UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

JANE DOE,

Plaintiff,

v.

MASSACHUSETTS DEPARTMENT OF CORRECTION; THOMAS A. TURCO III; SEAN MEDEIROS; JAMES M. O'GARA JR.; and STEPHANIE COLLINS,

Defendants.

Civil Action No. 1:17-CV-12255-RGS

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MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF JANE DOE'S MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

Plaintiff Jane Doe is a 53 year-old transgender woman who has been diagnosed with Gender Dysphoria, a serious medical condition resulting from a mismatch between her female gender identity and her assigned birth sex. She long ago completed gender transition and has lived her entire adult life as a woman. Four decades of hormone therapy has feminized her body. She has normal female breast development and typical female body fat distribution, limited body hair, feminine vocalization from the long-term effects of hormones on her vocal chords, and softened skin. Notwithstanding that she is a woman, she is incarcerated in a men's prison because she is transgender.

This case challenges the daily brutalization she experiences from being wrongly incarcerated in a men's prison. She is forced while showering, and at other times, to reveal her naked body to male inmates who rightly view her as the only woman in their midst and treat her as a sex object, taunting her about her "boobs" and what they would like to do with her body; subjected to strip-searches by male correctional officers who lift and touch her breasts, including one particularly harrowing incident in which she was forced to strip naked in view of ten male inmates; and regularly denied the ability to live, function, and be recognized as a woman, which is the essential medical treatment for her condition (e.g., male guards refuse to call her by her female name or use female pronouns, refer to her as a "chick with a dick," and regularly tell her she is a man).

The consequences to her health and safety are dire. A corrections expert with 45 years of experience has concluded that Ms. Doe is at high-risk for physical and sexual assault potentially "escalating into a life and death situation" if she is not removed from the men's prison and appropriately housed in a female facility. Affidavit of James Aiken ("Aiken Aff."), at ¶¶ 10, 14 (discussed infra). A psychologist with expertise in Gender Dysphoria evaluated Ms. Doe in

December 2017 and diagnosed her with Post Traumatic Stress Disorder and an anxiety disorder as a direct result of incarceration in a men's prison, and warned that Ms. Doe's "mental health is devolving" and she is at "risk for further emotional and physical decline" which may render her unable to function at all. Affidavit of Randi Ettner, Ph.D.[1] ("Ettner Aff."), ¶¶ 33, 37 (discussed infra).

Ms. Doe brings claims under the Americans with Disabilities Act ("ADA"), the Federal Rehabilitation Act ("FRA"), the United States Constitution (Equal Protection and Due Process) and 42 U.S.C. § 1983 for redress of the correctional facility's refusal to properly place her in the women's correctional facility and for denials of requests for reasonable modifications necessary for treatment of her medical condition.[2] The ADA and FRA, in particular, guarantee that the ability of people with disabilities to function in society be based on medical judgment, not bias, stereotypes, stigma, or unfounded beliefs. These laws recognize that people with medical conditions often face barriers because policies and practices incorrectly presume that all human bodies function the same. The fulfillment of their promise requires that social institutions, including prisons, make reasonable accommodations when deeply entrenched policies and practices interfere with a person's equal access to and inclusion in those institutions.

Ms. Doe's condition, Gender Dysphoria, is a quintessential stigmatized and misunderstood health condition. The current scientific medical information relevant to her claim is well-established: Ms. Doe is a woman, and the recognized medical treatment protocol for a

[1] Dr. Ettner is one of the nation's foremost experts on the diagnosis, treatment, and management of gender dysphoric individuals. She is the co-editor of a leading treatise in the field, Principles of Transgender Medicine (2007; 2d. ed. 2016), and is an officer and member of the board of directors of the leading professional association specializing in the treatment of gender variant people. Ettner Aff. ¶¶ 1-2.

[2] Plaintiff agrees to the dismissal without prejudice of her cognate state constitutional claims (Counts V, VI and VII).

woman with Gender Dysphoria requires that she live as a woman. Defendants, however, have acted at every turn in contravention of the medical, health and safety needs of Ms. Doe and have ignored her repeated requests that her medical condition be taken into account when enforcing prison policies. Ms. Doe needs immediate relief from this Court. This Court should grant her motion for a preliminary injunction by ordering Defendants to: (1) transfer Jane Doe to MCI-Framingham; (2) enjoin Defendants from using male correctional officers to conduct strips searches of Jane Doe, except in exigent circumstances; (3) enjoin Defendants from forcing Jane Doe to shower in the presence of men and with a shower curtain that does not adequately cover her; (4) enjoin Defendants from treating Jane Doe differently than other women held by the DOC; (5) train all staff on how to appropriately accommodate, treat and communicate with individuals with Gender Dysphoria within 60 days of this Order; (6) enjoin Defendants from using male pronouns when speaking to or about Jane Doe; (7) enjoin Defendants from referring to Jane Doe by her former male name (or any abbreviated version thereof); (8) refer to Jane Doe by her chosen female name; and (9) award such other and further relief as is just and proper.

STATEMENT OF FACTS

I. Jane Doe is a Woman with a Diagnosis of Gender Dysphoria.

Jane Doe knew at a young age that she is a girl. Affidavit of Jane Doe ("Doe Aff.") ¶ 2. Although ascribed the sex of male at birth, Ms. Doe began wearing girls' clothes and playing with girls' toys at a young age. *Id.* ¶ 2. As a teenager she adopted the female name she has used ever since. *Id.* She also sought and received medical care for the anguish she experienced as a result of the incongruence between her gender identity (i.e., her inner felt sense of being a woman) and the sex she was designated at birth. Doe Aff. ¶¶ 2-3; Ettner Aff. ¶¶ 6-11, 22. During her teenage years, she also began the process of gender transition that included hormone therapy to enable her to successfully live and function as a woman. Doe Aff. ¶ 3. She has been on

hormone therapy since that time. *Id.* ¶ 3. Ms. Doe has lived her entire adolescent and adult life as a woman; she was never socialized as a man. Ettner Aff. ¶ 29; *see also* Doe Aff. ¶¶ 4-6, 9.

Now, at age 53, Ms. Doe is, by the current scientific and medical understanding of sex, female. Ettner Aff. ¶¶ 24, 25 (explaining that current medical and scientific understanding of sex includes numerous components: genitals, chromosomes, gender identity, brain, and hormonal makeup). In addition, Ms. Doe has been taking "appropriate, confirming" female hormones for such a long time (almost four decades) that she has the same circulating sex steroids as a woman of similar age and testosterone levels that are barely measurable, also comparable to other women her age. *Id.* ¶ 27. Ms. Doe's hormone laboratory measurements indicate that she has been hormonally reassigned to female. *Id.* Consistent with Ms. Doe's long-time estrogen therapy, she has female secondary sex characteristics, including normal female breast development, redistribution of body fat consistent with a female shaped body, loss of muscle mass, female vocalization, and diminution of body hair. *Id.* ¶ 28. Ms. Doe's long-time estrogen therapy and lack of testosterone have also resulted in significant genital changes. *Id.* ¶ 30. If one were to view Ms. Doe naked, as correctional officers who strip-search her do, her genitals would not appear as typical male genitals. *Id.* Long-term female hormone therapy, especially when started at such a young age, creates significant atrophy and decreased mass of the genitals. *Id.* Nor would Ms. Doe have male genital function. *Id.* The hormonal changes would render her unable to have erections, produce ejaculate fluid, or engage in penetrative sex. *Id.* She would not be capable of reproduction. *Id.* ¶¶ 30-31.

Ms. Doe's diagnosis and course of medical care are long-established and recognized in the field of medicine. In terms of medical diagnosis, typically, persons born with the physical characteristics of males psychologically identify as men, and those with the physical

characteristics of females psychologically identify as women. *Id.* ¶ 4. However, for transgender individuals, the body and the person's gender identity – the elemental conviction of belonging to a particular gender that all people have – do not match. *Id.* ¶¶ 3-4. In 1980 the American Psychiatric Association introduced the diagnosis of gender identity disorder ("GID") in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). This diagnosis remained in subsequent versions of the DSM issued in 1987 (DSM-III-R) and 1994 (DSM-IV). *Id.* ¶ 6. In 2013 the DSM removed the diagnosis of GID and replaced it with a fundamentally different diagnosis called Gender Dysphoria that is based on significant changes in our understanding of individuals whose assigned sex at birth does not match their gender identity. *Id.* ¶ 7. Importantly, consistent with the change in nomenclature, the new diagnosis reflects that the incongruence between a person's gender identity and birth sex is no longer by itself considered to be a disorder, but rather the critical element of the condition is the presence of clinically significant distress that results from such an incongruence. *Id.* ¶¶ 7, 10 (setting out diagnostic criteria).

Ms. Doe has long-standing early onset Gender Dysphoria. Although she was originally diagnosed with GID, consistent with the version of DSM in effect at the time, she meets all of the criteria for a diagnosis of Gender Dysphoria. *Id.* ¶ 22. *See also* Doe Aff. ¶ 7 (confirmation of diagnoses by Massachusetts Department of Correction).

DSM-V in 2013 also recognized that the medical research that supports the Gender Dysphoria diagnosis is different and discusses the genetic and hormonal contributions to Gender Dysphoria. Ettner Aff. ¶ 11. In fact, there is now a scientific consensus that gender identity is biologically based and a significant body of scientific research that Gender Dysphoria has a physiological and biological etiology that emanates from a different interaction of sex hormones

with the developing brain. *Id.* ¶¶ 11-14. The scientific evidence demonstrates different brain composition in transgender women and men, and a significant co-occurrence of Gender Dysphoria in families and twins. *Id.*

Without treatment, adults with Gender Dysphoria experience serious psychological debilitation (e.g., anxiety, depression, suicidality and other mental health issues). *Id.* ¶ 15. Fortunately, Gender Dysphoria is treatable by medically-recommended and supervised gender transition in order to ameliorate the debilitation of Gender Dysphoria and allow the individual to live a life consistent with one's gender identity. *Id.* ¶¶ 16-17. The protocol is contained in the World Professional Association for Health Standards of Care (7th version, 2011), which are endorsed by the nation's major medical and mental health organizations, and entail an individualized approach of one or more of four components: living consistent with one's gender; hormone therapy to feminize or masculinize the body; surgery to change primary and/or secondary sex characteristics; and psychotherapy. *Id.* ¶ 17. All of the standards are applicable to incarcerated persons. *Id.* ¶ 18.

II. Ms. Doe's Placement in a Male Correctional Facility Impedes the Medical Treatment for her Gender Dysphoria, Causes Extreme Psychological Damage, and Places Her at High Risk for Physical Violence and Sexual Assault.

As Dr. Ettner has explained:

> A key component of medical treatment for gender dysphoric individuals is to live, function in society, and be regarded by others consistent with their gender identity. If any aspect of this social role transition is impeded, it will undermine an individual's core identity and psychological health . . . . The failure to treat a woman with Gender Dysphoria as a woman in an institutional setting will intensify gender dysphoria and psychological distress and precipitate psychological disorders.

Id. ¶¶ 19-20. In particular, Ms. Doe's Gender Dysphoria requires life-long medical care, including "the requirement that she live and function as a woman." *Id.* ¶ 23.

The placement of Ms. Doe in a male prison has resulted in inhumane conditions and severe harm caused by the refusal of prison officials to follow her medical protocol and treat her as a woman, and the resulting sexual harassment and intimidation by male inmates who rightly perceive her as the only woman in their midst. *See generally* Doe Aff. ¶¶ 12-23. Ms. Doe has, with rare exception, been denied access to a separate shower and forced to shower in areas where male prisoners view her naked body. *Id.* ¶¶ 12-17. She has frequently been forced to shower in stalls that can be watched from an upper tier where male prisoners routinely gather to see her naked and taunt her about her "boobs" and "shout out what they would like to do with [her] sexually." *Id.* ¶ 14. Currently and often throughout her incarceration she has been forced to shower in bathrooms open to men in a stall that has only a transparent curtain with an opaque strip intended to cover the genitals. But this leaves her torso, including her breasts, completely exposed to the bathroom's male occupants. *Id.* ¶¶ 14, 16 (noting that a fully opaque curtain she was afforded for a short while was taken down because a correctional officer told her "we're all men here"). Separate showers pose no threat to the security of the normal operations of the facility, and are in fact required by federal regulation. (28 C.F.R. § 115.42(f)) ("[t]ransgender . . . inmates shall be given the opportunity to shower separately from other inmates")). Aiken Aff. ¶ 9.[3]

Ms. Doe has also endured regular strip searches by male guards who lift and touch her breasts. Doe Aff. ¶ 19. In one particularly cruel and harrowing circumstance, during an institution-wide lockdown, two male correctional officers entered Ms. Doe's cell and forced her

[3] Mr. Aiken has 45 years of experience in the administration, operation, and management of correctional facilities, including as the Commissioner of the Indiana Department of Correction. Aiken Aff. ¶ 1. He is distinguished by his Congressional appointment to the nine-member National Prison Rape Elimination Commission charged with developing standards that would lead to the prevention, detection and elimination of prison rape. *Id.* ¶ 3.

to strip naked for a search with her cell door open in full view of approximately 10 male prisoners who yelled "things at [her] about [her] body and things they would like [her] to do to them." *Id.* ¶ 21. There is no operational reason that a correctional system cannot arrange to have a female correctional officer strip-search Ms. Doe. Aiken Aff. ¶ 8.

Ms. Doe has also endured harassment and the refusal to acknowledge and treat her as a woman by correctional officers who are charged with her safety and welfare. They refuse to call her by her female name and use female pronouns when referring to her. Doe Aff. ¶ 25; Ettner Aff. ¶ 35 (appropriate female name crucial to psychological well-being). When Ms. Doe has asked for assistance securing a separate shower or with other concerns, she has been met with derision by correctional officers who ask whether she has a penis. Doe Aff. ¶ 17. Correctional officers make derogatory comments about her to other corrections personnel and other inmates, referring to transgender women as "chicks with dicks," and "wannabe women," and use other epithets such as "fags" and "homos." *Id.* ¶ 25. Since filing this lawsuit Ms. Doe has endured increased harassment. *See id.* ¶¶ 29-31.

Ms. Doe's continued placement in a male correctional facility places her at high risk for physical and sexual assault. As Mr. Aiken explains:

> [C]ontinuing to house Ms. Doe in a male correctional facility creates an unnecessary perilous endangerment for her. Her placement in a male facility is the direct cause of Ms. Doe being the subject of systemic taunting, intimidation, harassment and violence, and needlessly subjects her to a very high risk of an event escalating into a life and death situation . . . . If prison officials do not remove her from this environment and place her in a proper setting, more intense perils are likely to occur.

Aiken Aff. ¶¶ 10, 14. *See also Id.* ¶ 4 (noting peril of housing in male facility "a person who lives and presents as a woman"). He concludes that "Ms. Doe's safety requires that she be transferred to a women's correctional facility to abate this clear, present and known endangerment issue." *Id.* ¶ 18.

Further, Ms. Doe has suffered severe psychological damage as a result of being in an environment that subjects her to a high risk of assault and rape, refuses to treat her as a woman, forces her to reveal her naked body to male prisoners, permits her to be strip-searched and have her breasts touched by men, and is permeated by taunts about her womanhood. Ettner Aff. ¶¶ 33-35. It is Dr. Ettner's assessment that Ms. Doe has developed Post Traumatic Stress Disorder and an Anxiety Disorder as a direct result of being housed in a male correctional facility. *Id.* ¶ 33.

Even more concerning, given what she has endured and continues to endure on a daily basis, Ms. Doe's "mental health is steadily devolving" and she is at "risk for further emotional and physical decline," including the risk that she will be "render[ed] . . . incapable of functioning, a condition known as psychological decompensation, which can be irremediable." *Id.* ¶ 37. *See also* Doe Aff. ¶¶ 13-14, 19, 31 (describing fear of being raped, nightmares, anxiety, the dehumanization of feeling like a sex object, and the terror of having male guards handling her breasts).

