IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JESSICA HICKLIN, Plaintiff, v. ANNE PRECYTHE, et al., Defendants.	)	Cause No. 4:16-cv-01357-NCC

DEFENDANT CORIZON, LLC'S RESPONSE TO PLAINTIFF'S MEMORADUM OF LAW [DOC 164]

COMES NOW Defendant Corizon, LLC, by and through counsel, and for its response to Plaintiff's Memorandum of Law in support of Plaintiff's Motion for Declaratory Relief and Permanent Injunction [Doc 164] state the following:

Introduction

Corizon, LLC ("Corizon") is the contracted provider of medical services for the Missouri Department of Corrections ("DOC"), and its various correctional facilities, including at Potosi Correctional Center, the facility at which the Plaintiff is currently housed. As the evidence adduced in this case previously demonstrates, Corizon professionals diagnosed Plaintiff with the condition of gender dysphoria, and have made ongoing recommendations for Plaintiff's treatment in that regard, including

recommendations for the initiation of hormone therapy, access to body hair removal when medically necessary, and gender affirming canteen items that may be made available to the Plaintiff at the DOC's canteen. At no time has Corizon, LLC, or any of its personnel developed, authored, or implemented any type of policy that would otherwise deny Plaintiff the aforementioned modalities of treatment for gender dysphoria, and have, in fact, continued to advocate for the patient from the inception of the Plaintiff's diagnosis of gender dysphoria.

DEFENDANT CORIZON'S ANSWER TO PLAINTIFF'S STATEMENT OF UNCONTROVERTED FACTS

I: PLAINTIFF JESSICA HICKLIN'S GENDER DYSPHORIA DIAGNOSIS

1: **Admit**

2: **Admit**

3: **Admit**

II. GENDER DYSPHORIA AND THE STANDARDS OF CARE

4: **Admit**

5: **Admit**

6: Defendant Corizon, LLC, admits that individuals with untreated gender dysphoria may experience clinically significant depression, anxiety, and mental impairment. Exhibit A, Transcript of the Deposition of Dr. George Brown page 45, lines 21 – 25, page 46, lines 1 – 18. If left untreated, they may suffer additional serious medical problems including suicidality and compulsion to engage in self castration and self-harm. Exhibit A, Transcript of the Deposition of Dr. George Brown, page 142, lines 23 – 25, page 143, lines 1 – 16. There is, however, no uniformity in the signs, symptoms,

or conditions suffered by individuals with gender dysphoria, as each patient is different. Exhibit A, Transcript of the Deposition of Dr. George Brown, page 48, lines 23 – 25, page 49, lines 1 – 7.

7: **Admit**

8: **Admit**

9: **Admit**

10: Defendant Corizon, LLC, admits that hormone therapy is fundamental to the treatment of gender dysphoria in many patients, and the denial of hormone therapy in patients for whom such treatment is medically indicated may lead to significant deterioration and impairment in patients, including the possibility of depression, suicidal ideation, and surgical self treatment by auto castration or auto-penectomy. Exhibit A, Transcript of the Deposition of Dr. George Brown, page 57, lines 8 – 24; page 58, lines 5 – 14; page 58, lines 18 – 25, page 59, lines 1 – 5; page 71, lines 1 – 20.

11: Defendant Corizon, LLC, admits that counseling may provide support for many individuals with gender dysphoria, but does not alone usually substitute for medical intervention. Exhibit A, Transcript of the Deposition of Dr. George Brown, page 81, lines 7 – 25, page 82, lines 1 – 9. Defendant Corizon, LLC, further admits that providing only counseling and/or psychotropic medication to a severely gender-dysphoric patient is a departure from the standard of care when the patient's condition specifically warrants or requires additional/other treatment. Exhibit A, Transcript of the Deposition of Dr. George Brown page 82, lines 10 – 15. Defendant Corizon, LLC, admits that inadequate treatment of this condition puts an individual at serious risk of psychological and physical harm. Exhibit A, Transcript of the Deposition of Dr. George Brown page 86, lines 11 – 25.

III. THE FREEZE-FRAME POLICY

12: **Admit**

13: **Admit**

14: **Admit**

IV. DEFENDANTS' FAILURE TO PROVIDE MEDICALLY NECESSARY GENDER DYSPHORIA TREATMENT FOR MS. HICKLIN

15: Defendant Corizon, LLC, admits that Dr. Meredith Throop and Dr. Evelyn Stephens diagnosed the Plaintiff with gender dysphoria and prescribed medically necessary hormone medicine for her in 2015. Exhibit B at EM 0111-2, EM 0114; Exhibit D, Transcript of the Deposition of Dr. Evelyn Stephens, page 108, lines 10 – 25, page 109, lines 1 – 15. Defendant Corizon, LLC, admits that for three years, Corizon Defendants were not authorized to provide Plaintiff with the recommended hormone therapy due to the freeze-frame policy in effect at that time. Exhibit C, Transcript of the 30(b)(6) deposition of Corizon, page 159, lines 14 – 17.

16: Defendant Corizon, LLC, denies that there were not individualized evaluations of Plaintiff Jessica Hicklin performed, and states that Corizon, LLC, physicians regularly had personal contact with the Plaintiff, performed multiple individualized evaluations, and made recommendations specific for her care, including the initiation of hormone treatment. Exhibit D, Transcript of the Deposition of Dr. Evelyn Stephens, page 27, lines 11 – 23; Exhibit C, Transcript of the 30(b)(6) deposition of Corizon, page 186, lines 5 – 15; page 187, lines 11 – 15 and line 25; page 188, lines 2 – 14. Said medical providers, however, did not consistently conclude that access to permanent hair removal devices was medically necessary prior to the initiation of

hormone therapy, since hormone therapy has a propensity to effect hair growth on its own. Exhibit C, Transcript of the 30(b)(6) deposition of Corizon, page 188, lines 2 – 14. Corizon, LLC professionals did recommend that the Plaintiff have access to gender affirming canteen items to the extent available and supplied by the DOC. Exhibit B at EM 0154-7.

