Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO,

Plaintiff,

v.

IDAHO DEPARTMENT OF CORRECTION, *et al.*,

Defendants.

Case No. 1:17-cv-00151-BLW

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

INTRODUCTION

For more than forty years, the Supreme Court has consistently held that consciously ignoring a prisoner's serious medical needs amounts to cruel and unusual punishment in violation of the Eighth Amendment. *See Estelle v. Gamble*, 429 U.S. 97, 103 (1976). After all, inmates have no choice but to rely on prison authorities to treat their medical needs, and "if the authorities fail to do so, those needs will not be met." *Id.* Prison authorities thus treat inmates with all manner of routine medical conditions – broken bones are set; diabetic inmates receive insulin; inmates with cancer receive chemotherapy; and so on. This constitutional duty also applies to far less routine, and even controversial, procedures – if necessary to address a serious medical need. And so it is here. Plaintiff Adree Edmo alleges that prison authorities violated her Eighth Amendment rights by refusing to provide her with gender confirmation surgery. For the

reasons explained below, the Court agrees and will order defendants to provide her with this procedure, a surgery which is considered medically necessary under generally accepted standards of care.

The Court will explain its reasoning below but will first pause to place this decision in a broader context. The Rule of Law, which is the bedrock of our legal system, promises that all individuals will be afforded the full protection of our legal system and the rights guaranteed by our Constitution. This is so whether the individual seeking that protection is black, white, male, female, gay, straight, or, as in this case, transgender. This decision requires the Court to confront the full breadth and meaning of that promise.

Adree Edmo is a male-to-female transgender prisoner in the custody of the Idaho Department of Correction ("IDOC"). She has been incarcerated since April 2012. In June 2012, soon after being incarcerated, an IDOC psychiatrist diagnosed Ms. Edmo with gender dysphoria. An IDOC psychologist confirmed that diagnosis a month later.

Gender dysphoria is a medical condition experienced by transgender individuals in which the incongruity between their assigned gender and their actual gender identity is so severe that it impairs the individual's ability to function. The treatment for gender dysphoria depends upon the severity of the condition. Many transgender individuals are comfortable living with their gender identity, role, and expression without surgery. For others, however, gender confirmation surgery, also known as gender or sex reassignment surgery ("SRS"), is the only effective treatment.

To treat Ms. Edmo's gender dysphoria, medical staff at the prison appropriately

began by providing Ms. Edmo with hormone therapy. This continued until she was hormonally confirmed – meaning she had the same circulating sex hormones and secondary sex characteristics as a typical adult female. Ms. Edmo thus achieved the maximum physical changes associated with hormone treatment. But, Ms. Edmo continued to experience such extreme gender dysphoria that she twice attempted self-castration. For her second attempt, Ms. Edmo prepared for weeks by studying the anatomy of the scrotum and took steps to diminish the chance of infection by boiling a razor blade and scrubbing her hands with soap. She was successful in opening the scrotum and exposing a testicle. But because there was too much blood, Ms. Edmo abandoned her second self-castration attempt and sought medical assistance. She was transported to a hospital where her testicle was repaired.

As already noted, an inmate has no choice but to rely on prison authorities to treat their medical needs. For this reason, the United States Supreme Court has held that deliberate indifference to a prisoner's serious medical needs constitutes cruel and unusual punishment in violation of the Eighth Amendment to the United States Constitution. *See, e.g., Estelle v. Gamble*, 429 U.S. 97, 103 (1976). To show such deliberate indifference, Ms. Edmo must establish two things. First, she must show a "serious medical need" by demonstrating that failure to treat a medical condition could result in significant further injury or the "unnecessary and wanton infliction of pain." Second, she must show that the prison officials were aware of and failed to respond to her pain and medical needs, and that she suffered some harm because of that failure.

Ms. Edmo's case satisfies both elements of the deliberate indifference test. She has presented extensive evidence that, despite years of hormone therapy, she continues to experience gender dysphoria so significant that she cuts herself to relieve emotional pain. She also continues to experience thoughts of self-castration and is at serious risk of acting on that impulse. With full awareness of Ms. Edmo's circumstances, IDOC and its medical provider Corizon refuse to provide Ms. Edmo with gender confirmation surgery. In refusing to provide that surgery, IDOC and Corizon have ignored generally accepted medical standards for the treatment of gender dysphoria. This constitutes deliberate indifference to Ms. Edmo's serious medical needs and violates her rights under the Eighth Amendment to the United States Constitution. Accordingly, for the reasons explained in detail below, IDOC and Corizon will be ordered to provide Ms. Edmo with gender confirmation surgery. Thus, the Court will grant in part Plaintiff's Motion for Preliminary Injunction (Dkt. 62).

In so ruling, the Court notes that its decision is based upon, and limited to, the unique facts and circumstances presented by Ms. Edmo's case. This decision is not intended, and should not be construed, as a general finding that all inmates suffering from gender dysphoria are entitled to gender confirmation surgery.

FINDINGS OF FACT

I. Transgender and Gender Dysphoria

1. Transgender is an umbrella term for a person whose gender identity is not congruent with their assigned gender. Tr. 50:5-11. A transgender person suffers

from gender dysphoria when that incongruity is so severe that it impairs the individual's ability to function. Tr. 50:12-14.

2. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") sets forth specific criteria which must exist before a diagnosis of gender dysphoria is appropriate. Specifically, two conditions are required:

   a. First, there must be marked incongruence between one's experienced/expressed gender and assigned gender, of at least six month's duration, as manifested by at least two of the following:

      i. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.

      ii. 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.

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

      iv. A strong desire to be of the other gender.

      v. A strong desire to be treated as the other gender.

      vi. A strong conviction that one has the typical feelings and reactions of the other gender.

   b. Second, the individual's condition must be associated with clinically

significant distress or impairment in social, occupational, or other important areas of functioning. Exh. 1001 at 3-4.

3. "Clinically significant distress" means that the distress impairs or severely limits the person's ability to function in a meaningful way and has reached a threshold that requires either medical or surgical interventions, or both. Tr. 51:3-8.

4. Not every person who identifies as transgender has gender dysphoria. Tr. 50:5-11.

II. WPATH

5. The World Professional Association of Transgender Health ("WPATH") Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People were first promulgated in 1979 and are the internationally recognized guidelines for the treatment of individuals with gender dysphoria. Tr. 42:6-20; Exh. 15. WPATH Standards of Care are "flexible clinical guidelines." Tr. 118:16-24, 119:1-7, 8-25, 288:7-23, and "are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people." Exh. 15 at 8.

6. The WPATH Standards of Care have provided treatment guidelines for incarcerated individuals since 1998. Tr. 54:11-21; Exh. 15 at 73. The current WPATH Standards of Care apply equally to all individuals "irrespective of their housing situation" and explicitly state that health care for transgender people "living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same

community." Tr. 54:11-21; Exh. 15 at 73. The next update to the WPATH Standards of Care will also apply to an individual regardless of where that person is housed, including in a prison setting. Tr. 54:25-55:12.

7. The WPATH Standards of Care indicate that options for psychological and medical treatment of gender dysphoria include:

   a. changes in gender expression and role,

   b. hormone therapy to feminize or masculinize the body,

   c. surgical changes of primary or secondary sex characteristics, and

   d. psychotherapy. Exh. 15 at 15-16.

8. The WPATH Standards of Care suggest options for social support and changes in gender expression, including:

   a. offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;

   b. offline and online support resources for families and friends;

   c. voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;

   d. hair removal through electrolysis, laser treatment, or waxing;

   e. breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks; and

   f. changes in name and gender marker on identity documents. Exh. 15 at 16.

9. The WPATH Standards of Care provide that the purposes of psychotherapy include "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." Exh. 15 at 16.

10. Cross-sex hormone therapy results in development of secondary sex characteristics of the other sex and provides an increase in the overall level of well-being of a person with gender dysphoria. Tr. 60:8-22. For a transgender woman, hormone treatment has physical effects such as breast growth, thinning of facial hair, redistribution of fat and muscle, and shrinkage of the testicles. Tr. 246:7-20. The maximum physical effects of hormone therapy will typically be achieved within two to three years. Exh. 15 at 42; Tr. 60:23-61:5, 246:7-247:1.

11. Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. Exh. 15 at 60.

12. Many transgender individuals find comfort with their gender identity, role, and expression without surgery. Exh. 15 at 60. For many others, however, surgery is essential and medically necessary to alleviate their gender dysphoria. Exh. 15 at 60. For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary or secondary sex characteristics to establish greater congruence with their gender identity. Exh. 15 at 60.

13. For individuals with severe gender dysphoria, where hormone therapy is insufficient, gender confirmation surgery is the only effective treatment and is medically necessary. Tr. 168:23-169:15; *see also* Ettner Decl. ¶ 51.

14. The WPATH criteria for genital reconstruction surgery in male-to-female patients include the following:

    a. Persistent, well documented gender dysphoria;

    b. Capacity to make a fully informed decision and to consent for treatment;

    c. Age of majority in a given country;

    d. If significant medical or mental health concerns are present, they must be well controlled;

    e. 12 continuous months of hormone therapy as appropriate to the patient's gender goals; and

    f. 12 continuous months of living in a gender role that is congruent with their gender identity. Exh. 15 at 66.

15. Regarding the first criterion, "persistent, well documented gender dysphoria" is deemed to exist when the person has a well-established diagnosis of gender dysphoria that has persisted beyond six months. Tr. 55:21-56:3.

16. Regarding the fourth criterion, the WPATH Standards of Care make clear that the presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery. Exh. 15 at 31. But these concerns need to be optimally managed prior to,

or concurrent with, treatment of gender dysphoria. Exh. 15 at 31.

a. It is often difficult to determine whether coexisting mental health concerns are a result of gender dysphoria or are unrelated to that medical condition. Tr. 171:1-14, 24-25, 172:1-5; 387:20-25, 388:1, 398:2-18, 601: 11- 602: 2; Campbell Decl., Dkt. 101-4, ¶¶ 30-33. Co-existing mental health issues directly tied to an individual's gender dysphoria should not be considered in assessing whether an individual meets the fourth WPATH criterion that significant medical or mental health concerns must be well controlled. Tr. 387:6 to 388:6.

17. Regarding the sixth criterion – a twelve-month experience of living in an identity-congruent role – the WPATH Standards of Care provide that this is intended to ensure that the individual has had the opportunity to experience the full range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, and in other settings). Exh. 15 at 67.

18. An individual in prison can satisfy the criterion of living in a gender role congruent with their gender identity. Tr. 62:16-63:4, 584:16-25.

III. Expert Testimony

A. Plaintiff's Experts

19. Dr. Ettner is one of the authors of the WPATH Standards of Care, version 7. Tr. 42:21-24. Dr. Ettner has been a WPATH member since 1993 and chairs its Committee for Institutionalized Persons. Tr. 43:2-16; Exh. 1003.

    a. Dr. Ettner has treated approximately 3,000 individuals with gender dysphoria, including evaluating whether gender confirmation surgery is necessary for certain patients. She has referred approximately 300 patients for gender confirmation surgery and assessed approximately 30 incarcerated individuals with gender dysphoria. Tr. 43:17-44:1, 44:9-13.

    b. Dr. Ettner has extensive experience treating patients who have undergone gender confirmation surgery. Tr. 44:2-8.

    c. Dr. Ettner is an author or editor of numerous peer-reviewed publications on treatment of gender dysphoria and transgender healthcare. Dr. Ettner is an editor for the textbook, "Principles of Transgender Medicine and Surgery," which was revised in 2017 and is the textbook used in medical schools. Tr. 44:14-45:1; Exh. 1003.

    d. Dr. Ettner also trains medical and mental health providers on treating people with gender dysphoria, including assessing whether gender confirmation surgery is appropriate, through the global education initiative of WPATH and other presentations. Tr. 41:8-16, 45:17-46:18.

e. Dr. Ettner has been appointed by a federal court as an independent expert related to evaluation of an incarcerated patient for gender confirmation surgery. Tr. 46:19-22.

f. However, Dr. Ettner is not a Certified Correctional Healthcare Professional, and she has not treated inmates with gender dysphoria. Tr. 106:21-24, 107:11-18.

20. Dr. Gorton is an emergency medicine physician who practices at a federally qualified healthcare center that primarily services uninsured patients or those with Medicare or Medicaid. Exh. 1004; Tr. 234:24-235:2. Dr. Gorton also works with Project Health, which has provided training for numerous clinics regarding the provision of transgender health care in California. Tr. 233:5-21. Dr. Gorton is a member of WPATH and is on WPATH's Transgender Medicine and Research Committee and its Institutionalized Persons Committee. Tr. 238:4-6; Exh. 1004.

a. Dr. Gorton has been the primary care physician for approximately 400 patients with gender dysphoria and is currently the primary care physician for approximately 100 patients with gender dysphoria. Exh. 1004; Tr. 237:4-12. Dr. Gorton currently provides follow-up care for about thirty patients who have had vaginoplasty. Exh. 1004; Tr. 249:20-250:3.

b. Dr. Gorton has published peer-reviewed articles regarding treatment of gender dysphoria. Tr. 239:16-18, Exh. 1004.

c. Dr. Gorton has been qualified as an expert in multiple cases involving transgender healthcare. Tr. 239:19-240:19; Exh. 1004.

d. However, Dr. Gorton has no experience treating inmates with gender dysphoria. Tr. 269:17-23. Dr. Gorton is not a Certified Correctional Healthcare Professional. Tr. 270:9-16.

B. Defendants' Experts

21. Dr. Garvey is a psychiatrist and Certified Correctional Healthcare Professional under the National Commission on Correctional Health Care. Tr. 525:15-23. As the Chief Psychiatrist in the Massachusetts Department of Corrections, Dr. Garvey served as the chair of the Gender Dysphoria Treatment Committee. Tr. 508:10-11. Dr. Garvey directly treated patients in the Massachusetts Department of Correction who had gender dysphoria. Tr. 508:13-509:1.

a. Prior to evaluating Ms. Edmo, Dr. Garvey had never conducted an in-person evaluation to determine whether a patient needed gender confirmation surgery. Tr. 558:10-14.

b. Dr. Garvey has never recommended that a patient with gender dysphoria receive gender confirmation surgery or done long-term follow-up care with a patient who has had gender confirmation surgery. Tr. 556:20-557:9.

22. Dr. Andrade is a licensed independent clinical social worker and is a Certified Correctional Healthcare Professional with an emphasis in mental health. Tr. 626:1-21. Dr. Andrade has over a decade of experience providing and supervising the

provision of correctional mental health care, including directing and overseeing the treatment of all inmates diagnosed with gender dysphoria in the custody of the Massachusetts Department of Corrections in his role as clinical director, chair of the Gender Dysphoria Supervision Group, and member of the Gender Dysphoria Treatment Committee. Tr. 627:22-23.

a. Over the last decade, Dr. Andrade has provided treatment to gender dysphoria inmates in his role on the treatment committee and has evaluated and confirmed diagnoses of gender dysphoria for over 100 inmates. Tr. 627:2-14. But Dr. Andrade has never provided direct treatment for patients with gender dysphoria and has never been a treating clinician for a patient who has had gender confirmation surgery. Tr. 647:8-14, 651:10-12.

b. As part of a committee, Dr. Andrade has recommended gender confirming surgery for incarcerated inmates on two occasions. Tr. 627-629:1-10. But the recommendation was contingent upon the requirement that the inmates first live in a women's prison for approximately twelve months. Tr. 647:19-648:25. The Massachusetts Department of Corrections houses prisoners according to their genitals, so the inmates were not allowed to move to a women's prison. Tr. 649:1-650:11. To Dr. Andrade's knowledge, the inmates had not been moved to a women's prison at least seven months after his recommendation. Tr. 649:1-650:11. Thus, the twelve-month period of living in a women's prison could not have started. Tr. 650:6-11.

c. As a licensed independent clinical social worker, Dr. Andrade does not qualify under IDOC's former gender dysphoria policy as a "gender identity disorder evaluator" who could assess someone for surgery. Tr. 660:11-17; Exh. 8 at 3.

23. Dr. Campbell is IDOC's Chief Psychologist. He has provided mental health services to incarcerated inmates since 2012. Campbell Decl., Dkt. 101-4, ¶¶ 2-7. Dr. Campbell is a member of WPATH and is familiar with the WPATH Standards of Care regarding gender dysphoria offenders and transgender inmates as provided by the National Commission on Correctional Healthcare ("NCCHC"), the National Institute of Corrections, and the Federal Bureau of Prisons. Campbell Decl., Dkt. 101-4, ¶¶ 8-10.

a. Dr. Campbell serves as chair of the Management and Treatment Committee ("MTC"), a multidisciplinary committee that meets monthly to discuss and evaluate the needs of inmates who have been diagnosed with gender dysphoria. Campbell Decl., Dkt. 101-4, ¶¶ 13-14.

b. Dr. Campbell has directly conducted six gender dysphoria assessments and has overseen the treatment and assessment of approximately fifty inmates who have requested gender dysphoria evaluations, through his role as chair of the Management and Treatment Committee and as the Chief Psychologist. Campbell Decl., Dkt. 101-4, ¶¶ 13-14.

c. There is no evidence that Dr. Campbell has ever recommended gender confirmation surgery for an inmate.

IV. NCCHC

24. The NCCHC endorses the WPATH Standards of Care as the accepted standards for the treatment of transgender prisoners. Exh. 1041 at 2, 4, n.1; Tr. 477:14-478:22.

V. Defendants' Policies and Practices Regarding Gender Dysphoria

A. Corizon's Policies and Practices

25. Corizon is a private corporation that contracts to provide health care to prisons and jails throughout the country. Corizon providers have never recommended gender confirmation surgery to a patient at any of the prisons where it provides medical services. Tr. 489:20-23.

26. Corizon's only written policy regarding gender dysphoria treatment does not include gender confirmation surgery as a form of treatment. Tr. 482:25-483:9; Exh. 14.

B. IDOC's Policies and Practices

27. The IDOC MTC is a multiple-disciplinary team that addresses treatment, planning, and security issues associated with IDOC inmates who have gender dysphoria. Tr. 322:12-20. The Management and Treatment Committee reviews the treatment of all inmates with gender dysphoria but does not make medical decisions. Tr. 323:4-13, 324:9-14.

28. There are currently 30 prisoners with gender dysphoria in IDOC custody. Tr. 322:21-323:3. No individual in IDOC custody has ever been recommended for, or received, gender confirmation surgery. Tr. 376:23-377:4.

29. IDOC's operative gender dysphoria policy when Ms. Edmo was assessed for surgery defined a "qualified gender identity disorder (GID) evaluator as '[a] Doctor of philosophy (PhD) level practitioner licensed by an appropriate state licensing authority as a psychologist, or a physician licensed by a state Board of Medicine, who has demonstrated an indicia of basic competence related to the diagnosis and treatment of GID and related mental or emotional disorders through their licensure, training, continuing education, and clinical experience.'" Exh. 8 at 3; Tr. 388:16-389:1.

30. This policy stated that gender confirmation surgery "will not be considered for individuals within the Idaho Department of Correction (IDOC), unless determined medically necessary by the treating physician." Exh. 8 at 8.

31. On October 5, 2018, shortly before the hearing in this matter, IDOC implemented a new gender dysphoria policy that would allow prisoners at Idaho State Correctional Institute ("ISCI") diagnosed with gender dysphoria to order and possess female commissary items and present in a manner consistent with their gender identity. Tr. 347:18-348:23; Exh. 9.

a. The new policy also states that "to avoid a sexually charged atmosphere in IDOC facilities . . .. [n]o provocative or sexually charged clothing or behavior will be permitted." Exh. 9 at 6.

b. IDOC's new gender dysphoria policy continues to state that gender confirmation surgery "will not be considered for individuals within the Idaho Department of Correction (IDOC), unless determined medically necessary by the treating physician." Exh. 9 at 8-9.

c. The policy further states that prisoners will be housed "based upon the inmate's primary physical sexual characteristics." Exh. 9 at 4.

V. Adree Edmo's Gender Dysphoria

32. Adree Edmo is a male-to-female transgender prisoner in the custody of IDOC. Ms. Edmo has been incarcerated at ISCI since April 2012. Tr. 192:19-20; *see also* Edmo Decl. ¶ 12. She is 30 years of age. Tr. 192:17-18.

33. From the age of 5 or 6, Ms. Edmo has viewed herself as female. In her words, "my brain typically operates female, even though my body hasn't corresponded with my brain." Tr. 193:7-8.

34. While others viewed her as being gay, that is not how she perceived herself. Tr. 193:18-23. While, she struggled with her gender identity as a child and teenager, she began living as a woman at age 20 or 21. Tr. 211:1-11. She views herself as a woman with a heterosexual attraction to men. Tr. 193:15-17.

35. Prior to being incarcerated, and learning about gender identity and transgender, Ms. Edmo struggled with her own identity and sexual orientation. On two occasions in 2010 and 2011, she attempted suicide. Tr. 206:12-15.

36. In June 2012, soon after being incarcerated, Ms. Edmo was diagnosed with gender identity disorder by Corizon psychiatrist Dr. Eliason. Exh. 1 at 321. In July 2012, Corizon psychologist Claudia Lake confirmed Ms. Edmo's diagnosis of gender identity disorder. Exh. 1 at 323-27. There is no dispute that Ms. Edmo suffers from gender dysphoria. Tr. 69:20-70:3, 251:23-252:3, 518:16-18, 635:1-7.

37. Ms. Edmo legally changed her name to Adree Edmo in September 2013. Tr. 192:6-9. Ms. Edmo has also changed her sex to "female" on her birth certificate to further affirm her gender identity. Tr. 203:13-22; Exh. 1002.

38. Ms. Edmo has consistently presented as feminine throughout her incarceration by wearing her hair in traditionally feminine hairstyles when able to do so, wearing makeup when able to do so, and acting in a feminine demeanor. Tr. 194:24-195:5, 411:1-7, 463:11-464:21. Ms. Edmo's feminine presentation has been documented by Defendants' medical providers since 2012. *See, e.g.*, Exh. 1 at 321, 347, 425, 452, 538. Ms. Edmo has also held two jobs while in prison and has presented as feminine at her places of employment. Tr. 201:24-202:10.

39. Ms. Edmo has continually sought to present herself as feminine despite receiving multiple disciplinary offense reports related to wearing makeup, styling her hair in a feminine manner, and altering her male-issued undergarments into female

panties. Tr. 195:11-20; Exh. 5 at 8, 9, 21-22, 25, 27-28, 33-34, 41-43, 48-57, 62-65; Yordy Dep. 47:4-49:15, 85:22-87:11; Edmo Decl. ¶ 19.

40. Ms. Edmo testified that hormone therapy helped treat her gender dysphoria to some extent. Tr. 223:9-14. The hormones "cleared her mind," and resulted in breast growth, body fat redistribution, and changes in her skin consistency. Tr. 196:15-25. As a result of hormone therapy, Ms. Edmo is hormonally confirmed, which means she has the same circulating sex hormones and secondary sex characteristics as a typical adult female. Tr. 72:14-21; Ettner Decl. ¶ 59.

41. Ms. Edmo has achieved the maximum physical changes associated with hormone treatment. Tr. 602:1-603:4. However, Ms. Edmo continues to experience distress related to gender incongruence, which is mostly focused on her male genitalia. She testified she feels "depressed, embarrassed, and disgusted" by her male genitalia and that this is an "everyday reoccurring thought." Tr. 197:7-24.

42. Ms. Edmo first attempted self-castration to remove her testicles in September 2015 using a disposable razor blade. She wrote a note to let the officers know she was not trying to commit suicide and was only trying to help herself. She attempted to cut her testicle sac open but was unsuccessful. Edmo Decl. ¶ 31; Tr. 197:25-198:8.

43. In January 2016, Ms. Edmo reported to Dr. Eliason that she was having difficulty sleeping due to thoughts of self-castration. In response, Dr. Eliason prescribed Ms. Edmo sleeping medication. Tr. 458:5-10, 461:18-24.

44. Ms. Edmo also reported her frequent thoughts of self-castration to her assigned clinician, Krina Stewart, in November 2016. Ms. Stewart testified that none of the interventions she identified for Ms. Edmo at that visit would alleviate her gender dysphoria or desire to self-castrate. Stewart Dep. 58:15-59:16; Exh. 1 at 584-85.

45. Ms. Edmo attempted self-castration a second time in December 2016. She prepared for weeks by studying the anatomy of the scrotum and took steps to diminish the chance of infection by boiling the razor blade and scrubbing her hands with soap. Ms. Edmo made more surgical headway on this attempt and was able to cut open the testicle sac and remove the testicle. Gorton Decl. ¶ 74. Because there was too much blood, Ms. Edmo abandoned her attempt and sought medical assistance. Tr. 198:9-16. She was transported to a hospital where her testicle was repaired. Tr. 198:25-199:13.

46. Ms. Edmo was receiving hormone therapy both times she attempted to self-castrate. Tr. 228:20-25.

47. After the procedure, Ms. Edmo felt disappointed in herself because she felt she had come so close to removing her testicle but had not succeeded. Tr. 199:17-23. Ms. Edmo continues to actively experience thoughts of self-castration. Tr. 197: 21-24. In an effort to avoid acting on them, when she has experienced extreme episodes of gender dysphoria in the past year, Ms. Edmo "self-medicat[es]" by using a razor to cut her arm. The physical pain she feels from

cutting helps her release the emotional torment and mental anguish she feels at the time. Tr. 199:24-200:15.

48. Ms. Edmo will likely be released from prison sometime in 2021. Tr. 201:14-15, 230:3-10.

VI. Defendants' Treatment of Ms. Edmo for Gender Dysphoria

49. On April 20, 2016, Dr. Eliason evaluated Ms. Edmo for sex reassignment surgery. Jt. Exh. 1 at 538. Dr. Eliason noted that Ms. Edmo reported she was "doing alright," that she was eligible for parole, but it had not been granted because of multiple Disciplinary Offense Reports ("DORs"). Jt. Exh. 1 at 538. The DORS were related to her use of makeup and feminine appearance. Jt. Exh. 1 at 538.

50. Dr. Eliason noted that Ms. Edmo had been on hormone replacement for the last year and a half, but that she felt she needed more. Jt. Exh. 1 at 538. Dr. Eliason specifically noted that Ms. Edmo stated an improvement in gender dysphoria on hormone replacement but had ongoing frustrations stemming from her current anatomy. Jt. Exh. 1 at 538. He also recognized Ms. Edmo's multiple attempts to "mutilate her genitalia" because of the severity of her distress. Jt. Exh. 1 at 538. He also noted that he spoke to prison staff about Ms. Edmo's behavior, "which is notable for animated affect and no observed distress." Jt. Exh. 1 at 538. Dr. Eliason then stated that he also personally observed Ms. Edmo in these settings and did not observe significant dysphoria. Jt. Exh. 1 at 538.

51. Nevertheless, Dr. Eliason noted that Ms. Edmo appeared feminine in demeanor and interaction style. Jt. Exh. 1 at 538. He concluded that Ms. Edmo had Gender Dysphoria, Alcohol Use disorder, and Depression, Jt. Exh. 1 at 538, but his ultimate conclusion was that Ms. Edmo "[d]oes not meet criteria for medical necessity for sex reassignment surgery." Jt. Exh. 1 at 538.

52. In assessing Ms. Edmo's need for gender confirmation surgery, Dr. Eliason indicated that he staffed her case with Dr. Jeremy Stoddart, Dr. Murray Young, and Jeremy Clark LCPC (clinical supervisor and WPATH member). Each of these individuals agreed with his assessment. Jt. Exh. 1 at 538.

53. Dr. Eliason indicated he would continue to monitor and assess Ms. Edmo for the medical necessity of gender confirmation surgery. Jt. Exh. 1 at 538. He further determined that the combination of hormonal treatment and supportive counseling is sufficient for Ms. Edmo's gender dysphoria for the time being.

54. To justify his conclusion, Dr. Eliason noted that while medical necessity for gender confirmation surgery is not very well defined and is constantly shifting, the following situations could constitute medical necessity for the surgery:

    a. Congenital malformations or ambiguous genitalia;

    b. Severe and devastating dysphoria that is primarily due to genitals; and

    c. Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage. Jt. Exh. 1 at 538.

55. He also explained that there may also be other situations where gender confirmation surgery is medically necessary as more information becomes available. Jt. Exh. 1 at 538.

56. Although not noted in his April 20, 2016 progress notes, Dr. Eliason testified that Ms. Edmo's mental health concerns were not "fully in adequate control." Tr. 430:22-431:2. He testified that not all of Ms. Edmo's mental health issues, such as her major depression and alcohol use disorders, stemmed from her gender dysphoria. His testimony, however, is contradicted by his April 20, 2016 clinician notes. Tr. 451:1-12.

57. Ms. Edmo has received mental health treatment from a psychiatrist and mental health nurse practitioner since she began her incarceration in 2012. Tr. 225:8-227:2. However, she has not consistently attended therapy to help her work through serious underlying mental health issues and a pre-incarceration history of trauma, abuse, and suicide attempts. Tr. 134:8-25, 135:1-23, 218:21-25, 219:1-14, 220:17-20; 221:16-19; Campbell Decl. Dkt., 101-4, ¶¶24, 29; Stewart Decl., Dkt. 101-1, ¶12; Watson Decl., Dkt. 101-3, ¶18; Clark Decl., Dkt. 101-7, ¶14).

58. Dr. Eliason testified that there were two primary reasons why sex reassignment surgery was not medically necessary at the time:

    a. Ms. Edmo had not satisfied the 12-month period of living in her identified gender role under WPATH standards. Tr. 430: 25-431:2; and

b. "[I]t was not doing Ms. Edmo any service to rush through getting gender reassignment surgery in that current social situation." Tr. 431:3-6.

59. Dr. Eliason's evaluation was the only time IDOC and Corizon evaluated Ms. Edmo for gender confirmation surgery prior to this lawsuit. Exh. 1 at 538; Tr. 419:1-10.

60. In concluding that surgery was not medically necessary for Ms. Edmo, Dr. Eliason did not review her prior criminal record, disciplinary history, or her presentence investigation reports. Tr. 468:4-18. The only information Dr. Eliason relied upon was Ms. Edmo's medical record, staff observations, and her therapist's notes. Tr. 469:16-25. Dr. Eliason testified that when he assessed her for surgery, he was aware of Ms. Edmo's prior self-surgery attempt. He believed Ms. Edmo's gender dysphoria had risen to another level, but he made no change to her treatment plan. Tr. 471:7-22.

VII. Ms. Edmo's Medical Necessity for Gender Confirmation Surgery

61. Plaintiff's and Defendants' experts disagree on whether Ms. Edmo meets all the WPATH standards criteria for gender confirmation surgery. Specifically, Defendants' experts believe that Ms. Edmo does not meet the fourth and sixth criteria – that any significant mental health concerns be well controlled and that she live twelve months in a fully gender-congruent role. Tr. 75:9-78:3; 252:13-254:11; 607:2-10, 639:14-640:25.

62. Notably, however, Dr. Eliason did not rely upon any finding that Ms. Edmo did not meet the WPATH criteria in concluding in his April 2016 assessment that she did not meet the criteria for gender confirmation surgery. Tr. 462:3-463:10.

63. With regard to the fourth criterion, Ms. Edmo has been diagnosed with Major Depressive Disorder, Alcohol Use Disorder, and Gender Dysphoria. *See, e.g.*, Exh. 1 at 538. These diagnoses were generally confirmed by each of the experts, with observation that any substance use disorder has been in remission while Ms. Edmo has been incarcerated. Tr. 67:16-18, 253:3-9, 518:16-219:6, 603:22-604:5.

   a. Plaintiff's experts testified that Ms. Edmo's depression and anxiety are as controlled as they can be and do not impair her ability to undergo surgery. Tr. 76:13-25, 123:14-124:11, 253:3-9; Exh. 15 at 30. In their view, the clinical significance of Ms. Edmo's self-surgery attempts and recent cutting of her arm is that she has severe genital-focused gender dysphoria and is not getting medically necessary treatment to alleviate it. Tr. 254:15-19, 98:11-22. Ms. Edmo's self-surgery attempts are not acts of mutilation or self-harm, but are instead attempts to remove her target organ that produces testosterone, which is the cure for gender dysphoria. Tr. 80:3-13. Ms. Edmo's gender dysphoria, not her depression and anxiety, is the driving force behind her self-surgery attempts. Tr. 254:20-255:8.

   b. Thus, Ms. Edmo's self-surgery attempts and cutting do not indicate she has mental health concerns that are not well controlled. Tr. 98:11-22. Rather,

Ms. Edmo's recent cutting is attention-reduction behavior that she uses to prevent herself from cutting her genitals. Tr. 98:16-22. Her self-surgery attempts indicate a need for treatment for gender dysphoria. Tr. 98:11-15.

c. In the more than six years she has spent in IDOC custody, no Corizon or IDOC provider has ever diagnosed Ms. Edmo with borderline personality disorder. Tr. 361:18-362:3, 470:4-6. Defense expert Dr. Andrade is the first person to ever diagnose Ms. Edmo with borderline personality disorder, and he was unable to identify his criteria for this diagnosis of Ms. Edmo during his testimony. Tr. 652:21-24, 638:16-22. None of the other experts, including Defense expert Dr. Garvey, diagnosed Ms. Edmo with borderline personality disorder. Tr. 131:24-132:3, 139:19-24.

d. One of the primary concerns underlying the fourth criterion is that the individual be able to properly participate in postsurgical care. Ms. Edmo has demonstrated the capacity to follow through with the postsurgical care she would require. Tr. 99:3-8, 169:23-170:25.

e. Although it is troubling that Ms. Edmo has declined to fully participate in the mental health treatment and counseling sessions recommended by Dr. Eliason and others, Dr. Ettner made clear that, "Psychotherapy is neither a precondition for treatment or a condition -- a precondition for surgery." Tr. 98:23-99:2.

f. Dr. Ettner concludes that Ms. Edmo meets the fourth criterion, since she has no unresolved mental health issues that would prevent her from receiving gender confirmation surgery. Tr. 98:3-10.

64. With respect to the sixth criterion, both Plaintiff's experts testified that Ms. Edmo meets and exceeds the condition of social role transition by living as a woman to the best of her ability in a male prison.

a. For the six-plus years she has lived in prison, Ms. Edmo has consistently sought to present as feminine, despite living in an environment hostile to her efforts, and despite the disciplinary consequences she faces. Tr. 77:9-78:3, 254:4-11.

65. Dr. Ettner testified that gender confirmation surgery would eliminate Ms. Edmo's gender dysphoria and significantly attenuate much of the attendant depression and symptoms she is experiencing. Tr. 104:24-105:9. She testified that gender confirmation surgery is the cure for gender dysphoria and will therefore result in therapeutic and beneficial effects for Ms. Edmo. Tr. 81:13-19.

66. Dr. Gorton testified that it is highly unlikely that Ms. Edmo's severe gender dysphoria will improve without gender confirmation surgery. Tr. 267:19-22.

67. The risks of not providing gender confirmation surgery to Ms. Edmo include surgical self-treatment, emotional decompensation, and risk of suicide given her high degree of suicide ideation. Tr. 80:24:81:8, 264:13-22. If she is not provided with surgery, Ms. Edmo has indicated that she will try self-surgery again to deal

with her extreme episodes of gender dysphoria. Tr. 199:24-200:5. Given that Ms. Edmo made increasing progress on her first two self-surgery attempts, it is likely that Ms. Edmo will be successful if she attempts self-surgery again. Tr. 264:13-22.

68. Scientific studies indicate that the regret rate for individuals who have had gender confirmation surgery is very low and generally in the range of one percent of patients. Tr. 103:25-12, 165:16-166:4. Ms. Edmo does not have any of the risk factors that make her likely to regret undergoing gender confirmation surgery. Tr. 266:1-267:1.

CONCLUSIONS OF LAW

I. Injunction Standard

1. Ms. Edmo asks for a preliminary injunction. A preliminary injunction is only awarded upon a clear showing that the plaintiff is entitled to the requested relief. *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 22 (2008).

2. To make this showing, the plaintiff must establish: (1) a likelihood of success on the merits; (2) a likelihood of irreparable harm to the moving party in the absence of preliminary relief; (3) that the balance of equities tips in favor of the moving party; and (4) that an injunction is in the public interest. *Id*.

3. The requirements are stated in the conjunctive so that all four elements must be established to justify injunctive relief. The court may apply a sliding scale test, under which "the elements of the preliminary injunction test are balanced, so that a

stronger showing of one element may offset a weaker showing of another." *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011).

4. A more stringent standard is applied where mandatory, as opposed to prohibitory, injunctive relief is sought. Prohibitory injunctions restrain a party from taking action and effectively "freeze[ ] the positions of the parties until the court can hear the case on the merits." *Heckler v. Lopez*, 463 U.S. 1328, 1333 (1983). Mandatory injunctions go well beyond preserving the status quo, as they order a party to take some action. *See Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009).

5. Although the same general principles inform the court's analysis in deciding whether to issue mandatory or prohibitory relief, courts should be "extremely cautious" about ordering mandatory relief. *Martin v. Intl Olympic Comm.*, 740 F.2d 670, 675 (9th Cir. 1984). Mandatory preliminary relief should not issue unless both the facts and the law clearly favor the moving party and extreme or very serious damage will result. *See Marlyn Nutraceuticals*, 571 F.3d at 879. Mandatory injunctions are not issued in doubtful cases, or where the party seeking an injunction could be made whole by an award of damages. *Id*.

6. The Court agrees with defendants that Edmo seeks mandatory relief. Thus, the Court will apply the more stringent standard.[1]

7. The Prison Litigation Reform Act ("PLRA") requires any preliminary injunction to be "narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct the harm. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system." 18 U.S.C. § 3626(a)(2).

II. Eighth Amendment Claim

A. Likelihood of Success on the Merits

8. The Eighth Amendment to the United States Constitution protects prisoners against cruel and unusual punishment. To state a claim under the Eighth

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[1] In discussions with counsel before the evidentiary hearing, the Court expressed the concern that the nature of the relief requested in this case, coupled with the extensive evidence presented by the parties over a 3-day evidentiary hearing, effectively converted these proceedings into a final trial on the merits of the plaintiff's request for permanent injunctive relief. Neither party addressed the Court's concern, and both parties appear to have treated the evidentiary hearing as a final trial of Ms. Edmo's claims.

In an abundance of caution, the Court has considered the standard for the issuance of a permanent injunction, which would have required the plaintiff to show (1) she has suffered an irreparable injury, (2) monetary damages would not compensate her for that injury, (3) after balancing the hardships between the parties, a remedy of equity is warranted, and (4) the public interest would not be disserved by a permanent injunction. S*ee, eBay Inc. v. MercExchange, L.L.C.,* 547 U.S. 388, 391 (2006). That standard appears to be no more rigorous than that applicable to a claim for preliminary mandatory relief. The Court concludes that under either standard Ms. Edmo is entitled to relief.

Amendment, Ms. Edmo must show that she is "incarcerated under conditions posing a substantial risk of serious harm," or that she has been deprived of "the minimal civilized measure of life's necessities" as a result of Defendants' actions. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994) (internal quotation marks omitted).

9. An Eighth Amendment claim requires a plaintiff to satisfy "both an objective standard – that the deprivation was serious enough to constitute cruel and unusual punishment – and a subjective standard – deliberate indifference." *Snow v. McDaniel*, 681 F.3d 978, 985 (9th Cir. 2012).

10. The Eighth Amendment includes the right to adequate medical care in prison, and prison officials or prison medical providers can be held liable if their "acts or omissions [were] sufficiently harmful to evidence deliberate indifference to serious medical needs." *Estelle v. Gamble*, 429 U.S. 97, 106 (1976).

11. Regarding the objective standard for prisoners' medical care claims, the Supreme Court of the United States has explained that "[b]ecause society does not expect that prisoners will have unqualified access to health care, deliberate indifference to medical needs amounts to an Eighth Amendment violation only if those needs are 'serious.'" *Hudson v. McMillian*, 503 U.S. 1, 9 (1992) (quoting *Estelle v. Gamble*, 429 U.S., 97, 103 (1976)).

12. The Ninth Circuit has defined a "serious medical need" in the following ways: failure to treat a prisoner's condition [that] could result in further significant injury or the unnecessary and wanton infliction of pain [;] ... [t]he existence of an injury

that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain . . . ." *McGuckin v. Smith*, 974 F.2d 1050, 1059–60 (9th Cir. 1992) (internal citations omitted), overruled on other grounds, *WMX Techs., Inc. v. Miller*, 104 F.3d 1133 (9th Cir. 1997) (en banc).

13. As to the subjective standard, a prison official or prison medical provider acts with "deliberate indifference . . . only if the [prison official] knows of and disregards an excessive risk to inmate health and safety." *Gibson v. Cnty. of Washoe, Nev.*, 290 F.3d 1175, 1187 (9th Cir. 2002) (citation and internal quotation marks omitted). "Under this standard, the prison official must not only 'be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists,' but that person 'must also draw the inference.'" *Toguchi v. Chung*, 391 F.3d 1051, 1057 (9th Cir. 2004) (quoting *Farmer*, 511 U.S. at 837).

14. "If a [prison official] should have been aware of the risk, but was not, then the [official] has not violated the Eighth Amendment, no matter how severe the risk." *Gibson*, 290 F.3d at 1188 (citation omitted). However, "whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, . . . and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." *Farmer*, 511 U.S. at

842; *see also Lolli v. County of Orange*, 351 F.3d 410, 421 (9th Cir. 2003) (deliberate indifference to medical needs may be shown by circumstantial evidence when the facts are sufficient to demonstrate that defendant actually knew of a risk of harm).

15. In the medical context, a conclusion that a defendant acted with deliberate indifference requires that the plaintiff show both "a purposeful act or failure to respond to a prisoner's pain or possible medical need and . . . harm caused by the indifference." *Jett v. Penner*, 439 F.3d 1091, 1096 (9th Cir. 2006).

16. Deliberate indifference can be "manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Estelle*, 429 U.S. at 104–05 (footnotes omitted).

17. Non-medical prison personnel are generally entitled to rely on the opinions of medical professionals with respect to the medical treatment of an inmate. However, if "a reasonable person would likely determine [the medical treatment] to be inferior," the fact that an official is not medically trained will not shield that official from liability for deliberate indifference. *Snow*, 681 F.3d at 986; *see also McGee v. Adams*, 721 F.3d 474, 483 (7th Cir. 2013) (stating that non-medical personnel may rely on medical opinions of health care professionals unless "they have a reason to believe (or actual knowledge) that prison doctors or their

assistants are mistreating (or not treating) a prisoner") (internal quotation marks omitted).

18. Differences in judgment between an inmate and prison medical personnel regarding appropriate medical diagnosis and treatment are not enough to establish a deliberate indifference claim. *Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir.1989). "[T]o prevail on a claim involving choices between alternative courses of treatment, a prisoner must show that the chosen course of treatment 'was medically unacceptable under the circumstances,' and was chosen 'in conscious disregard of an excessive risk' to the prisoner's health." *Toguchi*, 391 F.3d at 1058, (alteration omitted) (quoting *Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996)).

19. Mere indifference, medical malpractice, or negligence will not support a cause of action under the Eighth Amendment. *Broughton v. Cutter Labs.*, 622 F.2d 458, 460 (9th Cir.1980) (per curiam). Likewise, a delay in treatment does not constitute a violation of the Eighth Amendment unless the delay causes further harm. *McGuckin*, 974 F.2d at 1060.

1. Serious Medical Need

20. There is no dispute that Ms. Edmo suffers from gender dysphoria. And there is no dispute that gender dysphoria is a serious medical condition recognized by the DSM-5.

21. WPATH Standards of Care are the accepted standards of care for treatment of transgender patients. These standards have been endorsed by the NCCHC as applying to incarcerated persons.

22. There are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups.

23. The Court finds credible the testimony of Plaintiff's experts Drs. Ettner and Gorton, who have extensive personal experience treating individuals with gender dysphoria both before and after receiving gender confirmation surgery. Plaintiff's experts found that Ms. Edmo satisfied all six WPATH medical necessity criteria for surgery.

24. Defendants' experts, by contrast, have opined that surgery is not medically necessary for Ms. Edmo. However, neither Dr. Garvey nor Dr. Andrade has any direct experience with patients receiving gender confirmation surgery or assessing patients for the medical necessity of gender confirmation surgery. Defendants' experts also have very little experience treating patients with gender dysphoria other than assessing them for the existence of the condition.

25. Defendants' experts appear to misrepresent the WPATH Standards of Care by concluding that Ms. Edmo, despite presenting as female since her incarceration in 2012, cannot satisfy the WPATH criteria because she has not presented as female outside of the prison setting. But there is no requirement in the WPATH Standards of Care that a "patient live for twelve months in his or her gender role outside of

prison before becoming eligible for SRS." *Norsworthy v. Beard*, 87 F. Supp. 3d 1164 (N.D. Cal. 2015),

26. Indeed, Plaintiff's experts opine that Ms. Edmo exceeds this criterion because she has not only presented as female for far longer than twelve months, but has done so in an environment arguably more hostile to these efforts than the non-custodial community, and despite the disciplinary consequences of doing so. The WPATH Standards of Care explicitly provide that they apply "in their entirety . . . to all transsexual, transgender, and gender-nonconforming people, irrespective of their housing situation," and "including institutional environments such as prisons." Exh. 15 at 73. The Standards of Care make clear that "[d]enial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations." Exh. 15 at 74.

27. Defendants' evidence to the contrary is unconvincing and suggests a decided bias against approving gender confirmation surgery.

28. In 2016, Dr. Eliason contacted Dr. Steven Levine to lead a training for IDOC and Corizon providers on medical necessity for gender confirmation surgery. Tr. 433:23-434:24. Dr. Levine's training presentation was titled "Medical Necessity of Transgender Inmates: In Search of Clarity When Paradox, Complexity, and Uncertainty Abound." Exh. 17 at 1. Dr. Levine trained Corizon and IDOC staff that gender confirmation surgery is "not conceived as lifesaving as is repairing a

potentially leaking aortic aneurysm but as life enhancing as is providing augmentation for women distressed about their small breasts." Exh. 17 at 43; Exh. 16.

29. Dr. Levine is considered an outlier in the field of gender dysphoria and does not ascribe to the WPATH Standards of Care. Tr. 176:14-21. His training materials do not reflect opinions that are generally accepted in the field of gender dysphoria. Tr. 176:22-179:1.

30. Dr. Levine's training includes additional criteria proposed by Cynthia Osborne and Anne Lawrence that incarcerated individuals must meet in order to receive gender confirmation surgery. Exh. 17 at 39-41, 51; Exh. 19. These requirements are not part of the WPATH criteria and are in opposition to the WPATH Standards of Care. Tr. 101:15-22, 103:14-20. There are no scientific studies that support these additional requirements, and no professional associations or organizations have endorsed Osborne and Lawrence's proposed requirements for prisoners. Tr. 103:4-13. The NCCHC has not adopted Osborne and Lawrence's additional requirements. Tr. 480:12-16. Like Dr. Levine, Osborne and Lawrence are considered outliers in the field of gender dysphoria treatment, are not WPATH members, and do not ascribe to the WPATH Standards of Care. Tr. 101:2-14.

31. A decision of the U.S. District Court in the Northern District of California, *Norsworthy v. Beard*, 87 F. Supp. 3d 1164 (N.D. Cal. 2015), is noteworthy here. Dr. Levine was retained as a defense expert by the California Department of

Corrections and Rehabilitation in a suit filed by a transgender plaintiff in that case. In ordering the prison to provide the plaintiff gender confirmation surgery, the *Norsworthy* court afforded Dr. Levine's opinions "very little weight," stating: "To the extent that Levine's apparent opinion that no inmate should ever receive SRS predetermined his conclusion with respect to Norsworthy, his conclusions are unhelpful in assessing whether she has established a serious medical need for SRS." *Norsworthy*, 87 F. Supp. 3d at 1188. The court also determined that Dr. Levine's opinion was not credible because of illogical inferences, inconsistencies, and inaccuracies," including misrepresentations of the WPATH Standards of Care, overwhelming "generalizations about gender dysphoric prisoners" and Dr. Levine's fabrication of a prisoner anecdote. *Id*.

32. Under these circumstances, the Court gives virtually no weight to the opinions of Defendants' experts that Ms. Edmo does not meet the fourth and sixth WPATH criteria for gender confirmation surgery.

2. Deliberate Indifference

33. Defendants misapplied the recognized standards of care for treating Ms. Edmo's gender dysphoria.

34. Defendants insufficiently trained their staff with materials that discourage referrals for surgery and represent the opinions of a single person who rejects the WPATH Standards of Care.

35. Defendants' sole evaluation of Ms. Edmo for surgery prior to this lawsuit failed to accurately apply the WPATH Standards of Care. Specifically, Dr. Eliason's assessment that Ms. Edmo did not meet medical necessity for surgery did not apply the WPATH criteria.

36. Defendants have been deliberately indifferent to Ms. Edmo's medical needs by failing to provide her with available treatment that is generally accepted in the field as safe and effective, despite her actual harm and ongoing risk of future harm including self-castration attempts, cutting, and suicidal ideation.

37. Evidence also suggests that Ms. Edmo has not been provided gender confirmation surgery because Corizon and IDOC have a *de facto* policy or practice of refusing this treatment for gender dysphoria to prisoners.

38. In *Norsworthy*, the court found that the prison had a blanket policy barring surgery in light of evidence that the prison's "guidelines for treating transgender inmates, which do not mention SRS as a treatment option, and the 2012 training provided to CDCR staff by Levine, which indicated that SRS should never be provided to incarcerated patients." *Norsworthy*, 87 F. Supp. 3d at 1191.

39. Here, the only guidelines Corizon issued to assist its providers in treating gender dysphoria likewise do not include surgery as a treatment option. Moreover, Dr. Levine's training provided to Corizon and IDOC staff, and incorporated into further Corizon and IDOC training, discourages providing surgery to incarcerated persons with gender dysphoria.

40. Significantly, no Corizon or IDOC provider has ever recommended that gender confirmation surgery is medically necessary for a patient in IDOC custody. In fact, Corizon has never provided this surgery at any of its facilities in the United States.

41. As was the case in *Norsworthy*, "[t]he weight of the evidence demonstrates that for [Ms. Edmo], the only adequate medical treatment for her gender dysphoria is [gender confirmation surgery], that the decision not to address her persistent symptoms was medically unacceptable under the circumstances, and that [Defendants] denied her the necessary treatment for reasons unrelated to her medical need." *Norsworthy*, 87 F. Supp. 3d at 1192.

42. Accordingly, Ms. Edmo is likely to succeed on the merits of her Eighth Amendment claim.

B. Likelihood of Irreparable Harm

43. The Ninth Circuit has repeatedly held that serious psychological harm, in addition to physical harm and suffering, constitutes irreparable injury. *See, e.g.*, *Chalk v. U.S. Dist. Ct. Cent. Dist. of California*, 840 F. 2d 701, 709 (9th Cir. 1988) (plaintiff's "emotional stress, depression and reduced sense of well-being" constituted irreparable harm); *Thomas v. Cnty. of Los Angeles*, 978 F. 2d 504, 512 (9th Cir. 1992) ("Plaintiffs have also established irreparable harm, based on this Court's finding that the deputies' actions have resulted in irreparable physical and emotional injuries to plaintiffs and the violation of plaintiffs' civil rights.").

44. Ms. Edmo's gender dysphoria results in clinically significant distress or impairment of functioning.

45. Both Plaintiff's and Defendants' experts agree that Ms. Edmo is properly diagnosed with gender dysphoria and continues to experience serious distress from this condition.

46. Ms. Edmo has received hormone treatment and achieved the maximum feminizing effects years ago.

47. Other district courts have recognized that the significant emotional pain, suffering, anxiety, and depression caused by prison officials' failure to provide adequate treatment for gender dysphoria constitute irreparable harm warranting a preliminary injunction. *See, e.g.*, *Hicklin v. Precynthe*, 2018 WL 806764, at *9 (E.D. Missouri 2018); *Norsworthy*, 87 F. Supp. 3d at 1192.

48. Ms. Edmo has twice attempted self-castration resulting in significant pain and suffering.

49. The Court is persuaded by Plaintiff's experts that, without surgery, Ms. Edmo is at serious risk of life-threatening self-harm.

50. Thus, Ms. Edmo has satisfied the irreparable harm prong by showing that she will suffer serious psychological harm and will be at high risk of self-castration and suicide in the absence of gender confirmation surgery.

C. Balance of Equities

51. "Courts 'must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief.'" *Winter*, 555 U.S. at 24 (quoting *Amoco Production Co.*, 480 U.S. 531, 542 (1987)).

52. The balance of equities tips in a plaintiff's favor where the plaintiff has established irreparable harm in the form of unnecessary physical and emotional suffering and denial of her constitutional rights. *See, e. g.*, *Hicklin*, 2018 WL 806764, at *13; *Norsworthy*, 87 F. Supp. 3d at 1193.

53. Ms. Edmo has established that Defendants' refusal to provide her with gender confirmation surgery causes her ongoing irreparable harm.

54. Defendants have made no showing that an order requiring them to provide treatment that accords with the recognized WPATH Standard of Care causes them injury.

D. The Public Interest

55. The Court finds that a mandatory preliminary injunction is in the public interest. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *See Melendres v. Arpaio*, 695 F. 3d 990, 1002 (9th Cir. 2012).

56. "In addition, 'the public has a strong interest in the provision of constitutionally adequate health care to prisoners.'" *McNearney v. Wash. Dep't of Corr.*, 2012 WL 3545267, at *16 (W.D. Wash. 2012).

57. Accordingly, a mandatory preliminary injunction should issue because both the facts and the law clearly favor Ms. Edmo and extreme or very serious damage will result if it is not issued. *See Marlyn Nutraceuticals*, 571 F.3d at 879.

III. FOURTEENTH AMENDMENT AND ACA CLAIMS

58. Plaintiff has not met her burden for a preliminary injunction on her Fourteenth Amendment and Affordable Care Act claims at this time.

59. As explained above, to make this showing for preliminary injunction, the plaintiff must establish: (1) a likelihood of success on the merits; (2) a likelihood of irreparable harm to the moving party in the absence of preliminary relief; (3) that the balance of equities tips in favor of the moving party; and (4) that an injunction is in the public interest. *Winter*, 555 U.S. at 22.

60. While Ms. Edmo may ultimately prevail on her Fourteenth Amendment and Affordable Care Act claims, she is unable to show that she is entitled to injunctive relief at this time. Given the Court's ruling on her Eighth Amendment claim, there is no likelihood of irreparable harm to Ms. Edmo in the absence of injunctive relief on these two claims.

61. Moreover, the balance of equities tips in favor of Defendants because a more developed record on Defendants' treatment of transgender inmates is necessary before making a broader ruling based upon the Fourteenth Amendment or the Affordable Care Act.

62. Likewise, a more developed record is necessary to assess the public's interest in granting such injunctive relief. *Id.*

ORDER

IT IS ORDERED:

1. Plaintiff's Motion for Preliminary Injunction (Dkt. 62) is **GRANTED IN PART**. Defendants are ordered to provide Plaintiff with adequate medical care, including gender confirmation surgery. Defendants shall take all actions reasonably necessary to provide Ms. Edmo gender confirmation surgery as promptly as possible and no later than six months from the date of this order. However, given IDOC's implementation of an updated gender dysphoria policy on October 5, 2018 that appears to provide Plaintiff's requested injunctive relief related to accessing gender-appropriate underwear, clothing, and commissary items, the Court will not address that relief at this time. This is without prejudice to the plaintiff's right to raise the issue in the future, should IDOC revoke the new policy or if the implementation of the policy results in ongoing violations.

2. The Court's Deputy, Jamie Bracke, is directed to set a telephonic status conference in this case no later than two weeks after this decision issues.

DATED: December 13, 2018

B. Lynn Winmill
Chief U.S. District Court Judge

Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

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Dated: March 6, 2019

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, v. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	CIVIL ACTION FILE NO. 1:17-cv-151-BLW **DEFENDANTS CORIZON INC., SCOTT ELIASON, MURRAY YOUNG, AND CATHERINE WHINNERY'S NOTICE OF APPEAL AND/OR PRELIMINARY INJUNCTION APPEAL**

PLEASE TAKE NOTICE that Defendants, Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery ("Corizon Defendants"), by and through their counsel of record, Parsons Behle & Latimer, appeal to the Ninth Circuit Court of Appeals from the *Findings of Fact,*

Conclusions of Law, and Order (Dkt. No. 149) entered by Chief U.S. District Court Judge B. Lynn Winmill on December 13, 2018 along with those matters inextricably bound up with the Order. *Paige v. State of California*, 102 F.3d 1035 (9th Cir. 1996). The Order granted, in part, *Plaintiff's Notice of Motion and Motion for Preliminary Injunction and Memorandum of Points and Authorities in Support Therefore* (Dkt. No. 62), thus making it immediately appealable pursuant to 28 U.S.C. § 1292(a)(1). To the extent the Order entered a final decision on the merits as suggested in footnote 1 of the Order, then the Ninth Circuit Court of Appeals also has appellate jurisdiction pursuant to 28 U.S.C. § 1291.

DATED this 9th day of January, 2019.

PARSONS BEHLE & LATIMER

By: */s/ Dylan A. Eaton*
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Catherine Whinnery

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 9th day of January, 2019, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, vs. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	Case No. 1:17-cv-00151-BLW **NOTICE OF APPEAL AND/OR PRELIMINARY INJUNCTION APPEAL**

PLEASE TAKE NOTICE that Defendants Idaho Department of Correction, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert appeal to the Ninth Circuit Court of Appeals from the *Findings of Fact, Conclusions of Law, and Order* (Dkt. No. 149) entered by Chief U.S. District Court Judge B. Lynn Winmill on December 13, 2018 along with those matters inextricably bound up with the Order. *Paige v. State of California*, 102 F.3d 1035 (9th Cir. 1996). The Order granted, in part, *Plaintiff's Notice of Motion and Motion for Preliminary Injunction and Memorandum of Points and Authorities in Support Therefore* (Dkt. No. 62), thus making it immediately appealable pursuant to 28 U.S.C. § 1292(a)(1). To the extent the Order entered a final decision on the merits as suggested in footnote 1 of the Order, then the Ninth Circuit Court of Appeals also has appellate jurisdiction pursuant to 28 U.S.C. § 1291.

Dated this 9th day of January, 2019.

