thank you. And in the course of treating patients, did you ever pursue a course of treatment that does not align with Christian values?

MR. JOHNSON: Objection, vague.

Go ahead and answer.

THE WITNESS: Can you repeat the question?

Q. (By Ms. Picasso) Yeah. In the course of treating patients, did you ever pursue a course of treatment that does not align with Christian values?

MR. JOHNSON: Same objection.

Go ahead.

THE WITNESS: Yeah, I don't know. Not intentionally insofar as there's nothing that's a part of good medicine that, to my knowledge, Christian tradition opposes. So I would not have -- I would not have intentionally practiced bad medicine and insofar as I was practicing good medicine

are clearly not medically necessary. And so if they're telling families what they are here saying under oath, which is what I assume they're doing if they're telling the truth, according to their rights, they are misinforming families.

Q. Okay. And you opine in paragraph 101 that "MGT brings lifetime physical and social implications, including risks of impaired brain development, sterilization, and loss of sexual function."

Did I read that correctly?

A. Almost. Close enough.

Q. Okay. Let me just -- would you like to correct anything that I misstated?

A. The last word was "response" not "function."

Q. Oh, I don't know why I said -- and I have it written as "response." I don't know where I got "function" from. So are these risks associated with any other medical treatment that are, in your opinion, ethically administered to minors?

A. Probably.

Q. Okay. And paragraph 102, you opine "Puberty blockers by design blocks the mental, physical, and emotional maturation of puberty, which

behalf of the child."

Did I read that correctly?

A. Almost, and close enough.

Q. Please do correct me whatever the mistake was.

A. You made "response" plural, but it's singular, but otherwise that was fine.

Q. Okay. Thank you. Are you familiar with the practice of penile circumcision?

A. I am.

Q. Okay. And generally speaking, is the practice of penile circumcision performed for the purpose of resolving an excess or deficiency that is likely to cause imminent bodily harm to the patient?

A. No.

Q. Okay. And do you know if penile circumcisions are performed on infants solely with the consent of the infant's parents?

A. I assume they are under done only with the consent of the parents or guardians.

Q. Okay. And do you know if performing a penile circumcision on an infant can result in the sterilization of the infant, however rare?

A. It would have to go very badly for that to happen, but I'm sure there has been a case where

complications ultimately resulted in sterility.

Q. And do you know if performing a penile circumcision on an infant can impair the infant's development of healthy sexual responses, however rare?

A. Same response, it would have to go very badly. That would be exceptionally rare.

Q. But it is possible?

A. Yes. I mean, unlike medicalized gender transition where it's very predictable that you will be sterile and not develop a mature sexual response.

Q. All right.

A. In the case of circumcision, it's exceptionally rare that those would happen.

Q. Do you think performing penile circumcisions on an infant is ethical?

A. I do.

Q. Okay. And what in particular about this surgical removal of healthy tissue on the genital of an infant is ethical?

A. The reason I think it's ethical is, to the best of our knowledge, after, you know, millennia of this practice, other than in very rare cases where there are real complications, penile circumcision does not result in any loss of health

function for the male child. It doesn't lead to problems with urination. It doesn't lead to problems with erection. It doesn't lead to problems with sterility. It doesn't lead to other problems. So it's a --

Q. Uniformly it never leads to any of those problems?

A. I already said except in very rare occasions where there are complications.

Q. Okay.

A. So in that respect, I don't -- it's done without -- without anticipation or without foreseeing adverse consequences, again, except in very rare cases.

In the same way that driving across the country, you could crash your car and die. You know, that's not a reason to never drive across the country. But if you know it's likely that you're going to crash your car and die, then it would be unreasonable to drive across the country.

So in that respect, I think it is ethical. Is it required by medicine? No.

Q. And what is penile circumcision -- what is it trying to treat?

A. I think in most cases, it's not trying to

treat any medical condition. It's done for cultural and -- cultural reasons. And, you know, there is -- it is known to reduce the risk of penile cancer, which is itself is very rare; so that's not a very strong reason to do a circumcision. But it is -- it is a reason. And there's some -- some reason to believe that it can reduce the transmission of sexually transmitted illnesses. Although I think that -- that's a -- you know, it's not perfectly clear whether that's the case.

Q. Okay. So primarily it's not aimed at necessarily treating any particular condition. It's being performed for cultural reasons?

A. Primarily for most people.

Q. Okay.

MS. PICASSO: Okay. Why don't we pause here, and I'd like to just confer with my team really quickly, and then I might be able to give you a better sense of about how much longer. I don't think it will be much longer, but just let me get back to you --

THE WITNESS: Sure.

MS. PICASSO: -- with how much more time we need.

How does that sound, Thane?

MR. JOHNSON: That's fine.

MS. PICASSO: All right.

MONTANA FOURTH JUDICIAL DISTRICT COURT

MISSOULA COUNTY

MOLLY CROSS, et al.,

Plaintiffs,

vs. Cause No. DV-23-541

STATE OF MONTANA, et al.,

Defendants.

VIDEO DEPOSITION UPON ORAL EXAMINATION OF

DR. SVEN ROMAN

BE IT REMEMBERED, that the videotaped deposition upon oral examination of DR. SVEN ROMAN, appearing at the instance of the Plaintiffs, was taken via Zoom, on October 22, 2024, beginning at 6:00 a.m., MST, pursuant to Montana Rules of Civil Procedure, before Robyn Ori English, Court Reporter - Notary Public.

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THE WITNESS: But should we take a break maybe?
PELECANOS: Yeah, ten minutes.
MR. JOHNSON: I'm just trying to see if I can get a better solution.
THE WITNESS: Good. Okay.
VIDEO OPERATOR: We'll go off the record. The time is 9:14 a.m. Mountain Time.

(Whereupon, a recess was taken)

VIDEO OPERATOR: We are back on the record. The time is 9:25 a.m. Mountain Time.
Q. (By Pelecanos) All right. We were just discussing the criteria for the provision of hormones under the Swedish recommendations. These criteria are fairly similar to the WPATH Standards of Care 8, correct?
A. I don't know because my opinion about WPATH and their recommendations is that they are -- differ a lot from this one.
Q. Okay. Do you have any specific examples of how the criteria differ?
A. No, not specific -- not specific examples, but WPATH have influenced all of the gender dysphoria treatment in all the Western world

for the last 20 years, so -- and that has been a medical standard, maybe the biggest in history.

Q. The second criteria that we were looking at for the provision of hormonal treatment for gender dysphoria says that no untreated psychiatric problems are a condition, but would you agree that that's different from saying that anyone with mental health comorbidities can't receive gender dysphoria treatment?

A. Let me just look at it once again. Yes, yes, I would. And I agree -- I could say, of course, I don't think that if you have any under psychiatric disorder that that should be a contraindication.

Q. And by "contraindication," you mean that --

A. For medical treatment. But the contraindication for me is the age, the maturity on the brain. That's the contraindication.

Q. Okay. And when you say for maturity in the brain, do you believe that minors or their parents can consent to, for example, puberty blockers in the context of precocious puberty?

A. Yes, because that's something different.

Q. Okay. And when adolescents, for example,

are receiving cancer treatment and they need to take hormonal therapy for that, can their parents or those minors consent to treatment in those conditions?

A. Yes, because it's a biological problem.

Q. Okay. If we go to page 86.

A. Yes.

Q. We're looking at essentially a list of criteria for puberty blockers, similar to what you just read for hormone therapy. I'm going to read this brief list, if you want to read along, just so we can affirm that we're discussing the same thing here.

The first criteria is "Basic conditions of thorough diagnostic evaluation, multidisciplinary decision-making, consent from guardians, provision of information and expected benefit/risk assessments are met."

No. 2, "The adolescent has a stable psychosocial situation, and there are no factors that obscure the certainty of the clinical assessments (neuropsychiatric or intellectual disability, untreated psychiatric problems, including suicidal risk and trauma, substance abuse).

"Gender incongruence has existed since childhood, and gender identity has remained stable over time. There is a lack of evidence about how long gender incongruence should have existed. A U.K. publication from 2021 has set the minimum at a minimum of five years." [As read]

"The onset and progression of puberty has brought clear suffering.

"DSM-5 diagnostic criteria for gender dysphoria are met.

"The adolescent should be between 12 and 15 years old. In a Dutch publication reflecting the Dutch protocol, treatment with GnRH-analogue was started on average at 14.75 years of age (Standard deviation equals 1.92, range 11.3 to 18.6). During the guidelines update process, comments were received both that 12 years is too low a cut-off and that treatment with extended follow-up may, in exceptional cases, be justified before the age of 12."

Did I read that correctly?

A. Yes, yes.

Q. These criteria are fairly similar to the hormone criteria that I just read, with the exception of age and the criteria regarding puberty

bringing suffering, correct?

A. Yes.

Q. Okay. Would you agree that these criteria taken as a whole are not essentially a ban, right?

A. Yes.

Q. Okay. These criteria would allow for treatment in a much broader number of cases than the example you gave of someone who has already started treatment and was being cut off from that treatment, correct?

A. Yes.

Q. All right. I'm directing you to page 69.

A. Yes.

Q. Let's see. Under -- where is this? Sorry. Under "Background," under the section on autism spectrum disorder and ADHD.

A. Yes.

Q. Below where the colored square is, the next paragraph below that.

A. Yes.

Q. It reads, "ASD," which stands for autism spectrum disorder, "and ADHD/ADD do not exclude a young person from a diagnosis of gender dysphoria or from treatment when indicated."

MR. JOHNSON: What page now?
PELECANOS: 81.
MR. JOHNSON: Okay. Thank you.
Q. (By Pelecanos) Under "Support and consent from guardians," do you see that section?
A. Yes.
Q. It says, "As a starting point, it is the guardian who has the right and obligation to decide on matters of healthcare for the child. However, as the child grows older and more mature, the child's wishes must increasingly be taken into account. A child may be considered mature enough to decide alone on his or her own about specific care or treatment if he or she can assimilate the relevant information and understand the consequences of the decision."
Did I read that correctly?
A. Yes.
Q. So under the recommendations, parents and sometimes, in rare cases, a minor without their parents can consent to gender-affirming care; is that correct?
A. Yes.
Q. Thank you. Moving on to other things. In your report, you talk about some of the practices

that.

A. J. J, okay. H, I, J. Yes, I've read that.

PELECANOS: Could we enter this as Exhibit 532? Is that what we're on? 2. Yeah, 532.

MR. JOHNSON: Is this the study gender services for children and adolescents across the EU?

PELECANOS: Correct, yes.

MR. JOHNSON: Okay. Thank you.