17: **Admit**

18: **Admit**

19: **Admit**

ARGUMENT

Defendant Corizon, LLC makes no response to the legal argument set forth in Plaintiff's Memorandum of Law in Support of Plaintiff's Motion for Declaratory Relief and Permanent Injunction [Doc 164].

Respectfully submitted,

/s/ J. Thaddeus Eckenrode
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing was served via electronic mail this 6th day of April, 2018 to the following:

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/s/ Paige McNary

3587.53

oftentimes people aren't even aware? Even though they're having difficulties kind of living in the role that they have been assigned to, oftentimes they're not even aware for many years that -- basically that they're transgender and that that's the source of the distress and the difficulty that they're going through; is that correct?

A. That is correct. And I have seen people in their 40s, 50s, and 60s who might be able to tell you that they were aware of something being different about them compared to other same-sex people based on their anatomy but not really able to put their finger on it or put a name to it and not until they read an article on the internet or see a television show do they have an ah-ha moment and realize, "That's what I've been experiencing for the last 10, 20, 30, 40, 50 years."

Q. I mentioned a term earlier, "gender dysphoria", but I had not asked you to explain what it is. So can you explain what gender dysphoria is?

A. Yes. So gender dysphoria with a small "g" and small "d" is a set of symptoms or a symptom complex that is predominantly about depression, irritability, and anxiety around a mismatch -- the perception of the mismatch between felt gender

identity and assigned sex at birth so that such that when a person looks at themselves in a mirror or directly that they see a body that does not match their internal perception of who they feel they are.

And the dysphoria is a symptom complex that involves these uncomfortable symptoms, and it has various levels of severity, from very mild to very severe.

Gender Dysphoria, capital "G"/capital "D", since the publication of DSM-5 in 2013, I believe, become also a diagnosis, a formal diagnosis, for the first time in American and Western psychiatry that operationalizes the symptoms of gender dysphoria and establishes a threshold above which, if a person experiences these symptoms at a certain level of clinical significance and severity, that they are diagnosed, officially diagnosed with a psychiatric disorder.

And there are specific criteria listed under 302.85 in the DSM-5 that -- it's a fairly long paragraph, but it involves a number of specific criteria.

Q. Can you describe the process for diagnosing someone with gender dysphoria?

A. So it's a clinical diagnosis, so there is

two-and-a-half-inch thick manual.

There are a couple of diagnoses for which there are -- research evidence that, you know, with certain types of challenges, you can demonstrate where someone has panic disorder, for example, or panic attacks; but those are not in widespread clinical use and tend to be used in a research setting only. That's one example where potentially there may be a lab test, but it involves putting somebody in a hospital and giving them infusions to try to determine that.

Q. Okay. So for the vast majority of psychiatric diagnoses for which there is no lab test that you can administer to someone to diagnose them, the fact that those kinds of tests don't exist in no way implicates the validity of any of these diagnoses, including gender dysphoria, correct?

A. That is correct.

Q. I touched on this earlier, but gender dysphoria can be treated, correct?

A. Correct.

Q. How is gender dysphoria treated?

A. Gender dysphoria, like -- again, like other psychiatric diagnoses and other medical diagnoses, is treated on an individualized, case-by-case basis

based on -- and by -- based on the time; so the time of the diagnosis is very important.

So take into the consideration the severity of the diagnosis, how long the person has had the diagnosis, what symptoms are currently manifesting, all done in an individualized way with an individualized treatment plan.

Q. You mentioned the time and you said time is very important. Could you extrapolate on that for me?

A. Sure. In any diagnosis, again, gender dysphoria not at all being unique in this regard, the timing of an intervention is extremely important. And I'll think of an example.

If someone is in the very early stages of developing appendicitis, there is some evidence that maybe an antibiotic is the right way to treat that person at that time in the development of their appendicitis, whereas, five days later, when their symptoms change or their white blood count goes through the ceiling, surgery for appendectomy, an appendectomy intervention, at that time may well be a lifesaving intervention, whereas five days before, that was an intervention that was not appropriate in the timing of that person's illness.

necessary, how would going through the process of social role transition help treat that person's gender dysphoria?

MR. ECKENRODE: Same objection.

THE WITNESS: So I'm still going to work from that as a hypothetical and that it's a reasonable hypothetical that I can answer.

So, in general, social transition in the hypothetical you just described tends to alleviate many of the symptom of irritability, depression, anxiety, the sense of just being wrong-bodied by starting to embrace in a public way who their authentic self is. So when somebody moves from an inauthentic life, moves in the direction of an authentic life, not surprisingly, many of these symptoms that are associated with gender dysphoria tend to improve.

There is a subset of people with gender dysphoria whose social transition is really all they need -- based on their reports, not based on my opinion -- and say, you know, "That's really all I need. I don't need to have hormones. I don't need to have surgery. I don't need to have electrolysis. I don't need to have voice therapy. Now that I've made this social transition and I am who I am in the

world, even if some people don't like that, I'm very comfortable with the transition I've made, and I feel much, much better about myself."