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I HEREBY CERTIFY that on this 9th day of January, 2019, I caused to be filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, v. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	CIVIL ACTION FILE NO. 1:17-cv-151-BLW **CLOSING STATEMENT IN OPPOSITION TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTIVE RELIEF**

Defendants, Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery ("Corizon Defendants"), by and through their counsel of record, Parsons Behle & Latimer, submit this Closing Statement in Opposition to Plaintiff's Motion for Preliminary Injunction.

I. INTRODUCTION

Plaintiff Adree Edmo must meet an exceptionally heavy burden to establish entitlement to the preliminary relief she is requesting. She has not come remotely close to doing so, failing to establish even one of the elements of the applicable preliminary injunction standard.

Ms. Edmo is demanding medical treatment in the form of major surgery, Sex Reassignment Surgery ("SRS") (also known as "Gender Confirmation Surgery"), for treatment of Gender Dysphoria ("GD").[1] Based on their evaluation of Ms. Edmo and their medical expertise and judgment, her treatment providers—and defendants' experts—have determined that SRS is not medically necessary or appropriate at this time. Though Ms. Edmo disagrees with that evaluation, as do her experts, such disagreements neither constitute deliberate indifference to a serious medical need nor discrimination on the basis of gender, sex, or any other protected category. For good reason, courts do not attempt to resolve such disagreements, which hinge on questions requiring medical expertise and judgement, and they particularly do not do so preliminary injunction phase.

None of the cases cited by Ms. Edmo are to the contrary. Ms. Edmo exclusively cites cases in which an inmate's correctional medical provider determined that a particular treatment for GD was medically necessary, but the judgment of that provider was ignored pursuant to a blanket correctional policy against the provision of such treatments. Ms. Edmo tries very hard to make the facts of this case analogous to those, but they are not. Here, there is no blanket policy, written or

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[1] Though Ms. Edmo's initial request for injunctive relief was broader, the Corizon Defendants understand that Ms. Edmo is now limiting her request for injunctive relief to an order requiring Sex Reassignment Surgery (or, Gender Confirmation Surgery). [*See* Plaintiff's Reply in Support of Motion for Preliminary Injunction, Dkt. 111, p. 1 n. 2 ("Plaintiff also claims that Defendants were deliberately indifferent to her serious medical needs by providing inadequate hormone therapy, but that claim is not the focus of her motion for preliminary injunction, which seeks access to surgery.")].

de facto, prohibited SRS; no medical provider—as opposed to a retained expert—has determined that SRS is medically necessary; and, in fact, several different providers, all understanding that SRS is an option where medically necessary, have independently determined that it is not medically necessary in Ms. Edmo's case. This is not a case in which a medically necessary treatment was denied for non-medical reason or pursuant to some general policy. It is a case in which treatment providers made a medical judgment based on their expertise, the evidence available to them, and in an attempt to provide quality care to Ms. Edmo.

II. ARGUMENT

A. The burden on Ms. Edmo is exceptionally high.

Even in the ordinary case, "preliminary injunctions are an extraordinary remedy never awarded as of right." *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015) (internal quotation marks omitted) (quoting *Winter v. NRDC,* 555 U.S. 7, 24, 129 S.Ct. 365, 172 L.Ed.2d 249 (2008)) "A plaintiff seeking a preliminary injunction must show that: (1) she is likely to succeed on the merits, (2) she is likely to suffer irreparable harm in the absence of preliminary relief, (3) the balance of equities tips in her favor, and (4) an injunction is in the public interest." *Id*.

Ms. Edmo's burden, though, is "doubly demanding: Because [she] seeks a mandatory injunction, she must establish that the law and facts *clearly favor* her position, not simply that she is likely to succeed." *Id*. (emphasis added). The relief Ms. Edmo is seeking is a "mandatory injunction, because it orders a responsible party to take action." *Id.* (internal quotation marks and citations omitted). The Ninth Circuit has repeatedly cautioned that "a mandatory injunction goes well beyond simply maintaining the status quo *pendente lite* and is particularly disfavored. The district court should deny such relief unless the facts and law clearly favor the moving party. In plain terms, *mandatory injunctions should not issue in doubtful cases*." *Id*. (emphasis added)

(internal citations, quotation marks, and alterations omitted). "In general, mandatory injunctions are not granted unless extreme or very serious damage will result and are not issued in doubtful cases or where the injury complained of is capable of compensation in damages." *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009).

For a separate and independent reason, the injunctive relief requested by Ms. Edmo is highly disfavored and the burden on her is particularly demanding. The preliminary relief Ms. Edmo is seeking is the very relief to which she might be entitled after a full trial.

> It is so well settled as not to require citation of authority that the usual function of a preliminary injunction is to preserve the status quo ante litem pending a determination of the action on the merits. The hearing is not to be transformed into a trial of the merits of the action upon affidavits, and it is not usually proper to grant the moving party the full relief to which he might be entitled if successful at the conclusion of a trial. This is particularly true where the relief afforded, rather than preserving the status quo, completely changes it.

Tanner Motor Livery, Ltd. v. Avis, Inc., 316 F.2d 804, 808–09 (9th Cir. 1963). "[T]he burden on plaintiff is a heavy one where . . . granting the preliminary injunction will give plaintiff substantially the relief it would obtain after a trial on the merits." *Redevelopment Agency of City of Stockton v. Burlington N.*, No. 05-2087 DFL JFM, 2006 WL 931059, at *3 (E.D. Cal. Apr. 11, 2006) (internal quotation marks, citations, and alterations omitted).

Both because the injunctive relief Ms. Edmo is seeking is mandatory—requiring defendants to provide a particular treatment—and because it would provide Ms. Edmo substantially all of the relief to which she might be entitled after a full trial, relief that cannot be "undone" after a full trial on the merits, her burden is "heavy" and her request is "highly disfavored." It should not be granted unless the law and the facts "clearly" favor her, not if the request is in any way "doubtful," and only if "extreme or very serious damage will result" absent injunctive relief.

B. Ms. Edmo has failed to establish, much less clearly establish and render in no way doubtful, a likelihood of success on the merits.

Ms. Edmo's request for injunctive relief as against the Corizon Defendants is based on her claims under the Eighth Amendment, for deliberate indifference to a serious medical need, and under the Eighth Amendment, for discrimination in the provision of medical care based on a protected category.[2] Ms. Edmo's claims—whether under the Eighth Amendment, the Fourteenth Amendment, or the Affordable Care Act—turn on her allegation that she was denied SRS not based on the medical judgment of her treating providers but based on a blanket policy that SRS is per se unavailable to inmates. There is *no* evidence to support that view. To the contrary, the evidence shows that SRS is available to inmates as medically necessary, that Ms. Edmo was

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[2] Ms. Edmo is basing her request for preliminary relief only on her Eighth Amendment, Fourteenth Amendment, and Affordable Care Act claims. [*See* Plaintiff's Notice of Motion and Motion for Preliminary Injunction and Memorandum of Points and Authorities in Support Thereof, Dkt. 62, p. 10 n.3 ("Ms. Edmo is also likely to succeed on the merits of her other claims, including her American with Disabilities Act claim. However, given that the law on those claims is less clearly established, Plaintiff's motion for a preliminary injunction focuses more narrowly on her Eight Amendment, Fourteenth Amendment, and ACA claims." (internal citation omitted)]. Her Affordable Care Act claim is not asserted against the Corizon Defendants. [*See* Second Amended Complaint, Dkt. 36, p. 20]. Though not asserted against the Corizon Defendants, that claim clearly cannot sustain a request for preliminary relief. In addition to the argument herein, establishing that there was no discrimination in the provision of care, the Corizon Defendants also rely upon and incorporate the argument of the IDOC Defendants regarding Ms. Edmo's Fourteenth Amendment and Affordable Care Act claims. [Dkt. 99, pp. 14 – 16]. As to her ACA claim in particular, it is noteworthy that Ms. Edmo has not cited a *single case* in which the ACA was applied as she would have the Court do here, in favor of an inmate and against a department of corrections and its employees. That fact alone should be sufficient to show that she has not established that the law is "clearly" in her favor as to her ACA claim. Finally, Ms. Edmo also has a negligence claim against Corizon, but is also not basing her motion for preliminary relief on that claim. Like her other claims, her negligence claim is without merit. Ms. Edmo has not asserted that any particular treating provider was in any way negligent. It is unclear how a negligence claim against an organization can be asserted absent negligence by some agent of the organization. Further, Dr. Garvey, defendants' expert in this matter, has testified that Corizon and its providers were in no way negligent with respect to the care provided to Ms. Edmo. Defendants' Joint Proposed findings of Fact and Conclusions of Law ¶¶ 56 – 81.

evaluated for SRS by her health care providers, and that they judged, based on her condition, history, and their medical expertise, that that treatment was not presently appropriate. That clinical judgment has since been confirmed by defendants' experts in this case.

Ms. Edmo relies heavily on *Norsworthy v. Beard*, 87 F. Supp. 3d 1164 (N.D. Cal.), *appeal dismissed and remanded,* 802 F.3d 1090 (9th Cir. 2015), to support her view that injunctive relief is appropriate here. Ironically, *Norsworthy* provides a very useful contrast to the facts of this case. In *Norsworthy*, the district court granted an inmate's—Norsworthy's—request for a preliminary injunction requiring SRS. It did so, however, in light of facts that are dramatically different than those at issue here.

First, the court emphasized that the evidence indicated that Norsworthy was denied SRS pursuant to "a blanket policy barring GRS as a treatment for transgender inmates," not based on an individualized judgement regarding that inmate and medical necessity. *Id*. at 1191. The Court noted that a written correctional policy provided that SRS "shall not be the responsibility of the Department," that prison medical staff testified that there was "an understanding that [SRS] would not be available," that no prison guidelines provided that SRS was an option, and a recent training to medical staff by Dr. Steven Levine—also defendants' expert in *Norsworthy*—stated that SRS should never be provided to inmates. *Id*.

Exactly the opposite is true here. SRS as a treatment for gender dysphoria is not prohibited by the IDOC, either by written policy or by "de facto" policy. Defendants' Joint Proposed Findings of Fact and Conclusions of Law ("FOF") ¶¶ 31 – 33. An IDOC Standard Operating Procedure ("SOP"), in place since 2011, specifically provides that SRS is available as a treatment for GD when recommended as medically necessary by a qualified provider. *Id*. As is generally true with determinations regarding the medical necessity of particular forms of treatment for any medical

need, IDOC personnel defer to Corizon's qualified medical providers regarding the propriety and medical necessity of SRS as a treatment in particular cases. *Id*. If one of the approximately 30 inmates housed in IDOC facilities diagnosed with GD expressed the desire for surgery and met the criteria for SRS after an evaluation with a qualified GD evaluator, the IDOC would not prohibit such a surgery and would defer to the professional judgment of the mental health and medical providers assessing the inmate's particular condition. *Id*. ¶ 33. Corizon and its providers recognize that SRS is an available treatment for appropriate GD patients, not in any way prohibited as a treatment for GD by either IDOC or Corizon. *Id*. ¶ 28. As with all determinations of medical necessity, Corizon relies on the clinical judgment of its providers as to the medical necessity of particular treatments, including SRS. *Id*.

Ms. Edmo attempts to make much of the fact that Dr. Steven Levine, involved in the *Norsworthy* case, also provided a training to some Corizon and IDOC employees in early 2016. [*See* Plaintiff's Reply in Support of Motion for Preliminary Injunction [Dkt. 62] at 5 – 6]. Again, however, even the facts regarding Dr. Levine's training in this case as opposed to *Norsworthy* are importantly different. In *Norsworthy*, the training stated that SRS is never appropriate in the correctional context. *Norsworthy*, 87 F. Supp. 3d at 1191. Dr. Levine's training in this case did not state that SRS is never appropriate in the correctional context. More importantly, there is no evidence that Dr. Levine's training here was somehow adopted as policy by Corizon or IDOC. FOF ¶ 29 – 30. By contrast, in *Nosworthy*, there was testimony that Dr. Levine's then-expressed view was enshrined in written policy and was understood to be policy by medical providers, despite a finding (discussed further below) of medical necessity by treating providers. *Norsworthy*, 87 F. Supp. 3d at 1191. In this case, the views expressed by Dr. Levine at the training were considered by Corizon providers, but were not taken to be controlling or in any way policy. FOF ¶¶ 29 – 30.

There is simply no evidence to the contrary.

Next, Norsworthy's correctional mental health care provider, "who established a relationship with her over two years, unequivocally determined that she is in the group of patients for whom SRS is medically necessary." *Norsworthy*, 87 F. Supp. 3d at 1186. "Instead of following his recommendations, [correctional personnel] removed her from his care." *Id.* at 1190. Because "[a] prison official acts with deliberate indifference when he ignores the instructions of the prisoner's treating physician or surgeon," the court determined that Norsworthy was likely to succeed on the merits of her claim for deliberate indifference. In addition to the fact that a treating provider had made an affirmative determination that SRS was medically necessary for Norsworthy, there was "no evidence that any provider, as distinguished from an independent evaluator, ha[d] ever determined that SRS [was] not medically necessary for Norsworthy." *Id*. at 1190.

Again, exactly the opposite is true here. No provider has ever determined that SRS is medically necessary for Ms. Edmo, and numerous qualified treating providers have independently determined that it is not. FOF ¶¶ 45 – 55.

Corizon medical providers made this judgement, in part, by relying on the WPATH standards. As the WPATH standards explicitly state, they are "flexible clinical guidelines" that provide direction, but may be departed from, modified, and adjusted based on the patient's "unique social, or psychological situation." *Id*. ¶ 34. *See also Pinson v. United States*, No. 1:17-CV-00584, 2018 WL 1123713, at *3 (M.D. Pa. Feb. 26, 2018), *reconsideration denied,* No. 1:17-CV-00584, 2018 WL 3840820 (M.D. Pa. Aug. 13, 2018) ("The WPATH standards are an information resource which may provide guidance on medical and mental health treatment, which may include education, counseling, medical evaluations, hormone treatments, 'real-life' experience, and, in

some but not all cases, sexual reassignment surgery." (internal quotation marks omitted)). The WPATH only vaguely and generally addresses treatment for GD in the correctional context, the standards have not been universally adopted, and the evidence to support them is inconclusive at best. FOF ¶¶ 39 – 44. Treatment providers, particularly those in a correctional context, are certainly not obligated to follow those standards without deviation in all circumstances. *Id*.

Nevertheless, Ms. Edmo's providers did look to those standards to determine whether SRS was medically necessary. In particular, the WPATH standards require that mental health concerns must be well controlled prior to SRS, and whether such concerns are present and well controlled is a matter of clinical judgment. *Id*. ¶ 35 – 36. Both Dr. Scott Eliason, Corizon's Director of Psychiatry, and Jeremy Clark, LCPC, a supervising licensed mental health clinician and WPATH member, judged that Ms. Edmo had existing mental health concerns that were not in adequate control. *Id*. ¶¶ 10, 45 – 55. Ms. Edmo had existing diagnoses of Major Depressive Disorder and Anxiety; exhibited emotional instability; engaged in concerning behaviors, including assault of other inmates, sexual acting-out with other inmates, anger management issues, and problems with interpersonal relationships; she additionally exhibited borderline personality disorder traits, including sexual deviance, depression, relationship issues, and substance abuse. *Id*. ¶¶ 2 – 5, 19 – 27, 45 – 55. She refused to complete sex offender programing, refused to attend recommended Social Skills and Mood Management Groups, and had not consistently participated in individualized counseling. *Id*. ¶ 23. For these and additional reasons, Dr. Eliason, Jeremy Clark, and other providers judged that SRS was not currently medically indicated.

Defendants' experts have since confirmed that Ms. Edmo's Corizon providers were correct and provided care meeting the standard of care. *Id*. ¶¶ 56 – 81. Dr. Garvey, for example, agrees that Ms. Edmo has existing mental health comorbidities that are not sufficiently controlled for

purposes of SRS. *Id*. ¶¶ 65 – 69. For example, Ms. Edmo has engaged in self-harm, including cutting, just this year, and Dr. Garvey believes that it is important that Ms. Edmo learn and develop further coping skills to avoid further self-harm following any major surgical procedure. *Id*. Dr. Garvey has additionally opined that Ms. Edmo has not satisfied the WPATH standard requiring persistent, well-documented gender dysphoria. *Id*. ¶ 118. In particular, there are crucial inconsistencies between Ms. Edmo's self-report of consistent gender dysphoria and her history (or, lack thereof) of presenting as a female in the community that should be investigated and addressed before serious consideration of SRS. *Id*. ¶ 6 – 7. Finally, like Dr. Eliason, Dr. Garvey noted that WPATH explains that a patient under consideration for SRS must experience all of the things they are going to experience outside of prison, such as social transition or their physical transition, work response, family parties, and all sorts of things that one would encounter in their life, while Ms. Edmo has not been able to fully engage in such experience in prison. *Id*. ¶¶ 49, 68.

Ms. Edmo has presented contrary testimony from her own experts. That fact is irrelevant for a number of reasons. First, unlike Dr. Garvey, Ms. Edmo's experts, Drs. Ettner and Gorton have little or no experience treating GD in the correctional context or, for that matter, treating mental health issues more generally in the correctional context. *Id*. ¶¶ 82, 87. Second, and more importantly for present purposes, this is not a "battle of experts." A "difference of medical opinion"—even a difference of opinion amongst experts—regarding debatable treatment decisions is "insufficient, as a matter of law, to establish deliberate indifference." *Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996). *See also Savage v. Gelok*, No. 1:16-CV-00073-BLW, 2017 WL 3484159, at *10 (D. Idaho Aug. 14, 2017) ("[M]ere differences of opinion among medical personnel do not rise to the level of deliberate indifference."). Ms. Edmo is receiving treatment for GD, even if not the treatment she prefers. FOF ¶¶ 8 – 18. "The Constitution only requires that the

courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Mintun v. Corizon Med. Servs.*, No. 1:16-CV-00367-DCN, 2018 WL 1040088, at *5 (D. Idaho Feb. 22, 2018) (internal alterations omitted).

Even if negligence or malpractice, the view that SRS was and is not medically necessary for Ms. Edmo does not constitute deliberate indifference. *Toguchi v. Chung*, 391 F.3d 1051, 1057 – 60 (9th Cir. 2004) (deliberate indifference is a high legal standard; a difference of opinion concerning the course of treatment, negligence, or medical malpractice does not amount to deliberate indifference). Finally, the fact that Ms. Edmo's providers made a judgment as to medical necessity based on the evidence and their medical expertise establishes that there was no discrimination for purposes of a claim under the Fourteenth Amendment or the ACA. If their determination was based on their medical judgment and the evidence available to them, even if negligence or malpractice, it was not discrimination on the basis of some protected category.

For the reasons discussed above, this case is very unlike *Norsworthy*. It is far more like *Pinson v. United States*, No. 1:17-CV-00584, 2018 WL 1123713, at *14 (M.D. Pa. Feb. 26, 2018), *reconsideration denied,* No. 1:17-CV-00584, 2018 WL 3840820 (M.D. Pa. Aug. 13, 2018). In *Pinson*, an inmate diagnosed with GD demanded SRS, filed suit claiming deliberate indifference, and that suit was dismissed on summary judgment. Relying in part on the WPATH standards, the relevant mental health provider determined that SRS was not medically necessary or appropriate based on uncontrolled mental health issues, including anxiety, oppositional behavior, failure to comply with all treatment recommendations, and failure to live continuously as a female for an appropriate period of time. *Id*. at *8, *14. There was no policy or blanket prohibition on SRS; the court determined that the mental health provider made a "professional judgment" regarding the

propriety of that care in the particular case; that she treated appropriately by providing hormone therapy instead; and that the inmate's mere disagreement regarding the propriety of SRS was not sufficient to support a claim for deliberate indifference. *Id* at *12 – 13. Those facts are virtually identical to the facts here.

Like *Norsworthy*, the other cases centrally relied upon by Ms. Edmo are not on point. Each involves (1) a determination by a treatment provider that SRS (or that other treatment) was medically necessary that was then ignored by other correctional personnel, and/or (2) explicit blanket policies prohibiting SRS (or, some other treatment for GD) in the correctional context. *See Hicklin v. Precynthe*, No. 4:16-CV-01357-NCC, 2018 WL 806764, *3, *11 – 12 (E.D. Mo. Feb. 9, 2018) (primary care providers determined that hormone therapy was medically necessary, but such therapy was denied in compliance with a blanket policy against it); *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011) (affirming determination that statute prohibiting hormone therapy and SRS in correctional contexts was unconstitutional).

Ms. Edmo is not likely to succeed on her claims. The evidence shows that her providers made a medical judgment regarding the propriety of a certain treatment based on the evidence available to them and their medical expertise. Right or wrong, Ms. Edmo's disagreement (and the disagreement of her retained experts) does not give rise to a claim for deliberate indifference or for discrimination under either the Fourteenth Amendment or the ACA. As a matter of fact, however, the evidence also shows that the judgment of Ms. Edmo's treating providers was not only reasonable, but right.

C. Ms. Edmo cannot establish, much less clearly establish and render in no way doubtful, that extreme or very serious damage that cannot be compensated in damages will result absent injunctive relief.

Generally, "a plaintiff seeking a preliminary injunction [must] demonstrate that irreparable

injury is *likely* in the absence of an injunction," not merely possible. *Herb Reed Enterprises, LLC v. Fla. Entm't Mgmt., Inc.*, 736 F.3d 1239, 1249 (9th Cir. 2013) (internal quotation marks omitted) (emphasis in original). Such a showing must be grounded in evidence; it cannot be cursory or conclusory. *Id*. Because Ms. Edmo's request for injunctive relief is both mandatory and seeks substantially all of the relief to which she might be entitled after trial, she must show that "extreme or very serious damage *will* result absent injunctive relief" and that damage cannot be compensable. *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009) (emphasis added).

In support of her claim that this element is met, Ms. Edmo points to her previous suicide attempts, to previous self-harm, and to psychological injury. [Dkt. 62, 16 – 17]. She then further points to the allegation that her constitutional rights are presently being violated. [Id. at 18]. This argument ignores a number of crucial pieces of evidence.

First, as discussed above, both Ms. Edmo's Corizon providers and Dr. Garvey see good reason to be concerned that Ms. Edmo does not have the coping skills and mental and emotional stability to handle SRS and possible relocation to a female prison after such procedure is complete. FOF ¶ 25, 67, 69, 81. If Ms. Edmo's providers are correct that she does not meet the WPATH standards because, among other reasons, she has mental health issues that are not adequately controlled, lacks appropriate coping skills, and has not had the opportunity to live as a female for an extended period of time, SRS is likely to *cause* harm to Ms. Edmo, not prevent it.

Second, and relatedly, Ms. Edmo has a history of self-harm and suicide attempts apparently unrelated to GD. She reported repeated suicide attempts related to relationship problems, economic distress, other feelings of worthlessness, and legal troubles. FOF ¶¶ 3 – 5. Her pre-incarceration records do not reflect that her suicide attempts and mental health issues were related to GD in any

way. *Id*. Dr. Garvey has opined that, if Ms. Edmo is not mentally stable with her mental health issues under control, SRS is likely to exacerbate, not resolve, suicidal ideations. *Id*. ¶ 69.

Next, there are no quality studies regarding outcomes after SRS, making it difficult to form a reasoned and informed judgment about the extent to which SRS will ameliorate Ms. Edmo's pattern of self-harm. Studies that report a low regret rate after SRS have small pool samples and a significant number of people that are lost to follow-up. *Id*. ¶ 64. There are other studies that report a regret higher rate—19.1%—when comparing post-SRS patients with the general population. *Id*.

In sum, while SRS is sometimes medically indicated, the suggestion that SRS is a means to avoid mental suffering, self-harm, and suicide attempts in individuals who have uncontrolled mental health issues is belied by the evidence. The WPATH standards require that mental health issues be well-controlled prior to SRS precisely because SRS can exacerbate such issues, putting patients at risk. Ms. Edmo's uncontrolled mental health issues suggest that SRS may well cause extreme or very serious damage. The evidence certainly does not show that it will prevent that result. Finally, Plaintiff makes no showing, or even any argument, that any harm or damage she might suffer would not be compensable in damages. *See Brady v. Gebbie*, 859 F.2d 1543, 1557 (9th Cir. 1988) (noting that mental and emotional distress is compensable under section 1983).

D. Ms. Edmo has failed to establish, much less clearly establish and render in no way doubtful, that the balance of equities favors granting preliminary relief.

The Corizon Defendants concede that *if* Ms. Edmo can establish that she is receiving constitutionally inadequate care, then this factor weighs in favor of a preliminary injunction. As discussed above, however, Ms. Edmo *cannot* establish that she is receiving constitutionally inadequate care. Because she cannot, she also cannot show that the balance of equities tips in her favor. It is not a balancing of equities to interfere in prison administration and order a health care

provider to provide treatment that he or she reasonably judges, based on evidence and on medical expertise, to be unnecessary and contraindicated.

E. Ms. Edmo has failed to establish, much less clearly establish and render in no way doubtful, that the public interest favors granting preliminary relief.

"The public interest inquiry primarily addresses [the] impact on non-parties rather than parties." *Sammartano v. First Judicial Dist. Court, in & for County of Carson City*, 303 F.3d 959, 974 (9th Cir. 2002). As a result, "[w]hen the reach of an injunction is narrow, limited only to the parties, and has no impact on non-parties, the public interest will be at most a neutral factor in the analysis rather than one that favors granting or denying the preliminary injunction." *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1138–39 (9th Cir. 2009).

The Corizon Defendants acknowledge that the public has an interest in ensuring that constitutional rights are vindicated. But, again, Ms. Edmo has not shown that her constitutional rights are being or are likely being violated. That claimed interest is therefore not at issue. In addition, the Corizon "Defendants' interests and the public interests in penological order could be adversely affected if the Court began dictating the treatment for the Plaintiff, one inmate out of thousands in the state prison system." *White v. Smyers*, No. 212CV2868MCEACP, 2016 WL 4445338, at *6 (E.D. Cal. Aug. 23, 2016), *report and recommendation adopted,* No. 212CV2868MCEACP, 2016 WL 5661773 (E.D. Cal. Sept. 30, 2016) (internal quotation marks and alterations omitted). To the extent that this element supports either party, therefore, it supports the Corizon Defendants. At any rate, clearly does not support Ms. Edmo.

III. CONCLUSION

Ms. Edmo's motion should be denied. She is requesting substantially all of the relief to which she might be entitled at trial in the form of a mandatory injunction. But even if she was pursuing only ordinary injunctive relief, she falls far short of the required showing.

DATED this 26th day of October, 2018.

PARSONS BEHLE & LATIMER

By: */s/ Dylan A. Eaton*
Dylan A. Eaton
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Catherine Whinnery

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 26th day of October, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

ADREE EDMO,

Plaintiff,

v.

IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15;

Defendants.

NO. 1:17-cv-151-BLW

DEFENDANTS' JOINT PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

COME NOW Corizon Defendants and IDOC Defendants, by and through their respective counsel of record, and hereby jointly submit these proposed findings and conclusions of law.

I. PROPOSED FINDINGS OF FACT

A. Procedural Posture of the Case

1. Plaintiff Adree Edmo filed a Motion for Preliminary Injunction (Dkt. 62) on June 1, 2018. While Ms. Edmo's motion sought injunctive relief on several issues, Ms. Edmo now only seeks an injunction ordering gender confirming surgery and as of yet undefined cessation of discipline related to Gender Dysphoria ("GD"). (Dkt. 111, fn. 2).

B. Edmo's Mental Health History Prior to Incarceration

2. Prior to her most recent incarceration in 2012, Ms. Edmo demonstrated a significant history of mental health and substance abuse issues and was diagnosed with Major Depressive Disorder, Anxiety, and Alcohol Dependence. Ms. Edmo exhibited multiple serious mental health concerns. (Tr. 128:16-25, 209:21-25, 210:1-5; DEF Ex. 2007, DEF Ex. 2009, DEF Ex. 2010_0045, 0046, 0073). Ms. Edmo was sexually abused repeatedly as a child and was a victim of domestic abuse by partners in her early twenties. (Tr. 129:1-6, DEF Ex. 2007_0005; DEF Ex. 2010_0067, 0071, 0082). Ms. Edmo has a history of cutting herself and several criminal offenses related to alcohol, including intoxicated driving. (DEF Ex. 2009; DEF Ex. 2010_0004-0005, 0036-0038).

3. Also prior to her incarceration, Ms. Edmo made at least two serious suicide attempts, but reported to an IDOC clinician that she had attempted suicide as many as five times prior to 2012. (Tr. 207:18-21, 209:5-20; JT Ex. 1-379; DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010). On one occasion, Ms. Edmo severely lacerated her right arm after a dispute with a boyfriend and was hospitalized afterward in the BHU in Pocatello. In another attempt, Ms. Edmo overdosed on prescription pills and alcohol. (Tr. 129:7-10, 210:6-9; DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010).

4. Ms. Edmo's documented suicide attempts were related to her alcohol abuse, relationship problems, economic distress, sustained unemployment, legal troubles, and feelings of

worthlessness. (Tr. 210:6-25, DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010). At the time of her first suicide attempt in 2010, Ms. Edmo was prescribed an anti-depressant and was recommended to treat her depression with psychiatry. (DEF Ex. 2007_0001, 0006; DEF Ex. 2009_0015). After her second suicide attempt in 2011, she expressed a desire to attend counseling and was referred for counseling and a medication evaluation. (DEF Ex. 2007_0009).

5. Ms. Edmo's pre-incarceration records, including her PSI reports, hospital, and other mental health records demonstrate that her prior suicide attempts, substance abuse, depression, anxiety, and cutting were not related to GD. Further, there is no evidence in those records that Ms. Edmo was experiencing anatomical GD due to her genitals. Rather, Ms. Edmo's pre-incarceration records demonstrate that Ms. Edmo's depression and anxiety were related to substance abuse, relationship problems, personal failures, past trauma, impulsivity, sexual orientation, and anger. Ms. Edmo never reported gender identity issues during the PSI process nor in any of the records related to her suicide attempts. (Tr. 126:14-25, 127:1-25; DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010_0005, 0046, 0051, 0054, 0057, 0058, 0067, 0077, 0078, 0113). Despite her serious suicide attempts, Ms. Edmo failed to participate meaningfully in treatment to address her mental health issues, including cutting, major depression, anxiety, and substance abuse. (DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010_0048- 0051, 0067). In fact, when Ms. Edmo entered prison in 2012, she was taking anti-depressants and anti-anxiety medication, but was nevertheless still identified as having a significant risk for suicide. (JT Ex. 1-299-300; DEF Ex. 2010_0045, 0057, 0067, 0071, 0077).

C. Credibility Issues with Ms. Edmo

6. Ms. Edmo claims that she "began living full-time as a woman around the age of 20 or 21." (Dkt. 62-2, ¶7.) Ms. Edmo made similar claims regarding living as a woman pre-incarceration to her experts in this case. (Ettner Decl., Dkt. 62-1, p. 10, ¶16; Gorton Decl., Dkt.

62-1, p. 59, ¶33). To the contrary, Ms. Edmo has made several statements inconsistent with those accounts. (Tr. 116:8-25, 117:1-6). Ms. Edmo's pre-incarceration records are notably silent as to her ever presenting as a female or living as a female. (DEF Ex. 2007; DEF Ex. 2009; DEF Ex. 2010). In the psychosexual evaluation conducted as part of her PSI report in 2012, Ms. Edmo denied ever cross-dressing. (DEF Ex. 2010_56, 69). Likewise, on June 25, 2012, Dr. Eliason indicated in his initial assessment of Ms. Edmo that she "reported only dressing as a female during rare occasions." (Tr. 450:1-16; JT Ex. 1-321). Moreover, Ms. Edmo's probation officer, Cliff Cummings, who supervised her from June, 25, 2010, until February 8, 2011, and met with her in person fifteen times, never observed Ms. Edmo wearing women's clothing or makeup, nor did he observe Ms. Edmo wearing a feminine hairstyle. She did not present or appear as a woman in any way and did not ask Mr. Cummings to refer to her using female pronouns. (Cummings Decl., Dkt. 101-5, ¶¶ 1-7, Ex. 1).

7. Additionally, Ms. Edmo testified under oath at the evidentiary hearing that she was not aware of GD or Gender Identity Disorder ("GID") until she entered prison. (Tr. 194:6-10). This testimony is directly contradicted by Ms. Edmo's sworn declaration, filed in support of her *Motion*, where she testified that she first heard of GID during a visit with a psychiatrist at her own tribal health center. (Dkt. 62-2, ¶9). Ms. Edmo's Declaration further describes how, around the time that she first learned about GID from her psychiatrist, she met transgender people who informed her about hormone replacement therapy and surgical procedures to help her transition. (Dkt. 62-2, ¶10). Ms. Edmo also told Dr. Gorton that she was aware of GID prior to her incarceration and wanted hormone therapy and surgery, but knew that it was "a lengthy process." (Gorton Decl., Dkt. 62-1, p. 59, ¶32).

D. Edmo's Incarceration, Early Diagnosis of GID, and Early Treatment

8. Ms. Edmo entered IDOC custody on April 26, 2012, after pleading guilty to felony Sexual Abuse of a Child Under the Age of Sixteen Years. (DEF Ex. 2010_0032; JT Ex. 04-6). Ms. Edmo was previously incarcerated in 2009 after felony convictions for Drawing a Check Without Funds. (DEF Ex. 2010_0001; JT Ex. 04-1).

9. During her mental health intake screening upon entering prison, Ms. Edmo showed signs of depression, reported feelings of hopelessness and helplessness, and was overly anxious, afraid, or angry. (JT Ex. 1-299-300). As part of her intake suicide risk assessment, Ms. Edmo reported severe anxiety and depression and experienced recent suicidal ideations. She also stated that she had recently experienced a loss of a relationship and was fearful for her safety. (JT Ex. 1-301-306). Ms. Edmo stated that she believed that "relationship issues were the primary reasons for [her] depressed mood and suicide attempts." (JT Ex.1-311). During each of those mental health visits and intakes to screen her for mental health conditions, Ms. Edmo did not report having depression or anxiety related to her gender identity or genitals.

10. Less than three months after her incarceration, on or about July 19, 2012, Ms. Edmo was diagnosed with GD (formally GID) by Dr. Scott Eliason, the Corizon Director of Psychiatry. (JT Ex. 1-321). Dr. Eliason is a well-qualified psychiatrist with specialization in the correctional setting. He is Board Certified in Forensic and General Psychiatry. He also is a Certified Correctional Healthcare Provider (CCHP); he is a CCHP certified medical doctor and mental health provider. Before working in the Idaho prisons, Dr. Eliason shadowed a doctor in his residency who worked with transgender inmates at San Quentin in California. (Tr. 400:23-406:21; See DEF Ex. 2022.)

11. Dr. Eliason has been the Corizon Director of Psychiatry since about 2010. He sees patients and also oversees the psychiatric providers throughout the state, including other

psychiatrists, nurse practitioners, and physician's assistants throughout the Idaho state prisons. He sees patients approximately 90% of the time and then the other 10% of his time is spent on administrative activities, such as peer reviews, reading credentialing interviews, and being involved in the hiring process. (DEF Ex. 2022).

12. Dr. Eliason was not the only provider to evaluate Ms. Edmo for GD. Dr. Claudia Lake, a Corizon Psychologist, also assessed Ms. Edmo and came to the same conclusion diagnosing her with GID. (JT Ex. 1-323-327). Both Dr. Eliason and Dr. Lake used the DSM-IV to assess GID and their assessments included a thorough transgender history of Ms. Edmo. (JT Ex. 1-321, 323-327). On August 23, 2012, a team of Corizon providers and IDOC employees met at a Management and Treatment Committee ("MTC") meeting and agreed Ms. Edmo could start hormone therapy, among other things. (JT Ex. 7-1-4).

13. The MTC continued to meet over the years to discuss Ms. Edmo's GD, her treatment and care, address her cooperation with mental health groups, recommend treatment, assess her behavior, and discuss housing options for Ms. Edmo. (JT Ex. 7-5-110).

14. Dr. Cathy Whinnery, M.D., who was the ISCI Medical Director at the time, started hormone therapy soon after Ms. Edmo was diagnosed with GID in 2012 and then appropriately managed her hormone therapy until early 2015. (Jt. Ex. 1-188, 223-224, 238-239, 690-692, 694-695, 699-702, 726-727, 731, 733). Ms. Edmo began to feel better after beginning hormones and felt as if her mind had cleared and a cloud had been lifted. She developed breasts, her body fat was redistributed, and her skin softened. (Tr. 196:15-25, 223:9-14).

15. To support her growing breasts, Ms. Edmo was issued a medical memo for and received a bra. (Tr. 224: 6-18; JT Ex. 1-729). Ms. Edmo was also provided a jock strap and some

pads, which supported Ms. Edmo's sensitive testicles and allowed Ms. Edmo tuck her penis. (Tr. 224:19-25, 225:1-7; JT Ex. 1-734).

16. Additionally, Ms. Edmo had numerous appointments with Dr. Eliason and other mental health medical providers over other the years regarding treatment of her other mental health issues, such as anxiety and depression. From about 9/19/12 to 1/27/16, Dr. Eliason had approximately 12 appointments with Ms. Edmo regarding addressing her mental health issues and managed her antidepressant medications, among other things. (E.g., JT Ex. 1-337, 1-339, 1-342, 1-347, 1-352, 1-425, 1-435, 1-438, 1-447, 1-452, 1-479, 1-527). At one point, around August 28, 2013, Dr. Eliason signed a letter to the Idaho Department of Transportation to help Ms. Edmo change her driver's license to reflect that she was female. (JT Ex. 1-370).

17. Ms. Edmo has also been permitted to feminize appropriately and, since 2013, has maintained a demonstrably feminine appearance and presentation while housed in male facilities. (Tr. 142:9-16; JT Ex. 4-1-8; Campbell Decl., Dkt. 101-4, ¶ 21; Yordy Decl., Dkt. 101-12, ¶ 6, Ex. 1-4). In addition, Ms. Edmo has obtained female underwear and will be permitted to order makeup and female grooming items from the prison commissary, pursuant to the revised IDOC policy and guidelines for the treatment of GD inmates. (Tr. 216:11-13; 348:10-23; JT Ex. 9-1-9).

18. After receiving her diagnosis of GD, Ms. Edmo was encouraged by IDOC mental health clinicians to attend group and individualized therapy specifically for inmates who have been diagnosed with GD. (Tr. 218:22-25, 219:1; JT Ex. 7-35, 37, 39, 40, 47, 93; Campbell Decl., Dkt. 101-4, ¶ 21; Stewart Decl., Dkt. 101-1, ¶ 8).

E. Ms. Edmo's Disciplinary History

19. Since her incarceration in 2012, Ms. Edmo has received 32 Disciplinary Offense Reports ("DORs") for various offenses, which is a very high number for an offender who has been incarcerated for six years. (JT Ex. 5-1-71; Yordy Decl., Dkt. 101-12, ¶¶ 10-11, Exs. 5, 6). Ms.

Edmo's DORs have been issued for various reasons, including sexual contact, destruction of property, and assault. Ms. Edmo has not been disciplined for appearing feminine *per se*. Rather, Ms. Edmo has been disciplined repeatedly for being openly disobedient to correctional officers' direct orders to remedy Ms. Edmo's inappropriate or sexually provocative appearance. (Tr. 213:5-25, 214:1-25, 215:1, 15-21; Yordy Decl., Dkt. 101-12, ¶¶ 10-11, Exs. 5, 6; JT Ex. 5-1-71). Ms. Edmo's significant disciplinary problems, notably her assaultive behavior, sexual acting-out, and disobedience to direct orders, demonstrate that Ms. Edmo's underlying mental health conditions are not well-controlled. Such behaviors demonstrate traits of borderline personality disorder. (Tr. 340:7-23, 341:10 - 343:2, 364:19 - 365:1-4; Watson Decl., Dkt. 101-3, ¶17).

F. Ms. Edmo's Current Mental Health Concerns Unrelated to GD and Lack of Cooperation in her Treatment

20. Ms. Edmo continues to suffer from depression, anxiety, and borderline personality traits and currently exhibits other maladaptive behaviors, including co-dependency, relationship issues, disobedient behaviors, and sexually acting-out. (Tr: 125:12-20, 130:21-25, 131:1-3; 200:6-15; 339:14 - 340:4, 345:24 - 346: 25, 528:16 - 529:16, 538:6-24, 542:19 - 543:11; DEF Ex. 2016; Campbell Decl., Dkt. 101-4, ¶ 25; Stewart Decl., Dkt. 101-1, ¶¶9-13; Watson Decl., Dkt. 101-3, ¶10, 17-19).

21. During her clinical interview with Ms. Edmo in March of 2018, Plaintiff expert Dr. Randi Ettner conducted testing, which revealed that Ms. Edmo exhibited severe anxiety, depressive symptoms, and feelings of worthlessness, along with moderately high hopelessness scores, and the highest possible score on the scale measuring suicidal ideation. (Tr. 125:7 – 128: 15).

22. Ms. Edmo also demonstrates symptoms related to severe unresolved childhood trauma and borderline personality disorder. (Tr: 131:12-23, 635:9-14, 495:13-18, 640:10 - 641:20;

665:24-13, 667:5-19; Campbell Decl., Dkt. 101-4, ¶25; Stewart Decl., Dkt. 101-1, ¶10; Watson Decl., Dkt. 101-3, ¶17; Clark Decl., Dkt. 101-7, ¶112).

23. Despite several recommendations from her treating clinicians, Ms. Edmo has repeatedly not attended therapy to help her work through her serious underlying mental health issues and pre-incarceration history of trauma, abuse, and suicide attempts. Ms. Edmo has repeatedly refused to attend recommended groups such as Mood Management, Healthy Relationships, and Social Skills. (Tr. 134:8-25, 135:1-23, 218:21-25, 219:1-14, 220:17-20; 221:16-19; JT Ex.7-26-28, 34-36; Campbell Decl. Dkt., 101-4, ¶¶24, 29; Stewart Decl., Dkt. 101-1, ¶12; Watson Decl., Dkt. 101-3, ¶18; Clark Decl., Dkt. 101-7, ¶14). As with her pre-incarceration mental health issues, Ms. Edmo at times expressed a desire to attend counseling and groups for her significant mental health concerns, but did not follow through with those treatment recommendations (Tr. 219:15-25, 220:17-25, 221:1-19; DEF Ex. 2009_0008-0016; DEF Ex. 2010_0048- 0051, 0067; Watson Decl., Dkt. 101-3, ¶¶ 11, 12).

24. After assaulting another inmate with GD on two occasions, Ms. Edmo was prohibited from attending GD group for six months. She was later approved to return to the GD group so long as she also completed a Social Skills group, but Ms. Edmo refused. (JT Ex.7-26-27; Stewart Decl., Dkt. 101-1, ¶¶ 7, 8). In addition, Ms. Edmo has not completed her mandated sex offender treatment programming, making her ineligible for parole. (Tr. 219:8-10, 221:16-19; Watson Decl., Dkt. 101-3, ¶ 18; Jones Decl., Dkt. 101-6, ¶ 13).

25. Ms. Edmo has not developed healthy coping skills to address her major depressive disorder, anxiety, or GD. For example, Ms. Edmo engages in unhealthy coping strategies by cutting her arms. (Tr. 345:24 - 346: 25, 347:1-14, 529:7-16, 538:6-24, 546:3-9, 605:13-19; Watson Decl., Dkt. 101-3, ¶18; Stewart Decl., Dkt. 101-1, ¶10). In addition, on 9/30/15 and 12/31/16, Ms.

Edmo alleges to have unsuccessfully attempted self-castration (Edmo Decl., Dkt. 62-2, ¶31, 33), which further evidences her instability and poor coping skills. However, Ms. Edmo believes that it is important to preserve her male anatomy so that in the future, if surgery becomes appropriate, her genital tissue will be available to create female anatomy. (Tr. 218:7-14).

26. IDOC Clinical Supervisor and certified CCHP, Laura Watson, was one of Ms. Edmo's mental health clinicians from 2013 to 2015. Ms. Watson is a member of the MTC and also ran the GD group for which Ms. Edmo attended in 2013. Ms. Watson is qualified to treat GD and is familiar with Ms. Edmo's mental health history and treatment. (Watson Decl., Dkt. 101-3, ¶¶ 1-11). Ms. Edmo requested specifically to meet with Ms. Watson after allegedly having attempted to remove her testicles in 2015. Ms. Edmo admitted that she struggled with wanting and needing male attention, and although she wanted to remove her testicles, she knew it would not fix her long-standing mental health issues. Ms. Edmo also agreed that if she did not address her underlying mental health issues, she would still be broken inside, even after surgery. (JT Ex. 1-489-490; Watson Decl., Dkt. 101-3, ¶11, Ex. 1).

27. LCPC Krina Stewart has been Ms. Edmo's treating mental health clinician since 2016. Ms. Stewart also participates in the MTC. Ms. Stewart is qualified to treat GD and is familiar with Ms. Edmo's mental health history and treatment while in the custody of IDOC. (Stewart Decl., Dkt. 101-1, ¶¶ 1-8). During her clinical contacts with Ms. Edmo, Ms. Stewart observed that Ms. Edmo speculates that GD is the main cause of her depression and attempts at self-castration. However, Ms. Edmo has other stressors that contribute to her depression, including relationship issues, past trauma, and past abuse. In Ms. Stewart's experiences with Ms. Edmo, Ms. Edmo's dysphoria fluctuates depending on her life stressors, including her job, housing, and relationships. When Ms. Edmo experiences a stressful life event, such as a break-up with a boyfriend, Ms.

Edmo's dysphoria increases and she is unable to distinguish depression related to her major depressive disorder or GD. (Stewart Decl., Dkt. 101-1, ¶¶ 9, 10, 11).

G. Corizon's Practices Related to Gender Dysphoria (formerly GID)

28. Corizon has not issued any formal written policies and procedures regarding assessment and treatment for inmates with GD (formally GID), such as for sex reassignment surgery. Rather, Corizon defers to the clinical judgment of its providers and also follows the IDOC standard operating procedures. (Tr. 453:20-454:3). Corizon allows its providers to consider any and all treatment options that are necessary for an inmate with GD, including but not limited to psychotherapy, hormone therapy, and surgery (including sex reassignment surgery). (Tr. 453:5-19). Specifically, surgery as a treatment for GD is not prohibited by Corizon. (Tr. 453:9-11). As of March 2017, Corizon issued a Clinical Pathways regarding GD that is primarily focused on hormone replacement therapy. This document is available to Corizon providers and is a guideline, but not a mandatory policy, regarding such treatment and care. (Tr. 491:1-18). This Clinical Pathway document does not preclude surgery. (JT Ex. 14).

29. Starting in the winter of 2016, Corizon started utilizing an offsite physician, Dr. Alviso, who specializes in treatment of care of inmates with GD. Dr. Alviso is not an employee or contractor with Corizon. He has agreed to be a consultant for GD care and treatment. (Tr. 451:13-452:2). Dr. Alviso has seen and treated Ms. Edmo multiple times since winter of 2016. (E.g., JT Ex. 1-215; 1-1512-13; 1-1561-64; 1-1357; 1-1358, 1-1360; 1-1565; 1-1505-06; 1-1508; 1-1509; 1-1510; 1-1371; 1-1591; 1-1592; 1-1593).

30. In 2016, Corizon asked Dr. Alviso and another specialist, Dr. Stephen Levine, to present on GD. These presentations were not adopted as policy. Rather, they were presentations for consideration by treatment providers as they exercised their clinical judgment in treating GD inmates. (Tr. 433:21 - 436:15, 437:2-11, 493:10-17; 494:24 - 495:1-9).

H. IDOC's 2011 Standard Operating Procedure (SOP) Regarding GD

31. IDOC's SOP that governed the treatment of inmates with GD from 2011 to October, 2018, provided guidelines for the diagnosis, treatment, management, and placement of offenders diagnosed with GD as outlined in the DSM. (JT Ex. 08-3). That SOP expressly recognized that sex reassignment surgery was an available treatment option for prisoners, so long as it was deemed medically necessary by a qualified GD evaluator. (JT Ex. 08-1-9). The SOP recognized the treatment options recommended in the WPATH guidelines, including hormone therapy, mental health services, and surgery. (JT Ex. 08-1-9). The SOP explicitly stated that offenders diagnosed with GID (now GD) would be provided access to the full range of services and programs available within IDOC to the same extent as other offenders. (JT Ex. 08-9).

32. When surgery is requested, the IDOC defers to the decisions of Corizon medical providers, such as Dr. Eliason, who are qualified to evaluate whether sex reassignment surgery is medically necessary. (Tr. 419:5 - 420:13; Campbell Decl., Dkt. 101-4, ¶20). No Corizon medical provider ever determined that sex reassignment surgery is medically necessary for Ms. Edmo. (Tr. 217:9-13). If such a surgery was recommended by a medical provider, the IDOC would provide it. (Tr. 454:4 - 455:13).

33. Sex reassignment surgery as a treatment for GD is not prohibited by the IDOC, either by written policy or by a "de facto" policy based on training received by Dr. Levine. (Tr. 334:23-25, 335:1-5, 347:18-25, 348:1-9, 382:12-21, 433:21 - 436:15, 437:2-11, 493:10-17; 494:24 - 495:1-9). Indeed, should one of the approximately 30 GD inmates housed in IDOC facilities meet the criteria for surgery after an evaluation with a qualified GD evaluator, the IDOC will not prohibit such a surgery and will defer to the professional judgment of the providers assessing the inmate's condition. (Tr. 322:21-25, 323:1-3, 382:22-25, 383:1-13).

I. Medical Standards or Guidelines for Treatment and Care of Patients with GD, including Criteria for Sex Reassignment Surgery/Vaginoplasty

34. The World Professional Association for Transgender Health (WPATH) has established a document called Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. (JT Ex. 15). There are multiple versions over the years of these WPATH guidelines and Version 7, the most recent version, has been in effect since 2011. While the title of the WPATH guidelines are entitled "Standards of Care," they are actually "flexible clinical guidelines." (Tr. 118:16-24, 119:1-7, 8-25, 288:7-23). The WPATH guidelines explicitly state that they "are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people." The same is true for the guidelines governing hormone therapy and surgery for GD: they are "clinical guidelines; individual health professionals and programs may modify them." Clinical departures from the guidelines may be necessary due to a patient's "unique social, or psychological situation." (JT Ex. 15-8).

35. The WPATH guidelines further provide that it is important to address any coexisting mental health concerns for persons with GD. The guidelines dictate that mental health providers should screen for anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, and personality disorders, because those concerns can be "significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of [GD]." (Tr. 122:16-25, 123:1-5; JT Ex. 15-31). Consistent with the guidelines, IDOC and Corizon providers constantly evaluated Ms. Edmo's coexisting mental health concerns and made recommendations to address those concerns, in addition to treating Ms. Edmo's GD. In other words, Ms. Edmo's treatment providers considered her as a whole person, rather than just the individual GD diagnosis. (Tr. 652:25 – 653:14, 667:5-23; Clark, JT Ex. 1).

36. The WPATH guidelines also provide that the presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to surgery, "rather, these concerns need to be optimally managed prior to or concurrent with treatment of [GD]. In addition, clients should be assessed for their inability to provide educated and informed consent for medical treatments." (Tr. 123:14-25; JT Ex. 15-31). Whether a patient has coexisting mental health concerns that need to be optimally managed is left to the clinical judgment of their qualified mental health providers. (Tr. 124:12-18). It is difficult to determine whether coexisting mental health concerns occur as a result of GD or due to other sources. (Tr. 171:1-14, 24-25, 172:1-5; 387:20-25, 388:1, 398:2-18, 601: 11- 602: 2; Campbell Decl., Dkt. 101-4, ¶¶ 30-33). Individual counseling and psychotherapy are useful ways to help identify the source of a patient's coexisting mental health concerns, such as depression, borderline personality disorder, and trauma. (Tr. 640: 10 – 641:20, 642:1-8).

37. The WPATH guidelines state that options for psychological and medical treatment of GD include: (1) changes in gender expression and role, (2) hormone therapy to feminize the body, (3) surgical changes primary and/or secondary sex characteristics, (4) psychotherapy. (JT Ex. 15-15-16). According to the WPATH guidelines, for the male-to-female patient, surgical procedures may include a variety of options, including breast/chest surgery, genital surgery (penectomy, orchiectomy, vaginoplasy, cliteroplasty, vulvoplasty) and other options, such as facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation, and hair reconstruction. (JT Ex. 15-6).

38. The WPATH guidelines for vaginoplasty are: 1) Persistent, well documented gender dysphoria; 2) Capacity to make a fully informed decision and to consent for treatment; 3) Age of majority in a given country; 4) Significant medical or mental health concerns are present,

they must be well controlled; 5) 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones); 6) 12 continuous months of living in gender role that is congruent with their gender identity. Although not an explicit criterion, WPATH recommends that patients also have regular visits with a mental health or other medical professional. (JT Ex. 15-66-67).

39. The WPATH guidelines have a short (1 ½ page) section on "Applicability of the Standards of Care to People Living in Institutions Environments," but it is very general and applies broadly to "institutions," including prisons and health care facilities. (JT Ex. 15-73). The guidelines do not provide any specific guidance on how to apply surgical criteria in a correctional setting. (JT Ex. 15-73-74). Indeed, the WPATH guidelines were not developed based on extensive clinical experience with incarcerated persons. (JT Ex. 19-3).

40. The WPATH guidelines do not have the quality of evidence behind the recommendations that are typically seen with treatment guidelines, such as with Endocrine society guidelines for hormone therapy. (Tr. 531: 3-23). More specifically, the WPATH guidelines do not have an evidence-based grading system. (Tr. 531: 3-23). As a result, they have not been universally adopted. The Centers for Medicare and Medicaid Services ("CMS") decided not to adopt the WPATH guidelines as controlling because it did not believe that the evidence was strong enough and wanted to allow providers to either use WPATH or their own standards based on their decision-making. (Tr. 532:21-533:5). Although this CMS opinion related to the Medicare population, CMS performed a thorough review of all the studies and cited several issues with the quality of evidence regarding outcomes after surgery, including small sample sizes, different methodology, different outcomes that were studied, and significant loss of evidence to follow-up when a population is not analyzed in any way. (Tr. 532:2-20).

41. In addition, the American Psychiatric Association ("APA") concluded that there were issues with the quality of the data and the quality of the evidence, including numbers of regret after surgery. (Tr. 533:6-17). In fact, some members of WPATH have raised concerns about the lack of scientific standards to ground the WPATH guidelines, which was one reason that WPATH in 2017 asked Johns Hopkins University to conduct an independent evidence-based review of those standards. (Tr. 147:7-25, 148:1-5).

42. Due to these deficiencies, the WPATH guidelines are a valuable resource, but are not so definitive that they can be equated with success. (Tr. 533:18-21). Accordingly, providers need to proceed cautiously in determining whether surgery is appropriate for an inmate in light of the lack of data. (Tr. 531:3-23; 534:4-7).

43. Given the flexibility of the WPATH guidelines and their deficiencies, medical and mental health providers can look to other resources for guidance on providing treatment and care. (Tr. 530:19 - 531:23). One such resource is an article entitled "Male Prison Inmates With Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?" by Cynthia S. Osborne and Anne A. Lawrence, published in the peer-reviewed journal, The Archives of Sexual Behavior. (JT Ex. 19-1). The WPATH guidelines cite to and rely upon a number of articles that have been published by the Archives of Sexual Behavior. (Tr. JT Ex. 15-81-84, 15-87-88, 15-90-92, 1l5-94-99).The WPATH guidelines also cite to several articles published and authored by Anne A. Lawrence (JT Ex. 15-12, 15-17, 15-69-70, 15-90, 15-99, 15-113).

44. The Osborne and Lawrence resource recommends additional eligibility requirements (permitted by the flexible application of the WPATH guidelines) to maximize the likelihood of successful outcomes and minimize regret: 1) Prominent genital anatomic GD; 2) A long period of expected incarceration after SRS; 3) A satisfactory disciplinary record and

demonstrated capacity to cooperate with providers and comply with recommended treatment; 4) A period of psychotherapy, if recommended by responsible practitioner; and 5) Willingness to be assigned to a women's prison after SRS. (JT. Ex. 19-12-13).

J. Assessment that Sex Reassignment Surgery (SRS) was Not Medically Necessary for Ms. Edmo.

45. On April 20, 2016, Dr. Eliason evaluated Ms. Edmo for sex reassignment surgery. Dr. Eliason met the criteria for a "qualified GD evaluator" under the IDOC GD SOP. (Tr. 419:18 - 420:13). Dr. Eliason began his evaluation by stating Ms. Edmo's subjective complaints. Ms. Edmo reported she was doing alright. However, she said she was eligible for parole, but it had not been granted to date due to DORs. Dr. Eliason noted that she had been on hormone replacement, which improved her GD. Dr. Eliason documented that Ms. Edmo noted frustrations with current anatomy and mentioned she had attempted to cut her genitals the past fall. She also requested to be assigned to a different housing unit. (JT Ex. 1-538).

46. Dr. Eliason also noted Ms. Edmo's weight and that she was taking Effexor, for depression and anxiety, and Remeron, which is an antidepressant. Dr. Eliason spoke with staff about the Ms. Edmo's behavior, which was notable for animated affect and no observed distress at that appointment. (JT Ex. 1-538). Dr. Eliason made objective observations of Ms. Edmo, including that she appeared feminine in her demeanor and interaction style and that her mood was "doing alright." (JT Ex. 1-538).

47. Dr. Eliason began his assessment by noting that medical necessity for SRS is not well defined and is constantly shifting. He then noted some examples of situations that could meet medical necessity, which he indicated Ms. Edmo did not meet. Ultimately, Dr. Eliason determined that SRS was not medically necessary. (JT Ex. 1-538).

48. One reason for Dr. Eliason's decision was that he determined that Ms. Edmo's mental health concerns were not fully in adequate control. (Tr. 430:22 - 431:2). Dr. Eliason documented in his April 20, 2016 assessment note that Ms. Edmo had diagnoses of Major Depressive Disorder (MDD), GD, and Alcohol Use Disorder. (JT Ex. 1-538). Dr. Eliason did not conclude that all of her mental health issues stemmed from her GD, but did conclude that her major depression and alcohol use disorders were separate mental health issues that needed to be more adequately controlled. (Tr. 451:1-12). Indeed, Dr. Eliason's SRS assessment note indicated, among other things, that she needed further "supportive counseling." (JT Ex. 1-538.)