III. Ms. Doe will Function Well in a Female Correctional Facility.

Ms. Doe will function well and she will likely be symptom-free if placed in an appropriate facility and treated as a female. Ettner Aff. ¶ 39. She has lived her whole life as female, excluding periods of incarceration. *Id.* ¶ 40. Mr. Aiken, with his extensive experience in corrections, has opined that "[t]here is no basis to conclude that Ms. Doe's placement in a female correctional facility creates any security or management concern solely because she is a woman who is transgender." Aiken Aff. ¶ 19. The classification for risk of violence or any other concern must be based on an individualized assessment of risk. *Id.* ¶ 12. There is no danger that Ms. Doe will be physically or sexually assaultive to other inmates. Ettner Aff. ¶¶ 41-42. Her psychological testing reveals low levels of anger or aggression, and no sexual concerns on any measure. *Id.* Mr. Aiken also concludes that there is nothing to suggest that Ms. Doe has any risk

factors assessed under objective criteria that would raise concerns about such a transfer. Aiken Aff. ¶ 18.

ARGUMENT

I. STANDARD OF REVIEW.

The standards for a preliminary injunction are well established. "A plaintiff seeking a preliminary injunction must establish that [s]he is likely to succeed on the merits, that [s]he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [her] favor, and that an injunction is in the public interest." *Winter v. Nat'l Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (citations omitted); *see also Borinquen Biscuit Corp. v. M.V. Trading Corp.*, 443 F.3d 112, 115 (1st Cir. 2006); *Black Tea Soc'y v. City of Boston*, 378 F.3d 8, 11 (1st Cir. 2004). While all four factors support preliminary relief in this case, "[t]he first two factors are the most critical. Both require a showing of more than mere possibility. Plaintiffs must show a strong likelihood of success, and they must demonstrate that irreparable injury will be likely absent an injunction." *Respect Maine PAC v. McKee*, 622 F.3d 13, 15 (1st Cir. 2010) (citing *Winter*, 555 U.S. at 21); *Sindicato Puertorriqueño de Trabajadores v. Fortuño*, 699 F.3d 1, 10 (1st Cir. 2012).

II. MS. DOE HAS A SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS OF HER CLAIMS.

A. Ms. Doe is Likely to Succeed on Her Claims under Title II of the ADA and Section 504 of the FRA in Counts I and II of the Complaint.

Defendants have discriminated against Ms. Doe on the basis of her disability, Gender Dysphoria, by treating her differently than women without Gender Dysphoria who are properly placed in the female correctional facility; subjecting her to disadvantageous treatment in the male correctional facility; and failing to provide modifications to policies and practices that are necessary for the medical treatment of her Gender Dysphoria.

Title II of the ADA provides that:

> Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132. The substantive provisions of Title II of the ADA and § 504 of the FRA, 29 U.S.C. § 794, are similar:

> No otherwise qualified individual with a disability in the United States . . .shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

The standards of liability under the FRA have been considered identical to those under the ADA, and thus the claims are usually analyzed together. *See, e.g.*, *Nat'l Ass'n of the Deaf v. Harvard Univ.*, 2016 WL 3561622, at *4 (D. Mass. Feb. 9, 2016), *report and recommendation adopted*, 2016 WL 6540446 (D. Mass. Nov. 3, 2016).[4] There is no dispute that these standards apply to a state prison. *Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 209-10 (1998).

To state a claim under the ADA, a plaintiff must establish "(1) that [s]he is a qualified individual with a disability; (2) that [s]he was either excluded from participation in or denied the benefits of some public entity's services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was by reason of the plaintiff's disability." *Cox v. Massachusetts Dep't of Corr.*, 18 F. Supp. 3d 38, 48–49 (D. Mass. 2014) (quoting *Parker v. Universidad de Puerto Rico*, 225 F.3d 1, 5 (1st Cir. 2000)); *Reaves v. Dep't of Corr.*, 195 F. Supp. 3d 383, 418 (D. Mass. 2016) (applying FRA to state prisons).

[4] Accordingly, plaintiff will analyze these claims under the ADA, with references to § 504 as appropriate.

1. Ms. Doe is an Individual with a Disability Under the ADA and FRA.[5]

The ADA defines disability as: "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment (as described in paragraph (3))." 42 U.S.C. § 12102(1). Ms. Doe's Gender Dysphoria is squarely within all three prongs of the ADA's definition of disability.

For the first prong, Ms. Doe's Gender Dysphoria is both a physical and a mental impairment that substantially limits her major life activities of reproduction and caring for one's self. Gender Dysphoria is a "physiological . . .condition . . . affecting . . . [the] endocrine [system]" because it is marked by an atypical interaction of sex hormones with the brain and, as a result, a person with Gender Dysphoria is born with circulating hormones inconsistent with their gender identity. *See* 28 C.F.R. § 35.108(b)(1)(i). Gender Dysphoria also meets the definition of a "mental or psychological disorder" in 28 C.F.R. § 35.108(b)(1)(ii) as a serious and debilitating psychiatric diagnosis.[6]

[5] Ms. Doe will establish that she is a "qualified" individual with a disability in Section 2, *infra*.

[6] Case law also supports that gender dysphoria is a serious disability subject to protection. *See, e.g., Doe v. United States Postal Service*, 1985 WL 9446, at *2-3 (D.D.C. June 12, 1985) (holding that a transgender woman plaintiff "allege[d] the necessary 'physical or mental impairment' to state a claim" for disability under the Rehabilitation Act before the ADA was passed by Congress); *Blatt v. Cabela's Retail, Inc.*, 2017 WL 2178123, at *4 (E.D. Pa. May 18, 2017) (finding that Plaintiff's gender dysphoria "substantially limits her major life activities of interacting with others, reproducing, and social and occupational functioning" and thus is covered by the ADA); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 244 (D. Mass. 2012) (finding GID to be a "serious medical need" under the Eighth Amendment depending on the degree of severity.

In addition, Ms. Doe's Gender Dysphoria substantially limits her major life activities.[7] Ms. Doe's medical treatment for Gender Dysphoria has rendered her incapable of reproduction, Ettner Aff. ¶ 31, which is a substantial limitation on a major life activity under the ADA. *See Bragdon v. Abbott*, 524 U.S. 624, 639 (1998) ("reproduction is a major life activity"). She is also substantially limited in the major life activity of caring for one's self because her Gender Dysphoria requires that she follow a lifelong medical protocol. *See* Ettner Aff. ¶¶ 16-20; *United States v. Happy Time Day Care Ctr.*, 6 F. Supp. 2d 1073, 1080-81 (W.D. Wis. 1998) ("[c]aring for oneself" is one of the enumerated examples of "major life activities, and describing the lifelong need for medical care for HIV when looked at over an extended period of time as a "major life activity" under the ADA). *See also* 42 U.S. C. § 12102(2)(B) (major life activity "includes the operation of a major bodily function, including . . . endocrine, and reproductive functions").[8]

For the second prong, Ms. Doe clearly has a "record of such an impairment," as she was diagnosed with Gender Dysphoria decades ago, a diagnosis that has been confirmed by correctional officials in previous incarcerations. Doe Aff. ¶¶ 2, 7.

Finally, for the third prong, Congress clarified in 2008 in the ADAAA that under the "regarded as" prong, a plaintiff need only demonstrate adverse action on the basis of an

[7] The findings and purposes of the ADA Amendments Act of 2008 ("ADAAA") explicitly reject the notion that these terms "'need to be interpreted strictly to create a demanding standard for qualifying as disabled'." 42 U.S.C. § 12101, Pub. L. No. 110-325, 122 Stat 3553 (quoting *Toyoto Motor manufacturing, Kentucky, Inc. v. Williams*, 534 U.S. 184 (2002)).

[8] In concluding that Ms. Doe's Gender Dysphoria is a disability, the Court must be mindful that "[t]he definition of disability in [the ADA] shall be construed in favor of broad coverage of individuals under this Act" (42 U.S.C. § 12102(4)(A), Pub. L. No. 110-325, § 3 (4)(A), 122 Stat 3553) and that "the question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis." 42 U.S.C. § 12101 (b)(5), Pub. L. No. 110-325, § 2(b)(5), 122 Stat 3553.

impairment, here Ms. Doe's Gender Dysphoria. *See* 42 U.S.C. § 12102(3)(A) ("An individual meets the requirement of 'being regarded as having such an impairment' if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental *impairment* whether or not the impairment limits or is perceived to limit a major life activity") (emphasis added); ADAAA, Pub. L. No. 110-325, § 2(b)(3), 122 Stat. 3553 (2008) (reinstating "broad view of the third prong" of the definition of disability); 28 C.F.R. § 35.108(a) (2)(iii) (no showing of substantial limitation required under regarded as prong). *See* Sec. A(2), *infra,* for a discussion that Ms. Doe has been subjected to discrimination on an action prohibited by the ADA.

2. Ms. Doe Has Been Subjected to Discrimination by Reason of her Gender Dysphoria in Violation of Title II of the ADA and § 504 of the FRA.

Title II of the ADA and § 504 of the FRA contain broad, all-encompassing prohibitions of discrimination by public entities. *See* 42 U.S.C. § 12132; 28 U.S.C. § 794(a). These prohibitions are not limited to exclusion from specific programs, activities, or services of a prison. Rather, the phrase "or be subjected to discrimination by any such entity" makes plain that "the language of Title II's anti-discrimination provision does not limit the ADA's coverage to conduct that occurs in the 'programs, services, or activities.' . . . [I]t is a catch-all phrase that prohibits all discrimination by a public entity, regardless of context." *See Innovative Health Systems, Inc. v. City of White Plains*, 117 F.3d 37, 44-45 (2d Cir. 1997), *superseded on other grounds by Zervos v. Verizon N.Y.*, 252 F.3d 163 (2d Cir. 2001); *Nattiel v. Tomlinson*, 2017 WL 5799233, at *5-7 (N.D. Fla. July 13, 2017).[9]

[9] *See also Noel v. N.Y. City Taxi & Limousine Comm'n*, 687 F.3d 63, 68 (2d Cir. 2012) ("[T]he phrase 'services, programs or activities has been interpreted to be a 'catch-all phrase that prohibits all discrimination by a public entity.'"); *Jaros v. Illinois Dep't of Corr.*, 684 F.3d 667, 672 (7th Cir. 2012) ("Although incarceration is not a program or activity . . . showers made available to inmates are."); *Hason v. Med. Bd. Of California*, 279 F.3d 1167, 1172-73 (9th Cir.

Ms. Doe has a strong likelihood of success on her claim that she has been "subjected to discrimination . . . by reason of her disability [Gender Dysphoria]" under the statutory prohibition of disparate treatment." Ms. Doe is a woman. The differential treatment Ms. Doe has experienced as a woman with Gender Dysphoria is flagrant. All women – except those with Gender Dysphoria – are given access to and housed in the women's prison. This is plainly discrimination "by reason of" Ms. Doe's Gender Dysphoria. *See, e.g., Henderson v. Thomas*, 913 F.Supp. 2d 1267, 1276 (M.D. Ala. 2012) (determining that Alabama Department of Corrections excluding HIV-positive inmates from all prison and work-release facilities except for one violated ADA and FRA).

Ms. Doe is a "qualified individual with a disability" with respect to her appropriate placement in a female correctional facility because she is female. [10] As Dr. Ettner explained, current medical and scientific understanding of transgender identity recognizes that a person's sex includes numerous components, including genitals, chromosomes, gender identity, brain, and hormonal makeup. Ettner Aff. ¶¶ 24-25. Ms. Doe has a female gender identity, completed hormonal reassignment to female and has lived consistently as a female from her teens to her current age of 53. *Id.* ¶¶ 27-30. Ms. Doe's Gender Dysphoria does not alter the conclusion that nearly 40 years after undergoing gender transition, she is female. *Id.* ¶ 24.

2002) ("[T[he ADA's broad language brings within its scope anything a public entity does."); *Yeskey v. Com. of Pa. Dep't of Corr.*, 118 F.3d 168, 170-71 (3rd Cir. 1997), *aff'd sub nom, Pennsylvania Dept. of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998) ("[t]he statutory definition of '[p]rogram or activity' in Section 504 indicates that the terms were intended to be all-encompassing," and broadly interpreting Section 504 and Title II of the ADA to 'appl[y] to anything a public entity does").

[10] Under Title II, the term "qualified individual with a disability means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices … meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 28 C.F.R. § 35.104; *see also* 28 C.F.R. § 42.540(l) (2) (definition of qualified individual under FRA).

The flip side of the exclusion from the women's prison is that Ms. Doe has necessarily been subjected to disadvantageous treatment in a male correctional facility because of her Gender Dysphoria. By virtue of her diagnosis and its medical treatment, Ms. Doe has a female gender identity and a female body. As a result, she is treated disadvantageously relative to other inmates housed at MCI-Norfolk who do not suffer from Gender Dysphoria. For example, Ms. Doe is subjected to sexualized harassment, violations of privacy, and increased risk of sexualized violence. When she is strip-searched by male correctional officers, her breasts are groped. Inmates without Gender Dysphoria placed in the men's correctional facility at MCI-Norfolk do not experience these adverse consequences because they have the same gender identity as the correctional officers who search them, but Ms. Doe does because she is a person with a female gender identity and female body – i.e., she has Gender Dysphoria.

Ms. Doe is also likely to prevail on her claim that defendants' apparent practice of using a person's genital status or assigned birth sex as a criterion for the gender-based housing classifications has a disparate impact on inmates with Gender Dysphoria. The language and legislative history of Title II prohibit policies or practices that have the effect of discriminating against an individual with a disability. *See Wis. Cmty. Servs. v. City of Milwaukee,* 465 F.3d 737, 753 (7th Cir. 2006) (en banc) ("defendant's rule disproportionally impact[ing] disabled people" actionable under Title II); *Crowder v. Kitagawa*, 81 F.3d 1480, 1483-1484 (9th Cir. 1996) (discussing Congressional intent to "cover both intentional discrimination and discrimination as a result of facially neutral laws" that "deny disabled persons public services disproportionately due to their disability"); *Ability Ctr. of Greater Toledo v. City of Sandusky*, 181 F. Supp. 2d 797, 800 (N.D. Ohio 2001) ("The Statutory language prohibiting discrimination and the definition of a 'qualified individual with a disability' do not necessarily require an intent to discriminate . . .

[but include] taking action that has the effect of discriminating against an individual with a disability").[11]

Once Ms. Doe makes a prima facie case establishing that defendant's actions or policies cause a disparate impact, a defendant may "explain the valid interest served by their policies." *See Texas Dep't of Housing and Cmty. Affairs v. Inclusive Communities Project*, 135 S. Ct. 2507, 2522 (2015) (in context of Fair Housing Act). If a defendant successfully does so, the plaintiff must then show "an available alternative . . . practice that has less disparate impact and serves the [entity's] legitimate needs." *Id*. at 2518 (quoting *Ricci v. DeStefano*, 557 U.S. 557, 578 (2009)).

A policy based solely on a person's genitalia, anatomy, or assigned birth sex disadvantages inmates with Gender Dysphoria whose treatment does not include genital surgery. Inmates with Gender Dysphoria who have not had genital surgery are, unlike other inmates, placed in correctional facilities contrary to their gender and their required medical treatment protocol and accordingly are subjected to harassment, severe psychological harm, and risk of sexual assault. Further, defendants cannot assert a "valid interest" served by any policy or practice exclusively and categorically based on anatomy, genital status, or assigned birth sex where such a policy itself violates Federal regulations. The Department of Justice regulations on housing transgender inmates reject any categorical rule and instead provide that "[i]n deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in

[11] A helpful discussion of the availability of disparate impact theory under Title II is contained in Margo Schlanger, *How the ADA Regulates and Restricts Solitary Confinement for People with Mental Disabilities,* AM. CONST. SOC'Y FOR L. & POL'Y , May 2016, at 6-7. Professor Schlanger notes that the ADA's Title II regulations include language that supports a disparate impact theory of liability. *Id.* ("The ADA's Title II regulations include two uses of the word 'effect,' which unambiguously reference a disparate impact theory of liability") (citing 28 C.F.R. §§ 35.130(b)(3)(i)-(ii)).

making other housing and programming assignments, the agency shall consider on a case-by-case-basis whether a placement would ensure the inmate's health and safety, and whether the placement would prevent management or security problems." 28 C.F.R. § 115.42 (c).