BY MS. GORDON:

Q. I'm going to take a step back to talk about -- you laid out the current triatic therapy as most people in the professional community understand it: social role transition, hormone therapy, surgical interventions.

For any individual person, the menu, so to speak, of the treatment options that would be required to effectively treat their gender dysphoria has to be determined on an individualized basis, correct?

MR. ECKENRODE: Just going to object to the overbroad form of the question and the premise.

But go ahead.

THE WITNESS: I would answer that, basically, for any complex psychiatric or medical disorder that has a number of different treatments that it is definitely done on an individualized basis, also taking into consideration the time course of the condition.

BY MS. GORDON:

Q. So speaking specifically about gender

dysphoria, determining what is medically necessary for any given person who has been diagnosed with gender dysphoria is necessarily an individualized and case-by-case process, correct?

A. Yes.

Q. So with respect specifically to the current triatic therapy framework of social transition, hormone therapy, and surgical interventions, which, if any, of those things and in what combinations might be medically necessary for any individual person diagnosed with gender dysphoria is necessarily an individualized and a case-by-case process, correct?

MR. ECKENRODE: Same objection.

THE WITNESS: I'm sorry. I'm not following what the question is.

BY MS. GORDON:

Q. Basically, you laid out the current understanding or the current conception of triatic therapy, and it has at least three things in it. Well, "triatic" means three, so that makes sense. And the three things you laid out are social transition, hormone therapy, and surgical interventions.

So what I'm trying to get at is: How do you

And then, psychological or psychiatric changes that may involve a whole variety of emotional changes that I found to be very individualized from person to person. Some people develop emotional stability, and some people develop emotional instability and lability, particularly early on in treatment, highly variable from person to person and not always predictable.

What I've seen more often than not is improvement in some of the cardinal features of gender dysphoria under the influence of appropriate doses of cross-sex hormones that are appropriately monitored to include a reduction in anxiety, a reduction in depression, reductions in suicidality, and in gender dysphoria as a symptom complex, in general.

In some patients, it resolves entirely. In some patients, it resolves only in part. And it's highly variable what -- what the outcomes of those -- of those treatments can be.

Q. Have you in any of the cases that you worked on involving transgender individuals -- scratch that. Let me be more specific.

Have you on any of the cases that you've worked on involving transgender women recommended

that.

If I -- if I refresh my memory looking at my list, I might -- I reserve the right to change that, but those are the two that come to mind. Usually, I have not been asked to render an opinion on that.

Q. Dr. Brown, psychotherapy can also be helpful for transgender people who have been diagnosed with gender dysphoria; is that true?

A. I think it's not only true, I think it's grossly underutilized. And -- and it's a general comment, not specific to this case.

In fact, in this case, the person is getting pretty amazing gender confirming mental health support, far more than I've seen in any prison that I've ever been in.

Q. Psychotherapy is not a substitute for social role transition when social role transition has been determined to be medically necessary; is that correct?

A. Their -- they often go hand -- they often go hand-in-hand or are done concurrently because social transition involves a lot of changes in a person's life, and they may or may not be prepared for how others are going to respond to them. So I think a

combination of the two for people who are willing to engage in that is probably optimal.

But your question was as a substitute for it.

So, if somebody -- if somebody has progressed and they -- and they need to have social transition as part of their care, psychotherapy about that without them engaging in it would not be a substitute.

Q. And for someone for whom hormone therapy has been determined to be medically necessary to treat their gender dysphoria, psychotherapy is not a substitute in that situation for hormone therapy, correct?

A. Correct.

MR. LUEPKE: I object that the question is vague and confusing.

Subject to that, you may answer.

THE WITNESS: I answered, "Correct".

BY MS. GORDON:

Q. I believe you already answered.

And for someone for whom gender confirmation surgery or sex reassignment surgery has been determined medically necessary to treat their diagnosis of gender dysphoria, psychotherapy is not

A. Okay. So, in that hypothetical situation, the person would likely have depression and anxiety and other symptoms associated with gender dysphoria. And if they were to be treated, which is not uncommonly the case, if they were to be treated with traditional antidepressants or traditional anxiety treatments and not treated with more gender dysphoria specific treatments like cross-sex hormones, those treatments are not likely to be effective.

Q. Okay. So turning now to someone who may have comorbid diagnoses, I think is the term you used, but also has a confirmed diagnosis of gender dysphoria, in your experience, are those people typically effectively treated solely with antidepressants and antianxiety medications?

A. So, in the scenario that you're describing now is actually the more common scenario where people with gender dysphoria do have other diagnoses. But treating their other diagnoses that may include depression or an anxiety disorder with appropriate systematic treatment, like traditional antidepressants or anxiolytic anxiety medications but without treating the gender dysphoria, the gender dysphoria is likely to continue unabated.

diagnosis of gender identity disorder that is undiagnosed and untreated with numerous examples of such behaviors occurring in correctional facilities in multiple countries.

And, again, this was based on your experience and your observations, correct?

A. Yes, and on the literature, as well.

Q. Okay. And so, I'm not going to go through these, but starting on Page 33 through 35, you actually have the case summarize of four individuals laid out in some detail. And, based on my review, you talk about the fact that several, if not all, of these individuals and histories of drug abuse and alcohol dependence. Some of them had histories of child abuse, histories of other mental health diagnoses.

So my question is: Did these histories of drug and alcohol dependence, child abuse, histories of being diagnosed with various other mental health diagnoses in the past, did these histories affect your opinion about these individuals' need for gender dysphoria treatment?