(Deposition Exhibit No. 532 was marked for identification)

Q. (By Pelecanos) This is one of the studies conducted by the University of York at --

A. Okay.

Q. -- the request of Hilary Cass; is that correct?

A. Yes, yes. And -- yes, and I read that, so I -- yes.

Q. Okay. If you look at page 2 under "Participation," the study looks at responses from Australia, Belgium, Denmark, Norway, Northern Ireland, the Netherlands, Spain, and Finland, correct? And if you look at page 6 --

A. Yes.
Q. -- under "Medical interventions," it states, "All services routinely offer interventions to suppress puberty and masculizing/feminizing hormone interventions except for one regional service (The Netherlands), which referred to a national gender service." Is that right?
A. Okay, yes.
Q. So care's not banned in Norway, correct?
A. Yes, and I've never said or written that it is banned in Norway.
Q. What have you written about the --
A. That they are -- they are following Finland, Denmark, and Sweden with the precautionary approach. And that's -- and I stand for that opinion.
Q. So you would consider all services routinely offered, including both puberty blockers and hormonal therapy, to be the model that they're following?
A. No. This survey was a couple of years ago, and it has happened a lot of things since that. This survey was from September 2022 to April 2023. It's one and a half years ago. It has happened a lot of things.

IN THE FOURTH JUDICIAL DISTRICT COURT

MISSOULA COUNTY

PHOEBE CROSS, et al.,

Plaintiffs,

vs. Cause No. DV 23-541

STATE OF MONTANA, et al.,

Defendants.

VIDEOCONFERENCE DEPOSITION

UPON ORAL EXAMINATION OF

GEETA NANGIA

BE IT REMEMBERED, that the deposition upon oral examination of GEETA NANGIA, appearing at the instance of Plaintiffs, was taken via Zoom through the offices of Fisher Court Reporting, 442 East Mendenhall, Bozeman, Montana, on Tuesday, October 29, 2024, beginning at the hour of 9:00 a.m., MST, pursuant to the Montana Rules of Civil Procedure, before Kasey L. Fisher, Registered Professional Reporter - Notary Public.

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Also present: Alex Rate, Marthe VanSickle, Mary Grace Thurmon, Meeghan Dooley, ALCU Clinic Student

identity itself may be stable over time.

And my question is do you think psychotherapy can cause a change in the gender identity itself as distinct from somebody's understanding of their gender identity?

A. I wouldn't distinguish between the two. I -- I just -- I feel like I've answered that question the best I can. I apologize, but that's the best way I can answer it.

Q. Do you believe that psychotherapy can cause a change in gender identity for all transgender people?

A. No, not necessarily. As I've said, I've had four patients who, you know, through the process of therapy felt, you know, very comfortable with their gender incongruence and their dysphoria had become mild and they decided to become adults and transition.

Q. If a minor patient came to you and wanted psychotherapy for the purpose of bringing their gender identity into alignment with their sex assigned at birth, would you agree to provide that psychotherapy?

A. No. I think that -- I think that's conversion therapy. I don't think that's

Q. In your expert report, did you cite to any peer-reviewed articles finding that psychotherapy alone was adequate to treat gender dysphoria in minors?

A. No, because the study -- I was clear that the research hasn't been done and it needs to be done.

Q. Are you aware of any studies rated as high quality under the GRADE system finding psychotherapy alone is adequate to treat gender dysphoria in minors?

A. No. I wish it would be researched to begin with.

Q. We'll talk more about the Cass review later.

But it relied upon a systematic review of psychosocial interventions for minors experiencing gender dysphoria, correct?

A. The Cass review was actually broad in its scope. What I loved about that study is that they had interviews with transgender patients, they had -- you know, they went to groups like LGBTQ support groups. So they took into consideration patient input. They took into consider -- go ahead.

explained to parents what my -- you know, my experience is and that's all.

Q. Do you believe that psychotherapy can cause a change in a person's sexual orientation?

A. Again, I would have the same answer that I gave you earlier with regard to gender. No, I don't believe psychotherapy can change sexual orientation. I believe that the role of psychotherapy is to address unconscious conflicts and bring them into conscious awareness for the person so that they themselves can feel that they find an understanding of themselves that's more clear.

Q. Would you agree that gender identity is resistant to voluntary change?

A. Please clarify.

Q. Is there a piece of that that's unclear?

A. What to you mean "voluntary change"? Like if a person wants to...

Q. As distinguished from gender identity changing over time, I'm asking specifically about somebody who causes that to occur.

Would you agree that gender identity is resistant to voluntary change?

A. Yes. Probably, yes.

A. I mean, there are phase 1 through 4, I believe, clinical trials, and I believe they start out with -- they're animal studies, et cetera. There's -- and then it proceeds to human studies. I can't tell you all that off the cuff.

Q. At phase 1, it's not as though there's a clinical trial proving the efficacy of the drug at that point, right?

A. Okay.

Q. Is that your understanding?

A. Yes. Yes.

Q. It's also fair to say that the safety of the drug is also unproven at phase 1?

A. Right.

Q. Okay. Do you oppose parents being able to consent for their children to receiving drug that have only received phase 1 approval even outside the setting of clinical trials?

A. It would depend on acuity and risk.

Q. So there might be circumstances where you think parental consent might be sufficient?

A. It would depend on acuity and risk, right?

Q. But the answer is yes, there are circumstances --

A. Yes. Yes.
Q. So you don't think a categorical ban is appropriate?
A. For?
Q. Parents being able to consent for their children to receive drugs that have only received phase 1 FDA approval?
A. It would depend on acuity and risk.
Q. Again, so that indicates that you don't support a categorical ban on parents being able to provide consent in that context, right?
A. No, incorrect. I'm saying quite the opposite. It would depend on acuity and risk. So if you're talking, for instance, about a medication that is, hypothetically, to treat depression, okay, and I have a child who has exhibited treatment refractory depression and nothing else is helping.
And so if we have a medicine that is available for treatment, what I would weigh in that and whether or not I would support a categorical ban of that medication would be whether or not that medicine has significant risk to the child's long-term mental health and future. And so that's -- that's where I sit on that issue.

expert report, correct?
A. Correct.
Q. The opening conclusion of this article is that children who are 12 or older should generally be able to provide informed consent to medical treatment alongside their parents providing informed consent, correct?
A. That's correct.
Q. Okay. You can set that aside.
A. Okay.
Q. Have you ever prescribed a minor antidepressants?
A. Yes.
Q. What's the youngest age patient to whom you've prescribed antidepressants?
A. Six.
Q. It's not uncommon for minors to be prescribed antidepressants, correct?
A. No.
Q. Does a minor need to present an immediate risk of harm to themselves or others in order for you to prescribe antidepressants?
A. No.
Q. In order to provide -- sorry.
In order to prescribe a minor

antidepressants, you obtain informed consent from the minor's parents, correct?

A. Correct. And I go into it with the minors as well and try to garner the best I can to garner informed consent or assent.

Q. Do you provide the parents and the minor information about the risks and benefits of antidepressants?

A. I do.

Q. So let's take the example of Prozac. What are some of the risks of Prozac?

A. The FDA black box warning would be a 2 percent risk for suicidal thoughts or ideation or behaviors. Additionally, you can have activation. You can have psychosis if the person were to start hearing voices or seeing things that weren't there.

And then the more common side effects would be belly ache, headache, nausea, GI upset, not wanting to eat as much. You can see shakiness. Would you like me to go on?

Q. If those are the highlights, you can stop.

A. Okay.

Q. Is it true that one of the potential

for suicidality.

Q. Okay. Have you -- actually, let me pause. We've been talking about antidepressants.

Are there particular medications that you prescribe as a psychiatrist that have even greater levels of risk than antidepressants when we're talking about the minor population?

A. I personally only would utilize treatments that are like more significant in a situation that high risk was a problem. So, for instance, a patient who has bipolar 1 and is manic and at risk for significant harm to themselves or to others. Then -- you know, then you -- they require medication that can carry more risk say than an antidepressant may carry.

Or psychosis, for instance. That's another event where I would treat. Or a child or adolescent who demonstrated significant threat to others with regard to aggression. Those are examples where I would utilize a medicine that may contain more risk than the antidepressant.

Q. Can you give me some specific examples of medications that you prescribe that are riskier than antidepressants?

A. I would say Lamictal.

Q. I think you're going to have to spell that for Kasey.

A. Lamotrigine, which is L-a-m-o-t-r-i-g-i-n-e. That's an example. That's a mood stabilizer.

Trileptal, which is oxcarbazepine. Those are some examples.

Q. What are some examples of the risks that they pose that are greater than antidepressants?

A. Changes in blood counts, so you can see white cell count drop. You can see pancytopenia. You can see issues with tremulousness, rashes that can occur, that, you know, one would have to discontinue the medication for.

So, I mean, those would be liver function, making sure that you monitor liver function and sure that that's okay. Those are examples.

Q. Have you ever provided medical treatment to a minor where there was a risk that the treatment could have a negative effect on fertility?

A. I'm very careful in that regard. There are a couple of medications on the market that can do that. The antipsychotics in particular. And I

A. The point that the WPATH makes is that they want to argue that -- that puberty blockers would allow or buy the child more time to make a decision as to whether or not they want to proceed along the gender-affirming care route.

Q. Is one of the reasons for puberty blockers in that population to prevent a mental health decline that might occur as a result of the changes associated with endogenous puberty?

A. That's what they claim.

Q. Okay. So let me just stop there.

Okay. Let's shift gears again.

Earlier in your career, you worked at Palmetto Christian Psychiatry, correct?

A. It was my own business.

Q. Okay. What role did Christianity play in that practice?

MR. NOONAN: Objection. Relevance.

BY MR. RENN:

Q. You can answer.

A. So I can tell you -- are you asking why I have the word "Christian" in my name?

Q. Let's start there.

A. Yeah. Absolutely. I had grown up in New England, went to school in Boston. And when I

IN THE FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

MOLLY CROSS, ET AL.,

PLAINTIFFS,

VS. CAUSE NO. DV-23-541
HON. JASON MARKS

STATE OF MONTANA, ET AL.,

DEFENDANTS.

ZOOM DEPOSITION OF DAVID ORTLEY

BE IT REMEMBERED, that the Zoom deposition upon oral examination of David Ortley, was taken via Zoom, on January 10, 2025, beginning at 10:10 A.M. MDT, pursuant to Montana Rules of Civil Procedure, before Marla C. Cole, BCR, Certified Court Reporter and Notary Public.

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ALSO PRESENT:

Mary Thurmon

Fisher Court Reporting Video Technician

BY MR. RATE:

Q. So we've been talking about the stated interest as drafted in the text of Senate Bill 99. I want to talk about any other State interest the State might have in a ban on gender-affirming care for minors. Can you identify and describe for me the potential impact of untreated gender dysphoria on the health of minors?

A. I was making the mistake of thinking in advance of listening to your entire question. Would you repeat it again? I'm sorry.

Q. Sure. Can you identify and describe the potential impact of untreated gender dysphoria on the health of minors?

A. Well, certainly anxiety, depression. There's much discussion about whether or not there's a -- the consequences -- suicidal ideation. Those are the ones that come to mind.

Q. And if Senate Bill 99 were to go into effect, what would that mean for trans minors currently receiving gender-affirming health care?

MR. JOHNSON: Objection. Foundation. Beyond his expertise. Go ahead.

A. My -- excuse me, I thought I had silenced this phone but, apparently, I did not.

Once again, if you would, repeat that

BY MR. RATE:

Q. So for example if Dr. Mistretta, in this case, recommended that a minor travel outside of Montana to receive gender-affirming care, do you know whether that would fall under the prohibitions enumerated in the Senate Bill 99?

MR. JOHNSON: Same objection.

