UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

CODY FLACK and SARA ANN MAKENZIE, Plaintiffs, v. WISCONSIN DEPARTMENT OF HEALTH SERVICES and LINDA SEEMEYER, in her official capacity as Secretary of the Wisconsin Department of Health Services, Defendants.	Case No. 3:18-cv-00309 Judge William Conley

SUPPLEMENTAL EXPERT WITNESS DECLARATION
OF STEPHANIE L. BUDGE, PhD, LP

I, Stephanie L. Budge, PhD, LP declare as follows:

1. I have been retained by counsel for the Plaintiffs as an expert in the above-captioned lawsuit. I submitted an expert witness declaration [Dkt. No. 24] ("Budge Dec.") in connection with Plaintiffs' motion for a preliminary injunction in this case. I submit this declaration to supplement my original declaration and to respond to points raised in the declaration of Chester W. Schmidt, Jr., M.D., which was submitted by Defendants in connection with their response to Plaintiffs' preliminary injunction motion. My background, qualifications, and compensation for my services in this case, and the basis for my opinions in this case are described in my original declaration and in my C.V. attached as an exhibit to that declaration. The additional sources I have consulted in preparing this supplemental declaration are identified below. I have personal knowledge of the matters stated in this supplemental declaration.

2. First, I would like to respond to Dr. Schmidt's statement that neither Mr. Flack nor Ms. Makenzie has received "a current mental status examination." This is incorrect.

3. As a preliminary matter, a mental status exam is comprised of asking questions or observing the patient's major systems of psychiatric functioning (including their level of insight, cognitive functioning, and appearance) (Groth-Marnat & Wright, 2016). Consistent with professional practice in the field of psychology, a mental status exam is a part of every mental health evaluation, including independent psychological assessments like the ones I conducted of Mr. Flack and Ms. Makenzie in April and May 2018. It should be noted that mental status exams are often brief during a psychological evaluation, because "many areas reviewed by the mental status exam are already covered during the assessment interview and through interpretation of psychological test results." (p. 94, Groth-Marnat & Wright, 2016).

4. I can confirm that I conducted a mental status exam as part of my psychological evaluation of both Cody Flack in May 2018 and Sara Ann Makenzie in April 2018. It is standard practice to conduct a brief mental status exam as part of any psychological evaluation to determine the patient's ability to engage in the evaluation. Based on each of the independent psychological evaluations I conducted, I concluded that Mr. Flack and Ms. Makenzie were oriented to person, time, place, and situation, and were able to provide consent and understand each of the processes within the psychological evaluation.

5. Dr. Schmidt indicates that he does not see evidence of this exam being conducted in the notes from Flack and Makenzie's mental health providers. As I describe above, the purpose of a mental status exam is to ensure that a patient's psychiatric functioning has been assessed. When ongoing care is provided to a patient (e.g., weekly therapy), the mental health provider is constantly assessing mental status throughout the therapy session and will be able to

note any changes in mental status from week to week. These changes in mental status would be charted by the provider indicating if insight, cognitive functioning, hygiene, etc. have changed and are not usually flagged by indicating that a formal mental status exam has been conducted. Accordingly, Dr. Schmidt's inability to find a formal mental status examination report for Mr. Flack or Ms. Makenzie in their medical records is not surprising and in no way suggests that their providers have not assessed mental status during the weekly therapy sessions each receives.

6. Indeed, Mr. Flack's records indicate that his treating therapist, Daniel Bergman, has routinely assessed his mental status during Mr. Flack's weekly therapy sessions. I independently reviewed Mr. Flack's therapy notes from Mr. Bergman. It is clear from those therapy notes that Mr. Flack's mental status has been assessed by Mr. Bergman in their sessions. For example, Mr. Bergman refers Mr. Flack's mental status by describing the following aspects in the notes: expressive language, rate of speech, quality of speech, affect and mood, perception, memory, attention span, concentration, appearance, and Mr. Flack's ability to process and work through emotional content. All of these are defined as aspects of mental status (see Groth-Marnat & Wright, 2016).

7. Second, Dr. Schmidt improperly discounts or disregards the significant harm that both Mr. Flack and Ms. Makenzie have suffered, and are likely to continue to suffer, from being denied access to medically necessary care. Instead, Dr. Schmidt focuses narrowly on whether Mr. Flack and Ms. Makenzie are currently suicidal or about to engage in self-harm, rather than on the current and continuing negative mental health impacts each is suffering. In my professional opinion, denying Mr. Flack and Ms. Makenzie medically necessary care places them at high risk of suicidality or self-harm in the foreseeable future. As well, in my professional opinion, Dr. Schmidt's conclusion that there is no medical basis for determining the severity of

Mr. Flack's or Ms. Makenzie's indications of future mental health harms, which may include self-harm and suicidality, has no basis and is incorrect.