A. I think the point of the article in describing the cases in the detail that they're described -- by the way, I have double this number

of cases now who have engaged in surgical self-treatment through autocastration -- is to point out, like with other people with gender dysphoria who may have not engaged in surgical self-treatment, there are a variety of mental health psychiatric diagnoses that may be present.

But in the absence of some very specific ones, like active psychosis with or without being intoxicated from some substance, the likelihood that any of those other conditions would be responsible for a calculated surgical self-treatment is extremely low to virtually nonexistent. That it's the untreated gender dysphoria, particularly in an incarceration environment, because this is an extremely rare behavior in any outside prison setting.

Q. So looking at Page 35 specifically of this exhibit, the last sentence says that: The case reports described above indicate that surgical self-treatment is generally not spontaneous and is proceeded by substantial efforts both written -- sorry -- both verbal and written at obtaining psychiatric and medical care for gender dysphoria.

Why is that significant?

A. The significance of that statement, one, is

DOC ID OFFENDER
00527993 JAMES W HICKLIN
******* ASSESSMENT CONTINUATION FROM PREVIOUS PAGE *******
a mental health score of 2. 20150317 145049
PLAN
P= Follow-up will be conducted as mental health services 20150317 145049
are requested per the MSR 20150317 145049

TECH./MH CAK000EMMH CATHERINE A KLEIN

**MSR DATE TIME COMPLAINT **
03/18/2015 10:38 A MH - REFERRAL TO PSYCHIATRIST

TECH/MH ENCOUNTER APPOINTMENT DATE 03/18/2015 TIME 12:00 P SHOW UP Y PCC
SUBJECTIVE
S= Refer to non-contact note this date. 20150326 103953
OBJECTIVE
O= Refer to non-contact note this date. 20150326 103953
ASSESSMENT
A= Refer to non-contact note this date. 20150326 103953
PLAN
P= Refer to non-contact note this date. 20150326 103954

TECH./MH CAK000EMMH CATHERINE A KLEIN

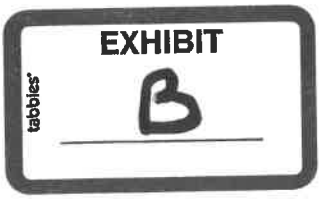
**MSR DATE TIME COMPLAINT **
03/18/2015 01:05 P MH - NON-CONTACT NOTE

TECH/MH ENCOUNTER APPOINTMENT DATE 03/18/2015 TIME 11:30 A SHOW UP Y PCC
SUBJECTIVE
S= This writer presented Offender's request to be seen by 20150320 123801
Psychiatry for assessment of possible diagnosis to the 20150320 123801
Treatment Team on this date at approximately 11:30 AM. The 20150320 123801
Treatment Team agreed to refer Offender to Psychiatrist for 20150320 123801
assessment. 20150320 123801
OBJECTIVE
O= Documentation. 20150320 123801
ASSESSMENT
A= None per non-contact. 20150320 123801
PLAN
P= Offender to be scheduled and seen by Psychiatrist per 20150320 123801
Offender's request. 20150320 123801

TECH./MH CAK000EMMH CATHERINE A KLEIN

**MSR DATE TIME COMPLAINT **
03/18/2015 03:23 P PSYCHIATRIST - INITIAL EVALUATION

DOCTOR ENCOUNTER APPOINTMENT DATE 03/23/2015 TIME 12:45 P SHOW UP Y PCC
SUBJECTIVE
S: Mr. Hicklin is a 36yo CM who does not yet carry a mental 20150324 151027
health diagnosis within the DOC system. He is seen today for 20150324 151028
evaluation. Mr. Hicklin states that he identifies as female, 20150324 151028



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***** SUBJECTIVE CONTINUATION FROM PREVIOUS PAGE *****

and has done so since the age of 8. As a child, he reports	20150324	151028
feeling greater comfort in the play styles and activities of	20150324	151028
his sisters and female classmates (dress-up, dolls), and a	20150324	151028
discomfort with contact sports such as football and hockey,	20150324	151028
which he was expected to pursue. He reports always feeling	20150324	151028
that his male anatomy was "wrong", and did not understand	20150324	151028
why he did not have female anatomy if he felt "female". In	20150324	151028
the romantic relationships he maintained as an adolescent,	20150324	151028
he states he always fit into the role as the (stereotypical)	20150324	151028
female. From a young age, he preferred the typically female	20150324	151028
attire, as it felt more appropriate. He endorses preferring	20150324	151028
the company of females as confidants and supporters	20150324	151028
throughout his childhood and adulthood. He admits that he	20150324	151028
was unaware as a child and adolescent what a	20150324	151028
"transgendered"	20150324	151028
person was, or that they had the option of transitioning, or	20150324	151028
living a life of the sex which they felt they were. He has	20150324	151028
never felt that he "embodied "the male gender in any way,	20150324	151028
and while not disgusted with his male anatomy, repeats that	20150324	151028
it always felt "incorrect" or "wrong". And in this way,	20150324	151028
never has found it possible to follow the male gender role.	20150324	151028
He does not express any interest in gaining benefit from	20150324	151028
cultural advantages of the female gender. Coming to terms	20150324	151028
with "who I really am" has caused him serious impairment of	20150324	151028
function in his daily life, most prominently within the	20150324	151028
prison system, and due to the fact that current cultural	20150324	151028
beliefs about gender roles tend to be more traditional,	20150324	151028
especially in the small town in which he was raised. He has	20150324	151028
been the target of several violent physical /sexual	20150324	151028
assaults, which he believes has been due to the fact that	20150324	151028
transgender culture is little understood and not generally	20150324	151028
accepted. He has been incarcerated since the age of 16, due	20150324	151028
to what he describes as a "drug deal gone bad". He admits to	20150324	151028
drug use as an adolescent as a means of easing the	20150324	151028
psychological pain he was experiencing. Pt is very involved	20150324	151028
in the legal aspects of his case, as well as well-versed in	20150324	151028
the legal rights of transgendered individuals. He believes	20150324	151028
that he may be released some time within this year or next.	20150324	151028
His end goal is to physically transition to the female	20150324	151028
gender, including cross-sex hormone treatment in the near	20150324	151028
future, as well as gender-reassignment surgery. Feels safe	20150324	151028
in his environment at this time. Denies any current feelings	20150324	151028
of depression or anxiety, but endorses having had episodes	20150324	151028
of depression in the past. Denies SI/HI. Denies AVH, ideas	20150324	151028
of reference, feelings of paranoia. No apparent delusions.	20150324	151028
No signs or symptoms consistent with a manic episode at this	20150324	151028
time or in the past. Denies feelings of anxiety that he is	20150324	151028
unable to manage. Pt states that the use of masculine or	20150324	151028
feminine pronouns are not of concern to him at this time,	20150324	151028
but does report that he is initiating legal name change. He	20150324	151028