49. Another reason for determining that SRS was not medically necessary for Ms. Edmo at that time was Dr. Eliason's decision that he was not doing Ms. Edmo any service to rush through getting gender reassignment surgery in her current social situation in the prison. Dr. Eliason did not believe that Ms. Edmo had satisfied the 12-month period of living in her identified gender role under WPATH standards. Dr. Eliason was aware of a study that he understood suggested that patients, after SRS, were more likely than the general population to kill themselves, in part because people's social networks were not supporting patients enough through their transitions. At that time, Ms. Edmo was parole-eligible and Dr. Eliason believed it would be most helpful to have her experience as a woman with her real social network – family and friends – outside the prison. (Tr. 431:3 – 432:11).

50. Dr. Eliason then stated his plan was to continue to monitor Ms. Edmo and "For the time being it is my opinion that the combination of hormonal treatment and supportive counseling is sufficient for her gender dysphoria." (JT Ex. 1-538).

51. In assessing Ms. Edmo for SRS in April 2016, Dr. Eliason also staffed the issue of medical necessity of SRS with multiple other providers, including Dr. Jeremy Stoddart, another

Corizon psychiatrist; Dr. Murray Young, Corizon's Regional Medical Director in Idaho; and Jeremey Clark, LCPC, who all agreed with his assessment. (JT Ex. 1-538). Mr. Clark recalls his conversation with Dr. Eliason in April 2016 and remembers telling Dr. Eliason that he did not believe surgery was medically necessary for Ms. Edmo and explained his reasoning. (Tr. 340: 24 - 341:15, 344:20 - 245:23; 383:14-25, Clark Decl., Dkt. 101-7, ¶¶ 1-11).

52. Mr. Clark has been a WPATH member since 2013 and has attended several WPATH conferences and correctional health care trainings, reviewed articles and publications regarding the treatment of transgender inmates with GD, and provided clinical supervision and training to IDOC clinical staff regarding the treatment and assessment of GD inmates. Mr. Clark is qualified under the WPATH to provide treatment to GD inmates. (Tr. 325:7 - 334:6, 397:16 - 398:19; DEF Ex. 2019, Clark Decl., Dkt. 101-7, ¶ 3-7). Mr. Clark is also a member of the MTC, which is a multidisciplinary committee that meets monthly to evaluate the needs of GD inmates. Those needs include issues with housing, clothing, treatment, and requests for hormone replacement therapy. (Tr. 323:4-10; DEF Ex. 2019, Clark Decl., Dkt. 101-7, ¶ 3-7).

53. Mr. Clark believed, based on his review and understanding of Ms. Edmo's complete health history and mental health records, along with his discussions with Ms. Edmo's providers and clinicians over the years, that surgery was not appropriate for Ms. Edmo. (Tr. 340:24 - 341:1-15; Dkt. 101-7, ¶ 11). Mr. Clark was primarily concerned that Ms. Edmo's coexisting mental health issues were not well controlled, as required by WPATH. Mr. Clark was concerned that Ms. Edmo displayed behaviors, such as assault of other inmates; sexual acting-out with other inmates, anger management issues, and problems with interpersonal relationships, all of which demonstrated to him that Ms. Edmo was emotionally unstable. He also was concerned that Ms. Edmo demonstrated

borderline personality disorder traits, including sexual deviance, depression, relationship issues, and substance abuse. (Tr. 341:16 - 344:3; Dkt. 101-7, ¶ 12).

54. Mr. Clark also noted that Ms. Edmo's emotional instability gave him concerns about her ability to handle the stressful process of surgery and possibly relocating to a female prison after the procedure was complete. Ms. Edmo was noncompliant with prison rules and he noted that she refused to complete sex offender programming, both of which raised concerns about Ms. Edmo's ability to comply with the care required after surgery. (Tr. 343:3 - 344:3; Dkt. 101-7, ¶ 13). Moreover, Mr. Clark felt that Ms. Edmo had not addressed her underlying Major Depressive Disorder, Anxiety, and other mental health issues. For example, he noted that Ms. Edmo had refused to attend recommended Social Skills and Mood Management groups and had not consistently participated in individualized counseling. (Tr: 344:5-19, Dkt. 101-7, ¶ 14). Mr. Clark still has the above concerns today regarding to Ms. Edmo. (Tr. 347:1-14, 383:9-17; Dkt. 101-7, ¶ 16).

55. On May 18, 2016, Dr. Eliason met with Ms. Edmo and explained that he was planning to set up a committee of Corizon medical providers to further assess SRS. (JT Ex. 1-543). This committee was not formed, however, because the medical providers he was considering for the committee stopped working for Corizon. Nevertheless, the MTC, which was already in place, can still consider SRS if appropriate. (Tr. 452:3 - 453:4). Dr. Eliason has a long working relationship with the IDOC and believes it is highly professional and that, if a medical provider came to the IDOC recommending surgery as medically necessary, then the IDOC and the MTC would follow that advice. (Tr. 454:4 - 455:13).

K. Sex Reassignment Surgery is Not Medically Necessary at this Time

56. Defense Expert, Keelin Garvey, M.D., is well-qualified to offer opinions about all options of treatment and care for inmates with GD, including whether surgery is medically

necessary. (DEF Ex. 2032.) In fact, she is the only expert in this case who is a psychiatrist and, as such, is in the unique position to be able to opine about the standards of care and appropriateness of care of a psychiatrist, such as Dr. Eliason. (Tr. 617:6-12). Also, unlike Ms. Edmo's experts, Dr. Garvey has experience working and treating patients in correctional settings, including experience with GD treatment committees in a prisons. (Tr. 617:13 - 618:7).

57. Dr. Garvey has a bachelor degree from Yale University and graduated from the University of Massachusetts Medical School. She then attended Brown University for her general psychiatry residency, followed by a one-year forensic psychiatry fellowship at UC Davis in California. She is a licensed psychiatrist in eight states and board certified in general adult psychiatry and also in forensic psychiatry. (Tr. 504:10-25; DEF Ex. 2032). Dr. Garvey has education in correctional healthcare as well, including a residency and two-month elective in the prison system in Rhode Island. She also had a forensic fellowship at the University of California Davis that involved two and a half days per week of correctional treatment work, which was more than most fellowships. (Tr. 505:1-23). Moreover, Dr. Garvey is a Certified Correctional Health Professional (CCHP) under the National Commission on Correctional Health Care. (Tr. 525:15-23). As a psychiatrist, she was trained under DSM-4, trained all mental health staff in the Massachusetts system, and has conducted national trainings on DSM-V. (Tr. 505:24 - 506:17).

58. As for experience, Dr. Garvey was a staff psychiatrist with a full caseload of patients whom she followed and treated in the Massachusetts Department of Correction (MDOC). (Tr. 506:21-25). She was promoted to deputy medical director for psychiatry, where she took on administrative responsibilities as well as maintained her clinical work. (Tr. 507:1-4). Then, in August of 2015, she became the chief psychiatrist in the MDOC, where she still provided clinical treatment to inmates, but also oversaw other providers (approximately 11 to 16 or so psychiatrists

and nurse practitioners). As the Chief Psychiatrist in the MDOC, one of Dr. Garvey's roles was to serve as the chair of the GD Treatment Committee. (Tr. 508:10-11).

59. Dr. Garvey directly treated patients in the Massachusetts Department of Correction who had GD. She oversaw up to about 30 to 40 inmates with GD at any given time. (Tr. 508:13 - 509:1). In the Massachusetts prison system, Dr. Garvey was involved in all aspects of treatment for GD patients; all treatment options were on the table for inmates with GD, including access to a treating clinicians and mental health therapy, hormone therapy, and sex reassignment surgery. (Tr. 509:2 - 510:9).

60. Dr. Garvey is qualified to render opinions on sex reassignment surgery. She has experience in treating patients, has reviewed a lot of literature on the topic, and attended WPATH trainings. She also had some training in her residency. Additionally, she was the Director of Psychiatry for the Massachusetts prison system and on the GD treatment committee in that setting where they reviewed the treatment plans of every individual in the state who had GD and conducted the confirmatory evaluation for every patient that entered the system that reported gender issues. Moreover, she was on the supervision group that also met monthly and talked about the total treatment plan for everyone that was being treated for GD, including discussion of gender confirmation surgery for certain individuals and analysis of why SRS was not recommended for other individuals. WPATH guidelines also are discussed at her NCCHC conferences. Dr. Garvey also has presented at several national conferences regarding treatment and care of patients with GD, which includes Sex Reassignment Surgery options. (Tr. 618:8 - 619:10; 512:19 - 514:8; 525:15 -526:16). This is significant experience in all aspects of treatment and care of inmates with GD, including assessment of Sex Reassignment Surgery, in the correctional setting, especially since only one inmate to date in the United States has received SRS surgery. (Tr. 514:9-11).

61. Dr. Garvey issued a report in this case and has rendered expert opinions about the treatment and care provided by Corizon's providers to Ms. Edmo and regarding the medical necessity of gender confirmation surgery. In doing so, she reviewed all records in this case, including the medical and mental health prison records for Ms. Edmo, the Second Amended Complaint, Ms. Edmo's expert's reports, Ms. Edmo's pre-incarceration records from Portneuf Medical Center, Sho-Ban Tribes, Indian Health Service, the presentence investigation reports from 2009 and 2011, discovery, IDOC records, and declarations filed and deposition transcripts in the case. She also reviewed a number of articles related to treatment and care of patients with GD. She also conducted a clinical interview with Ms. Edmo. (Tr. 515:25 - 517:15; Dkt. 100-2).

62. Dr. Garvey agrees that Ms. Edmo has GD. (Tr. 517:25 - 519:1). Dr. Garvey also diagnosed Ms. Edmo with major depressive disorder, alcohol use disorder, opioid use disorder, and stimulant use disorder. (Tr. 519:2-6).

63. Dr. Garvey opines that the assessment of GD by Dr. Eliason and the subsequent approval for hormone therapy for Ms. Edmo was appropriate and fairly quick. (Tr. 521:2 - 522:22). Dr. Garvey is qualified to discuss hormone therapy and she is of the opinion that the hormone therapy provided to Ms. Edmo was appropriate, including that she was placed on estrogen and antiandrogen medications. (Tr. 522:21 - 524:11).

64. Dr. Garvey notes that there are not quality studies regarding outcomes after SRS. Studies that report a low regret rate after SRS have small pool samples and a significant number of people that are lost to follow-up. There are other studies that report a higher regret rate of 19.1% when comparing post-SRS patients with the general population. (Tr. 527:23 - 528:12; 596:22 - 599:8).

65. Dr. Garvey opines that Dr. Eliason's assessment and determination that SRS was not medically necessary for Ms. Edmo was appropriate. Dr. Eliason appropriately used his clinical judgment and assessed her current clinical status as to this assessment of Ms. Edmo. He considered Ms. Edmo's attempted self-castration and consulted with additional medical professionals, including clinician Jeremy Clark, who was a WPATH member. (Tr. 526:23 - 17) Dr. Garvey opines that the treatment and care provided to Ms. Edmo was within the applicable standard of care. (Tr. 542:14-18).

66. Further, Dr. Garvey opines that SRS is not medically necessary at this time for Ms. Edmo. (528:13-17). There are three primary reasons for this opinion. First, Dr. Garvey believes that the first WPATH guidelines' criterion for SRS that she needs to have persistent, well documented GD is not met. While she has GD, there are inconsistencies between her self-report and her history regarding living as a female in the community that should be further investigated and discussed before sex reassignment surgery is considered. (Tr. 528:20 - 529:1).

67. Second, Dr. Garvey is of the opinion that Ms. Edmo's other mental health comorbidities are not sufficiently well controlled, hence not meeting another one of the WPATH criteria. She is actively self-injuring herself, including cutting herself on the arm this year. Dr. Garvey believes it is important for Ms. Edmo to develop further coping skills that she would be able to use following surgery so that she is not engaging in self-injury after the surgery. (Tr. 529:2-16). Self-injurious behavior is usually associated with trauma and is never seen as an effective coping strategy. Good coping skills are especially important with Ms. Edmo who would need them to manage a very stressful surgery, SRS, if indicated. (Tr. 538). Ms. Edmo's pre-incarceration records show that Ms. Edmo's mental health issues are not solely related to her GD. (Tr. 543:12 – 544).

68. Third, Dr. Garvey is of the opinion that Ms. Edmo has not satisfied the 12-month real-life experience criteria under the WPATH guidelines for SRS. The guidelines explain that a patient under consideration for SRS must experience all of the things they are going to experience outside of prison, such as social transition or their physical transition, work response, family parties, and the experiences that one would encounter in their life. Ms. Edmo has not been able to fully engage in such an experience in prison and she is scheduled to get out of prison in 2021. (Tr. 529:17 – 530:18).

69. Dr. Garvey is concerned about Ms. Edmo's risk of suicide after surgery if she does not work with mental health providers to develop more effective coping strategies for the stress that she is going to experience. Dr. Garvey does not believe that her risk of suicide will decrease based on her current state and is concerned that SRS at this time would not be successful for Ms. Edmo. (Tr. 545:19-546:9)

70. IDOC Chief Psychologist, Dr. Walter Campbell, is a licensed psychologist who received his Ph.D. in Counseling Psychology and his Masters of Sciences degree in Counseling and Counseling Education, both from Indiana University and has been the IDOC Chief Psychologist since 2016. Dr. Campbell is a member of the American Psychological Association and the Idaho Psychological Association. He has provided mental health services to incarcerated inmates since 2012. (Campbell Decl., Dkt. 101-4, ¶¶ 2-7).

71. Dr. Campbell is also a member of WPATH and has attended the 2017 WPATH conference. He has also received training on GD at two NCCHC annual conferences. Dr. Campbell has reviewed dozens of articles and publications regarding the treatment of transgender inmates, including inmates with GD. Dr. Campbell is familiar with the WPATH guidelines, along with statements and guidelines regarding GD and transgender persons set forth by the American

Psychological Association and the American Psychiatric Association. He is also familiar with the guidelines regarding GD offenders and transgender inmates as provided by the NCCHC, the National Institute of Corrections, and the Federal Bureau of Prisons. (Campbell Decl., Dkt. 101-4, ¶¶ 8-10).

72. Dr. Campbell also serves as chair of the MTC, which is a multidisciplinary committee that meets monthly to discuss and evaluate the needs of inmates who have been diagnosed with GD. The MTC also receives and reviews inmate requests to be assessed for GD. Dr. Campbell has directly conducted six GD assessments and has overseen the treatment and assessment of approximately fifty inmates who have requested GD evaluations, through his role as chair of the MTC and as the Chief Psychologist. (Campbell Decl., Dkt. 101-4, ¶¶ 13-14).

73. In his role as Chief Psychologist and chair of the MTC, he has reviewed Ms. Edmo's file, including Ms. Edmo's mental health treatment records, treatment plans, DORs, concern forms, and PSI reports. He is familiar with Ms. Edmo's treatment for GD while she has been in the custody of IDOC. (Campbell Decl., Dkt. 101-4, ¶ 23). Based on his review of the records, his experience, and training, Dr. Campbell believes that the clinical evidence demonstrates that Ms. Edmo's feelings of dysphoria have a very complex origin, related to trauma, relationship difficulties, and other unresolved life events, precisely as Ms. Edmo's IDOC mental health clinicians have described in treatment notes over the last several years. Furthermore, Ms. Edmo has not demonstrated a willingness to address these underlying mental health issues through treatment, making assessment of her full mental clinical picture difficult. (Campbell Decl., Dkt. 101-4, ¶ 29).

74. Dr. Campbell further believes that Ms. Edmo's mental health history, history of suicide attempts, and her inconsistent reports about living full time as a woman prior to entering

prison demonstrate that there are many unanswered questions that need to be explored to evaluate the root cause of Ms. Edmo's depressive symptoms and GD. Her serious and severe mental health concerns should not be ignored, overlooked, or downplayed when assessing the causes of her dysphoria. (Campbell Decl., Dkt. 101-4, ¶ 30).

75. Dr. Campbell believes that Ms. Edmo's overall clinical picture is not fully understood and it is not clear that Ms. Edmo's GD is the sole cause of her dysphoria. Until Ms. Edmo's dysphoria is fully understood, an extreme irreversible intervention such as sex reassignment surgery is not warranted, appropriate, or without a considerable risk of harm. Dr. Campbell is not convinced that there would be no adverse outcome if Ms. Edmo undergoes sex reassignment surgery, in light of the many unanswered questions posed by her complex mental health history. (Campbell Decl., Dkt. 101-4, ¶¶ 30-33).

76. Expert witness Dr. Joel T. Andrade, Ph.D., LICSW, CCHP-MH, is well-qualified to offer opinions about all options of treatment and care for inmates with GD, including whether sex reassignment surgery is medically necessary. (DEF Ex. 2021_9-25). Dr. Andrade is a licensed independent clinical social worker and is a CCHP, with an emphasis in mental health. (Tr. 626:1-21). Dr. Andrade has over a decade of experience in providing and supervising the provision of correctional mental health care, including directing and overseeing the treatment of all inmates diagnosed with GD in the custody of the Massachusetts Department of Corrections in his role as clinical director, chair of the GD Supervision Group, and member of the GD Treatment Committee. (Tr. 627:2-14; DEF Ex. 2021_9-25).

77. Over the last decade, Dr. Andrade has provided treatment to GD inmates in his role on the treatment committee and has evaluated and confirmed diagnoses of GD for over 100 inmates. Dr. Andrade has also provided treatment recommendations for all potential treatment for

GD inmates, including hormone therapy, and gender affirming surgery. On two occasions, Dr. Andrade has recommended surgery for incarcerated inmates. (Tr. 627-629:1-10). Dr. Andrade has further reviewed and relied upon dozens of publications, articles, guidelines, and position statements regarding transgender healthcare, the assessment and diagnosis of persons with GD, and the treatment options available for persons with GD, including surgery. (Tr. 624:15-20; DEF Ex. 2021_5-8). These publications include the WPATH guidelines (JT Ex. 15) and the Osborne and Lawrence article (JT Ex. 19).

78. Dr. Andrade conducted a clinical interview with Ms. Edmo on July 31, 2018, and reviewed Ms. Edmo's complete mental health treatment record, including her pre-incarceration records, and interviewed Ms. Edmo's treating clinicians. (Tr. 630:12 - 634:24). Based on his review of the documents in this case, and his interview with Ms. Edmo, Dr. Andrade has concluded that Ms. Edmo does not meet the WPATH criteria for surgery (Tr. 639:3-16).

79. First, while Ms. Edmo claims that she lived full-time as woman and was well accepted as such in her community for years prior to entering prison, Dr. Andrade could find no support for that claim in Ms. Edmo's pre-incarceration medical records and PSI. Dr. Andrade is concerned that Ms. Edmo does not appreciate and understand what it means to fully live in the gender role consistent with her identity prior to being released from prison in 2021. Dr. Andrade believes that Ms. Edmo is at risk for increased harm if she enters the community after having received surgery without a real opportunity to assimilate to life full-time as a female outside of prison. (Tr. 639:17-25, 640:1-9, 643:3-21).

80. Dr. Andrade also believes that, due to Ms. Edmo's unresolved mental health issues, including borderline personality disorder traits, related to her early-life trauma and substance abuse, pursuing surgery at this time actually increases Ms. Edmo's risk for suicide post-surgery.

Ms. Edmo made representations to Dr. Andrade during the clinical interview that her feminine appearance enticed her abuser or led to her sexual abuse. It is apparent to Dr. Andrade that Ms. Edmo has not fully addressed in psychotherapy the relationship between her early childhood trauma and her mental health conditions; in particular, Ms. Edmo's GD. Working through those issues with a mental health provider is something that Ms. Edmo must do before she can fully and meaningfully elect to proceed with surgery. Otherwise, Ms. Edmo will not be able to successfully cope with the stressors of surgery, increasing her risk of harm. At this time, Ms. Edmo has not developed healthy coping strategies and instead deals with her depression and GD by cutting herself. Ms. Edmo must develop healthy tools to manage her depression, anxiety, and GD that do not involve maladaptive behaviors such as cutting, sexual acting out, and codependency. (Tr. 640:10- 642:8, 643:3-21).

81. Ms. Edmo's former and current treating clinicians Ms. Watson and Ms. Stewart also believe, based on their education, training, and experience, including experience providing individual and group counseling treatment to Ms. Edmo, their correctional experience treating inmates with complex and unique mental health concerns, their experience as members of the MTC, and their review of Ms. Edmo's PSI reports and mental health records, that surgery is not appropriate for Ms. Edmo at this time, due to her coexisting mental health concerns that are not well-controlled and her unwillingness to acknowledge or address those concerns while in prison. Ms. Watson believes that those coexisting mental health concerns complicate Ms. Edmo's treatment for GD. Ms. Stewart believes that Ms. Edmo's use of self-harm in the form of cutting to deal with emotional dysregulation and her belief that surgery will solve her depression and low sense of self demonstrate that Ms. Edmo may be worse off if she receives the surgery before

developing healthy coping mechanisms and addressing her coexisting mental health conditions. (Stewart Decl., Dkt. 101-1, ¶¶ 1-14; Watson Decl., Dkt. 101-3, ¶¶ 1-19).

L. Dr. Gorton Credibility Issues

82. Dr. Gorton has no experience providing treatment to inmates, has never worked in a prison, has never been part of a GD treatment committee at a prison, and has never provided treatment to an inmate with GD while incarcerated. (Tr. 269:23-269:17). Dr. Gorton is not a psychiatrist, psychologist, mental health clinician, or therapist. (Tr. 269:20 - 270:6). He is not a certified correctional healthcare professional. (Tr. 270:9-16). Dr. Gorton does not perform gender confirmation surgery. (Tr. 270:17-19). He utilizes mental health clinicians and psychiatrists sometimes when a patient has complex mental health issues. (Tr. 272:25 - 273:2).

83. Dr. Gorton realizes that getting documentation of a person's prior mental health treatment is important when assessing a person for SRS. However, when assessing Ms. Edmo and rendering opinions critical of Defendants, Dr. Gorton did not even attempt to obtain her prior mental health records and did not consider Ms. Edmo's PSI records, DORs, MTC records, sex offender treatment records, pre-incarceration medical and mental health records, Bannock County jail records, IDOC policies or procedures regarding GD, and IDOC PREA policy. (Tr. 276:20 – 281:2).

84. Dr. Gorton agrees that psychotherapy and participation in mental health groups is important for Ms. Edmo (Tr. 291:11-16).

85. Dr. Gorton does not believe that SRS for GD is emergent and testified that it is "kind of absurd" to think in such terms. (Tr. 301:6-23). Dr. Gorton also acknowledges that about three of his patients have attempted suicide after a vaginoplasty. He also estimates that a handful of his patients have attempted suicide after some kind of SRS. He recalls one patient expressing regret after an orchiectomy and then suing Dr. Gorton and his clinic. (Tr. 309:18 - 310:13).

86. Dr. Gorton was critical of Defendants, stating that they did not take an appropriate transgender history of Ms. Edmo. However, Dr. Gorton now admits that opinion is not correct. (Tr. 314:11 - 317:3).

M. Dr. Ettner Credibility Issues

87. Plaintiff's expert psychologist, Dr. Randi Ettner, is not a Certified Correctional Healthcare Professional (CCHP), nor does she have any experience treating inmates with GD who are currently incarcerated. (Tr. 106:21-24, 107:11-18). Dr. Ettner is not a board-certified psychiatrist nor is she a medical doctor (Tr: 153:9-13, 154:24-25). Dr. Ettner has never been employed by a prison and has no formal training on prison operations or security. (Tr. 106:25, 107:1-10). Dr. Ettner has never been published in a peer-reviewed journal on a topic related to providing care to transgender inmates in a correctional setting. (Tr. 108:14-22).

88. Prior to her deposition in this case and prior to forming her opinions regarding the medical necessity for sex reassignment surgery for Ms. Edmo, Dr. Ettner had never read the peer-reviewed article entitled "Male Prison Inmates With Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?" by Cynthia S. Osborne and Anne A. Lawrence. (Tr. 108:23-25; 109:1-5, 111:9-15).

89. Prior to forming her opinions, Dr. Ettner did not interview any of Ms. Edmo's medical or mental health providers, and is unaware of their qualifications and education (Tr. 112:2-5, 120:19-25, 121:1-10, 184:11-17). Also prior to forming her opinions in this case, Dr. Ettner had not reviewed any IDOC policies, Ms. Edmo's disciplinary records, MTC records, offender history, pre-incarceration records, PSI reports, or her complete medical and mental health records. (Tr. 112:6-25, 113:1-25, 114:1-5, 117:7-13).

N. IDOC's 2018 Standard Operating Procedure for GD

90. On October 5, 2018, IDOC implemented a revised GD SOP, which, among other things, updated references from GID to GD and included revised sections allowing female GD offenders to use makeup, wear their hair in traditionally female hairstyles, and have access commissary items available to other female inmates, including bras and underwear. (JT Ex. 9-1-9). The revised SOP also provides that inmates be referred to by medical and mental health staff as their preferred gender, while other IDOC staff is required to refer to GD inmates in gender neutral terms. (JT Ex. 9-6). The revised SOP still recognizes sex reassignment surgery as an available option for treatment, should it be deemed medically necessary by the treating physician and explicitly states that inmates diagnosed with GD will be provided access to the full range of services and programs available within IDOC to the same extent as other inmates. (JT Ex. 9-6).

II. PROPOSED CONCLUSIONS OF LAW

A. Standard for Motion for Mandatory Injunction

91. Ms. Edmo incorrectly seeks a preliminary injunction ordering the Defendants to provide her with gender confirmation surgery. In order to be awarded the relief sought on a preliminary injunction, a moving party must establish that they are likely to succeed on the merits, that they are likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in their favor, and that an injunction is in the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20, 129 S. Ct. 365, 374, 172 L. Ed. 2d 249 (2008).

92. The basic function of a preliminary injunction is to preserve the status quo, pending a determination of the action on the merits. *Tanner Motor Livery, Ltd. v. Avis, Inc.*, 316 F.2d 804, 808–09 (9th Cir. 1963). Here, Ms. Edmo does not seek preservation of the status quo pending a trial on the merits of her claim. Rather, Ms. Edmo seeks an order altering the status quo and ordering the Defendants to take a particular action – providing her with a permanent, irreversible,

medical procedure. Mandatory injunctions ordering a party to take action are particularly disfavored. *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015). Indeed, courts should be extremely cautious about ordering mandatory relief. *Battelle Energy All., LLC v. Southfork Sec., Inc.*, 980 F. Supp. 2d 1211, 1216 (D. Idaho 2013), citing *Martin v. Int'l Olympic Comm.*, 740 F.2d 670, 675 (9th Cir.1984)).

93. This Court and the Ninth Circuit have recognized a separate, higher standard for the issuance of a mandatory injunction, such as the relief sought by Ms. Edmo in this case. See *Battelle Energy All., LLC*, 980 F. Supp. at 1216 ("An even more stringent standard is applied where mandatory, as opposed to prohibitory, preliminary relief is sought."); *Garcia*, 786 F.3d 40 (mandatory injunctions go well beyond simply maintaining the status quo and the court should deny such relief unless the party establishes that the law and facts clearly favor their position). See also *Taiebat v. Scialabba*, No. 17-CV-0805-PJH, 2017 WL 747460, at *2 (N.D. Cal. Feb. 27, 2017) (movant must meet a higher degree of scrutiny where the injunction will provide the movant with "substantially all of the relief that would be available after a trial on the merits.").

94. As a result, mandatory preliminary relief should not issue unless both the facts and the law clearly favor the moving party and extreme or very serious damage will result. *Battelle Energy All., LLC*, 980 F. Supp. 2d at 1216, citing *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir.2009)(emphasis added). Mandatory injunctions are not issued in doubtful cases, or where the party seeking an injunction could be compensated in damages. *Id*. In other words, it is not sufficient for a moving party seeking a mandatory injunction to establish a likelihood of success on the merits or a likelihood of irreparable harm, as set forth in the standard for a preliminary injunction. Rather, the party must demonstrate that both the facts and the law clearly favor their position and that they will suffer extreme or very serious damage.

95. The Prison Litigation Reform Act ("PLRA") also governs prospective relief sought in civil actions concerning prison conditions. See *Gilmore v. People of the State of California*, 220 F.3d 987, 999 (9th Cir.2000) ("no longer may courts grant or approve relief that binds prison administrators to do more than the constitutional minimum."). The PLRA defines "prospective relief" as "all relief other than compensatory monetary damages." 18 U.S.C.A. § 3626(g)(7). In cases such as this, where a prisoner seeks a mandatory injunction seeking substantially all of the relief that would be available after a trial on the merits, the PLRA dictates that any prospective relief "shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs." 18 U.S.C.A. § 3626(a)(1)(A). Further, a court shall not order any prospective relief unless it finds that the relief is "narrowly drawn, extends no further than necessary to correct the Federal right, and be the least intrusive means necessary to correct the violation of the Federal right." *Id*. The PLRA also requires the court to give "substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief." *Id*.

B. The Law and Facts are not Clearly in Ms. Edmo's Favor Regarding her Eighth Amendment Claim for Deliberate Indifference

96. Ms. Edmo asserts that the Defendants were deliberately indifferent to her medical needs in violation of the Eighth Amendment. "[D]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Estelle v. Gamble*, 429 U.S. 97, 104, 97 S.Ct. 285 (1976) (internal citation omitted). Such indifference may be "manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Id.*

97. In the Ninth Circuit, a plaintiff alleging deliberate indifference must first "show a serious medical need by demonstrating that failure to treat a prisoner's condition could result in further significant injury or the unnecessary and wanton infliction of pain." *Jett v. Penner*, 439 F.3d 1091, 1096 (9th Cir.2006) (citing *Estelle*, 429 U.S. at 104, 97 S.Ct. 285) (internal quotation marks omitted). Second, she "must show the defendant's response to the need was deliberately indifferent." *Id*., at 1186. This second prong "is satisfied by showing (a) a purposeful act or failure to respond to a prisoner's pain or possible medical need and (b) harm caused by the indifference." *Id*. Mere negligence alone does not establish a valid Eighth Amendment claim. *Estelle*, 429 U.S. at 104, 97 S. Ct. at 291. Rather, a prison official is deliberately indifferent only if the official "knows of and disregards an excessive risk to inmate health and safety." *Id*. (quoting *Toguchi v. Chung*, 391 F.3d 1051, 1057 (9th Cir. 2004)) (emphasis added). "[T]he official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." *Id*. (quoting *Farmer v. Brennan*, 511 U.S. 825, 837 (1994)).

98. The subject matter of the Plaintiff's Eight Amendment claim is her diagnosed GD, which is a mental health condition recognized by the DSM-V. This Court has very recently articulated that it is particularly difficult to establish deliberate indifference to a mental health need for numerous reasons, most notably because "psychiatrists themselves differ on the underlying theories and thus on the methods of treatment." *Id*. "[T]he Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Id*. (internal quotation marks omitted) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 314 (1982)). *Mintun v. Corizon Med. Servs*., No. 1:16-CV-00367-DCN, (D. Idaho Feb. 22, 2018) (emphasis added).

99. The Defendants were not deliberately indifferent by not providing Ms. Edmo with gender confirmation surgery. The treatment and care provided by Defendants to Ms. Edmo was appropriate and within the applicable standard of care. The WPATH guidelines are flexible and Defendants have applied them as such in providing Ms. Edmo with every type of treatment recommended by the WPATH, including changes in gender expression and role, hormone therapy, and psychotherapy. IDOC's 2011 and 2018 policies expressly recognize that surgery is an available treatment if medically necessary.

100. The records, testimony, and evidence in this case do not demonstrate that the facts and the law are clearly in Ms. Edmo's favor on her claim for deliberate indifference for not recommending surgery at this time. There is no evidence of a blanket prohibition of surgery by any of the Defendants, nor have Defendants ignored or disregarded Ms. Edmo's GD. Rather, the evidence shows that the Defendants have taken thoughtful consideration of her request for surgery and have treated Ms. Edmo as a whole person with various mental health needs and a tragic history of abuse, trauma, and depression. As contemplated by the WPATH guidelines, Ms. Edmo's underlying mental health issues complicate the resolution of Ms. Edmo's GD and must be well-controlled before any surgical intervention is appropriate. The decision not to recommend surgery for Ms. Edmo was an exercise of professional judgment.

101. While Ms. Edmo's retained expert witnesses are certainly experienced in treating patients with GD in the community, they have no experience in a correctional setting and do not have the day-to-day contact and experience of treating mentally ill prisoners who are currently incarcerated. They rely heavily on their advocacy and will not recognize the difficulties of applying the WPATH guidelines in a correctional setting, particularly the requirement to live authentically in a preferred gender role for 12 months. For inmates like Ms. Edmo, who will be released in less

than three years, that experience cannot be fully accomplished in prison, which differs dramatically from the community. Furthermore, there is no evidence that she had lived 12 months as a female prior to her incarceration. A difference of professional opinion between Ms. Edmo's experts and Ms. Edmo's treatment providers does not constitute deliberate indifference, particularly in a correctional setting.

102. The U.S. Supreme Court has held that prison administrators should be accorded wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security. *See Whitley v. Albers*, 475 U.S. 312, 321–22, 106 S. Ct. 1078, 1085, 89 L. Ed. 2d 251 (1986). Such deference extends to "prophylactic or preventive measures" intended to reduce the incidence of breaches of prison discipline. *Id.* "It does not insulate from review actions taken in bad faith and for no legitimate purpose, but it requires that neither judge nor jury freely substitute their judgment for that of officials who have made a considered choice." *Id.*

103. Here, the IDOC Defendants have not been deliberately indifferent to Ms. Edmo's needs by disciplining her for refusing direct orders to remove makeup or take down her hair, for destroying property to make thong underwear, for assaulting another GD inmate on two separate occasions. TMs. Inappropriate use of makeup and feminine hairstyles the alteration of female undergarments raises serious security and safety concerns, as does allowing offenders to appear or act sexual in prison. Ms. Edmo recognizes that her feminine appearance puts her at an additional risk for sexual assault and the IDOC Defendants must be allowed to set appropriate limits to prevent her from harm. "The duty of prison officials to protect the safety of inmates and prison personnel is a factor that may properly be considered in prescribing medical care for a serious medical need." *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 161 (D. Mass. 2002).

C. The Law and Facts are not Clearly in Ms. Edmo's Favor Regarding her Fourteenth Amendment Claims

104. The standard regarding the validity of a prison regulation that allegedly impinges on an inmate's Constitutional rights is whether such a regulation is "reasonably related to legitimate penological interests." *Turner v. Safley*, 482 U.S. 78, 89, 107 S. Ct. 2254, 2261–62. However, in this case, the Court need not reach the question of whether the denial of surgery serves a penological interest because the Defendants do not have a policy, practice, or regulation that denies medically necessary care to Ms. Edmo based on her status as a transgender person. The evidence demonstrates that, since 2011, IDOC policy has specifically allowed for surgery when deemed medically necessary.

D. The Law and Facts are Not Clearly in Ms. Edmo's Favor Regarding her Affordable Care Act Claims

105. Section 1557 of the Affordable Care Act 42 U.S.C. § 18116(a) ("ACA") is not applicable to Ms. Edmo, as she and IDOC do not meet the requirements for applicability, including Section 1557. The ACA applies to an individual through either engaging with insurance companies on the free exchange or as an employee receiving insurance from an employer. The Federal Code specifically notes that incarceration is an eligibility disqualifier for a person to participate on the free exchange. 45 C.F.R. 155.305. Ms. Edmo is not employed by IDOC, nor does she receive health insurance from IDOC. Therefore, the ACA does not apply to Ms. Edmo as an individual.

106. Similarly, the ACA does not apply to IDOC as an entity. For the ACA to apply, IDOC would need to participate in a "health program or activity." 42 USC §§ 18032(2)(A)&(B). According to the Department of Health and Human Services, an entity qualifies as participating in a "health program or activity" if it is principally engaged in the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, "such as a hospital, health clinic, community health center, group health plan, health insurance issuer,

physician's practice, nursing facility, or residential or community-based treatment facility." 81 Fed. Reg. 31375, 31385. IDOC is not "principally engaged" in providing or administering health services. Rather, IDOC is principally engaged in managing felony offenders housed in prisons and supervised on probation and parole. Accordingly, the ACA does not apply to the IDOC Defendants and the law and facts are not clearly in Ms. Edmo's favor on those claims.

E. Plaintiff is Not Likely to Suffer Extreme or Serious Harm While Awaiting a Trial on the Merits

107. This Court heard competing opinions regarding whether Ms. Edmo's overall mental health concerns would worsen, improve, or remain unchanged if she is provided surgery. Ms. Edmo has a long history of serious mental illness, including several serious suicide attempts, dating back to 2010. There are no reliable anecdotes or evidence-based studies to suggest that Ms. Edmo's depression, anxiety, dysphoria, or possibility of self-harm will decrease if she is provided surgery, especially in light of Ms. Edmo's incarceration and significant co-existing and uncontrolled mental health concerns. Accordingly, making any predictions as to whether, absent surgery now, Ms. Edmo will experience extreme or serious harm is speculative.

108. Ms. Edmo's significant unresolved history of trauma and abuse will not be resolved or alleviated through surgery and Ms. Edmo has not developed or attempted to develop healthy coping skills to address those stressors and the stressors that come with surgery. Without the requisite coping skills to handle the stressors of such a serious and irreversible surgery, and without yet having the opportunity to live as a woman in the community, a likelihood exists that Ms. Edmo will be at an increased risk of depression and suicide if she is provided the surgery at this time.

109. The evidence and testimony on the record supports the conclusion that Ms. Edmo will not suffer any irreparable – let alone extreme or serious harm – if she is not provided the surgery pending resolution of this dispute at a trial on the merits. Ms. Edmo has not made any

attempts at self-castration since 2016, and she testified that she now understands the importance of, and is committed to, preserving the tissue from her scrotum and penis for future use in a vaginoplasty procedure. Further, while Ms. Edmo's depression and anxiety appear to be at the same high levels as they were prior to her incarceration, she has not made any attempts to commit suicide since 2011. Moreover, Dr. Gorton, Plaintiff's own medical expert, testified that the surgery Ms. Edmo is requesting is not an emergency procedure requiring immediate attention.

110. For the foregoing reasons, Ms. Edmo has not made a clear showing that Defendants have been deliberately indifferent to her serious medical needs by not recommending gender confirmation surgery at this time. In addition, Ms. Edmo has not established that she is likely to suffer extreme or serious harm while awaiting a trial on the merits. Accordingly, Ms. Edmo's *Motion* is DENIED.

DATED this 26th day of October, 2018.

PARSONS BEHLE & LATIMER

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 26th day of October, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, vs. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	)	Case No. 1:17-cv-151-BLW **IDOC DEFENDANTS' WRITTEN CLOSING STATEMENT**

COME NOW Defendants Idaho Department of Correction ("IDOC"), Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert (hereinafter collectively "IDOC Defendants"), by and through their counsel of record, Moore Elia Kraft & Hall, LLP, and pursuant to the Court's request for written closing statements, do hereby submit the following in supplement to the oral closing statements provided by the IDOC Defendants and the Corizon Defendants (hereinafter collectively referred to as "Defendants") on August 12, 2018 (Tr. 686-699). The following is also provided in addition to the arguments the IDOC Defendants submitted in their *Response to Plaintiffs' Motion for Preliminary Injunction* (Dkt. 99).

1. Ms. Edmo actually seeks a mandatory injunction (not a preliminary injunction), which is subject to a much higher and stringent standard.

Ms. Edmo incorrectly postured her instant motion (Dkt. 62) as one seeking a preliminary injunction for gender confirmation surgery.[1] However, a preliminary injunction seeks only to preserve the "status quo" pending determination of the action on the merits. *Tanner Motor Livery, Ltd. v. Avis, Inc*., 316 F.2d 804, 808–09 (9th Cir. 1963). Ms. Edmo is not seeking to merely preserve the status quo; Ms. Edmo is instead seeking to alter the status quo by having this Court order the Defendants to provide her with final relief – the provision of a permanent and irreversible surgical procedure to remove her penis and scrotum. Accordingly, the relief Ms. Edmo requests can only be provided if she meets the much higher and stringent standard of a mandatory injunction.

The federal courts are directed to be extremely cautious about ordering mandatory relief absent a full trial on the merits. This Court and the Ninth Circuit prohibit the granting of mandatory injunctions unless the moving party establishes that the law and facts clearly favor

[1] Ms. Edmo's motion does not specify the particular surgical procedure she believes the Court should order in this case and there was no testimony at the hearing from a qualified surgeon who had determined whether Ms. Edmo was a candidate for any particular gender confirmation surgery, of which there are several.

their position and, moreover, that extreme or very serious damage will result. *See Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015); *Battelle Energy All., LLC v. Southfork Sec., Inc.*, 980 F. Supp. 2d 1211, 1216 (D. Idaho 2013), citing *Martin v. Int'l Olympic Comm.*, 740 F.2d 670, 675 (9th Cir.1984)). Mandatory injunctions are not issued in doubtful cases and will not be awarded if the plaintiff merely shows a likelihood of success on the merits and a likelihood of irreparable harm, as set forth in the standard for a preliminary injunction. *Id*.

2. Regardless, Ms. Edmo has not met (and cannot meet) her burden for the issuance of either a preliminary or mandatory injunction.

a. <u>There is no reasonable likelihood – let alone the requisite clear showing – that Ms. Edmo will prevail on the merits of her claims, most notably her Eighth Amendment deliberate indifference cause of action.</u>

It is well settled that, to prevail on her Eighth Amendment claim, Ms. Edmo must establish that the Defendants were "deliberately indifferent" to an actual serious need for the surgical procedure. *Estelle v. Gamble*, 429 U.S. 97, 104, 97 S.Ct. 285 (1976) (internal citation omitted). In other words, Ms. Edmo must show that the Defendants unnecessarily and wantonly inflicted pain on her by intentionally denying or delaying a surgery that the Defendants actually knew was necessary and recognized that not providing the surgery created a serious risk of harm to Ms. Edmo. *Jett v. Penner*, 439 F.3d 1091, 1096 (9th Cir.2006) (citing *Estelle*, 429 U.S. at 104, 97 S.Ct. 285) (internal quotation marks omitted).

"In the context of mental health care [as here], courts have recognized that it is particularly difficult to establish deliberate indifference to a serious need for numerous reasons." *Mintun v. Corizon Med. Servs.*, No. 1:16-CV-00367-DCN, 2018 WL 1040088, at *5 (D. Idaho Feb. 22, 2018)(internal citations omitted). One of those reasons, which is at the center of the dispute in this case, is that "psychiatrists themselves differ on the underlying theories and thus on the methods of treatment." *Id*. "[T]he Constitution only requires that the courts make certain that

professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Id*.

Allegations of professional negligence fall far short of deliberate indifference. Additionally, prison officials are generally provided wide-ranging deference in their treatment of inmates and the courts are not given free rein "to substitute their judgment for that of officials who have made a considered choice." *Whitley v. Albers*, 475 U.S. 312, 321–22, 106 S. Ct. 1078, 1085, 89 L. Ed. 2d 251 (1986). A court's inquiry under the Eighth Amendment should therefore be limited to reviewing treatment decisions made by mental health professionals when made arbitrarily or in bad faith.

Here, despite Plaintiff's baseless assertions and unfair insults to the contrary (Tr. 676:12-15, 684:17-18), the Defendants did not determine that surgery was inappropriate and unnecessary for Ms. Edmo due to any reason other than the thoughtful consideration of Ms. Edmo's individual mental health concerns and needs. The actual facts and testimony on the record in this case demonstrate that the Defendants did not consider cost, religious or political objections, prejudice against transgender inmates, or Ms. Edmo's status as a felon in determining whether surgery was medically necessary for her. Nor is there any basis in this case to suggest that the Defendants acted arbitrarily, in bad faith, or pursuant to any actual or *de facto* policy containing a blanket denial of surgery to an inmate with Gender Dysphoria ("GD").

To the contrary, substantial evidence in the record illustrates that the Defendants have long recognized, embraced, and provided the various treatment options for GD patients that are available in the community and set forth in the flexible guidelines provided by the WPATH Standards of Care ("SOC"). Since 2011, IDOC's written policy has expressly held that treatment options, including surgery, will be provided when medically necessary. Furthermore, IDOC

policy explicitly provides that GD inmates will be provided access to the full range of services and programs available within IDOC to the same extent as other offenders.

The treatment provided to Ms. Edmo further evidences the Defendants' commitment to providing adequate mental health treatment to GD inmates. It is undisputed that, very shortly after she requested an evaluation in 2012, Ms. Edmo was appropriately diagnosed with GD and started on hormones. Ms. Edmo has since been provided hormone therapy and monitoring by qualified medical doctors and, since 2016, has been followed by a Boise-based specialist from the community. Further, Ms. Edmo has been permitted to appropriately feminize within IDOC policy in a manner that prison security believed balanced the competing security interests and did not subject her to an increased risk of sexual assault. Any assertion that Ms. Edmo has not been allowed to feminize in a meaningful way while in prison would be simply disingenuous, especially in light of the stark contrast of Ms. Edmo's documented change in physical appearance from 2010, 2012, 2014, and to the present day, which clearly demonstrates that Ms. Edmo's transition from an outwardly-appearing man to an effeminate woman has been very successful with the support of her custodians, clinicians, and doctors.

Additionally, since 2012, the Defendants have provided Ms. Edmo with individual mental health clinical contacts. In addition to having been followed regularly by a multidisciplinary Management and Treatment Committee ("MTC"), Ms. Edmo's mental health clinicians have repeatedly offered and recommended that Ms. Edmo undergo a number of therapy classes and groups including, but not limited to, Mood Management, Social Skills, Healthy Relationships, and GD group, which her clinicians believe will be helpful in addressing and reducing not only her GD symptoms, but her co-existing symptoms and trauma related to severe and longstanding depression, anxiety, sexual abuse, self-harm, substance abuse, unhealthy

and co-dependent relationships, high-risk sexual behavior, and borderline personality disorder traits and characteristics that have plagued Ms. Edmo, long before she ever identified as a transgender woman or experienced documented dysphoria related to her male genitalia.

Despite the repeated recommendations of her mental health clinicians, Ms. Edmo has repeatedly and consciously refused to participate in the available therapy classes and only infrequently appeared at and engaged in GD group and her regularly-scheduled clinical contact appointments. Similarly, Ms. Edmo has refused to complete her Sex Offender Treatment Programming and has exhibited a pattern of ongoing disobedience to direct orders and prison rules, which is illustrated by her extensive disciplinary record and further demonstrates the severity and relevance of her uncontrolled mental health concerns. Her disciplinary troubles and her decisions not to participate in recommended treatment and programming also raise serious questions regarding her ability and/or willingness to follow any post-surgical treatment protocols and orders, particularly if those protocols and recommendations come from prison officials.

Although Ms. Edmo has, both prior to her incarceration in 2012 and since, exhibited moments of clarity where she recognized her underlying trauma and co-existing mental health conditions and their contribution to her overall mental health, she has not followed through on her treatment recommendations and at times outright ignores the problems that plague her. Since her incarceration, Ms. Edmo has remained focused only on treating her GD and obtaining surgery, which she perceives will be the panacea for her severe and lifelong mental health problems. The guidelines in the WPATH SOC recognize the serious complications that uncontrolled and coexisting mental health concerns pose to social transition and treatment of GD patients, and the Defendants and their mental health professionals have taken seriously their obligation to ensure that Ms. Edmo works to achieve mental stability and develops healthy

coping skills to manage the multiple and significant stressors that returning to the community as a woman and undergoing an irreversible genital surgery will certainly pose.

Accordingly, the evidence in this case shows clearly that this is not a situation where the Defendants refused or delayed to provide adequate and necessary treatment to Ms. Edmo related to her GD and other mental health concerns. Nor is this a case where the Defendants refused to consider all treatment options, including surgery, to treat Ms. Edmo's GD. Rather, it is undisputed that, in 2016, the Defendants did evaluate Ms. Edmo for surgery, and that after engaging in a thoughtful analysis of this complex mental health issue, which involved numerous mental health and medical professionals and a subsequent review by the multi-disciplinary MTC, it was universally agreed upon that Ms. Edmo did not meet the WPATH SOC criteria, or any other criteria for surgery. Rather, after careful thought and consideration Defendants determined, within their professional judgment, that providing Ms. Edmo surgery was neither medically necessary, appropriate, nor in Ms. Edmo's best interests.

During closing arguments, Ms. Edmo's counsel referred the Court to *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1189 (N.D. Cal.), *appeal dismissed and remanded*, 802 F.3d 1090 (9th Cir. 2015). In that case, Michelle Norsworthy, an inmate in the California correctional system, who had been diagnosed with GD, requested and was denied surgery, even after her treating psychologist found that surgery was medically necessary. *Id.*, at 1174. Furthermore, the Court in that case found that the California Department of Corrections and Rehabilitation ("CDCR") had written regulations that stated that vaginoplasty was not medically necessary and "shall not be provided." *Id.* at 1176. CDCR's operation manual also provided that vaginoplasty "shall be deferred beyond the period of incarceration." *Id.*, at 1177. Furthermore, correctional health care providers in that case understood that hormone therapy and mental health treatment

were the only treatment options for prisoners. *Id*. (emphasis added). The District Court for the Northern District of California found that, as a result, CDCR were deliberately indifferent to the recommendations of her treating psychologist and had a blanket policy against providing surgery for GD inmates. *Id*., at 1189-1191. Notably, the Court in *Norsworthy* made the specific finding that CDCR did not make a professional medical judgment in choosing between two possibilities, nor was there a difference of opinion between a prisoner and her provider or between providers." *Id*., at 1191-92. Rather, the Court held that CDCR overruled the recommendations of Norsworthy's mental health providers. *Id*.

The instant case is distinguishable from the facts in *Norsworthy* on many levels. First, there are absolutely no written or "de facto" policies at IDOC that prohibit surgery for GD inmates. The IDOC's policies state that surgery will be provided when it is deemed medically necessary. Contrary to the testimony by treatment providers at the hearing in *Norsworthy*, the testimony in this case from the treating psychiatrist and supervising clinician establishes that IDOC will provide surgery if it is deemed medically necessary. In fact, clinical supervisor and WPATH member Jeremy Clark testified that he believes there will come a day when a GD inmate will meet criteria for surgery. In addition, unlike in *Norsworthy*, Ms. Edmo's treating psychiatrist, Dr. Scott Eliason, decided surgery was neither necessary nor appropriate after an exercise of his professional judgment and after consulting with Mr. Clark and others. Further, Dr. Eliason's decision was (and still is) supported by Ms. Edmo's current treatment providers, the MTC, at least two members of WPATH, and experts with years of experience treating and supervising inmates with GD.

Ms. Edmo's counsel made one other attempt to inappropriately relate the facts of *Norsworthy* to this case. In repeated inferences during questioning and direct references during

closing argument, Ms. Edmo's counsel attempted to taint the independent clinical judgment of IDOC's and Corizon's providers and experts by associating them with Dr. Stephen Levine. Dr. Levine was a witness in this *Norsworthy* case. He is not a witness here and Ms. Edmo's treating providers attended only a single training with Dr. Levine. And, when providing supervision and treatment to Ms. Edmo (along with the hundreds, if not thousands, of inmates incarcerated at IDOC who also have coexisting mental health conditions), the IDOC and Corizon providers have relied upon their own education, training, and correctional experience, along with their experience treating Ms. Edmo's individual needs, participating in the MTC, attending WPATH trainings, attending NCCHC trainings, reading literature, and using their best clinical judgment.

Whether Plaintiff's expert witnesses (who admittedly have no experience providing treatment to GD patients in a prison context and have never had a patient-provider relationship with Ms. Edmo) may have come to a different conclusion in 2016 than Dr. Eliason is wholly irrelevant to the question before the Court at this time. This is not a negligence analysis. And, despite Plaintiff's experts' baseless and conclusory attempts to paint all of the Defendants' providers as incompetent, unqualified, and ignorant, it is undisputed that Dr. Eliason performed a thoughtful evaluation in 2016 and that he exercised his professional judgment, after considering Ms. Edmo's uncontrolled mental health concerns and the fact she had not lived as a woman in the community prior to her incarceration. Ultimately, Dr. Eliason rendered his professional opinion that surgery was neither appropriate nor medically necessary based upon consideration of Ms. Edmo's individual medical and mental health situation. Dr. Eliason's conclusion was not based on a consideration of the cost of the procedure or any written or *de facto* policy prohibiting such a surgery.

Accordingly, Ms. Edmo cannot demonstrate with any likelihood that one or more of the Defendants were deliberately indifferent to her alleged need for surgery to treat her GD. Where the decision not to provide a specific type of treatment was based on an exercise of professional judgment, a showing of deliberate indifference cannot be made and it is not the role of the Courts to intervene and order that the surgery must nevertheless be provided because Plaintiff's two retained experts hold a different opinion.

Furthermore, while Ms. Edmo has not since 2016 asked for a reevaluation for surgery, the testimony on the record is that serious doubt remains as to whether Ms. Edmo currently meets all of the criteria for surgery as set forth by the WPATH SOC. Specifically, Ms. Edmo still demonstrates severe levels of anxiety, depression, and borderline personality traits. Notably, during her clinical interview and testing with Plaintiff's expert, Dr. Randi Ettner, Ms. Edmo demonstrated extremely high levels of depression and anxiety, which are strikingly similar to the same levels of anxiety and depression that Ms. Edmo reported when entering prison, prior to ever receiving hormone therapy or demonstrating any symptoms of anatomical GD.

Ms. Edmo has also continued to refuse to address her coexisting mental health concerns in individual and group counseling, and she continues to exhibit cutting behaviors on her arms as a way of dealing with emotional dysregulation. Ms. Edmo's dysphoria fluctuates depending on her life stressors, including her job, housing, and relationships, not just when she has purported episodes of disgust related to her genitals. When Ms. Edmo experiences a stressful life event, such as a break-up with a boyfriend, Ms. Edmo's dysphoria increases and she is unable to separate out when her feelings of depression are related to her Major Depressive Disorder or GD related to relationship problems.

Ms. Edmo still needs to complete the work through psychotherapy to address her dysphoria, which the clinical evidence demonstrates has a very complex origin, related to trauma, relationship difficulties, and other unresolved life events.

For example, during Ms. Edmo's clinical interview with defense expert Dr. Joel Andrade, Ms. Edmo demonstrated that she had not fully addressed the relationship between her significant early childhood trauma and abuse. To be sure, there is no evidence that Ms. Edmo has ever attempted to work through the significant affects that her past substance abuse, sexual abuse, and domestic abuse have had on her feelings of self-worth, separate and apart from her feelings about her male anatomy. Such serious and severe mental health concerns should not be ignored, overlooked, or downplayed when assessing the causes of her dysphoria. Indeed, Ms. Edmo's experts did not testify, nor is there any support for the contention, that all of Ms. Edmo's depression and anxiety is related to her GD. Nor did they testify that surgery or Ms. Edmo's current anti-depressant medication will assist Ms. Edmo in sorting out and working through her significant history of trauma and abuse.

Although not specified in her *Motion* or during argument at the evidentiary hearing, Defendants now understand that Ms. Edmo is also requesting a mandatory injunction from this Court ordering the "cessation of discipline related to Ms. Edmo's GD." Here, the IDOC Defendants have not been deliberately indifferent to Ms. Edmo's needs by disciplining her for refusing direct orders to remove makeup or take down her hair, for destroying property to make thong underwear, engaging in sexual activity, or for assaulting another GD inmate on two separate occasions. Ms. Edmo's DORs were issued for violations of IDOC policy and rules put into place to maintain a safe and secure environment for all inmates and staff. In prohibiting inmates, including Ms. Edmo, from appearing or acting sexual in prison, destroying property,

having sex, and injuring other inmates, IDOC officials acted reasonably and in good faith to protect the safety and security of all inmates, including Ms. Edmo, and were thus not deliberately indifferent to her medical needs. The IDOC defendants, then, must be afforded deference in implementing those policies and in meting out reasonable discipline for such serious offenses. *See Whitley v. Albers*, 475 U.S. 312, 321–22, 106 S. Ct. 1078, 1085, 89 L. Ed. 2d 251 (1986).

In addition, IDOC's recently updated GD policy specifically allows inmates with GD to wear appropriate makeup, style their hair in traditionally female hairstyles, and present as female. Furthermore, the updated policy allows inmates who have been diagnosed with GD to access commissary items, such as bras, underwear, female makeup, and grooming items. As a result, there is no basis for IDOC to issue discipline to Ms. Edmo for wearing makeup or her hair in a feminine manner or possess female items from commissary. However, the updated policy does not relieve IDOC of its obligation to maintain a safe and secure environment. IDOC must still be afforded the ability and subjective judgment to issue discipline related to behaviors that are specifically prohibited by the new policy, including "provocative or sexually charged clothing or behavior." Certainly, Ms. Edmo's sexual and assaultive behavior cannot be excused by her GD, and there is no evidence or expert witness testimony in the record to suggest that it should.

b. <u>That any "irreparable harm" or "extreme or very serious damage" will result if Ms. Edmo is not provided the surgery immediately is entirely speculative and, in fact, unlikely.</u>

The expert testimony in this case highlights the competing opinions that Ms. Edmo's overall mental health concerns and dysphoria may worsen, improve, or remain unchanged regardless if she is provided the surgery or not. In fact, without the requisite coping skills to handle the stressors of such a serious and irreversible surgery, and without yet having the

opportunity to live as a woman in the community, a likelihood exists that Ms. Edmo will be at an increased risk of depression and suicide if she is provided the surgery at this time. As discussed above, Ms. Edmo's significant unresolved history of trauma and abuse will not be resolved or alleviated through surgery and Ms. Edmo has not developed or attempted to develop healthy coping skills to address those stressors and the stressors that will certainly come with surgery.

It is undisputed that there are no reliable anecdotes or evidence-based studies to suggest that Ms. Edmo's depression, anxiety, dysphoria, or possibility of self-harm will decrease if she is provided surgery, especially in light of Ms. Edmo's incarceration and significant co-existing and uncontrolled mental health concerns. Accordingly, making any predictions as to whether, absent surgery now, Ms. Edmo will experience irreparable injury or extreme or serious harm is entirely speculative.

However, the evidence and testimony on the record supports the conclusion that Ms. Edmo will not suffer any irreparable – let alone extreme or serious harm – if she is not provided the surgery pending resolution of this dispute at a trial on the merits. Ms. Edmo has not made any attempts at self-castration since 2016, and she testified that she now understands the importance of, and is committed to, preserving the tissue from her scrotum and penis for future use in a vaginoplasty procedure. Further, while Ms. Edmo's depression and anxiety appear to be at the same high levels as they were prior to her incarceration, she has not made any attempts to commit suicide since 2011. Moreover, Dr. Gorton, Plaintiff's own medical expert, testified that the surgery Ms. Edmo is requesting is not an emergency procedure:

> I mean, it's not like your appendix is going to rupture and you have to get surgery tonight. So all patients who are treated for this, they are seen, they are evaluated, there is a process you have to go through. It's not something that happens overnight. So that's not -- I mean, that's not what you do clinically.