Indeed, Ms. Doe presents the quintessential example of why the health and safety of a female with Gender Dysphoria require placement in the women's correctional facility. *See* Ettner Aff. ¶¶ 19-20, 23-27, 33-42; Aiken Aff. ¶¶ 10, 14, 18-19. The facts of this case underscore that there is no alternative to placement in a women's correctional facility that would adequately protect Ms. Doe's health and safety and that would not interfere with her medical care.

Finally, Ms. Doe has a strong likelihood of prevailing on her claim that that she has been denied reasonable modifications to policies and procedures necessary for her Gender Dysphoria. Title II regulations require that:

> A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

28 C.F. R. § 35.130 (b) (7)(i); *see also* 29 C.F.R. § 1614.203(d)(3). The denial of a requested modification necessary to implement a medical treatment protocol violates this provision. For example, in *Lonergan v. Fla. Dep't of Corr*., 623 F. App'x 990 (11th Cir. 2015), a dermatologist ordered that an inmate with pre-cancerous skin lesions be provided a hat, sunblock, and be kept out of the sun. *Id*. at 991. Plaintiff requested, among other things, a transfer to a prison where no required activities are conducted outdoors in the sun. *Id*. The Eleventh Circuit reinstated plaintiff's "reasonable accommodation" claim, noting that "in the context of the ADA, a prisoner's transfer from or to a particular prison may become relevant when prison officials attempt to determine what constitutes a 'reasonable accommodation.'" *Id.* at 993-94. In addition, it noted that the "plaintiff successfully alleges more than the mere disagreement with his medical

treatment. He seeks the treatment recommended by his dermatologist." *Id.* at 994. *See also Tomlinson*, 2017 WL 5799233, at *5-7 (N.D. Fla. July 13, 2017) (plaintiff with asthma successfully alleged substantial risk of injury that other inmates were not subjected to by failure to provide reasonable accommodation to forego use of chemical agents in restraint); *Levesque v. State of New Hampshire*, 2010 WL 2367346, *34 (D.N. H. May 12, 2010) (claim for disabling skin condition requires provision of special footwear and access to showers sufficient to maintain certain level of cleanliness).

Ms. Doe's requested modifications that she be placed in a female correctional facility, be provided with privacy in showering and other areas, and be referred to and recognized as a woman (Doe Aff. ¶ 10) are all, as set forth above, necessary medical care and essential to avoid the profound psychological harm she has experienced due to being a person with Gender Dysphoria placed in a male prison. There is nothing in these requested reasonable modifications that would entail any fundamental alteration of defendant's correctional system. *See supra* STATEMENT OF FACTS Section III, discussing placement of a female in a female correctional facility; Aiken Aff. ¶¶ 7-8 (no operational reason a correctional system cannot have a female staff member strip search Ms. Doe); ¶ 9 (noting 28 C.F.R. § 115.42 (f) requires that "transgender inmates shall be given the opportunity to shower separately from other inmates" and finding no justification for failing to implement this provision). Defendants have unlawfully denied Ms. Doe reasonable modifications to its policies and procedures necessary to address her Gender Dysphoria.

3. Gender Dysphoria is Not Excluded from the ADA.

Ms. Doe's ADA claim based on Gender Dysphoria is not foreclosed because the statute and its regulations "specifically exclude . . . *gender identity disorders not resulting from physical impairments*." Any argument for precluding Ms. Doe's claim based on the GIDs exclusion finds

no support in the text of the ADA, disregards the plain langauge of the statute, and therefore is not a reasonable interpretion of the ADA. But even if it were, such an interpretation results in a categorical exclusion of transgender people from coverage under the ADA, violates constitutional guarantees of equal protection, and should be avoided under basic principles of statutory interpretation.

a. ***No Exclusion for Gender Dysphoria Appears Anywhere in the Text of the ADA.***

There is no statutory exclusion for Gender Dysphoria and gender identity disorder is not the same as Gender Dysphoria. While exclusions from the ADA's definition of disability refer to "gender identity disorders," ("the GIDs exclusion")**,** 42 U.S.C. § 12211(b), they are silent as to Gender Dysphoria. Gender Dysphoria is different from gender identity disorder in key ways; the two diagnoses are not the same. Ettner Aff. ¶ 7.

The replacement of the diagnosis of gender identity disorder with Gender Dysphoria in the DSM-V was more than semantic; it reflects a substantive difference between the medical conditions themselves. *Id.* Unlike the outdated diagnosis of gender identity disorder, the hallmark or presenting feature of Gender Dysphoria is ***not*** a person's gender identity. Rather, it is the clinically significant distress, termed dysphoria, that some people experience as a result of the mismatch between a person's gender identity and their assigned sex. *Id.*

Reflecting this distinction, the diagnostic criteria for Gender Dysphoria in the DSM-V are different than those for gender identity disorder. Gender identity disorder had been characterized by a "strong and persistent cross-gender identification" and a "persistent discomfort" with one's sex or "sense of inappropriateness" in the gender role of that sex. *See* DSM-IV at 581. In contrast, Gender Dysphoria is defined as a "marked incongruence" between gender identity and assigned sex, rather than a cross-gender identification *per se*. DSM-V at 452; *see also id.* at 814

(stating that DSM-V "emphasiz[es] the phenomenon of 'gender incongruence' rather than cross-gender identification per se, as was the case in DSM-IV gender identity disorder").

The criteria for Gender Dysphoria, unlike gender identity disorder, also include a "post-transition specifier for people who are living full-time as the desired gender." *See* AMERICAN PSYCHIATRIC ASSOCIATION, *GENDER DYSPHORIA* 1 (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf. The specifier was "modeled on the concept of full or partial remission," recognizing that treatment can relieve the distress associated with the diagnosis, but that someone who undergoes gender transition, putting them in remission, can still have a Gender Dysphoria diagnosis. DSM-V at 815. Significantly, this substantive change means there are people with Gender Dysphoria that would not meet the criteria for gender identity disorder, underscoring that Gender Dysphoria is a different diagnosis.

Lastly, the removal of the diagnosis of GID and inclusion of the diagnosis of Gender Dysphoria reflects changed understanding of the underlying medical condition. Ettner Aff. ¶ 11. "Unlike DSM's treatment of GIDs, the DSM-5 includes a section entitled 'Genetics and Physiology,' which discuss the genetic and hormonal contributions to Gender Dysphoria." *Id.* *See also* Christine Michelle Duffy, *The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973, in* GENDER IDENTITY AND SEXUAL ORIENTATION DISCRIMINATION IN THE WORKPLACE: A PRACTICAL GUIDE 16-72 to 16-74 & n.282 (Christine Michelle Duffy ed., Bloomberg BNA 2014) [hereinafter "Duffy"] (citing numerous medical studies conducted in past eight years that "point in the direction of hormonal and genetic causes for the in utero development of Gender Dysphoria").

Therefore, even if the GIDs exclusion could be interpreted to exclude all persons with *gender identity disorder* from bringing claims, it does not apply to persons like Ms. Doe with *Gender Dysphoria*, a new and distinct diagnosis.[12]

b. ***Even if Gender Dysphoria is a GID, the ADA's GIDs Exclusion Does Not Apply to All Claims Based on that Condition.***

The ADA only excludes "gender identity disorders *not resulting from physical impairments*." 42 U.S.C. § 12211(b)(1) (emphasis added). Therefore, even if this Court were to disregard the significant differences between gender identity disorder and Gender Dysphoria, and determine that the two are somehow the same or equivalent, Ms. Doe has a strong likelihood of success because she can establish that her medical condition results from a physical impairment. *Id.*

"There is now a scientific consensus that gender identity is biologically based and a significant body of scientific and medical research that Gender Dysphoria has a physiological and biological etiology." Ettner Aff. ¶ 12. *See also, e.g.*, Duffy at 16-72 to 16-74 & n.282; Aruna Saraswat, MD, Jamie D. Weinand, BA, BS & Joshua D. Safer, MD, *Evidence Supporting the Biologic Nature of Gender Identity*, 21 ENDOCRINE PRACTICE 199, 199-202 (Feb.2, 2015) (providing a review of data in support of a "fixed, biologic basis for gender identity" and concluding that "current data suggest a biologic etiology for transgender identity"). As Dr. Ettner states: "It has been demonstrated that transgender women, transgender men, non-

[12] Recently faced with the same argument presented in Defendants' motion to dismiss, the Eastern District of Pennsylvania advanced a separate reason for why the GIDs Exclusion does not apply to Gender Dysphoria. The GIDs Exclusion, the court stated, "refer[s] to only the condition of identifying with a different gender, [and does] not . . . encompass (and therefore exclude from ADA protection) a condition like . . . gender dysphoria, which goes beyond merely identifying with a different gender and is characterized by clinically significant stress and other impairments that may be disabling." *Blatt*, 2017 WL 2178123, at *2. Simply put, the GIDs Exclusion "exclude[es] certain sexual identities from the ADA's definition of disability" – not the "disabling conditions that persons of those identities might have." *Id.* at *3.

transgender women, and non-transgender men have different brain composition, with respect to the white matter of the brain, the cortex (central to behavior), and subcortical structures." Ettner Aff. ¶ 12 (citing to scientific studies). "It is now believed that Gender Dysphoria evolves as a result of the interaction of the developing brain and sex hormones." *Id.* ¶14.

The United States Justice Department ("DOJ") is in accord with this view and has taken the position that individuals with Gender Dysphoria are not precluded from bringing claims under the ADA. *See* Second Stat. of Int. of the U.S., *Blatt v. Cabela's Retail, Inc.*, 2015 WL 9872493 (November 16, 2015 E.D. Pa.); Stat. of Int. of U.S. at 2-3, *Doe v. Dzurenda*, No. 3:16-CV-1934 (D. Conn. Oct. 27, 2017), ECF No. 57; Stat. of Int. of U.S. at 2-3, *Doe v. Arrisi*, No. 3:16-cv-08640 (D.N.J. July 17, 2017), ECF No. 49. As the DOJ explains:

> While no clear scientific consensus appears to exist regarding the *specific* origins of gender dysphoria (*i.e.*, whether it can be traced to neurological, genetic, or hormonal sources), the current research increasingly indicates that gender dysphoria has physiological or biological roots. . . . In light of the evolving scientific evidence suggesting that gender dysphoria may have a physical basis, along with the remedial nature of the ADA and the relevant statutory and regulatory provisions directing that the terms "disability" and "physical impairment" be read broadly, the GID Exclusion should be construed narrowly such that gender dysphoria falls outside its scope.

Second Stat. of Int. of the U.S., *Blatt*, 2015 WL 9872493 (November 16, 2015 E.D. Pa.) (emphasis added).

Because plaintiff can show that Gender Dysphoria results from a physical impairment, Defendants cannot rely on the GIDs exclusion to refute her claim.

c. ***The GIDs Exclusion is a Transgender and Sex-Related Classification that Violates the Equal Protection Clause under the Fourteenth Amendment to the Constitution.***

Under well-settled law, courts must, where possible, construe statutes to avoid rendering them unconstitutional. *United States v. Dwinells*, 508 F.3d 63, 70 (1st Cir. 2007) ("between two

plausible constructions of a statue, an inquiring court should avoid a constitutionally suspect one in favor of a constitutionally uncontroversial alternative"). The GIDs exclusion cannot be interpreted to create a sweepingly broad and discriminatory exclusion from the ADA's protection for transgender people. Such class-based discrimination against a discrete and insular minority is inherently suspect and triggers strict scrutiny. At a minimum, because it is discrimination based on a person's sex or gender identity, it is subject to intermediate review. And where, as here, the basis for the exclusion is animus, the exclusion fails under any level of review.

Policies that target transgender individuals constitute a suspect classfication under the United States Supreme Court's four-factor test and are therefore, subject to strict scrutiny. First, "hostility and discrimination that transgender individuals face in our society today is well-documented." *Brocksmith v. United States*, 99 A.3d 690, 698 n.8 (D.C. 2014); *see also Adkins v. City of New York*, 143 F. Supp. 3d 134, 139 (S.D.N.Y. 2015); *Doe 1 v. Trump*, 2017 WL 4873042, at *27 (D.D.C. Oct. 30, 2017) ("As a class, transgender individuals have suffered, and continue to suffer, severe persecution and discrimination."); *Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017) ("There is no denying that transgender individuals face discrimination, harassment, and violence because of their gender identity."); Prison Rape Elimination Act, 28 C.F.R. § 115.5-501 (acknowledging "the particular vulnerabilities of inmates who are LGBTI or whose appearance or manner does not conform to traditional gender expectations"). Second, the incongruence transgender people experience between their assigned sex and gender identity "bears no relation to ability to contribute to society." *Adkins*, 143 F. Supp. 3d at 139; *Trump*, 2017 WL 4873042, at *27 ("the Court is aware of no argument or evidence suggesting that being transgender in any way limits one's ability to contribute to society"). Third, being transgender is an immutable distinguishing

characteristic that is core to a person's identity. *Adkins*, 143 F. Supp. 3d at 139. And fourth, transgender people are a minority at 0.6% of the adult population and lack political power. *Id.* at 139; *Trump*, 2017 WL 4873042, at *27 ("transgender people as a group represent a very small subset of society lacking the sort of political power other groups might harness to protect themselves from discrimination").

Apart from the four factor test, a construction of the statute that excludes all transgender people warrants heightened scrutiny because a transgender classification is sex-based. *See Trump*, 2017 WL 4873042, at *28 ("well-established that gender-based discrimination includes discrimination based on non-conformity with gender stereotypes.") (citation omitted); *Schwenk v Hartford*, 204 F.3d 1187, 1200-02 (9th Cir. 2000) (holding that discrimination based on a person's transgender status is sex-based discrimination); *Whitaker*, 858 F.3d at 1051 (applying heightened scrutiny in case brought by transgender student challenging school bathroom policy); *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011) (holding that discrimination against a transgender individual because of her gender-nonconformity is sex discrimination); *Smith v. City of Salem, Ohio*, 378 F.3d 566, 577 (6th Cir. 2004) (same); *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016) (same); *Schroer v. Billington*, 577 F. Supp. 2d 293, 308 (D.D.C. 2008) (discrimination against transgender woman was "literally discrimination 'because of . . . sex'"). A wall of established precedent recognizes that transgender-based classifications are subject to heightened review.[13]

[13] *See, e.g.*, *Stockman v. Trump*, No. EDCV 17-1799 JGB (KKx) (C.D. Cal. Dec. 22, 2017); *Karnoski v. Trump*, 2017 WL 6311305, at *7 (W.D. Wash. Dec. 11, 2017); *Stone v. Trump*, 2017 WL 5589122, at *15 (D. Md. Nov. 21, 2017); *Adkins*, 143 F. Supp. 3d at 139-40 (S.D.N.Y. 2015); *Bd. Of Educ. Of the Highland Local Sch. Dist. v. United States Dep't of Educ.*, 208 F. Supp. 3d 850, 872-77 (S.D. Ohio 2016); *Trump*, 2017 WL 4873042, at *27-28 (holding the transgender community satisfies the criteria for heightened review); *Evancho v. Pine–Richland Sch. Dist.*, 237 F.Supp.3d 267, 288 (W.D. Pa. 2017) (holding that "all of the indicia for the

Circuit courts agree that transgender discrimination is sex-based whether because it reflects sex-stereotypes, or because the root of the discrimination is based on a person's change of sex or assigned sex at birth. *See, e.g.*, *Rosa v. Park W Bank Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000). The First Circuit was among the first to recognize that disparate treatment against a person for being transgender or having a gender identity that does not match a person's assigned birth sex is sex-based. *See Rosa*, 214 F.3d at 215-16. Numerous circuits have since agreed, often citing the First Circuit's case in support. *See, e.g.*, *Whitaker*, 858 F.3d at 1049 (7th Cir.); *Glenn*, 663 F.3d at 1317 (11th Cir.); *Smith*, 378 F.3d at 574 (6th Cir.).