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******* SUBJECTIVE CONTINUATION FROM PREVIOUS PAGE *******
understands, as well as appreciates, the significance of his 20150324 151028
past and current feelings concerning his gender and his 20150324 151028
gender role, as well as the physical and psychological 20150324 151028
issues of the future. 20150324 151028
OBJECTIVE
O: 20150324 151028
General: Good hygiene and grooming. Hair worn in the 20150324 151028
traditionally female style. Cooperative, friendly. 20150324 151028
Speech: Nl r/v/t 20150324 151028
Mood: "I'm doing well" 20150324 151028
Affect: Euthymic, congruent with mood. 20150324 151028
TP: GD, logical, appropriate. 20150324 151028
TC: Denies SI/HI. No apparent delusions. 20150324 151028
Perception: Denies VAH 20150324 151028
Judgment/Insight: Good 20150324 151028
ASSESSMENT
A: Mr. (Ms.) Hicklin is a 36yo biologically (phenotypically) 20150324 151028
male Caucasion who carries a psychiatric diagnosis of Gender 20150324 151028
Dysphoria. 20150324 151028
PLAN
P:
1. At this time, will make a referral for pt to be seen by endocrinology for evaluation of cross-sex hormone txt. Currently, hormone therapy (estrogen, testosterone blockers) is the accepted treatment for individuals with Gender Dysphoria diagnoses.
2. Pt was encouraged to cont processing psychological issues related to his diagnosis with his counselor. He reports comfort reaching out to the MH team if feeling unsafe in his current environment.
3. Will f/u in 4-12 weeks, or sooner if needed, to assess progress.
Addendum: Please note, that after researching DOC protocols, it was found that endocrinology consult is NOT the appropriate next step for psychiatry in the txt of Gender Dysphoria. Endocrinology consult was not requested.

DOCTOR MLT000EMMH MEREDITH L THROOP

MSR DATE TIME COMPLAINT *
05/27/2015 02:50 P MH - NON-CONTACT NOTE

TECH/MH ENCOUNTER APPOINTMENT DATE 05/27/2015 TIME 11:30 A SHOW UP Y PCC
SUBJECTIVE
S= Per request of Offender, Offender was discussed with the 20150527 145347
Treatment Team on this date for admission into the Chronic 20150527 145347
Care Clinic for mental health symptoms related to diagnosis 20150527 145347
of gender dysphoria (PTSD and anxiety). The Treatment Team 20150527 145347
agreed to this at approximately 11:45 AM on this date. 20150527 145347
OBJECTIVE

AFS923C COMPLETE MENTAL HEALTH HISTORY PAGE: 95

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***** OBJECTIVE CONTINUATION FROM PREVIOUS PAGE *****

Speech had normal rate, tone, and volume.	20160115	164700
Insight was fair.	20160115	164700
Judgment generally intact with high expectations of the	20160115	164700
outcome of his legal issues.	20160115	164700
Attitude seemed mostly optimistic.	20160115	164700
Demeanor was coopertive.	20160115	164700
ASSESSMENT		
A: The offender is an MH3. (Gender Dysphoria with	20160115	164700
associated panic secondary to current body characteristics	20160115	164700
(per Dr. Stephens 12-16-15). Current mild to moderate	20160115	164700
anxiety signs evident due to his current situation with	20160115	164700
legal matters. No significant risk of harm to self oro	20160115	164700
thers evident at this time. The offender seems to be very	20160115	164700
self aware and coping adequately at this time.	20160115	164700
PLAN		
P: The offender will be seen per chronic care clinic	20160115	164700
protocol. He may submit an HSR to access Mental Health if	20160115	164700
needed.	20160115	164700