> So, I mean, I would never say this person needs emergency sex reassignment surgery. Let's send them in an ambulance to the hospital. That's kind of absurd.

(Tr. 301: 15-23)

Under the circumstances, common sense and sound professional judgment support selecting a course of action at this time that will afford Ms. Edmo the opportunity to experience living in the community as a woman prior to receiving such an invasive and irreversible procedure. While Ms. Edmo's credibility as a witness has been damaged by her prior testimony falsely claiming she lived full-time as a woman prior to her incarceration, it is undisputed that Ms. Edmo will have that opportunity very shortly. Ms. Edmo is not serving a life sentence. Her sentence will be completed on July 3, 2021, and she will be released at that time.

Upon her release, Ms. Edmo will have the opportunity to live full-time as a woman in the community, which will allow her to further evaluate in a real world setting whether or not she wants to continue to live as a woman and, more importantly, whether she still desires to undergo such an irreversible surgery to remove her penis and scrotum. After all, it is undisputed that prison is a unique and artificial environment that does not, in any way, mirror or resemble life in the community. With the exception of transgender individuals, inmates are typically separated from members of the opposite gender. Life is very structured in prison and human interaction and expression is severely limited. Female and male inmates wear very similar uniforms, and no one is allowed to express their sexuality or gender identity fully – whether through appearance, dress, or behavior – as those living in the community do.

c. Under the circumstances, the balance of equities does not tip in Ms. Edmo's favor and supplanting the sound professional judgment of Ms. Edmo's treatment providers for that of the Court is not in the public's interests.

Ms. Edmo has no constitutional right to dictate that she receive one specific treatment option over others. This statement is even more true when Ms. Edmo's providers have exercised their professional judgment and determined that the treatment option she requests is neither medically necessary, appropriate, nor in her best interests. The Defendants in this case have an obligation to provide for the safety and well-being of all inmates in custody, including Ms. Edmo, which includes ensuring that no harm comes to Ms. Edmo by providing unnecessary or inappropriate medical and mental health treatment. For this Court to now order mental health treatment that Ms. Edmo's providers have determined to be inappropriate after applying the WPATH SOC would not only interfere impermissibly with those powers the public entrusted to the executive branch, but would also interfere with mental and medical health providers' efforts to provide medically necessary care and follow their ethical obligations to "do no harm" to their patients.

Dated this 26th day of October, 2018.

MOORE ELIA KRAFT & HALL, LLP

By: */s/Brady J. Hall*
Brady J. Hall
Counsel for IDOC Defendants

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 26th day of October, 2018, I caused to be served the foregoing document to the following parties or counsel by email.

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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; and DOES 1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

PLAINTIFF'S [PROPOSED] FINDINGS OF FACT AND CONCLUSIONS OF LAW

Complaint Filed:	April 6, 2017
Discovery Cut-Off:	None Set
Motion Cut-Off:	None Set
Trial Date:	None Set

regret. Tr. 266:1-267:1.

CONCLUSIONS OF LAW

I. Legal Standard

110. "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. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2009); *Pimentel v. Dreyfus*, 670 F. 3d 1096, 1105 (9th Cir. 2012) (applying *Winter* to claim under 42 U.S.C. § 1983). Under Ninth Circuit law, likelihood of success on the merits is the most important factor. *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015). "[S]erious questions going to the merits and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest." *Alliance for the Wild Rockies v. Cottrell*, 632 F. 3d 1127, 1135 (9th Cir. 2011) (internal quotation marks omitted).

111. Injunctive relief is treated as a mandatory injunction when "it orders a responsible party to take action." *Garcia*, 786 F.3d at 740. A plaintiff seeking a mandatory injunction " must establish that the law and facts clearly favor her position, not simply that she is likely to succeed." *Id.* at 740. "Mandatory injunctions are most likely to be appropriate when 'the status quo . . . is exactly what will inflict the irreparable injury upon complainant.'" *Hernandez v. Sessions*, 872 F.3d 976, 999 (9th Cir. 2017) (quoting *Friends for All Children, Inc. v. Lockheed Aircraft Corp.*, 746 F.2d 816, 830 n.21 (D.C. Cir. 1984)).

112. The Prison Litigation Reform Act requires any preliminary injunction to be "narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct the harm." 18 U.S.C. § 3626(a)(2).

113. Plaintiff's request for a preliminary injunction ordering Defendants to provide her medical care is, unfortunately, not an unusual procedural posture, nor does it seek procedurally inappropriate relief. Courts have authority to grant mandatory preliminary injunctions directing

prisons and medical providers to provide incarcerated plaintiffs medical care where the factors supporting such relief are present. *See, e.g.*, *Mason v. Ryan*, 2018 U.S. Dist. LEXIS 77688 (D. Ariz. May 8, 2018) (granting in part preliminary injunction and ordering Corizon to provide specialist-recommended treatment and medication); *Hicklin v. Precynthe*, 2018 U.S. Dist. LEXIS 21516, at *49-50 (E.D. Mo. Feb. 9, 2018) ("*Hicklin I*") (granting in part preliminary injunction requesting that defendants provide plaintiff medically necessary treatment for gender dysphoria, including hormone therapy, access to permanent body hair removal, and access to gender-affirming canteen items); *Norsworthy*, 87 F. Supp. 3d at 1195 (ordering defendants to "take all of the actions reasonably necessary to provide [plaintiff] sex reassignment surgery as promptly as possible"); *Hamby v. Hammond*, 2014 U.S. Dist. LEXIS 117346, at *1-2 (W.D. Wash. July 7, 2014) (applying *Winter* factors to plaintiff's motion for preliminary injunction seeking surgical repair for hernia); *McNearney v. Wash. Dep't of Corr.*, 2012 U.S. Dist. LEXIS 115802, at *38 (W.D. Wash. June 15, 2012) (granting preliminary injunction and ordering defendant to arrange for plaintiff to be examined by outside specialists and authorize recommended treatment); *Miller v. Bannister*, 2011 U.S. Dist. LEXIS 14858, at *2 (D. Nev. Feb. 14, 2011) (ordering defendants to arrange for plaintiff, who suffered from end-stage liver disease, to be evaluated by a liver transplant specialist); *Rhea v. Wash. State Dep't of Corr.*, 2010 U.S. Dist. LEXIS 97784, at *5 (W.D. Wash. Sept. 27, 2010) (granting preliminary injunction requiring defendants to arrange for plaintiff to be examined by an outside specialist and to "authorize, perform and/or facilitate any treatment" recommended by the specialist to treat plaintiff's neuroma).

114. District courts faced with motions for injunctive relief requesting surgery or other forms of irreversible treatment have evaluated these requests under the preliminary injunction standard. *See, e.g.*, *Norsworthy*, 87 F. Supp. 3d at 1184-95 (plaintiff's motion for preliminary injunction requesting gender confirmation surgery evaluated under preliminary injunction standard); *Hamby*, 2014 U.S. Dist. LEXIS 117346, at *1-2 (applying *Winter* factors to plaintiff's motion for preliminary injunction seeking surgical repair for hernia). A ruling on a motion for a preliminary injunction "leaves open the final determination of the merits of the case." *Ranchers Cattlemen*

Action Legal Fund United Stockgrowers of Am. v. U.S. Dep't of Agric., 499 F.3d 1108, 1114 (9th Cir. 2007). "This rule acknowledges that decisions on preliminary injunctions are just that—preliminary—and must often be made hastily and on less than a full record." *Id.* (internal quotations omitted). While the Court recognizes that an order granting Ms. Edmo's motion for preliminary injunction may have the effect of granting ultimate relief on some of her claims, the mere fact that Ms. Edmo's requested relief is surgical and therefore irreversible does not convert her request for urgent relief to a motion for permanent injunction that would result in a final judgment on the merits of her claims.[2] Accordingly, the Court evaluates Ms. Edmo's motion under the preliminary injunction standard.

II. Analysis

A. The Law Clearly Favors Plaintiff's Position on Her Claims

1. Eighth Amendment Claim

115. It is well-established that "[d]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (internal citation omitted). Prison officials are liable for violations under the Eighth Amendment when they are deliberately indifferent to a substantial risk of serious harm to a prisoner, which the Supreme Court has described as "the equivalent of recklessly disregarding that risk." *Farmer v. Brennan*, 511 U.S. 825, 836 (1994); *see also id.* ("Deliberate indifference lies somewhere between the poles of negligence at one end and purpose or knowledge at the other."). "Much like recklessness in criminal law, deliberate indifference to

[2] While one district court in the Ninth Circuit reached the opposite conclusion in *Boldon v. Humana Ins. Co.*, 466 F. Supp. 2d 1199 (D. Ariz. 2006), this case is distinguishable. In *Boldon*, the court granted an injunction to an employee seeking a determination that his medical plan should provide him medical treatment coverage. The court concluded that the standard for a final rather than preliminary injunction applied because "the requested injunction . . . is final in substance, with the opportunity for full presentation of material evidence attendant to a final injunction after trial on the merits." *Id.* at 1208. In the instant case, however, the parties have thus far conducted only limited discovery because of the balance necessary between time for initial discovery and a timely decision on the requested preliminary injunction due to the nature of the medical need alleged. The record before the Court that does not represent all the evidence that would be presented at a full trial on the merits. However, as set forth *infra*, this evidence is more than sufficient for the Court to rule on Plaintiff's motion for preliminary injunction.

D. The Public Interest

163. The Court finds that a mandatory preliminary injunction is in the public interest. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *See Melendres*, 695 F. 3d at 1002 (citations and internal quotations omitted)); *see also United States v. Raines*, 362 U.S. 17, 27 (1960) ("[T]here is the highest public interest in the due observance of all constitutional guarantees.").

164. "In addition, 'the public has a strong interest in the provision of constitutionally adequate health care to prisoners.'" *McNearney*, 2012 U.S. Dist. LEXIS 115802, at *44 (quoting *Flynn v. Doyle*, 630 F. Supp. 2d 987, 993 (E.D. Wis. 2009)). There is no public interest in forcing Ms. Edmo to continue to suffer unnecessary and life-threatening harms during this litigation. *See Fields*, 653 F. 3d at 556; *Norsworthy*, 87 F. Supp. 3d at 1194.

CONCLUSION

165. For the foregoing reasons, Plaintiff's motion for a preliminary injunction is granted in part.[3] Defendants are ordered to provide Plaintiff with adequate medical care, including gender confirmation surgery. Defendants shall take all actions reasonably necessary to provide Ms. Edmo gender confirmation surgery as promptly as possible and no later than six months from the date of this order. Defendants are further enjoined from disciplining or punishing Plaintiff for expressions of her gender identity that are reasonably related to her diagnosis of gender dysphoria, including hairstyle and wearing of makeup that are generally permitted in IDOC's women's prisons.

166. The Court has considered the mandates of the Prison Litigation Reform Act requiring that a court "shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the federal right," and "shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice

[3] Given IDOC's implementation of an updated gender dysphoria policy on October 5, 2018 that appears to provide Plaintiff's requested injunctive relief related to accessing gender-appropriate underwear, clothing, and commissary items, the Court will not address this relief at this time. This is without prejudice should IDOC implementation of the policy result in ongoing violations.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

Adree Edmo Plaintiff, v. Idaho State Board of Corrections, et al. Defendant.	)	Case Number: 1:17−cv−00151−BLW

NOTICE OF FILING OF OFFICIAL TRANSCRIPT

Notice is hereby given that an official transcript of a proceeding has been filed by the court reporter/transcriber in the above−captioned matter. The parties have five (5) business days to file with the court a Notice of Intent to Request Redaction of this transcript. If no such Notice is filed, the transcript may be available electronically to the public without redaction after 90 calendar days.

Counsel are required to serve the court reporter/transcriber with the Notice of Intent to Request Redaction.

Any party needing a copy of the transcript to review for redaction purposes may purchase a copy from the court reporter/transcriber or view the document at the clerk's office public terminal.

DATED: 10/19/2018 Stephen W. Kenyon ,Clerk

EVIDENTIARY HEARING - Motion for Preliminary Injunction (Day 3)

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

Judge: B. Lynn Winmill
Case No: 1:17-cv-151
Date: October 12, 2018
Place: Boise

Deputy Clerk: Jamie Bracke
Reporter: Tammy Hohenleitner
Time: 6 hours and 3 minutes

ADREE EDMO v. CORIZON INCORPORATED, et al

Counsel for Plaintiffs: Amy Whelan, Shaleen Shanbhag, Lori Rifkin, Deborah Ferguson, and Craig Durham

Counsel for Corizon Defendants: Dylan Eaton and Kevin West

Counsel for IDOC Defendants: Brady Hall and Marisa Crecelius

WITNESSES

Defendants:

1) Scott Eliason (continued from 10/11/18)
2) Dr. Keelin Garvey
3) Joel Andrade, Ph.D

EXHIBITS

Joint: 20

Plaintiff: 1041, 1030, and 1029

Defendant: 2032, 2033, 2021, and 2010

Evidence closed.

Closing arguments held.

Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

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Dated: March 6, 2019

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UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

ADREE EDMO (a/k/a MASON EDMO), Plaintiff, vs. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; and DOES 1-15, Defendants.	CASE NO. 1:17-cv-00151-BLW **EVIDENTIARY HEARING DAY 3**

TRANSCRIPT OF PROCEEDINGS - VOLUME 3
BEFORE THE HONORABLE B. LYNN WINMILL
FRIDAY, OCTOBER 12, 2018, 8:37 A.M.
BOISE, IDAHO

Proceedings recorded by mechanical stenography, transcript produced by computer.

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I N D E X

OCTOBER 12, 2018 - VOLUME 3

D E F E N D A N T S' W I T N E S S E S

J O I N T E X H I B I T S

PLAINTIFF EXHIBITS

DEFENDANTS' EXHIBITS

P R O C E E D I N G S

October 12, 2018

THE CLERK: The court will now hear Civil Case 17-151, Adree Edmo vs. Corizon, Incorporated, et al., for day three of a motion for preliminary injunction.

THE COURT: Good morning, Counsel.

Before we continue with the examination of Dr. Eliason, Mr. Severson advised me that there was an issue. I'm going to lay out what I understand to be the situation and then have counsel confirm that I have got it right or wrong, correct me where I am wrong, and then I'll indicate how we're going to resolve this. I don't really want to waste a lot of time arguing or getting hung up on that.

My understanding is the defendants have now chosen not to call certain witnesses that were previously identified on their witness list. The defendants had anticipated -- and that the defendants are going to rely upon the declarations that were filed under oath in this proceeding for those same witnesses.

The defendant -- the plaintiffs are concerned that there have been depositions taken of those individuals, and they feel that the untested affidavits, without being able to impeach those individuals, really does not give the court a full sense of what the record is or should be. And apparently you can't reach an agreement as to how to resolve it.

If I have got it right, you can just confirm; if I have got

it wrong, let me know where I have got it wrong.

MS. RIFKIN: Your Honor, that's correct. We had suggested that, given that defendants are no longer calling certain witnesses that were on their witness list they had intended to call, that we be able to submit written impeachment through submitting their deposition testimony following the hearing. We could lodge the full original deposition transcripts in the same manner that we discussed yesterday with the court and submit the written excerpts as impeachment testimony, but defendants have declined to agree to that proposal.

THE COURT: All right. Mr. Hall, Mr. Eaton.

MR. HALL: Your Honor, I mean, in all candor, I haven't had a lot of time to think about this, because it's not something we ever contemplated when we put together our stipulation in June of this year where we agreed that in lieu of, or in addition to, live testimony, parties could submit -- all parties could submit declarations. And the parties would then have time to depose fact nonretained expert witnesses or retained expert witnesses.

We filed a lot of declarations because we knew, with this not being a full trial and having only three days, there was no way to possibly get to all of them. So we submitted those on the record, provided those to plaintiff's counsel in August. And a lot of those, there was no request from the plaintiff to

take the depositions of those individuals. They let them lie.

They scheduled three depositions of three witnesses we identified as nonretained expert witnesses and fact witnesses, and they decided to take those depositions before we ever included them in our final witness list.

My concern right now of allowing them to use the deposition transcript is there was no opportunity or real need at that time to rehabilitate witnesses on the record. They were not identified as witnesses to be called for sure at the trial at that time -- or the hearing.

And they weren't trial depositions. They were just discovery depositions. If plaintiffs wanted to rebut the assertions in the declarations, they could have gone about it a different way. They could have scheduled their depositions earlier after receiving them in August. They could have filed motions to strike. They could have filed, you know, contradictory declarations.

I just -- I do have a concern about now allowing plaintiffs to submit impeachment testimony by way of a deposition where we have no opportunity to rehabilitate the witness.

That's it, Your Honor.

THE COURT: Okay. Mr. Eaton.

MR. EATON: Your Honor, I don't believe this issue applies to us.

THE COURT: All right.

MR. EATON: We don't have any declarations other than our expert who will be on the stand.

MS. RIFKIN: That's not quite true, Your Honor.

THE COURT: Ms. Rifkin, I don't think I need to hear any more. I'm going to allow the -- here is how we're going to resolve it.

The plaintiffs -- or the defendants will be put to their choice to either call the witness live or they submit the affidavit. If they submit the affidavit, plaintiffs will be allowed to indicate designations from the -- I don't want to read the entire deposition. Although you can submit it, I'm not going to read it all. I want you to designate those portions -- only those portions that you think are impeaching or otherwise contradictory.

And then, Mr. Hall, you'll have a chance to cross-designate any items in the depositions that you think are necessary to provide context for what the witness said in the designation -- the excerpts designated by the plaintiffs.

That's why I'm giving you the choice. If you are going to rely upon the affidavit, then you have to accept the fact that there may be some impeachment that's going to occur from the depositions, but you will have the opportunity to provide context but only context by cross-designation of additional excerpts.

I want a complete record. I want to let the parties -- I

need to know -- I want information, and I'm not going to stand on formality in the, I guess, search for truth.

And so, from that point of view, this thing was put together hurriedly for the hearing. It was not perfect, but I'm going to make it as perfect as I can to make sure both parties have a fair opportunity, the defendant first by being able to choose now.

You can call them live, or you can rely upon the declarations. But if you rely on the declarations, the plaintiffs will have a chance to designate portions of the excerpts that they think are impeaching, with the defendant, IDOC, having the opportunity to cross-designate to ensure that the court has a full context.

So I think that's the best way we can approach it. I can't resolve it any better than that, but that's how we're going to go forward. All right?

MR. HALL: That's fine, Your Honor.

MS. RIFKIN: Yes, Your Honor.

THE COURT: Mr. Eaton, I believe we had Dr. Eliason on the stand under your examination, as I recall.

MR. EATON: Thank you, Your Honor.

I believe there is a dispute as to whether our expert, Dr. Garvey, can sit in here during the testimony. I was planning to have her in here. Their experts weren't excluded, and I don't think anyone has been excluded.

THE COURT: Well, generally, I'll allow opposing counsel's expert to be in the room just to avoid delay in having -- so they can know what it is they're being called to rebut. But your own expert, your other expert, I'm not sure I feel the same rule would apply.

But no one has asked to exclude witnesses, anyway, under Rule 615. So it's all fair game, I guess, until witnesses have been excluded. Nobody made the motion up to this point in time, and I'm not sure it's fair to do it in the middle of the hearing.

I guess my inclination is to let everybody in because nobody has been excluded up to this point.

MS. RIFKIN: Your Honor, we did not have our experts in the courtroom for testimony. I believe our expert, Dr. Gorton, accidentally came in for the space of a minute. But we did not have our experts sit in on the testimony.

Also, Dr. Eliason testified extensively yesterday, and Dr. Garvey was not in the courtroom. And so to the extent that Dr. Garvey is in the courtroom now for a portion of his testimony, I think that --

THE COURT: Well, I think under those circumstances, Mr. Eaton -- you know, typically, counsel agree that experts can stay in during the opposing side's expert testimony, but I have never heard anyone argue they should be allowed to do it during their own expert.

MR. EATON: Your Honor, I'll defer to the court. We don't need to take any more time on this.

THE COURT: All right. No. Let's -- let's have them stay outside the courtroom. Okay?

All right. Is Dr. -- oh, you're, here. Sorry. You snuck up on me there, although you were there the whole time. My brain is not connected yet this morning.

All right. With that, I'll remind you, Dr. Eliason, that you are still under oath.

Mr. Eaton, you may resume your examination.

The one thing I would suggest to all counsel is that we kind of cut to the chase as much as you can. I think it's always good early in a hearing or trial to take a little more time with the first few witnesses to make sure I have a general sense of what's going on. I think I have got that.

So I think now we should be right and direct to the point both on direct and cross-examination, particularly mindful of the fact that we don't have a lot of time left.

So, with that, go ahead and inquire.

MR. EATON: Yes. I plan to be quick with this witness, Your Honor.

Madam Clerk, could we pull up the computer on the far side.

Could you zoom in on the top paragraph.

SCOTT ELIASON, M.D., DEFENDANTS' WITNESS, PREVIOUSLY SWORN

CONTINUED DIRECT EXAMINATION

BY MR. EATON:

Q. Dr. Eliason, yesterday we talked about this note.

Do you remember that?

A. Yes.

Q. And this note was regarding your original assessment of gender identity disorder?

A. Yes.

Q. Okay. I just wanted to bring one thing up quickly.

Right next to where I put the line, there is a quote, "Actually, a woman," quote, and then there is another sentence.

I was just wondering if you could tell us what Ms. Edmo told you in that regard.

A. After where it says "woman"?

Q. Yes.

A. It says that "He reported only dressing as a female during rare occasions."

Q. Okay. Thank you.

Now, it's been suggested that all of plaintiff's mental illness issues stem from her gender dysphoria, by plaintiffs.

When you assessed Ms. Edmo for SRS in 2016 --

MS. SHANBHAG: Objection. I'd move to strike the testimony by counsel as to the characterization.

THE COURT: Overruled. I think it's a characterization, frankly, of the questions I have asked the witnesses.

So go ahead and proceed.

MR. EATON: Thank you.

Q. BY MR. EATON: Again, it's been suggested by plaintiffs that all of plaintiff's mental health issues stem from her gender dysphoria.

When you assessed Ms. Edmo for sex reassignment surgery in April of 2016, did you agree with such a characterization?

A. No.

Q. And why is that?

A. Because Ms. Edmo also had other mental health disorders.

Q. Such as?

A. Major depression and alcohol use disorder.

Q. Okay. And then I believe yesterday at the end of the day when we left off, you mentioned you appeared by phone for a presentation by Dr. Alviso; is that right?

A. That's right.

Q. Okay. And who is Dr. Alviso?

A. Dr. Alviso is a local doctor. I'm not sure if he is a family doctor or an internist, but he works at the Family Medicine Clinic or Family Medicine Residency of Idaho clinic. And he treats a lot of the transgender population in town, mostly prescribing hormones.

Q. Okay. And is he an employee of Corizon?

A. No. He is a consultant that Corizon works with sometimes.

Q. Okay. And do you know when Corizon started working with

Dr. Alviso?

A. I think it was in the fall of 2016.

Q. Okay. And then I believe we were talking that you mentioned you were going to set up a committee to further address sex reassignment surgeries, and then you talked about some presentations that you had lined up.

Do you remember that testimony?

A. Yes. Yeah.

Q. Okay. And then what happened after that with regard to the committee?

A. Yeah. So it was my idea to form this committee of physicians who could determine this. And I set up these trainings. And I had identified multiple physicians.

If you pull up the attendance sheet of the Dr. Levine training, I had several physicians that attended that with me.

And then the problem is, since that time, they all quit. And, you know, it's a classic correctional medical problem is that retaining staff is really hard to do. Turnover happens a lot. But every single one of those physicians that I have identified all left the company, and so my committee evaporated, basically.

Q. And were there some Idaho Department of Correction folks at that presentation?

A. Yes. Almost everybody who was on the Management and Treatment Committee attended that training.

Q. And so was it your understanding that the Management Treatment Committee then would consider SRS?

A. Yes. From there on, that was a consideration that we did in the committee.

Q. Okay. And as a Corizon regional psychiatric director, are you familiar with Corizon policies and procedures and practices related to the treatment and care of gender dysphoric inmates?

A. Yes.

Q. Is sex reassignment surgery as a treatment for gender dysphoria prohibited by Corizon?

A. Absolutely not.

Q. What treatment options are available for treating a gender dysphoria patient through Corizon?

A. All -- all treatment options that are seen as medically necessary.

Q. And what would that include?

A. So it would include -- I mean, it's not limited to this, but it would include psychotherapy, hormone treatment, surgical procedures.

Q. Okay. And are there any Corizon written policies or procedures regarding sex reassignment surgery?

A. No.

Q. And if there are no policies and procedures, then what's the practice related to sex reassignment assessments?

A. It's really left to the clinical judgment of the providers.

Q. And do you follow the Idaho Department of Corrections standard operating procedure as well Corizon?

A. Yes.

Q. There has been some discussion regarding the gender dysphoria Management Treatment Committee at Idaho Department of Corrections.

Did the Management Treatment Committee ever deny anything you deemed medically necessary?

A. I can't -- I can't think of a single incidence.

Q. Okay. And further, is it your understanding that sex reassignment surgery --

A. Well, let me -- let me answer that last question in a different way.

I mean, there may have been times when a committee member of some sort disagreed, and then the committee would discuss things. But it was never something where somebody didn't either change their mind because of input from the committee. And that was the same case with me.

So I never felt like, after discussing something, I felt like it was still medically necessary and they denied it.

Q. Fair enough.

And is it your understanding that sex reassignment surgery would be available to a patient in the Idaho Department of Corrections' custody if you recommended it was medically necessary?

A. Yes.

Q. And what's that understanding based on?

A. Well, I have had that specific conversation several times with the department where if we felt it was medically necessary, you know, would it be provided. And the answer was yes.

And I've had a long relationship with the Idaho Department of Corrections, and I have worked with the department of corrections in other states, too.

And what has always been remarkable to me about Idaho is the care that they provide for the people that they house in their prisons. And I think that they are highly professional. And I think if a provider came to them and thought something was medically necessary, they would follow that advice.

MR. EATON: I don't want to preempt the court, Your Honor, but I believe you were asking the witness a question the other day, and so I was going to pose that to the witness.

Q. BY MR. EATON: And I believe that question, if I understood it correctly, was: What would you change to WPATH to make it work in a correctional setting? Do you have some thoughts on that?

A. I do have some thoughts. I'll try to keep them concise.

I think even in WPATH, it does allow for flexibility in different housing situations. And so I think you need to apply that flexibility to their standards.

And the first thing I would look at is they have a

real-life -- a 12-month real-life test of living as your chosen gender identity. And that's, I think, a really crucial step; and I think that prison is not the optimal place for that step.

And so there would need to be some sort of prolonged period of incarceration where it had to be really long to say that we're going to do this real-life test in prison. And I don't -- I don't have a real number to give you, but I would imagine it would be longer than five years.

And it also -- it would need to allow for the level of cooperation with mental and medical staff. Because if the patient is always at odds with medical and mental health staff, frequently engaging in self-harm, frequently getting disciplinary write-ups and things like this, then they wouldn't be a good candidate to go through such a stressful procedure.

You know, getting the procedure, there is a lot of medical follow-ups, a lot of bad outcomes that can happen. And you need to have that cooperation to work through those. And if you don't have that, I think that that -- the level of cooperativeness would have to be another criteria that would be in there.

And I think those two would really help.

And then, lastly, one glaring problem that we have is there is just no clinical evidence that sex reassignment surgery in the inmate population is a safe and effective treatment.

You know, in the United States, I think we have had one --

a case of one person who has had a sex reassignment surgery as an inmate. And I think this is kind of a unique population that needs to be studied more before we really can say whether it's safe and effective.

MR. EATON: Thank you. No further questions.

THE COURT: Mr. Hall, do you have any?

MR. HALL: No, Your Honor.

THE COURT: Ms. Shanbhag.

MR. EATON: Madam Clerk, could we take this down. Thank you.

CROSS-EXAMINATION

BY MS. SHANBHAG:

Q. Good morning, Dr. Eliason.

A. Good morning.

Q. I would like to begin with your April 20, 2016, assessment of Ms. Edmo's request for surgery.

Can we pull up Joint Exhibit 1-538. I think we are having a little -- Exhibit 1, page 538. Thank you.

And you testified yesterday that when you met with Ms. Edmo on April 20, 2016, that you knew she had attempted to cut off her testicles in September of 2015; is that correct?

A. I don't think I worded it that way, but I did know -- like if you see in the note, it says -- in the middle of that top paragraph, it cites that she made attempts to mutilate her genitals this past fall.

Q. Right. And at your deposition, you testified that you had seen Ms. Edmo not long after this self-castration attempt; correct?

A. In my deposition, I said that I -- say that one more time.

Q. At your deposition, you testified that you had seen Ms. Edmo not long after she attempted to castrate her testicles.

A. You know, I don't -- I don't remember how soon after I saw her.

Q. That's fine. We discussed a January 2016 visit.

A. Okay.

Q. And during that visit, she reported to you that it was difficult to stop her mind from thinking at night because she had thoughts about castration; correct? Do you remember that?

A. Do you have -- do you have that note?

Q. I can show you the deposition testimony.

A. Yeah. That would be helpful.

MS. SHANBHAG: Your Honor, we only have a certified copy for the court, but this deposition was taken over 30 days ago, and I don't believe we received any corrections.

MR. EATON: Your Honor, I object. I don't think this is proper impeachment at this point.

THE COURT: Well, the witness is just asking to have his memory refreshed as to what --

MR. EATON: With the document?

THE COURT: Ell, I think what we should do is ask him

whether that's his current recollection. If he -- if he says something contrary to the deposition, then you can show him the deposition.

So rather than ask him about what he testified to, let's ask him what his current memory is, and we'll proceed from there.

Q. BY MS. SHANBHAG: Do you remember Ms. Edmo reporting to you that it was difficult to stop her mind from thinking at night because she had thoughts about castration?

A. I don't remember that off the top of my head.

THE COURT: What was the date of that interaction?

MS. SHANBHAG: January 27, 2016, I believe.

THE WITNESS: But we have that note.

THE COURT: You're talking about the medical note?

THE WITNESS: Yeah. Because if the medical note says that, then it would refresh my memory.

Q. BY MS. SHANBHAG: Right. I'm asking about what you testified to.

A. Oh, in the deposition?

Q. Yes.

A. I can't remember. I mean, it was a nine-hour deposition, so...

MS. SHANBHAG: May I approach, Your Honor?

THE COURT: Yeah.

Mr. Severson?

Q. BY MS. SHANBHAG: This is the cover of your deposition transcript; correct?

A. Correct.

Q. And can we go to page 104, please.

A. Yes. Okay. I'm there.

Q. I would like to direct you to line 12.

A. Okay. Line 12? Is that what you said?

Q. Yes.

A. Okay.

Q. Do you mind if I read it to you?

A. Sure.

Q. Question: "And is there a reason you didn't see her until January of 2016?"

Answer: "Well, it sounds like she wasn't in. From my note, it says the inmate reported she had been in Unit 8, which is a different unit, and so there is a different provider there."

Question: "And she also -- or you wrote that she noted it is difficult to stop her mind from thinking at night and, quote, 'I just have all these thoughts about castrating myself,' end quote; correct?"

Answer: "Yes."

Do you remember this discussion with Ms. Edmo now?

A. Yes.

Q. And in response to Ms. Edmo's report --

MR. EATON: Your Honor, I'm going to object to foundation. I'm not sure I understand where we're going here.

THE COURT: Well, I don't -- I think we are back -- it's really not impeaching. We are just putting in the deposition testimony because the witness has never had an opportunity to say something contrary to what was in the deposition.

So I think the better approach is to just go through the same line of inquiry. And if the witness gives you a contrary response from what he provided during the deposition, then it's proper to impeach.

So I think, in this instance, simply doing the same thing, showing him the treatment notes and then asking him the same questions, would be the proper way to proceed.

So I don't -- I'll sustain the objection. I don't think this is a proper form of impeachment.

Let's go ahead and proceed.

Q. BY MS. SHANBHAG: And in response to Ms. Edmo's reports that she -- it was difficult to stop thinking about self-castration at night, you prescribed her medication to help her sleep; is that correct?

A. Yes.

Q. And that prescription was Remeron; right?

A. Correct.

Q. I would like to go back to the April 20, 2016, note.

THE COURT: Is this part of Exhibit 1?

MS. SHANBHAG: Exhibit 1, page 538, yes.

Q. BY MS. SHANBHAG: You testified yesterday that there were two bases for your conclusion that Ms. Edmo did not meet medical necessity for surgery.

Do you remember that?

A. Yes.

Q. And the first basis you stated was that her mental health concerns were not controlled; correct?

A. Yes, correct.

Q. And I'm looking at your progress note dated April 20, 2016. And nowhere in this note do you cite mental health concerns as a basis for denying Ms. Edmo's surgery; correct?

A. Correct.

Q. In fact, at your deposition just two months ago, you testified that you could not remember if your decision to deny Ms. Edmo's surgery was based upon her mental health stability; right?

A. I guess I can't remember, but -- I don't remember.

Q. But yesterday you said for the very first time that your decision to deny Ms. Edmo's surgery was because of uncontrolled mental health concerns; correct?

A. I did say that was one of the two reasons.

Q. And you also testified yesterday that the second basis for denying Ms. Edmo's surgery was your belief that she did not meet

the criterion regarding 12 continuous months of living in a gender role congruent with a gender identity; correct?

A. Yes, in a way.

Q. Again looking at the April 20, 2016, note, nowhere in this note do you cite her failure to live in a congruent gender role as a basis for denying her surgery; correct?

A. Correct.

Q. And at your deposition, you did not mention this reason at all; correct?

A. I don't remember.

Q. In fact, you admitted yesterday that Ms. Edmo presented as feminine in demeanor and interaction style when you first met with her in June 2012; right?

A. Yes. Correct.

Q. And I would like to now show Joint Exhibit 1-347.

This is one of your progress notes dated April 10, 2013; am I right?

A. Yes. Correct.

Q. And in this note, in the second part, you note that Ms. Edmo has groomed eyebrows and appears feminine in demeanor and interaction style; right?

A. Correct.

Q. I would like to show another progress note, Exhibit 1, page 425.

And this is a progress note dated April 9, 2014; correct?

A. Correct.
Q. And in this note, you also write that Ms. Edmo had groomed eyebrows and appears feminine in demeanor and interaction style; correct?
A. Correct.
Q. I would like to show Joint Exhibit 1, page 452, please.
And this is a progress note dated January 28, 2015; correct?
A. Correct.
Q. And in this note, you again note that Ms. Edmo had groomed eyebrows and appears feminine in demeanor and interaction style; right?
A. That is correct.
Q. And if we could go back to the April 20, 2016 note which is page 1 -- Exhibit 1-538.
You testified yesterday that on April 20, the date you assessed Ms. Edmo for surgery, you documented that her eyebrows were colored in with black pencil, she was wearing foundation and, again, appeared feminine in demeanor and interaction style; correct?
A. Correct.
Q. And you were also aware that Ms. Edmo had been disciplined multiple times for looking too feminine; correct?
A. I was aware that that's what Ms. Edmo told me.
Q. So is it your opinion that now, two-and-a-half years after

you had documented Ms. Edmo appearing and acting in a feminine demeanor, that she has met the criteria regarding 12 continuous months of living in a gender role congruent with a gender identity?

A. I still --

Q. That's a yes-or-no answer, please.

MR. EATON: I ask that he be able to answer the question, Your Honor.

THE COURT: Well, is it your opinion or not?

THE WITNESS: It's -- I can't really give a yes or no because I disagree with the criteria in general the way it's kind of presented; right? That's the problem, is that I --

MR. EATON: I object to foundation and also --

THE WITNESS: I could explain how --

THE COURT: No. No.

MS. SHANBHAG: I would move to strike counsel's comments.

THE COURT: What's the objection?

MR. EATON: It misstatements testimony, and it also lacks foundation.

THE COURT: Are you objecting to the question --

MR. EATON: Yes.

THE COURT: -- or the continuing response?

MR. EATON: No. The question.

THE COURT: Overruled. You know, again, my sense is

you would acknowledge that, construed according to the actual WPATH standards, she was living for at least 12 months or attempting to live for at least 12 months as a woman.

Your disagreement is that it's not 12 months in the real world. And that's the point you're making?

THE WITNESS: That's exactly it, yes.

THE COURT: All right. Go ahead, Counsel.

THE WITNESS: That's it.

Q. BY MS. SHANBHAG: And during your deposition, you did testify that an individual could meet the WPATH criteria even though that person is incarcerated; correct?

A. Correct.

THE COURT: And as I understand your testimony, it is, for example, someone who is incarcerated for 20 years with no opportunity for parole or a fixed life sentence, that's their real world at that point.

But where someone is parole eligible within a number of years, you're saying it's simply not appropriate to do it because they will live in a different world within a number of years; and, therefore, the standard -- WPATH standards need to take that into account?

THE WITNESS: Exactly.

THE COURT: Counsel, I'm just -- you know, I get a pretty clear sense of what the testimony is. And we can object to foundation, and we can ask questions all we want, but I need

to know what the witness is saying.

That's my understanding of what he has already testified to. So go ahead. I'm trying to help counsel out here.

MS. SHANBHAG: Thank you, Your Honor.

Q. BY MS. SHANBHAG: And you testified yesterday that you denied Ms. Edmo's request for surgery in part because you noted she was eligible for parole as of April 20, 2016; is that correct?

A. That is correct.

MR. EATON: Sorry to keep objecting, Your Honor. But the use of the word "deny" I take exception to. There is nothing -- there is no specific deny --

THE COURT: I'm going to overrule the objection. If you feel you never denied it, then you can so indicate.

So go ahead. Restate the question, though, if you would, Ms. Shanbhag.

Q. BY MS. SHANBHAG: You testified yesterday that you found Ms. Edmo's -- Ms. Edmo did not meet medical necessity for surgery, in part because she was eligible for parole as of April 20, 2016; correct?

A. Correct.

Q. But you did not reevaluate Ms. Edmo for surgery after she was no longer eligible for parole, did you?

A. I didn't.

Q. And at your deposition, you testified that your

determination that surgery was not medically necessary was not based on any of Ms. Edmo's prior criminal record; right?

A. Could you say that again.

Q. Sure. Your determination that surgery was not medically necessary for Ms. Edmo was not based on her prior criminal record?

A. Correct.

Q. And you also testified that your determination that surgery was not medically necessary was not based on her disciplinary history or DORs; correct?

A. I -- at my deposition, what did I testify about?

Q. That you did not base your decision on Ms. Edmo's disciplinary history.

A. Correct.

Q. And you also testified that your determination that surgery was not medically necessary, it was not based on a review of her presentence investigation reports; correct?

A. Correct.

Q. But you did testify that information you relied upon in reaching your decision was the medical record, staff observations, Ms. Edmo's therapist, and her therapist's notes; correct?

MR. EATON: Objection. Misstates testimony.

THE COURT: Just a moment. Just a moment.

Did you testify that way or not? If you disagree, you can

so indicate.

THE WITNESS: And some other things, but those things were included as well.

MS. SHANBHAG: Your Honor, I would like to use Dr. Eliason's deposition testimony.

THE COURT: All right. Do we have -- do you have that? All right. So you can show --

MS. SHANBHAG: Can we go to page 113, please.

THE COURT: Counsel, for the record, again, we are not doing this in the normal course, but I'm publishing the deposition of Dr. Eliason. I'm assuming you either have or will submit the final sealed copy to the court.

MS. SHANBHAG: Yes, Your Honor.

Q. BY MS. SHANBHAG: Referring to line 6, page 113.

A. Okay.

Q. Question: "And you also mentioned obtaining collateral sources of information as another factor in determining whether a patient needs sex reassignment surgery.

"What collateral sources of information did you rely upon here?"

Answer: "I relied upon the previous medical record, staff observations, her therapist, and their notes. And that's it."

A. Okay.

Q. Is that accurate?

A. Yes, that is accurate.

Q. And, Dr. Eliason, you also testified at your deposition that gender dysphoria and depression can be related; correct?

A. Yes.

Q. And you have never diagnosed Ms. Edmo with borderline personality disorder; right?

A. Correct.

Q. You have also never diagnosed her with PTSD; correct?

A. Correct.

Q. Can we pull up Joint Exhibit 1, page 538 again.

Yesterday you testified about the three specific situations that you believed could meet medical necessity; correct?

A. Correct.

Q. And in this note here in the assessment portion, you concluded that this inmate does not meet any of those above criteria; right?

A. I don't see where I said that.

Okay. There we go. Yes.

Q. These three examples of what you call medical necessity are not the WPATH criteria for surgery; correct?

A. Correct.

One of them is very similar --

Q. I just asked for a --

A. Sorry. Correct.

Q. And in fact, you testified at your deposition that you don't know where you got these three examples of medical

necessity from; correct?

A. Correct.

Q. And you did agree at your deposition that attempted self-castration could meet your own example of medical necessity; correct?

A. Correct.

Q. You also testified that you believed Ms. Edmo's gender dysphoria had risen to another level when you assessed her for surgery; correct?

A. Correct.

Q. But you made no change to Ms. Edmo's current treatment plan at this visit; correct?

A. At this visit, I was -- correct.

Q. Can you zoom out a little bit on the note.

Your treatment plan for Ms. Edmo on April 20, 2016 -- which is reflected, I believe, in the "P" portion at the bottom; is that right?

A. That is correct.

Q. Your treatment plan was to continue her sleep and antidepressant medications and for her to return to clinic in three months; right?

A. Correct.

Q. And you knew that Ms. Edmo attempted to castrate herself again a few months after you determined surgery was not medically necessary; correct?

A. Correct.
Q. And you have never found gender confirmation surgery medically necessary for any patient diagnosed with gender dysphoria; correct?
A. Correct.
Q. There was some testimony yesterday from you about contacting Dr. Stephen Levine to lead a day-long training for IDOC and Corizon staff; correct?
A. Correct.
Q. And you also testified that you knew Dr. Levine was a defense expert for the Massachusetts Department of Correction; correct?
A. No.
MR. EATON: Objection.
THE WITNESS: That is not correct.
THE COURT: I'm sorry?
MR. EATON: Misstates testimony.
THE COURT: Overruled. I mean, the question was asked whether that is what he testified to, and he can either confirm or not.
THE WITNESS: Should I answer?
THE COURT: Yes.
THE WITNESS: So not correct.
Q. BY MS. SHANBHAG: I would like to show Dr. Levine's PowerPoint from the training, Joint Exhibit 17, please.

Is this Dr. Levine's PowerPoint from the training that you organized, Dr. Eliason?

A. Yes, I believe so.

Q. Can we please show page 43 of this exhibit.

And this is a slide from Dr. Levine's presentation; correct?

A. Correct.

Q. And after organizing and attending Dr. Levine's training, you then presented a training on gender dysphoria with other Corizon health providers; correct?

A. Correct.

MS. SHANBHAG: I would like to show Joint Exhibit 20.

And, Your Honor, this is an exhibit that it was not included on the parties' original list. It's simply a clearer version of Exhibit 18.

THE COURT: I assume there is no objection to using this in lieu of Exhibit 18?

MR. EATON: No, Your Honor.

THE COURT: All right. Exhibit 20 will be admitted. And I guess we'll keep 18 as part of the record, as well, with the understanding that it's an exact copy of the same exhibit.

MS. SHANBHAG: Thank you, Your Honor.

(Joint Exhibit 20 admitted.)

Q. BY MS. SHANBHAG: And is this the PowerPoint from the training that you presented?

A. Yes.

Q. Can we move to page 7, please.

Did you present the portion titled "Gender Dysphoria: A Psychiatric Perspective"?

A. Yes.

Q. And that presentation was comprised of seven slides; correct?

A. I don't remember.

Q. And three of your slides were attributed to Dr. Levine; correct?

A. I assume.

Q. But you didn't select all of Dr. Levine's slides for this training, did you?

A. No. He -- oh, no.

Q. I would like to show one of the slides of Dr. Levine's that you chose.

Can you show Exhibit 20, page 28, please.

This slide is titled "SRS and Suicidal Threats"; correct?

A. Correct.

Q. And at the bottom or very close to the title, you see Dr. Stephen Levine's name; is that correct?

A. Yes.

Q. So you trained other providers, in looking at the second bullet point, that "SRS is not conceived as lifesaving, as is repairing a potentially leaking aortic aneurysm, but as

life-enhancing, as is providing augmentation for women distressed about their small breasts."

Is that correct?

A. That's correct.

Q. And this is a direct quote from Dr. Levine's presentation; correct?

A. Correct.

Q. And you never reevaluated Ms. Edmo for surgery after April 20, 2016; correct?

A. Correct.

Q. Even though you testified that you had hoped to reconvene -- or reassess and convene a committee, you never actually reevaluated her; correct?

A. Incorrect. In person, I never reevaluated her. But on the Management and Treatment Committee, I did.

Q. Dr. Eliason, you testified at your deposition that you never reevaluated Ms. Edmo for surgery; correct?

A. Well, that is true that I never said --

Q. I'm asking for a yes-or-no answer.

A. True.

Q. Thank you.

And you are unaware of any patient in IDOC custody who has been provided gender confirmation surgery; correct?

A. That is correct.

Q. Yesterday you testified that you're a certified

correctional healthcare professional through the National Commission on Correctional Health Care?

A. Correct.

Q. Can I call that NCCHC?

A. Yes.

Q. And that means you're familiar with NCCHC policies and recommendations for providing treatment in prison; right?

A. Yes.

Q. I would like to show Plaintiff's Exhibit 1041.

And this is an NCCHC position statement on Transgender, Transsexual, and Gender Nonconforming Health Care in Correctional Settings; right?

A. Yes.

Q. Are you familiar with this document?

A. Yes.

MS. SHANBHAG: Your Honor, I would like to move to admit Plaintiff's Exhibit 1041 into evidence.

THE COURT: Any objection?

MR. EATON: No objection.

THE COURT: Exhibit 1041 will be admitted.

(Plaintiff's Exhibit 1041 admitted.)

MS. SHANBHAG: If we can move to page 2, please.

Q. BY MS. SHANBHAG: The last sentence under the position statement, that reads:

"The National Commission on Correctional" --

THE COURT: Is it possible you could blow that up or call out -- thank you.

Q. BY MS. SHANBHAG: The last sentence reads:

"The National Commission on Correctional Health Care recommends that the following principles guide correctional health professionals in addressing the needs of transgender patients."

Right?

A. Correct.

Q. And you're familiar with the principles below?

A. Yes.

Q. And you agree with them; right?

A. Yes.

Q. As a certified correctional healthcare provider under NCCHC, you follow the NCCHC guidelines for treating patients; right?

A. Yes.

Q. I would like to direct you to No. 5 of that page.

If we could blow that up, please.

No. 5 reads:

"The management of medical or surgical transgender care should follow accepted standards developed by professionals with expertise in transgender health."

Right?

A. Correct.

Q. Do you see the footnote 1 there after the word "standards"?
A. Yes.
Q. Will you please turn to the last page of the exhibit, which I believe is page 4. Blow that up on the notes part.
Can you read footnote 1, Dr. Eliason.
A. Yes. It says:
"'Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7,' available from the World Professional Association for Transgender Health."
Q. So these are the WPATH standards of care; correct?
A. Correct.
Q. And this reflects that NCCHC's specific endorsement of the WPATH standards of care as accepted standards developed by professionals with expertise in transgender health; correct?
MR. EATON: Objection. Foundation.
MR. HALL: Join.
MR. EATON: I don't think there is any testimony that he can speak on behalf of WPATH or NCCHC.
MR. SHANBHAG: Your Honor, I asked if he agreed.
THE COURT: Overruled. You may answer.
THE WITNESS: Correct.
Q. BY MS. SHANBHAG: I would like to go to page 3 of this exhibit. Can we zoom in on No. 16.
And this reads:

"Treatment for genital self-harm or for complications arising from self-treatment should be provided when medically necessary."

Right?

THE COURT: This is item No. 16, and we're again on Exhibit 1041?

MS. SHANBHAG: Page 3, yes, Your Honor.

THE COURT: Page 3. Thank you.

Q. BY MS. SHANBHAG: And this No. 16 discusses genital self-harm arising from self-treatment; correct?

A. Correct.

Q. So this document recognizes that patients with gender dysphoria may attempt self-treatment by trying to remove their genitals; correct?

A. Correct.

Q. So the NCCHC recognizes that patients with gender dysphoria may engage in genital self-harm in attempt to self-treat; correct?

MR. EATON: Objection. Foundation. It hasn't been established that he speaks on behalf of the NCCHC.

THE COURT: Well, he said that he is a member. If you feel that -- you can indicate whether you think they have indicated as much or not.

The objection is overruled.

THE WITNESS: That's correct.

Q. BY MS. SHANBHAG: And as a certified provider for NCCHC, you're not aware whether the NCCHC has adopted the extra criteria for medical necessity advocated by people such as Osborne and Lawrence; correct?

A. That's incorrect. They have -- in the lectures that you attend at NCCHC, they do go into detail specifically talking about the flexibility of the criteria.

Q. I'm asking if they have adopted the specific criteria for medical necessity.

A. Can you rephrase that one more time?

Q. Sure.

Has the NCCHC adopted the criteria proposed by Osborne and Lawrence?

A. I would say --

Q. Yes or no.

A. No. No.

THE COURT: Could you bring that up again, item 16 on that page. Thank you.

Q. BY MS. SHANBHAG: You testified earlier about your proposed new criteria for evaluating gender confirmation surgery; correct?

A. Correct.

Q. Have you ever proposed these criteria in any publication?

A. No. Honestly --

Q. Just yes or no.

A. No. No.

Q. Have you ever proposed your new criteria in any peer-review context?

A. No.

Q. And you have never published anything regarding gender dysphoria; correct?

A. Correct.

Q. And Mr. Eaton mentioned Corizon policy regarding gender dysphoria earlier.

And you are aware of a Corizon guideline document regarding gender dysphoria; correct?

A. I'm not sure which one you're talking about.

MR. EATON: Your Honor, I just -- objection to the extent we're getting into a document that has been sealed. I'm concerned that the clinical pathways is where we're going here, and I have concern about discussing that in detail. I don't mind it being mentioned.

THE COURT: Well, I can't preclude counsel -- even if it's been sealed, I can't preclude counsel from examining a witness about it. I can clear the courtroom. That's the only thing I can do.

In sealing documents, I didn't mean that they would be precluded from the court's consideration or for examination but only that they would not be available for general dissemination or available to the public.

So I can't -- if we're going to get into it, we will need to clear the courtroom.

MS. SHANBHAG: Your Honor, I will be very vague. I will not get into the specifics.

THE COURT: Go ahead.

Q. BY MS. SHANBHAG: And this guideline document regarding gender dysphoria does not mention gender confirmation surgery; correct?

A. I'm not sure.

MS. SHANBHAG: Your Honor, I would like to show the document now, so if we could clear the courtroom.

THE COURT: If you are just showing it, I can turn off this projector. How much are you going to -- I mean, are you going to --

MR. EATON: Your Honor, I don't think -- if she is just going to show it to the witness, I have no objection if nobody else is going to see it at this point.

THE COURT: All right. The projector is off, so you can go ahead and put it on for just the witness.

MS. SHANBHAG: One second, Your Honor.

Your Honor, may we give the witness the exhibit directly?

THE COURT: Yes.

Q. BY MS. SHANBHAG: Dr. Eliason?

A. Yes.

Q. You're looking at Joint Exhibit 14; is that correct?

A. That is correct.
Q. And this document regarding gender dysphoria, it's a Corizon guideline document; correct?
A. Yes.
Q. And this document does not mention gender confirmation surgery at all; correct?
A. I would have to review it.
Q. Please review it.
A. That is correct.
Q. And do you agree that individuals with gender dysphoria should have access to all necessary types of treatment regardless of whether they are incarcerated; correct?
A. Yes.
Q. And that one type of treatment for individuals with gender dysphoria is gender confirmation surgery; correct?
A. Correct.

MS. SHANBHAG: No further questions.

THE COURT: Can you put that up on the screen? The jury can't -- do you have it where -- I mean, I guess I have it here. I can look at it. Give me a moment. I may --

MS. SHANBHAG: One minute, Your Honor. I can publish it.

THE COURT: Well, that's all right. It's 14, Exhibit 14?

MS. SHANBHAG: Yes. Yes, Joint Exhibit 14.

THE COURT: And just from the page --

MS. SHANBHAG: It's a two-page document, I believe.

THE COURT: All right. Let me look at it.

The question asked was that gender confirmation surgery was not listed as a treatment option?

MS. SHANBHAG: Correct.

MS. RIFKIN: Your Honor, we can put it up now so that it appears on the screen.

THE COURT: I have got it on the screen here.

Okay. All right. You're done with your cross?

MS. SHANBHAG: Yes.

THE COURT: I'm going to ask a few questions. I try to do it -- I sometimes do it at the right time, but this will give both sides a chance on redirect and recross to follow up. And some of these have been covered on cross, and so let me --

EXAMINATION

BY THE COURT:

Q. In the -- I have that exhibit number. I want to say Joint Exhibit 1.

On Exhibit No. 1, page 538, you list those three circumstances in which gender confirmation surgery would appear to be justified; at least I think that's what it said.

Have I got that right?

A. Yeah. Well, what I was trying to do is list some examples.

Q. Examples?

A. Yeah.

Q. All right. The second one was you referred to a severe and devastating gender dysphoria primarily due to genitals.

I assume -- again, obviously, I'm not no psychologist or psychiatrist, but I'm assuming that gender dysphoria comes in different forms, and at least form is where one has a strong concern for their genitalia and views it as kind of the enemy of sorts?

A. Yes.

Q. That lends itself or results in self-castration attempts.

Is that what you were referring to?

A. Yes. That and just like the pervasiveness of it, you know, where it's just constantly on the mind.

In gender dysphoria, oftentimes other interventions take away the dysphoria, such as taking a female haircut or dressing as a female or being called a female name. A lot of times, that decreases the dysphoria to a level where it's sustainable.

Q. Does it also reduce the focus on genitalia?

A. So sometimes the focus isn't as extreme, you know. And so anytime you make those gender-affirming moves, sometimes that takes away that pain from the genital focus or --

Q. So is the thought -- the recent change in policy last Friday, was the thought that that might reduce the pain, as you refer to it, and, therefore, perhaps make gender confirmation surgery unnecessary?

MR. HALL: Objection. Foundation. It doesn't speak for IDOC policy.

THE COURT: Well, good point, good point. All right. I'll not ask that question.

Q. BY THE COURT: Well, then, just -- you know, my real question was: What keeps the plaintiff from falling within that description, that example you gave of when gender conforming surgery would be --

A. I do think that that one, No. 2, is where the plaintiff, Ms. Edmo, does primarily meet that criteria. But then, like, when you focus on that, then you have to look at the details. And that's where I believe that doing it on the outside would best suit Ms. Edmo.

Q. Okay. So, well, that kind of leads me to another question I had.

You indicated that there was the need to have an inmate living 12 months as a -- in a gender-conforming role or a gender -- I'm not sure I'm going to get hung up in the terminology here -- but living as a woman in Ms. Edmo's case in a real-life setting, not in an incarcerated setting. But, of course, that would change if there is long-term incarceration.

Now, but does that dynamic or that calculation change when the inmate engages in dangerous behavior while incarcerated, such as self-castration or suicidal ideation?

A. I think it could.

Q. Okay. But it didn't in Ms. Edmo's case?
A. Yeah. In this specific case, I didn't think that it did.
The self-castration and those incidences, primarily Ms. Edmo's cases usually happened when Ms. Edmo was going through stress from other reasons; like she was getting a disciplinary infraction and gets sent to Unit 8. And then while there and in a state of being upset, she would engage in this self-harm.
And if you look past through her history, she has these different episodes of cutting and suicide attempts, which were her ways to deal with stress.
Q. Okay. A prison, particularly for a transgender individual, is going to be a very stressful environment?
A. True; yes.
Q. That's going to be true today, yesterday, tomorrow, and as long as they are incarcerated?
A. Yes.
Q. Do you agree?
A. Totally.
Q. Okay. The last and I think I asked -- I think it was Dr. Ettner -- I'm not sure who all I asked this question of. But one of the challenges is that the defendant clearly has gender dysphoria -- I don't think anyone is disputing that -- and then there are a number of other mental health concerns. The ones that are pretty clearly recognized would be depression

and anxiety, perhaps substance abuse, which may be a form of self-medication.

But there is no way to tell whether those are a function of -- kind of manifestations of -- what's the word -- gender dysphoria impacting her in adverse ways, or is there?

A. No. You know, I mean, I honestly think it's disingenuous to say you know specifically where painful symptoms come from, because oftentimes we don't know why we're upset ourselves.

Q. But -- okay. I guess my concern is whether or not the requirement -- I think it was the fourth requirement under the WPATH standards -- if, indeed, the mental health concerns are either caused or seriously exacerbated by gender dysphoria, that kind of creates a classic catch-22. She is in need of something, but she can only have it by not being in need of it, which is the catch-22.

A. Yeah. It is a little bit of a --

Q. How do you get out of that? As a clinician, what's the way you address that?

A. You know, it's a challenging thing that we deal with a lot as mental health professionals. Because, you know, you want to try to help them through these different impulses, but oftentimes the thing that they want is the thing that will end up actually maybe being harmful to them.

I mean, this is the hardest part of my job, really, is that patients oftentimes want something now that I know in the long

run is not a good idea for them.

For example, they want to get into the hospital; they want to get sedative medications; they want things that really would help their immediate pain right now, it would make it feel better right now. But in the long run, I know these things are going to be bad for them.

So I have to advocate and try to help the patient not do that thing because I know that in the long run, it won't be good for them.

And like in Ms. Edmo's case, I feel like Ms. Edmo really wants to have the gender reaffirming surgery right now, but I feel like that would be doing her a disservice.

Q. Okay. And I -- a lot of questions about how many inmates have been treated with gender confirmation surgery. My understanding is there has been one in the state of California.

Does Corizon provide that contract for the State of California?

A. No. At least I don't think Corizon has any prison contracts in California.

Q. So there are no inmates in any facility in which Corizon is providing healthcare in which gender confirmation surgery has been selected as a treatment option?