A. I believe it would simply -- simply taking the position the State's interest in protecting the interests of the adolescents. It wouldn't matter where that care was obtained, inside or outside, that minor and their parents remain residents, citizens of the State of Montana. So I think the State would -- or the Attorney General's office would have an interest in prohibiting that, yes.

BY MR. RATE:

Q. So your understanding is that SB 99 would prohibit a health care provider from referring an individual out of state to receive gender-affirming care as a minor?

A. I think that's implicit in it, yes.

Q. Okay. Let's turn to the World Professional Association on Transgender Health. If I refer to that to WPATH, do you understand what I'm referring to?

A. I do now, yes.

Q. Okay. And what is WPATH to your knowledge?

A. It is a -- just as it's name suggest, it's an

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MONTANA FOURTH JUDICIAL DISTRICT COURT, MISSOULA COUNTY

SCARLET VAN GARDEREN, et al. Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. DV 2023–541 Hon. Jason Marks **EXPERT DECLARATION OF DR. SVEN ROMÁN**

at birth will resume. Puberty-delaying medical treatment does not cause infertility." As already stated in the previous point, the changes during treatment with puberty blockers are not irreversible. Whether fertility is affected by puberty blockers is not known, but it is very possible as it interrupts the maturation of germ cells.[31] However, it is undeniable that cross-sex hormones can cause infertility.[32]

53. Point 49: "Without the support of puberty blockers, the stresses and anxieties that are common among pubertal transgender youth are markedly increased, often to the point of clinically significant social isolation, depression, self-harm, suicidal ideation, and suicide." There is no evidence for these claims, and it is highly questionable to claim that suicide risk increases when it is not proven.

54. Point 51: "For some young people, it may be medically necessary and appropriate to initiate hormonal puberty consistent with the young person's gender identity through gender-affirming hormone therapy (e.g., testosterone for transgender boys, and estrogen and testosterone suppression for transgender girls)." This should not be done for four reasons: 1) the lack of evidence, 2) the severe side effects, including the relatively high risk of stroke, osteoporosis and infertility, 3) the unknown long-term effects, 4) the weak evidence that the new majority of children with gender dysphoria - most often born female, onset in adolescence and

[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6626312/
[32] https://pubmed.ncbi.nlm.nih.gov/25933804/

often with one or more treatable psychiatric conditions - are indeed permanently diagnosed with gender dysphoria. As for the fourth reason, a certain proportion of children with gender dysphoria have it permanently, but so far we cannot distinguish between those children who have it temporarily, i.e. for a few years, and those who have it permanently. Studies of pre-pubescent children with gender dysphoria have shown that at least 85% lose their gender dysphoria at puberty and that the majority of these children come out as homosexual or bisexual. We have no idea how many of those in the new and now dominant group, those with Rapid Onset Gender Dysphoria (ROGD),[33] later revert to their original gender.

55. Point 52, what the Endocrine Society Clinical Guidelines consider should be given for information to the adolescent regarding fertility: "Has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options for preserving fertility.)" Here the plaintiffs are contradicting what they previously wrote about infertility.

56. Point 59: “Gender-affirming hormone therapy is prescribed for minors when it is deemed medically necessary to ameliorate the potentially severe symptoms of gender dysphoria and when it is medically safe and consistent with the youth’s gender identity.” I cannot comment on how assessments are made in the USA, but my experience of the six gender dysphoria clinics for children in Sweden

[33] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330

this life-saving medical care. She has seen how even discussing the loss of gender-affirming care can cause so much discomfort, pain, fear, and anxiety in her patients that she must seriously consider the most appropriate time and manner to initiate the discussion to minimize its negative consequences to their health and wellness." Irrelevant arguments. Trans children, like all other children, should have the right to evidence-based care.

70. Point 158: "Dr. Mistretta is deeply concerned for her young transgender patients because her educational, clinical, and practical experience fully confirm her knowledge that denying them access to the gender-affirming care proscribed by the Act will likely lead to an increase in their depression, anxiety, suicidal ideation, and even suicidal attempts." This opinion is not scientifically supported.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 30th day of August 2023.

Sven Roman

Dr. Sven Roman

STATE OF MONTANA FOURTH JUDICIAL DISTRICT COURT

MISSOULA COUNTY

MOLLY CROSS, et al., Plaintiff, v. STATE OF MONTANA, et al., Defendants.	Case No. DV 2023-541

Deposition of JOHANNA OLSON-KENNEDY, taken on behalf of Defendants, at 633 West 5th Street, Suite 5850, Los Angeles, California, commencing at 10:11 a.m. on Monday, October 28, 2024, before Katherine Jones, CSR 10097.

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ELIZABETH GILL, ESQ.

JAMAR BROWN, Videographer

Via Zoom:

ALEX RATE, ESQ.

KALA LINDGREN, ESQ.

MARTHE VAN SICKLE, ESQ.

NORA HUPPERT, ESQ.

SARA CLOON, ESQ.

APPEARANCES: (continued)

Via Zoom: (continued)

MARY GRACE, ESQ.

PETER RENN, ESQ.

XIMENA VELASQUEX-ARENAS, ESQ.

A The medical risks?
Q Yes.
A No.
Q Okay. So what are the risks of prescribing cross-sex hormones to males assigned at birth?
A So the first thing that we talk about is blood clots. So estrogen -- the delivery of estrogen to both cis gender people and transgender female people is -- makes them more hyper coagulable, which means they can form blood clots easier.
Q Which is a risk of a stroke or a heart attack?
A Correct. That's the first thing that we talk about.
Q Okay.
A We talk about why yes use bioidentical hormones, because the risks of blood clots is lower.
Q What's a bioidentical --
A It's a hormone that is closest to what your body is making already. And they're, also, plant-derived.
Q All right. What is the risk -- if you can quantify it -- of suffering a stroke and/or a heart

Q Okay.
A And again, that's because hormones get secreted twice a day. So at the peak, they would be close to 1,000. At the trough, it would be closer to 300. We can't do that with trans men because people don't take hormones twice a day. We achieve a more consistent level throughout the week and it's somewhere between 300 and 1,000. For my patients, it's very rare for somebody to be over 800.
Q Is 1,000 toxic?
A No.
Q Are there medical complications if you get to that level?
A I've never had anyone at that level, so I can't answer that question. Most of the information we know about toxicity comes from cis gender men using testosterone for sports enhancement.
Q Got it. And what are the consequences of that of cis gender men using testosterone for sports enhancement? Since you brought it up.
MR. GORDON: Object to form.
THE WITNESS: Again, not my area of expertise, but certainly shrinking of the testicles, the development of acne, potentially, roid rage. These are just things that I've heard about, again,

BY MR. THANE:
Q No?
A No.
Q Does anybody know what the results are?
A Diane Chen is the one working on it. I; don't know where they are in the process of that analysis.
Q So we don't know whether they went up down or stayed neutral?
A Correct.
MR. THANE: Let's go with this. Did I give you your copy? Did I give you one?
MR. GORDON: I don't think so.
MR. THANE: Here you go (indicating).
MR. GORDON: Thank you.
MR. THANE: And I'm handing you Exhibit 42 and ask you if you know what it is.
(Defendants Exhibit 42 was marked for identification.)
THE WITNESS: I do.
BY MR. THANE:
Q And what is Exhibit 42?
A It's a New York Times article.
Q And how did this come about where you were interviewed by Azeen -- and I'm gonna mess this last

name up -- Ghorayshi?
A I don't know how to pronounce her last name, I'd just do the same job you would.
Q Let's call her, "Azeen." How did it come about where you were interviewed by Azeen?
A She reached out to the hospital or me, I don't remember, exactly, which. And said that she was doing interviews of many people across the field.
Q And I want to the take you to the next page, first paragraph, and the statement is, "puberty blockers did not lead to mental health improvements." Did you say that to Azeen?
A I don't remember my exact quote, word for word, but I remember us talking about this.
Q Okay. What do you mean by, "puberty blockers did not lead to mental health improvements"?
A So I was doing a piece of an analysis for a two-year paper, and the construct that I was looking at, the mean of the sample was relatively flat over the two-year period.
Q Okay. Had it decreased?
A Well, it started out below the clinically concerning range.

Q Okay.
A And it ended up below the clinically concerning range.
Q So both the beginning, which is Exhibit 41, was below the clinically concerning range?
A The numbers that are reported in this study come from a different construct. So what's recorded here is, specifically, the Beck depression index and the anxiety measure that we use. The -- what I was talking about comes from a different measure, it's called the child behavioral checklist, and it's a parent report of the young people.
Q Okay. And I don't want to take that statement out of context, because you, then, qualify with, "Most likely because the children were already doing well when the study began." Did you say something like that to Azeen?
A Yes.
Q And would you agree that the results of -- I guess, the percentages of the children in the study, as referenced on Exhibit 41, speak for themselves? In other words -- let's go to Exhibit 41?
A Okay. What page?

Q It would be page 2 so it would be 2 of 25. Right there.
A In the abstract?
Q Yeah.
A Okay.
Q And in -- at the time of beginning the study, the majority were white, 52.6 percent; correct?
A Yes.
Q And 51.6 had elevated depression symptoms?
A No, 51.6 is designated --
Q 51.6 percent. It's getting late in the day in that way. Elevated depression symptoms were endorsed by 28.6 of the -- that's the cross-sex hormone cohort youth, right?
A That's the blocker group.
Q Blocker group, okay. And 22.1 endorsed clinically significant anxiety?
A Correct.
Q And 23.6 endorsed lifetime suicidal ideation?
A Correct.
Q And 7.9 had past suicide attempts, right?
A Yes.
Q And from that, it was Azeen that concluded

that this data contradicted your statement that they were most likely because the children were already doing well when the study began?

MR. GORDON: Object to form.

THE WITNESS: Yes.

BY MR. THANE:

Q Okay. Do you agree with her conclusion?

A I think that the challenge, here, is, this is really complex data. And I think these two things can simultaneously exist. So the mean of the group be not in a clinically concerning range and there to be a proportion of the group that is having -- is struggling.

Q Okay. Do you agree that the group of 95 -- as referenced in Exhibit 41 -- are struggling?

A Some of them are.

Q Okay. And why did you say to her the puberty blockers did not lead to mental health improvements?

A Because the mean of that group, it didn't -- it didn't go up over time, it remained under the clinically concerning range.

Q Did it go down, if you recall?

A The mean? No, there was no statistically significant change --

Q Okay.
A -- from baseline to 24 months.
Q And then it quotes you down below, "I do not want our work to be weaponized." She said, "It has to be exactly on point and clear and concise." Is that an accurate quote?
A I assume it is, I don't know for certain. But I would agree with it.
Q And it states that the reason you have not published the data -- I assume that is the mental health issue regard to puberty blockers -- is because it might fuel political attacks. Is that fair?
A No. We haven't published the data because the analysis isn't complete.
Q So you would assert that that's a misstatement of yours because it says, "Asked why, she said the findings might fuel the kind of political attacks that have led to the bans in gender treatments."
A Yeah, I don't know how that misunderstanding happened.
Q So if Ms. Azeen testified that that's what you said, would you -- I mean, did you keep any notes, or anything?