TECH./MH KRF01#OZMH KIMBERLY R FOSTER

MSR DATE TIME COMPLAINT ******** 02/02/2016 02:48 P PSYCHIATRIST - CHRONIC CARE/FOLLOW-UP**

DOCTOR ENCOUNTER APPOINTMENT DATE 02/03/2016 TIME 02:15 P SHOW UP Y PCC

SUBJECTIVE		
Patient seen for 6 week follow up of gender dysphoria with	20160203	171139
associated panic secondary to current body characteristics.	20160203	171139
He (will use male pronone per protocol, however please note	20160203	171139
patient identifies as female, name is legally changed to	20160203	171139
Jessica) started propranolol 20mg po bid last visit to aid	20160203	171139
in body anxiety symptoms. This was stopped by provider 5	20160203	171139
days after start for complaint of migraine, upon talking	20160203	171139
with patient today he states that he did have a headache	20160203	171139
but it subsided quickly, his main problem with the	20160203	171139
medication was that it did stop his restlessness and with	20160203	171139
that he had more time to think about his situation and he	20160203	171139
became hopeless, he felt crippled by this and overall	20160203	171139
implies that at this point in his transition he would	20160203	171139
rather have restlessness than time to think about his	20160203	171139
current situation. Discusses frustration over lack of	20160203	171139
treatment with hormone therapy, discusses wish that his	20160203	171139
previous therapist,who had to leave for medical reasons,	20160203	171139
was still here. Discusses continued agitation surrounding	20160203	171139
facial hair, how he used a hair removal cream but it either	20160203	171139
"does nothing or burns my face." He does state it is	20160203	171139
helpful in hair removal on other parts of his body which he	20160203	171139
appreciates. Discusses frustration over recent write up	20160203	171139
for appearing more feminine per his report. He brings in	20160203	171139
write up which is written for 1945 1/31/16 and states that	20160203	171139

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***** SUBJECTIVE CONTINUATION FROM PREVIOUS PAGE *****

he "was wearing a personal long sleeve gray shirt that the	20160203	171139
neckline was stretched so the shirt would hang off his	20160203	171139
shoulder." Patient feels that he was being singled out for	20160203	171139
looking more feminine and asks if I suggested he be able to	20160203	171139
appear as a woman. I discuss that my suggestion based on	20160203	171139
standards of care set by the 2012 APA taskforce on GID is	20160203	171139
that he be allowed to live as a woman for a period of time	20160203	171139
prior to hormone treatment, it must be noted that this	20160203	171139
would be within the confines of DOC policy and that if	20160203	171139
policy for female DOC offenders may also not allow for his	20160203	171139
form of dress. Patient expresses understanding and	20160203	171139
agreement. He continues to have agitation over gender,	20160203	171139
increases as hair grows on his face. Noted to scratch at	20160203	171139
his legs at times due to agitation surrounding his more	20160203	171139
masucline features. Does not feel he will harm himself	20160203	171139
currently (worry about self mutilation to testicals last	20160203	171139
visit) as he is making progress toward his goal for hormone	20160203	171139
thearpy. He also found out that a recent court case	20160203	171139
allowed for a re-evaluation of his current sentence of life	20160203	171139
without parole. Patient is happy about this and is hopeful	20160203	171139
he may be able to go home someday, hopefull when that day	20160203	171139
comes he will go home as a woman. Discuss possible risks	20160203	171139
of transitioning in prison system, relationships with	20160203	171139
others will be affected, how weekly therapy during this	20160203	171139
time would be helpful. Patient agrees, noted he had	20160203	171139
increased therapy during initial stage of living as a	20160203	171139
female (increased QMHP notes in 2015) and it did help. He	20160203	171139
feels that the people at work will accept him with hormonal	20160203	171139
changes as they have accepted his more feminine appearance	20160203	171139
and preference for female name and pronoun. He feels that	20160203	171139
his cellie will be accepting overall but if a problem	20160203	171139
arises he feels comfortable discussing with custody and has	20160203	171139
an alternative cellie that he knows will be accepting per	20160203	171139
inmates report. Noted to have thought out plans	20160203	171139
surrounding change and frustration over concern that his	20160203	171139
risk of sexual assault may increase given recent report he	20160203	171139
read in Black and Pink and that I was able to find that	20160203	171139
lists:	20160203	171139
"The federal Bureau of Justice Statistics (BJS) this week	20160203	171139
reported national statistics for the first time on sexual	20160203	171139
abuse of transgender people in US prisons and jails. BJS	20160203	171139
estimates there were over 3,200 transgender people in US	20160203	171139
prisons nationwide in 2011-12, of whom 39.9% reported sexual	20160203	171139
assault or abuse in the last year by either another prisoner	20160203	171139
or staff. BJS also estimated there were over 1,700	20160203	171139
transgender people in US jails in 2011-12, of whom 26.8%	20160203	171139
reported sexual assault or abuse in the last year.	20160203	171139
Transgender prisoners were victimized at rates nearly ten	20160203	171139
times those for prisoners in general (4% in prisons and 3.2%	20160203	171139
in jails)." He describes victim blaming and that the	20160203	171139