A. Yeah. I would be fairly confident in saying yes.

THE COURT: All right. Okay. Maybe I'll just leave it at that. All right. I'm sorry.

Mr. Eaton, redirect.

MR. EATON: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. EATON:

Q. You never denied SRS forever for Ms. Edmo; correct?

A. Correct.

Q. All right. At the time you made your assessment, you indicated it would be continued to be monitored; right?

A. That is correct.

Q. All right. And is doing SRS, sex reassignment surgery, going to eliminate plaintiff's other mental health issues?

A. No.

THE COURT: Could I -- I'm going to jump in.

You're pretty emphatic on that "no." I asked earlier whether it's possible to sort out what's caused by gender dysphoria, what's not.

And you indicated reluctance to be able to say emphatically how you could ever rule that out, but you seem to be ruling it out now.

Am I misreading your testimony?

THE WITNESS: No.

I think you're reading an important nuance in that there are numerous studies that show that in the transgender population, there is a significant amount of comorbid mental health disorders and that that those comorbid disorders tend to

continue and not be cured by the --

THE COURT: Okay. All right.

MR. HALL: I'm sorry. By the what?

THE WITNESS: By getting the surgery.

MR. HALL: Thank you.

Q. BY MR. EATON: And I believe we were talking about Exhibit 14, the clinical pathways for Corizon; right?

A. Yes.

Q. Counsel talked to you about that?

A. Yes.

Q. That's -- those are just guidelines; right?

A. Yes.

Q. Okay. And they are not mandatory?

A. I think they are meant to be helpful and help guide through specifically the details of the hormone treatments but by no means limits what you can do.

Q. Okay. So it doesn't preclude SRS surgery?

A. No.

You know, I'm in a leadership role with Corizon as a regional psychiatric director, and I'm in meetings with this. And they take this issue very seriously, and I have never once felt that Corizon was trying to guide us away from recommending surgery.

Q. And plaintiff's counsel talked to you about the NCCHC manual or document; right?

A. Yes.
Q. And I believe they reference a position statement.
A. Yes.
Q. Is a position statement mandatory guidelines?
A. No.
Q. And that's where it was referencing WPATH; right?
A. Yes.
Q. And NCCHC may reference WPATH, but are these -- but those are guidelines that are flexible; right?
A. Exactly.
Q. Does WPATH have specific guidelines for the correctional setting?
A. Well, it does -- in their standards of care, it does include all different types of housing situations. So you could say that that includes correctional environments. But it leaves room for clinical judgment, and it leaves room for flexibility.
Q. And the guidelines, say, for vaginoplasty don't specifically address how to apply those in a correctional setting in the WPATH; right?
A. Yes.
Q. Counsel asked you if you've ever reevaluated plaintiff, and I believe you were trying to elaborate on your answer. Could do that now.
A. Yes. So Ms. Edmo did move out of the unit in which I treated, and so I didn't continue to see him, but Ms. Edmo

continued to see other providers and then continued to see her therapists, who are on the Management and Treatment Committee, and we reviewed her case at our meetings.

Q. And did Ms. Edmo ever send you a concern form after you assessed her in April of 2016 regarding her reevaluation?

A. No.

Q. Have you ever been asked to do -- by anyone to do a reevaluation of Ms. Edmo?

A. No.

Q. You were asked about your slides with some other presenters where you included some of Dr. Levine's slides.

A. Yes.

Q. Are those adopted -- are the Levine slides and what's in them adopted Corizon policy?

A. No.

Q. And what was your purpose of including those slides?

A. You know, Dr. Levine had some really great talking points. And if you look at that one point where it talks about basically equating gender reassignment surgery to the same thing as getting a breast enhancement, Dr. Levine put that in there as kind of a talking point to get the audience thinking about the differences between these things.

MS. SHANBHAG: Objection. Lacks foundation.

THE COURT: Just a moment. I'm sorry?

MS. SHANBHAG: Lacks foundation. He is testifying as

to --

THE COURT: Just a moment. I'm sorry.

Okay. Sustained.

You can't speculate as to what Dr. Levine intended when he put something in or didn't. You can obviously testify about what he did put in and your take on it but not what Dr. Levine intended.

THE WITNESS: Gotcha.

Q. BY MR. EATON: We are talking about your slides, and you incorporated those into your --

A. So I was seeing --

Q. Hold on. Hold on.

A. Sorry.

Q. And we are talking about your slides and your presentation. And I'm trying to ask why you incorporated those in there and your understanding about those talking points.

A. So I understood that those talking points were meant to be a discussion point and not to equate it as the same as a breast enhancement.

Q. And so that was just to present a -- to get people talking?

A. It was a --

MS. SHANBHAG: Objection. Leading.

THE COURT: Sustained. Rephrase.

Q. BY MR. EATON: And so why was it presented as a talking point?

A. To help the audience participate and to understand.
Q. Were you specifically adopting those points?
A. No.
Q. And with respect to Corizon, there were other trainings besides Levine on gender dysphoria and treatment and care; right?
A. Yes.
Q. Such as Dr. Alviso's presentation?
A. Yes.
Q. Does attempted self-castration, in and of itself, qualify you for SRS?
A. No.
Q. You were asked if you had ever diagnosed Ms. Edmo with PTSD or borderline personality disorder.

Do you have any thoughts on whether she has borderline personality disorder traits?
A. Yes. I think that that probably does fit Ms. Edmo very well.
Q. You were asked about your April 2016 note regarding your SRS assessment by counsel, and they indicated that there were some things that weren't in that note.

Do you remember that conversation?
A. Okay. Can you say that again.
Q. I'm talking about your SRS assessment note that counsel was asking you about.

A. Uh-huh. Okay.
Q. And I believe they indicated that your specific mention of mental health concerns that you had as why she may not qualify -- one of the reasons that she may not qualify for SRS was not in that note?
A. Yes.
Q. Okay. But you do, in that note, document her other mental health conditions, including major depressive disorder; right?
A. Yes.
Q. And as to the living 12 months as a female criteria, you testified in your deposition that you talked over that with Ms. Edmo, didn't you?
A. Yes.

MS. SHANBHAG: Objection. Leading.

THE COURT: Sustained.

Q. BY MR. EATON: Did you talk to Ms. Edmo about the 12-month living requirement as a female in the prison setting?
A. I don't know if I phrased it exactly like that.
Q. Generally, did you --
A. Yes.
Q. -- talk to her about that?
A. Yes.
Q. What was that discussion?
A. Just the importance of having the real-life test not be in the prison.

Q. So the April 2016 note regarding the SRS assessment, does that capture all of your thinking regarding that assessment?

A. No.

MR. EATON: I don't believe I have any further questions, Your Honor.

THE COURT: Any further questions, Ms. Shanbhag?

MS. SHANBHAG: Yes. I'll be brief, Your Honor.

RECROSS-EXAMINATION

BY MS. SHANBHAG:

Q. Dr. Eliason, you're taught in medical school that it's important to document treatment of a patient; correct?

A. Correct.

Q. And do you agree that the purpose of a physician's progress note is to document treatment of a patient?

A. Yes.

Q. And you agree it's important for a physician to document diagnoses of a patient in the medical record; correct?

A. Yes.

Q. And you did diagnose Ms. Edmo with major depressive disorder; correct?

A. Correct.

Q. And that diagnosis was reflected in your progress notes; correct?

A. Correct.

Q. But you never documented diagnosing her with borderline

personality disorder or exhibiting borderline personality disorder traits; correct?

A. That is correct.

Q. And earlier you told the court that Ms. Edmo's castration attempts were related to being placed in segregation.

Do you know whether Ms. Edmo was, in fact, in segregation, or what you called "Unit 8," when she attempted self-castration?

A. I believe --

MR. HALL: Object to the form, vague. There were multiple times -- there were twice; correct?

THE COURT: Overruled. The question was: Do you know whether Ms. Edmo was, in fact, in segregation, or Unit 8, when she attempted self-castration? The question is: Do you know?

THE WITNESS: That was my understanding, yes.

Q. BY MS. SHANBHAG: But, in fact, she wasn't in Unit 8, was she?

A. Well, it was my understanding that she was.

MS. SHANBHAG: No further questions.

THE COURT: All right. I have a couple follow-up, and I'll --

FURTHER EXAMINATION

BY THE COURT:

Q. Doctor, it's -- I guess I have been around psychologists and psychiatrists long enough that my sense is that when you're dealing with mental health, it's pretty dicey to say that

someone is cured of a mental health problem.

That's the word you used, though, when I asked you about, you know, this concern about chicken and egg, that if the gender dysphoria is actually contributing, exacerbating, or even causing other mental health issues. You indicated that studies indicate that after sex reassignment surgery or gender confirmation surgery, that no one is cured.

The other question -- the more pointed question is whether there is any studies done indicating whether those mental health concerns have been improved -- not cured, but improved.

So is that what you meant, that there is no indication -- any studies done to show whether there is any improvement in the mental health?

A. I would say that the evidence is just very poor.

Q. Okay. All right. That's fair, certainly.

Do you have any opinion as to whether sex reassignment surgery would minimize, exacerbate, or have no change on Ms. Edmo's mental health if the procedure were performed tomorrow?

In other words, what would her status be in six months, a year, two years from now?

A. You know, I guess I couldn't predict. If I had to just leap in one direction and have that done, one thing that I see is I see a problem cooperating with staff very well. And if there were complications, I think it would be a poor outcome.

Q. I understand that.
A. But if it went smoothly, it could maybe be better.
Q. Okay. Of course, why I'm asking that question is to try to get back to my original question, is the catch-22 thing.
There is no way we can sort that out, is what you're saying?
A. Yeah. Yeah.
Q. The other question I was going to ask, I think you or someone indicated that there are 30 inmates under the -- in the custody of the Idaho Department of Corrections who are currently either being treated for or been diagnosed with gender dysphoria.
Is that --
A. That's my understanding. About there, yeah.
Q. So, systemwide, of all the facilities managed by Corizon, do you have any idea what the numbers are?
A. Oh, gosh. I don't have any idea, but I think our numbers are going to be fairly --
Q. Representative?
A. Yeah. And we only have 7,000 inmates in Idaho. So some of Corizon's other states will be a lot bigger.
Q. Okay. So there is probably hundreds, maybe even thousands?
A. Yeah, very well could be.
THE COURT: Okay. All right. Any further follow-up, Counsel, with the questions I have asked?

Plaintiff, anything?

MS. SHANBHAG: Nothing, Your Honor.

THE COURT: Mr. Eaton?

MR. EATON: No, Your Honor.

THE COURT: Mr. Hall?

MR. HALL: No, Your Honor. Thank you.

THE COURT: All right. You may step down.

Call your next witness.

MR. HALL: We were just going to sneak out real quick and use the restroom, if that's okay, Your Honor.

THE COURT: We would take -- you know, today is going to be a little different because we are going a little longer to make sure you get all your hours. So we can take a 10-minute break now. We were going to take one in about 20 minutes, but we can do it now.

I don't see anybody objecting, so we'll take a 10-minute recess. We'll be in recess.

(Recess at 10:02 a.m. until 10:20 a.m.)

THE COURT: Call your next witness.

MR. EATON: Your Honor, defense calls Dr. Keelin Garvey.

THE COURT: Dr. Garvey, please step before the clerk and be sworn.

KEELIN GARVEY, M.D., DEFENDANTS' WITNESS, SWORN

THE CLERK: Please take a seat in the witness stand.

Please state your complete name and spell your name for the record.

THE WITNESS: My name is Dr. Keelin Garvey. K-E-E-L-I-N, G-A-R-V-E-Y, M.D.

THE COURT: You may inquire.

MR. EATON: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. EATON:

Q. Dr. Garvey, thank you for being here. I understand you flew in from the Boston area.

A. Yes, that's correct.

Q. All right. Well, I wanted to get into some of your qualifications and experience.

Madam Clerk, could we pull up the computer for our table, please.

And, Jen, could you pull up the CV for Dr. Garvey.

Do you see a document in front of you, Dr. Garvey?

A. Yes, I do.

Q. What is this document?

A. It appears to be my CV.

Q. Okay. Why don't we just scroll through it real fast.

THE COURT: I don't know what the purpose is of scrolling through it fast, because nobody can read it at that rate, so --

Q. BY MR. EATON: I just wanted to -- is it a complete copy of

your CV?

A. It appears to be, yes.

Q. Okay. And this is a document you created?

A. Yes.

MR. EATON: All right. We would move to admit this into evidence, Your Honor.

THE COURT: Any objection?

MR. HALL: No objection.

THE COURT: The exhibit will be admitted into evidence. I don't know that I have the exhibit number. I'm not sure it was identified.

MR. EATON: Exhibit 2032.

THE COURT: All right. 2032 is admitted.

(Defendants' Exhibit 2032 admitted.)

MS. RIFKIN: And, Your Honor, I was just going to ask that we make sure that it's being published or shown when they're talking about exhibits so we have a chance to look at it and object.

MR. EATON: It's up right now, Your Honor.

THE COURT: There is an -- I'm sorry. I thought there was no objection.

MS. RIFKIN: I just -- I expected it to be on the screen where I could see it, Your Honor.

THE COURT: Well, don't you have your own monitors there?

MS. RIFKIN: Now I do, yes. Thank you.

THE COURT: Okay. I will turn it back on, but you should have it on your own monitors.

MS. RIFKIN: Thank you.

MR. EATON: Are we good?

MS. RIFKIN: Yes. I'm sorry.

Q. BY MR. EATON: All right. So the court now has your CV, and they can read it and consider it, but I want to just highlight a few of your experiences.

Can you briefly tell us your formal education.

A. Sure. I received my undergraduate bachelor degree from Yale University. I attended the University of Massachusetts Medical School, where I received my medical doctorate degree. And then I attended Brown University for my general psychiatry residency, followed by a one-year forensic psychiatry fellowship at UC Davis in California.

Q. And are you board certified in general adult psychiatry?

A. Yes, I am.

Q. And are you board certified in forensic psychiatry?

A. Yes, I am.

Q. And are you a licensed psychiatrist?

A. Yes, that's correct. I'm licensed in eight states.

Q. Including -- can you list them?

A. Massachusetts, Rhode Island, Pennsylvania, Minnesota, Arizona, Florida, Texas, and California.

Q. And you mentioned residencies.

Did you have experience in the correctional setting during your residency?

A. Yes, I did. I was interested in correctional healthcare very early in my career, my training. So I did several electives in correctional healthcare during residency and did a two-month elective in the prison system in Rhode Island.

And I also did a two-month elective that involved doing competency to stand trial evaluations, which was not a treatment role; it was an evaluation role, but it also involved going into the correctional system.

Q. And did you have a forensic fellowship?

A. Yes, I did.

Q. Where was that?

A. That was at the University of California Davis.

Q. And was that in a correctional setting?

A. It involved correctional work.

Because I was interested in correctional healthcare, I looked at programs specifically that involved more extensive exposure to correctional healthcare. So at University of California at Davis, at that time, we had two about two-and-a-half days per week of correctional treatment work, which was more than a lot of the other fellowships had.

Q. And as a psychiatrist, I assume you have a lot of training and education and experience with the DSM-5.

A. Yes, I do.
Q. And briefly explain what that is.
A. Sure. When I was a resident, we were still using the DSM-4 -- you mean explain my experience or explain the DSM-5?
Q. Yeah, and what the DSM-5 is.
THE COURT: I pretty much know what the DSM-5 is.
MR. EATON: All right. Just your experience, then.
THE COURT: I'm just concerned about time. Go ahead.
MR. EATON: I appreciate it, Your Honor.
THE WITNESS: So I trained under the DSM-4. But when the DSM-5 was drafted, I actually was responsible for doing the training on the DSM-5 for my company, MHM, at the time. So I trained all the mental health staff in the Massachusetts system and then also did some national trainings on the DSM-5.
Q. BY MR. EATON: And the gender dysphoria is one of the diagnoses in the DSM-5?
A. That's correct.
Q. Now let's talk a little bit about your experience, your work experience.
Can you tell the court briefly what that is.
A. Sure. Following my forensic fellowship in California, I took a job in the Massachusetts Department of Correction. I was a staff psychiatrist initially, so that meant that I had a caseload of patients that I followed and provided psychiatric treatment for.

About a year into that role, I was promoted to deputy medical director for psychiatry. So I took on some administrative responsibilities, as well, but also maintained my clinical work.

And then in August of 2015, I became the chief psychiatrist in the system, still maintaining -- so I had more administrative responsibility, but I still maintained my caseload of patients as well.

By that point, it had gotten a little bit smaller, but I had some patients that I had followed the whole seven years of my career in Massachusetts.

Q. And as a deputy medical director, what were your duties?

A. Primarily still clinical. So most of my time was spent providing clinical treatment to inmates, but I also oversaw the work of other providers.

We had about -- anywhere from 11 to 16 or so psychiatrists and nurse practitioners. So they would come to me if they had questions about particular cases. I coordinated peer review and the supervisory review process and just kind of had some general oversight over the system.

Q. And did you treat patients with gender dysphoria in that role?

A. I did, yes.

Q. Okay. And what was your role in that respect?

A. At that point, it was as a treating provider. So somewhere

around when I started in 2010 -- I don't remember the exact date, but somewhere around 2010 or 2011, I had a couple of patients that were under my treatment who had gender dysphoria.

Q. And then as a statewide -- statewide psychiatric director, did you have -- did you encounter gender dysphoria patients?

A. Yes, I did.

So in the Massachusetts system at that time, the chief psychiatrist was also the chair of the Gender Dysphoria Treatment Committee. We had a pretty established policy and procedure at that point. So when I took on the role of chief psychiatrist, I became the chair of the Gender Dysphoria Treatment Committee.

Q. And about how many inmates had a GD diagnosis around the time you were working in the Massachusetts correctional system?

A. I don't remember the exact numbers. I know when I started in that role, we had a smaller group, probably somewhere like 12 to 15 or so.

In the two years that I was responsible for that treatment committee, it grew fairly rapidly. So we had anywhere, I would say, from 30 to 40 at any given time.

The numbers fluctuated because in the Massachusetts system, the Department of Correction also houses what we consider jail detainees for the women's side. So we had a number of trans men that were in and out of the system and not there longer term. So the number tended to vary, but it was about 30 to 40, I would

say.

Q. And in your role at the Massachusetts state prison system, were treatment options available for inmates diagnosed with gender dysphoria?

A. Yes, they were.

Q. And what were they?

A. They involved every -- every patient in our system, regardless of gender dysphoria or other diagnosis, has a treating clinician if they have any kind of mental health diagnosis.

So our gender dysphoria population did each have an individual assigned clinician to address stressors and other kinds of issues therapeutically.

We also had -- did hormone -- cross-gender hormone therapy for gender-dysphoric individuals.

We set up a system for getting hair removal. So we had both an electrologist that would come into the system and also a dermatologist that we referred to for laser hair removal. And she was the one that made the recommendations for which form of hair removal.

We had -- we discussed gender confirmation surgery on case-by-case basis, so it was available as an option.

Q. And in your role in this Massachusetts prison setting, were you involved in all aspects of the treatment for gender dysphoria patients?

A. I was.

So each patient also had an assigned psychiatrist, so I wasn't the one that was individually treating each patient.

If the assigned psychiatrist or the assigned clinician had recommendations for the person's treatment, including their gender dysphoria treatment, that those recommendations would come to the committee, and we would discuss them. And then I, along with the other members of the treatment committee, would make decisions about those recommendations.

Q. And then as a deputy medical director, you also had some gender dysphoria patients that you were directly working with; correct?

A. I did while I was the deputy medical director.

When I became the chief psychiatrist, the department of correction had said that I could no longer be the individual treater for those patients because of my role on the treatment committee. But I did have at least a couple at a time up until I became the chief psychiatrist.

Q. And very briefly, why is it that you work in a correctional setting or have worked in a correctional setting?

A. Well, I think I went into it for reasons that are different from the reasons that kept me in.

I initially knew that I was going to go into forensic psychiatry and envisioned a career doing more criminal competency, not guilty by reason of insanity, those types of

evaluations.

I was always interested in corrections, because I think there is so many seriously mentally ill people that end up in the system. But also, there is a lot of -- there's a lot of depth to working in that environment, that I really enjoyed. But I didn't anticipate staying in corrections for so long. I thought I would kind of do that for a few years.

As I got into it, both because of my administrative responsibilities and sort of greater involvement in the whole system -- and also I think largely because of my caseload -- I developed more of an interest in the actual treatment of inmates.

I always had an interest, but I had kind of the luxury of working with some people for seven years during my whole time in Massachusetts, so it became more like a calling for me. I really enjoyed working with that population.

It's obviously challenging at times, but I had an opportunity to see people really improve their lives while they were incarcerated. Ideally, that would happen without incarceration, but it was very rewarding to see some of the work that we could do in the correctional system.

Q. Thank you.

And then what's your current work?

A. Currently, I'm working for a company called InnovaTel. It's a telepsychiatry company. And we primarily do community

mental health, but I was hired to expand into reentry programs and also a smaller correctional systems.

So right now, I am the director of forensic psychiatry and correctional psychiatry for InnovaTel. I do clinical work typically four days a week, and that currently involves working with the forensic population of people that are coming out of jail.

Q. And when you say "reentry program," what do you mean?

A. So it's a program -- so reentry is usually referring to the period of time when individuals are close to getting out of prison or jail and then entering the community.

So we focus on a lot of the practical aspects of that. They have case managers that help them get licensure and their driver's license and housing and medical care and all that stuff.

And then I'm the treating psychiatrist for them, so I will make changes or continue their psychiatric medication if they are satisfied with it.

Q. Okay. And please tell the court about your experience with patient requests for sex reassignment surgery.

A. Sure. So in our system, we had a policy that governed -- it was a department of correction policy that was written by the Massachusetts Department of Correction. And that governed the process for requesting and evaluating gender confirmation surgery.

So in our system, for me to formally evaluate the medical necessity of gender confirmation surgery, it would come in the form of a recommendation from that person's clinician and/or psychiatrist.

But part of the -- besides the treatment committee, we also had a supervision group that met also once a month before the treatment committee. And that was where all the clinicians would come and they would talk about their patients, and we would review treatment plans and talk about changes that needed to be made.

So, technically, one of the clinicians would have had to make a formal recommendation for gender confirmation surgery for me to formally evaluate. But as of when I left, we had several patients that it was really discussed every time we met because we -- their clinicians felt like they were probably approaching medical necessity and that, at some point in the near future, they would recommend that.

So it was an ongoing discussion for -- for several people.

Q. And what training and experience do you have with regard to sex reassignment surgery?

A. So I had a little bit of training on gender dysphoria in my residency. My training since then has been primarily through conferences.

I did attend a WPATH training in Atlanta in January of 2016. That was, I believe, a four-day program that was pretty

comprehensive.

I have read a lot of the primary literature on gender confirmation surgery.

And as part of my role in Massachusetts, we had a consultant who joined for an hour of the supervision committee each month and an hour of the treatment committee each month. And he would also provide annual training once a year but did that two hours of supervision every month during our meetings.

Q. And how many inmates have received SRS surgery while incarcerated in the United States, if you know?

A. There is one that I am aware of.

Q. And did you author an expert report in this case?

A. In this case, yes, I did.

Q. Okay. Could you pull up her expert report, please.

MS. RIFKIN: Your Honor, prior to the expert report, we do not believe counsel has laid foundation for the expert opinions that Dr. Garvey has given in this case in her report.

THE COURT: Okay. We could have taken that up before the hearing.

But have you notified counsel of the specifics?

So you're going to object to the report itself?

MS. RIFKIN: Well, depending on the opinions that counsel is about to ask, we don't believe he has laid the foundation during this examination yet.

THE COURT: Well, are you offering the exhibit at this

point? Because it might be better just to go through and get the opinions out, and then we can address any *Daubert* issue or 702 issue concerning the opinions.

MR. EATON: Your Honor, I was going to ask her to confirm that she wrote the report and that it was accurate and she signed it.

THE COURT: Well, I think we can stipulate to that. So let's --

MS. RIFKIN: So stipulated.

THE COURT: Yeah. And for that matter, I mean, I can receive the opinion or the disclosure but may decline to rely on it or use it depending upon what we hear at this point.

So I'm going to give you leeway to use the report, go through and have Dr. Garvey indicate what the opinions are that she wants to offer to the court, and then at that point in time we get an objection from Ms. Rifkin and proceed in that fashion. All right?

MR. EATON: Thank you, Your Honor. I was going to ask if the witness would like to have a copy of the report in front of her so that she could reference it.

THE COURT: Do you have a copy?

THE WITNESS: I don't have one here; so, yes, that would be helpful.

MR. EATON: This is Docket 100-2, which is her report.

Q. BY MR. EATON: And what records did you review in

preparation for preparing your expert report in this case?
A. I reviewed Corizon medical and mental health records zero to 1599. I reviewed the second amended complaint and the associated discovery. I reviewed the reports of the plaintiff's experts, Dr. Ettner and Dr. Gorton.

I reviewed, as part of the discovery, additional past records of Ms. Edmo, including records from Portneuf Medical Center, Sho-Ban records, Indian Health Service records.

There were several reports that had been authored, including a presentence investigation report in 2009 and 2011; I reviewed those. I reviewed a psychosexual evaluation that was done in 2011. And I reviewed a PowerPoint and a document that had been provided by Dr. Alviso as well.

Q. Okay. And that was -- those are the documents you reviewed for your report?
A. That's correct.
Q. And then did you review any documents subsequent to that report?
A. I did. I reviewed several depositions, including the deposition of Ms. Edmo; the plaintiff's experts, Dr. Gorton and Dr. Ettner; the deposition and report of Dr. Andrade; the deposition of Dr. Eliason, Dr. Menard, Dr. Alviso.

And I believe that was it, that I can recall.
Q. And with the additional information that you reviewed, did that change your opinions in this case?

A. No, it did not.
Q. Did you do a clinical interview with Ms. Edmo?
A. I did, yes.
Q. And was that audio-recorded?
A. It was audio-recorded, yes.
Q. And how long did that clinical interview last?
A. About 2 hours and 35 minutes.
Q. Anything else you have reviewed related to your expert reports and opinions in this case?
A. There were a number of articles that I had read previously and reviewed prior to this as well. I think that covers all of the records that I can recall reading.

I also read -- there are some declarations that came out recently. So I read those more recently, after I wrote my report also.

Q. Okay. In what general areas were you asked to opine in this case?
A. I was asked to opine about the treatment that Ms. Edmo received from medical providers that are -- work for Corizon as well as psychiatric providers with Corizon and also to form an opinion about the medical necessity of gender confirmation surgery.
Q. And also the gender dysphoria assessment?
A. Yes. That was part of the clinical interview.
Q. Did you assess whether Ms. Edmo has gender dysphoria?

A. Yes, I did.

Q. And how did you go about doing that?

A. Through my interview, I asked Ms. Edmo about her history and about her current experience. And I -- at that point, I did not have -- at the point that I saw Ms. Edmo for the interview, I did not have the prior pre-prison records, but I talked about her experience and her -- the history that she reported to me.

Q. And you have familiarity with diagnosing a person with gender dysphoria?

A. Yes, I do.

As part of my role in Massachusetts, I was responsible for evaluating every person in the system that reported symptoms of gender dysphoria, whether they were new and entering the system or had been there for a long time, but newly reported symptoms. So I did those evaluations regularly.

Q. What determination did you make, if any, about Ms. Edmo?

A. At that point, I did diagnose Ms. Edmo with gender dysphoria.

Q. And what was the basis for that?

A. The basis was Ms. Edmo's report to me of her symptoms currently and her experience of living as a female in prison since 2012.

I did include in my report the pieces of information that Ms. Edmo had shared with me from her childhood. I did -- at that point, again, I didn't have the prior records to rely on,

but I did have those prior to writing my report.

Q. And did you make any determination as to whether she has other mental health disorders?

A. I did. I diagnosed Ms. Edmo with major depressive disorder, alcohol use disorder, opioid use disorder, and stimulant use disorder.

Q. And are any of those relevant in your determination of gender dysphoria and treatment, therefore, for Ms. Edmo?

A. They are -- they are comorbidities, meaning that they're illnesses that are occurring simultaneous with her gender dysphoria. So it is all relevant.

It doesn't mean that she doesn't have gender dysphoria, but it is all relevant to her treatment plan.

MS. RIFKIN: I'm going to object, Your Honor, to the extent Dr. Garvey is testifying about treatment for gender dysphoria as distinct from her assessment of the diagnosis of gender dysphoria, because she does not have the requisite expertise to opine about treatment.

THE COURT: About treatment options?

MS. RIFKIN: Yes, Your Honor, about -- about actually assessing what treatment is appropriate for actual patients with gender dysphoria. Rather, she can -- she can testify about what treatment options are discussed in literature that she has reviewed. But as far as how to assess what treatment is necessary for patients, we object to her offering an expert

opinion.

MR. EATON: May I, Your Honor?

THE COURT: Yes.

MR. EATON: I mean, she testified about her experience. You can have qualifications through education, training, and experience. And she has testified that she has treated gender dysphoria patients in the Massachusetts correctional setting as a deputy, and then she oversaw and was involved in the treatment decisions at --

THE COURT: I'm going to overrule the objection. Certainly, you can get into that on cross, but I don't think -- I'll just overrule the objection at this point.

Go ahead and proceed.

MR. EATON: Thank you, Your Honor.

Q. BY MR. EATON: In your expert opinion, are there treatment options available for a gender dysphoria patient?

A. In general?

Q. Yes.

A. Yes. Treatment --

Q. What are those?

A. What was that? I'm sorry.

Q. What are those options?

A. Those options include cross-gender hormone therapy, surgeries, hair removal. Psychotherapy is often recommended to help individuals process some of the stress associated with

transition.

Q. And did you consider Ms. Edmo's psychiatric treatment?

A. Yes, I did.

Q. And did you consider the time it took to evaluate gender dysphoria?

A. Yes, I did.

So I looked at the medical records, the mental health records. And from what I saw in the records, it appeared that Ms. Edmo's first request for an evaluation was around June 1st of 2012.

She had her first evaluation for the diagnosis with Dr. Eliason around -- I think it was June 25th, so it was less than a month later. And then was subsequently transferred for a follow up and more extensive evaluation with Dr. Claudia Lake in July of 2012.

And then I also reviewed a committee meeting record from the Management Treatment Committee that also reviewed her history as provided during those evaluations and --

Q. And what was your determination?

A. My determination was that relative to cases that I have seen, that was a fairly quick time to do the evaluation and then approving the hormone therapy and then initiating hormones.

Q. And was the diagnostic process for determining GID appropriate?

A. Yes, it was.

Dr. Eliason did cover what WPATH recommended as part of the evaluation. And then when Claudia Lake saw Ms. Edmo the following month, she went into a lot more depth about the history.

Q. And what about the time it took for treatment, including hormones, after the GID evaluation? Do you have an opinion on that?

A. Yes. Based on my experience, that was also fairly rapid.

At the time that this was happening -- this was 2012 -- WPATH standards of care had been updated and had removed some of the criteria that they previously required for hormone treatment.

The endocrine guidelines at the time were from 2009 and had not been updated yet. So it was kind of a period of transition where some were still using the older criteria to determine eligibility for hormones, but the standards of care, the WPATH document, had removed some of those criteria.

So based on my experience with patients, even now, I think that's a pretty quick turnaround time. I think it was in late August or September that the hormones were first ordered.

Q. And with regard to hormones, do you have experience with treatment with hormones?

A. Yes.

So in our system, we reviewed the treatment plans every month of every individual that was diagnosed with gender

dysphoria.

We used an outside consultant for our hormone recommendations, so we would -- the initial initiation of hormones would happen per his recommendations. His name is Dr. Joshua Safer. So I would approve the referral to Dr. Safer, who would provide recommendations.

The medical provider responsible for each patient would be responsible for ordering the medication, but we reviewed everyone's treatment regimen at almost every month's meeting in a supervision group. Some were on a fairly stable regimen, so there wasn't a lot of discussion.

Q. And do you have education, training, and experience in hormone treatment?

A. I do.

I have attended the WPATH conference in January of 2017 -- I might have said 2016 before. It was January -- I think it was 2017.

And I have also read a lot of the literature about hormones. I have read the Endocrine Society guidelines and the Center for Excellence guidelines and, again, reviewed all of the treatment plans for the individuals in the Massachusetts system and looked at their hormone regimen.

Q. And do you have an opinion as to whether the hormone therapy provided to Ms. Edmo was appropriate?

A. I do. Yes, I think that the hormone therapy was

appropriate.

The general method of providing hormone treatment involves an estrogen and then an antiandrogen to block testosterone. So she was started on both.

They appear to have been titrated, according to her report. And the medical records that I saw did address what kind of symptoms she was having or what kind of response she was having to the hormone therapy.

But the regimen she was started on and then the continued adjustments were consistent with what I have seen in other cases of people with hormone therapy.

Q. Okay. I would like to turn to your SRS evaluation for sex reassignment surgery.

At the outset, do you believe sex reassignment surgery can be appropriate treatment for inmates under certain circumstances?

MS. RIFKIN: I would like to renew my objection specifically as to Dr. Garvey's opinion on gender confirmation surgery on the basis that she has never treated a patient, evaluated a patient, recommended a patient for gender confirmation surgery.

THE COURT: Mr. Eaton?

MR. EATON: Your Honor, again, it can be qualified by education, training, and experience. She indicated that she has some education, I believe her testimony was, regarding treatment

options for gender dysphoria including sex reassignment surgery. She has indicated that she has gone to WPATH trainings regarding sex reassignment surgery. She has indicated that she, as a deputy and as the chief psychiatrist, also had experience with sex reassignment surgery options.

THE COURT: I'm going to overrule the objection. It goes to the weight of the witness's testimony and opinion. Obviously, someone who has done all the things that Ms. Rifkin pointed to, presumably their opinion has more weight. But I think by training and by some of the roles that she has played in the various prison settings, I think she is qualified to offer an opinion. And through cross-examination, you can test that as well.

So the objection is overruled.

Q. BY MR. EATON: Also, do you have any certifications in a correctional setting?

A. I do. I'm a certified correctional health professional by the National Commission on Correctional Health Care.

Q. And what does that mean?

A. It's a certification that involves taking a test, studying policies and procedures in correctional systems. And you maintain it on an annual basis, attend their conferences typically as well.

Q. And would WPATH and sex reassignment surgery come up in those conferences?

A. It typically does. I presented at several conferences myself, so I did present at the National Commission on Correctional Health Care on gender dysphoria treatment in correctional settings.

I have also presented at the American Correctional Association conference and the American Academy of Psychiatry and the Law on gender dysphoria treatment in correctional settings.

Q. And that would include sex reassignment surgery?

A. Yes. That's often the -- we talk about all the treatment forms and the evaluation process, but that's often what people want to hear about the most, because there are a lot of questions about it. So I do talk about that in my training.

And every training that I have done involves pretty significant discussion with the audience, so everyone sort of shares their experience and their methods of assessing this.

Q. Okay. We need to move quickly here. But there has been discussion by plaintiff's experts that the regret loss after -- the regret after sex reassignment surgery is 1 to 2 percent.

I guess -- sorry. We are just cramped for time here, so I'm monitoring time.

First of all, what is your opinion as to whether the evaluation by Dr. Eliason on sex reassignment surgery was appropriate or not?

A. I believe that it was appropriate. I have read his evaluation from that time and then also his deposition and the declaration of the person that he had consulted with, I think Mr. Clark.

So I do -- I believe that he was using his clinical judgment to apply decision-making and making that decision for Ms. Edmo.

Q. Can you elaborate on that a little bit.

A. Sure.

So he did consider Ms. Edmo's self-castration attempts and that, and he sought consultation with additional medical professionals with Corizon and also with Jeremy Clark, who I believe is a WPATH member.

He -- and from reading the deposition, too, he appeared to be considering her current clinical status and made the determination that he didn't think it was medically necessary at that time.

Q. I will ask you in a second whether you -- about whether you think she is qualified for a sex reassignment surgery now.

But before we discuss that, as I was mentioning a minute ago, plaintiff's experts have been talking about this 1 to 2 percent regret rate.

Very briefly, do you -- after sex reassignment surgery, very briefly, what are your opinions on that?

A. I believe that those numbers are quoted commonly, but they

don't reflect the totality of the literature. I have read the 1 to 2 percent regret rate in the literature as well. However, there are significant problems with the quality of the data, primarily involving a significant number of people that are lost to follow-up.

So many of the studies are quoted, that 1 to 2 percent comes from the people that they were able to follow up. But in many cases, up to half or even more of the sample had been lost, and their results are not counted in this 1 to 2 percent. We don't have any data on the people that were not followed up.

So I believe that those numbers don't represent the full picture.

Q. All right. And so where did you -- did you come to an opinion about whether Ms. Edmo is -- currently satisfies the criteria for sex reassignment surgery now?

A. I -- my opinion was that gender confirmation surgery is not medically necessary at this time for Ms. Edmo.

Q. And what's the basis for that?

A. The basis was three different factors.

One was the discrepancy between some of her self report of her history and the records that demonstrated that she did not appear to be presenting as female in the community prior to being incarcerated.

Now, there can be a lot of different reasons for that inconsistency, but that's an important part that needs to be

fleshed out further with her treating clinicians.

I also believe that her other medical -- her other mental health comorbidities are not sufficiently well controlled. She is actively self-injuring. At the time that I saw her, she said she had cut herself as recently as one month prior. She said that she was doing that with feelings of dysphoria.

But as a mental health professional, self-injury in any form is never considered a healthy or productive coping mechanism. So in my career as a mental health professional, we try to work with people to develop better coping strategies so that they don't engage in self-injury in any form.

So, in my opinion, that is not going to go away if she does have gender confirmation surgery. I would like to see her develop further coping skills that she would be able to use following the surgery so that she is not engaging in self-injury after the surgery.

And then third reason that I cited was that WPATH still includes the 12-month real-life experience, and they provide -- in the standards of care document, they provide a rationale for continuing to include that. And it lists the importance of the person experiencing all of the things that they are going to experience on the outside -- so family response to their social transition or their physical transition, work response, family parties, all sorts of things that you would encounter in your life.

Ms. Edmo is not -- is not serving a life sentence. She is going to be getting out of prison, I believe, in July of 2021. I think there is a lot of -- there is challenges to using her time in a men's prison as this real-life experience because it doesn't offer her the opportunity to actually experience all those things she is going to go through on the outside.

Q. And, in fact, does WPATH address that rationale for the 12-month experience?

A. They do. So --

Q. And what does it say?

A. It says that -- they included that and they didn't take it out of the Standards of Care 7 because they felt that it was important for people to experience all of those social issues and settings that they are going to experience after they have the surgery.

So to go through those first as a socially transitioned or hormone-treated individual prior to undergoing gender confirmation surgery.

Q. So I just want to make sure I didn't skip over it, but you utilized, in part, the WPATH criteria for sex reassignment surgery?

A. Right.

So the WPATH standards of care document has a section where it talks about these as being flexible clinical guidelines. So I used the criteria that they have outlined and applied my

experience and clinical judgment to each of the criteria to come up with a answer about her medical necessity.

Q. Is the WPATH the end-all and be-all of resources that a provider will consider for sex reassignment surgery?

A. I think it's commonly cited. I do use it. I've read the whole document several times. I attended the training. It doesn't have the quality of evidence behind its recommendations that I typically see with a treatment guideline.

So if I'm looking at a treatment guideline for depression, generally researchers will grade the level of evidence behind each recommendation. So even if you look at the Endocrine Society guidelines for hormone therapy, they use the grading system -- that's what it's called -- to rank the levels of recommendation as a suggestion or a recommendation based on the quality of the evidence. And they also give a number for the quality of the evidence.

The WPATH standards of care document lists references, but it doesn't have that evidence-based grading system. So behind each of their recommendations, I'm not sure how much data there actually is to support that particular recommendation.

And for that reason, I think it's important that they are interpreted flexibly and that we are allowed to use clinical judgment and use them as a guideline.

Q. And I know in your report, you go through some of the poor-quality studies; correct?

A. Yes.

Q. Okay. And can you briefly go through some of the CMS study.

A. Sure. So I used the CMS reference because it was a very thorough review of all of the evidence and studies that had been done as of that point.

I am aware that CMS refers -- is usually dealing with the elderly and people that have disabilities. But prior to drawing their conclusion about their population, they reviewed all of the studies and made determinations about the quality of the evidence.

They cited several issues with the quality of the evidence, including sometimes small sample sizes, different methodology, different outcomes that were studied, and significant loss of follow-up where the loss to follow a population is not analyzed in any way.

And they made recommendations about doing additional research that would more carefully look at the population that is lost, to follow up to determine what factors are unique to them.

Q. And was there a consideration by the CMS about whether WPATH should be adopted?

A. Yes. I believe it was in response to a question. There is an open call for questions, and someone asked if they adopt WPATH as a controlling guideline.

They made a decision that they would not adopt WPATH as the controlling guideline because they did not feel like the evidence was strong enough and that they wanted to allow other providers to either use WPATH or use their own standards based on their decision-making.

Q. Okay. And you mentioned the APA.

Why is that?

A. The APA was another -- this was an academic now resource that was looking at the data to determine whether there was enough to develop a practice guideline.

They also concluded that there were issues with the quality of the data and the quality of the evidence, including the numbers on regret. And they concluded that there was enough information to make -- to draft recommendations but not to formally develop a practice guideline because their threshold for developing a practice guideline was not met with the quality of the data.

Q. So why would we bring up these deficiencies in the WPATH?

A. Because I think it's important to recognize that it is a valuable resource, but it's not -- it's not so definitive that we can equate their recommendations with success.

So it doesn't have -- it doesn't consider the correctional population specifically. There is a section where they briefly address institutional settings.

But there is no data -- as we have talked about before,

there is only one person we know in the system that has had gender confirmation surgery while incarcerated. So we don't have any data.

Until we get that data, we just need to be cautious in using the guidelines, using what we know about what makes someone a good candidate, and be able to apply our clinical judgment.

Q. So you briefly went over -- is it criteria 1 of the WPATH that is persistent, well-documented gender dysphoria is one of the criteria for sex reassignment surgery?

A. Yes.

Q. Okay. And so if you're assessed with gender dysphoria, then, in your opinion, do you automatically satisfy those criteria?

A. In my opinion, no.

Q. And why is that?

A. When I'm making a diagnosis of gender dysphoria, often it's an individual who has not sought any treatment for that prior. Some people have never heard of it and maybe just learning about it and kind of exploring it.

Giving the diagnosis often allows them to progress in their treatment. They might have opportunities to participate in groups or get additional property items and be able to feminize to the degree it's allowed in the system. So it kind of gives them the opportunity to explore it with very little harm.

However, as you get into more and more irreversible and permanent treatments, my opinion is that the threshold for conclusively making the diagnosis is higher.

So you can never be certain of a diagnosis, but when I'm treating someone and doing an evaluation, I always request prior treatment records. We are not always able to get them, but when I do, I always use them in making my determination.

When I reviewed Ms. Edmo's prior records, I saw the inconsistencies in her report. That didn't change my opinion about her diagnosis. But prior to recommending irreversible surgeries, that needs to be explored further. She needs to be able to speak with her clinicians about why there is that discrepancy.

Q. So you mentioned the North Idaho Correctional Institution records as page 31 of your report.

And why did you mention those records?

A. So that was at a facility that she was at. I believe it was part of probation on a prior charge. She was there for, I believe, about six months.

And there was no mention that I saw in those records of her presenting as female or entering the system as female. And there was no -- no mention of using any female pronouns or describing her as appearing female.

Q. You also mentioned the Portneuf Medical Center records.

Why is that?

A. Those were the -- her two hospitalizations for her suicide attempts; one was in 2010, and one was in 2011.

When I'm reviewing records --

Q. Just for the record, that's prior to her incarceration; correct?

A. Correct. Yeah, prior to her incarceration.

When I am reviewing records, I put a lot of value in what the patient says at that time, because sometimes their recollection of what they say or what they were experiencing is not completely consistent with the records.

So when I reviewed those records, she reported the reasons for her suicide attempts as related to relationship issues, alcohol use, inability to find a job and some financial problems, and kind of general life difficulties.

She didn't mention gender at that time, at either of those times of admission, as being a contributing factor. And also, I have worked in inpatient units, and we -- when we are meeting with people, we do a mental status exam, and you describe the appearance of the person.

I didn't see any description of her presenting as female during that time, which differs from her report to me that she was presenting as female at that time period.

Q. And you go through some other records on page 31 and 32.

Did any of those suggest that she was living as a female at that time?

A. No. I reviewed the Sho-Ban Tribe Counseling and Family Services records and then some other Indian Health Services records, and I didn't see any mention of her presenting as female or reporting any gender issues.

Q. And why did you review the psychosexual evaluation, number 5 on page 32?

A. That was a very comprehensive evaluation of her past sexual activity that was ordered because of the nature of her offense. So it was very comprehensive.

There was also a polygraph examination involved with a prepolygraph interview. But some of what she reported there did differ from her report to me.

This is a quote. It says: "He denied ever cross-dressing." This is a quote from the report. And also, the report said that Ms. Edmo had reported that she had sexual contact with two females in the past, which is different from what she told me during my interview.

Q. Okay. I would like to move on to the next criteria.

Is there anything else significant you want to mention there?

A. Just the part about the photographs. I saw a declaration from, I believe, a parole officer or probation officer who worked with Ms. Edmo prior to this incarceration and had confirmed that Ms. Edmo didn't present with feminized appearance during any of those contacts.

Q. And I believe you indicated another criteria that is not met in Ms. Edmo's case regarding sex reassignment surgery is that her medical and mental health concerns are not well controlled; is that right?

A. Yes, that's correct.

Q. Okay. And you briefly mentioned self-injury. Can you elaborate on that a little bit.

A. Sure. So self-injurious behavior is done for a variety of reasons, but it's almost always associated with a history of trauma. It can be a component of a personality disorder or depression; but, again, it's often associated with trauma.

It's never seen by a mental health professional as being an effective or healthy coping strategy. And it's always -- for anyone that engages in self-injurious behavior, if I am their treating provider, that's going to be a main point of our treatment plan.

It's especially important -- if Ms. Edmo does undergo gender confirmation surgery, that's going to be a very stressful undertaking, both physically and socially. And she will need to have strong, effective coping strategies to manage all of those issues.

And she -- in my opinion, she hasn't demonstrated that she has effective coping strategies that she would be able to use after the surgery.

Q. I'm going to move on to the next criteria. Do you have any

other comments, though, as to criteria 4?

A. I didn't include this, but I talked it about elsewhere in my report, is her substance abuse history. I diagnosed her with alcohol use disorder, opoid use disorder, and stimulant use disorder.

In my almost 10 years of experience in corrections, I saw a lot of people who were sober during their incarceration but then immediately relapsed.

So I didn't talk about it here because I know she -- I don't see any evidence that she has been actively using substances, and some people do even while they are incarcerated. But I think it's an important thing to consider also, because I haven't seen that she has spent a lot of time doing substance abuse treatment. I know she had at one point been discharged from one of those treatment programs.

And that's also going to be something that she is going to have to manage when she gets out, because she was -- she told me that she was pretty much consumed in substance abuse prior to her incarceration.

Q. Okay. And then I wanted to give you a brief chance to elaborate on why she doesn't satisfy criteria No. 6, the 12 months living as a female.

A. Sure. So WPATH, in their section about the 12-month criteria, they note that sometimes providers have to get collateral information to verify that someone has lived through

the 12-month experience.

In my opinion, the time prior to incarceration has -- I have a lot of questions about whether she was presenting as female, because the records just don't support that.

But also, she was so active with her substance abuse, that the true clinical meaning behind this recommendation to experience life in her preferred gender could not be met while someone is actively using substances to that degree.

And in a men's prison, I think it's very complicated. I'm sure it's been challenging for her, as well, but it doesn't allow her to live through the social events and work and kind of general life on the outside that she is going to live once she gets out.

Q. And then, briefly, you talk about alternative supplementary approaches to treatment of gender dysphoria, and I believe you referenced the Osborne and Lawrence article.

Can you briefly explain to the court why you referenced that.

A. Sure. So this was -- there is not a lot of literature that's written directly about the correctional environment when it comes to gender confirmation surgery.

When I present on this, a lot of people have the same questions about, you know, how to determine medical necessity. And the general theme is that people want to do the right thing, and they don't want to harm people.

This was one of the few articles I have seen that does directly talk about the correctional population as being different from the general population. They do note that we should never exclude gender confirmation surgery in a prison setting.

Obviously, there are going to be cases before we have really good data, and we're going to use those cases to develop the data. But until then, they made recommendations for having additional criteria.

Now, I haven't seen these criteria specifically adopted anywhere, but I think it was -- it's important because it note -- they do talk about the limitations of the standards of care document in the correctional setting. And they think it's an oversimplification to just say that we should do exactly the same thing inside as we do outside.

Q. And did you analyze any of those criteria under the Osborne and Lawrence article as to Ms. Edmo?

A. I did. I'm just going to refer to my report here.

So should I list the criteria? I know it's in my report, but --

Q. Why don't you say it briefly, and then just tell them, quickly, what your opinions are.

A. Okay. There are some that she -- like, one of them is willingness to live in a women's prison after. If she did have the surgery, that's where she would be housed. So that's kind

of an easy one. She said that she would be willing to live there.

They also talked about a satisfactory disciplinary record and the capacity to cooperate with providers. That's something that Ms. Edmo struggles with. I won't get into the disciplinary reports too much, but I'm more concerned about her ability to work with her treatment providers because that's going to be an essential component if she does have the surgery, that she is going to need the support and need to discuss what she is experiencing as she is making that transition.

At this point, she hasn't demonstrated that she is able to do that and to process her experience with her treatment providers.

Q. Okay. And did you come to a conclusion as to whether the treatment and care provided by Corizon and its medical providers, was it appropriate and within the applicable standards of care?

A. Yes, I believe that it was within standard of care.

Q. Is attempted self-castration an automatic qualifier for gender confirmation surgery?

A. In my opinion, no, it's not.

Q. Why is that?

A. Again, mental health providers don't see any form of self-harm as being productive or healthy regardless of what's driving the self-harm.

Now, I have worked in prison for almost 10 years. I have seen very extreme forms of self-harm that were not driven by suicidal ideation or by a desire to permanently alter themselves but were driven by all sorts of factors that are unique to the correctional system.

I think that it's -- demonstrates that Ms. Edmo had -- did not -- has not developed coping strategies to deal with distress. If she has the surgery, she is still going to deal with distress. She had a lot of distress in her life prior to entering the system, and I want to see her develop strategies that don't involving harming herself in any capacity.

Q. Do you have an opinion as to whether her mental health issues are solely related to gender dysphoria?

A. In my opinion, they are not solely related to gender dysphoria.

Q. And why is that? What's that based on?

A. I have reviewed her past records prior to incarceration. Again, she did not report having gender issues at that point. Despite her report to me that she was living as a female, I haven't seen that in the records.

At the time of her suicide attempts -- and she had two very serious attempts; one was by an overdose on a very lethal medication and another was by cutting; it was a very serious cut. And at the time of those suicide attempts, she reported issues with alcohol, relationships, kind of general life

dissatisfaction.

She also reported to me that she had a history of depression going back to childhood. She -- when I asked her directly if she believes that she has major depression as well as gender dysphoria, she said she believes that she has both.

Now, I recognize it's very difficult to sort those out, sort out which dysphoric feelings are related to the gender dysphoria and which ones are depression. But I do believe there is enough evidence there to say that she has gender dysphoria and major depression.

Q. Would that be part of your job as a mental health professional and psychiatrist, to help sort that out?

A. Yes, absolutely.

Q. Okay. Do you have opinions as to the risk of suicide after SRS, for Ms. Edmo?

A. There is limited data on that. There is a Swedish study by Cecilia Dhejne -- I'm probably saying that wrong. It's D-H-E-J-N-E. That was a population-based cohort study, so they didn't --

MS. RIFKIN: Your Honor, I'm going to object. Opposing counsel repeatedly objected to our experts speculating about a risk of suicide or harm to Ms. Edmo after -- after surgery. And I believe that their answers were limited as a result of those objections. And now they are eliciting the same opinion from their expert.

THE COURT: Well, I don't recall they were precluded from offering the opinion.

MR. EATON: I don't believe -- I think that's right, Your Honor.

MS. RIFKIN: Withdrawn, Your Honor.

THE COURT: All right. Proceed.

THE WITNESS: So that study looked at a sample of a little over 300, I believe, patients who had had gender confirmation surgery over a 30-year period.

It compared that sample to general population, so it did not give us, like, before and after kind of comparison, which would be really helpful.

But compared to the general population of people that don't have gender dysphoria, postsurgery patients had a 19 times higher risk of suicide. They concluded that that means that we need to continue to provide mental health and medical care following surgery, but I have not seen the data to support that gender confirmation surgery cures people of their suicidality.

Q. BY MR. EATON: Again, what are your opinions as to the suicide risk after SRS for Ms. Edmo?

A. Based on her current coping strategies, I would be concerned about her suicide risk after surgery if she doesn't work with mental health and begin to develop more effective coping strategies for the stress that she is going to experience.

Q. Do you think her suicide risk will decrease with SRS?
A. I don't think it will decrease at her current state.
Q. And do you think her cutting will decrease at her current state after SRS?
A. I think it might temporarily, but I would be worried. Because on the street, she was using alcohol and drugs as a coping mechanism. And then inside, now she is using cutting. I would be worried about that returning and/or the substance abuse returning as a coping strategy.
Q. Finally, what are the harms if Ms. Edmo were to get surgery now?
A. Well, I think that's what everyone is concerned about. We'd all like to see her succeed. If she has it now when we haven't sorted out some of these questions and helped her to develop better coping strategies, I'm worried that it would not be a success and that she would be at risk of having complications, both physically and psychiatrically.
Q. Can you elaborate on that a little bit.
A. I think, again, she doesn't have the proper coping strategies. This is going to -- gender confirmation surgery is a significant life event. For the right candidate, it can be very effective and associated with very low regret.

I'm not convinced that she is the right candidate at this point, and that's why I recommend that we need -- she needs -- we need to sort out -- I mean her treatment providers need to

sort out some of the discrepancies with her history provided, also help her to develop better coping strategies that she will use following the surgery, and then sort out the real-life experience. But this is something where WPATH doesn't give a lot of guidance in terms of the correctional setting.

MR. EATON: Your Honor, I would move to admit her report into evidence for consideration of the court.

THE COURT: Same objections?

MS. RIFKIN: Same objections.

THE COURT: I'll admit it. But as I've indicated, I think the witness has expertise. It goes to the weight, not the admissibility of the exhibit -- or of the opinion.

So I'll overrule the objection and admit the report. It's technically hearsay. But since all the reports are coming in, I'm going to admit this exhibit as well.

What's the number on that again?

MS. RIFKIN: Your Honor, may I just -- we had a stipulation with counsel that the expert reports would not actually be offered as exhibits into evidence.

THE COURT: Oh, then I stand corrected. I thought they were.

MS. RIFKIN: That is why we did not offer our exhibits. They have been filed in the case --

THE COURT: Okay.

MS. RIFKIN: They have been filed in the case --

THE COURT: Okay.

MS. RIFKIN: -- but not as evidence at the hearing.

THE COURT: All right. I will not admit, then, the exhibit. Often counsel will stipulate the exhibits -- the reports come in, but they are hearsay. The opinions should be offered in court under cross-examination, not by way of a written document unless the parties agree for all parties that they will come in.

So, assuming that's all correct, the report will not be admitted. All right?

MR. EATON: That's fine, Your Honor, as long as it's the same for all parties.

THE COURT: It is.

MR. EATON: I thought they had all been admitted.

THE COURT: Well, I guess I thought they had as well, but I'm going to trust Ms. Rifkin is not misleading me that she's never really offered that. I thought it was a joint -- that they were joint exhibits, but I didn't look that carefully at all of them.

MR. HALL: Right. And I would like a point of clarification as to whether Ms. Rifkin's position is limited only to the retained experts. We have filed nonretained expert declarations, which was our understanding completely pursuant to our stipulation, that those would be considered and admissible pursuant to our stipulation in addition to or in lieu of live

testimony.

MS. RIFKIN: Yes, Your Honor. That is correct for the nonexpert declarations.

And for the declarations, the stipulation was they were already on file with the court in support of and opposition to the briefs. My distinction is that they are hearsay, and so they cannot be considered as evidence by the court unless the actual evidence was established at the hearing.

They are in the court's file. We don't object to the court considering them.

THE COURT: Okay. Does that clarify it, Mr. Hall?

MR. HALL: Yes, as to the nonretained --

THE COURT: Right.

MR. HALL: -- as long as the limitations on plaintiff's retained expert declarations are the same, that they are not admitted into evidence.

MS. RIFKIN: That's correct.

THE COURT: All right. Let's go ahead and proceed. Cross.

CROSS-EXAMINATION

BY MS. RIFKIN:

Q. Good morning, Dr. Garvey.

A. Good morning.

Q. In your -- just before counsel ended his direct, he asked you about potential harms to Ms. Edmo. And you said: "We would

all like to have her succeed."

Do you remember that?

A. Yes.

Q. Who is the "we" that you were referring to when you said "We'd all like to have her succeed" and went on to describe with "we"?

A. I guess I'm generally referring to mental health professionals. I mean, her treatment team, I'm sure her plaintiff's experts.

Q. You're not a treater of Ms. Edmo; correct?

A. That's correct.

Q. But you identify very closely with Ms. Edmo's treaters employed by Corizon at IDOC; that's why you used the word "we"; correct?

A. No. I wouldn't say that.

Q. Dr. Garvey, you have never previously been qualified as an expert in any court regarding treatment of gender dysphoria; correct?

A. No. This is the first case that I have been involved in that's gone to court.

Q. Until today, you have never testified in court as an expert regarding treatment of gender dysphoria, any kind of treatment of gender dysphoria; correct?

A. That's correct.

Q. In fact, prior to this case, you have never been retained

and provided an expert report regarding any aspect of treatment of gender dysphoria; correct?

A. I was retained but not disclosed, so I can't speak about the details.

Q. You didn't provide an expert report; correct?

A. Correct. It was dismissed prior to getting to that point.

Q. You have never published any peer-review article relating to treatment of gender dysphoria; correct?

A. I was acknowledged in an article --

Q. Please answer the question.

A. No. I -- I have not published in a peer-review journal on gender dysphoria.

Q. And the acknowledgement, you were talking about a newsletter that someone wrote and, at the end, said thank you with a number of individuals for talking to me; is that fair?

A. No, that's not fair.

That individual had attended one of my talks and talked to me after the talk and developed this article in collaboration. So he sent it to us, a couple of us. And I reviewed it and gave him some feedback.