A I did not --
MR. GORDON: Object to form.
THE WITNESS: I did not keep notes, no.
BY MR. THANE:
Q Did you -- was the interview recorded?
A Yes.
Q So that recording will speak for itself?
A It will. I think it's important that there's a lot of context. This was a three and a half hour interview and this was a very small portion of the interview, so I that I there's a lot of context.
Q Would you agree that it's important for you to publish the data so that, in evidence-based medicine, treating physicians can use that in providing best medical practice?
A Yes, that's why we publish 16 manuscripts already.
Q Okay. But you have not published this data?
A No, because the analysis isn't complete yet.
Q When will it be complete?
A So the person that was doing the biostatistics for this paper left and went to a

different institution, and so we have to engage a new person that will take on and finish this analysis. So I don't know when that's gonna be. I'm hoping, soon.

Q How much --

MR. THANE: Let me look at that. I want to sort that out.

BY MR. THANE:

Q How much has the -- how much money from the 9.7 -- 9.6 -- I think it's accurately stated in this exhibit. I don't want to misstate anything.

A This is the horizontal one, right?

Q Yeah.

MR. GORDON: Exhibit 40?

MR. THANE: Yeah.

BY MR. THANE:

Q I know it says it on here. I've seen -- oh, there it is (indicating). It's on -- right on the history it has $9,665,715. I'll show it to you.

A Oh, I believe you.

Q How much of that funding has gone to the Children's Hospital of Los Angeles?

A Well, it doesn't -- doesn't, like, arrive in a chunk, right? It happens, like, spaced out over time, a little more than a fourth, I think, has

come to us.
Q How much of that fourth has gone to you personally?
A I have ranged anywhere from 10 percent of my time which is .1 FTE to .2 FTE.
Q What's "FTE" mean?
A "Full-time employee."
Q Okay. And how much --
A So 10 percent of my salary.
Q How much do you get paid then -- oh, so they -- you're still just --
A It's really embarrassing, I don't want to tell you.
Q You're still getting paid your salary, right?
A Yes.
Q Okay. We are winding up. We're gonna have -- you bill at 200 an hour for the Plaintiffs.
A For this, yeah.
Q Yeah. And approximately, how much -- how many hours have you billed? I don't know if you know.
A For this case?
Q Yes.
A I haven't billed anything.

Q Oh, really? You're too kind.
A No.
Q Wow.
MR. THANE: Let me take a quick break, because I may be done.
MR. GORDON: Okay.
VIDEOGRAPHER: Off the record at 3:44 p.m.
(Off the record.)
VIDEOGRAPHER: We are back on the report at 3:52 p.m.
BY MR. THANE:
Q On Exhibit 42, there is a kind of a quote from Dr. Tishelman. Do you know Dr. Tishelman?
A I do.
Q Do you agree with her, it's really important to get the science out into the public?
A Yes.
Q And that's for purposes of medicine?
A Yes.
Q Because even if the -- even if the results of the study show no improvements, it can help change how doctors treat their patients; correct?
MR. GORDON: Object to form.
THE WITNESS: I think it can change the way doctors talk about their treatments for sure.

BY MR. THANE:
Q And if the results are negative, in other words, there hasn't been an improvement, actually been a decline, it can help doctors decide whether they want to provide treatment at all?
A Yes.
Q I just want to make it -- did you tell Azeen, the reporter, that the reason the data with regard to puberty blockers, results of the 95-person study, has not been published is because the analysis is not complete?
A I told her that, I think, in fact-checking -- I can't remember if the interview was in April or late March, so I can't remember if I told her that during the interview or not.
Q Okay.
A But yes, in fact-checking.
Q Oh, it's in fact-checking?
A That's -- that's my memory of it.
Q So you didn't tell her -- when she asked why, is that the -- it might fuel some kind of political attacks? You didn't say that to her?
MR. GORDON: Object to form.
THE WITNESS: So we were not, specifically, having a conversation about this

study. We were talking about the political landscape, in general, and I was talking about the way that some of the data that has been published has been kind of looked at in an incorrect way or analyzed or looked at or considered in a different way. I was just -- we were not and are not done with this analysis that I was talking about from here. I was trying to make the point, though, of, like -- because there have been other studies that have demonstrated the mental health remains about the same on blockers, and those studies have been picked apart and criticized for not demonstrating an improvement. That's -- so that's when we were talking about.

Q So it's your testimony today that she has misconstrued the interview, what you told her?

MR. GORDON: Object to form.

BY MR. THANE:

Q Azeen.

MR. GORDON: Object to form.

THE WITNESS: I think she misunderstood what I was talking about.

BY MR. THANE:

Q Okay.

A The implication of the article that they

were not publishing this data because of political reasons, but that is not true.

Q Okay. That's -- and that would be on Azeen's [sic] for misconstruing it or misunderstanding you?

MR. GORDON: Object to form.

THE WITNESS: She wrote the article, so --

BY MR. THANE:

Q Okay. But her quote about, "I do not want our work to be weaponized is accurate?

A That's true about all our work.

MR. GORDON: Object to form. Asked and answered.

Go ahead.

THE WITNESS: That's true about all of our work.

BY MR. THANE:

Q What did you tell her about the political landscape with respect to your type of work, the gender-affirming care?

A I don't remember the exact words that I told her, but I was telling her -- and this -- like, what's quoted in here is that this work has a wider audience, people are reading it who might not normally read science, that things have to be

presented in a very clear way so that people were not reading it and misinterpreting it. That's what we were talking about.

MR. THANE: Okay. That's all the questions I have.

MR. GORDON: One second. Can we have a couple minutes off the record?

MR. THANE: Is it better if we leave the room?

MR. GORDON: No, step out.

VIDEOGRAPHER: You want to go off?

MR. GORDON: Yes, sorry.

VIDEOGRAPHER: We are off the record at 3:57 p.m.

(Off the record.)

VIDEOGRAPHER: We are on the record at 4:04 p.m.

MR. GORDON: No questions from us. We'll read and sign.

VIDEOGRAPHER: Do you want copies of video synced?

MR. THANE: Regular. What does "synced," mean?

VIDEOGRAPHER: Transcript synced to video.

MR. THANE: No, I think, just regular.

VIDEOGRAPHER: And you?

MR. GORDON: I'll let you know.

MR. THANE: Maybe we might -- bear with us.

MS. LANSING: Synced makes it easier to follow, right?

VIDEOGRAPHER: The time is now 4:05 p.m. and we are going off the record concluding the deposition of Johanna Olson-Kennedy. Today's date is October 28, and it's 4:05 p.m.

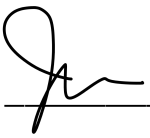
(Deposition concluded at 4:05 p.m.)

DECLARATION OF WITNESS

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at Los Angeles, CA, on 1/10/25.

(PLACE) (DATE)



(SIGNATURE OF WITNESS)

ERRATA SHEET

PAGE	LINE	CHANGES MADE
10	8	I live in the city of South Pasadena, County of Los Angeles
22	7	Should say "individuality"
22	11	Should say "wearing" not wiring
25	6	Should say "remember" not "rebel"
25	23	Currently reads "That's the one that I was talking people with gender that I remember that the Court signed off on." correct to "That's the one I was talking about and remember that the Court provided consent."
27	9	please change "were" to "with"
33	22	Should read "I do not"
58	1,9	Cooper is spelled Kuper
59	4	Cooper should be spelled Kuper
59	20	I'm not sure what this means: "I think Scott has by CV attached to it, but this one does not --"
67	17	"let me try toe explain this" should be changed to "let me try to.."
68	5	"If somebody is not" should be changed to "If somebody has not"
82	11	"Tanner State" should be "Tanner stage"
82	24	"Yes, we always let people know that he that's" should read "Yes, we always let people know when there is a black box warning"
83	6	inter-cranial should be intracranial
85	1	Change to Tanner Stage
85	13	Change to Tanner Stage
85	25	"But I want to the clarify something" please remove "the"
86	15	Should read: "the ova are"
87	19	I think is supposed to be "about" not "but"
91	18	Should read "We talk about why we use bioidentical.."
92	23	Should read "With synthetic hormones."
94	15	Should read: "they can have shrinking"

ERRATA SHEET

PAGE	LINE	CHANGES MADE
95	13	should be "resembles"
96	2	Should read "harvest or carry a pregnancy"
101	19	Should read: ""DIY hormones,"
102	11	This sentence: "regard to women identified as a woman at birth?" I think is referring to individuals who identify as male but were designated female at birth
102	20	Should be "accesses care"
104	1	area of expertise
104	9	should be "it" not "mit"
105	23	Change Tanner State to Tanner Stage
107	6	"do and they're this therapy for whatever's happening" change "this" to "in"
112	4	I think it is Dr. Moyer, not trillion Moyer
112	12	I don't know what this is supposed to be, "this billfolds in access to blockers," but I am sure I didn't say billfolds.
121	6	I think this is supposed to read "patients" not "page"
124	3	Should read "missing" not "mischaracterizing"
139	17	Should read "probably less important if you had a gender neutral name"
141	14	I am not sure what I had said here: "been on existing, maintain existing." but pretty sure I didn't say that
142	13	Should be "to" not "top"
145	22	remove the word "in"
148	7	change "toe" to "to"
153	12	change "knew" to "new"
155	12	add the word "setting" after
157	10	I don't think this was the question "sometimes a pain for medical studies?"
159	5	We most certainly did not get an additional $48 million. I think this is supposed to be 4.8 million
162	7	2024 should be 2020

EXPERT REPORT OF GEETA NANGIA, M.D.

TABLE OF CONTENTS

128. The WPATH SOC-8, in its adolescent chapter, states: "We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner." (Coleman 2022, Recommendation 6.3) It goes on to state:

> ***The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met):***
>
> **6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:**
>
> **6.12.a- the adolescent meets the diagnostic criteria of gender incongruence as per the ICd-11 in situations where a diagnosis is necessary to access health care . . . .**
>
> **6.12.b- the experience of gender diversity/incongruence is marked and sustained over time.**
>
> **6.12.c- the adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.**
>
> **6.12.d- the adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.**
>
> **6.12.e- the adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been**

> **discussed in the context of the adolescent's stage of pubertal development.**
>
> **6.12.f- the adolescent has reached [T]anner [S]tage 2 of puberty for pubertal suppression to be initiated.**
>
> **6.12.g- the adolescent had at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.**

(Coleman 2022, Recommendation 6.12)

129. On page S5 of the WPATH SOC-8 guidelines, the Introduction presents the guidelines as reliable, comfort-oriented, safety-oriented, and evidence based. "The overall goal of the . . . (SOC-8) is to provide clinical guidance to health care professionals to assist transgender and gender diverse (TGD) people in accessing safe and effective pathways to achieving lasting personal comfort with their gendered selves with the aim of optimizing their overall physical health, psychological well-being, and self-fulfillment." The introduction continues: "WPATH envisions a world wherein people of all gender identities and gender expressions have access to evidence-based health care, social services, justice, and equality." In the next paragraph, WPATH assures readers that "[o]ne of the main functions of WPATH is to promote the highest standards of health care for individuals through the Standards of Care (SOC)

200. They deserve to be supported, cared for, and shown that they are valued, as all individuals should.

201. Minor patients with gender dysphoria deserve to be treated with respect for their vulnerability and their stage of development, which makes them unable to provide informed consent. They deserve for their future autonomy to be protected.