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***** SUBJECTIVE CONTINUATION FROM PREVIOUS PAGE *****

"teenage" phase people have at the start of their	20160203	171139
transition does lend itself to more risky behavior which he	20160203	171139
feels may place that population at increased risk. He	20160203	171139
states that, "I am a grown woman now," and indicates that	20160203	171139
his base character would protect him from this, redirection	20160203	171139
on how therapy would be helpful as well, patient voices	20160203	171139
agreement. He denies si/hi/v/v, no noted general anxiety,	20160203	171139
depression, psychosis or mania. Body anxiety and obsessive	20160203	171139
body hair removal directly related to gender dysphoria.	20160203	171139
OBJECTIVE		
O: (MH02) MENTAL HEALTH: FOLLOW UP FOR PSYCHIATRIC CLINIC VI	20160203	171139
SYMPTOM CHECKLIST:	20160203	171139
y Y/N APPETITE ADEQUATE:	20160203	171139
y Y/N SLEEP ADEQUATE:	20160203	171139
n Y/N ENERGY LEVEL APPROPRIATE FOR CLIENT: restless body	20160203	171139
anxiety	20160203	171139
n Y/N MOOD APPROPRIATE AND STABLE: restless, focused on	20160203	171139
dislike of masculine attributes	20160203	171139
y Y/N ANXIETY PRESENT: CONTROLLED : _ Y/N	20160203	171139
y Y/N ABLE TO FEEL PLEASURE:	20160203	171139
y Y/N COGNITIVE ABILITY INTACT:	20160203	171139
y Y/N ABLE TO CONTROL/DIRECT THOUGHTS:	20160203	171139
y Y/N REALITY TESTING INTACT:	20160203	171139
n Y/N HALUCINATIONS ELICITED:	20160203	171139
n Y/N DELUSIONAL STATEMENTS NOTED:	20160203	171139
INSIGHT/JUDGEMENT: _fair	20160203	171139
n Y/N SUICIDAL/HOMICIDAL/VIOLENT IDEATIONS PRESENT: _future	20160203	171139
oriented, connected to others, no current concern for self	20160203	171139
injurious behavior as he feels he is acting in a positive	20160203	171139
direction	20160203	171139
***IF PRESENT, ABLE TO CONTROL IDEATIONS:	20160203	171139
n Y/N STATES SATISFACTION/COMFORT WITH CURRENT MEDICATIONS:	20160203	171139
S/E NOTED/STATED: _increased time to consider situation	20160203	171139
with decreased body anxiety -- patient states this was too	20160203	171139
uncomfortable currently	20160203	171139
naY/N STATES COMPLIANCE WITH MEDICATIONS:	20160203	171139
CURRENT APPLICABLE LAB VALUES:	20160203	171139
naY/N CURRENT MEDICATIONS THERAPEUTIC:	20160203	171139
n Y/N MEDICATION CHANGES INDICATED:	20160203	171139
O:::MH02:: End of: MENTAL HEALTH: FOLLOW UP FOR PSYCHIATRIC	20160203	171139
ASSESSMENT		
Gender dysphoria with panic symptoms and obsessive hair	20160203	171139
removal related to anxiety surrounding masculine	20160203	171139
attributes.	20160203	171139
PLAN		
Propranolol was discontinued -- would consider in future if restless anxiety continues and patient engaged in active weekly therapy to evaluate hopelessness that his noted with less anxiety.		

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***** PLAN CONTINUATION FROM PREVIOUS PAGE *****
F/U q 6 weeks for supportive psychotherapy

Suggestions made to gender dysphoria committee as noted in previous note in accordance to standards set by APA task force on gender identity disorder in 2012:
psychotherapy ongoing, 3-6 months living as a female with access to products that females in DOC have access to for self care, then referral to medicine for hormone therapy.
Suggest weekly psychotherapy if possible given severity of illness.

DOCTOR EMS000EMMH EVELYNN M STEPHENS

MSR DATE TIME COMPLAINT **********
03/14/2016 08:14 A PSYCHIATRIST - CHRONIC CARE/FOLLOW-UP

DOCTOR ENCOUNTER APPOINTMENT DATE 03/16/2016 TIME 02:15 P SHOW UP Y PCC
SUBJECTIVE

Patient seen for follow up of gender dysphoria, currently	20160316 165435
on no medication, shows improvement with 2x monthly	20160316 165435
psychotherapy sessions, have been supportive in nature.	20160316 165435
Today patient states that he (will use male pronoun per DOC	20160316 165435
protocol, however please note this patient identifies as	20160316 165435
female - name Jessica) has recently found out of a blanket	20160316 165435
decision that would make him eligible for parole at 4.5	20160316 165435
years as he would then have a total of 25 years in the	20160316 165435
system. States this still needs to be individualized and	20160316 165435
he is hopeful that less time may be required but feels that	20160316 165435
it is a step in the right direction and he is now seeing	20160316 165435
that he is very likely to be able to get treatment at some	20160316 165435
point in the future which helps him greatly. Still with	20160316 165435
anxiety surrounding worry of hair loss due to maternal	20160316 165435
family members with 'male pattern baldness.' He describes	20160316 165435
this as his only way to express his femininity outwardly	20160316 165435
and concern over the loss is still bothersome, however now	20160316 165435
that he can see a future not incarcerated he is able to	20160316 165435
cope with less restlessness or desire for self harm. If he	20160316 165435
has desire to remove testicles he is able to quickly	20160316 165435
redirect to desire to have eventual surgery, not wanting to	20160316 165435
disfigure himself to ensure able to proceed with this, per	20160316 165435
past discussions, no noted intrusive thoughts today.	20160316 165435
Also notes increased support from LGBT group in chicago,	20160316 165435
feels this will help him overall. Discussion shifts to	20160316 165435
sense of self as a member of his family which he describes	20160316 165435
in a manner consistent with a constant need to please a	20160316 165435
volitile family with a perceived lack of concern or	20160316 165435
understanding of gender dysphoria or his identity in	20160316 165435
general.	20160316 165435
Patient notes relationships are of concern as they have	20160316 165435
in the past affected his decisions. Trying to decide now	20160316 165435

the absence of hormone treatment?

A. Per what the patient is indicating, that would be desirable, but that is right now at the discretion of the department.

Q. Doesn't Corizon think, though, that in the absence of hormone treatment -- especially in the absence of hormone treatment, canteen items could be beneficial for Ms. Hicklin?