Q. This article, you're talking about a newsletter; right? It's not a peer-reviewed publication? I want to be clear for the court.

A. It's in the American Academy of Psychiatry, in a newsletter; that's correct.

Q. Newsletter.

You have never completed any peer-review research relating to treatment of gender dysphoria; correct?

A. That's correct. Most of my career has been --

Q. Please just answer the question.

A. That's correct.

Q. You have never served on the board of any organization that relates to treatment of gender dysphoria; correct?

A. Outside of the Department of Correction in Massachusetts, that would be correct.

Q. And your only university or graduate-level teaching experience regarding treatment of gender dysphoria was a single lecture at Brown University; correct?

A. I provided a lecture at Brown University.

Q. One lecture; correct?

A. It was to the forensic fellowship program. There is only one fellow at a time. Yes, that's correct.

Q. And that was your only university or graduate-level teaching experience regarding treatment of gender dysphoria; correct?

A. Well, I presented at three conferences, including an academic conference.

Q. You're talking about correctional conferences.

Those aren't university or graduate-level teaching courses, are they?

A. They are typically sponsored by a university. And the CME that's given out is from the university. So I'm not sure if technically that counts as being university.

Q. Okay. We'll move on.

You said your training on treating gender dysphoria consists of attending a WPATH conference. And you can't remember whether it was 2016 or 2017; correct?

MR. EATON: Objection. Misstates the testimony.

Q. BY MS. RIFKIN: That's one -- that was one part of your training?

THE COURT: State the question one more time and then -- so counsel can object. It kind of got garbled. Go ahead.

MS. RIFKIN: Sure.

THE COURT: Because of the objection. Go ahead. Restate the question.

Q. BY MS. RIFKIN: You stated that one of the bases of your training for treating gender dysphoria was attending a WPATH conference, and you can't remember whether it was 2016 or 2017; correct?

A. It was January of 2016.

Q. And another bases of your training was attending a talk on gender dysphoria at the July 2017 National Commission on Correctional Health Care conference; is that correct?

A. I attended a talk by Dr. Timothy Beach from California at

that conference, yes. And then I also received two hours a month of supervision with Dr. Stephen Levine as part of the Gender Dysphoria Treatment Committee and supervision group.

Q. And that plus reading literature, that's your training on treating gender dysphoria; correct? That's the universe?

A. Well, and treating the patients that I had prior to becoming involved in the committee.

Q. In your report, you wrote that you received monthly formal consultation from Dr. Stephen Levine plus additional extended in-person training; correct?

A. That's correct.

Q. The monthly formal consultation was your participation on the Massachusetts Department of Corrections Gender Dysphoria Treatment Committee with three other members, including Dr. Levine; correct?

A. It was that, and it was also the supervision group, which had a larger number of members. He participated in that and the treatment committee. So both.

Q. He was a consultant to each of these groups, so he would call into each of these groups' meetings for one hour for each meeting; correct?

A. Yes. And we would review cases with him and ask his opinion. He would provide --

Q. And the extended in-person training that you refer to in your report, you testified in your deposition that was actually

a one-day training you attended where the Massachusetts Department of Corrections brought Dr. Levine in to provide a training; correct?

A. There is one that I can recall. So I believe that that's correct.

Q. That was your extended in-person training; correct?

A. Well, extended beyond the monthly, because it was longer, and it was in person.

Q. Your only experience directly treating any patient who has received gender confirmation surgery was with a patient who was in a hospital program for somewhere between three to seven days when you were doing your residency; correct?

A. That patient, yes. I have other patients that had gender dysphoria, but that was the only postsurgical one. Other than I think I mentioned in the deposition, too, there was a patient in the Massachusetts system who had had a surgery that didn't go well, and I believe it was done in another country.

Q. You were not that person's direct clinical treater, assigned clinical provider, as I think you mentioned earlier; correct?

A. I was the supervisor for the nurse practitioner that was treating her. So I did the supervision over her treatment.

Q. So I'm going to ask my question again.

Your only experience directly treating any patient who has received gender confirmation surgery was with a patient who was

in a hospital program for somewhere between three to seven days when you were doing your residency; correct?

A. To the best that I can recall, that's correct.

Q. And you have never made any recommendation that a patient with gender dysphoria receive gender confirmation surgery; correct?

A. At this point, I have not. But, again, we discussed it on several patients that --

Q. I'm going to ask you --

THE COURT: Let me -- I think that question is pretty much yes or no.

Restate the question, if you would.

And try to answer counsel's questions very directly. We can move this much more quickly. Mr. Eaton will have a chance to allow you to clarify and elaborate on redirect. But for our purposes here on cross, answer the questions yes or no, if they can be answered that way.

Would you restate the question, Ms. Rifkin.

MS. RIFKIN: Sure. Thank you.

Q. BY MS. RIFKIN: And you have never made any recommendation that a patient with gender dysphoria receive gender confirmation surgery; correct?

A. Yes.

Q. And you have never written a letter of referral for gender confirmation surgery; correct?

A. Correct. That would be -- that wasn't part of my role in prison because it would have been through the committee. So I have --

Q. I'm going to ask you, once again, to answer my question that I'm asking you.

A. Yes, that's correct.

Q. You have never done long-term follow-up care with a patient who has had gender confirmation surgery; correct?

A. Yes.

Q. Prior to your work that defendants paid you for in this case, you had never personally assessed any patient with gender dysphoria as to the medical necessity of gender confirmation surgery; correct?

A. Again, the process in the system that I --

Q. I'm going to ask you to answer my question, please.

THE COURT: Just a moment.

Again, answer the question yes or no. Again, Mr. Eaton will have a chance to allow you to elaborate later. But if the question can be answered fairly yes or no, it should be.

Restate the question one more time, if you would, Ms. Rifkin.

Q. BY MS. RIFKIN: Prior to your work defendants paid you for in this case, you had never personally assessed any patient with gender dysphoria as to the medical necessity of gender confirmation surgery; correct?

A. I mean, again, the process that -- I would say I didn't do a formal evaluation specifically for that purpose, that's correct.

MS. RIFKIN: I'm going to move to strike that as nonresponsive.

THE COURT: I think it is responsive. Let's go ahead and put another question.

But, again, yes or no if you can.

Go ahead.

Q. BY MS. RIFKIN: You had never done an in-person evaluation, including a clinical interview, to assess any patient with gender dysphoria as to the medical necessity of gender confirmation surgery; correct?

A. Yes, that's correct.

Q. And at the time of your deposition approximately three weeks ago, you had billed defendants more than approximately $60,000 for your work on this case; correct?

A. I have an hourly rate, and I reviewed many records and spent a long time on the report. So that is the rate that I charge; correct.

Q. And your interview -- so you had billed defendants, as of the time of your deposition three weeks ago, approximately $60,000 for your work on this case; correct?

A. I don't remember exactly how many hours I had. I think that sounds a little bit --

THE COURT: The question is the dollar amount, not the hours.

THE WITNESS: Mm-hmm. Right.

Q. BY MS. RIFKIN: At your deposition, you testified that you had spent between 75 to 85 hours to be averaged at 80 -- at $600 an hour, so that's $48,000, plus $6,000 per day for your two-day trip to Idaho to interview Ms. Edmo; correct?

A. Yes, that sounds approximately correct.

Q. And $48,000 and $12,000, that's $60,000; correct?

A. That sounds correct.

Q. And, in fact, for the record to be very clear, your interview with Ms. Edmo was the first time you had ever done any clinical interview of a patient as to the medical necessity of gender confirmation surgery; correct?

A. Specifically for that purpose, correct.

MS. RIFKIN: Your Honor, I'll continue with my questioning, but I would like to put on the record that we once again move to strike and exclude the opinions by Dr. Garvey as to the medical necessity of gender confirmation surgery for Ms. Edmo. She does not have any experience to support her opinions in this case.

THE COURT: As counsel pointed out, Rule 702 and 703 indicates that the expertise can be based upon training, experience, and education. And given her role as a psychiatrist working within the prison setting, I think she can offer an

opinion.

But you have done a good job of pointing out some weaknesses in the resume, and that's something the court obviously will consider, but it does not preclude her from testifying.

Go ahead and proceed.

Q. BY MS. RIFKIN: Dr. Garvey, your experience with gender dysphoria comes almost exclusively, based on what you told us during the direct, from your participation on the Massachusetts Department of Corrections Gender Dysphoria Treatment Committee and Supervision Group; correct?

A. That's been most of my experience, yes.

Q. And you were part of that group for two years; correct?

A. Correct. I had -- I believe it was around 2013, I did a couple of preliminary evaluations that I presented to the group. So --

Q. I'm going to ask you, once again, to listen to my question and please answer my question.

You were a part of that group for two years; correct?

A. I was a part of the group for two years. I had gone to meetings prior to that.

Q. For the time that you served in the capacity as a member of the Massachusetts Department of Corrections Gender Dysphoria Treatment Committee and Supervision Group, IDOC's expert in this case, Dr. Andrade, was also part of that treatment committee;

correct?

A. Yes, that's correct.

Q. As well as Massachusetts Department of Corrections outside consultant, Dr. Levine; correct?

A. Correct.

Q. And there were four members of the treatment committee; correct?

A. Or five. There was a Department of Correction representative who was a health service division director, so sort of the person that oversaw our contract. Sometimes she had an additional health services representative there. And then also the general medical director for my company was also part of that group.

Q. The treatment committee?

A. The treatment committee, yes.

Q. You testified at deposition you couldn't quite remember; it might be five. Dr. Andrade testified that there were four.

Does four to five members of the treatment committee sound correct to you?

A. It does. It was up to the Department of Correction who else would be allowed. So I know that a health services division director was part of it. Sometimes she sends someone in her place, and sometimes she might have brought someone with her.

So, yeah, that sounds correct.

Q. So you, Dr. Andrade, IDOC's expert in this case, and Dr. Levine, who has been referenced extensively in this case, you were three of the four or five members of the Massachusetts Department of Corrections Gender Dysphoria Treatment Committee; correct?

A. Yes, that's correct.

Q. And that's where, as you testified a few moments ago, besides attending one WPATH conference and another presentation at a conference, you testified that the majority of your training came from those group meetings and Dr. Levine's supervision; correct?

A. And from reading a lot of the literature, yes.

Q. And you and Dr. Andrade in the Massachusetts Department of Corrections, you worked close together; correct?

A. I did. At some point, he was promoted within the company and was no longer in Massachusetts in a large capacity, but he was still part of the Gender Dysphoria Committee.

Q. And within the Gender Dysphoria Committee, you testified that one of your roles was to go out and provide a second interview as to a gender dysphoria diagnosis; correct?

A. Correct.

Q. And while Dr. Andrade was serving in the role on the Gender Dysphoria Treatment Committee, you and he would go together to conduct those assessments; correct?

A. Correct. Most of the time, we did, yes.

Q. So you and Dr. Andrade worked very closely together in the Massachusetts Department of Corrections; wouldn't you agree?

A. In the gender dysphoria, yes.

Q. And you have done at least three presentations together relating to gender dysphoria at a corrections -- at corrections conferences?

A. Yes, that's correct.

Q. And both of you, then, as part of your role on the Gender Dysphoria Treatment Committee received your supervision from Dr. Levine; correct?

A. Yes. He was a consultant, and he provided recommendations, and we ran cases by him. It wasn't really a supervisory role, more of a consultant.

Q. So when you described earlier in your testimony here today that Dr. Levine was a supervisor of this group and provided supervision regarding treatment of gender dysphoria, that's not quite accurate; correct?

A. Yeah. I guess I might have misspoken there.

He was retained by, I believe, the Department of Correction as a consultant, so we ran cases by him. He offered -- he did the one annual training, but he did a lot of training within those meetings also.

Q. So his was a training role, or it was a consulting role?

A. A little of both.

Q. All right. If we can show Plaintiff's Exhibit 1030,

please.

You and Dr. Andrade gave a conference presentation together that you titled "Tax Dollars at Work, Treating Inmates With Gender Dysphoria"; correct?

A. Correct. As I explained in the deposition --

Q. I'm going to just --

THE COURT: Just answer counsel's question.

THE WITNESS: Correct, but the title is in quotes for a reason.

MS. RIFKIN: Move to strike.

THE COURT: Well, I'll strike the response.

I'll again caution the witness to listen to counsel's question. That's why you'll have redirect in a moment when Mr. Eaton will have a chance to correct and clarify that, but answer the questions directly as they are asked.

Proceed.

Q. BY MS. RIFKIN: You were the one who came up the title of this presentation; correct?

A. Yes, that's correct.

Q. And you testified in your deposition you wanted it to be catchy; correct?

A. For this conference, that was usually a necessity.

Q. You testified in your deposition that you wanted the title to be catchy; correct?

A. That sounds correct, yes.

Q. And you and Dr. Andrade wrote a summary of your presentation for the conference program; correct?

A. I think there was an abstract in the --

Q. I would like --

A. -- conference program.

MS. RIFKIN: Before we move on, I would like to admit Plaintiff's Exhibit 1030, Your Honor.

THE COURT: Any objection?

MR. HALL: No objection, Your Honor.

MR. EATON: No objection.

THE COURT: 1030 will be admitted.

(Plaintiff's Exhibit 1030 admitted.)

MS. RIFKIN: I would like to show Plaintiff's Exhibit 1029.

Q. BY MS. RIFKIN: This was the meeting at which you and Dr. Andrade presented this presentation; correct? The APA, the American Academy of Psychiatry and the Law meeting in 2017?

A. Yes, that's correct.

Q. All right. If we can go to the next page. And can we please zoom in on the bottom half of this page.

Under the summary you wrote with Dr. Andrade:

"For the correctional mental health professional who treats gender dysphoria, however, this means navigating a minefield of advocates on one side and disapproving taxpayers on the other, while maintaining

focus on the psychosocial complexity and unique needs of the individual inmate. Careful exploration of trauma and ambivalence, and consideration of the irreversibility of highly desired forms of treatment, are often represented by plaintiffs' experts as negligence and discrimination. Advocacy groups call for gender dysphoric inmates to receive treatment that mirrors the community. These advocates emphasize inmate patients' rights and deemphasize important distinctions between community-dwelling gender dysphoric individuals and those serving life sentences for violent crimes."

This is what you and Dr. Andrade wrote as the summary of your presentation, isn't it?

A. Yes, that's correct.

Q. In your deposition, you testified that in addition to the WPATH standards of care, you rely on the NCCHC, the National Commission on Correctional Health Care, guidelines for treatment of dysphoria; correct?

A. I considered those, yes.

Q. You testified that the guidelines you use or rely upon when treating gender dysphoria are the WPATH standards of care and the NCCHC guidelines; correct?

A. Yes, that's correct.

Q. And you're aware -- you're familiar with the NCCHC

guidelines; correct?

A. Yes. I haven't read them recently. But, yes, I'm relatively familiar with them.

Q. Why don't we -- can we bring those up for Dr. Garvey. I believe it's Plaintiff's Exhibit 1041. Thank you.

Do these look like guidelines you have reviewed, Dr. Garvey?

A. Yes. There is more to it, but let me just look at it quickly.

THE COURT: Do you wish to see the other pages or just --

THE WITNESS: Sure. Do you have the other pages? Right. Okay. Yeah. There is usually -- there are a couple of sections.

MS. RIFKIN: Can you just flip through the pages so Dr. Garvey can see.

THE WITNESS: Okay. Yeah. I wasn't able to read all of them, but that does look like the document that I have seen.

Q. BY MS. RIFKIN: You -- you testified that you rely on these when you're treating patients with gender dysphoria; correct?

A. Yes, that's correct.

Q. And as an expert in treating patients with gender dysphoria, then, you're pretty familiar with these guidelines, aren't you?

A. I am familiar with these, yes.

Q. And these NCCHC guidelines specifically incorporate the WPATH standard of care as the standard of care for treating gender dysphoria in corrections settings; correct?

A. Yes, they do refer to WPATH. Yes.

Q. Can we go to page 2 of this exhibit, please. Can we zoom in on No. 5.

These NCCHC guidelines say that the management of medical or surgical transgender care should follow accepted standards developed by professionals with expertise in transgender health.

In the accepted standards, there is one reference, and that's to the WPATH standard of care, isn't it?

A. It is. The WPATH does talk about using them flexibly, so --

Q. I'm going to ask you --

THE COURT: Again, just answer the question.

THE WITNESS: Yes, that's correct.

THE COURT: All right. Thank you.

Q. BY MS. RIFKIN: So because you've used these and you're familiar with these and you're presenting yourself as an expert on treating gender dysphoria, and you're certified by the National Commission on Correctional Health Care, you understand that this represents the statement from the National Commission on Correctional Health Care that WPATH standards are the accepted standards for treatment of patients in corrections; is that -- is that fair?

A. That's correct.

MR. EATON: Misstates testimony.

THE COURT: I'm sorry?

MR. EATON: Misstates the document.

THE COURT: Well, there is a lot packed into that.

MR. EATON: And compound.

MS. RIFKIN: I can break it down, Your Honor.

THE COURT: Go ahead.

MS. RIFKIN: I'm happy to break it down.

Q. BY MS. RIFKIN: You testified earlier -- counsel asked you whether you had a CCHP; is that correct?

A. Yes, that's correct.

Q. And that is a certification from the National Commission on Correctional Health Care; correct?

A. Yes, that's correct.

Q. And you testified in deposition that you thought that was important for you to get in order to be better suited to provide correctional healthcare; is that right?

A. Yes. I think it's important.

Q. And it's not a board-certified -- it's not a board-recognized certification; right?

A. No. I'm board certified also, but it's an additional.

Q. You are not board certified in correctional healthcare; correct?

A. There is not a board certification in correctional

healthcare. For -- it's a component of forensic psychiatry, which I am board certified in.

Q. So as having to become a CCHP, you had to sit for an exam and pay a fee to get that certification; is that accurate?

A. Yes, that's correct.

Q. And you had to be familiar with the NCCHC standards; is that accurate?

A. Yes, that's correct.

Q. You had to understand what they mean; is that accurate?

A. Yes.

Q. Okay. So based on your certification by NCCHC and your testimony that you rely on these standards when treating patients with gender dysphoria, is it fair that you understand that this represents NCCHC's statement that the WPATH standards of care should be followed as the accepted standards for treating patients in a correctional setting?

MR. EATON: Objection. Compound, misstates the document, and foundation.

THE COURT: The witness can testify she either does or does not understand it that way.

THE WITNESS: So it has some of the same weaknesses as the WPATH. I mean, again, WPATH --

MS. RIFKIN: That is not my question.

THE COURT: All right. I think the witness is saying, no, she doesn't accept it unqualifiedly. So I'm going to allow

her to explain that. Because there's -- this is not the kind of question that I think can fairly just be answered yes or no. It's just too compound or complex.

So I'm going to give the witness a chance to explain why it is that you think this does not constitute kind of the accepted standard of care.

THE WITNESS: So I'm familiar with this, and I am aware that they cite WPATH as the reference. When I use WPATH and apply it to correctional systems, I use it as the flexible document that it says that it is.

I think there are some weaknesses in the NCCHC guidelines, as well, in that they also don't talk about the specific components of applying the standards to the correctional setting.

I think they are very strong in other areas in terms of safety and other kinds of, you know, making sure that staff are trained, but they also don't get into the specifics about applying WPATH standards of care to the correctional environment.

I think I also said previously that there isn't -- I'm not aware of any kind of competing set of guidelines. So I use what's available, which is the NCCHC and WPATH, and I apply clinical judgment to the WPATH standards.

THE COURT: All right. So what I hear you saying is that you have -- you feel that there is some inadequacy to these

NCCHC standards.

But I think the question is: Do you recognize that they are kind of -- that they are the only developed standards for treating patients with gender dysphoria?

And I think you acknowledged that when you said there is nothing competing. Do you acknowledge this is the only standard that's been published or put out by any reputable organization?

THE WITNESS: It's the only one that I'm aware of, yes.

THE COURT: All right. Go ahead.

MS. RIFKIN: Can we --

THE COURT: Counsel, we are probably close to taking another break, but I'll let you go for another five, maybe ten minutes but not more than that before we take a break.

Q. BY MS. RIFKIN: All right. In you -- in the direct testimony, you talked about a CMS decision that talked about WPATH standards.

Do you recall that discussion with Mr. Eaton?

A. Yes.

THE COURT: Okay. I have not been very thoughtful of Ms. Hohenleitner's almost impossible role in this courtroom. Let's try to speak a little more slowly and not speak over each other. All right.

MS. RIFKIN: Thank you, Your Honor. And I apologize.

Q. BY MS. RIFKIN: So you recall that discussion; correct?

A. Sorry. Say that -- remind me which discussion.
Q. You discussed with Mr. Eaton a CMS decision about coverage -- about coverage of surgery for gender dysphoria.
A. Yes.
Q. Do you recall that?

The decision that you were talking about, that was actually a decision by CMS about whether they would issue an affirmative coverage decision saying that surgery would affirmatively be covered for the Medicare population; correct?

A. That's correct.
Q. And you're aware that there -- two years prior to that, there was a decision by the Department of Health and Human Services also talking about surgery and coverage of surgery to treat gender dysphoria; correct?
A. Yes. That was where they did away with the exclusion against treating surgery. And then this was to look at whether it would automatically be covered, and they concluded it would be on a case-by-case basis.
Q. It was -- and I want to be really clear here. It was a conclusion about whether it would automatically be covered for the Medicare population; correct?
A. That's correct, based on their review of the literature in general, not specific to the Medicare population. Their conclusions were drawn --

MS. RIFKIN: I'd move to strike.

THE COURT: Again, listen carefully to the question. The question was: Was there a conclusion about whether it would be automatically covered for the Medicare population?

THE WITNESS: That's correct.

Q. BY MS. RIFKIN: And Ms. Edmo is not part of the Medicare population, as far as you know? That's what you testified at your deposition; correct?

A. I am not aware of her being part of the Medicare population.

Q. All right. If we can show Plaintiff's Exhibit 1026, please.

This is the decision by the Department of Health and Human Services on May 30, 2014. And this is where the board determined to end an exclusion. They had a blanket exclusion on covering surgery -- gender confirmation surgery; right?

A. Yes, that's correct.

Q. And they just --

MR. HALL: Objection. Hearsay.

MR. EATON: Join.

THE COURT: It's not being offered for the truth of the matter asserted but just to cross-examine the witness about her knowledge of the standard? I'm not sure --

MS. RIFKIN: And about her testimony about these CMS decisions and what the Department of Health and Human Services and CMS --

THE COURT: I don't know how we cannot get in -- I mean, we have talked all around about this decision. I don't know how we can't look at the original document -- not for the truth of the matter asserted, but how it bears upon all of the discussion we have already had.

I'll overrule --

MR. HALL: I'll object on foundation as well. I don't think there is any testimony as to what this is or counsel's representations.

MR. EATON: Join.

Q. BY MS. RIFKIN: Dr. Garvey, you understand when I -- we just talked about two different decisions.

You described a decision, right, about CMS not issuing an affirmative coverage decision saying it would affirmatively cover all surgeries for the Medicare population; correct?

A. That's correct.

Q. And I asked you if you were aware of a preceding decision that eliminated the ban on covering surgery which they had prior; right?

A. Yes. I'm aware of that.

Q. And this is that document; correct?

A. I haven't -- I can't --

THE COURT: Let's take a break and give her a copy, and she can review it and come back and tell us if it's that document or not.

MS. RIFKIN: Okay.

THE COURT: I mean, if, in fact, it's something other than what we have been talking about, then I think Mr. Hall or Mr. Eaton is perfectly right to object.

If it's exactly what we have been talking about, then I think we are wasting time over something that is really pretty inconsequential, and we have already been all through it through other witnesses, anyway.

One thing, Ms. Rifkin, Exhibit 1029, you didn't offer it. Now, you don't need to offer an exhibit when you're using it only for impeachment purposes. But between now and when we come back, if you want that admitted into evidence, you need to formally move for its admission. That's Exhibit 1029.

All right. We'll be in recess for 15 minutes.

(Recess at 11:57 a.m. until 12:20 p.m.)

THE COURT: For the record, we have reconvened. I'll remind you, Dr. Garvey, you are still under oath.

You may resume your cross-examination, Ms. Rifkin.

MS. RIFKIN: Yes. Before I resume, I would like to move Plaintiff's Exhibit 1029 into evidence.

THE COURT: Is there any objection?

MR. EATON: I don't believe so, Your Honor.

MR. HALL: No, Your Honor.

THE COURT: 1029 will be admitted.

(Plaintiff's Exhibit 1029 admitted.)

Q. BY MS. RIFKIN: Dr. Garvey, in your expert report in this case, you discussed -- you specifically cited Dr. Ettner, the plaintiff's expert's report and her discussion of the CMS overturning Medicare's policy barring coverage for transition-related surgeries in May 2014.

Do you recall discussing that?

A. Yes, I do.

Q. It's on page 27 of your report?

A. Okay.

Q. All right. So if we can go back to Plaintiff's Exhibit 1026, please.

This is the decision, the Department of Health and Human Services decision, you were referencing on page 27 of your report, correct, about Dr. Ettner's discussion? You talked about this 2014 decision and then the subsequent decision?

A. This is discussing that decision, yes. I'm not sure if I had seen -- I have seen a couple of different versions of it. But, yes, I believe so. This was to do away with the exclusion of the treatment.

Q. All right. And if we can turn to page 15 of this exhibit. Can we please zoom in on the paragraph that starts "We conclude," down through the next heading.

This was the decision to overturn the surgery. And the Department of Health and Human Services concluded that:

"The APA has shown that the NCD statement that

transsexual surgery is unsafe and has a high rate of complications is not reasonable in light of the evolution of surgical techniques and the studies of outcomes discussed in the new -- in the unchallenged new evidence presented here."

That was part of their decision in May 2014; correct?

A. That's correct. Again, this was to do away with the exclusion. So they disagreed that the research was not -- did not support doing the surgery in general.

Q. In fact, they concluded and it's summarized in the heading that begins -- the very next heading:

"The new evidence indicates that transsexual surgery is an effective treatment option in appropriate cases."

Correct?

A. Correct. And I agree it is an effective treatment option in appropriate cases.

Q. Okay. And they cited -- there is a footnote to this heading, footnote 22.

And CMS cited to the WPATH standards in that footnote; correct?

A. I'm just going to look at it quickly.

You're talking about the one that says, "We do not read the new evidence as necessarily" --

Q. You don't need to read it, Dr. Garvey. I'm asking you

about the footnote 22.

THE COURT: It's been blown up on the screen for you there, too.

THE WITNESS: Okay. I'm reading it. What was the question?

Q. BY MS. RIFKIN: The question is whether footnote 22 that's cited for new evidence indicates that transsexual surgery is an effective treatment option in appropriate cases.

Then there is a footnote, whether that footnote refers to WPATH standards of care.

A. Yes. The footnote discusses appropriate cases and refers to WPATH.

Q. If we can put up Joint Exhibit 15, please.

THE COURT: Do you intend to offer Exhibit 1026?

MS. RIFKIN: Yes, Your Honor. Thank you for the reminder.

THE COURT: Any objection?

MR. EATON: Yes, I would object. We offered -- tried to offer the CMS records previously, and the court said no, that it's hearsay.

MS. RIFKIN: Well, Your Honor, Dr. Garvey referenced this, and they affirmatively brought it out on their direct.

THE COURT: You have been able, through cross-examination, to highlight what you need to from the document. So I don't think we need to admit the entire

document.

So I'll sustain the objection.

Q. BY MS. RIFKIN: All right. So these are the WPATH standards of care. And there has been talk about the applicability of these to people in prisons.

Let's go to page 73 of this exhibit, please. Can we please blow up the bottom half of the page.

You're familiar with this section of the WPATH standard of care; right, Dr. Garvey?

A. Yes, I'm familiar with it.

Q. You said you have read the WPATH standards multiple times; correct?

A. Yes.

Q. And these begin by saying:

> "The standards of care in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation."

Correct?

A. That's what it says, yes.

Q. It goes on to say that:

> "People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments, such as prisons, or long-/intermediate-term health care facilities."

That's the next sentence; correct?

A. Yes.

THE COURT: Counsel, is that -- that's part of the WPATH?

MS. RIFKIN: Yes, Your Honor.

THE COURT: All right. Exhibit 15?

MS. RIFKIN: Yes. Page 73, Your Honor.

Q. BY MS. RIFKIN: And then it states:

"Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a noninstitutional setting within the same community."

Correct?

A. That's what it says, yes.

Q. And you agree with that statement, don't you?

A. I would like to see more detail. That's where I don't agree with every statement in this section, because there are --

Q. Dr. Garvey, I'm asking you about this -- the sentence that I just read, the last sentence of this paragraph.

Do you agree that healthcare for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a noninstitutional setting within the

same community? Do you agree with that statement?
A. I agree that all treatment options that are available in the community should be available.
I wouldn't use the word "mirror" because that does not take into account unique aspects of the correctional environment. There are some things that we have to make treatment decisions on that are not a treatment decision outside. So, actually, to say that it mirrors the community would leave out some important pieces of the treatment.
Q. So you disagree with this sentence; is that accurate?
A. I agree that all the options should be available. I do disagree with the sentence as written, yes.
Q. So it's your opinion that if a person inside a prison with gender dysphoria, if surgery would be medically required to treat that person if they were in the community, that doesn't mean that they should get it if they are in prison? Is that -- is that your opinion?
A. No, that's not my opinion.
MR. HALL: Objection. Vague.
THE COURT: I'm sorry. What?
MR. HALL: Objection. Compound, vague. But she answered.
THE COURT: All right.
MR. HALL: I'll withdraw.
THE COURT: I'll take the objection as withdrawn.

Go ahead.

THE WITNESS: That's not my opinion, no.

Q. BY MS. RIFKIN: The next sentence is:

"All elements of assessment and treatment as described in the standard of care can be provided to people living in institutions. Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements."

MR. EATON: I'm going to object as vague. Institution is defined as prison or long-/intermediate-term --

MS. RIFKIN: I didn't ask a question.

THE COURT: Counsel, she is just reading from the document. You can say the document is vague, but there is no question yet. So if there is an objection, it's overruled.

Proceed.

Q. BY MS. RIFKIN: Do you agree that access to the medically necessary treatments described in the standard of care should not be denied on the basis that somebody is in prison?

A. Yes. I just want to make sure because of the double negative.

I agree that they should not be denied based on being in prison, yes. I do agree with that sentence.

Q. If we can turn to the -- can we zoom out, please. Can we turn to the next page, page 74.

This is the second part of this section of applicability of

the standards of care to people living in institutional environments that you're familiar with; right, Dr. Garvey?

A. Yes.

Q. Can we zoom in on the paragraph "Reasonable accommodations," please.

I would like to direct your attention to the last sentence of this paragraph, Dr. Garvey.

> "Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the standard of care."

Is it your understanding that somebody housed in prison cannot meet criteria No. 6 for surgery, 12 months of living in a congruent role of their preferred gender identity?

A. No, that's not my opinion.

Q. So it's your opinion that somebody living in a prison can satisfy that criteria of living for 12 months in a role congruent with their preferred gender identity?

A. Yes, on a case-by-case basis.

It's easier to do that in someone that is going to be serving a life sentence, but I think on a case-by-case basis, it could be met even for someone that's not serving a life sentence. It would probably have to incorporate elements of the community, like family involvement and things like that, but I do believe it's possible.

Q. What about interacting with people at a job? Would that -- would that be part of what qualifies you for that 12 months of congruent living?

A. Well, this is where I wish that there was more guidance on how to apply that standard. This section, I think, should talk about that.

Q. I'm asking for you -- I'm sorry. I'm asking for your opinion, Dr. Garvey, your opinion of how somebody in prison -- which you said they can do -- can meet that 12-month requirement. And you said on a case-by-case basis, in certain situations, for example, family.

And I'm asking: On a case-by-case basis, can having a job count towards that 12 months of living in a congruent role?

A. It's possible. It won't give the same experience as having a job in the community. I think, again, it's all case by case.

Q. In your opinion, if that job involves interacting with nonincarcerated persons, does that make it more like the community?

A. It's possible.

Q. When you say "it's possible," have you thought about that before?

A. Well, I have had patients -- in my experience in Massachusetts, we had patients on a work release, so they did go out into the community and work. So it is something that I thought about. That particular -- those particular patients

were getting out soon and not seeking surgery. So I wasn't thinking about it then specifically regarding the real-life experience.

But since then, since I know that people do go out into the community and have jobs with people in the community, I think it's possible.

Q. Because you didn't evaluate it -- because for those patients, you didn't evaluate whether surgery was medically necessary for them; correct?

A. For those patients, they were not looking for surgery.

Q. For those patients, you didn't evaluate whether surgery was medically necessary for them; correct?

A. None of them requested surgery, or we did talk about surgery, but they did not want surgery.

Q. All right. I would like to turn to page 67 of the WPATH, this exhibit, the WPATH standards of care.

Do you see the section titled "Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role"?

A. Yes, I do.

Q. Okay. If we can please -- well, that works.

I would like to direct your attention to the second paragraph that's up on the screen.

"The duration of 12 months allows for a range of different life experiences and events that may occur

throughout the year..." and gives some examples.

Do you see that?

A. Yes, I do.

Q. This sentence doesn't say the duration of 12 months must include every type of different life experience that somebody can have in a year, does it?

A. It doesn't.

I see this as a clinically relevant experience. So, no, I don't think you have to check a bunch of boxes and make sure they have gone on a vacation and done all of those things. But this, to me, speaks to the rationale behind the clinical experience of experiencing the identified gender prior to undergoing surgery.

So I don't think all those boxes need to be checked, but it has to be a clinically meaningful experience.

Q. A clinically meaningful experience would be interacting with people in a preferred gender role and understanding how they interact back with you, understanding the both positive and negative interactions you might have living like that.

Do you agree with that?

A. I think that that can happen to a degree, but there is going to be another social adjustment that happens in the community. So that's certainly part of it. It's not going to completely mimic what the adjustment will be in the community.

Q. Is it your opinion that if somebody in the community

is -- wants sex reassignment surgery and it's medically necessary, but they may transition to a new job at some point in the future or move to a different state at some point in the future -- let's say from California to North Dakota or Texas, where they might interact with people with different sets of ideas -- they should be denied sex reassignment surgery because if they move to Texas or North Dakota, it might be a social adjustment for them?

A. You're asking if that's my opinion that they should be denied?

Q. That's right. Because they may move to a different community in the future where that -- there might be a social adjustment for them as a post-op transsexual person.

A. No, that's not my opinion.

Q. You have never treated any people with gender dysphoria outside of prison other than that single patient for that three- to seven-day period during your residency; correct?

A. No, that's not correct.

I had a patient more recently who had gender dysphoria and was looking for -- she was in a rural part of the country and was very young and didn't have access to resources. So we talked about what resources were available.

Q. Was that in the last three weeks, between the time of your deposition and today?

A. No. I think I mentioned this in my deposition. This was a

patient in a community mental health setting.
Q. How long did you treat that patient?
A. I was only in that location for about six months. So about six months, maybe a little bit less.
Q. Okay. So besides those two patients that you've told us about with gender dysphoria you have interacted with the community, you haven't treated other people with gender dysphoria in the community, have you?
A. No. I think I mentioned also that I had a therapy patient who was sort of exploring gender but that hadn't -- hadn't identified fully, but we were doing therapy and working primarily on other things.

So other than that, no.

Q. Are you making a determination or offering an expert opinion about whether it's easier to be a transgender person outside of prison or inside of prison?
A. No, I'm not.
Q. You would agree that you don't have a basis based on experience to provide that opinion; correct?
A. I'm not sure that -- I mean, I -- I haven't seen any definitive comparative studies, so I wouldn't offer an opinion on that, no.
Q. You would agree that you don't have the basis to provide an expert opinion as to whether it's easier to be a transgender person inside a prison or outside a prison; correct?

MR. HALL: Objection. Relevance. She hasn't offered the opinion, so --

THE COURT: Just a moment. I'll allow it. I'm not going to let you to go much further than this. But given the testimony about -- by both Dr. Garvey and Dr. Eliason about the need for 12 months outside of the prison setting, I think it's fair cross.

Do you want to restate the question for the witness?

MS. RIFKIN: Sure.

Q. BY MS. RIFKIN: You would agree that you don't have a basis for providing an expert opinion as to whether it's easier to be a transgender person inside a prison versus outside a prison; correct?

A. No. I mean, in my 10 years of correctional experience, I know a lot about the differences for individuals in general inside prison and outside but not specific to the gender dysphoria population.

Q. In your report, you stated, quote:

"Gender confirmation surgery should not be outright prohibited in a correctional environment. But until more data is available, it is appropriate for correctional healthcare professionals to use caution in making determinations regarding gender confirmation surgery."

Correct?

A. Yes. What page are you on? That sounds familiar, but I just want to get to where you are.

THE COURT: Is that from Dr. Garvey's written report?

MS. RIFKIN: Yes, Your Honor.

THE COURT: All right.

MS. RIFKIN: We will come back to that. I don't want to waste time looking for it now.

Q. BY MS. RIFKIN: But, Dr. Garvey, you agree that sex reassignment surgery is a safe, effective, and widely accepted treatment for gender dysphoria; correct?

A. Yes, I do -- for the correct candidate, yes.

Q. You testified in your deposition that sex reassignment surgery is a safe, effective, and widely accepted treatment for gender dysphoria; correct?

A. Yes, it is, in general. Yes, I believe that.

Q. And you agree that disputing the medical necessity of sex reassignment surgery based on assertions to the contrary is unsupportable; correct?

A. Yes.

Q. But you also opine that better and more data is needed for the results of surgery for inmates in order to approve these surgeries; correct?

A. Yes.

Q. And in your report, you cite to the American Psychiatric Association Task Force's 2012 report on the treatment of gender

identity disorder; correct?

A. Yes. Let me find it.

Q. You can just -- do you recall whether you --

A. Yes.

Q. -- cited to that article?

A. I recall, yes.

Q. You characterized this report as concluding that the quality of evidence pertaining to sex reassignment surgery is low; correct?

A. Correct. I remember saying that, yes.

Q. Can we show Defendant's Exhibit 2033, please.

Is this the report you were referring to in your -- or the paper you were referring to in your expert report, Dr. Garvey?

A. I haven't read through the whole thing. It looks to be the one that I was referring to.

Q. Do you need to review the entire article to know whether it's the one you cited in your report?

A. No. The authors and the date and the journal are correct.

Q. If we can zoom in on the second-column paragraph of the page, please.

All right.

> "The American Psychiatric Association Task Force concluded that current evidence was judged sufficient to support recommendations for adults in the form of an evidence-based APA practice guideline with gaps in

the empirical data supplemented by clinical consensus."

They wrote that, right.

A. Further in the report, they explain that the evidence --

Q. Dr. Garvey, is this --

A. That's correct. That's part of the report, yes.

Q. If we can turn to page 2, please. I'm not sure how possible it will be to blow this up, but I'll try. Can we sort of move towards -- I'll circle it, so hopefully we can blow it up.

All right. You cited these -- this article in your expert report to make a point that you do not believe the data and evidence -- quality of evidence pertaining to sex reassignment surgery is of high enough quality in your opinion; correct?

A. Yes. I believe there is some deficiencies in the data. And I don't know if I can speak more to what this article states, but they also talked about --

Q. I'm just asking why you -- I'm asking if I'm right about why you included it, if I'm fairly --

A. Yes. Yeah. Having reviewed the literature myself, the small sample sizes, the different methodologies with lack of control groups and the very high number of people that are lost to follow-up are concerns to me about the quality of the data.

Q. In your expert report, you didn't discuss the APA's observation in this paragraph that, given the very nature of

GID, such trials or even unblinded trials with random assignment to treatment groups are not likely to be forthcoming due to a lack of feasibility and/or ethical concerns.

You didn't cite that part of the article in your report; correct?

A. I didn't cite the whole -- I mean, I put a part of the article that was relevant. I read the further discussion.

Q. All right. Can we pull up page 24, please.

Later in this article, the American Psychiatric Association Task Force stated that:

> "For some important aspects of transgender care, it would be impossible or unwise to engage in more robust study designs."

Do you see that?

A. I do. I mean, you're only showing parts of the article. There is other further discussion about this.

Q. It's similar to quoting just one quote in a report, isn't it?

All right. If we can zoom out again, please. I think we're going to have to go piece by piece with the sentence.

Do you see that last sentence here that's blown up?

> "Although few systematic studies of suicide among gender-transitioning persons have" --

I think the word "not" is a typo there, but --

> -- "have not been conducted" --

And I'll just read the rest:

-- "the case report literature suggests that this is a relatively rare outcome."

Do you agree with that, that the case reports suggests that suicide among gender-transitioning persons is a relatively rare outcome?

MR. HALL: Hold on. Your Honor, we can't see the portion that's being read.

MS. RIFKIN: And this is a defendants' exhibit, 2033.

THE WITNESS: I'm sorry. What is your question?

Q. BY MS. RIFKIN: Whether you agree that the study -- that the case report literature, which you said you reviewed, suggests that suicide among gender-transitioning persons is a relatively rare outcome.

MR. EATON: Your Honor, I'm going to object. I know it's hard for counsel to have the sentence all together, but there is also a comment by counsel where there was "not" in the sentence, and then she said I think that's a mistake. So it's confusing --

MS. RIFKIN: That's fine.

MR. EATON: -- question in that regard.

MS. RIFKIN: I'm not sure this is going to help, but --

THE COURT: Well, zoom in on the bottom left-hand corner, read through it, and then just shift to the top

right-hand corner. I think that will work. Okay.

Q. BY MS. RIFKIN: All right.

"Although few systematic studies of suicide among gender-transitioning persons have not been conducted, the case report literature suggests that this is a relatively rare outcome."

A. I see that, yes.

Q. Do you understand what that sentence means?

THE COURT: Could you keep up the next part of that?

MS. RIFKIN: I'm sorry.

THE COURT: Counsel, just so I'm clear, then it goes on to say that this other study found an increased risk of death by suicide and of suicide attempts among subjects who had received sex reassignment surgery relative to age-matched population controls. But that's, again, comparing the general population with those who received sex reassignment surgery, not those who received sex reassignment surgery compared to other gender-dysphoric members of the population?

MS. RIFKIN: Those were my next questions, Your Honor.

THE COURT: All right.

MS. RIFKIN: I'll just move straight to those.

Q. BY MS. RIFKIN: Dr. Garvey, in your -- in the direct, you cited this study actually -- I believe the Dhejne article -- and you said there was a -- that article found a 19 percent rate that -- suicide rate for individuals who had undergone sex

reassignment surgery had a relatively increased suicide rate, 19 percent, compared to the general population; correct?

A. It was death by suicide. So the increased rate of suicide attempts was not as significantly increased as the death by suicide. The death by suicide rate was 19 times higher than the general population.

Sorry. Go ahead.

Q. Do you know the -- the suicide rate for transgender individuals compared to the general population?

THE COURT: Transgender without sex reassignment surgery?

MS. RIFKIN: All transgender individuals.

THE WITNESS: No. That's why, as I have talked about --

Q. BY MS. RIFKIN: I'm just asking you to answer the question.

No? You said, no, you don't know that?

A. Of completed suicide, I haven't found a reference for that. I'm talking about completed suicide, not the suicide attempts part.

Q. So you haven't heard the -- that it's approximately 44 times the rate of the general population? You're unfamiliar with that?

A. For suicide attempts or completed suicide?

Q. You believe that's suicide attempts?

A. That sounds probably close for suicide attempts but not --

completed suicide is a much more rare event. So I haven't heard of 44-fold increase in completed suicide. I don't think that that's accurate.

Q. You agree that the 19 times -- you agree that the completed -- the rate of completed suicides for all transgender individuals is significantly higher than the gender -- than the general population; correct?

A. Of completed suicides? That's what -- I guess I don't have a reference for that number. Completed suicides is, again, a very rare event compared to suicide attempts. So I don't know what the baseline rate of completed suicide for gender-dysphoric individuals is.

Q. So you agree, then, that this 19 times figure that you cited, that doesn't tell us anything about -- anything clinically significant about the effect of sex reassignment surgery on the transgender population specifically as to completed suicides; correct?

A. It does not tell us the effects. It tells us that of that cohort, which was a representative sample with no one lost to follow-up, there was a 19 times increased risk. So it does not tell us -- that could be lower. It could be lower than the risk might have been.

THE COURT: But, again, it's 19 times when compared to the general population, not the gender-dysphoric population; correct?

THE WITNESS: Correct. So I use that sample because I see people argue that gender confirmation surgery will cure people of their suicidality.

To me, this doesn't tell us anything about the effect of gender confirmation surgery on completed suicide. It does tell us that it doesn't do -- it doesn't eliminate completed suicide because we know that a significant number complete suicide. They might --

MS. RIFKIN: You have answered my question. Thank you, Doctor.

THE WITNESS: Okay.

Q. BY MS. RIFKIN: So in deposition, you agreed that you -- you did not understand either of plaintiff's experts in this case, Dr. Gorton or Dr. Ettner, to be positing that gender confirmation surgery for Ms. Edmo would be treatment in order to solve potential suicidality; correct?

A. From what I recall -- I think I didn't remember this part of Dr. Gorton's report. But with Dr. Ettner, she had written that Ms. Edmo was at increased risk of suicide if she didn't have the surgery. I think that's what we had talked about.

Q. But you agreed that you understood both plaintiff's experts to be determining that surgery is necessary to treat Ms. Edmo's gender dysphoria; they were not suggesting this is prescribed to treat her suicidality directly; correct?

A. Right. But Dr. Ettner had said that she was at increased

risk for suicide if she doesn't have the surgery. So, to me, those are kind of saying a similar thing.

If she -- if Dr. Ettner's report said that Ms. Edmo was at high risk for suicide if she didn't have the surgery.

THE COURT: Just to be clear, I think counsel's original question was whether you understood that Dr. Ettner and Dr. Gorton were not opining that this would cure any other non-gender-dysphoria problems which may make her suicidal. They weren't suggesting it would cure her; you agree with that?

THE WITNESS: I guess I think the suggestion that her risk of suicide is higher if she doesn't have the surgery --

THE COURT: That's not -- that wasn't the question. It's whether they suggested it would cure her of any other suicidal problems attributed to non-gender-dysphoric concerns.

THE WITNESS: Right. That, to me -- so they don't state it, but saying that her -- that she is at high risk of suicide if she doesn't have the surgery, to me, does suggest that the surgery might do away with her suicidality.

Q. BY MS. RIFKIN: Is it possible that they were suggesting that the surgery might alleviate rather than necessarily eliminate her risk of suicide? Do you think that's fair?

MR. EATON: Objection. Speculation.

THE WITNESS: Yeah. I'm not sure what --

THE COURT: I'm going to overrule the objection. Again, just so we're clear, I mean, we're not -- we're talking

about curing mental health concerns.

Did you think, explicitly or implicitly, Dr. Gorton or Dr. Ettner were suggesting that the gender confirmation surgery would cure her other mental health issues?

THE WITNESS: I guess I wouldn't say it was suggesting that it would cure, necessarily.

THE COURT: That's what the question was. So the answer is, no, you did not understand that?

THE WITNESS: No, not from what I recall.

THE COURT: Proceed.

Q. BY MS. RIFKIN: You testified in your deposition that you, when examining Ms. Edmo, found it difficult to separate Ms. Edmo's depressive symptoms from her gender dysphoric symptoms; correct?

A. That sounds familiar. I think that's true for a lot of people with gender dysphoria. And Ms. Edmo told me herself that she thinks she has depression and gender dysphoria.

Q. You testified in your deposition that you -- while examining Ms. Edmo, you, yourself, found it difficult to separate Ms. Edmo's depressive symptoms from her gender dysphoric symptoms; correct?

A. That sounds correct.

Q. And you testified that that's common when people have gender dysphoria and major depressive disorder; correct?

A. That sounds correct.

Q. And it's fair that you do not know how much of Ms. Edmo's depression is related to her gender dysphoria; correct?
A. I think that's correct, yes.
Q. And would it also be fair to state that you don't know how much of Ms. Edmo's suicidality -- that is, increased suicide risk -- is related to her gender dysphoria; correct?
A. That's correct. I --
Q. That's -- that's what I asked.
You assessed Ms. Edmo, you told us, as having gender dysphoria; correct?
A. Correct.
Q. And you added to your diagnosis of Ms. Edmo for gender dysphoria the phrase "posttransition"; correct?
A. Correct.
Q. And you explained in your deposition that that means that she has made changes towards living in her preferred gender; correct?
A. Correct.
Q. You believe Ms. Edmo has presented as female since 2012; correct?
A. Yes. From the records that I reviewed, that seems to be correct.
Q. And that was six years ago; would you agree?
A. Yes, that's correct.
Q. And you agree that, given that Ms. Edmo has been on

feminizing hormones since 2012, you do not expect that she will have many more physical changes associated with the hormones; correct?

A. Correct.

Q. You agree that presently Ms. Edmo continues to experience gender dysphoria; correct?

A. Correct.

Q. When you evaluated Ms. Edmo, you did not see any evidence of psychosis or any kind of obsessional sort of thinking with her; correct?

A. That's correct.

Q. In your review of Ms. Edmo's medical records, you didn't see any evidence of psychosis in her records; correct?

A. That's correct.

Q. You concluded that her insight appeared fair and her judgment appeared to be reasonably intact; correct?

A. That's correct.

Q. And at the time of your evaluation of Ms. Edmo, you didn't see any evidence that she was making negative choices, such as being uncooperative; correct?

A. That's correct.

Q. You did not attribute Ms. Edmo's gender dysphoria to hysteria, psychosis, malingering, or exaggeration; correct?

A. Correct.

Q. You believe that Ms. Edmo's substance use disorders are in

full, sustained remission in a controlled environment; correct?
A. Correct.
Q. And you also assess Ms. Edmo as having major depressive disorder at the moderate level; correct?
A. Correct.
Q. You explained in your deposition, there is a mild level, a moderate level, and a severe level of major depressive disorder; correct?
A. That's correct. And with the information that I had, that was the --
Q. I was just asking you --
A. Sure. Yes, that's correct.
Q. And you assessed Ms. Edmo as not having severe major depressive disorder but as having moderate major depressive order [*sic*]; correct?
A. Correct. And that gets to where it's difficult to --
Q. Thank you for the answer.

In your deposition, you testified that you don't know why Ms. Edmo attempted to cut off her genitals; correct?
A. Correct.
Q. You don't believe Ms. Edmo is being manipulative by attempting to castrate herself or cutting on her arm; correct?
A. No. I don't think that she is doing it intentionally to be manipulative, no.
Q. You also testified that you do not know whether providing

gender confirmation surgery would do anything to relieve Ms. Edmo's experience of gender dysphoria; correct?

A. I don't have the transcript of the deposition in front of me. I mean, I -- I think the concern is the outcome following the surgery, not that it wouldn't necessarily -- I guess I don't -- I don't know. There are -- when I did Ms. Edmo's interview, I didn't have her --

Q. I'm going to stop you and ask you my question again.

You also testified at your deposition that you do not know whether providing gender confirmation surgery would do anything to relieve her experience of gender dysphoria; correct?

A. Correct.

Q. Ms. Edmo has been -- and although, as you just told us, you're not able to understand why Ms. Edmo attempted to castrate herself, you believe that this issue has to be addressed before she can have gender confirmation surgery; correct?

A. That and her other forms of self-injury, yes, because it is a maladaptive coping strategy that would not do her well following surgery.

Q. So before Ms. Edmo can have gender confirmation surgery to remove her genitals that give rise to gender dysphoria, she has to stop wanting to cut them off? Is that your testimony?

A. The patients that I have reviewed and considered for gender confirmation surgery were not --

Q. I'm sorry.

A. -- engaging in --

Q. You haven't evaluated any patients for gender confirmation surgery. You told us that multiple times; correct?

MR. EATON: Objection. Misstates testimony.

THE COURT: Is that correct?

THE WITNESS: The distinction I was trying to make -- and I was cut off -- is that we discussed it at every monthly meeting. I didn't formally do an evaluation, but we were discussing their treatment plans and reviewing the people that looked like they were heading towards medical necessity for gender confirmation surgery. So that was discussed on a monthly basis.

And the people that were close, in looking like it was going to be approved at some point, were functioning relatively well, were not engaging in active self-injury in any form.

Q. BY MS. RIFKIN: You agree, based on your experience with gender dysphoria, that gender dysphoria can take different forms for different people? Not every person with acute gender dysphoria wants to cut off their genitals themselves; correct?

A. It seems to be relatively rare outside of prison. So, yes, I'm sure that that's true. Not everyone wants to cut off their genitals.

Q. And you -- counsel asked you if attempting to self-castrate automatically meant you get sex reassignment surgery, and you said no; correct?

A. Correct. But --

Q. But you seem to view -- I want to understand this. In your opinion, you view trying to cut off your testicles as disqualifying for sex reassignment surgery; correct?

A. I wouldn't say "disqualifying."

Q. But you have to stop trying to do that in order to then get the surgery you're trying to perform on yourself; correct?

A. So the point I'm making is that she needs to be able to use healthy coping strategies to deal with stress. Doing that is not a healthy coping strategy.

Q. So you're a medical doctor; right?

A. Yes.

Q. And in medical school, you study cancer; is that fair?

A. Yes.

Q. Treatments for cancer, like chemotherapy and radiation?

A. Yes.

Q. Were you trained that in order for a patient with a tumor to have a procedure that would remove the tumor, first they have to think about themselves how to reduce the tumor and not be anxious about the tumor in order to have chemotherapy or radiation?

MR. EATON: Object to the form.

THE WITNESS: I haven't seen --

THE COURT: Just a moment. Just a moment. Overruled.

THE WITNESS: I haven't seen a patient attempt to

remove their own tumor, so I don't -- I guess I don't really see that comparison.

Q. BY MS. RIFKIN: Have you ever seen a patient who was denied any treatment for their tumor?

A. I can't recall.

Q. Do you think it's possible that if a patient was denied treatment for a tumor that they knew was growing inside them and would kill them, they might try to cut it out themselves?

MR. EATON: Object to form.

THE COURT: Just a moment.

I'll overrule the objection, but I think the point is made, Counsel. You might want to just move on.

MS. RIFKIN: I'll move on.

THE COURT: You can answer that question.

THE WITNESS: I'm sorry. Can you repeat the question?

MS. RIFKIN: I'll move on.

Q. BY MS. RIFKIN: Ms. Edmo has been compliant with her hormone therapy for the past six years; correct?

A. Yes. From the records I read, yes, that looks correct.

Q. Ms. Edmo meets with the psychiatrist assigned to her when she is given an appointment; correct?

A. Yes.

Q. And it's your understanding that Ms. Edmo doesn't attend meetings with Clinician Stewart, that her primary assigned clinician right now, because she feels that Clinician Stewart is

not qualified to treat gender dysphoria; correct?

A. Yes, that's my understanding.

Q. And in deposition, you were not able to identify any other members of Ms. Edmo's treatment team who she refuses to meet with; correct?

A. I think I mentioned that there were some groups that she was refusing to participate in.

Q. But as far as members of her treatment team actually assigned to her -- her psychiatrist, other doctors, Dr. Alviso who she sees once a year -- you don't -- you're not aware of any times she has refused to meet with them; correct?

A. With those individuals, no.

THE COURT: Counsel, I would just -- both sides have about an hour, a little over an hour left of your total time. I just want to let both counsel know so you can think accordingly as to how you plan the rest of the afternoon.

Go ahead, Ms. Rifkin.

MS. RIFKIN: Okay. Thank you, Your Honor.

Q. BY MS. RIFKIN: In your deposition, you could not identify any studies that you are relying on for your opinion that there is a risk that Ms. Edmo may regret gender confirmation surgery; correct?

A. Yes, that's correct.

Q. You agreed that peer-review articles typically report statistics of regret for gender confirmation surgery as being

very low; correct?

A. Yes. I think I already discussed my concern with the quality of those numbers.

Q. I would like you to turn to --

Do we have Dr. Garvey's report that we're able to show? Okay. I would like to show Dr. Garvey's report and turn to page 43. If we can blow up sort of the top two paragraphs, please.

You opined in your report that you disagree with Ms. Edmo's allegation that defendants failed to enact appropriate standards and procedures that would have prevented the harm that she has experienced; correct?

A. Correct.

Q. And even though you're not a lawyer, you opined that Corizon has not been deliberately indifferent because it has not disregarded an excessive risk to an inmate's health or safety; correct?

A. Correct.

Q. You opined that despite Ms. Edmo's -- what you call dissatisfaction with her treatment, defendants are not disregarding risk to her health or safety; correct?

A. Correct.

Q. You believe that concerns that Ms. Edmo is at risk of grave harm without sex reassignment surgery, including suicide, are unfounded; correct?

A. Are you reading this from my report?

Q. No. I'm asking you.
A. So can you repeat that.
Q. You believe that concerns that Ms. Edmo is at risk of grave harm without sex reassignment surgery, including suicide -- you believe those concerns are unfounded; correct?
A. Yeah. This gets to the discussion about suicide as a -- surgery as a treatment for suicide.
Q. It gets to the treatment -- surgery as a treatment for gender dysphoria, which may alleviate risk of suicide.
But you don't believe that; right?
A. I haven't seen evidence that firmly supports that, so I have concerns about making that conclusion.
Q. You're aware that in 2016 and 2017, there were three suicides at ISCI, the institution where Ms. Edmo was housed; correct?
MR. HALL: Objection. Foundation --
MR. EATON: Objection.
MR. HALL: -- relevance. Objection. Foundation, relevance.
THE COURT: Sustained.
Q. BY MS. RIFKIN: You are opining that you do not believe Ms. Edmo is at increased risk of suicide because defendants will not provide her sex reassignment surgery; correct?
A. I believe that Ms. Edmo's risk of suicide is critically increased because of her history of suicide attempts and her

self-injury. I do not believe that it is caused by the treatment that she has or has not received.

Q. Can we show Plaintiff's Exhibit 1042, please.

You testified that you are a certified correctional healthcare provider under NCCHC; correct?

A. Correct.

Q. And NCCHC does an audit, a court-mandated audit, of ISCI, the institution where Ms. Edmo is housed as a result of the court lawsuit.

Can we turn to page 35 of this exhibit, please.

MR. HALL: Objection. Foundation.

MR. EATON: Join.

THE COURT: Well --

MS. RIFKIN: Your Honor, this -- you will see this is directly relevant.

THE COURT: I think it's premature to object yet. Let's find out what we're getting at and what --

MS. RIFKIN: Can you please zoom in for the recommendation.