Accordingly, at a mininimum, to defend a broad construction of the ADA exclusion, Defendants would have to show that there is an important or exceedingly persuasive justification for the exclusion of transgender people from the ADA's scope and that the exclusion is substantially related to that interest. Because there is not even a legitimate interest in excluding transgender people from the law's protection, much less an important or compelling one, an interpretation of the GIDs exclusion that sweeps in all claims by transgender indvividuals based on a related health condition, fails review.

The GIDs exclusion also fails under any level of review because it reflects animus toward a disfavored group. The legislative history associated with the GIDs exclusion is replete with evidence of animus, including statements that erroneously equate medical conditions associated with being transgender with moral failure. *See, e.g.*, 135 Cong. Rec. S10734-02, 1989 WL 183115 (daily ed. Sep. 7, 1989) (statement of Sen. Armstrong) ("I could not imagine the [ADA] sponsors would want to provide a protected legal status to somebody who has such [mental] disorders, particularly those [that] might have a moral content"); *id.* at S10765-01, 1989 WL

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application of the heightened intermediate scrutiny standard are present" for transgender individuals).

183216 (statement of Sen. Helms) ("What I get out of all of this is here comes the U.S. Government telling the employer that he cannot set up any moral standards for his business"); *see also id.* (statement of Sen. Rudman) ("In short, we are talking about behavior that is immoral, improper, or illegal and which individuals are engaging in of their own volition, admittedly for reasons we do not fully understand.").[14]

Such moral animus against transgender people is plainly insufficient to constitute a compelling, important, or even legitimate governmental interest. *See Romer v. Evans*, 517 U.S. 620, 634-35 (1996) (concluding that "a bare . . . desire to harm a politically unpopular group cannot constitute a *legitimate* governmental interest" – much less a compelling or important one) (quoting *U.S. Dep't of Agric. v. Moreno*, 413 U.S. 528, 534 (1973)) (emphasis in original). For that reason alone, Defendants' proposed construction cannot survive review.

B. Ms. Doe is Likely To Succeed on the Merits of Her Equal Protection Claim Under the Fourteenth Amendment and U.S.C. § 1983 in Counts III and VIII of the Complaint.

Ms. Doe is a transgender woman who is housed in a men's facility. Doe Aff. ¶¶ 2-3, 7-9; Ettner Aff. ¶ 22. She was told that she could not be transferred to the women's facility because she has not had genital surgery. Doe Aff. ¶ 27. As a result, unlike other women prisoners in DOC facilities, she is strip-searched by male correctional officers, and made to shower and use toilet facilities in the presence of and under the gaze of men. *Id.* ¶¶ 12-21. Inmates without Gender Dysphoria throughout DOC facilities and who are not transgender are not subjected to the kinds of sexual harassment, violation, and indignities that result from being a transgender inmate housed exclusively based on the individual's birth sex or genitals without regard to the

[14] *See also* Kevin M. Barry et al., *A Bare Desire to Harm: Transgender People and the Equal Protection Clause*, 57 B.C. L. Rev. 507, 574 (2016) ("Senators Armstrong, Helms, and Rudman repeatedly invoked immorality as the justification for the transgender exclusions, decrying the ADA's coverage of "sexually deviant behavior.").

person's gender identity or the fact of having undergone gender transition. As set forth above, *see* ARGUMENT Section II.A.3.c, because DOC's policy regarding prison placement discriminates against transgender inmates, it is subject to heightened scrutiny.

DOC's placement policy cannot satisfy any level of review, much less the heightened review that is required here. DOC has done no individualized assessment to determine where Ms. Doe should be placed and there is no justification that survives constitutional scrutiny for categorically placing transgender women in men's prisons, without regard to their individual circumstances. Transgender women such as Ms. Doe pose no unique safety threats to other women. Aiken Aff. ¶¶ 12, 19. And because DOC has not done an individualized review of Ms. Doe's placement, it can hardly be heard to justify its placement decision based on safety. Nor could it. *Id.* ¶¶ 11-12.

DOC's blanket policy of placing transgender inmates based on their assigned birth sex or genitals does not serve a compelling, important, or even legitimate purpose. Accordingly, Ms. Doe has a likelihood of succeeding on her equal protection claim.

C. Ms. Doe is Likely to Succeed on the Merits of Her Due Process Claims Under the Fourteenth Amendment and 42 U.S.C. § 1983 in Counts IV and VIII of the Complaint.

Finally, Ms. Doe is likely to succeed on her procedural and substantive due process claim. First, Ms. Doe's liberty interest in not being confined in a men's prison, with the constant affront to her very existence and the unique unending risk of harm that such confinement entails, gives rise to a procedural due process claim. State regulations create a liberty interest if they impose a form of restraint that represents an "atypical and significant hardship on the inmate in relation to the ordinary incidents of prison life." *Sandin v. Conner*, 515 U.S. 472, 484 (1995). Such is undeniably the case here. The ongoing harms and heightened potential for victimization that come with being a woman housed in a men's prison give rise to a liberty interest,

particularly where such placement is indefinite, and where Ms. Doe's placement in the men's prison is not necessary for safety. *See Wilkinson v. Austin*, 545 U.S. 209, 224 (2005) (indefinite placement in supermax facility, even if facility's conditions are necessary, gives rise to liberty interest in avoiding such placement).

Even if state regulations did not already create a liberty interest, Ms. Doe would still have one because the restraint in question – requiring her to be housed in a men's prison where it is foreseeable that she would be openly discriminated against, harassed and threatened – clearly creates an "atypical and significant hardship" on Ms. Doe that so exceeds "the normal incidents of prison life" that it gives rise to due process protection by its own force. *Sandin*, 515 U.S. at 484. Her confinement in a male facility, and the consequences that flow from it, implicate due process because of the atypical hardship it imposes on her and the departure it represents from the experiences of other prisoners. *See id.* (citing cases finding due process protection in transfer to mental hospital or involuntary administration of psychotropic medication to prisoner).[15]

Where there is a liberty interest, the question in a procedural due process claim is whether the process afforded to the plaintiff is sufficient. In Ms. Doe's case, where there was no individualized consideration of her placement, there is not. Ms. Doe is faced with an administration that has categorically rejected her requests to be considered for placement at MCI-Framingham, the DOC's facility for female prisoners, Doe Aff. ¶ 27, and has otherwise allowed Ms. Doe to be subjected to discrimination and harmful treatment as described above, *see, e.g.*, Doe Aff. ¶ 23-26. DOC policy requires case-by-case assessments of housing

[15] The DOC's own policy acknowledges how unusual Ms. Doe's circumstances are. *See* Massachusetts Department of Correction: Identification, Treatment and Correctional Management of Inmates Diagnosed with Gender Dysphoria, 103 DOC 652, Att. B ("Risk of Victimization" factors on internal housing form include "Is or perceived to be transgender, intersex, Gender Dysphoria . . .").

assignments with consideration of, *inter alia*, individual safety, criminal and disciplinary history, treatment needs, and vulnerability to sexual victimization, as well as the prisoner's own views concerning her safety. 103 DOC 652.09(A).[16] By showing that her housing requests received no individualized consideration, *see* Doe Aff. ¶ 27, in violation of DOC's own rules, Ms. Doe has a likelihood of success on her procedural due process claim.

Second, the persistent sexual harassment and constant affront to her long-standing identity as a woman that Ms. Doe experiences, as a direct result of her placement in a men's prison, supports a likelihood of success on her substantive due process claim. To place a woman in a men's prison, subjecting her to a known increased risk of sexual harm and to intentionally place her in an environment that inherently denies her the identity-affirming treatment required by her Gender Dysphoria is the type of government action that is clearly improper "regardless of the fairness of the procedures" afforded to her. *Gonzalez-Fuentes v. Molina*, 607 F.3d 864, 880 (1st Cir. 2010) (quoting *Daniels v. Williams*, 424 U.S. 327, 331 (1986)). Government action violates substantive due process if it is "so egregious, so outrageous, that it may fairly be said to shock the conscience." *Id.* (quoting *County of Sacramento v. Lewis*, 523 U.S. 833, 847 n.8 (1998)). The established facts in this case including Ms. Doe being regularly sexually violated, harassed, and objectified (Doe Aff. ¶¶ 2-20; 23-24; 28-31) readily meets the standard.

III. PRELIMINARY RELIEF IS NECESSARY TO PREVENT IMMEDIATE AND IRREPARABLE HARM TO MS. DOE.

The irreparable harm that Ms. Doe experiences, and will continue to experience in her current circumstances and without transfer to a female correctional facility, is harrowing. She has been diagnosed with Post Traumatic Stress Disorder and Generalized Anxiety Disorder as a

[16] This policy closely tracks, and presumably is intended to adhere to, federal regulations implementing the Prison Rape Elimination Act. *See* 28 C.F.R. § 115.42; 103 DOC 519.02 ("The Department shall embrace the [PREA] standards").

result of her placement in a men's prison and the violations and indignities she has endured there, and "if she remains in a male prison under current conditions, she is at risk for further emotional and physical decline . . . [including] a condition known as psychological decompensation" which "render[s] an individual incapable of functioning . . . which can be irremediable." Ettner Aff. ¶¶ 33, 37. Housing her in a men's prison also "creates an unnecessary perilous endangerment for her . . . [and subjects her to] high-risk for violence, including sexual violence . . . [including] a very high risk of an event escalating into a life and death situation," Aiken Aff. ¶¶ 10, 16.

Ms. Doe will also suffer an additional form of irreparable harm absent an injunction: the continued deprivation of her constitutional rights. *See Vaqueria Tres Monjitas, Inc. v. Irizarry*, 587 F.3d 464, 484 (1st Cir. 2009) (finding irreparable harm for "long-standing violations of constitutional rights for extensive protracted periods of time"); *Gordon v. Holder*, 721 F.3d 638, 653 (D.C. Cir. 2013) ("[A] prospective violation of a constitutional right constitutes irreparable injury."); *Mills v. D.C.*, 571 F.3d 1304, 1312 (D.C. Cir. 2009) ("It has long been established that the loss of constitutional freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury.") (internal quotations omitted); *DynaLantic Corp. v. U.S. Dep't of Def.*, 885 F. Supp. 2d 237, 292 (D.D.C. 2012) (equal protection violation constitutes irreparable harm); *Simms v. D.C.*, 872 F. Supp. 2d 90, 105 (D.D.C. 2012) (procedural due process violation constitutes irreparable harm); *Goings v. Court Servs. & Offender Supervision Agency for D.C.*, 786 F. Supp. 2d 48, 78 (D.D.C. 2011) (substantive due process violation constitutes irreparable harm). Defendants' violations of Ms. Does equal protection and due process rights constitute irreparable harm.

IV. THE BALANCE OF THE EQUITIES AND THE PUBLIC INTEREST FAVOR A PRELIMINARY INJUNCTION.

The balance-of-equities factor directs the Court to "'balance the competing claims of injury and . . . consider the effect on each party of the granting or withholding of the requested relief.'" *ConverDyn v. Moniz*, 68 F. Supp. 3d 34, 52 (D.D.C. 2014) (quoting *Winter*, 555 U.S. at 24). *See also Gammett v. Idaho State Bd. of Corr.*, 2007 WL 2186896, *15-16 (D. Idaho July 27, 2007) (find balance of harms "sharply" favored plaintiff, who would experience mental harm without Gender Dysphoria treatment). The harm to Ms. Doe without preliminary relief from this Court is flagrant. In contrast, there is no injury to the defendants who are prohibited by federal regulation from determining housing assignments for transgender prisoners based solely on genital status, anatomy, or assigned birth sex, and instead must consider the health and safety of a transgender prisoner. 28 C.F.R. § 115.42 (c). All of the evidence here points to the ease of housing Ms. Doe in the women's prison.

The public interest in this case also weighs strongly in favor of Ms. Doe. Federal regulations prohibit the defendants' categorical exclusion of Ms. Doe from a women's correctional facility. It is also in the public interest to promote the implementation of medical treatment protocols for people with disabilities like Ms. Doe, and to end practices that unnecessarily exacerbate mental health conditions. Finally, "it is always in the public interest to prevent the violation of a party's constitutional rights." *See Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1145 (10th Cir. 2013) (en banc), *aff'd*, 134 S.Ct. 2751 (2014); *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (same); *American Freedom Def. Initiative v. Metro. Area Transit Auth.*, 898 F. Supp. 2d 73, 84 (D.D.C. 2012) (same).

CONCLUSION

For the foregoing reasons, this court should grant Ms. Doe's motion for a preliminary injunction and order Defendants to: (1) transfer Jane Doe to MCI-Framingham; (2) enjoin Defendants from using male correctional officers to conduct strips searches of Jane Doe, except

in exigent circumstances; (3) enjoin Defendants from forcing Jane Doe to shower in the presence of men and with a shower curtain that does not adequately cover her; (4) enjoin Defendants from treating Jane Doe differently than other women held by the DOC; (5) train all staff on how to appropriately accommodate, treat and communicate with individuals with Gender Dysphoria within 60 days of this Order; (6) enjoin Defendants from using male pronouns when speaking to or about Jane Doe; (7) enjoin Defendants from referring to Jane Doe by her former male name (or any abbreviated version thereof); (8) refer to Jane Doe by her chosen female name; and (9) award such other and further relief as is just and proper.

/s/ J. Anthony Downs_____
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Dated: February 2, 2018

CERTIFICATE OF SERVICE

I, J. Anthony Downs, hereby certify that this document filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF), and paper copies will be sent to those indicated as non-registered participants on February 2, 2018.

/s/ J. Anthony Downs

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

JANE DOE, Plaintiff v. MASSACHUSETTS DEPARTMENT OF CORRECTION; THOMAS A. TURCO III; SEAN MEDEIROS; JAMES M. O'GARA JR.; and STEPHANIE COLLINS, Defendants.	Civil Action No. 17-12255-RGS

AFFIDAVIT OF JAMES AIKEN

1. I have over 45 years of experience in the administration, operation, and management of correctional facilities, including as the Director of the Bureau of Corrections for the United States Virgin Islands (1992-1994), the Commissioner of the Indiana Department of Correction (1989-1992), and in various positions in the South Carolina Department of Corrections (1971-1989).

2. In the United States Virgin Islands I was given the specific mission to remedy overcrowding, gang problems, random and systemic violence, and general mismanagement. As the Commissioner of the Indiana Department of Correction, I was responsible for the overall administration of the Indiana corrections system that consisted of 46 separate adult and juvenile facilities with a population of 14,000 inmates. As a Deputy Regional Administrator of the South Carolina Department of Corrections (1987-1989), I supervised sixteen South Carolina institutions at all security levels. I was also Warden of the Central Correctional Institution (state

penitentiary, 1982-1987), the largest correctional facility in South Carolina with 1,800 medium and maximum-security custody male inmates and the South Carolina death row. Prior to that I was the Warden of the South Carolina Women's Correctional Institution (1979-1982) responsible for all aspects of female inmate welfare and rehabilitation. In addition, I have consulted with the United States Department of Justice, National Institute of Corrections, and federal, state, and local prisons on a variety of subjects, including, but not limited to: inmate classification, management of women offenders, management of youthful offenders in adult prisons, prison security systems, security operational performance, prison critical event avoidance, and riot/gang management. A full statement of my background and expert qualifications is attached as Exhibit A.