8. As I documented in my original declaration, I completed psychological evaluations with Mr. Flack and Ms. Makenzie. Mr. Flack provided an extensive history of suicidal ideation, suicide attempts, and self-harm when we discussed his mental health history. (Budge Dec. ¶¶ 54-55). Ms. Makenzie also provided accounts of her history of suicidality. (Budge Dec. ¶ 49). Both Mr. Flack and Ms. Makenzie reported in the evaluation that they anticipated experiencing suicidality if denied gender confirmation surgery and they both indicated the possibility of future self-harm. (Budge Dec. ¶¶ 48-49, 65-67). Both Mr. Flack's and Ms. Makenzie's mental health providers independently expressed concerns to me about their patients' suicidality and self-harm, should they be denied surgery.

9. Dr. Schmidt states erroneously that Mr. Flack has "no prior evidence of self-harm," which is in direct conflict with Mr. Flack's self-reports of prior self-harm discussed in paragraph 55 of my original declaration (including multiple suicide attempts and other self-injurious behavior). Also, Mr. Flack's eating disorder (discussed in paragraph 63 of my original declaration) is itself a form of self-harm, given that he has restricted his eating in order to decrease the size of his chest, despite the knowledge of the health harms it inflicted on him.

10. At the time of my psychological evaluation with Ms. Makenzie in April, she had noted experiencing psychological distress that resulted in her meeting criteria for several psychological disorders. (Budge Dec. ¶ 45). She had also reported experiencing more stability due to having hope that she would be able to have gender confirmation surgery in the future, in part due to her hope for a good outcome in this lawsuit. (Budge Dec. ¶ 49). This is consistent with the conclusions of Ms. Makenzie's primary mental health provider, Jessica Bellard, LCSW,

who has indicated that that Ms. Makenzie continues to experience distress (including anxiety, depression, anger, and distress directly caused by her gender dysphoria), and that her symptoms have stabilized insofar as she was ready for gender confirmation surgery at the time the letter was written (see June 14, 2018 Letter from J. Bellard to K. Gast). Psychological stability does not indicate that one does not currently experience significant distress, nor does it indicate that one will not experience continuing or worsening distress.

11. Mr. Flack's and Ms. Makenzie's self-reports of suicidality and self-harm should be taken seriously. First, there is evidence of these factors in their history to corroborate this risk. Previous suicidality is a risk factor for future suicide attempts and completion of suicide (e.g., Bostwick, Pabbati, Geske, & McKean, 2016). As well, a recent meta-analysis indicates that self-injurious thoughts and behaviors are risk factors for future suicidal ideation, attempts, and death from suicide (Ribeiro et al., 2016).

12. There is previous evidence of this deterioration for both Mr. Flack and Ms. Makenzie when they have received information in the past regarding denial of treatments for gender dysphoria. (Budge Dec. ¶¶ 49, 66). Stroumsa (2014) supports the definition of harm here, indicating that denying access to medically necessary treatments for gender dysphoria "takes an enormous toll on [transgender individuals'] health through direct harm" (p. e36).

13. Both Mr. Flack's and Ms. Makenzie's mental health providers indicated their concerns about the deterioration of their patients' mental health, should they be denied gender confirming surgeries. It is also my clinical opinion that they would both experience significant and worsening distress as long as they remain unable to access these surgeries.

14. It is my clinical opinion that Mr. Flack and Ms. Makenzie will both experience deterioration in their mental health if they are unable to obtain the surgeries they need. This

deterioration in mental health is—by definition—significant harm that is a direct result of not being able to access medically necessary care. At the moment, both Mr. Flack and Ms. Makenzie have some hope that they may be able to access medically necessary treatment for their gender dysphoria, which may be temporarily mitigating their respective symptoms of depression, anxiety, active thoughts of self-harm, or active suicidality. However, it is my professional opinion that that if this hopefulness was replaced with information that they would be denied care permanently, or if their legal claims take an extended period of time to be resolved, they are both likely to experience immediate and significant distress and further exacerbation of these symptoms.

References:

Bostwick, J. M., Pabbati, C., Geske, J. R., & McKean, A. J. (2016). Suicide attempt as a risk factor for completed suicide: even more lethal than we knew. *American journal of psychiatry*, *173*(11), 1094-1100.

Groth-Marnat, G. & Wright, J. (2016). *Handbook of psychological assessment* (6th Edition). Hoboken, New Jersey: John Wiley and Sons.

Ribeiro, J. D., Franklin, J. C., Fox, K. R., Bentley, K. H., Kleiman, E. M., Chang, B. P., & Nock, M. K. (2016). Self-injurious thoughts and behaviors as risk factors for future suicide ideation, attempts, and death: a meta-analysis of longitudinal studies. *Psychological medicine*, *46*(2), 225-236.

Stroumsa, D. (2014). The state of transgender health care: policy, law, and medical frameworks. *American journal of public health*, *104*(3), e31-e38.

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

Dated: 7/16/2018

Stephanie Budge

Stephanie L. Budge, PhD, LP