THE COURT: Well, just a second. If the objection is to foundation -- I mean, I presided over the *Balla* case. I assume I can take judicial notice of anything that's been filed in that proceeding. I'm not sure -- I'm not sure how far I'm going to let Ms. Rifkin go with it, but I'm not sure the objection is that it's not truly what it purports to be.

MR. HALL: Your Honor, I object on the grounds of relevance and hearsay as well.

THE COURT: Okay. Well, that might be a good objection, but --

MR. EATON: Join.

THE COURT: -- I'm assuming you are not objecting that this isn't, in fact, the special master's report in *Balla*.

But let's see where we're going to go with it, and then I'll sustain the objection or not depending upon -- if you were offering it for the truth of the matter asserted, it's going to be hearsay, and I won't allow it.

If you're using it to impeach the witness in some fashion, that may be appropriate if this witness has ever seen it or is aware of it. Otherwise, I don't know how you can use it.

But go ahead and --

MR. HALL: Your Honor, may I ask a question in lieu of an objection?

THE COURT: In aid of objection. If you ask in lieu of objection, that means you weren't going to make the objection, so just to be clear. But, yeah, you may.

MR. HALL: Dr. Garvey, have you ever seen this document?

THE WITNESS: I have not.

MR. HALL: Thank you.

MS. RIFKIN: Your Honor --

THE COURT: Ms. Rifkin, just give me a proffer as to how you intend to use it.

MS. RIFKIN: Sure.

THE COURT: Because I'm not seeing how it's relevant to the proceeding.

MS. RIFKIN: Two reasons, Your Honor. Dr. Garvey, in her report -- I just went through the opinions that she offered -- and she opined that defendants -- she disagrees with the allegation that defendants failed to enact appropriate standards and procedures that would have prevented the harm that she has experienced.

She testified that she reviewed IDOC and Corizon's -- the policies and procedures regarding inmates with gender dysphoria, and she believes they are not deliberately indifferent and they don't disregard an excessive risk to inmates' health or safety.

That's her opinion she is offering in this case. And I think information, especially if she didn't review it before offering that opinion, is directly relevant about the harm to inmates with gender dysphoria at the institution where Ms. Edmo is housed.

THE COURT: All right. Well, she has acknowledged that she, in fact, has not reviewed it. So the fact that there is --

MS. RIFKIN: So I'll ask a question about the general information.

THE COURT: Yes, just as to what she has reviewed or not reviewed.

Q. BY MS. RIFKIN: Did you review any information in order to form your opinions about defendants' policies and procedures and the risk they pose to gender-dysphoric inmates at ISCI -- did you review any information about the three inmates who committed suicide, two of whom had a gender dysphoria diagnosis and one of whom was dealing with sexual identification issues? Did you review that when you offered this opinion?

MR. EATON: Objection.

MR. HALL: Objection. Misstates facts -- assumes facts not in evidence.

MS. RIFKIN: So if they are going to object that this misstates facts --

THE COURT: Just a moment. Just a moment. Let's tie ourselves to what the report actually says.

She has indicated she didn't review it. So if you want to ask if she was aware of those facts as reported in the report -- not your characterization, but as reported in the report -- then let's move on.

MS. RIFKIN: Okay.

Q. BY MS. RIFKIN: Are you aware that this report noted that ISCI had had three suicides in the past year, in October 2016, in February 2017, and in August 2017?

A. No, I'm not -- I was not.

Q. Are you aware that this report stated that one notable aspect of these suicides is that two of the inmates had a diagnosis of gender dysphoria and the third was associated with the GD inmate community and was exploring sexual identification issues?

MR. HALL: Objection. Hearsay.

MR. EATON: Join.

THE COURT: Well, it's -- I think for impeachment purposes, it's not being offered to prove the truth, but whether she was aware there was a report out there that said this.

This goes to the credibility of the opinions offered, not the substance. I'm obviously not going to rely upon the truth of those statements but only on the extent to which they call into question the thoroughness of the opinion offered or the evaluation that went into the opinion that was offered.

So were you aware of those facts?

THE WITNESS: I was not, no.

THE COURT: All right. Let's proceed. Move on.

MS. RIFKIN: No further questions at this time, Your Honor.

THE COURT: All right. Mr. Eaton.

I have some questions, but I think they are not -- I'm not going to take the time, given where we are and how thorough we have covered all of this.

So go ahead, Mr. Eaton.

REDIRECT EXAMINATION

BY MR. EATON:

Q. Dr. Garvey, are you the only expert psychiatrist in this case?

A. I believe so, yes.

Q. And you're a board-certified psychiatrist; right?

A. Correct.

Q. And so you are able to opine about standards of care and appropriate care of a psychiatrist; right?

A. Yes, that's correct.

Q. And that would be including Dr. Eliason?

A. Yes, correct.

Q. And unlike plaintiff's experts, you have experience working and treating in a correctional setting; correct?

A. Yes, in three different states.

Q. And is the treatment of gender dysphoria treatment committees that we have talked about, is that unique in a correctional setting?

A. I think some states haven't organized in that fashion, but it's becoming more and more common. So that's a pretty -- it's becoming a more standard way of making treatment decisions.

Q. And you had a treatment committee -- a Gender Dysphoria Treatment Committee that you were on and presided over at times in Massachusetts; right?

A. Yes, that's correct.

Q. And at issue in this case, in part, is a treatment -- a management treatment care committee that oversaw gender dysphoria; right?

A. Correct.

Q. And so you have expertise in the correctional setting regarding that unique set of facts; right?

A. Correct, yes.

Q. All right. Why do you believe you're qualified to render opinions on SRS?

A. Because of my experience in treating patients and also the literature that I have reviewed and the WPATH training that I attended and kind of ongoing attention to standards and my experience on the gender dysphoria treatment committee where I reviewed the treatment plans of every individual in the state who had gender dysphoria and conducted the initial evaluation for -- a confirmatory evaluation for every patient that entered the system that reported gender issues.

Q. And I believe you were asked about have you ever written a recommendation for SRS and weren't allowed to explain your answer at that time.

Would you like to do that now?

A. Sure. So in our -- in our system in Massachusetts, the process would be that a clinician treating the patient made a formal recommendation to the treatment committee, who would then evaluate that recommendation and make a decision.

In the supervision group that also met monthly, we talked about the total treatment plan for everyone that was being treated for gender dysphoria. And including in that -- included in that was a discussion of gender confirmation surgery for certain individuals.

We discussed it. The clinicians would discuss what their thought process was and what concerns they still had that had led them to not yet recommend surgery. But that was an ongoing discussion for several patients, that we talked about the readiness and the medical necessity of the surgery.

Q. So I need to move on and give Mr. Hall time.

But you wanted to -- did you want to mention anything about your "Tax Dollars at Work" title?

A. Yes.

MS. RIFKIN: Objection. Leading.

THE COURT: Overruled.

THE WITNESS: Just to clarify, that title was taken from a news article. And the reason that I used it is because I wanted to draw attention to the fact that this was still a perception in the community that this is -- comes down to nothing but money.

So it was in quotes. They incorrectly eliminated the quotes in the program, but that was definitely not my sentiment. And the point of using that title was to draw attention to the fact that some people still viewed it that way.

MR. EATON: Your Honor, I would like to move to admit Defendants' 2033 that was discussed with plaintiff's counsel.

THE COURT: I had a note to inquire about that.

Is there any objection, since it was used in cross-examination?

MS. RIFKIN: No, Your Honor.

THE COURT: Exhibit 2033 will be admitted.

(Defendants' Exhibit 2033 admitted.)

Q. BY MR. EATON: And I believe, lastly, you were asked by plaintiff's counsel about suicide and related to gender dysphoria and sex reassignment surgery. I believe you were trying to qualify your answer.

Did you want to do that now?

A. Yes. I don't remember the exact question. But the article that I cited in my report by Cynthia Osborne and Anne Lawrence talked about the lack of data to support claims that gender confirmation surgery will decrease suicidality.

And the study, the Cecilia Dhejne -- I'm probably saying that wrong -- study does show that there is elevated, above general population, risk of completed suicide following sex reassignment surgery.

I am not comparing that to patients that have gender dysphoria and have not had surgery. I cited it to point out that there is still a high risk of suicide following the surgery.

Q. And finally and very quickly, there was a discussion about your diagnosis of moderate -- sorry. I'm blanking on --

THE COURT: Depressive disorder, I think.

MR. EATON: Thank you, Your Honor. Yes.

Q. BY MR. EATON: And I believe you wanted to clarify the distinction between moderate and severe.

A. Sure. It's a matter of the severity of the symptoms.

As I have said, it is difficult to completely separate the gender dysphoria from the depression. So that was -- with the available information that I had at that time, that was my best estimate of the severity.

MR. EATON: Thank you. No further questions.

MR. HALL: No questions, Your Honor.

MS. RIFKIN: Just one, Your Honor.

THE COURT: That's all I'll give you. Go ahead.

RECROSS-EXAMINATION

BY MS. RIFKIN:

Q. Dr. Garvey, during the time that you served on the Massachusetts Department of Corrections Gender Dysphoria Treatment Committee and supervisory group, surgery -- that group did not recommend surgery or did not -- I'm sorry -- did not provide surgery to any gender dysphoric inmate in the Massachusetts Department of Corrections; correct?

A. Define "surgery." It can be used to discuss a lot of different things.

Q. During the time that you served on the Massachusetts Department of Corrections Gender Dysphoria Treatment Committee and supervisory group, that committee did not provide genital reconstruction surgery to any inmate with gender dysphoria in the Massachusetts Department of Corrections; is that right?

A. There has only been one that I'm aware of in the country. And during that two-year period that I was on the committee, no -- that is correct, there was not that surgery.

MS. RIFKIN: No further questions, Your Honor.

THE COURT: All right. Doctor, you may step down. Thank you.

Counsel, it troubles me that we don't have any data comparing suicide rates -- we obviously have suicide rates of the general population, and apparently somebody has done suicide rates of people who have had gender confirmation surgery.

But there seems to be distinctions between suicide attempts and successful suicide. And I know, of course, you can't do a double-blind study because of ethical concerns of a placebo group. But are there any statistics, any studies done to just try to compare, as best we can, apples and apples rather than apples and oranges about suicide rates among the general incarcerated or nonincarcerated gender-dysphoric community compared to those who have had -- I'm going to assume that if there was, somebody would have offered it.

But it's frustrating that we seem to have all the studies

in the world except the one we need.

All right. I'm just whining. I apologize.

Defense may call their next witness.

MR. HALL: Your Honor, may we have a three-minute break to use the restroom and grab --

THE COURT: Yes. We'll take a ten-minute break. Did you say 20-minute break?

MR. HALL: I said three-minute, in fact. We'll make it five.

THE COURT: I'm not going to go there. We'll take a ten-minute break or until everybody is back. We'll be in recess.

(Recess at 1:29 p.m. until 1:42 p.m.)

THE COURT: You may call your next witness.

MR. HALL: Defendants call Dr. Joel Andrade.

THE COURT: Dr. Andrade, would you step before the clerk and be sworn.

JOEL ANDRADE, Ph.D., DEFENDANTS' WITNESS, SWORN

THE CLERK: Please a take a seat in the witness stand.

MR. HALL: Move a little faster, please.

(Laughter.)

THE CLERK: Please state your complete name and spell your name for the record.

THE WITNESS: Joel Andrade, A-N-D-R-A-D-E.

DIRECT EXAMINATION

BY MR. HALL:

Q. Doctor, do you recognize the exhibit marked as Defendants' Exhibit 2021?

That's not counted against my time, is it?

Do you see that there, Doctor?

A. Yes.

Q. Is that your resume?

A. Yes.

Q. Is that true and correct?

THE COURT: Can we stipulate to the admission as we have the others?

MS. RIFKIN: Yes, Your Honor.

THE COURT: The exhibit will be admitted.

(Defendants' Exhibit 2021 admitted.)

Q. BY MR. HALL: Doctor, do you recognize this document here marked as Defendants' Exhibit 2021?

A. Yes.

Q. Is that a list of publications and journals that you reviewed and relied upon in this case?

A. Yes.

MR. HALL: Move to admit, Your Honor.

THE COURT: Any objection?

MS. RIFKIN: Well, I think it's hearsay, the same as the underlying report, Your Honor.

MR. HALL: I can ask him if he has reviewed every

single one, Your Honor.

THE COURT: I'm going to allow it. I -- you have got to move on. And I assume you had it in advance. If there was some misrepresentation, that could have been pointed out.

MS. RIFKIN: Your Honor, if we're moving to admit that document which contains the Medicare decision, Plaintiff's Exhibit 1026 that we talked about at length with Dr. Garvey, I would just move to admit Plaintiff's Exhibit 1026, as well, which is referenced by Dr. Andrade in that document.

THE COURT: I apologize. 1026 was the --

MS. RIFKIN: 2014 decision eliminating --

THE COURT: From the Medicaid?

MS. RIFKIN: Yes. And Dr. Andrade just testified he relied upon it, and counsel moved to admit that list.

MR. HALL: I don't know why we need to admit it, Your Honor.

THE COURT: Well, you need a reference or why do I need to see all the studies that have been done?

MR. HALL: That's fine, Your Honor. Withdrawn.

THE COURT: Let's just not admit that and move on.

MR. HALL: Okay. Doctor --

Your Honor, I'm going to lead in the interest of time here to lay some foundation.

THE COURT: I'll give you a lot of leeway.

MR. HALL: Thank you.

Q. BY MR. HALL: Doctor, you have your doctorate of philosophy in social work; correct?

A. Yes.

Q. And you have a master's in social work as well; correct?

A. Yes.

Q. And you are licensed -- you are a licensed independent clinical social worker in the State of Massachusetts and Florida; correct?

A. Yes.

Q. Okay. And you are also a certified correctional healthcare professional; correct?

A. Yes.

Q. You have an MH designation after that. I don't think that's been put on the record.

Would you briefly state what that MH designation is.

A. Yes. NCCHC, the National Commission on Correctional Health Care, has two levels of accreditation, the CCHP and then the higher level for different disciplines for physicians, for administrators, and for mental health professionals, psychologists, psychiatrists, psychologists. And that's the designation I have.

Q. Okay. Thank you, Doctor.

Your employment experience over the last 10 years has consisted of working as a mental health professional in the correctional industries in Massachusetts; correct?

A. Yes.

Q. Okay. Describe for me your roles and duties that you've held over the last 10 years.

A. Okay. Really, two main roles. The first was the clinical director and program manager of the Massachusetts contract. So oversaw all mental health services in the State Department of Correction in Massachusetts, including being the chair of the Gender Dysphoria Supervision Group and member of the Gender Dysphoria Treatment Committee.

My other role and my current role, I work for MHM Services as the director of clinical operations. So I'm based from home out of the corporate office, actually, in Virginia, and I travel to wherever the company has contracts. We have about 17 different contracts, so I travel to all those contracts.

Q. In your employment, have you had the opportunity to provide treatment to gender-dysphoric inmates?

A. Yes.

Q. Okay. And have you provided assessments in your employment for the diagnosis of gender dysphoria?

A. Yes.

Q. Approximately how many?

A. In my role in Massachusetts, I would evaluate individuals and confirm diagnosis. So well over 100, hundreds of patients.

Q. And have you also been involved in assessments for the appropriateness of certain treatment options for

gender-dysphoric inmates?

A. Yes.

Q. And does that include hormone therapy?

A. Yes.

Q. Approximately how many times have you been involved in that?

A. In dozens of cases.

Q. And have you made referrals for hormone therapy?

A. Yes.

So the process was the treatment committee would approve hormone therapy, and we would refer to an endocrinologist for the specific medications to be given. But we would evaluate and approve based on the person's gender dysphoria to help alleviate the dysphoria.

Q. And would that require you to have familiarity with the individual's treatment history and mental health records?

A. Yes.

Q. And have you had an opportunity in your employment to provide -- excuse me -- assessments to gender-dysphoric patients in a correctional institution for the appropriateness of sex reassignment surgery or gender-confirming surgery?

A. Yes.

Q. Okay. Approximately how many times?

A. Approximately six individual assessments for gender affirming surgery, and two were approved. There are specifics

to each of those cases.

Q. You said two approved; correct?

A. Yes.

Q. Okay. Did you make recommendations, as part of that process, that it was appropriate for those two individuals to receive gender-confirming surgery?

A. Yes.

Q. Okay. And in providing your opinions and your assessment in that process, did you rely upon the WPATH standards of care?

A. Yes.

Q. Are you familiar with the WPATH standards of care?

A. Yes.

Q. Have you received training in the WPATH standards of care?

A. I've attended WPATH conference and, as part of the treatment committee, consistently reviewed the standards of care, which were updated while I was on the treatment committee. So the previous standards and now the seventh version, yes.

Q. Have you attended other conferences besides WPATH where you received training on treatment of gender-dysphoric inmates?

A. Yes. I regularly attend and present at NCCHC, National Commission on Correctional Health Care; ACA, which is the American Correctional Association. I have also attended and presented at the American Psychiatric Association conference, and AAPL, which is the American Academy of Psychiatry and Law conference.

Q. Thank you, Doctor.

I have marked here Joint Exhibit 15, page 28.

Do you recognize this document?

A. Yes.

Q. Is it your understanding that this is the WPATH standards of care criteria for competency of mental health professionals?

A. Yes.

Q. And have you reviewed those criteria before?

A. Yes.

Q. And do you meet each of those criteria?

A. Yes.

Q. Now, Doctor, you have been retained in this case by the defendants; correct?

A. Yes.

Q. And as part of your retention, have you been asked to assess Mrs. Edmo's mental health?

A. Yes.

Q. And have you done so?

A. Yes.

Q. And in -- did you have an opportunity to meet Ms. Edmo?

A. Yes.

Q. And was that through a clinical interview?

A. Yes.

Q. And did that occur in approximately late July or early August of this year?

A. Yes. July 31st.
Q. And did you have an opportunity to interview Ms. Edmo about her prior preincarceration history?
A. Yes.
Q. Including mental health history?
A. Yes.
Q. And was part of your role to make an assessment as to whether or not Ms. Edmo has any mental health concerns?
A. Yes. That was part of the evaluation.
Q. And were you asked to diagnose Ms. -- well, see if Ms. Edmo met the diagnosis for gender dysphoria?
A. Yes.
Q. And were you asked to assess her for the appropriateness of gender-confirming surgery?
A. Yes.
Q. Okay. And did you do that?
A. Yes.
Q. Prior to rendering your opinions, did you review documents?
A. Yes.
Q. Doctor, my office provided you with a whole list of documents. In the interest of time, I just want to read a few and have you say yes or no as to whether or not you reviewed them prior to you issuing your opinions in this case. Okay?
A. Yes.
Q. Did you review the preincarceration mental health records

from the Sho-Ban Tribe?

A. Yes.

Q. From Portneuf Medical Center?

A. Yes.

Q. Bannock County Jail?

A. Yes.

Q. Did you review the presentence investigation report?

A. Yes.

MR. HALL: And that's Exhibit 2010. And, Your Honor, to the extent it's not already on the record by stipulation, I would like to confirm that that is admitted.

THE COURT: Exhibit 2010, did you say?

MR. HALL: 2010, correct.

THE COURT: It is not.

MR. HALL: It was agreed to be admitted subject to our joint stipulation and motion under seal.

THE COURT: Any objection? That's the presentence report.

MS. RIFKIN: Oh --

THE COURT: Or the confidential PSI documents. I assume it was the state presentence report.

MR. HALL: Correct, Your Honor.

MS. RIFKIN: Well, the agreement was that it would be submitted to the court under seal. The agreement was not that it was admitted under seal.

We object to the relevancy of any of this document based on the -- based on the testimony that Ms. Edmo's preincarceration history is not applicable. But that objection is for the record.

THE COURT: And the objection is overruled.

Exhibit 2010 -- I think the -- I don't know how you can exclude certain portions of Ms. Edmo's total medical and psychological evaluation. It just has to be considered. Now, some is more important than others, but the exhibit is admitted. 2010 is admitted.

(Defendants' Exhibit 2010 admitted.)

Q. BY MR. HALL: Doctor, do you believe that it's important in your -- as part of your assessment to review all relevant preincarceration mental health and medical records?

A. Yes.

Q. And does that also extend to presentence investigations that are conducted and go into topics regarding mental health and psychosexual evaluations?

A. Yes.

Q. Okay. And you did review the PSI report; correct?

A. Yes.

Q. And you have reviewed the records of incarceration, including the mental and medical health records, approximately 1500 pages that were provided to you; is that correct?

A. Yes.

Q. And did you review the MTC meetings?
A. Yes.
Q. Did you review the incident reports?
A. Yes.
Q. The DORs?
A. Yes.
Q. The C notes and offender summaries?
A. Yes.
Q. Parole records?
A. Yes.
Q. Did you speak to anyone prior to issuing your report in your opinions other than Ms. Edmo?
A. I spoke to two clinicians that work at the facility, Krina Stewart, and I'm forgetting the other person's name right now, but two mental health professionals that worked with Ms. Edmo.

I also met briefly with the warden for about a half-hour interview the day I was onsite.

Q. Was the other mental health clinician -- excuse me -- interviewed Laura Watson?
A. Yes.
Q. And what was your understanding as to their role in providing treatment or clinical contact to Ms. Edmo?
A. Both had been involved in treating Ms. Edmo in the past and were very familiar with policies, procedures of the facility.
Q. I want to talk about your opinions in this case, Doctor.

You're familiar with the DSM criteria for gender dysphoria?

A. Yes.

Q. And did you apply that during your review of Ms. Edmo and the clinical interview?

A. Yes.

Q. And does Ms. Edmo, in your opinion, meet the diagnosis for gender dysphoria?

A. Yes, she does.

Q. Did you determine as to whether or not Ms. Edmo meets the diagnosis for any other mental health disorders under the DSM?

A. Yes.

Q. Okay. And was one of those borderline personality disorder?

A. Yes.

Q. Doctor, do you recognize the document marked as Plaintiff's Exhibit 1036, page 1?

A. Yes.

MS. RIFKIN: Objection. Foundation, hearsay.

THE COURT: Just a moment.

Okay. The question is whether he reviewed it. It's not been offered yet. So let's see where it goes, and then you can restate your objection.

Q. BY MR. HALL: Doctor, do you recognize the document here marked as Plaintiff's Exhibit 1036?

A. Yes.

Q. Okay. What are we looking at? What is this?
A. This is the diagnostic criteria in the DSM-5 for --
MS. RIFKIN: Objection, Your Honor.
THE WITNESS: -- borderline personality disorder.
MS. RIFKIN: It is not just that. It is one with the circles on it.
THE COURT: Counsel, if you want to offer a clean copy, that may be different. But if there is any emphasis given to any portion of it, it shouldn't be admitted in that form.
MR. HALL: Right. This is a version that was provided by plaintiff's counsel as an exhibit.
THE COURT: Well --
MS. RIFKIN: An exhibit for a witness who is not testifying.
MR. HALL: That's fine.
Q. BY MR. HALL: Dr. Andrade, are you familiar with the criteria for diagnosis of borderline personality disorder?
A. Yes.
Q. Okay. And do you believe that Ms. Edmo meets those criteria?
A. I do.
Q. And which of those criteria do you believe that Ms. Edmo meets?
A. There were nine criteria for borderline personality disorder. And in my evaluation, I -- my opinion was that she

met criteria for five, which is the diagnostic criteria for borderline personality disorder.

Q. Do you believe that she met the criteria for a pattern of unstable and intense interpersonal relationships?

A. Yes.

MS. RIFKIN: Leading, Your Honor.

THE COURT: Sustained.

Q. BY MR. HALL: What criteria do you believe that she met?

A. I believe she met criteria -- I have listed it in my report. Am I able to --

Q. Would it refresh your recollection to have a copy of the DSM criteria for borderline personality disorder?

A. Yes.

MR. HALL: Your Honor, may I provide this to the witness?

THE COURT: Yes.

Mr. Severson.

I assume, Ms. Rifkin, you have a copy of that as well.

MR. HALL: Plaintiff's exhibit.

MS. RIFKIN: I'm sorry. I thought he was providing his report.

THE COURT: That's what I thought it was, too.

MS. RIFKIN: Not -- the exhibit we've been talking about is hearsay.

MR. HALL: That's fine. Is there an objection, then,

to that?

THE COURT: There is. I thought you were providing him with his report.

MS. RIFKIN: Yes. It's not what you represented.

MR. HALL: I'm sorry. It was the criteria for borderline personality disorder.

MS. RIFKIN: I believe the witness stated it was in his report, not in the document.

THE COURT: That's what I was thinking it was, too. Counsel, we have got to get through this.

MR. HALL: I understand.

THE COURT: I'm going to give you some more leeway to proceed. I don't think this -- you can get at it in cross-examination.

MR. HALL: Right.

THE COURT: So just list the five -- you don't know what the five are that you thought applied?

THE WITNESS: Not off the top of my head. I listed all nine --

THE COURT: In your report?

THE WITNESS: -- in my report and identified which five I thought she met the criteria for.

MS. RIFKIN: And so we don't object to him refreshing with his report. But a document --

THE COURT: That's what I thought we were doing.

Mr. Eaton, you need -- or, Mr. Hall, you need to proceed in that fashion. So let's move -- move along.

Q. BY MR. HALL: Okay. Doctor, do you -- do you have concerns with whether or not Ms. Edmo meets the criteria for SRS?

A. Yes.

Q. Okay. And are you familiar with the criteria for sex reassignment surgery under the WPATH?

A. Yes.

Q. Okay. And do you recognize Joint Exhibit 15, page 66?

A. Yes.

Q. Okay. And are these the criteria under the WPATH for sex surgery?

A. Yes.

Q. Doctor, do you believe that Ms. Edmo has met all of the criteria under the WPATH for surgery?

A. Not all.

Q. Do you believe that she has met criteria No. 1?

A. I think there are -- I have questions about whether she has. And my concerns are that she -- her persistent, well-documented history is while incarcerated but not prior to her incarceration.

So that raises concerns for me because she has only presented full time, as the WPATH standards recommend, for at least 12 months in a correctional setting.

So my concern would be if she had surgery in a correctional

setting, you know, she has an understanding of how that would play out because she has presented as female for several years -- since 2012, at least -- but if she were then to transition to the community where she has not presented full time as female, that she wouldn't know what to expect.

Q. Doctor, in your review of the records, did you see any documentation that would corroborate Ms. Edmo's claim that she lived full time as a woman prior to her incarceration?

A. I did not see any.

Q. And, Doctor, do you believe that Ms. Edmo's borderline personality disorder traits are well controlled at this time?

A. I have concern, other mental health concerns. One is her borderline personality disorder and also, in my opinion, her unresolved trauma which we talked about during our interview, which she attributes her early childhood trauma, potentially, to either her gender dysphoria at the time resulted in the sexual abuse; or, because she was sexually abused, she then became an adult transgender woman.

And I think there are things she needs to work out in therapy in the short and long term before she can make a really well-informed decision about surgery.

Q. What are those things that you believe Ms. Edmo should work out in therapy before surgery is appropriate?

A. I think resolving her understanding of her early-life sexual abuse.

Like I said, she attributes -- she goes back and forth whether she caused the abuse herself because of her feminine presentation, or the result of the abuse is growing up to be a transgender woman.

I think that's something she needs to work on in therapy to hopefully understand that she was a 9-year-old child that was sexually victimized by a much older person; and her gender -- that's not her fault, you know, that that was someone that sexually abused her.

I think the symptoms of her borderline personality disorder, so her -- one is intense interpersonal relationships, that she needs to work on that issue, too. Because I think, right now, she has the belief, based on her time living in prison as a woman, that surgery will fulfill a lot of her hopes, where I'm not confident that that would be true when she completes her sentence and reintegrates into society.

My hope would be it does, but I'm not confident in that. And I want her to be able to make that decision on her own when she is able to feminize in the community for an extended period of time.

Q. So, Doctor, looking back at Joint Exhibit 15, page 66, do you believe that Ms. Edmo meets the criteria for No. 4, if significant medical or mental health concerns are present, they must be well controlled?

A. No. I think that's a concern.

Q. Do you believe that surgery will cure Ms. Edmo of her coexisting mental health concerns?

A. No.

Q. Why not?

A. Well, the cure for unresolved trauma and borderline personality disorder is psychotherapy. There are a lot of -- there is a lot of research on outcomes for folks with unresolved trauma and borderline personality disorder.

DBT, dialectical behavioral therapy, or CBT, cognitive behavioral therapy, are interventions that have shown good efficacy. And I think those --

MS. RIFKIN: Your Honor, this is beyond the scope of any opinions in Dr. Andrade's report.

THE COURT: Well, we're back to reports.

Mr. Hall, do you have --

MR. HALL: I think these matters were addressed in the deposition.

THE COURT: Well, as I've said, if the opinions were expressed in the deposition or in the report, they are fair game. If not, then I'm not going to allow it.

So I don't have access to either. So, Mr. Hall, you need to point out where that is in the expert report or the deposition.

MR. HALL: Why don't we move on from there, Your Honor.

THE COURT: You can come back to this, if need be.

MR. HALL: Thank you.

Q. BY MR. HALL: Doctor, do you believe that if Ms. Edmo is provided with surgery, that it could be potentially harmful to her?

A. Yes.

Q. In what ways?

A. My concern is that she has not feminized in the community; she has expressed to various people that she has, which raises concerns for me regarding her understanding of how she presented in the community before.

So I would want her to continue along the path she is on, continue with therapy while incarcerated, transition to the community, hopefully have the supports, still, you know, present as female, as the WPATH standards recommend, in all realms of life.

To this point, she has only presented as female while incarcerated. So in the community, I think it would be very different for her. My hope is it would all work out, and then she would decide surgery makes sense, and it would help her in the long run.

MR. HALL: Thank you, Doctor. No further questions at this time.

THE COURT: I assume -- Mr. Eaton, you have no questions?

MR. EATON: No questions, Your Honor.

THE COURT: Cross, Ms. Rifkin.

MS. RIFKIN: Yes, Your Honor.

CROSS-EXAMINATION

BY MS. RIFKIN:

Q. Dr. Andrade -- I am saying that right; correct?

A. Yes.

Q. Okay.

THE COURT: Is it Dr. "An-drade" or "An-drad-ee"?

THE WITNESS: I respond either way. I say "An-drade," but a lot of people say "An-drad-ee."

THE COURT: Okay.

MS. RIFKIN: I try hard to pronounce it the right way.

THE WITNESS: Right. It's Portuguese, and it's gotten very Americanized as "An-drade."

Q. BY MS. RIFKIN: All right. Dr. Andrade, your experience with gender dysphoria comes almost exclusively from your participation on the Massachusetts Department of Corrections Gender Dysphoria Treatment Committee and Supervision Group; correct?

A. Yes.

Q. And for the time that you served in that capacity, Corizon's expert in this case, Dr. Garvey, was also part of that treatment committee; correct?

A. For a portion of that time, yes.

Q. As well as Massachusetts Department of Corrections outside consultant, Dr. Levine; correct?

A. Yes.

Q. You testified in your deposition there were four members of the treatment committee; correct?

A. Yes.

Q. You, Dr. Garvey, and Dr. Levine were three of the four members of that committee; correct?

A. Dr. Garvey for a short period of time.

Q. Two years; right?

A. Yes.

Q. How long were you on the committee?

A. Eight.

Q. So for two years, you, Dr. Garvey, and Dr. Levine were three of the four members of the treatment committee where you gained almost all of your experience with gender dysphoria; correct?

A. Yes.

Q. As part of your role on the treatment committee, if a prisoner was given a preliminary diagnosis of gender dysphoria, you would interview them to confirm the diagnosis; correct?

A. Yes.

Q. The -- and you would often do these interviews with Dr. Garvey or her predecessor on the committee; correct?

A. Correct.

Q. And the majority of the interviews that you and Dr. Garvey conducted with the actual patient to confirm gender dysphoria diagnosis were around 15 minutes; correct?

A. The majority. I mean, there was a wide range, but most were very straightforward. The person met criteria, so we didn't need much more time than that.

Q. And outside of confirming diagnoses of gender dysphoria, you personally have never provided any treatment for gender dysphoria directly as a clinician to patients; correct?

A. Prior to my time on the committee and supervision group; correct.

Q. At present, outside of confirming diagnosis of gender dysphoria, you have never provided any treatment for gender dysphoria directly as a clinician to patients; correct?

A. That's very difficult to answer. I can explain.

Q. Well, can you give me a "yes" or a "no" answer, please.

A. Not based on that question, I don't think I can.

Q. Do you recall giving me an answer in your deposition?

A. Not specifically. I mean, the way you are asking the question, to provide treatment on the treatment committee, we were the only folks that could approve treatment. So that's -- we approved all treatments. So I never --

THE COURT: The question was whether, outside of confirming the diagnosis, have you ever provided any treatment for gender dysphoria directly?

THE WITNESS: And the treatment committee was the group that provided all the treatment -- approved all treatment into --

THE COURT: They approved it. But did they provide the treatment? That was the question.

THE WITNESS: Okay. Right. I wasn't the primary care clinician, no.

Q. BY MS. RIFKIN: So outside of confirming diagnoses of gender dysphoria, you have never provided any treatment for gender dysphoria directly as a clinician to patients; correct?

A. Any -- right. Psychotherapy, no.

Q. Or any other treatment for gender dysphoria directly as a clinician to patients; correct?

A. Correct.

Q. Within the Massachusetts Department of Corrections, you have never been the primary care clinician treating any patient with gender dysphoria; correct?

A. Correct.

Q. And earlier, on the direct testimony, you discussed two patients within the Massachusetts Department of Corrections that you said you approved surgery for; correct?

A. Correct.

Q. You actually -- you actually only recommended that surgery with a requirement that prior to receiving that surgery, they had to live in a women's facility, a women's prison, for

approximately 12 months before they could receive that surgery; correct?

A. Yes.

Q. So you added that requirement in order -- as a precursor for them receiving surgery; correct?

A. I mean, it's much more complicated than that, so it's more --

Q. You added that requirement; right? Before they could get surgery, you and the treatment committee required that they live in the women's prison for approximately 12 months before you would actually provide surgery; correct?

A. It's a very complicated -- I mean, each case was very complicated.

Can I explain further?

Q. No. I would like a yes or a no.

A. Can you repeat the question.

Q. For these two inmates, before -- the treatment committee, before they could actually be provided surgery, you required that they live in a female prison for approximately 12 months before they would actually be provided surgery; correct?

THE COURT: You will have a chance to explain. Mr. Hall will give you a chance to elaborate.

THE WITNESS: Okay. Yes.

THE COURT: Was that a requirement you imposed?

THE WITNESS: Yes.

Q. BY MS. RIFKIN: And you were aware at the time that you imposed that requirement that the Massachusetts Department of Corrections houses prisoners according to their genitals; correct?

THE COURT: If you know.

THE WITNESS: For the majority, yes. But there were some patients that lived in both at different times during incarceration. So the majority, yes; like, 99.9 percent were based on genitals.

Q. BY MS. RIFKIN: And, in fact, while you were still working with the Massachusetts Department of Corrections, the Massachusetts Department of Corrections did not allow either of these prisoners to move to a women's prison facility; correct?

A. Correct.

Q. And so the effect of the requirement that you added that they live in a female facility for 12 months prior to receiving surgery was that they haven't gotten surgery; correct?

A. At this point, I don't know. I mean, this -- at the time I left, we were in -- they asked us if there were any alternatives; we said no. And then I had not heard back from the Department of Correction.

Q. And when did you leave?

A. July 1st.

Q. Of this year?

A. Yes.

Q. And when was the recommendation that these individuals be provided surgery if, and only if, they had lived in a women's facility for approximately 12 months? When was that made?

A. The initial was late 2017, November-ish -- October-November 2017.

Q. So as far as you're aware, seven months after you made this recommendation that they needed to live in a facility for an additional 12 months before having surgery, they haven't been moved, so that 12-month period couldn't even start ticking; correct?

A. Yes.

Q. And that requirement that they move to a female facility, that is not in the WPATH; correct -- the WPATH standards of care?

A. Well, the WPATH standards of care say you can be flexible on a case by case.

So, yes, I think we were -- in requiring this, I think we were consistent with WPATH.

Q. The WPATH standards of care actually state that surgery should never be denied based on a housing situation, such as which prison you're housed at; correct?

A. Correct.

Q. Other than the two individuals we have been discussing, you have never approved any other patients for surgery to treat gender dysphoria; correct?

A. Correct.

Q. And you personally have only ever treated one patient who has had gender confirmation surgery; correct?

A. Treated or been involved with the treatment committee?

Q. Treated, as a clinician.

You have never been the actual treating clinician for a patient who has had gender confirmation surgery? That's only happened once; correct?

A. I have never been the treating clinician, no.

Q. So you have never been a treating clinician for a patient who has had gender confirmation surgery?

A. Correct.

Q. You testified in your deposition that you define "medically necessary" as it relates to gender dysphoria as, quote, "If any intervention can alleviate the dysphoria, it would be deemed medically necessary."

Do you recall that?

A. Yes.

Q. Is it your opinion that sex reassignment surgery cannot alleviate Ms. Edmo's gender dysphoria?

A. It's my opinion that there are other complicating factors that need to be answered first.

Q. Is it your opinion that sex reassignment surgery cannot alleviate Ms. Edmo's gender dysphoria?

THE COURT: The question is whether it cannot. Is it

your opinion that it cannot alleviate Ms. Edmo's gender dysphoria?

THE WITNESS: No.

Q. BY MS. RIFKIN: So, to clarify the record, you're saying it's not your opinion that sex reassignment surgery cannot alleviate Ms. Edmo's gender dysphoria? You're not offering the opinion -- let me just state it again.

THE COURT: Yeah. So is it your opinion that it could?

THE WITNESS: I don't know. I mean, based on all available information, I think there are things that need to -- she needs to work through first before that decision could be made.

THE COURT: Well, no. The question is whether the gender-confirming surgery, whether in your opinion it could solve her gender dysphoria.

THE WITNESS: Right. I don't think I can answer, because it could exacerbate it.

THE COURT: You're not ruling it out, though?

THE WITNESS: Right.

Q. MS. RIFKIN: You're aware, aren't you, that Ms. Edmo has never been diagnosed by anyone besides you as having borderline personality disorder?

A. Yes.

Q. And you agree that IDOC and Corizon have not been treating

Ms. Edmo for borderline personality disorder for the last six years; correct?

A. No.

THE COURT: You don't agree with that?

THE WITNESS: I don't.

THE COURT: Okay. If they have not diagnosed her with that, they have not been specifically treating her for that, although some of the treatment -- I don't know if "modalities" is the right word -- may, in fact, have been beneficial to someone with that condition; is that what you're saying?

THE WITNESS: I'm saying they didn't officially diagnose her with that. But in talking with clinicians, they identified traits of borderline personality disorder and were treating her for those.

THE COURT: For those -- all right. For those elements but not --

THE WITNESS: Yes.

THE COURT: -- the condition itself?

THE WITNESS: I mean, to identify the traits, I think they didn't formally diagnose.

THE COURT: Okay.

THE WITNESS: Which, in my report, I talk about that they --

THE COURT: Okay. Go ahead.

Q. BY MS. RIFKIN: It's your opinion, correct, that in the six

years that Ms. Edmo has been incarcerated and treated in IDOC, her Corizon and IDOC mental health treaters missed a diagnosis of borderline personality disorder for Ms. Edmo?

A. It's my opinion they did not officially document the diagnosis.

Q. You testified -- in your deposition in response to the question, "Is it your testimony that in the six years of treating her, her mental health treaters within the Department of Correction and Corizon missed the diagnosis of borderline personality disorder?" you testified, "Right. I did not see the diagnosis in the record."

Do you remember that?

A. Right. I did not see it documented.

Q. You agree that Ms. Edmo experiences distress over her genitals; correct?

A. Yes.

Q. And you agree that this can be acute distress; correct?

A. Yes.

Q. And it's your opinion that at the time she tried to castrate herself, she was experiencing so much distress, that she thought that would alleviate the distress; correct?

A. Yes.

Q. But you're testifying that you're not able to opine that gender-affirming surgery would lessen her gender dysphoria?

A. Correct.

Q. In your own experience, only individuals diagnosed with gender dysphoria have attempted to cut off their genitals; correct?

A. No.

Q. All right. I would like to show the witness his deposition.

THE COURT: Mr. Severson -- well, can you show it on the evidence presenter, or do you want --

MS. RIFKIN: I think we don't have it on there, Your Honor, but I do have multiple copies of it, a certified copy -- actually, we have the original.

THE COURT: If we have the original, let's publish that, but let's not go through the formality of it. I'll just direct Ms. Bracke to publish it.

MR. HALL: I don't think the witness has had an opportunity to review and sign that, so the same stipulation.

THE COURT: Then it's not -- oh, all right. I thought you said that it -- I thought it had been reviewed. So it will be under the same order that I indicated we follow yesterday or the day before; if there is any areas where the witness disagrees and would have corrected the deposition if he had had a chance to review it, then we'll point that out as we go along.

Q. BY MS. RIFKIN: If you could please turn to page 146 of your deposition.

We have another copy. Does the court want a copy?

THE COURT: No. That's fine.

Q. BY MS. RIFKIN: All right. Are you on page 146, Doctor?

A. Yes.

Q. If I can direct your attention to line 10.

A. Yes.

Q. Question: "Have you directly treated any patients who have attempted to cut off their genitals?

"MS. CRECELIUS: Object to form."

Answer: "As part of my work in Massachusetts, yes."

Question: "How many?"

Answer: "Less than ten, more than five."

Question: "How many of those individuals were diagnosed with gender dysphoria?"

Answer: "Oh, all right. So many.

"MS. CRECELIUS: Answer her question."

Answer: "Well, can we go back?"

Question: "Yes."

Answer: "The first question of attempting to cut off their genitals, yes, less than ten, more than five. And I believe all were diagnosed with gender dysphoria."

That's what your deposition testimony states; correct?

A. Yes. But I -- yeah. I remember talking about two other groups of patients that have attempted.

Q. To cut off their genitals?

A. I would have to review, like, more than just the one page.

Q. All right. We'll move on.

When you reviewed Ms. Edmo's prior medical records, did you see -- you concluded that she did not present as a woman in the community.

Is that what you responded on direct?

A. Yes.

Q. Did you see notes in one of the records when she was brought after her suicide attempt that she was wearing nail polish?

A. I did not see that.

Q. Did you -- you were provided with the photos of Ms. Edmo at the time she was booked into the Idaho Department of Corrections?

A. I believe so.

Q. Did you see that one of those photos noticed that -- noted that both of her ears were pierced?

A. No, I did not notice that.

Q. Would you agree that it's more typical in our society, in our culture here, that women wear nail polish versus men?

A. Yes.

Q. Would you agree that in our culture, it's more typical that women have both ears pierced, versus men?

A. Yes.

Q. But you didn't note those signifiers of Ms. Edmo's femininity in her prior medical records and her photo when she

was booked; correct?

A. I reviewed a lot of records and did not see evidence of her feminizing, no.

Q. It's your opinion in this case, same as in Massachusetts, that if Ms. Edmo was going to have surgery, she has to live for 12 months in a women's prison, isn't it?

A. It's my opinion that if -- if the court did approve surgery, that it would be in her best interest for her to transition to a female facility first, to ensure that she understands what the facility is like, whether she will be able to acclimate, have a peer group.

Q. You've answered the question, Doctor.

Are you aware of Idaho Department of Corrections policy as far as housing of inmates?

A. I have seen a policy.

Q. Have you seen their newest policy issued last Friday?

A. No.

Q. Are you aware that that policy and the email distributing it emphasize that inmates in IDOC will continue to be housed primarily based on genitals?

A. No. I haven't seen it.

Q. You have never published any research related to gender dysphoria in a peer-reviewed journal; correct?

A. Correct.

Q. You have never published any peer-reviewed work related to

gender dysphoria; correct?

A. Correct.

Q. You taught a class at Bridgewater State University on human behavior in a social environment, where you reviewed every section of the DSM and all diagnostic criteria; correct?

A. Yes.

Q. And as part of that class reviewing all of the DSM, you reviewed gender dysphoria or what was then called "gender identity disorder"; correct?

A. Yes.

Q. Other than that, you have never taught any other university or graduate classes related to gender dysphoria; correct?

A. Correct.

MS. RIFKIN: Your Honor, at this time, we would move to strike and exclude Dr. Andrade's opinions related to treatment of gender dysphoria and specifically his assessment of whether Ms. Edmo is -- whether gender reassignment surgery is medically necessary for Ms. Edmo, given that he has never treated a patient who has had this the surgery. He does not have the requisite experience or training to offer these opinions.

THE COURT: Okay. It's noted. I'll overrule the objection for the same reasons stated earlier with regard to Dr. Garvey.

I think it goes to the weight, not the admissibility of the

opinion. Dr. Andrade has the training and -- as a psychiatrist, I think, to offer opinions, but I think you have made your point about the lack of actual experience in treatment.

So the objection is noted and overruled, but I'll consider your arguments concerning the weight of the testimony.

MS. RIFKIN: Okay.

THE COURT: Proceed.

Q. BY MS. RIFKIN: And just for clarification, Dr. Andrade, you are not a psychiatrist; correct?

A. Correct.

Q. What is your licensure?

A. Licensed independent clinical social worker, with a doctorate in social work.

Q. Dr. Andrade, under the IDOC policy that you've reviewed, were you qualified as a gender identity disorder evaluator who could assess somebody for surgery?

A. The policy I saw said "psychologist." So, no.

MS. RIFKIN: No further questions, Your Honor.

THE COURT: Redirect.

MR. HALL: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. HALL:

Q. Dr. Andrade, in your profession, are you permitted within your scope to recommend hormone treatment for a transgender gender-dysphoric patient?

A. Yes.
Q. But do you actually administer those hormones?
A. No.
Q. And is it within the scope of your practice to provide an assessment for gender-confirming surgery?
A. Yes.
Q. But do you actually perform that surgery?
A. No.
Q. So mental health providers like yourself make recommendations for treatment but don't actually perform all those treatments; is that correct?
A. Correct.
Q. Doctor, I want to talk to you about these two individuals for whom you recommended surgery for in Massachusetts.

You were asked whether or not you had recommended that they be housed first for a year in a female prison; correct?
A. Yes.
Q. Okay. What was your rationale for making that recommendation?
A. For both, both were serving life sentences. Massachusetts only has one female prison, so they would have to acclimate to that one female prison.

Both were well engaged in the male prisons they were housed at, involved in programming, education, extracurricular services, and were functioning well. We worked with them over

the years and, over time, believed they met criteria for surgery but wanted to be sure that when they had the surgery, they were able to acclimate into that female facility and live a happy life better than they had in the male facility.

In both -- at the time, talking with both, both agreed to do that. One said, "I don't need to. I'm 100 percent confident the surgery will be effective. I don't need to, but I'll go along."

The other said --

MS. RIFKIN: Objection. Hearsay.

THE COURT: Sustained.

Q. BY MR. HALL: What was your understanding as to those two inmates' feelings about your recommendations?

MS. RIFKIN: Same objection.

MR. HALL: It doesn't call for statements of these other --

THE COURT: Overruled. You may go ahead.

MS. RIFKIN: Lack of foundation.

THE COURT: Sustained. I'd need to know what the basis is for the witness to have an understanding.

Q. BY MR. HALL: Did you have communications with these individuals about your treatment recommendations, particularly that they be housed in a female facility prior to surgery?

A. Yes. Both were based on extensive interviews.

Q. Okay. From your interviews, did you gain an understanding

as to what their feelings or thoughts were on that?

A. Yes. We processed this as a possibility with each. And one understood and had -- was ambivalent and thought it would be a good decision to try living at the female facility first.

The other basically said, "I'll go along with that, but I don't think it's necessary, but I will if it gets me a step closer to surgery."

Q. Did you believe, in your professional opinion, that that recommendation that you made for those two individuals was in their best interest?

A. Yes.

Q. Okay. And why?

A. Our concern for both -- again, both were serving life sentences, well integrated at the male facility -- that if they had genital surgery, gender-affirming surgery, and now living in a male facility was no longer an option and they became depressed and did not find the peer group, did not acclimate the way they expected -- because neither, obviously, had ever been inside a female facility -- that their risk for suicide would go up; they would be ostracized, and we will have done harm.

Q. Is it your opinion that wearing nail polish on one occasion is consistent with living full time as a woman in the community?

A. No.

Q. Is it your opinion that piercing your ears is consistent with living full time as a woman in the community?

A. No.
Q. You're not recommending right now, Doctor, that Ms. Edmo be transferred to a female facility, are you?
A. No.
Q. Okay. And why not?
A. As I said before, I think there is a lot of work she needs to do in therapy prior to mental health providers feeling comfortable that she is ready for surgery.
Q. And in your profession, Doctor, does a patient have to have a diagnosis of borderline personality disorder in order for treatment aimed at some of those traits to be appropriate?
A. No.
Q. Why not?
A. In my experience, mental health professionals, psychiatrists tend not to diagnosis personality disorders, especially in corrections, as often as they should.

The base rate of personality disorders is very high in corrections, and I think treatment providers, especially psychiatrists --

MS. RIFKIN: Objection. Outside the scope of expertise. He is not a psychiatrist or a psychologist, and he is testifying about why they do or do not diagnose these.

THE COURT: Was that a foundation --

MR. HALL: He has experience.

THE COURT: I'm sorry?

MR. HALL: He has experience working with psychologists and psychiatrists.

THE COURT: Well, I think we need to lay it more clearly that there is a foundation that, in fact, he has had experience and that that experience has caused him to be able to observe what psychiatrists and psychologists would require.

Q. BY MR. HALL: Doctor, do you have experience with working psychiatrists and psychologists regarding patients who are diagnosed or not diagnosed with borderline personality disorder?

A. With all mental health professionals -- and a licensed mental health professional is also able to diagnose and treat. In my experience with all mental health professionals in corrections and outside -- so master's level, doctorate level, psychologists, and psychiatrists -- underdiagnose --

MS. RIFKIN: Move to strike. I believe the witness can opine within his licensure. He is now generalizing about all mental health professionals.

THE COURT: Well, but he's only -- well -- I'll overrule the objection, but I took it only as his testimony concerning his own level of licensure.

So -- but don't -- we don't need to hear what your thoughts are on what's appropriate in other areas.

Go ahead.

Q. BY MR. HALL: Doctor, in your license, do you believe that it is -- it is necessary to have a patient diagnosed with

borderline personality disorder in order to treat their symptoms that may be consistent with the criteria for that diagnosis?

A. No.

Q. Okay. Why not?

A. Because personality disorders are enduring patterns of inner experience and behavior that clinical staff are trained to treat the symptoms. The symptoms together then meet the criteria for the diagnosis.

So it's like trauma. Just because someone has a trauma history doesn't mean they meet criteria for PTSD. That doesn't mean we're not going to treat someone who has a trauma history and relate it to the trauma they have experienced.

So we are treating symptoms.

Q. Doctor, I believe that you were asked by counsel whether or not it's your understanding if the defendants have been treating Ms. Edmo's traits for borderline personality disorder; is that correct?

A. Can you repeat. Sorry.

Q. You were asked a question as to whether or not defendants have been treating Ms. Edmo's traits for borderline personality disorder.

Do you remember that?

A. Yes.

MS. RIFKIN: Objection. Misstates the record.

Q. BY MR. HALL: Do you remember being asked that? Is that

your recollection?

A. Yes.

Q. Okay.

THE COURT: The objection is overruled. Go ahead.

Q. BY MR. HALL: Is it your understanding that the defendants have been attempting to treat Ms. Edmo's traits that are consistent with borderline personality disorder?

A. Yes.

Q. And how have they been trying to do that?

A. So the constellation of symptoms she has for borderline personality disorder -- some are behavioral, some self-injury; she has talked recently about cutting, that that's a behavior she has engaged in -- clinical staff work with her on that.

Her intense interpersonal relationships, which is one of the criteria for borderline personality disorder, is something that I talked with clinical staff about that they have worked with Ms. Edmo on.

So those are two of the main symptoms that she has met criteria for.

Q. Is it your understanding that clinicians at the Department of Corrections have attempted to -- or have recommended that Ms. Edmo undergo various therapy or groups?

A. Yes.

Q. Okay. And is it your understanding that Ms. Edmo has repeatedly refused to undergo those groups?

A. Yes, that's my understanding.
Q. Do you think that Ms. Edmo should engage in those groups?
A. Yes.
MR. HALL: No further questions.
THE COURT: Recross. Any recross?
MS. RIFKIN: Yes, Your Honor.

RECROSS-EXAMINATION

BY MS. RIFKIN:
Q. You have offered the opinion, Dr. Andrade, that without transferring to a women's prison first and without engaging in these groups, you don't think Ms. Edmo has an appropriate understanding of how gender reassignment surgery may or may not affect her life; correct?
A. In general, yes.
Q. And in your report, you talked about -- you suggested that she may have the idea that it's going to be a magic pill that will solve all her problems; correct?
A. I don't think I said "magic pill," did I?
Q. In your report, you talked about your concern -- as you've talked about here today, your concerns that Ms. Edmo doesn't understand that she would continue to face challenges after transitioning through sex reassignment surgery; correct?
A. Correct.
Q. Do you recall asking Ms. Edmo in your exam of her the question: "Without surgery, how would you rate dysphoria with

regard to your genitals, on a 1-to-10 scale, not having it?"

A. Yes.

Q. Do you recall that she answered "10"?

And you asked: "All the time?"

And she said: "Yes."

And you asked her: "If you had surgery, what do you think it would be?"

And she answered: "Lower than 10."

Do you remember that?

A. Yes.

Q. And you asked her: "10 is highest. Would it be, like, 8?"

And she responded: "Lower than 10 -- 7, 6, 5, 4, can't say exactly."

Do you recall that?

A. Yes.

Q. Do you recall that you asked her: "You don't think it's just going to make everything better?"

And she asked: "Yes" -- she answered: "Yes, I understand it can't just make everything better. But after surgery, I will be in a better place to handle other things."

Do you recall that?

A. Yes.

Q. And do you recall that, in response, you said: "In a correctional setting, you often hear the answer -- people have this magical idea that everything will be better. Good to hear

that you know there isn't something that will fix everything."

And she responded: "Right. Wish there were, but there isn't."

Do you recall that?

A. Yes.

MS. RIFKIN: No more questions.

THE COURT: Anything else?

MR. HALL: No further questions, Your Honor.

THE COURT: All right. You may step down. Thank you, Dr. Andrade.

Call your next witness.

MR. HALL: Defendants do not have any more witnesses, Your Honor.

THE COURT: Mr. Eaton, do you confirm that?

MR. EATON: No more witnesses, Your Honor.

THE COURT: Any rebuttal witnesses?

We can take a short break and then come back. I assume each side might have half an hour, roughly. So we can take a short break, and you can consider whether you, A, have other witnesses and, B, want to spend any time on closing argument.

My inclination -- I, frankly, find posthearing briefs to be more helpful, but I don't want to foreclose you from making an oral argument as well.

So take a short recess, and then you can advise us how you want to proceed.

MS. RIFKIN: Okay. We do not have any rebuttal witnesses, Your Honor.

THE COURT: All right. Then the evidence is closed. Maybe we can just deal with it now.

Do you wish to make a closing argument.

MS. RIFKIN: A short one.

THE COURT: Defendants, you have time to do it as well. Again, let's take a short break, and then we'll come back and hear closing argument.

MR. HALL: Sounds good, Your Honor.

THE COURT: All right. We'll be in recess.

(Recess at 2:44 p.m. until 3:02 p.m.)

THE COURT: Counsel, before we go any further, I had here -- but I can't find it -- a list of the relief requested. I would ask either today, or perhaps by stipulation next week, or at some point, I need to have the lay of the land set a bit. Because the requested relief includes sex reassignment surgery; and on that issue, I don't know how we can hear that on a preliminary injunction.

I mean, it's -- you can't -- if I order it, then it's done. And obviously, that's not maintaining the status quo; it's a mandatory injunction. Therefore, it seems to me that can only be resolved in a final hearing, and I have kind of treated this hearing as the final hearing on that issue.

Now, if there is some disagreement on that, then that's a

bit of a problem because I really have a hard time seeing how I could grant or deny that request under the preliminary injunction standard.

The other items, reinstatement of the -- I don't -- spironolactone -- I don't know if that's the right pronunciation -- which I assume is the testosterone-suppressing drug, access to gender-appropriate underwear, clothing, and commissary items, that may be moot given the change in policy effective last -- a week ago today. And then a catchall, for any other treatment that a medical professional qualified to assess and treat gender dysphoria determines to be medically urgent, and then some other relief.

So that's one of the first issues I have got, is: What relief really does the court need to consider stemming from this hearing? And secondly: What standard applies? And can we even really consider at least the sex reassignment surgery on anything short of a final injunction hearing?

So whether you want to address that orally or work it out next week early in the week before any briefs are filed is fine.

Then the second thing is: One of the reasons we are late getting back here is we're -- counsel in the case we have set for trial in Pocatello next week just alerted that the client may want to plead guilty straight up without a plea agreement, which means my trial goes away, and perhaps Ms. Hohenleitner is back on course to have the transcript ready by next Friday. But

that, again, remains to be seen as well.

So we need to work out kind of a schedule. I would assume that we could do pretty much expedited briefing, in any event, subject only to give you some time to wait for the transcript so that you can correlate the draft that you've prepared to the actual excerpts from the trial transcript.

So -- and then I have given you X amount of time to present your case, so I am not going to preclude any party from making a closing argument even if the other party would prefer to submit theirs in writing.

I find the written submissions more helpful because, you know, I try very hard to make these decisions very, very objective. And although oral argument and closing argument is helpful, I generally want to objectify, and it's much easier to do that just looking at the briefing.

So, your option. But I understand the plaintiffs want to give a brief closing argument. I don't know what the defendants want to do. So maybe I ought to hear first.

MR. HALL: Your Honor, I just want to clarify that there will be an opportunity to provide a written closing; correct?

THE COURT: Absolutely.

MR. HALL: Okay. And then providing a statement today orally will not preclude --

THE COURT: No.

MR. HALL: -- that opportunity? Thank you.

MR. EATON: That was my question as well.

THE COURT: No. It won't preclude it. I'll expect the briefs to be fairly short. I really want to focus in on the findings of fact and conclusions of law.

And I assume you understand I'm not just going to say, well, I adopt one side or the other. What I really want from that findings of fact and conclusions of law is if you were writing the decision, what would you want that decision to say so as to preserve an issue on appeal.

Because that's what I'm trying to do, is really make sure that every base is covered. And we think we do a pretty good job of that, but I think it's very helpful to see how you assess that as well. And we'll probably be in the process of at least outlining a decision even before we see what you have submitted.