202. While their immediate desire for relief needs to be addressed, they also need their desire for long-term happiness honored, as growing members of society. They deserve to have the capacity to make their own decisions about treatments that would systemically alter their bodies and thereby affect their future relationships, their ability to have children, their ability to breastfeed, their ability to experience and feel positively about sexual intimacy, and their ability to feel well about themselves. This capacity cannot be reached until adulthood.

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

Executed May 15th, 2024

MD

Geeta Nangia

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
Charleston Division

STERLING MISANIN, et al., *Plaintiffs*, v. ALAN WILSON, in his official capacity as the Attorney General of South Carolina, et al., *Defendants*.	Case No. 2:24-cv-04734-RMG

DECLARATION OF JOHANNA OLSON-KENNEDY, M.D., M.S.

I, Johanna Olson-Kennedy, M.D., M.S., hereby state as follows:

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

2. I am over the age of 18.

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 opinion.

4. I am aware of an article titled "U.S. Study on Puberty Blockers Goes Unpublished Because of Politics, Doctor Says," authored by Azeen Ghorayshi and published in the New York Times on October 23, 2024.

5. Based on a misleading title and selective quotations, the article by Ms. Ghorayshi presents an inaccurate and misrepresentative picture of the status of research I, along with others, have been conducting.

6. As I have previously testified, I am a principal investigator on a multisite study that has been funded in part through a National Institutes of Health grant and is examining the impact of gender-affirming medical care for transgender youth on physiologic and psychological health and well-being. The study involves over 400 study participants for whom thousands of data points have been collected. The first eight years of this study have already been completed and to date, the study has yielded over a dozen manuscripts.

7. Research takes time and significant resources, and we want to ensure that we publish our data accurately.

8. Among the multiple manuscripts relating to the study that have been published, our manuscript pertaining to the "Psychosocial Functioning in Transgender Youth after 2 Years of Hormones" was published in the *New England Journal of Medicine* in 2023 and our manuscript relating to "Laboratory Changes During Gender-Affirming Hormone Therapy in Transgender Adolescents" was published in *Pediatrics* in 2024.

9. Throughout this study, up to the present moment, we have continued to conduct detailed statistical analyses for numerous constructs, including thousands of data points we have gathered and multiple outcome measures. Some of these relate to the functioning of transgender youth who received gonadotrophin-releasing hormone analogues ("GnRHa") as a medical intervention in relation to the gender dysphoria.

10. As I testified previously, by its very nature, puberty suppression *stops* further development of physical characteristics inconsistent with the adolescent's identity, which is therefore meant to *prevent* (not necessarily improve) the worsening of gender dysphoria, the deterioration of mental health, and the development of further body dissatisfaction.

11. At the time of my conversation with Ms. Ghorayshi in the Spring of 2024 as well as at the time of this declaration, analyses pertaining to multiple data points and outcomes, including the impact of GnRHa on transgender youth, remain ongoing.

12. It is false that I, or anyone involved in the NIH-funded study, has withheld publication of data because of politics, as the headline of Ms. Ghorayshi's article falsely states.

13. Ms. Ghorayshi's article ignores key context I provided to her explaining that the analyses relating to multiple domains we are looking at remains ongoing and that that is why a manuscript pertaining to the impact of GnRHa treatments for transgender youth has yet to be published.

14. As even the article acknowledges, we have every intention to publish our data but the length of time it has taken to do so is attributable to the sheer amount of work and resources required to do so accurately, transparently, and clearly. This goal has been further impacted by resource limitations, including funding cuts and personnel changes.

15. In my conversation with Ms. Ghorayshi, the specter of politicization and weaponization of scientific work, including our ongoing study, was raised not as a reason or explanation for a delay in, or withholding of publication of our findings but as a reason for any scientist, including myself, to communicate their findings with clarity and in a manner in which they can be understood not just by the scientific community but by non-scientists as well. As such, I discussed our study, for which analyses are still ongoing, as a hypothetical example for why our work product "has to be exactly on point, clear and concise. And that takes time."

16. In our work as scientific and medical professionals, we strive to ensure the accurate, transparent, and detailed reporting of data to better understand phenomena, inform the scientific community and relevant stakeholders of our findings, and generate areas and new ideas for further

research. It is unfortunate, however, that to do so we must now worry about our words and findings being misunderstood or misrepresented. That prospect is not and should not be a reason to delay or not publish data, but rather an incentive to ensure that we do so carefully, clearly, and concisely, so that our findings cannot be twisted or misrepresented. The process to do so thus takes time and resources, which often are both limited.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 17th day of November 2024.

Johanna Olson-Kennedy, M.D., M.S.

MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS AND CLARK COUNTY

JESSICA KALARCHIK, an individual, and JANE DOE, an individual, on behalf of themselves and all others similarly situated, Plaintiffs, v. STATE OF MONTANA, et al., Defendants.	Cause No. ADV-2024-261 **ORDER – MOTION FOR PRELIMINARY INJUNCTION**

Before the Court is Plaintiffs Jessica Kalarchik (Kalarchik) and Jane Doe's (Doe) motion for a preliminary injunction. Alex Rate, Marthe Y. VanSickle, Malita Picasso, Jon W. Davidson, F. Thomas Hecht, Tina B. Solis, and Seth A. Horvath represent the Plaintiffs. Alwyn Lansing, Michael Russell, Thane Johnson, Michael Noonan, and Emily Jones represent Defendants State of Montana, Gregory Gianforte, in his official capacity as the Governor of the State of Montana (Gianforte), the Montana Department of Public Health and Human Services (DPHHS), Charles T. Brereton, in his official capacity as the Director of

the Montana Department of Public Health and Human Services (Brereton), the Montana Department of Justice (DOJ), and Austin Knudsen, in his official capacity as Attorney General of the State of Montana (Knudsen) (collectively "State").

STATEMENT OF FACTS

On April 18, 2024, Plaintiffs filed a complaint for declaratory and injunctive relief challenging Senate Bill 458 (SB 458), Montana Administrative Rule 37.8.311(5) (2022 Rule), and a 2024 Montana Motor Vehicle Division (MVD) policy to only issue an amended driver's license with a sex designation reflecting a person's gender identity if the person provides an amended birth certificate (MVD policy) (collectively "challenged state actions"). Plaintiffs allege Defendants' policies and practices are part of an effort to deny transgender people rights that are widely guaranteed to other Montanans and reflect an intent to discriminate against transgender people throughout the state.

The 2022 Rule, which originally went into effect on September 10, 2022, provides DPHHS would process applications for amending the sex designations on birth certificates only if the sex identified on the applicant's birth certificate was the result of a scriveners' error or incorrect data entry or if the sex of the individual was misidentified on the original certificate. In a February 2024 notice, DPHSS declared it would not amend birth certificates based on "gender transition, gender identity, or change of gender." *See* Mont. Admin. Reg. Notice 37-1002, No. 11 (Jun. 10, 2022).

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On May 19, 2023, Gianforte signed SB 458 into law. SB 458, codified at Montana Code Annotated § 1-1-201(1)(f), defines "sex" as applicable to the Montana Code Annotated as:

> . . . the organization of the body parts and gametes for reproduction in human beings and other organisms. In human beings, there are exactly two sexes, male and female, with two corresponding types of gametes. The sexes are determined by the biological and genetic indication of male or female, including sex chromosomes, naturally occurring sex chromosomes, gonads, and nonambiguous internal and external genitalia present at birth, without regard to an individual's psychological, behavioral, social, chosen, or subjective experience of gender.

Mont. Code Ann. § 1-1-201(1)(f).

Plaintiffs allege SB 458 is scientifically incorrect and improperly seeks to limit the meaning of sex without legal, medical, or scientific justification.[1]

Plaintiffs' complaint alleges the challenged state actions violate the Montana Constitution's equal-protection guarantee, privacy protections, and prohibition against compelled speech, as well as the provisions of Montana Code Annotated § 2-4-506. On May 17, 2024, Plaintiffs moved for a preliminary injunction requesting the Court:

> preliminarily enjoining Defendants, as well as their agents, employees, representatives, and successors, from directly or indirectly enforcing (1) the 2022 Rule on its face or as applied to issuing amended birth certificates, (2) the new MVD policy and practice as applied to issuing amended driver's licenses, and (3) SB 458 as applied to issuing amended birth certificates and amended

[1] SB 458 was recently declared unconstitutional and is permanently enjoined. *Reagor v. State of Montana*, Cause No: DV-23-1245 (Mont. Fourth Jud. Dist. Court, Missoula Cty.) (June 25, 2024).

> driver's licenses, including but not limited to prohibiting Defendants from denying applications to amend the sex designation on birth certificates or driver's licenses based on the 2022 Rule, the new MVD policy and practice, SB 458, or any further administrative rulemaking or other action directed toward enforcement of the 2022 Rule, the new MVD policy and practice, or SB 458 as applied to issuing birth certificates or driver's licenses.

Pl. Mot. For Prelim. Inj., p. 2 (May 17, 2024).

Following briefing, the Court held oral argument on the motion on November 14, 2024. The matter is now ripe.

PRINCIPLES OF LAW

Pursuant to Montana Code Annotated § 27-19-201(3), the party moving for an injunction "bears the burden of demonstrating the need for an injunction order." Under § 27-19-201(1), as amended by the 2023 Montana Legislature:

> A preliminary injunction order or temporary restraining order may be granted when the applicant establishes that: (a) the applicant is likely to succeed on the merits; (b) the applicant is likely to suffer irreparable harm in the absence of preliminary relief; (c) the balance of equities tips in the applicant's favor; *and* (d) the order is in the public interest.

Mont. Code Ann. § 27-19-201(1). The Montana Legislature intended for this standard to "mirror the federal preliminary injunction standard." Mont. Code Ann. § 27-19-201(4).

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The Montana Supreme Court further clarified the new preliminary injunction standard in *Stensvad v. Newman Ayers Ranch, Inc.*, 2024 MT 246, 418 Mont. 378. Adopting the preliminary injunction framework from the Ninth Circuit, the *Stensvad* court held:

> the preliminary injunction standard sets forth a conjunctive test that requires an applicant to make a sufficient showing as to each of the four factors…. Unless it is clear that an applicant fails to raise serious questions going to the merits, a district court should likewise consider and address each of the remaining factors.

Id. at ¶ 29. "The serious questions test continues to allow Montana courts to preserve the status quo until a full trial can be held without having to tread too far into the merits of the case." *Id*. at ¶ 26.

ANALYSIS

Plaintiffs have challenged 2022 Rule on its face and as applied to issuing amended birth certificates, the MVD policy and practice as applied to issuing amended driver's licenses, and SB 458 as applied to issuing amended birth certificates and amended driver's licenses on the grounds they violate the Montana Constitution's equal-protection guarantee, privacy protections, and prohibition against compelled speech, as well as the provisions of Montana Code Annotated § 2-4-506. "Statutes are presumed to be constitutional, and we regard that presumed constitutionality as a high burden to overcome. The challenging party bears the burden of proving the statute is unconstitutional." *Planned Parenthood v. State*, 2024 MT 178, ¶ 16, 417 Mont. 457, ¶ 16, 554 P.3d 153, ¶ 16 (citations omitted).