3. In 2004 the United States Congress appointed me to be one of nine Commissioners of the National Prison Rape Elimination Commission (the "Commission") established pursuant to 34 U.S.C. Sec. 30306 (detailing establishment and objectives of Commission). The Commission held hearings throughout the country and was responsible for the development of standards that would lead to the prevention, detection, and elimination of prison rape. *See* 34 U.S.C. Sec. 30306(d)(3)(B)(ii). The Commission issued the National Prison Rape Elimination Commission Report (the "Report") in June 2009 that became the basis for regulations issued by the Department of Justice in 28 C.F. R. Part 115.

4. The Commission's investigation and its Report accounted for the long-underrecognized reality that transgender inmates (as well as lesbian, gay and bisexual inmates) are particularly vulnerable to the prison's specific perils of intimidation, harassment, random and systemic violence to include sexual assault. The Commission, over a five year period, carefully considered the appropriate standard for the safe housing and placement of transgender inmates.

Based upon my over 45-years of experience and academic training in the correctional profession, prison systems have historically determined whether to place a transgender inmate in a male or female facility based solely and categorically on genital status. A housing policy and practice based on genital status creates significant threats to inmate health and safety. For example, when a person who lives and presents as a woman and has female secondary sex characteristics is placed by prison officials in a male correctional facility, they are perceived and treated by male inmates as a woman. For this reason, The Prison Rape Elimination Commission rejected the use of "genital status" as the sole basis to determine housing placements for transgender inmates. *See* Report at 77 ("The facility makes individualized determinations about how to ensure the safety of each inmate. Lesbian, gay, bisexual, transgender, or other gender-nonconforming inmates are not placed in particular facilities, units, or wings solely on the basis of their sexual orientation, genital status, or gender identity.").

5. The rejection of a housing standard and practice based solely on a transgender inmate's genital status is reflected in the Department of Justice regulations that provide "[i]n deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems." 28 C.F.R. Sec. 115.42 (c). In addition, the Department of Justice regulations require that "[a] transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration." 28 C.F.R. Sec. 115.42 (e).

6. I have reviewed the Complaint in this case, and the Affidavit of Jane Doe, that detail the conditions of Ms. Doe's confinement at the Massachusetts Correctional Institute at Norfolk

(MCI-Norfolk). I have also received detailed reports of Ms. Doe's experiences at MCI-Norfolk from her counsel.

7. More specifically, according Ms. Doe's Affidavit, she is routinely strip searched by male correctional officers. Department of Justice regulations require that inmates be strip-searched by corrections officers of the same gender, except in exigent circumstances. 28 C.F.R. Sec. 115.15. It is operationally unacceptable for a male corrections officer to strip-search an inmate who is female and who has female breasts. The avoidance of this practice is necessary to reduce the allegations of misconduct by staff and to ensure that inmates are not exposed to opposite gender searches which can present as an extremely traumatic unnecessary event for some inmates.

8. There is no operational reason that a correctional system cannot arrange to have a female correctional staff member strip search Ms. Doe, including in her current placement in a male correctional facility. Conducting strip searches is part of a corrections officer's job duties. While the Commission was in agreement that strip searches be conducted by a corrections officer of the same gender, the Commission also allowed for opposite sex strip searches in exigent circumstances. A Corrections officer must be prepared and willing to conduct a strip search on any prison inmate in a professional and respectful manner as part of their job duties.

9. According to Ms. Doe's Affidavit, she is repeatedly forced to shower in areas that men can access or see her. The Department of Justice regulations require that "[t]ransgender inmates shall be given the opportunity to shower separately from other inmates." 28 C.F.R. Sec. 115.42 (f). There is no reasonable justification for failing to follow this straightforward requirement as separate showers poses no threat to security or the normal operations of the facility.

10. However, even if the correctional facility were to accommodate Ms. Doe with private showers and appropriate strip searches, it is my opinion that continuing to house Ms. Doe in a male correctional facility creates an unnecessary perilous endangerment for her. Her placement in a male facility is the direct cause of Ms. Doe being the subject of systemic taunting, intimidation, harassment and violence, and needlessly subjects her to a very high risk of an event escalating into a life and death situation.

11. The correctional profession commonly uses a classification system as the foundation of a prison security delivery system. My operational definition of a prison classification system is a system that appropriately separates the inmate population based on demographic, social, health and behavioral factors. Such a management system is intended to ensure the reasonable security and safety of the public, staff and inmate population.

12. Classification system assessments and reassessments of risk for inmates must be made based on particularized evidence about an inmate, and not from stereotypes or the personal perceptions and biases of a prison official. An individualized classification assessment for risk of assault or violence would include objective factors exampled by the inmate's age; institutional behavior pattern; vulnerability to or propensity for sexual abuse or violence; crime; mental health status; education level; and gang involvement. If an inmate is involved in random or systemic violence, or is a threat to other inmates, that is reflected in the objective classification assessment for that inmate, which then helps determine the security and programming needs of the inmate.

13. In addition to the classification system, the abatement of random or systemic violence of any sort by any inmate depends on the effective implementation of direct staff supervision [1]. Direct staff supervision is more than mere observation. It also requires correctional

[1] Direct staff supervision "...means that the security staff are in the same room with, and within reasonable hearing distance of, the resident or inmate." As defined at - *Prison Rape Elimination Act; Prisons And Jail Standards;*

staff that are well-qualified, trained and supervised with appropriate coverage in all physical areas in order to oversee an inmate population to reasonably detect and prevent violent and illicit acts.

14. I understand that Ms. Doe has lived and presented as a woman since her teens, and has female secondary sex characteristics, including breasts. Therefore, prison officials must develop and implement a classification plan that addresses the reality, which is that male inmates at MCI-Norfolk regard Ms. Doe as a woman and react to her as a female. This misclassification of Ms. Doe into a male prison setting unnecessarily creates a life-threatening situation for her and compromises the safe and orderly operation of the prison. According to Ms. Doe's Affidavit and discussions with counsel, these perils are manifested by the reports that men rush into areas where they can view her showering, and use sexualized taunts, such as "You have some big, nice boobies," and "I would like to see you spread like that in my room." If prison officials do not remove her from this environment and place her in a proper setting, more intense perils are likely to occur such as Ms. Doe being the victim of violence, being forced into prison prostitution by predator inmates in exchange for her protection, and becoming the catalyst for rival predator inmates attacking each other to reap the benefits from Ms. Doe's prostitution activity.

15. Furthermore, it is well-documented and accepted in the field of corrections that transgender persons are at a greater risk for violence and sexual assault. For example, in a 2007 study commissioned by the California Department of Corrections and Rehabilitation, 4% of randomly sampled inmates in California state prisons reported being sexually assaulted, while 59% of transgender inmates reporting being sexually assaulted. Valerie Jenness, et al., *Violence*

United States Department of Justice Final Rule; National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act (PREA); 28 C.F.R. Part 115; Docket No. OAG-131; RIN 1105-AB34; May 17, 2012.

in California Correctional Facilities: An Empirical Examination of Sexual Assault 27 (Apr. 27, 2007), https://www.prearesourcecenter.org/sites/default/files/library/54-cafinalpreareport.pdf. Similarly, a 2014 report from the United States Department of Justice Bureau of Justice Statistics found that between 2007-2012, 34% of transgender inmates in federal, state prisons and local jails experienced sexual victimization. Allen J. Beck, U.S. Department of Justice, Bureau of Justice Statistics, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12: Supplemental Tables: Prevalence of Sexual Victimization Among Transgender Adult Inmates* 2 (Dec. 2014), https://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf.

16. The fact that Ms. Doe has not yet been physically or sexually assaulted should be of little comfort. The sexualized taunts Ms. Doe has already experienced, as referenced above, gives sufficient notice that she is at high- risk for violence, including sexual violence. Basic preventative actions must be taken to address this obvious peril to her wellbeing. It is simply not sound correctional practice to allow a known potential endangerment to remain and not take appropriate and validated steps to mitigate the issue.

17. Placing Ms. Doe in a male facility undermines the security and good order of the correctional facility's overall operation. Inmates fundamentally want to be protected and constantly assess their own personal safety vis à vis how the prison and prison system will protect them. Regular and ongoing taunting and intimidation of a prisoner, such as what Ms. Doe is experiencing, creates the perception, if not validation, that prison officials are unwilling to take basic actions to prevent predictable violence and endangerment within the prison. This dynamic gives other inmates an indication that they must take matters into their own hands to ensure that they are safe, such as joining a gang or collecting shanks or other contraband items for protection. This is as true in a medium security prison as in a maximum security prison. If

prison officials do not demonstrate a reasonable level of productivity regarding their duty to protect inmates in their custody, some inmates will inevitably engage in self-protection.

18. It is my opinion that Ms. Doe's safety requires that she be transferred to a women's correctional facility to abate this clear, present and known endangerment issue. Furthermore, I have seen nothing to suggest that Ms. Doe has any of the significant risk factors assessed under the objective classification criteria that would otherwise raise any concerns about such a transfer.

19. There is simply no basis to conclude that Ms. Doe's placement in a female correctional facility creates any security or management concern solely because she is a woman who is transgender as there is nothing inherently dangerous about being a transgender person.

SIGNED UNDER THE PENALTIES OF PERJURY THIS 1st DAY OF FEBUARY, 2018.

JAMES EVANS AIKEN

EXHIBIT A

EXHIBIT A - EXPERT BACKGROUND AND QUALIFICATIONS

James Evans Aiken

The undersigned maintains a consulting concern in prison management and adjustment matters as James E. Aiken & Associates, Inc. I also served as Director of Corrections for the United States Virgin Islands, and Commissioner for the Indiana Department of Correction. I began my corrections career in 1971 at the South Carolina Department of Corrections as a counselor with the Comprehensive Drug Abuse Treatment Program. Also, while with the South Carolina Department of Corrections, I held positions as Deputy Regional Administrator in the Midlands Correctional Region (managing 16 prisons), Deputy Warden and Administrative Assistant to the Warden of the Manning Correctional Institution, Deputy Warden and Warden at the Central Correctional Institution (state penitentiary), and Warden of the Women's Correctional Center. While serving in these positions, I received extensive experience in the areas of prison classification and management of inmate population. During my years in prison work, I have conducted thousands of inmate classification evaluations relative to their adjustment to prison and current/future danger to the public, prison staff, and other inmates. These reviews included minimum custody (low security offenders) to maximum security (violent, high profile, disruptive, predatory, aggressive inmates). Additionally, I participated in the development of prison classification systems designed to better protect inmate population from other more violent inmates and the public.

The United States Congress appointed me, in July 2004 to the National Prison Rape Elimination Commission. Over a five (5) year period, the Commission conducted comprehensive hearings and examined all penalogical, economic, physical, mental, medical and social issues relating to prison rape in America. At the conclusion of its review, the Commission issued a comprehensive report on the subject, including a recommended set of national standards to reduce and eliminate prison rape. Also, a grant program made annual grants (up to $40 million each year) to state and local programs that enhanced the prevention and punishment of prison rape and maintain safe and secure prisons despite budget reductions. The Commission had authority to issue subpoenas, and the statue allows for the Attorney General to seek enforcement of subpoenas in district court. The Federal Bureau of Prisons must have total compliance to the final standards.

I received a Master Degree in Criminal Justice from the University of South Carolina and Bachelors of Arts Degree from Benedict College, Columbia, South Carolina. I have also taught a number of courses in corrections at the university and technical college levels.

I have consulted with the U.S. Department of Justice, National Institute of Corrections, as well as served as a private contract provider to federal, state and county jurisdictions (jails and prisons) in a number of areas to include but not limited to inmate classification, managing violent youthful offenders in adult prisons, managing prison security systems, correctional leadership development, assessment of security operational performance, executive training for new and experienced wardens, prison critical event avoidance, management of super-maximum security prisons, management of the hard to manage-violent inmate, STG/gang management, and riot management.

I have also consulted with attorneys and rendered expert testimony in capital, criminal and civil cases. I have been qualified as an expert and provided such testimony in the states of Washington, Ohio, Georgia, Arizona, Delaware, North Carolina, Montana, Pennsylvania, New York, South Carolina, Indiana, Virginia, Maryland, Louisiana, Oregon, New Hampshire, Missouri, Alabama, Mississippi, Florida, Texas and the United States District Courts of New York, Connecticut, Virginia, Ohio, South Carolina, Michigan, Arizona, West Virginia, Florida, Texas, Georgia, Alabama, Missouri, Tennessee, District of Columbia and Pennsylvania as well as the Court of Queen's Bench, Canada relative to: future danger posed to inmates, staff and the community by trial defendants, the ability of inmates to adjust to prison, classification of inmates to determine proper confinement levels, prison conditions, and other matters generally relating to prisons, jails, and criminal justice matters.

More specific overview of background qualifications is submitted: From August 1992 to August 1994, I was Director of the Bureau of Corrections for the United States Virgin Islands. My responsibilities encompassed the overall administration of the bureau which included jail and prison facilities. I also worked closely with other territorial agencies, the legislature, courts, and federal governmental entities. In the Virgin Islands, I had a specific mission to re-establish a correctional system (prison and jail) which was diminished by overcrowded conditions, gang problems, random and systematic violence, escapes, non-compliance with court orders (to include medical care and delivery issues), general mismanagement, and public mistrust.

From March 1989 until August 1992, I was Commissioner for the Indiana Department of Corrections. I was responsible for the overall administration of the Indiana corrections system that consisted of 46 separate adult and juvenile facilities with a population of 14,000 inmates and parole services with a population of 3,490 parolees. I reported directly to the Governor of Indiana and worked closely with the state legislature. Also, during my Indiana administration, I created a Division of Security to address gang problems, contraband control, drug testing, and other concerns. My administration also initiated an Offender Relations Division to resolve offender grievances and complaints, and to reduce court involvement.

From September 1971 until March 1989, I was with the South Carolina Department of Corrections in a variety of capacities including Deputy Regional Administrator, and different times as Warden of the Central Correctional Institution, Warden of the Women's Correctional Institution and as an inmate social worker.

As Deputy Regional Administrator from April 1987 to March 1989, I supervised sixteen South Carolina institutions at all security levels including maximum. I supervised a workforce of 2,500 with an annual budget of $97 million. This position required that I select institution heads and I was intimately involved with new facility design.

As Warden of the Central Correctional Institution (state penitentiary) from May 1982 until April 1987, I operated the largest correctional facility in South Carolina with 1,800 medium and maximum custody inmates, 530 staff members, and an annual budget of $8 million. I was personally responsible for all activities involving security and treatment staff, as well as coordinating and supervising all welfare and morale services for inmates. CCI is now closed. At the time it was where the South Carolina death row was located and where executions were carried out. I was called upon to carry out two executions. From September 1976 until September 1979, I was Deputy Warden of this institution.

As Warden of the Women's Correctional Institution from September 1979 until May 1982, I was chief administrator of a state women's prison. I was responsible for all employee hiring, evaluation, and supervision as well as, all aspects of inmate welfare. During my tenure, I studied and reviewed all available records and files on assigned inmates to evaluate their behavior changes and rehabilitation progress.

From about 1990 to 1992, I was also Adjunct Professor at the Indiana University-Purdue University in Indianapolis, teaching corrections related criminal justice courses.

I am able to render an expert opinion, in an operational context, regarding future danger and adaptability of inmates and issues pertaining to prison/jail safety, operations, administration and security.