A. There are other things that we believe would be more beneficial.

Q. I understand. And one of those things is hormone treatment; correct?

A. Correct.

Q. But in the absence of hormone treatment, because I understand Corizon has recommended hormone treatment, and MDOC has thus far refused.

A. Correct.

Q. But in the absence of hormone treatment, given the situation as it exists, doesn't Corizon believe that access to canteen items could be helpful to Ms. Hicklin?

A. Per what Ms. Hicklin indicates, yes, we believe they would be desirable. We also believe in the absence of the HRT, that psychotropic medication for the treatment -- the direct treatment of the

plaintiff's request for hormone therapy and to purchase a hair removal device. The committee found that a referral to the medical department for consideration of hormone therapy was medically necessary for the treatment of plaintiff's gender dysphoria. The second meeting occurred January 26, 2017, at which the committee further discussed plaintiff's request for hormone therapy. After said discussion, the committee gave the opinion that cross-gender hormone treatment is needed as part of the offender's treatment. They believe that she is experiencing stress due to her diagnosis. The committee also discussed this offender's request for hair removal, which the committee found not to be medically necessary at that time. This committee recommended continued psychotherapy and psychiatric services."

So, first, I want to just get you to confirm that -- or just let me know whether there are any other meetings, other than the two listed here, during which decisions were made or discussion was had by the GDCSG related to Ms. Hicklin's gender dysphoria treatment.

A. No.

Q. And where in the context of the August 31,

2016, meeting this response says that the committee found that a referral to the medical department for consideration of hormone therapy was medically necessary for the treatment of plaintiff's gender dysphoria. Do you see that?

A. I do.

Q. How did this determination of medical necessity come about?

A. Through review of her case, primarily, the recommendations coming from Dr. Stephens.

Q. And at this January 26th, 2017, meeting, the committee again reached the conclusion that cross-gender hormone treatment was medically necessary?

A. Yes.

Q. And the next sentence says -- to be clear, I'm -- at the top of page 5, the second full sentence. It says: "They believe that she is experiencing stress due to her diagnosis."

Was it the GDCSG's view that Ms. Hicklin was experiencing stress due to her diagnosis and the fact that she was not receiving hormone treatment?

A. It was due to her diagnosis.

Q. Was it the committee's view that receiving hormone treatment could help alleviate the stress?

A. Yes.

Q. And the next sentence says: "The committee also discussed this offender's request for a hair removal device, which the committee found not to be medically necessary at that time."

Why did the committee determine that a hair removal device was not medically necessary at that time?

A. At the time and still today, we would like for Ms. Hicklin to receive hormone replacement therapy. And as I stated, we will continue to assess all of the other needs, but we really would like to begin that treatment for her and see where things go.

Q. I think you indicated that you're familiar with the WPATH standards of care.

A. Yes.

Q. And are you aware of the fact that according to those WPATH Standards of Care, for male to female transgender individuals, hormone treatment is not likely to result in complete removal of unwanted hair?

A. Generally, I have that understanding.

Q. So you understand that even if Ms. Hicklin receives hormone treatment, in order for her to have

between Dr. Throop and Ms. Hicklin?

A. Correct.

Q. What was discussed at the meeting that the three of you had in October of 2015?

A. I don't remember. It's documented.

Q. Do you recall if you discussed Jessica Hicklin's gender dysphoria diagnosis?

A. I don't recall the specifics of that meeting, so I cannot tell you. But it is documented in the system.

Q. How often do you see Jessica Hicklin?

A. Every four weeks.

Q. How long is each of these meetings?

A. Anywhere from 45 minutes to an hour.

Q. What does a typical visit look like between you and Ms. Hicklin?

A. It is supportive and insight-oriented therapy.

Q. Could you explain that?

A. So instead of just checking in on medications, we -- I treat her therapeutically as well so she gets more time. She, even when she was at a lower level, was seen more frequently. She requires supportive therapy to start the session to get her more ready to work on insight into her

of 2018. Do you know if Ms. Hicklin has received hormone therapy to date?

A. She has not.

Q. Do you know why that is?

A. It has not been approved.

Q. And who is -- before whom is it pending for approval?

A. From what Dr. Atterberry has told me, it is pending approval from DOC.

Q. So over the last two years and some, since you've been treating Ms. Hicklin, since you started in December of 2015 and now we're in January of 2018, during which time hormone therapy has not been approved for her, has the fact that in these two years hormone therapy has not been approved or provided for her, has that affected your ability to treat her gender dysphoria?

A. Yes.

Q. How has it?

A. She has not received hormone therapy, which is a treatment for gender dysphoria that I have suggested and believe would be helpful.

Q. Has it affected your -- has the fact that in these two years and some she has not received hormone therapy, has it affected your

approach to treating her gender dysphoria?

A. Can you clarify that a little bit?

Q. Okay. So you identified hormone therapy among the things that would be likely to decrease her distress from gender dysphoria over two years ago. She still has not received it to date, so I'm trying to understand how those facts have affected your approach to trying to treat her gender dysphoria.

A. Yes. So I -- I continue to suggest and recommend that this be the treatment. However, I have been informed by the people who are ahead of me that we are pending approval so that it is not something that is going to happen immediately, so we increased her therapy.

We increased therapy not only with me but also with her QMHP. I have discussed and offered multiple different options for treating the comorbidity, most notably anxiety symptoms which have shifted and changed through the years of treating her.

Her mental health score has been increased from an MH3 to an MH4, meaning before I was meeting with her monthly for an hour, even though she was only required to be met with for 15