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As a threshold matter, the Court rejects the State's argument this litigation presents a nonjusticiable political question. The State argues Plaintiffs' claims would impermissibly require the Court to write a new protected class into Montana law. Thus, the State concludes it is within the exclusive jurisdiction of the legislature to determine whether transgender status constitutes a protected class. However, "the courts, as final interpreters of the Constitution, have the final 'obligation to guard, enforce, and protect every right granted or secured by the Constitution…'" *Columbia Falls Elem. Sch. Dist. No. 6 v. State*, 2005 MT 69, ¶ 18, 326 Mont. 304, ¶ 18, 109 P.3d 257, ¶ 18 (quoting *Robb v. Connolly* (1884), 111 U.S. 624, 637, 4 S. Ct. 544, 551, 28 L. Ed. 542, 546). Determining whether a statute or state policy violates Plaintiffs' constitutional rights is directly in the jurisdiction of the Court.

Likelihood of Success on the Merits

The first step in the Court's preliminary injunction analysis is whether Plaintiffs are likely to succeed on the merits. Under Montana's preliminary injunction standard, "likelihood of success does not require the applicant to establish entitlement to final judgment, relief at all events on final hearing, relief at a trial on the merits, or evidence sufficient to prevail at trial." *Planned Parenthood of Mont. v. State*, 2024 MT 228, ¶ 18, 418 Mont. 253, ¶ 18, 557 P.3d 440, ¶ 18 (citing *Planned Parenthood of Mont.*, 2022 MT 157, ¶ 30). To satisfy this factor, Plaintiffs must raise a serious question going to the merits of their claims.

Although Plaintiffs have raised challenges under four separate legal theories, Plaintiffs only need to demonstrate one of their claims satisfies the requirements of Montana Code Annotated § 27-19-201(1) to obtain a preliminary

injunction. Because the Court finds the issue dispositive, it focuses its analysis on Plaintiffs' equal protection claim. Article II, Section 4 of the Montana Constitution provides no person shall be denied equal protection of the laws. Analyzing an equal protection claim involves a three-step process. The Court must:

> (1) identify the classes involved and determine if they are similarly situated; (2) determine the appropriate level of scrutiny to apply to the challenged legislation; and (3) apply the appropriate level of scrutiny to the challenged statute.

Goble v. Mont. State Fund, 2014 MT 99, ¶ 28, 374 Mont. 453, ¶ 28, 325 P.3d 1211, ¶ 28.

"The first prerequisite to a meritorious claim under the equal protection clause is a showing that the state has adopted a classification that affects two or more similarly situated groups in an unequal manner." *Powell v. State Comp. Ins. Fund*, 2000 MT 321, ¶ 22, 302 Mont. 518, ¶ 22, 15 P.3d 877, ¶ 22. The Montana Supreme Court has held, "two groups are similarly situated if they are equivalent in all relevant respects other than the factor constituting the alleged discrimination." *Goble* at ¶ 28. Plaintiffs have defined the classes as Montanans seeking to amend the sex designation on their birth certificates or driver's licenses and cisgender Montanans seeking to amend the sex designation on their birth certificates or driver's licenses.

Plaintiffs argue the two classes are equivalent in all relevant respects other than their status as transgender or cisgender. Plaintiffs further argue the challenged state actions discriminate against transgender people on the basis of their transgender status and on the basis of sex. Whereas cisgender

Montanans can obtain amended birth certificates and drivers licenses with a sex marker accurately reflecting their gender identity, transgender Montanans cannot. In contrast, the State argues Plaintiffs cannot prevail on their equal protection claim because they have failed to establish two similarly situated classes or differential treatment based on a protected class. The State's argument relies primarily on the conclusion discrimination on the basis of transgender status is not discrimination on the basis of sex. The State argues transgender Montanans do not constitute a protected class and therefore equal protection does not apply. Based on this conclusion, the State ends its equal protection argument at the class identification step.

However, whether the challenged state actions constitute discrimination on the basis of sex and whether transgender status is a protected class relate more to the appropriate level of scrutiny. "When a statute treats similarly situated individuals dissimilarly, but not on the basis of a suspect classification or in the exercise of a fundamental right, a court must subject the discriminating statute to rational-basis review." *Gazelka v. St. Peter's Hosp.*, 2015 MT 127, ¶ 21, 379 Mont. 142, ¶ 21, 347 P.3d 1287, ¶ 21 (citing *McDermott v. Mont. Dep't of Corr.*, 2001 MT 134, ¶¶ 31-32, 305 Mont. 462, 29 P.3d 992). Thus, even if the Court found the alleged discrimination did not involve a suspect class or fundamental right, that would not be the end of the equal protection analysis. Regarding the class identification step, Plaintiffs have established the challenged state actions affect cisgender and transgender Montanans in an unequal manner.

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The Court next turns to the appropriate level of scrutiny to apply to the challenged state actions. Plaintiffs urge the Court to apply strict scrutiny on the basis transgender Montanans constitute a suspect class. However, the Court finds it is not necessary at this point in the litigation to determine whether transgender Montanans constitute a suspect class on the basis of their transgender status. Rather, the Court addresses the State's contention discrimination on the basis of transgender status is not discrimination on the basis of sex. Based on a review of recent United States Supreme Court and federal court decisions, the Court disagrees with the State's conclusion.

In *Bostock v. Clayton County*, 590 U.S. 644, 140 S. Ct. 1731 (2020), the United States Supreme Court addressed discrimination based on sexual orientation or transgender status in the context of employment discrimination under Title VII. There, 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." *Id*. at 660. In the present matter, the State asks this Court to restrict the holding in *Bostock* to the context of Title VII of the Civil Rights Act of 1974. Plaintiffs, on the other hand, argue the logic of the holding applies broadly in an equal protection context.

In *Fowler v. Stitt*, 104 F.4th 770 (2024), the United States Court of Appeals for the Tenth Circuit applied the *Bostock* reasoning to an equal protection claim substantially similar to the one before this Court. In *Fowler,* the plaintiffs challenged an Oklahoma policy which denied sex-designation amendments on birth certificates on the grounds the policy violated the equal protection clause of the United States Constitution by unlawfully discriminating against transgender people on the basis of transgender status and sex.

Similar to the State's arguments here, the defendants in *Fowler* argued against applying the holding in *Bostock* in the equal protection context because there the Supreme Court noted, "[t]he only question before us is whether an employer who fires someone simply for being homosexual or transgender has discharged or otherwise discriminated against that individual 'because of such individual's sex.'" *Bostock* at 681. Thus, the defendants conclude, the Supreme Court only intended the holding to apply in the context of Title VII claims. However, the *Fowler* Court rejected the argument this language intended to limit the application of *Bostock* because, "[a]lthough that was the only question the Supreme Court decided, the Court did not indicate that its logic concerning the intertwined nature of transgender status and sex was confined to Title VII." *Fowler* at 790.

Relying on the United States Supreme Court decision in *Bostock*, the Tenth Circuit Court in *Fowler* concluded because the Oklahoma policy intended to discriminate based on transgender status, it necessarily intends to discriminate based in part on sex. This Court adopts the same reasoning. If the challenged state actions discriminate against transgender individuals on the basis of their transgender status, they also necessarily discriminate on the basis of sex. The Montana Supreme Court has not yet identified the level of scrutiny applicable to classifications based on transgender status or sex. However, if a right is "explicit in the Declaration of Rights in Montana's Constitution, it is a fundamental right." *Gryczan v. State* (1997), 283 Mont. 433, 449, 942 P.2d 112, 122. Article II, Section 4 of Montana's Constitution, found in the Declaration of Rights, establishes a fundamental right to individual dignity. It states:

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"Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color, *sex*, culture, social origin or condition, or political or religious ideas." (emphasis added) Therefore, the right to be free from discrimination on the basis of sex is a fundamental right. "Strict scrutiny applies when a classification affects a suspect class or threatens a fundamental right." *McDermott v. State Dep't of Corr.*, 2001 MT 134, ¶ 31, 305 Mont. 462, ¶ 31, 29 P.3d 992, ¶ 31 (citing *Armstrong v. State,* 1999 MT 261, P34, 296 Mont. 361, ¶ 34, 989 P.2d 364, ¶ 34).

Under a strict scrutiny analysis, "the State has the burden of showing that the classification or State action is narrowly tailored to serve a compelling State interest." *Id.* Because the State ended its equal protection analysis at the class identification step, it offers no argument regarding the state's interest or how the challenged state actions relate to a state interest. Plaintiffs argue the challenged state actions do not serve a compelling government interest. However, referencing 11 Mont. Admin. Reg. Notice 37–1002 (June 10, 2022), Plaintiffs suggest the purpose of the challenged state actions are to ensure "accurate vital statistics." The State may have a compelling state interest in ensuring accurate vital statistics. As this case moves forward, the Court anticipates the argument regarding the state interest will become more clear. However, even if the State can demonstrate a compelling state interest in ensuring accurate vital statistics, the challenged state actions still must be narrowly tailored to effectuate that interest. Here, the State has not demonstrated the challenged state actions are narrowly tailored. Prior to the implementation of the challenged state actions, transgender Montanans were able to obtain amended

birth certificates and drivers licenses. Plaintiffs argue nothing in the public record supports a finding there were problems maintaining accurate vital statistics before the implementation of the challenged state actions. Thus, the state interest could presumably be effectuated without the challenged state actions. If the challenged state actions are not necessary to effectuate the state interest, they cannot be narrowly tailored.

Plaintiffs have met their burden of establishing likelihood of success on the merits under the preliminary injunction standard. Plaintiffs have raised a valid prima facie case the challenged state actions violate their fundamental right to be free from discrimination on the basis of sex under the Montana Constitution. Although the State did not suggest any state interest served by the challenged state actions, Plaintiffs raised a potentially compelling state interest. However, Plaintiffs have succeeded in raising a serious question on the merits as to whether the challenged state actions are narrowly tailored.

Likelihood of Irreparable Harm

The next step in the preliminary injunction analysis is whether Plaintiffs are likely to suffer irreparable harm in the absence of an injunction. The Montana Supreme Court has consistently held, "the loss of a constitutional right constitutes irreparable harm for the purpose of determining whether a preliminary injunction should be issued." *Mont. Cannabis Indus. Ass'n v. State*, 2012 MT 201, ¶15, 366 Mont. 224, 286 P.3d 1161 (citing *Elrod v. Burns*, 427 U.S. 347, 373, 96 S. Ct. 2673, 2689-690, 49 L. Ed. 2d 547 (1976)). As addressed above, Plaintiffs have established a prima facie case the challenged

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state actions infringe their constitutional rights under the Montana State Constitution's equal protection clause. Therefore, Plaintiffs have demonstrated a likelihood of irreparable harm absent an injunction.