Summary of Qualifications:
I have over forty (45) years of experience in correctional administration, facility operations/management, inspection/assessment of facility performance and technical assistance consultations with clients in the United States, Dutch Kingdom, Canada, Costa Rica, Puerto Rico, and U.S. Virgin Islands. He has provided services to federal, state, county and local correctional facilities and jurisdictions in the areas of correctional leadership/organizational development, management of prison disturbances, system productivity, cost containment, enhancing prison security systems, managing the violent youthful offender in adult prisons, gang/security threat group (STG) management, new warden's training, super maximum security facility management training, inmate classification, assessment of prison security/operational performance, prison staffing analyses, reduction of prison critical security events (murder/suicide/riot/hostage situation) and advising governments relative to prison privatization transactions/productivity.

Employment History:
August 1994 to present, president, James E. Aiken and Associates, Inc. (correctional consultant firm); August, 1992 to August 1994, Director, Bureau of Corrections, United States Virgin Islands and consultant; March, 1989 to August, 1992, Commissioner, Indiana Department of Correction; April, 1987 to March 1989, Deputy Regional Administrator, South Carolina Department of Corrections; May, 1982 to April, 1987, Warden, Central Correctional Institution (state penitentiary) South Carolina Department of Corrections; September, 1979 to May, 1982, Warden, Women's Correctional Center, South Carolina Department of Corrections; September, 1976 to September, 1979, Deputy Warden for Administration, Central Correctional Institution(state penitentiary) South Carolina Department of Corrections; February, 1974 to September, 1976, Deputy Warden for Institutional Operations, Manning Correctional Institution, South Carolina Department of Corrections; September, 1972 to February 1974 Administrative Assistant to Warden, Manning Correctional Institution, South Carolina Department of Corrections; September, 1971 to September, 1972, Social Worker for Substance Abuse Treatment, South Carolina Department of Corrections.

Relevant Experience:
I have provided direct professional and consultant services in almost every aspect of the correctional field. More specifically, his scope of expertise includes the following:

Director, Bureau of Corrections, United States Virgin Islands
Held the position as Director that encompassed authority and responsibility for the overall administration of the Corrections Bureau for the United States Virgin Islands (jails and prison). Worked closely with other territorial agencies, the legislature, courts and federal governmental agencies.

My task was to coordinate a project to re-establish a jail/prison correctional system which was diminished by overcrowded conditions, lack of medical care, escapes, and noncompliance to court orders, corruption, general mismanagement, negative media, gang involvement, work force dysfunction, and public mistrust.

Commissioner, Indiana Department of Correction
The position encompassed the overall administration of the Department of Correction for the State of Indiana, which consisted of forty-six (46) separate adult and juvenile facilities (population 14,000) and parole services (population 3, 490) with an operations budget of $305 Million.

As Commissioner, reported directly to the Governor of the State of Indiana and worked closely with the legislature, other state and federal agencies, the courts and the public. My tasks were to establish an operational mission and priority of issues for the agency; establish agency mission goals; manage overpopulation, develop a new basic employee supervision program; and reorganized daily operations to ensure a more responsive and efficient structure.

My accomplishments included but were not limited to:

Offender Health Care Delivery: The department contracted with the Indiana University School of Medicine to provide a medical director for clinical services. Developed and implemented a program to reduce cost and increase the quality of medical care.

Security: Created the Division of Security to address agency security needs. Initiated a gang intelligence network to tract and evaluate their activities. Increased contraband control efforts by additional searches, drug testing, use of K-9 units, provided additional training and equipment, and increased prosecution efforts. Designed 650 bed maximum security unit that conformed to modern correctional security management and Court mandates. Conducted meetings with the National Guard, State Police, as well as other mutual aid agencies to coordinate and develop an emergency response and disaster preparedness program. Conducted full response drills to evaluate the agency's response capability. Evaluated and enhanced escape prevention/ apprehension measures. Conducted security audits and inspections of facilities.

Offender Relations: Established an Offender Relations Division and appointed a coordinator. This division functions as part of Internal Audits and works in tandem with the Division of Internal Affairs, the Operations Division and the Division of Legislative and Information Services. The task of this division is to resolve offender grievances and complaints that originate from inside the agency and resolve them prior to court involvement.

Prison Population:

- Completed site selection, plans and construction of a new maximum security Institution
- Increased community corrections coverage from 35 to 50 counties (from 3,500 to 7,000 clients)
- Established community service/restitution programs
- Established county work release programs
- Established residential treatment programs and created home detention utilizing electronic monitoring

- Created over five hundred (500) new emergency prison beds within the first nine months of tenure

Juvenile Justice:

- Reduced Indiana Boy's School population from a high of 670 in 1989 to a low of 380 in 1990
- Conducted comprehensive reviews using several committees of community representatives concerning treatment programs, educational programs and employee training programs
- Established a Research Department at the Indiana Boy's School.
- Group home placements had tripled during 1992.
- Community involvement and recreational programs have been increased at both Indiana Boy's School and Indiana Girl's School.

Cost Containment: Developed a plan to increase participative management and input to the budget process. Meetings were held with State Budget Agency personnel on a regular basis in an effort to increase the Budget Agency's participation in the department's budget preparation regarding cost control. Reduced the operational budget of 305 million dollars by 41 million dollars for fiscal year 1992.

Deputy Regional Administrator, Midlands Correctional Region, South Carolina Department of Corrections

Served as the Deputy Chief Administrator for the following: Directly planned, prescribed and supervised activities of sixteen (16) institutions, including minimum, medium and work release, shock probation (boot camp), restitution centers and maximum security facilities. Also, had general supervision of a ninety-seven (97) million dollar budget, as well as a work force of 2,500 employees. Duties also included policy development and interaction with lawmakers, management of over population, the community and other departmental agencies concerning long-range agency planning and developing agency future needs. Additionally, made selections of institutional heads, as well as being involved in new facility design, reviewed all use of force actions, and provided supervision to prison wardens during emergency situations and normal operations.

Warden, Central Correctional Institution, South Carolina Department of Corrections

The previous largest correctional facility in South Carolina with 1800 medium/-maximum/super maximum custody inmates, 530 staff members, and an operating budget of eight (8) million dollars. Served as the chief administrator for the following areas/- activities: Directly planned, prescribed and supervised all security control and safety activities/operations, as well as, conducted announced and unannounced inspections of the institution. Interviewed, selected and evaluated employee's performance and effected other personnel actions as required. Personally responsible for all activities involving population management, security and treatment staff, as well as, coordinated and supervised all welfare/morale services for inmates to include medical delivery and access. Supervised and coordinated all activities with representatives from non-departmental agencies. Duties also involved emergency preparedness, interpreting all laws, policies, rules and regulations, compliance with court orders (conditions of confinement) and

operating procedures for employees and inmates. Studied and analyzed long-range department requirements for institutions, as well as participating in litigation action involving the South Carolina Department of Corrections. Duties also included meeting with the Inmate Advisory Council and acting on recommendations received from the Inmate Grievance Committee, as well as meeting with members of the legislature on matters relating to corrections. Also was responsible for carrying out the capital punishment laws for the state of South Carolina. This facility also provided high security management for population that were under the jurisdiction of the South Carolina Department of Mental Health and for population that were in pre-adjudication status that required more intense security to which the jail system could not provide.

Warden, Women's Correctional Institution, South Carolina Department of Corrections
Served as the chief administrator for the following: Directly planned, prescribed and supervised all security, control and safety activities and operations, personally responded to all disturbances and emergencies, interviewed/selected and evaluated employee's performance, counseled employees, supervised and coordinated all activities of the security and treatment staff, management of overpopulation, coordinated ad supervised all welfare and morale services for female inmates including clothing, food service, mail service, visitation, medical services, religious services, educational programs and recreational programs. Supervised the implementation and executing of all laws, policies, rules, regulations and operating procedures applicable to the Women's Correctional Center. Also, studied and reviewed all available records/files on assigned inmates to evaluate their behavioral changes and rehabilitation progress. Duties included meeting with the Inmate Advisory Council as well as receiving and acting upon recommendations received from the Inmate Grievance Committee.

Deputy Warden/Administration, Central Correctional Institution, South Carolina Department of Corrections

Served as the Institutional Coordinator for the following areas/activities:

Maintenance/construction, boiler room/energy, food service, employee parking, canteen services, Adjustment Committee, mail service, all security systems, transportation, pest control, criminal investigations and emergency response.

Deputy Warden/Institutional Operations, Manning Correctional Institution South Carolina Department of Corrections

Served as the Institutional Coordinator for the following areas: Youthful Offender Division, medical services, living areas, maintenance/construction, laundry services, visitation, emergency response, security, transportation, food service, commissary, administrative/punitive segregation, officer's quarters, classification teams, inmate interview/correspondence, recreation programs, energy (usage/conservation), Parole Board (prepared parole evaluations), supervision of security staff of fifty-five (55) employees, Chairman of Employee Evaluation Committee, purchasing, inmate pay and Chairman of Adjustment Committee. Prepared correspondence for the warden, conducted the majority of institutional investigations, coordinated all escape apprehension efforts and remained on twenty-four (24) hour call.

Administrative Assistant/Institutional Operations, Manning Correctional Institution, South Carolina Department of Corrections

Responsibilities included vocational rehabilitation, alcoholics anonymous, Project Mate (Paraprofessional Counseling Program), Classification Team #2, Pastoral Care, Drug Abuse Treatment Program, Recreation Program, Occupational Safety and Health Act (O.S.H.A.), Emergency Response, Work Release Program, Education Program, tours, Employee Evaluation Committee member and inmate interviewing/correspondence.
Performed duties of deputy warden in his absence and remained on twenty- four (24) hour call at all times.

Social Worker/Drug Abuse Treatment Program, Manning Correctional Institution, South Carolina Department of Corrections

Responsibilities included conducting group therapy and individualized counseling to offenders with drug problems. Conferred with the warden and staff to integrate the Drug Abuse Program with other institutional activities. Member of the Adjustment committee and the Warden's Treatment Team.

A major focus of my career has been the assessment and restoration of facilities and systems that have experienced chronic and acute security critical events and management shortfalls. These have included issues of:

- Inmate management and security,
- staff malfeasance,
- corruption,
- prison violence,
- security critical-event prevention, evaluation, and management,
- budget shortfalls,
- public loss of trust in the confinement system,
- inmate loss of trust in the professionalism of confinement facility staff,
- staff loss of trust in the professionalism of administrators,
- emergency response and preparedness,
- inmate disruptive and violent behavior management,
- confinement facility and system culture assessment and improvement,
- confinement facility and system overall performance assessment,
- performance of death penalty executions of condemned inmates,
- inmate classification system (design, implementation and monitoring),
- addressing civil legal complaints,
- adherence with court orders,
- inmate disciplinary system performance assessments,
- confinement facility security technology (development, implementation and monitoring),
- new prison construction,
- renovation of existing confinement facilities to enhance security performance,
- confinement facility operational policy and procedure issues,
- post order development, reassessment, interpretation, and monitoring,
- facility operational performance assessments,

- policy development and interpretation,
- contraband control,
- staff training and development,
- evaluation of training,
- employee productivity evaluations,
- employee discipline,
- confinement facility cost containment strategies,
- use of force and restraint evaluation and implementation,
- criminal and administrative investigations (operational evaluations) of confinement setting critical incidents,
- staff supervision, and
- Gang/SGT management.

I have also assisted the legislative and executive branches of government on the state and federal levels by providing expert advice concerning budgetary issues and statutory reforms regarding confinement facilities and systems.

Additionally, I have provided consulting services to the U. S. Department of Justice, National Institute of Corrections, as well as served as a private contract provider to federal, state and county jurisdictions in a number of areas including, but not limited to:

- inmate classification,
- management of women offenders,
- managing violent youthful offenders in adult prisons,
- managing prison security systems,
- prison culture change,
- correctional leadership development,
- assessment of security operational performance,
- executive training for new and experienced wardens,
- prison critical event avoidance,
- management of super-maximum security prisons,
- management of the hard-to-manage violent inmate,
- riot/gang management,
- use of force evaluation and application, and
- post critical event evaluations.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

JANE DOE, Plaintiff v. MASSACHUSETTS DEPARTMENT OF CORRECTION; THOMAS A. TURCO III; SEAN MEDEIROS; JAMES M. O'GARA JR.; and STEPHANIE COLLINS, Defendants.	Civil Action No. 17-12255-RGS

AFFIDAVIT OF RANDI ETTNER, PH.D.

1. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my doctorate in psychology (with honors) from Northwestern University in 1979. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

2. I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with Gender Dysphoria and mental health issues related to gender variance from 1977 to present. I have published four books related to the treatment of individuals with Gender Dysphoria, including the medical text entitled Principles of Transgender Medicine and Surgery (co-editors Monstrey & Eyler; Rutledge 2007; and the 2d edition (co-editors Monstrey & Coleman; Routledge, June 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population. I have served as a member

of the University of Chicago Gender Board, and am on the editorial boards of The International Journal of Transgenderism and Transgender Health. I am the Secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH), and an author of the WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People (7th version), published in 2011. WPATH is an international association of 2,000 medical and mental health professionals worldwide specializing in the treatment of gender diverse people. I chair the WPATH Committee for Incarcerated Persons, and provide training to medical professionals on healthcare for transgender inmates. I have lectured throughout North America, Europe, and Asia on topics related to Gender Dysphoria and have given grand rounds on Gender Dysphoria at university hospitals. I am the honoree of the externally-funded Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of Gender Dysphoria. A copy of my *Curriculum Vitae* is attached as Exhibit A.

3. The term "gender identity" is a well-established concept in medicine, referring to one's internal sense of oneself as belonging to a particular gender. All human beings develop this elemental internal conviction of belonging to a particular gender, such as male or female. Gender identity is firmly established early in life.

4. At birth, infants are classified as male or female. This classification becomes the person's birth-assigned gender. Typically, persons born with the physical characteristics of males psychologically identify as men, and those with the physical characteristics of females

psychologically identify as women. However, for transgender individuals, this is not the case. The body and the person's gender identity do not match. For transgender individuals, the sense of one's self—one's gender identity—differs from the birth-assigned gender, giving rise to a sense of being "wrongly embodied."

5. For many transgender people, this incongruence between gender identity and assigned gender does not interfere with their lives. For others, however, the incongruence results in Gender Dysphoria, a serious medical condition characterized by a clinically significant and persistent feeling of stress and discomfort with one's assigned gender.

6. In 1980, the American Psychiatric Association introduced the diagnosis Gender Identity Disorder (GID) in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The diagnosis GID was maintained in a revised version of DSM, known as DSM-III-R (1987), as well as in DSM-IV which was issued in 1994.

7. In 2013, with the publication of DSM-5, the Gender Identity Disorder diagnosis was removed and replaced with Gender Dysphoria. This new diagnostic term was based on significant changes in the understanding of the condition of individuals whose birth-assigned sex differs from their gender identity. The change in nomenclature was intended to acknowledge that gender incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's *identity* disordered. Rather, the diagnosis is based on the distress or *dysphoria* that some transgender people experience as a result of the incongruence between assigned sex and gender identity and the social problems that ensue. The DSM explained that the former GID diagnosis connoted "that the patient is 'disordered'." American Psychiatric Association, Gender Dysphoria (2013), http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf. But, as the APA explained, "[i]t is important to note that gender nonconformity is not in itself a

mental disorder. The critical element of Gender Dysphoria is the presence of clinically significant distress associated with the condition." *Id*. By "focus[ing] on dysphoria as the clinical problem, not identity per se," the change from GID to Gender Dysphoria destigmatizes the diagnosis. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 451 (5th ed. 2013)

8. In addition, the categorization of Gender Dysphoria and its placement in the DSM system is different for Gender Dysphoria than it was for GID. In every version of DSM prior to 2013, GIDs were a subclass of some broader classification, such as Disorders Usually First Evident in Infancy, Childhood, or Adolescence, or alongside other subclasses such as Developmental Disorders, Eating Disorders, and Tic Disorders. For the first time ever, DSM-5 categorizes the diagnosis separately from all other conditions. Under DSM-5, Gender Dysphoria is classified on its own.

9. Importantly, neither the GID nor Gender Dysphoria are disorders of sexual behavior. Neither diagnosis has ever been classified in any DSM version as a disorder of sexual behavior, including as a Paraphilic Disorder.

10. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults in DSM-5 are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated sex characteristics).
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

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

11. In addition to renaming and reclassifying Gender Dysphoria, the medical research that supports the Gender Dysphoria diagnosis has evolved. Unlike DSM's treatment of GIDs, the DSM-5 includes a section entitled "Genetics and Physiology," which discuss the genetic and hormonal contributions to Gender Dysphoria. *See* DSM-5 at 457 ("For individuals with gender dysphoria . . . some genetic contribution is suggested by evidence for (weak) familiarity of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygoticsame-sex twins, and some degree of heritability of gender dysphoria").

12. There is now a scientific consensus that gender identity is biologically based and a significant body of scientific and medical research that Gender Dysphoria has a physiological and biological etiology. It has been demonstrated that transgender women, transgender men, non-transgender women, and non-transgender men have different brain composition, with respect to the white matter of the brain, the cortex (central to behavior), and subcortical structures. *See, e.g.*, Giuseppina Rametti et al., *White Matter Microstructure in Female to Male Transsexuals Before Cross-Sex Hormonal Treatment. A Diffusion Tensor Imaging Study*, 45 J. Psychiatric Res. 199-204 (2010); Giuseppina Rametti et al., The Microstructure of White Matter in Male to Female Transsexuals Before Cross-Sex Hormonal Treatment: A DTI Study, 45 J. Psychiatric Res. 949-54 (2011); Eileen Luders et al., *Gender effects on cortical thickness and the*

influence of scaling, 2 J. Behav. & Brain Sci. 357, 360 (2012); FPM Krujiver, et al., *Male-to-female transsexuals have female neuron numbers in a limbic nucleus*, 85 J. Clin. Endocr. Met., 2034-2041 (2000). Interestingly, differences in transgender individuals primarily involve the right hemisphere of the brain. The significance of the right hemisphere is important because that is the area that relates to attitudes about bodies in general, one's own body, and the link between the physical body and the psychological self.

13. In addition, scientific investigation has found a co-occurrence of gender dysphoria in families. Gomez-Gill et al. concluded that the probability of a sibling of a transgender individual also being transgender was 5 times higher than someone in the general population. E. Gomez-Gil, et al., *Familiarity of gender identity disorder in non-twin siblings*, 39 Arch Sex Behav., 265-269 (2010). And, in identical twins, there was a very high likelihood (33%) of both twins being transgender, even when reared apart, demonstrating the role of genetics in the development of gender dysphoria. *See* Milton Diamond, *Transsexuality among twins: identity concordance, transition, rearing, and orientation*, 14 Int'l J. Transgenderism 24 (2013) (abstract: "[t]he responses of our twins relative to their rearing along with our findings regarding some of their experiences during childhood and adolescence show their [gender] identity was much more influenced by their genetics than their rearing."). *See also* R Green, *Family co-occurrence of "gender dysphoria": ten siblings or parent-child pairs*, 29 Arch Sex Behav. 499-507 (2000).

14. It is now believed that Gender Dysphoria evolves as a result of the interaction of the developing brain and sex hormones. For example, one study found that:

> [d]uring the intrauterine period a testosterone surge masculinizes the fetal brain, whereas the absence of such a surge results in a feminine brain. As sexual differentiation of the brain takes place at a much later stage in the development than sexual differentiation of the genitals, these two processes can be influenced independently of each other. Sex differences in cognition, gender identity . . . , sexual orientation . . . , and the risks of developing

> neuropsychiatric disorders are programmed into our brain during early development. There is no evidence that one's postnatal social environment plays a crucial role in gender identity or sexual orientation.

Ai-Min Bao & Dick F. Swaab, *Sexual Differentiation of the Human Brain: Relation to Gender Identity, Sexual Orientation and Neuro-psychiatric Disorders*, 32 Frontiers in Neurology 214-216 (2011). In addition, Alicia Garcia-Falgueras & Dick F. Swaab find that:

> [t]he fetal brain develops during the intrauterine period in the male direction through a direct action of testosterone on the developing nerve cells, or in the female direction through the absence of this hormone surge. In this way, our gender identity (the conviction of belonging to the male or female gender) and sexual orientation are programmed or organized into our brain structures when we are still in the womb. However, since sexual differentiation of the genitals takes place in the first two months of a pregnancy and sexual differentiation of the brain starts in the second half of the pregnancy, these two processes can be influenced independently, which may result in extreme cases in transsexuality. This also means that in the event of ambiguous sex at birth, the degree of masculinization of the genitals may not reflect the degree of masculinization of the brain. There is no indication that social environment after birth has an effect on gender identity or sexual orientation.

Alicia Garcia-Falgueras & Dick F. Swaab, *Sexual Hormones and the Brain: As Essential Alliance for Sexual Identity and Sexual Orientation*, 17 Pediatric Neuroendocrinology 22-25 (2010). Similarly, Lauren Hare et al. finds that:

> a decrease in testosterone levels in the brain during development might result in incomplete masculinization of the brain . . . , resulting in a more feminized brain and a female gender identity.

Lauren Hare, et al., *Androgen Receptor Repeat Length Polymorphism Associated with Male-to-Female Transsexualism*, 65 Biological Psychiatry 93, 93, 96 (2009). Because the condition is biologically based, efforts to change a person's gender identity are futile, cause psychological harm, and are unethical.

15. Without treatment, adults with Gender Dysphoria experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental

health issues. They are frequently socially isolated as they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time proves ravaging to healthy personality development and interpersonal relationships. Without treatment, many gender dysphoric people are unable to adequately function in occupational, social or other areas of life. Many people without access to appropriate care are often so desperate for relief that they resort to life-threatening attempts at auto-castration (the removal of one's testicles) in the hopes of eliminating the major source of testosterone that kindles the dysphoria. A recent survey found a 41% rate of suicide attempts among this population, which is far above the baseline rates for North America.

16. Gender Dysphoria can be ameliorated through medical treatment. The standards of care for treatment of Gender Dysphoria are set forth in the *World Professional Association for Transgender Health (WPATH) Standards of Care* (7th version, 2011). The WPATH promulgated Standards of Care (SOC) are the internationally recognized guidelines for the treatment of persons with Gender Dysphoria, and inform medical treatment throughout the world. The *American Medical Association*, the *Endocrine Society*, the *American Psychological Association* the *American Psychiatric Association,* the *World Health Organization*, the *American Academy of Family Physicians*, the *American Public Health Association*, the *National Association of Social Workers,* the *American College of Obstetrics and Gynecology* and the *American Society of Plastic Surgeons* all endorse protocols in accordance with the WPATH SOC. *See, e.g.*, American Medical Association (2008) Resolution 122 n(A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).

17. As part of the SOC, many transgender individuals with Gender Dysphoria undergo a medically-indicated and supervised gender transition in order to ameliorate the debilitation of Gender Dysphoria and live life consistent with their gender identity. The SOC recommend an individualized approach to gender transition, consisting of one or more of the following protocol components of evidence-based care for gender dysphoria:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g. breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support improving body image; or promoting resilience.

18. The treatment of incarcerated persons with Gender Dysphoria has been addressed in the SOC since 1998. As with protocols for the treatment of diabetes or other medical disorders, medical management of Gender Dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the WPATH SOC expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients in prison (Section XIV) and the National Commission on Correctional Health (NCCHC) recommends treatment in accordance with the WPATH SOC for people in correctional settings (NCCHC Position Statement, Transgender, Transsexual, and Gender Non-Conforming Health Care in Correctional Settings (October 18, 2009, reaffirmed with revisions April, 2015), http: //www.ncchc.org/transgender-transsexual-and gender-nonconforming health-care).

19. A key component of medical treatment for gender dysphoric individuals is to live, function in society, and be regarded by others consistent with their gender identity. If any aspect

of this social role transition is impeded, it will undermine an individual's core identity and psychological health.

20. Housing and shower/bathroom facilities for individuals with Gender Dysphoria in institutional settings should be in accord with their gender identity and social role. The failure to treat a woman with Gender dysphoria as a woman in an institutional setting will intensify gender dysphoria and psychological distress and can precipitate psychiatric disorders.

21. I have reviewed Plaintiff Jane Doe's correctional medical records and conducted a psychological evaluation of her in person at MCI Norfolk on December 11, 2017. My evaluation consisted of an interview and the administration of a series of four standard psychometric indices.

22. Ms. Doe has long-standing, persistent, and well-documented early-onset Gender Dysphoria. There is no controversy about her diagnosis. She was gender dysphoric as a child and by age 13 her mother took her to a doctor for treatment of her gender incongruence. She has been on cross-gender hormone therapy since she was a teenager. Although Ms. Doe originally received a diagnosis of GID, consistent with the version of DSM in effect at that time, she meets all the criteria for and has a diagnosis of Gender Dysphoria.

23. Ms. Doe's Gender Dysphoria requires life-long medical care and monitoring in accordance with the treatment protocols in the SOC, including with respect to hormone therapy and the requirement that she live and function as a woman.

24. Based on the contemporary scientific and medical understanding of sex, Ms. Doe is female. The fact that she is transgender – that is, that she was ascribed the sex of male when born notwithstanding her female gender identity – does not alter that conclusion.

25. Based on current scientific and medical knowledge and understanding, sex is composed of several components: brain phenotype, gender identity, chromosomes and the hormones they script, internal reproductive organs and external genital structures.

26. For adults, where there is any lack of congruity among these characteristics, gender identity predominates in prioritizing these determinants. There is no dispute that Ms. Doe has a female gender identity.

27. After approximately four decades of appropriate, confirming hormones, Ms. Doe has been *hormonally reassigned*. In other words, she has the same circulating sex steroid hormones as perimenopausal females. Her testosterone levels are barely measurable and similarly in the reference range appropriate for a female.

28. Hormones have a primary effect on the brain, but also regulate every bodily system. Due to her long-term hormone therapy and estrogen levels comparable to other females, Ms. Doe has the secondary sex characteristics of a woman. She has normal female breast development. Consistent with her long-time hormone levels she also has softened skin, diminution of body hair, the absence of male pattern baldness, redistribution of body fat consistent with a female shaped body, loss of muscle mass, and genital changes.

29. Unlike people who transition later in life, Ms. Doe never attempted to live in her assigned birth gender. Individuals who begin cross-sex hormone therapy in adolescence never develop the male secondary sex characteristics, which aids enormously in the attainment of an authentic female presentation. Ms. Doe attended school as a girl and was treated as a girl by family, friends, and the community at large. She was never socialized as a *male.*

30. Based on her female hormone levels and the absence of testosterone, Ms. Doe's genitals would not appear or function as normal male genitals. Female hormone therapy,

especially when started at such an early age, creates considerable changes to genitalia. If one were to view her naked, as corrections officers strip-searching her do, her genitals would not visibly appear the same as male inmates. There would be significant atrophy and decreased mass of the penis and testicles due to the lack of testosterone. In addition, the hormonal changes would render her unable to have erections, produce ejaculate fluid, or engage in penetrative sex. Functionally, Ms. Doe's genitals are used only to urinate.

31. Due to treatment for Gender Dysphoria, Ms. Doe is not capable of reproduction.

32. My assessment of Ms. Doe's current psychological condition is based on my review of her records, my interview of her, and the administration of four standardized psychometric indices with high levels of reliability and validity: The Beck Anxiety Inventory, The Beck Depression Inventory-II, the Traumatic Symptom Inventory-2, and the Beck Hopelessness Scale.

33. Based on my assessment, it is my opinion that Ms. Doe has developed Posttraumatic Stress Disorder and a Generalized Anxiety Disorder as a direct result of being housed in a prison with male inmates and the intentional intimidation, harassment, and sexual objectification she has regularly experienced in that setting. She has no history of trauma or psychiatric disorders prior to her incarceration. The diagnosis of posttraumatic stress disorder is based on her current and acute symptoms and behaviors and the traumatic stressors she is routinely subjected to in her present environment. She has clinically elevated indicia of trauma, and scored in the severe range on a test of anxiety associated with hyperarousal and fear that are beyond her cognitive control. She has intrusive experiences such as nightmares and flashbacks and lives in constant fear of what will happen to her next.

34. Ms. Doe now suffers from "complex trauma." Complex trauma is a result of traumatic stressors that are interpersonal, i.e. *intentionally* caused and planned by humans. This

interpersonal trauma usually occurs when there is a power differential between the victim and the aggressor, and is more harmful and intractable than random or impersonal trauma, i.e. "acts of God." Additionally, interpersonal victimization is typically repeated and chronic. Whether it occurs routinely or intermittently, the victim does not have adequate time to regain emotional equilibrium between "assaults" and the fear that another attack can occur at any moment leads to states of hypervigilance, autonomic hyperarousal, hyperalertness and anxiety or panic attacks. This causes actual neurological damage - a dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis and the neurocircuitry of the brain. People with posttraumatic stress disorder can no longer mediate the fight-flight-freeze response.

35. Being referred to by the appropriate female name and being respectfully treated as a woman are crucial to the psychological well-being of a gender dysphoric woman. Absent respectful and appropriate interactions, psychological symptoms and disorders develop. Although deeply disturbing, the psychological harm from the placement of a woman in a male prison is not surprising, given what Ms. Doe has experienced at MCI-Norfolk. It is extremely distressing for a transgender woman to be viewed naked by male inmates; strip-searched by male guards who touch and grope her; forced to shower in view of male prisoners who crowd in excitedly to view her as a sex object; told by guards that she is a man because she has a penis; be referred to as a "chick with a dick," and "a wannabe woman"; and to be called "Mr. Doe" and referred to with male pronouns. When I asked Ms. Doe what was the worst thing that happened to her at this facility, she cried, and related a particularly disturbing incident in which a corrections officer intentionally made her shower on the second floor in the 3-2 Unit in front of male inmates. Not only was she feeling ashamed, but she also was fearful of being raped, as the male inmates talked about what she could do with her lips. Each of these humiliating incidents is

devastating and threatens her emotional stability because they do not emanate from mistakes or inadvertence. They are obvious and intentional attempts to harass, insult, stigmatize and undermine her female identity. These conditions would be damaging to any transgender woman, but they are especially traumatic for Ms. Doe, because having transitioned as a youngster, she has always only been treated as female. For her, the impact of not being treated as a woman is particularly demoralizing.

36. Strip searches by male correctional officers have a devastating impact on Ms. Doe. She has a female body with female breasts. That the same men who have been harassing her can put their hands on her is extremely traumatic.

37. Based on my assessment, it is my opinion that Ms. Doe's mental health is steadily devolving. If she remains in a male prison under the current conditions, she is at risk for further emotional and physical decline. Her coping strategies have diminished, and her resilience is rapidly eroding. In the face of intense stressors, and with no personal agency, symptoms intensify rendering an individual incapable of functioning, a condition known as psychological decompensation, which can be irremediable.

38. Excessive stress induces high levels of cortisol. This surge of cortisol leads to neural excitability and sometimes psychoses. Excessive cortisol may also accelerate the metabolism of Ms. Doe's hormones, which would render them less effective.

39. All of Ms. Doe's symptoms will improve if she is placed in a women's prison. While some anxiety symptoms may now be intractable, they will be attenuated. She will likely be largely symptom-free if placed in an appropriate facility and treated as a female.

40. Ms. Doe will function well in a women's prison. She has lived as a female her whole life, excluding periods of incarceration.

41. There is no danger that Ms. Doe would be physically or sexually assaultive to other women. Her test results show markedly low levels of anger and aggression. She is a pleasant person with no personality disorders, sociopathic tendencies, or any other maladaptive personality traits that could create a troublesome situation in any correctional setting. Her personality profile is passive. She does not fight back, but is more prone to, in lay person's terms, take anger and frustration out on herself.