Balance of Equities and Public Interest

The third step of the preliminary injunction analysis is whether the balance of equities tips in Plaintiffs' favor. The final step of the preliminary injunction test is whether an injunction is in the public interest. The Court analyzes these factors together because "[w]hen the government opposes a preliminary injunction, these two factors 'merge into one inquiry.'" *Planned Parenthood of Mont. v. State*, 2024 MT 228, ¶ 39, 418 Mont. 253, ¶ 39, 557 P.3d 440, ¶ 39 (quoting *Porretti v. Dzurenda*, 11 F.4th 1037, 1047 (9th Cir. 2021).

Citing Ninth Circuit precedent, the Montana Supreme Court has held, "[a] plaintiff's likelihood of success on the merits of a constitutional claim . . . tips the merged third and fourth factors decisively in his favor." *Id.* at ¶ 40 (quoting *Baird v. Bonta*, 81 F.4th 1036, 1042 (9th Cir. 2023)). Here, Plaintiffs have demonstrated a likelihood of success on the merits of their equal protection claim. Thus, under Montana law, the third and fourth factors weigh in Plaintiffs' favor.

Additionally, applying recent Montana Supreme Court precedent, the balance of equities "tips in [Plaintiffs'] favor because 'the government suffers no harm from an injunction that merely ends unconstitutional practices and/or ensures that constitutional standards are implemented.'" *Id.* (quoting *Doe v. Kelly*, 878 F.3d 710, 718 (9th Cir. 2017)). Finally, a preliminary injunction is

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"in the public interest because 'it is always in the public interest to prevent the violation of a party's constitutional rights.'" *Id*. (quoting *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012)).

CONCLUSION

Plaintiffs have demonstrated their request for a preliminary injunction satisfies the requirements of Montana Code Annotated § 27-19-201(1). Therefore, Defendants, as well as their agents, employees, representatives, and successors, are enjoined from directly or indirectly enforcing (1) the 2022 Rule on its face or as applied to issuing amended birth certificates; (2) the MVD policy and practice as applied to issuing amended driver's licenses without an amended birth certificate; and (3) SB 458 as applied to issuing amended birth certificates and amended driver's licenses.

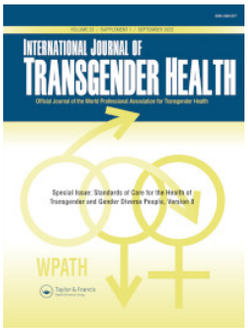
ORDER

IT IS HEREBY ORDERED Plaintiffs' motion for a preliminary injunction is **GRANTED.**

/s/ Mike Menahan
MIKE MENAHAN
District Court Judge

cc: All via email:
John Davidson
Alwyn Lansing
Seth A. Horvath
Robert Farris-Olsen
Marthe Y. Vansickle
Michael Russell

Alex Rate
Malita Picasso
F. Thomas Hecht
Thane P. Johnson
Emily Jones
Michael Noonan
Tina B. Solis
Austin M. Knudsen



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REPORT

Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

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ABSTRACT

Background: Transgender healthcare is a rapidly evolving interdisciplinary field. In the last decade, there has been an unprecedented increase in the number and visibility of transgender and gender diverse (TGD) people seeking support and gender-affirming medical treatment in parallel with a significant rise in the scientific literature in this area. The World Professional Association for Transgender Health (WPATH) is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, public policy, and respect in transgender health. One of the main functions of WPATH is to promote the highest standards of health care for TGD people through the Standards of Care (SOC). The SOC was initially developed in 1979 and the last version (SOC-7) was published in 2012. In view of the increasing scientific evidence, WPATH commissioned a new version of the Standards of Care, the SOC-8.

Aim: The overall goal of SOC-8 is to provide health care professionals (HCPs) with clinical guidance to assist TGD people in accessing safe and effective pathways to achieving lasting personal comfort with their gendered selves with the aim of optimizing their overall physical health, psychological well-being, and self-fulfillment.

Methods: The 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. Grading of recommendations was based on the available evidence supporting interventions, a discussion of risks and harms, as well as the feasibility and acceptability within different contexts and country settings.

Results: A total of 18 chapters were developed as part of the SOC-8. They contain recommendations for health care professionals who provide care and treatment for TGD people. Each of the recommendations is followed by explanatory text with relevant references. General areas related to transgender health are covered in the chapters Terminology, Global Applicability, Population Estimates, and Education. The chapters developed for the diverse population of TGD people include Assessment of Adults, Adolescents, Children, Nonbinary, Eunuchs, and Intersex Individuals, and people living in Institutional Environments. Finally, the chapters related to gender-affirming treatment are Hormone Therapy, Surgery and Postoperative Care, Voice and Communication, Primary Care, Reproductive Health, Sexual Health, and Mental Health.

Conclusions: The SOC-8 guidelines are intended to be flexible to meet the diverse health care needs of TGD people globally. While adaptable, they offer standards for promoting optimal health care and guidance for the treatment of people experiencing gender incongruence. As in all previous versions of the SOC, the criteria set forth in this document for gender-affirming medical interventions are clinical guidelines; individual health care professionals and programs may modify these in consultation with the TGD person.

KEYWORDS

adolescents; assessment; children; communication; education; endocrinology; eunuch; gender diverse; health care professional; institutional settings; intersex; mental health; nonbinary; population; postoperative care; primary care; reproductive health; sexual health; SOC8; Standards of Care; surgery; terminology; transgender; voice

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facilitate the necessary passage of time needed by the individual to explore gender identity and to actively participate in sex designation, especially for conditions in which sex role change is common (i.e., in female-raised individuals with 5α-RD-2 deficiency; Cocchetti, Ristori, Mazzoli et al., 2020; Fisher, Castellini et al., 2016).

HCPs can counsel individuals and their families directly if the providers have sufficient expertise and can leverage expertise needed to determine both a course of treatment appropriate for the individual and the logistics involved in implementing the chosen therapeutic option.

Statement 10.9

We suggest health care professionals counsel parents and children with intersexuality (when cognitively sufficiently developed) to delay gender-affirming genital surgery, gonadal surgery, or both, so as to optimize the children's self-determination and ability to participate in the decision based on informed consent.

International human rights organizations have increasingly expressed their concerns that surgeries performed before a child can participate meaningfully in decision-making may endanger the child's human rights to autonomy, self-determination, and an open future (e.g., Human Rights Watch, 2017). Numerous medical and intersex advocacy organizations as well as several countries have joined these international human rights groups in recommending the delay of surgery when medically feasible (Dalke et al., 2020; National Academies of Sciences, Engineering, and Medicine, 2020). However, it is important to note some anatomic variations, such as obstruction of urinary flow or exposure of pelvic organs, pose an imminent risk to physical health (Mouriquand et al., 2016). Others, such as menstrual obstruction or long-term malignancy risk in undescended testes, have eventual physical consequences. A third group of variations, i.e., variations in the appearance of external genitals or vaginal depth, pose no immediate or long-term physical risk. The above recommendation addresses only those anatomic variations that, if left untreated, have no immediate adverse physical consequences and where delaying surgical treatment poses no physical health risk.

Non-urgent surgical care for individuals with these variations is complex and often contested, particularly when an individual is an infant or a young child and cannot yet participate in the decision-making process. Older people with intersexuality have reported psychosocial and sexual health problems, including depression, anxiety, and sexual and social stigma (de Vries et al., 2019; Rosenwohl-Mack et al., 2020). Some studies have suggested individuals with a specific variation (e.g., 46,XX CAH) agree with surgery being performed before adolescence (Bennecke et al., 2021). Recent studies suggest some adolescents and adults are satisfied with the appearance and function of the genitals after childhood surgery (Rapp et al., 2021). A child's genital difference can also become a source of stress for parents, and there is research that reports a correlation of surgery to create binary genitals with a limited amount of reduction in parental distress (Wolfe-Christensen et al., 2017), although a minority of parents may report decisional regret (Ellens et al., 2017). Consequently, some organizations recommend surgery be offered to very young children (American Urological Association, 2019; Pediatric Endocrine Society, 2020).

This shows the division within the medical field regarding its management guidelines for early genital surgery. The authors of this chapter also did not reach complete consensus. Some intersex specialists consider it potentially harmful to insist on a universal deferral of early genital surgery for genital variations without immediate medical risks. Reasons supporting this view include 1) intersex conditions are highly heterogeneous with respect to type and severity as well as associated gonadal structure, function, and malignancy risk; 2) societies and families vary tremendously in gender norms and intersex stigma potential; 3) early surgery may present certain technical advantages; and 4) a review of surveys of individuals with intersexuality (most of whom had previously undergone genital surgery) show the majority endorse surgery before the age of consent, especially in the case of individuals with 46,XX CAH and less strongly for individuals with XY intersex conditions (Meyer-Bahlburg, 2022). Experts supporting this view call for an individualized approach to

decisions regarding genital surgery and its timing. This approach has been adopted by medical societies with high rates of intersex specialists (Bangalore Krishna et al., 2021; Pediatric Endocrine Society, 2020; Speiser et al., 2018; Stark et al., 2019) and by certain support organizations (CARES Foundation; Krege et al., 2019).

Nonetheless, long-term outcome studies are limited and most studies reporting positive outcomes lack a non-surgical comparison group (Dalke, et al., 2020; National Academies of Sciences, Engineering, and Medicine, 2020). There is also no evidence surgery protects children with intersex conditions from stigma (Roen, 2019). Adults with intersexuality do experience stigma, depression, and anxiety related to their genitalia, but can also experience stigma whether or not they have surgery (Ediati et al., 2017; Meyer-Bahlburg, Khuri et al., 2017; Meyer-Bahlburg et al., 2018). There is also evidence surgeries may lead to significant cosmetic, urinary, and sexual complications extending into adulthood (Gong & Cheng, 2017; National Academies of Sciences, Engineering, and Medicine, 2020). Recent studies suggest some groups of individuals may have particularly negative experiences with gonadectomy, although this risk has to be weighed against that of gonadal malignancy (Duranteau et al., 2020; Rapp et al., 2021). People with intersex conditions are also far more likely than the general population to be transgender, to be gender diverse, or to have gender dysphoria (Almasri et al., 2018; Pasterski et al., 2015). Genital surgeries of young children may therefore irreversibly reinforce a binary sex assignment that is not aligned with the persons' future. These findings, together with human rights perspectives, support the call for the delay in the decision for surgery until the individual can decide for him/her/themselves.

Systematic long-term follow-up studies are urgently needed to compare individuals with the same intersex conditions who differ in the age at surgery or have had no surgery with regard to gender identity, mental health, and general quality of life.

Statement 10.10

We suggest only surgeons experienced in intersex genital or gonadal surgery operate on individuals with intersexuality.

Intersex conditions are rare, and intersex genital and gonadal anatomy are heterogeneous. Surgeries have been associated with a risk of significant long-term complications (e.g., National Academies of Sciences, Engineering, and Medicine, 2020), and most surgical training programs do not prepare trainees to provide this specialized care (Grimstad, Kremen et al., 2021). In recognition of the complexity of surgical care across the lifespan, standards produced by expert and international consensus recommend this care be provided by multidisciplinary teams of experts (Krege et al, 2019; Lee, Nordenström et al., 2016; Pediatric Endocrine Society, 2020). Therefore, we advise surgical care be limited to intersex-specialized, multidisciplinary settings that include surgeons experienced in intersex care.