42. Ms. Doe has no sexual disturbances or dysfunctional sexual behavior. She has no problem with sexual boundaries or impulse control. Although Ms. Doe's sexual orientation would be to adult males, she has no interest in engaging in sexual activity. Indeed, on tests that measure sexual concerns and behavior, Ms. Doe scored in the "zero" range.

SIGNED UNDER THE PENALTIES OF PERJURY THIS 16 DAY OF JANUARY, 2018.

Randi Ettner Ph.D.

RANDI ETTNER, PH.D.

EXHIBIT A

RANDI ETTNER, PHD
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Evanston, Illinois 60201
847-328-3433

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association of Transgender Healthcare (WPATH)
Chair, Committee for Incarcerated Persons, WPATH
Global Education Initiative Committee
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgenderism*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical staff Weiss Memorial Hospital, Chicago IL

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois
BA, 1969-73	Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes

CLINICAL AND PROFESSIONAL EXPERIENCE

2016-present	Psychologist: Chicago Gender Center Consultant: Walgreens; Tawani Enterprises Private practitioner
2011	Instructor, Prescott College: Gender-A multidimensional approach
2000	Instructor, Illinois Professional School of Psychology
1995-present	Supervision of clinicians in counseling gender non-conforming clients
1993	Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
1992	Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
1983-1984	Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
1981-1984	Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
1976-1978	Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1975-1977	Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1971	Research Associate, Department of Psychology, Indiana University
1970-1972	Teaching Assistant in Experimental and Introductory Psychology Department of Psychology, Indiana University
1969-1971	Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS

Gender dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, 2017.

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, 2017.

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016.

Tomboys Revisited: Replication and Implication; Models of Care; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, 2015; Atlanta, 2016; Ft. Lauderdale, 2016; Washington, D.C., 2016, Los Angeles, 2017, Minneapolis, 2017, Chicago, 2017; Columbus, Ohio, 2017

Pre-operative evaluation in gender-affirming surgery-American Society of Plastic Surgeons, 2015

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care-Fenway Health Clinic, Boston, 2015

Gender reassignment surgery- Midwestern Association of Plastic Surgeons, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013;

Role of the forensic psychologist in transgender care; *Care of the aging transgender patient*- University of California San Francisco, Center for Excellence, 2013

Evidence-based care of transgendered patients- North Shore University Health Systems, University of Chicago, Illinois, 2011; Roosevelt-St. Vincent Hospital, New York; Columbia Presbyterian Hospital, Columbia University, New York, 2011

Children of Transsexuals-International Association of Sex Researchers, Ottawa, Canada, 2005; Chicago School of Professional Psychology, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

Gender Identity and Clinical Issues –WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychonueroimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984

Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

The Role of Denial in Dialysis Patients - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

PUBLICATIONS

Ettner, R. Mental health evaluation. Clinics in Plastic Surgery. Elsevier, in press.

Ettner, R. Etiology of gender dysphoria in Schechter (Ed.) Gender Confirmation Surgery: Principles and Techniques for an Emerging Field. Springer, in press.

Ettner, R. Pre-operative evaluation in Schechter (Ed.) Surgical Management of the Transgender Patient. Elsevier, 2017.

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"Social and Psychological Issues of Aging in Transsexuals," proceedings, Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, 2005.

"The Role of Psychological Tests in Forensic Settings," *Chicago Daily Law Bulletin,* 1997.

Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the Transgendered. Chicago Spectrum Press. 1996.

"Post-traumatic Stress Disorder," *Chicago Daily Law Bulletin,* 1995.

"Compensation for Mental Injury," *Chicago Daily Law Bulletin,* 1994.

"Workshop Model for the Inclusion and Treatment of the Families of Transsexuals," Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

"Transsexualism- The Phenotypic Variable," Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

"The Work of Worrying: Emotional Preparation for Labor," Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality

Screenwriters and Actors Guild
Phi Beta Kappa

AWARDS AND HONORS

The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016
Phi Beta Kappa, 1971
Indiana University Women's Honor Society, 1969-1972
Indiana University Honors Program, 9-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

JANE DOE, Plaintiff v. MASSACHUSETTS DEPARTMENT OF CORRECTION; THOMAS A. TURCO III; SEAN MEDEIROS; JAMES M. O'GARA JR.; and STEPHANIE COLLINS, Defendants.	Civil Action No. 17-12255-RGS

AFFIDAVIT OF JANE DOE

I, Jane Doe, hereby depose and state:

1. I am a 53 year old woman, born in Puerto Rico and raised in New York.

2. From a very young age, I felt great emotional anguish and stress when I was being treated as a boy. At approximately 13 years of age, I began wearing girl clothing and playing with girl toys. I also started using a female version of my name, which my family accepted and used. By the time I was a teenager, a doctor had diagnosed me with Gender Identity Disorder (GID).

3. At approximately 13-14 years of age, I began taking estrogen daily as prescribed by my doctor, and continued to live as a woman. I have continued with hormone therapy since then, and am currently on injection hormones.

4. When I was around 15 or 16 years old, I had a child. The person I had the child with is a transgender man today. We are still in touch and I have a close relationship with my

daughter. In fact, I am now a grandmother! My daughter has always seen me as her mother, and her birth mother as her father.

5. When I was around 17 years old, I applied for a received by NY Welfare ID, which listed me as female.

6. When I later moved to Massachusetts I applied for and received my Massachusetts State ID, which also designates me as female.

7. I was first in Massachusetts Department of Correction (DOC) custody in 2003, and was released in 2005. During this time, I was on hormone treatment because the DOC recognized my GID diagnosis. I was admitted a second time to DOC custody in 2010, and subsequently released in 2012. In 2010, while in DOC custody, my GID diagnosis was again confirmed by Dr. Diener and Dr. Andrade, who both worked with DOC prisoners through their medical contract.

8. After being convicted in October 2016 of a non-violent drug offense, I am again in DOC custody. While I was at MCI-Cedar Junction for admission and classification, I reminded the DOC that I am a woman and have a Gender Dysphoria (GD) diagnosis. Shortly thereafter, I was transferred to MCI-Norfolk, where I am currently housed.

9. Being a woman in a men's prison causes me extreme anxiety and stress and makes me a target for sexual assault and harassment. I have lived in housing environments that were very unsafe for me, am forced to shower in plain view of men, am strip searched by men, and am consistently and systematically denied recognition of my identity as a woman. All this despite living socially and legally as a woman outside prison walls and having a long-standing Gender Dysphoria diagnosis that is recognized by the DOC.

10. I have made multiple attempts to remedy these serious problems. I have spoken many times with my mental health clinician about the trauma I am experiencing. My clinician has also reported various incidents to DOC staff and has communicated with the Gender Dysphoria Committee. I have filed multiple institutional and medical grievances and have raised these issues with Inner Perimeter Security (IPS). I have also written directly to Superintendent Medeiros and attended bi-weekly Staff Access Hour on multiple occasions where I spoke with MCI-Norfolk officials. Additionally, I submitted a Request for Reasonable Accommodation to a DOC administrator asking that my Gender Dysphoria be accommodated by securing access to a separate shower, strip searches by women, and that I be generally recognized as a woman. Finally, I have asked to be classified to MCI-Framingham. These requests were all either ignored or denied.

11. Below I describe in more detail the problems related to my status as a woman in a men's prison that I have been unsuccessful in addressing with the DOC.

Housing and Showering

12. Upon arriving at MCI-Norfolk, I was housed in a dormitory setting, which is an open living space that houses approximately 60 men. I was forced to sleep and shower in full view of dozens of men.

13. Being housed in such a setting made me feel extremely unsafe. I felt emotional stress, depression, anxiety and would frequently cry. I often would stay awake all night out of fear of being sexually assaulted or raped. I complained about my situation and communicated my fears and distress to the mental health director at MCI-Norfolk, but it was not until Prisoners' Legal Services intervened on my behalf that I was moved into a single cell.

14. Although I no longer sleep and reside in a dormitory setting, I continue to be denied access to safe showering. I have been forced to shower in stalls where men can easily

watch me from an upper tier. Male prisoners routinely stand on the tier above the bathroom to see me naked and sexually harass me. They often verbally taunt me with comments about my "boobs" and my female body, and shout out what they would like to do to me sexually. This makes me feel like a sex object and completely dehumanized. I live in constant fear that this harassment could escalate to physical harm or rape. Currently, and at times during my incarceration, I shower in bathrooms open to men with only a transparent shower curtain that does not provide privacy. These transparent curtains have an opaque strip in them intended to cover the genitals of prisoners, but they leave my breasts completely exposed.

15. For a brief period of time, I was housed in a unit with other transgender women. I was initially housed on the second floor of this unit, and purportedly because of this, was denied the opportunity to use the "transgender shower" on the third floor, which provides some privacy due to its fully opaque curtains. It wasn't until a sympathetic lieutenant intervened that I was moved to a cell on the third tier, which allowed me to access the transgender shower. I was grateful for this move, but anxious knowing that I could be moved again at any time.

16. I was then transferred to a different unit. On this new unit, there were a few weeks during which I was allowed to shower with a fully opaque curtain, but it was then taken down by a sergeant who told me it wasn't needed because, "we're all men here." Since then, I have not had access to a private shower.

17. On multiple occasions, I asked correctional officers on my unit to assist me in securing a private shower, explaining to them that men watch me naked and sexually harass me. Most officers respond by asking me if I still have a penis and dismiss my concerns. This makes me fearful and depressed because these are the same officers who are responsible for my safety, and instead seem to want to punish me for being who I am.

Strip Searches

18. I am required to strip naked to be searched whenever I have a visitor, including meetings with my attorneys, leave the facility for outside medical appointments, and during institutional shakedowns. These searches are always conducted by male correctional officers, who force me to lift my breasts for them, and often touch my breasts. Having a male correctional officer handling my breasts and body leaves me feeling extremely vulnerable and is simply terrifying. I feel physically violated every single time and emotionally degraded.

19. At least one particular occasion still causes me great emotional distress today. In the spring of 2017, during an institution-wide lockdown, two male correctional officers came to my cell and told me to strip naked for a search. This made me particularly uncomfortable and scared because not only would the strip search be conducted by multiple male officers, but it would also take place in my cell in plain view of male prisoners. I told these correctional officers that I am a woman and did not want to do the search in this manner. When I told them that I have a GD diagnosis, they called a captain who informed me that if I did not submit to this public strip search, I would be sent to solitary confinement.

20. Because of my mental health issues, I have great difficulty coping with any period of time in solitary confinement, so I was sincerely terrified of this prospect. I began crying and removed my clothes, including my undergarments, while the three male officers watched me in my cell. I was forced to conduct the strip search with the door open, and stand there naked as approximately 10 male prisoners watched. As they watched me, male prisoners yelled things at me about my body and things they would like me to do to them. While the officers conducted a search of my cell and clothing, I was allowed to only partially re-dress with my cell door open

and while onlookers continued to verbally harass me. The three officers present did nothing to prevent this harassment or afford me any privacy.

Privacy

21. I was also forced to expose my breasts to a male correctional officer for an extended period of time during my recent mammogram at Lemuel Shattuck Hospital (LSH). A correctional officer insisted on coming with me into the exam room where my mammogram was conducted.

22. The officer refused to leave the room, even after the mammogram technician raised the issue of privacy twice. The officer stared at me while I undressed and put a hospital gown on. The female technician tried to cover me up for modesty, but because it was a mammogram, I had to let the gown fall below my breasts. I had to put my breast into the mammogram machine while the male correctional officer continued to stare. After the first set of images were taken, the technician left the room to view the results. While she was gone, I was forced to remain half naked with my breast in the mammogram machine. Exposing my breasts and undergoing a mammogram with a man looking on was deeply degrading and utterly humiliating.

Discrimination

23. Upon arriving at MCI-Norfolk, I began experiencing frequent verbal and sexual harassment from both correctional officers and male prisoners who refuse to accept and treat me as a woman. The first incident of such harassment that I can specifically recall took place in November 2016. I was in the dormitories and was having a very hard time because I was not allowed private showers. A sergeant decided to place a sign in the bathroom to allow me to shower alone one day and left Officer Duszak in charge. I came out of the shower in my towel

and saw that men were in the bathroom area despite the sign. I was very distraught and felt unsafe. When I came out, I asked officer Duszak if he had seen the sign and why he allowed the men to come in. He turned to me and said he did not "give a fuck." This was very upsetting to me so I reported it at that time to my mental health clinician, Elizabeth Samson.

24. I still experience frequent discrimination from correctional officers. Some officers at MCI-Norfolk accept me as a woman, and treat me as such, for example, by using feminine pronouns to refer to me. Other officers make repeated derogatory comments to me and about me to other correctional officers and male prisoners. Examples of such comments include, "chicks with dicks," "wannabe women," "fags," and "homos."

25. The harassment I am currently experiencing from Officer Duszak, for example, is a persistent problem. His frequent verbal harassment is so bad that I go out of my way to avoid him, even skipping meals to avoid an interaction with him. Although I have named him explicitly in more than one grievance, and verbally expressed my concerns about his treatment of me to MCI-Norfolk officials, his behavior has not changed.

26. I have filed grievances on this distressing verbal harassment by correctional officers and discussed the harassment with my mental health clinician. I eventually stopped filing grievances on abusive officers because the lack of results was discouraging and because I was fearful that continuing to call out specific officers in my grievances would result in retaliation and further harm from those officers.

27. I have asked to be transferred to MCI-Framingham and turned down. I was told that I could not be transferred to the women's prison because I have not had genital surgery.

28. Even since the filing of this lawsuit in October 2017, I continue to fear for my safety and experience sexual harassment and discrimination based on my status as a transgender

woman. On November 29, 2017, someone hung a shank (knife) over my cell door with a homophobic slur written on an attached piece of paper. In response, I was distraught and crying heavily, so I was put on a mental health watch in the medical unit overnight. Mental health watch is worse than solitary confinement. Upon returning to the unit the following day, I learned that my cell had been trashed by a lieutenant, with food thrown everywhere, and a significant amount of my property had been stolen, especially items I am afforded as a transgender woman diagnosed with gender dysphoria.

29. I had another particularly traumatizing incident on January 11, 2018. I was being taken to the Lemuel Shattuck Hospital for my hormone treatment. Apparently, Sergeant Clemente commented on the way my derriere looks in my pants when I was getting into the transport vehicle. I did not hear him make this comment, but the driver did and disclosed what was said because he found it inappropriate. When I returned to the facility, Sergeant Clemente was there again to process me back in. He told me to take my pants off and that he didn't want me wearing them anymore because of how tight they were around my behind. He also said that women at Framingham can't even walk around like that. I have been wearing these pants, which I bought from Framingham canteen as I am entitled to due to my GD diagnosis, since I arrived at MCI-Norfolk over a year ago. No one has ever commented on my pants or felt they were inappropriate in any way.

30. Sergeant Clemente made me take the pants off in front of him and wear a pair of baggie pants that are not mine and so big that I have to fold the waistband over just so they won't fall off. I felt so degraded because of the way he commented on my body and because he insisted that I remove the pants in front of him. It was clear to me that he was doing this only because he fundamentally disrespects who I am and wanted to use his power to put me down and

literally strip me of my identity. I have reported this incident and it is currently being investigated.

31. The abuse and harassment I have experienced over the past year at MCI-Norfolk, and that I continue to experience, has had a significant negative impact on my mental health. The humiliation, shame, degradation and fear I frequently experience has led to extreme anxiety, depression, nightmares, sleeplessness, and a constant fear of being harassed and physically harmed or raped. I am now on medication to help treat some of these symptoms, and I am finding it more and more difficult to cope with the stress of being a transgender woman incarcerated in a male prison.

Signed and sworn to under the pains and penalties of perjury this

19th day of January, 2018.

/s/ Jane Doe
Jane Doe