Statement 10.11

We recommend health care professionals who are prescribing or referring for hormonal therapies/surgeries counsel individuals with intersexuality and fertility potential and their families about a) known effects of hormonal therapies/surgery on future fertility; b) potential effects of therapies that are not well studied and are of unknown reversibility; c) fertility preservation options; and d) psychosocial implications of infertility.

Individuals with certain intersex conditions may have reproductively functional genitalia but experience infertility due to atypical gonadal development. Others may have functioning gonads with viable germ cells but an inability to achieve natural fertility secondary to incongruent internal or external genitalia (van Batavia & Kolon, 2016). Pubertal suppression, hormonal treatment with sex steroid hormones, and gender affirming surgeries may all have an adverse impact on future fertility. The potential consequences of the treatment and fertility preservation options should therefore be reviewed and discussed.

Individuals with functioning testes should be advised prolonged treatment with estrogen and suppression of testosterone, as studied in TGD people without intersexuality, may cause testicular atrophy and a reduction in sperm count (Mattawanon et al., 2018). Although interruption

Lamotrigine (la MOE tri jeen)

- **Lamotrigine**
  - Tablets: 25 mg, 100 mg, 150 mg, 200 mg
  - Chewable tablets: 5 mg, 25 mg
  - Oral disintegrating tablets: 25 mg, 50 mg, 100 mg, 200 mg
  - Extended-release tablets: 25 mg, 50 mg, 100 mg, 200 mg, 250 mg, 300 mg
- **Lamictal®**
  - Tablets: 25 mg, 100 mg, 150 mg, 200 mg
- **Lamictal Blue Starter Kit®**
  - Tablets: 25 mg
- **Lamictal CD ®**
  - Chewable tablets: 2 mg, 5 mg, 25 mg
- **Lamictal ODT ®**
  - Oral disintegrating tablets: 25 mg, 50 mg, 100 mg, 200 mg
- **Lamictal XR®**
  - Extended-release tablets: 25 mg, 50 mg, 100 mg, 200 mg, 250 mg, 300 mg
- **Subvenite®**
  - Tablets: 25 mg, 100 mg, 150 mg, 200 mg
- **Subvenite Blue Starter Kit®**
  - Tablets: 25 mg

All FDA warnings are at the end of this fact sheet. Please consult them before taking this medication.

If you or someone you know is in crisis, please call 911 and/or the toll-free National Suicide Prevention Lifeline at 800-273-TALK (8255) to speak with a trained crisis counselor 24/7. A help line and other resources are also available through the National Alliance on Mental Illness at nami.org.

National Alliance on Mental Illness

What is lamotrigine and what does it treat?

Lamotrigine is a mood stabilizer medication that works in the brain. It is approved for the treatment of bipolar disorder (also known as manic depression) and certain types of seizure disorders. Bipolar disorder involves episodes of depression and/or mania.

Symptoms of depression include:

- Depressed mood – feeling sad, empty, or tearful
- Feeling worthless, guilty, hopeless, or helpless
- Loss of interest or pleasure in normal activities
- Sleep and eat more or less than usual (for most people it is less)
- Low energy, trouble concentrating, or thoughts of death (suicidal thinking)
- Psychomotor agitation ('nervous energy')
- Psychomotor retardation (feeling like you are moving in slow motion)

Symptoms of mania include:

- Feeling irritable or "high"
- Having increased self esteem
- Feeling like you don't need to sleep
- Feeling the need to continue to talk
- Feeling like your thoughts are too quick (racing thoughts)
- Feeling distracted
- Getting involved in activities that are risky or could have bad consequences (e.g., excessive spending)

Lamotrigine may also be helpful when prescribed "off-label" for bipolar depression. "Off-label" means that it hasn't been approved by the Food and Drug Administration for this condition. Your mental health provider should justify his or her thinking in recommending an "off-label" treatment. They should be clear about the limits of the research around that medication and if there are any other options.

What is the most important information I should know about lamotrigine?

Bipolar disorder requires long-term treatment. Do not stop taking lamotrigine, even when you feel better. With input from you, your health care provider will assess how long you will need to take the medication. Missing doses of lamotrigine may increase your risk for a relapse in your mood symptoms.

Do not stop taking lamotrigine or change your dose without talking to your health care provider first.

In order for lamotrigine to work properly, it should be taken every day as ordered by your health care provider.

Are there specific concerns about lamotrigine and pregnancy?

If you are planning on becoming pregnant, notify your health care provider so that he/she can best manage your medications. People living with bipolar disorder who wish to become pregnant face important decisions. It is important to discuss the risks and benefits of treatment with your doctor and caregivers.

Lamotrigine has been associated with an increased risk of oral cleft birth defects. There may be precautions to decrease the risk of this effect. Do not stop taking lamotrigine without first speaking to your health care provider. Discontinuing similar medications during pregnancy has been associated with a significant increase in symptom relapse.

Regarding breastfeeding, caution is advised since lamotrigine does pass into breast milk.

What should I discuss with my health care provider before taking lamotrigine?

- Symptoms of your condition that bother you the most
- If you have thoughts of suicide or harming yourself
- Medications you have taken in the past for your condition, whether they were effective or caused any adverse effects
- If you experience side effects from your medications, discuss them with your provider. Some side effects may pass with time, but others may require changes in the medication.
- Any other psychiatric or medical problems you have
- All other medications you are currently taking (including over the counter products, herbal and nutritional supplements) and any medication allergies you have
- Other non-medication treatment you are receiving, such as talk therapy or substance abuse treatment. Your provider can explain how these different treatments work with the medication.
- If you are pregnant, plan to become pregnant, or are breastfeeding
- If you drink alcohol or use illegal drugs

How should I take lamotrigine?

Lamotrigine is usually taken 1 or 2 times daily with or without food.

Typically patients begin at a low dose of medication and the dose is increased slowly over several weeks.

The dose usually ranges from 25 mg to 400 mg. Only your health care provider can determine the correct dose for you.

Extended release tablets: Swallow whole. Do not crush, chew or split tablets.

Lamotrigine orally disintegrating tablets must remain in their original packaging. Open the package with clean dry hands before each dose. Do not try to put tablets in a pillbox if you take the orally disintegrating tablets. Lamotrigine orally disintegrating tablets will dissolve in your mouth within seconds and can be swallowed with or without liquid.

Use a calendar, pillbox, alarm clock, or cell phone alert to help you remember to take your medication. You may also ask a family member a friend to remind you or check in with you to be sure you are taking your medication.

What happens if I miss a dose of lamotrigine?

If you miss a dose of lamotrigine, take it as soon as you remember, unless it is closer to the time of your next dose. Discuss this with your health care provider. Do not double your dose or take more than what is prescribed. If you miss more than 3 days of medication, contact your prescriber because he/she may need to adjust your dose.

What should I avoid while taking lamotrigine?

Avoid drinking alcohol or using illegal drugs while you are taking lamotrigine. They may decrease the benefits (e.g., worsen your condition) and increase adverse effects (e.g., sedation) of the medication.

What happens if I overdose with lamotrigine?

If an overdose occurs call your doctor or 911. You may need urgent medical care. You may also contact the poison control center at 1-800-222-1222.

A specific treatment to reverse the effects of lamotrigine does not exist.

What are the possible side effects of lamotrigine?

Common side effects

- Nausea
- Insomnia
- Runny nose
- Non-serious rash
- Headache
- Diarrhea
- Abnormal dreams
- Dizziness or drowsiness
- Fatigue

Rare/Serious side effects

A serious, life-threatening skin rash (also known as Stevens–Johnson Syndrome) may occur with the use of lamotrigine. Contact your health care provider immediately if you have any of the following: a skin rash, blistering or peeling of your skin, hives, shortness of breath, or painful sores in your mouth or around your eyes. Extra caution is needed in children and teenagers ages 2-17 receiving lamotrigine. These patients may be at an increased risk of developing this life-threatening rash.

Studies have found that individuals who take antiepileptic medications including lamotrigine have suicidal thoughts or behaviors up to twice as often than individuals who take placebo (inactive medication). These thoughts or behaviors occurred in approximately 1 in 500 patients taking the antiepileptic class of medications. If you experience any thoughts or impulses to hurt yourself, you should contact your doctor immediately.

Aseptic meningitis, a serious inflammation of the protective membrane that covers the brain and spinal cord has been identified as a very rare but serious side effect of lamotrigine. Contact your health care provider immediately if you experience headache, fever, nausea, vomiting, stiff neck, rash, unusual sensitivity to light, muscle pains, chills, confusion, or drowsiness while taking lamotrigine.

Patients with certain underlying cardiac disorders or heart rhythm problems may experience serious arrhythmias or life-threatening effects. Those with structural or functional heart disease should be counseled on risk versus benefits of using this medication.

A rare but life-threatening immune system reaction which can cause serious blood or liver problems has been reported with lamotrigine use. Contact your health care provider immediately if you experience fever, frequent infections, severe muscle pain, swelling of the face, eyes, lips, or tongue, swollen lymph glands, unusual bruising or bleeding, weakness, fatigue, or yellowing of the skin or white part of your eyes. Onset usually occurs within the first several weeks after starting therapy. Patients with HLH symptoms should be evaluated promptly; discontinuation and conversion to alternate therapy may be required.

Seizures may occur if a patient taking lamotrigine suddenly stops taking it.

Are there any risks for taking lamotrigine for long periods of time?

To date, there are no known problems associated with long term use of lamotrigine. It is a safe and effective medication when used as directed.

It is important to note that some of the side effects listed above (particularly rash and suicidal thoughts) may continue to occur or worsen if you continue taking the medication. It is important to follow up with your doctor routinely and to contact your doctor immediately if you notice any skin rash or changes in mood or behavior.

What other medications may interact with lamotrigine?

The following medications may **increase** the level and effects of lamotrigine:

- Valproate/divalproex (Depakote®)

The following medications may **decrease** the level and effect of lamotrigine:

- Anticonvulsants such as phenytoin (Dilantin®), carbamazepine (Tegretol®/Carbatrol®/Equetro®), phenobarbital, and primidone (Mysoline®)
- Oral contraceptives (birth control pills)
- Rifampin (Rifadin®), ritonavir (Norvir®)

Lamotrigine may **increase** the level and effects of:

- Clozapine (Clozaril®, FazaClo®)

How long does it take for lamotrigine to work?

It is very important to tell your doctor how you feel things are going during the first few weeks after you start taking lamotrigine. It will probably take several weeks to see big enough changes in your symptoms to decide if lamotrigine is the right medication for you.

Mood stabilizer treatment is generally needed lifelong for persons with bipolar disorder. Your doctor can best discuss the duration of treatment you need based on your symptoms and illness.

Summary of Black Box Warnings

Serious Skin Reactions

Serious and sometimes fatal skin reactions have been reported with lamotrigine use. Since it is not always possible to predict which rashes will prove to be serious or life threatening, it is important to talk to your doctor at the first sign of a rash while taking lamotrigine.

CERTIFICATE OF SERVICE

I, Alexander H. Rate, hereby certify that I have served true and accurate copies of the foregoing Answer/Brief - Brief in Opposition to the following on 02-19-2025:

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