So with that, Ms. Rifkin, were you going to --

MS. RIFKIN: Yes, Your Honor.

THE COURT: Yes.

MS. RIFKIN: Your Honor, I understand, and I will try to keep it short and to the point.

The first thing I want to address is what you just raised about the mandatory injunction. We are happy to provide further briefing on this. But the answer is: Yes, you can consider the relief that Ms. Edmo has requested for sex reassignment surgery as a preliminary injunction. It is a mandatory injunction.

And under the Ninth Circuit standard, there is a higher standard. You have to prove a stronger likelihood of success. And you also have to make sure that the showing of irreparable harm is serious. But this -- a mandatory injunction in the Ninth Circuit can be issued as a preliminary injunction.

Judge Reinhardt specifically stated: Mandatory injunctions are most likely to be appropriate when the status quo is exactly what will inflict the irreparable injury upon complainant.

And we are happy to provide further briefing, but the answer is yes. And we believe this is exactly such a situation.

What we have heard in the last three days is that there is an undisputed serious medical condition here. There is also undisputed suffering. The DSM definition of gender dysphoria -- by definition, this condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Every single witness that has testified agrees that Ms. Edmo has gender dysphoria and agrees that it's causing her clinically significant distress. Even defendants acknowledge that it's causing her acute distress. No witness was willing to testify under oath that gender confirmation surgery will not treat Ms. Edmo's gender dysphoria.

So the question, I think, for the court is -- in addition to whether the court can issue such relief, the underlying question is: Does the standard of care require that she be

provided surgery? Is surgery medically necessary?

And the Eighth Amendment -- regardless of what the WPATH standards of care say, the Eighth Amendment provides the answer. It is black-letter Eighth Amendment law that the standard of care is the same in the community and in a prison.

The arguments defendants are making is nothing new. It's the same rationale departments of corrections used decades ago to justify refusing to provide incarcerated persons with chemotherapy, surgery, and mental health treatment.

The underlying idea -- and we saw this in the slides, Dr. Levine's slides and the slides that defendants and their experts embraced. The underlying idea was that people in prison have committed crimes; they have done bad things; and they should not get the same medical care that good, honest people in the community get.

THE COURT: Okay. Just so we're clear -- and I totally agree with you that that should not be a reason for denying someone medical care.

The Eighth Amendment standard requires a showing that the failure to treat the condition -- apparently in accordance with the standard of care prescribed in this case by the WPATH standards -- could result in further significant injury or the unnecessary and wanton infliction of pain.

So doesn't that become the focus of the case?

I mean -- you know, there have been two primary objections

to -- by the defendants' experts to the application of the WPATH standards to Ms. Edmo.

One has to do with whether or not her mental health concerns are well controlled. And I think that turns upon a very difficult question of whether or not those mental health concerns really are a product of or substantially exacerbated by her gender dysphoria.

But the other factor that -- the suggestion that the 12 months living in a chosen gender lifestyle should not be allowed in a -- needs to be something other than in a prison setting.

What I'm struggling with here is that there are distinguishing characteristics here, but it almost seems to me it turns more on whether -- if she is denied this treatment, whether that is going to result in further significant injury or unnecessary and wanton infliction of pain.

The case law, I think, is pretty clear that it's not a malpractice standard; it has to be something more than that. It has to be deliberate indifference coupled with an inmate suffering from further significant injury.

If I'm wrong on that as far as the legal standard, how so?

But I am troubled when you say that the standard of care is the same in prison as out of the prison. If you're talking in terms of what is the medically indicated standard of care, that's -- I would agree. But if you're saying the standard of care in prison is the same for Eighth Amendment purposes as what

the standard of care for medical malpractice is outside a prison, I think I part company with you unless you can show me some case law from the Ninth Circuit or the Supreme Court to indicate I'm wrong.

MS. RIFKIN: No, Your Honor. I completely agree with that analysis. I think I'm focusing on the standard of care because I think the undisputed evidence in this case shows that Ms. Edmo is suffering.

THE COURT: Okay.

MS. RIFKIN: And so I think the irreparable harm prong for the injunction -- I don't think we have heard any evidence -- because every single one of the defendants and their experts testified that Ms. Edmo is not malingering, she is not manipulating, she is not faking it, she is not exaggerating, and she has tried to castrate herself twice. That's very life-threatening harm.

So I don't -- there is no evidence, none, that is before the court to suggest that the irreparable harm prong isn't satisfied here.

And so I think -- I'm focusing on the only part I think defendants have contested here. Because they don't actually -- they don't contest that if this were determined to be medically necessary for Ms. Edmo, that they would provide it.

We heard defendants from both IDOC, Mr. Clark, and Dr. Eliason get on the stand and say that their understanding is

that IDOC has no problem with providing the surgery to an inmate for whom it is found to be medically necessary.

So, really, that's what it -- I think that's the only evidence that it comes down to in this case. And defendants are picking around the edges.

The WPATH standards -- they presented two experts who have almost zero experience treating anyone with gender dysphoria and no experience with the surgery, no experience evaluating patients for surgery. And they say: We don't believe the WPATH standards should apply, hypothetically this and hypothetically that.

And I think we have established that Dr. Levine, who is not a witness in this case, trained and was very involved in every single -- every single one of defendants' witnesses.

Mr. Clark was trained by Dr. Levine, got his slides from Dr. Levine, embraced those slides. Dr. Eliason brought Dr. Levine in; that's who he trained with; he reproduced his slides.

And defendants -- both of their experts, remarkably, are from the same correctional system who were trained by Dr. Levine.

And I think something very important is that in the *Norsworthy* case, the district court found, after considering Dr. Levine, who was there, and an actual expert in that case --

THE COURT: What case is this?

MS. RIFKIN: This is *Norsworthy v. Beard*, 87 F.Supp.3d 1164.

THE COURT: What district?

MS. RIFKIN: This is, I believe, the Northern District of California, 2015.

THE COURT: By the way, was the one case in California where gender confirmation surgery was performed for an inmate -- was that ordered by the court, or was it just a decision made by the department of -- California Department of Corrections?

MS. RIFKIN: I believe, Your Honor, that that was a settlement after the court ordered surgery for Michelle Norsworthy that CDCR then paroled. So they did not provide her surgery.

But Shiloh Quine had another case. And so the result of the *Norsworthy* case was that CDCR adopted policies that it would provide surgery, and that was the settlement, and it has provided surgery.

I'm informed that, according to CDCR attorneys, two more individuals in CDCR have since been provided surgery, but I don't have that as evidence, Your Honor.

THE COURT: Okay. All right.

MS. RIFKIN: So this court, who was directly considering Levine, found that -- essentially concluded that Levine's apparent opinion that no inmate should ever receive SRS predetermined his conclusion with respect to *Norsworthy*, who was

the plaintiff. Therefore, his conclusions are unhelpful in assessing whether she has a serious medical need for surgery.

Now, Levine isn't here today. But what you heard from Dr. Eliason, and essentially what you heard from Dr. Andrade and Dr. Garvey, is the same thing. They say -- defendants' defense in this case is: We don't have a ban. Our policy would allow it.

But the standard, the criterion that they are suggesting creates a de facto ban on surgery for anyone who isn't serving a life sentence. They say, on the one hand -- Dr. Garvey said that Ms. Edmo wasn't presenting as feminine; there is no evidence she was presenting as feminine prior to prison six years ago. On the other hand, she said, even if she were, the substance abuse history would make that meaningless.

So on the one hand, they say that her six years of consistent, persistent gender presentation in prison don't count and can't count toward the standard. On the other hand, they say, and it never could, because nothing -- nothing counts unless it's in the community.

THE COURT: Well, I mean, hypothetically, someone could have spent a year having dressed or acted -- having adopted that gender identity and then been arrested. That would have satisfied it. But, generally, you're right. It's going to a rare circumstance where anybody short of a very long prison sentence would ever qualify. That's the point.

MS. RIFKIN: That's the point, Your Honor.

I mean, it's also important to consider that Ms. Edmo wasn't given a diagnosis of gender dysphoria until after she entered the prison. She testified she didn't know what the -- what the -- what the condition was. And so she has provided testimony that she considered herself effeminate from the time she was small.

Whether Dr. Garvey thinks that her shirt was feminine enough as recorded in the record, Dr. Ettner explained to us clearly, that's not the measure of gender identity. The measure of gender identity is how somebody perceives their gender identity.

And no one in this case suggested that Ms. Edmo has been manipulative or is faking this or lying. And so regardless of whether she wore a skirt or a shirt or earrings before she entered prison, it is undisputed that for six years, in the face of discipline -- and this is important -- defendants have disciplined her for, quote, "disobeying orders" that were related to appearing feminine. Some of that discipline involved escorting Ms. Edmo to the segregation unit and forcing her to spend time in segregation for this.

This is not something that she is doing lightly or has done lightly. And I think that matters.

Now, Your Honor asked a question at the end of Dr. Garvey's presentation about whether there are statistics that actually

measure suicide rates. There is that information. It's in the exhibit that we did not admit, but it specifically talks about that.

We didn't present it with our experts because we didn't anticipate that Dr. Garvey would testify that way. In her report, she specifically says that that 19-times rate number, she acknowledges that the authors of that study say this is not to be confused with saying that gender confirmation surgery increase a risk. This is not to be used to make this argument. This is not what it's saying.

She said that in her report, so we did not be expect her to opine that as if that somehow mattered in this case.

So there is evidence, Your Honor. And I think you'll find that Dr. Ettner actually explained this in her testimony when the record is reviewed. There is substantial evidence, it's uncontroverted evidence that gender confirmation surgery has a significant effect on increasing the mental health of people who receive it.

Suicide is the result of decompensating mental health. Dr. Garvey herself testified suicide -- the completed suicide is extremely rare.

So, I mean, the information is there, and it's been uncontroverted. Even the experts in this case acknowledge that surgery is a well-established treatment for this condition, and to say otherwise is unethical. I mean, that's what Dr. Garvey

stood up and agreed to.

So these -- these are red herrings. These are hypotheticals by people. All four witnesses defendants put on, not one of them has any experience with someone who has actually had the surgery; and yet, they speculate that Ms. Edmo will somehow be harmed.

Again, these are the kinds of arguments that used to be used in Eighth Amendment cases for things we now consider absolutely common sense. But because this population of people with gender dysphoria, of transgender people, there is still a lot of prejudice, the idea that they are lying, they are manipulating, they are somehow making this up, they have other things going on.

Dr. Garvey in her report ruled out transvestic fetishism, which isn't even a disease recognized by the World Health Organization anymore.

These are -- these are ignorant. These are ignorant, and they are prejudiced. And it's important that we have come to a point, what Justice Kennedy called "evolving standards of decency," that we understand the harm we are doing to people by leaving them untreated.

Dr. Ettner said that in prison, we see the natural progression. Because it's only in prison at this point, because the rest of society knows that you treat this now. That's why there is a CMS decision ending a blanket ban. That's why this

is covered by insurance now. Because there are evolving standards and understanding of medical knowledge recognize this as a medical treatment for a medical condition. And that can't be disputed.

And this -- I think this ends up being a simple Eighth Amendment question. I think irreparable harm is clear. The medical necessity is clear. And it's a question of do we apply the same standard of care in the community and in prison; and the Eighth Amendment establishes that.

I think, in closing -- I know Your Honor knows this because she has been in court for three days, but defendants' expert Dr. Andrade described Ms. Edmo as a young, intelligent woman.

And defendants' arguments look at her as if she can't comprehend what she is asking for, even though she has lived as a woman for six years in a male prison.

She brought this case on her own, Your Honor. She brought this case pro se. She has been seeking surgery since 2014. This is the second case she has filed to seek it. Ms. Edmo is not confused about her gender identity. This is her real life.

Defendants and their experts talk about the sixth criterion, which used to be called "real-life experience." This is Ms. Edmo's real life. But defendants' experts have literally no real-life experience of their own treating this condition. They have no real-life experience with surgery.

And I think it's really important that their theoretical

disagreements with what is the established standard of care by people who have no experience with this not be allowed to cause a human being to continue what is very real, very acute suffering.

THE COURT: Thank you.

MS. RIFKIN: Thank you.

THE COURT: Counsel, do you wish to --

MR. HALL: Your Honor, to the extent there is time after Mr. Eaton gives his closing, I would like to say a few words.

THE COURT: All right. Very good.

MR. EATON: Your Honor, I would first also -- like Mr. Hall, I wanted to thank you for giving us the summer to conduct discovery and provide a more complete picture of all of this to the court and for the opportunity the last three days, and to close today. We will want to submit a short brief, as well, in closing.

You know, it's interesting. When I listened to plaintiff's counsel talk, I didn't hear a whole lot of facts. And what I heard was trying to put Dr. Levine's PowerPoints and slides on trial as a red herring.

And what I hear is saying: Look, there has been a lot of prejudice and lying and ignorance in the Department of Corrections previously, but then they -- in kind of talking out of both sides of her mouth, but then said she agreed that

we're -- all of our witnesses agreed that Ms. Edmo is not lying and trying to put that on trial.

What's on trial is the facts of this case, and I know that's what the court will look at.

At the outset, the court was very acute in recognizing two key issues: First, as you've mentioned, the standards for granting a permanent and mandatory injunction; and, second, whether, given Ms. Edmo's numerous mental health issues, SRS is appropriate.

Now, as to the second issue, the day-to-day treatment providers all speak with one voice: SRS is not appropriate at this time. It's never been barred entirely. They have been trying to work with her and provide appropriate care and treatment to the extent she will cooperate.

There are underlying mental health issues; there is no dispute. And there is no dispute she does have gender dysphoria, but she also has anxiety, she has major depressive disorder, she has depression, and all of that bubble that Mr. Hall put up at the beginning in his opening, all of those issues -- borderline personality disorder. Those are all still there. And if the court ordered sex reassignment surgery, those issues are still going to be there afterwards.

Now, this is a complex case and a complex issue. There is poor studies regarding outcomes of sex reassignment surgery. There is a lack of clarity as to the applicability of standards

and how to apply them in the correctional setting.

THE COURT: Wasn't the -- I couldn't quite pull up the exhibit number, but is it NCCS -- I don't recall --

MR. EATON: NCCHC I believe.

THE COURT: Yeah, NCCHC. That criteria adopted the WPATH standards and two pages -- I want to say 73 and 74 -- of the WPATH standards seems to clearly say you don't consider housing arrangements, including institutionalization, in applying these standards.

Doesn't that provide some clarity?

MR. EATON: Well, I believe that that was the recommendation, first of all. I don't believe that was an official adoption. And I would want the court to look at that. That's in evidence.

THE COURT: I can do that. I just glanced at it when it was on the screen.

MR. EATON: And it was a position -- I believe a position statement, so a recommendation, not an official adoption by the NCCHC.

And in any event, the reference to the WPATH still allows for flexibility, and it doesn't provide a lot of helpful guidance on medical necessity. It doesn't provide a lot of helpful guidance on, for instance, how to apply criteria 6 of the sex reassignment surgery criteria as to --

THE COURT: What was No. 6?

MR. EATON: -- living as a female -- living as a female for 12 months in a correctional setting. So there is -- I believe there is a lack of clarity.

But my point is that there is some of this lack of clarity. And because of that, this is, at a minimum, a doubtful case where I can't see how the court can grant a mandatory injunction that is a permanent, irreversible surgery.

And, you know, this is just such a case where it was appropriate for Dr. Eliason to exercise his clinical judgment in assessing Ms. Edmo.

And I know the court doesn't want to spend a lot of time on the facts, and I know you're aware of them. But what did Dr. Eliason do? He assessed her with gender identity disorder in 2012 to help her, and she said that helped her. And why? To help her get hormones, and she got hormones.

What did Dr. Eliason do? He then monitored and saw her periodically over many, many years to help monitor and treat the underlying mental health disorders -- giving her Zoloft, adjusting the medications, and trying to deal with those other issues.

And then the mental health providers provided appropriate hormone therapy to her, and she got results that she wanted and helped to decrease her dysphoria; such as developing breasts, the fat distribution, and those kind of things. She found that helpful, and that was because of what Dr. Eliason started.

And then when he assessed sex reassignment surgery, what did he do? He talked with her, he staffed it, he documented it. He made up -- he made objective observations. He did an assessment, noted that there was criteria indicated that WPATH was important, and that's why he said he staffed it with a WPATH clinician, and then made a determination.

And the determination was not an outright denial forever, but he indicated at that time hormone therapy was appropriate to continue, and should also continue with needed counseling.

And she continued to receive treatment and care for the underlying mental health issues. And the clinicians also have been working tirelessly with Ms. Edmo to try to help her. And, unfortunately, she hasn't cooperated with some of the recommendations that they think will help with her underlying mental health conditions.

And you've heard our experts say that those need to be resolved or at least much better well controlled before sex reassignment surgery should be on the table.

THE COURT: Well, Dr. Ettner and Dr. Gorton, who have been quite involved in the WPATH process, have said what that means is not that we -- that they need to be controlled where they can cooperate and follow up, that sort of thing. Now, there is some concern about that given Ms. Edmo's behavior while incarcerated.

But well controlled, I guess I'm struggling with how

that -- who is going to measure that? Does it mean something more than just simply controlled enough that we can make sure that she, in fact, cooperates with the surgery and the follow-up and whatnot?

Now, you may dispute that given the problems that she has had while incarcerated.

MR. EATON: Well, I think, in part, that's why there needs to be a lot of deference to the clinical judgment of the clinicians and the therapists and the medical providers in trying to help work through those things before SRS may be indicated at some other time.

Additionally, I think you do bring up a good point, which is when you talk about the WPATH, there is the criteria for an informed consent, and then there is a separate criteria for -- that the mental health conditions need to be well controlled.

And I think Your Honor picked up on it, but their experts and plaintiffs want to lump those together. And I think that's telling. They don't want to distinguish that you have to have well-controlled mental health issues. They want to say: Well, that's solely just so they can have informed consent, and they just want to make it about psychosis only.

And that's not what the WPATH says. It wants to have things in order so that there can be good coping mechanisms before and after surgery, and that there has been time spent in an appropriate community in the outside community before that

sex reassignment surgery is performed, so that after, they know what that experience is going to be like. As you heard the experts talk about, that's a clinical point.

I also wanted to mention that, you know, the Idaho Department of Corrections and Corizon don't have a blanket policy prohibiting SRS. And, in fact, witnesses from both sides testified that they allow all treatment options and even SRS if it's medically necessary.

And so a lot of the cases that are being cited by plaintiff's counsel are cases where there was a blanket prohibition against one of these treatment options, hormones or sex reassignment surgery. That's not this case.

As to the other issue that Your Honor picked up on, this is a mandatory injunction, and it's not to be taken lightly. And the Ninth Circuit, in *Garcia v. Google, Inc.*, summarized some of the case law in this regard.

> "This relief is treated as a mandatory injunction because it orders the responsible party to take action. As we have cautioned, a mandatory injunction goes well beyond simply maintaining the status quo and is particularly disfavored. The district court should deny such relief unless the facts and law clearly favor the moving party. In plain terms, mandatory injunction should not be issued in doubtful cases."

This is not a clear case by plaintiffs in any regard. And

we feel that defendants have defended this well and on the merits. And in any event, at a minimum, this is simply a doubtful case where a mandatory injunction should not be issued and granted.

It's an extraordinary step for a court to order a surgery. That's -- that's -- that's a big deal, and I know the court appreciates that.

And, you know, there is case law out there that suggests that asking the court to exercise medical and mental health decisions is not really the place of the court, and that's why there needs to be deference to the medical providers and what they have been -- what they are doing and their judgment.

Your Honor is very familiar and aware with the deliberate indifference standard, and this just simply is not a deliberate indifference case. There is no deliberate indifference, and there is no likelihood that they are going to prove that with what they have put on before the court today.

As Mr. Hall indicated in his opening, what this really boils down to is a difference of opinion by medical professionals about the treatment. And that is not deliberate indifference.

And as Your Honor recognizes, even negligence or gross negligence does not arise to a level of deliberate indifference.

You know, I -- the judge also -- the court also needs to decide -- I'm finding my note here. Excuse me.

The court also needs to decide that there is a substantial risk of serious harm. And I believe it was -- I think it was telling, among other things, that Dr. Gorton indicated, I believe, if I recall the testimony correctly, that it was absurd that this needed to be an emergent surgery.

And even their own experts were suggesting that, you know, it could be now or in six months or there is time. So there is nothing to suggest that there is anything emergent and urgent at this point.

And there are concerns about what would happen after her surgery. There is concerns as to suicide. There is concerns as to cutting continuing. Our experts have opined -- like Dr. Garvey opined that the suicidal rate would not be decreased after sex reassignment surgery.

THE COURT: Well, did she actually say that it would not be decreased, or she just said there is no information from which she can draw a conclusion on that?

MR. EATON: I thought that's what she said, but I agree that there has been a lot of discussion about how the -- it's difficult to tell, and the -- and the studies just are poor out there as to what will happen, which, again, makes this a case where it's a doubtful case, that mandatory judgment should not be issued.

THE COURT: Well, in terms of the likelihood of her -- Ms. Edmo resorting again to efforts at self-castration or

even suicide --

I apologize, Ms. Edmo, for talking about you. It's got to be a little bit discomforting to have people -- I guess that's what this whole trial is about or hearing is about.

But is it -- what significance should we draw from the fact that two efforts were made -- I think one in 2015 and one in 2016; I don't know the exact date when the pro se filing was made or when the case was picked up by defense counsel. Is it somewhat significant that after litigation was filed and there was going to be light at the end of the tunnel, that the efforts at self-castration stopped? Is that of any significance, or is there no connection between those dots?

MR. EATON: Well, I believe that the defendants' experts testified that the point is that -- with the self-castrations, there is still self-harming behavior, and there is also cutting behavior. And that's very dangerous and shows that there is not good coping mechanisms and that there likely may not be a good result after the surgery. And that's the concern.

THE COURT: So you are saying anyone who attempts self-castration is categorically excluded, then, because they don't qualify under that fourth element of the WPATH standards?

MR. EATON: No. I think they analyzed it for Ms. Edmo's case specifically. And there is lots of self-harming behavior, and that may be one factor. But she also had

self-harming behavior preincarceration, and that there was no mention of gender dysphoria or those type of comments in those preincarceration records. And now she is cutting herself again, and at least our experts indicated that that could be related to borderline personality disorder or other, you know, mental health issues as well.

So unless Your Honor has any other comments --

THE COURT: No, that's fine.

MR. EATON: -- we'll reserve the rest of our -- rest of our argument for briefing.

I would just close by saying that we do believe that the motion for preliminary injunction should be denied in all respects, and that there is no proof of likelihood of success on deliberate indifference. And there are concerns about harm after SRS, and Your Honor needs to take that into consideration when you hopefully deny it.

Thank you.

THE COURT: Thank you.

Mr. Hall.

MR. HALL: Is there any time remaining?

LAW CLERK: Nine and a half minutes.

THE COURT: I'll give you 10.

MR. HALL: Very generous, Your Honor.

I think I heard the words "ignorant" and "prejudiced." That's a first because usually only my wife calls me ignorant.

I think that I would like to end where I began, Your Honor, and just highlight that this case is about a difference in medical opinion made by professionals, and that is not deliberate indifference alone.

This is not a case where the defendants have denied or refused to recognize the WPATH, which we have referred to as standards. But the WPATH, admittedly, agrees that they are guidelines, that they are flexible guidelines to be provided and to provide recommendations to professionals who have to apply them on these highly complex mental health issues.

To say that or use the cancer analogy is not accurate here because, as we know, not everyone who has cancer is eligible, or is it appropriate for them to have chemotherapy.

The defendants, their experts, and plaintiff's experts disagree about the appropriateness of the guidelines, about the appropriateness of surgery at this time. And that is not deliberate indifference to have engaged in a thoughtful analysis.

And are they the experts on this evolving area of the world? That's -- that's debatable, plaintiff's as well. Plaintiff's experts come from one portion of this debate.

They have zero experience in correctional -- in the correctional world; yet, both Dr. Gorton and Dr. Ettner sit on a committee that appears to be prepared to dictate how they should be applied in a correctional institution.

And no one with the defendants has said that they should not be applied in a correctional institution. They are just saying: We need to apply that flexibility so that we can do the right thing and do no harm. And they disagree that Ms. Edmo actually meets all the criteria.

Your Honor, I fail to see how that is deliberate indifference to any medical need -- to recognize the treatment options, to provide treatment, but to decide that one potential treatment option, one appropriate treatment option is not appropriate at this time.

This case is, in essence, asking this court to step in, exercise its own judgment, and determine whether or not it's appropriate, whether she meets the criteria despite this dispute over whether or not it is appropriate at this time.

Plaintiffs want to advance an argument that there is only two experts in this world, two individuals in this world who could have done the right thing for Ms. Edmo, that they have the most experience; so, therefore, what they say is right.

Now, they never treated Ms. Edmo. They never had that patient-provider relationship. Defendants' employees, defendants' doctors, defendants' mental health clinicians, they did, and they have taken that seriously.

I think it would be a dangerous precedent to have the court step in whenever there is a debate as to whether or not a patient in a correctional institution meets the criteria for

some standards or guidelines which are ever evolving, whether it's in a cancer case or gender dysphoria case.

The Department and its employees need the discretion to be able to do their job, to apply the data that is out there, to apply their experience to the person that they know.

This is not a clear-cut, you know, broken tibia case where it's really not in dispute how you treat that. This is a highly complex mental health case. And it requires, even under the WPATH, that flexibility be provided and that, ultimately, those treating physicians or those treating providers be given the discretion to exercise their sound clinical judgment.

Thank you, Your Honor.

THE COURT: Thank you.

Counsel, Mr. Severson reminded me that I think we actually did set out a briefing schedule. If our trial next week goes off and Ms. Hohenleitner can get the brief *[sic]* as we discussed, then we will just keep those deadlines. If there is a delay -- and I'm not putting any pressure on her because we're going into a trial the next week, as well, and I have got a pretty full docket apart from the trial next week anyway.

So if -- I guess the same number of days it takes her beyond that one week to prepare the transcript is the number of days we'll move back on the briefing schedule, just so we don't have to issue any new orders.

If you want to reach agreement on something different from

that, you can, but that's going to be the presumptive briefing schedule unless you reach an agreement otherwise.

And I would, I guess, suggest that you submit your posttrial briefs along with the proposed findings and conclusions, the same schedule.

Is there anything else we need to take up at this point?

MS. RIFKIN: No, Your Honor. But we do very much appreciate the efforts of the courtroom staff and know that that's a lot of pressure. Thank you.

THE COURT: Yeah. I have got the world's greatest staff; I know that for sure. They make me look a lot better than I deserve to look.

Anything else from the defendants?

MR. HALL: No, Your Honor. Thank you.

MR. EATON: No, Your Honor. Thank you.

THE COURT: We will -- now, the only thing I would add is we're very much going to put this on the front of our list of things that need to be done. And so we will try to work very hard to get a decision out very quickly once all the briefing and proposed findings and conclusions have been submitted.

I don't intend to let this sit. I would hope within a week or two, maybe, after it's submitted, we will try to have something out. But things happen that may make that a little difficult, but that will certainly be our objective.

All right. We will be in recess.

(Proceedings concluded at 3:52 p.m.)

CERTIFICATE OF OFFICIAL REPORTER

I, Tamara Hohenleitner, Federal Official Realtime Court Reporter, in and for the United States District Court for the District of Idaho, do hereby certify that pursuant to Section 753, Title 28, United States Code, that the foregoing is a true and correct transcript of the stenographically reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

Dated this 19th day of October, 2018.

/S/ TAMARA I. HOHENLEITNER

TAMARA I. HOHENLEITNER, CSR NO. 619, CRR
FEDERAL OFFICIAL COURT REPORTER

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Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

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Dated: March 6, 2019

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62	06/01/18	Plaintiff's Notice of Motion and Motion for Preliminary Injunction and Memorandum of Points and Authorities in Support Thereof (Excerpted)	ER 3505 to ER 3508
62-1	06/01/18	Declaration of Lori Rifkin and Exhibits	ER 3509 to

		in Support of Plaintiff's Motion for Preliminary Injunction	ER 3608
62-2	06/01/18	Declaration of Adree Edmo in Support of Plaintiff's Motion for Preliminary Injunction	ER 3609 to ER 3619
59	04/04/18	Minute Entry regarding hearing on Defendants' First Motion for Dispositive Relief	ER 3620 to ER 3622
39	11/01/17	IDOC Defendants' First Motion for Dispositive Relief	ER 3623 to ER 3628
37	09/22/17	Joint Motion and Stipulation Re: Defendants' Answers/Responsive Pleadings	ER 3629 to ER 3633

VOLUME 17
(ER 3634-ER 3885)

36	09/01/17	Second Amended Complaint	ER 3634 to ER 3696
30	06/23/17	Order	ER 3697 to ER 3699
29	06/22/17	Joint Motion and Stipulation to Vacate and Reset Deadlines	ER 3700 to ER 3704
27	06/19/17	Entry of Appearance of Deborah A. Ferguson as counsel of record for Plaintiff Adree Edmo	ER 3705 to ER 3708
26	06/19/17	Entry of Appearance of Craig H. Durham as counsel of record for Plaintiff Adree Edmo	ER 3709 to ER 3710
25	06/08/17	Amended Complaint and Jury Trial	ER 3711 to

		Demanded	ER 3755
24	06/08/17	Order Granting Motion to Amend and Order of Reassignment	ER 3756 to ER 3760
23	06/07/17	Defendants Kevin Kempf, Richard Craig, Rona Siegert and Howard Keith Yordy's Non-Opposition to Plaintiff's Motion for Leave to Amend	ER 3761 to ER 3765
22	06/07/17	Defendants Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery's Non-Opposition to Plaintiff's Motion for Leave to Amend	ER 3766 to ER 3770
20	05/17/17	Motion for Leave to Amend (Excerpted – pgs. 1-6 only)	ER 3771 to ER 3776
12	04/14/17	Initial Review Order	ER 3777 to ER 3803
10	04/13/17	Memorandum of Law in Support of Motion for TRO and Preliminary Injunction	ER 3804 to ER 3812
7-0	04/06/17	Plaintiff's Motion for Temporary Restraining Order and Preliminary Injunction Order	ER 3813 to ER 3814
7-1	04/06/17	Plaintiff's Affidavit in Support of Motion for Temporary Restraining Order and Preliminary Injunction	ER 3815 to ER 3819
7-2	04/16/17	Plaintiff's [Proposed] Order to Show Cause and Temporary Restraining Order	ER 3820 to ER 3822
3	04/06/17	Civil Rights Complaint and Jury Trial Demanded	ER 3823 to ER 3864

n/a	01/09/19	Trial Court Docket as of February 25, 2019	ER 3865 to ER 3885

VOLUME 18
CONFIDENTIAL
(ER 3886-ER 3893)

119-3	10/05/18	Declaration of Joseph M. Pastor, M.D., CCHP in Support of Motion to Seal and Exhibit A – Corizon Clinical Pathway	ER 3886 to ER 3893

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V

Gender Dysphoria: A Comprehensive Approach to Treatment and Policy Management

Mark C. Fleming, Ph.D., CCHP-MH
Vice President of Operations-Nashville, Tennessee

Scott Eliason, MD, CCHP-MH
Regional Director of Psychiatry-Boise, Idaho

Mariann Atwell, Psy.D., CCHP
Senior Vice President of Behavioral Health Operations-Brentwood, Tennessee

Laura Mckinnon, MA, CCHP-MH
Mental Health Director-Rawlins, Wyoming

Jessica Lee, MSN, CCHP
Vice President of IT Customer Solutions Integration-Brentwood, Tennessee

Faculty Disclosure

"We have the following relevant financial relationship(s) with a commercial interest:" and explain….

All Presenters currently work for Corizon Health.

Educational Objectives

- Participants will learn the most up to date approaches to treating patients with gender dysphoria utilizing national standards as a guideline for treatment planning.

- Participants will learn how to create a gender dysphoria policy for a correctional environment.

- Participants will learn how to address specific issues when treating this population from six major areas including behavioral health, psychiatry, nursing, prison and jail administration and PREA

INTRODUCTIONS

Dr. Mark Fleming—
Moderator and Introduction
to Gender Dysphoria

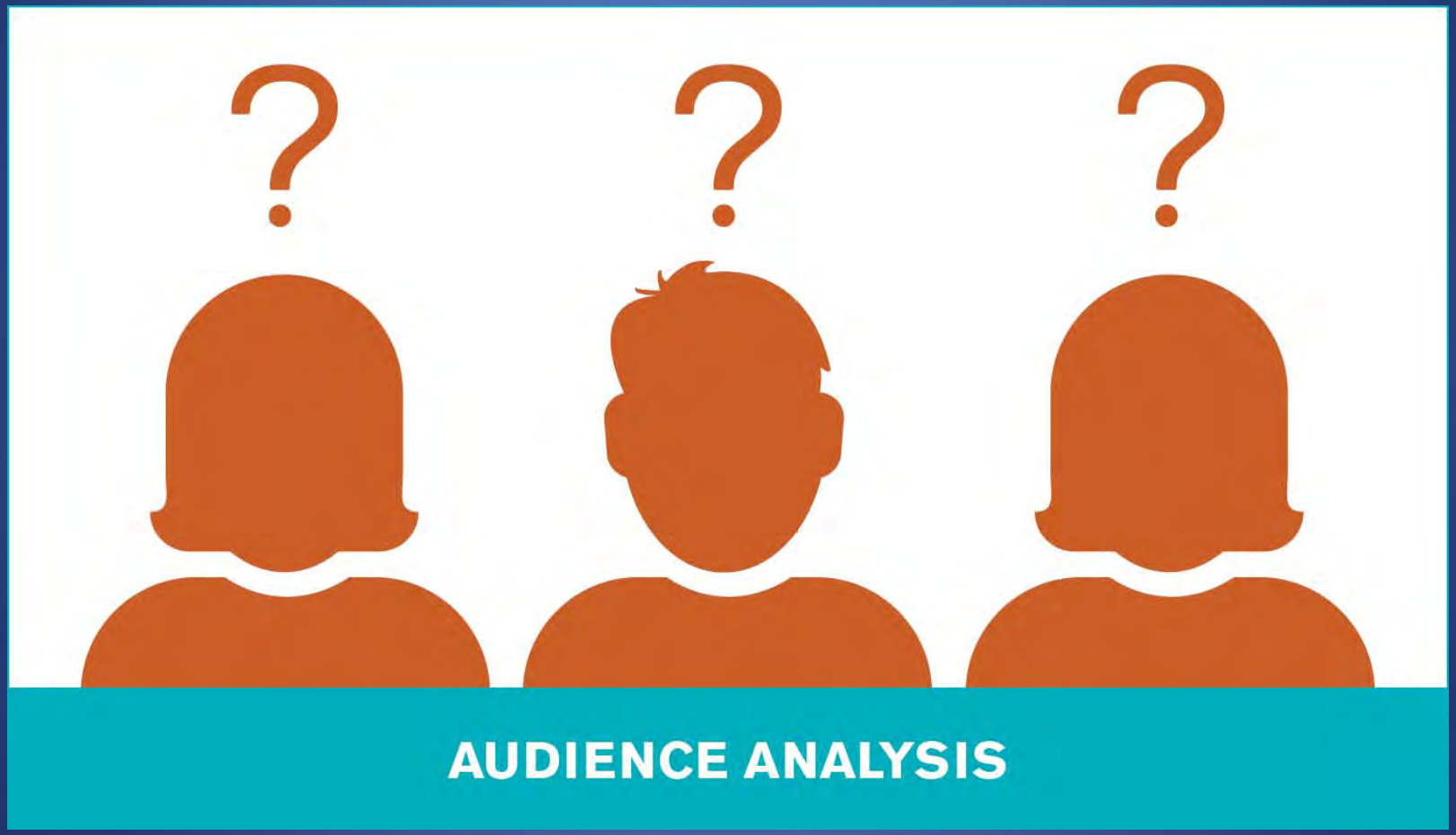
Dr. Scott Eliason-Behavioral
Health and Gender Dysphoria

Jessica Lee-Nursing

Dr. Mariann Atwell—
Administration

Laura Mckinnon--PREA

WHO IS IN THE AUDIENCE?



ER 438

JT Ex. 20-5

PBL 0403

PRESENTATION FORMAT

ER 439

JT Ex. 20-6

PBL 0404

SCHEDULE

1:30-1:45 PM—Introductions

1:45-2:15 PM—Introduction to Gender Dysphoria

2:15-2:45 PM—Gender Dysphoria: A Psychiatric Perspective

2:45-3:15 PM—Nursing

3:15-3:30 PM—Break

3:30-4:00—Administration

4:00-4:30 PM—PREA

4:30-5:00PM—Discussion

ER 440

JT Ex. 20-7

PBL 0405

Managing Gender Dysphoria From A Behavioral Health Perspective

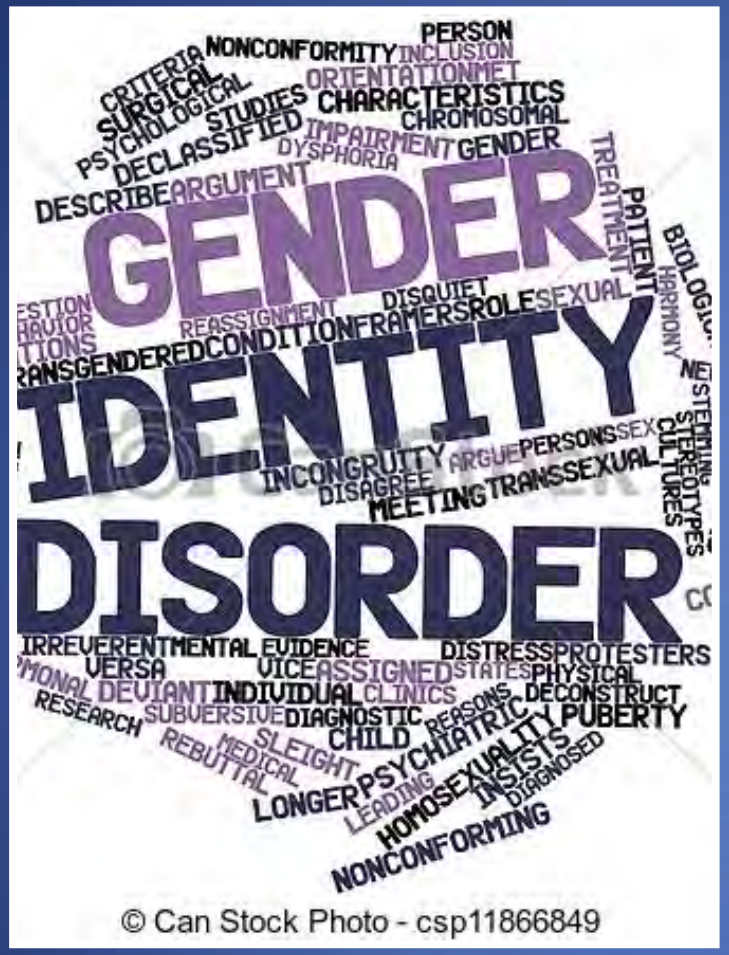
Important Areas For Consideration

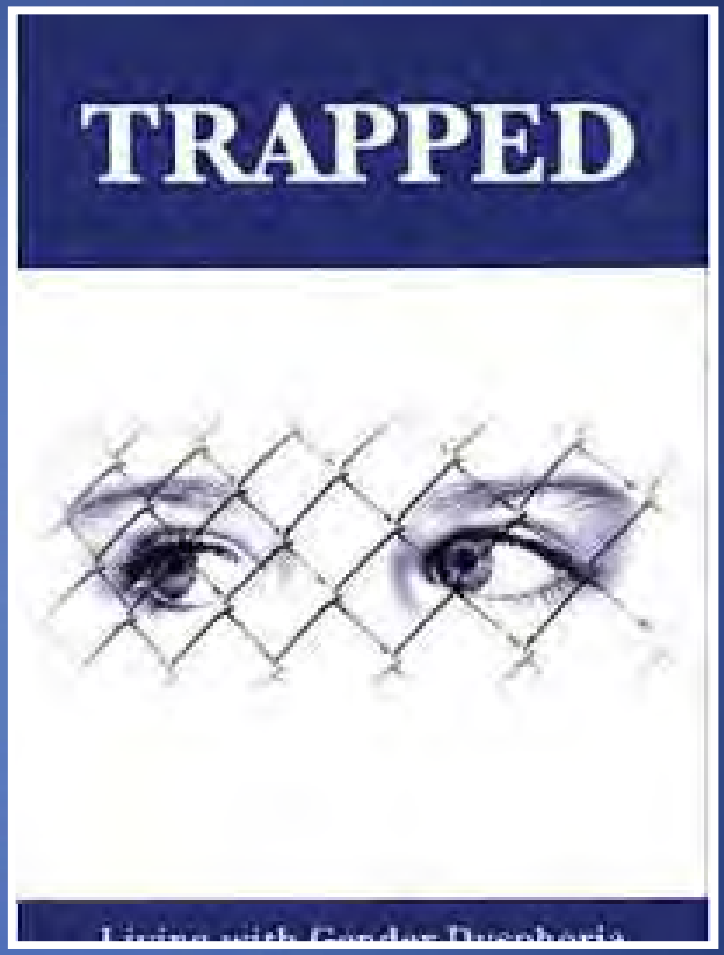
WHAT IS GENDER DYSPHORIA?

- Gender Dysphoria refers to the unhappiness that some people feel with their physical sex and/or gender role.
- There is a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months.
- In children, the desire to be of the other gender must be present and verbalized.
- The condition causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender Dysphoria Statistics

- It affects more males than females (On average, men are diagnosed with gender dysphoria five times more often than women) and it is estimated that 1in 11,000 people have the condition.
- The role of hormones is used to alter their physical features of the person i.e. give them a more masculine or feminine appearance with the ultimate remedy being gender re-assignment surgery.





GENDER IDENTITY DISORDER

DSM-IV

GENDER DYSPHORIA

DSM 5

ER 444

JT Ex. 20-11

PBL 0409

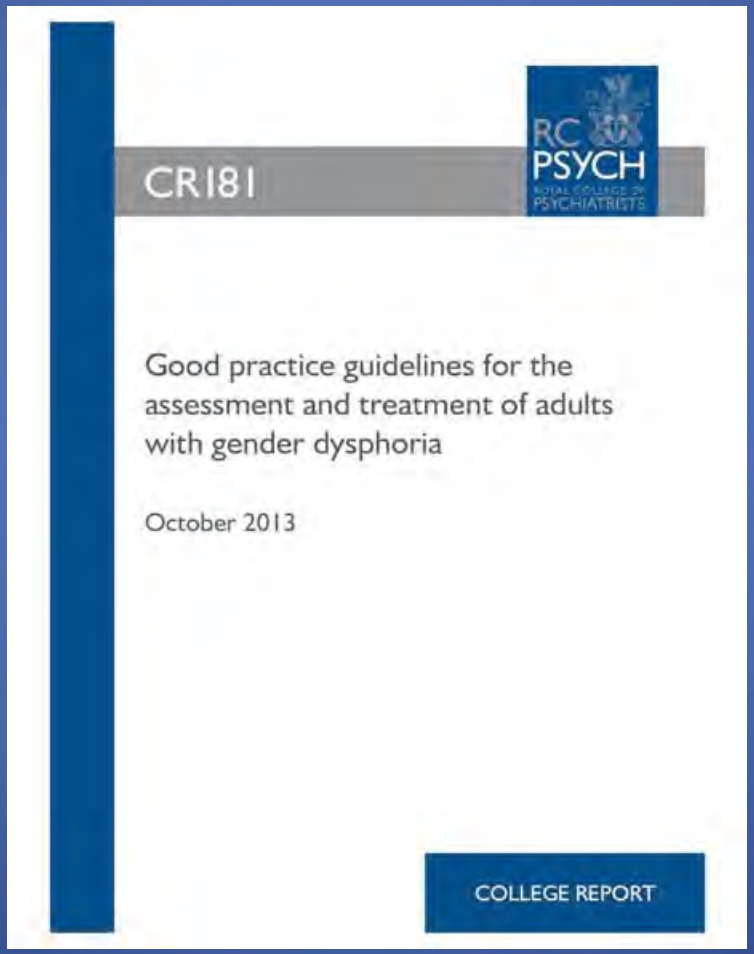
Similarities and Differences Between GID and Gender Dysphoria

- Both GID and Gender Dysphoria describe a condition in which someone is intensely uncomfortable with their biological gender and strongly identifies with, and wants to be, the opposite gender.
- GID focused on the "identity" issue-namely the incongruity between someone's birth gender and the gender with which he or she identifies.
- While this incongruity is still crucial to Gender Dysphoria, the DSM 5 emphasizes the importance of distress about the incongruity for the diagnosis of Gender Dysphoria.
- Gender Dysphoria removes the notion that the person needs to be fixed or cured and indicates the issues that need to be addressed that lie outside the individual.

Similarities and Differences Between GID and Gender Dysphoria cont…

- The DSM 5 uses the term gender rather than sex to allow for those born with both male and female genitalia to have the condition
- The shift to Gender Dysphoria reflects recognition that the disagreement between birth gender and identity may not necessarily be pathological if it does not cause the individual distress.
- As a result, those who identify with a gender different than the one they were assigned at birth and are not distressed by their cross-gender identification should NOT be diagnosed with Gender Dysphoria.

Treating Gender Dysphoria



ER 447

JT Ex. 20-14

PBL 0412

General Treatment Guidelines

- Gender treatment should have a multi-disciplinary base, and may include a number of medical and allied health professionals.
- Patients must be offered a choice of clinically appropriate treatments.
- People with Gender Dysphoria should have access to high-quality services without undue and unnecessarily long waits.
- People with Gender Dysphoria have a right to counseling and psychotherapy as part of their overall package of care.

General Treatment Guidelines

- Treatment must be patient-centered and should recognize the individual's preferences, needs and circumstances.
- Treatment must not be prescriptive, and patients should be given a substantial role in determining which treatments are appropriate for them, and at what stage during the pathway of transition.
- The transfer of care of patients from adolescent to adulthood services should be managed so that treatments that have been initiated for adolescents continue without interruption.
- More research in the field should be encouraged, and funding should be set aside to offer specific grants looking at patient outcome and satisfaction with interventions and transition.

Wpath Recommendations for Treatment

- Changes in gender expression and role (which may involve living part time or fulltime 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.

Gender Dysphoria in Prisons

Recommendations

- Educate staff on appropriately identifying and recognizing differences in definitions (gender, transgender, identity, orientation).
- Designation of housing should address the "the inmate's health and safety, and whether the placement would present management or security problems" (BOP).
- Training for staff on Gender Dysphoria and how to address individuals who have Gender Dysphoria.
- Have specific guidelines on what items are allowed for someone with Gender Dysphoria so that these items are not inappropriately taken away during a cell search.

Recommendations cont…

- To the extent possible and consistent with security and safety concerns, inmates with Gender Dysphoria should be allowed to dress as the identified gender even if they are not housed with inmates of the identified gender.
- Inmates with Gender Dysphoria should be identified by qualified professionals including inmates who assert they have Gender Dysphoria.
- A treatment plan should be developed for those identified with Gender Dysphoria which promotes the physical and mental stability of the patient.

Recommendations cont…

- If an inmate is on hormone therapy, the patient should continue on these as prescribed.
- If an inmate requests hormone treatment but has never used hormones prior to their incarceration, the MDST should review the request.

Gender Dysphoria: A Psychiatric Perspective

Gender Dysphoria and Psychiatry

- Risk of Suicide
- Co-morbid/Confounding diagnosis
- Further considerations
- Requesting SRS

Suicide Attempts

- General Population 4.6%
- LGB population- 20 %
- Transgender population- 41%
- Incarcerated Population- 3X GP
- Post Op Transgender Population- 19X GP

Co-Morbid/Confounders

- Psychosis
- Depression
- Trauma
- Autism
- Body Dysmorphic
- Suicidal ideation/attempts
- Substance Abuse

Paraphilias
Self-mutilation
Anorexia and Bulimia
Personality Disorders

Important Considerations - Dr. Steven Levine

1. Vocational and scholastic history
2. Complete criminal history including sex offenses
3. Quality of early life attachments within the family history
4. When did the current gender crystallization occur?
5. What experience and emotional state preceded it?
6. What is person's concept of its motivation?
7. What previous identities have been important?
8. Does inmate want to live among women in prison or stay among men? Why?
9. What worries does the person have about this new form of being? Do not accept "none."
10. What is the quality of thinking from magical to realistic?

SRS and Suicidal Threats -Dr. Steven Levine

- Individuals with Gender Dysphoria are well known to have suicidal ideation and to suicide before hormones, during hormonal treatment and after SRS
  - Suicide rate after SRS is far greater than the general population
  - Suicide rate is comparable with VA patients with chronic mental disorders
- SRS is not conceived as lifesaving as is repairing a potentially leaking aortic aneurysm but as life enhancing as is providing augmentation for women distressed about their small breasts.
- When inmates declare they will suicide without SRS, their desperation and manipulation are separately addressed.
- When experts declare a prisoner is likely to suicide without SRS, they overlook their profession's poor track record at prediction and what else can be done to deal with their depression.

More SRS -Dr. Steven Levine

- Disappointment, despair, depression and suicidal ideation* are likely to follow the rejection of a request for SRS as an inmate comes to grips with the obstacles fulfilling this desire
- Some have argued that SRS will prevent genital self-mutilation. Mutilation is far more often considered than attempted, and more often attempted than completed
  - It often is a response to the inmate's sense that her identity is being ignored
  - As a result of increasing experience with trans inmates, such desperation is less frequently ignored
  - Inmates considering this act often say that they will begin the process in the hope that the doctors will finish it.
    - Corrections staff cannot provide SRS under these conditions.

Managing Gender Dysphoria From A Nursing Perspective

Important Areas For Consideration

"Nurses have been described as the backbone of correctional health care. Yet the complex challenges of caring for this disenfranchised population are many"- L. Schoenly

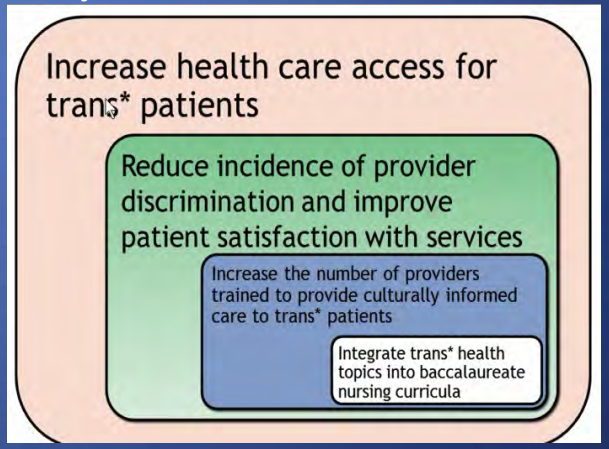
Nursing is your gatekeeper…even if you may not want them to be.

- Nursing Role in a Collaborative Healthcare Team
  - Facilitate communications within the clinical team
  - Support patients to be assertive with questions and needs.
  - Provide understanding of impact of health interventions ordered (and not ordered) for them (side effects, medication compliance and changes in condition).
  - Provide nuanced understanding of impact from the patient perspective for other members of the clinical team.
  - Support treatment adherence and know when treatment is not working; communicate to team members to make any necessary information that may be needed to consider making adjustments.

  Overall support for the patient to navigate the course of the healthcare system

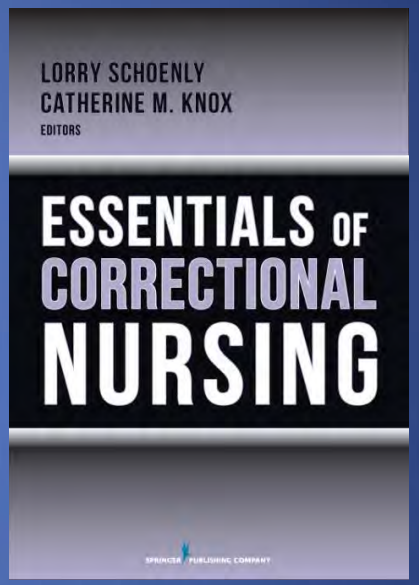
Nurses Do Not Graduate Prepared for to Discuss These Topics

- Provider education/bias (Lurie, 2005, Poteat, 2013, Sanchez, 2006, Schilder, 2001)
- Limited Access to Trained Providers (Obedin-Maliver et. Al., 2011, Solursh et al., 2003)
- Baccalaurette nursing programs dedicate a median of 2.12 total hours to LGBT – related content
- Mistreatment & Future Avoidance (Reisner et. al 2015)
- Nursing Transhealth Johns Hopkins Study



“Tell us what we need to know”- Nursing Staff Everywhere

- Patient Experience/Challenges
  - Pronouns, clothes, names
- Nurses Role
  - System Policy
  - Treatment/Therapies offered in Facility
  - Patient Education
  - Environment/Climate
  - Housing/Shower Bathrooms
- Vignettes
  - Give Permission to Be Polite- “I’d like to interact with you respectfully. What pronoun would you like me to use? What name would you like me to use?”
- Ethic Responsibility
- Manager/Supervisory Duties



ER 466

JT Ex. 20-33

PBL 0431

SCENARIO TIME!

ER 467

JT Ex. 20-34

PBL 0432

Consider This…

There is a new patient who is knows to identify as transgendered at door of the medical area. You overhear the patient be called the wrong name and pronoun by the officer. The other inmates that were in earshot are now laughing.

When you call the patient in for their visit, they walk up to you in tears and say they would like to refuse to be seen today..

Consider This…

You are in sick call and call your next patient. When she enters the cubicle, she tells you that she never told anyone this before today but in the community she is transitioning from female to male and just and would like to discuss her medical transition.

She asked the nurse who was at sick call yesterday and that nurse told her to put in a mental health sick call slip.

Remember the Previous Patient At Sick Call?

- The sick call nurse did the right thing and had the patient see the medical provider. In that encounter the medical provider told the patient that they would be denied hormone therapy.
- As the patient was walking out the physician's assistant hears them say, "Fine, if they do not help me, I will just do it myself".

ER 470

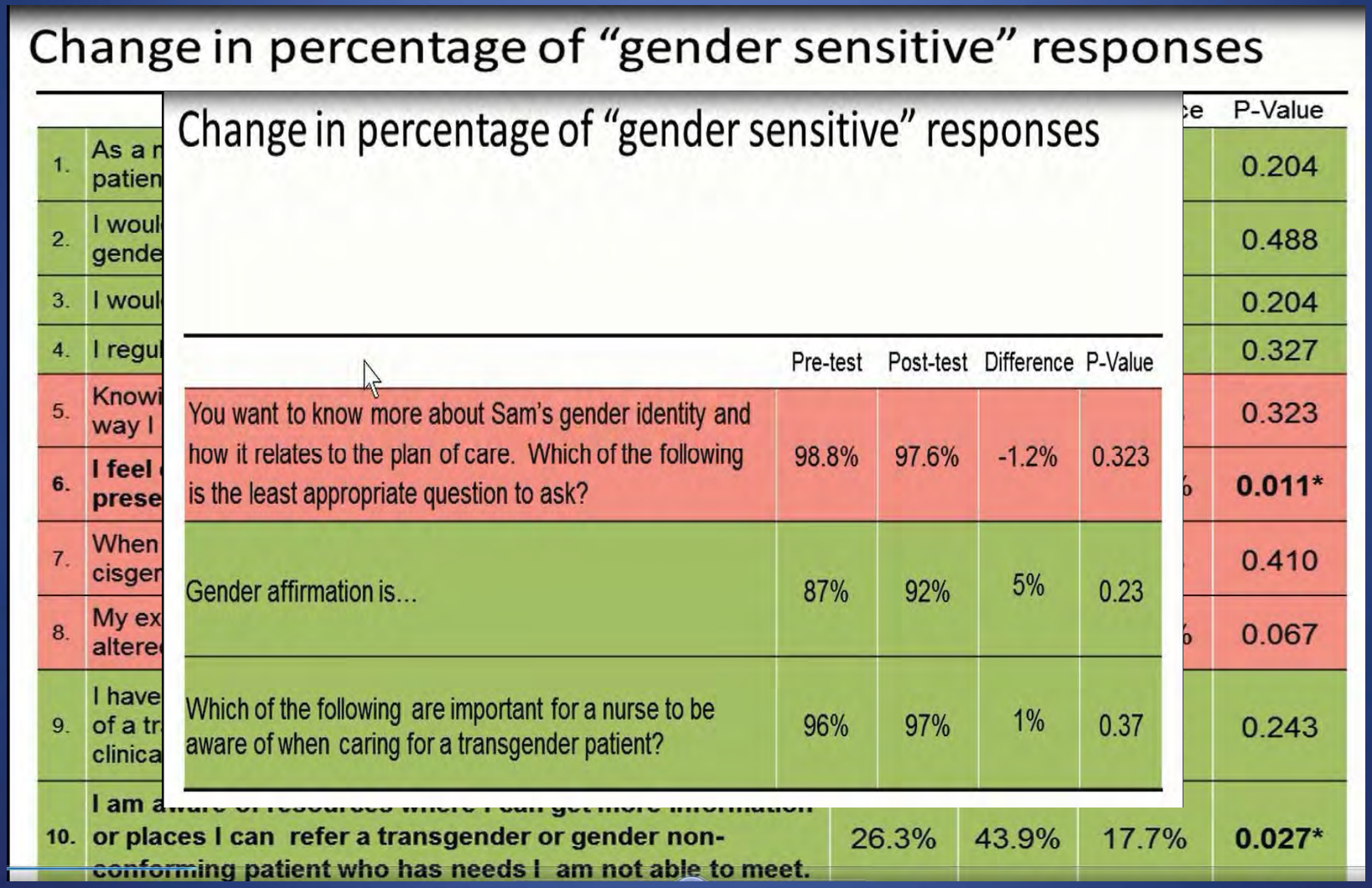
Consider This…

You are orienting a new nurse completing an intake. During the intake and assessment for a transgendered female to male patient, it is discovered that the patient has been incarcerated during their transition and has an intact uterus.

Transgender Curriculum Integration Project

- Used a student faculty partnership to develop and integrate content into the existing baccalaureate program at the Johns Hopkins University School of Nursing
- Aims to increase knowledge of trans health issues and confidence in ability to provide care to trans* patients
- 9/2014-Survey administration- data collected and analyzed at aggregate level.
- Survey finalized in 12/2015
- Positive results indicated that knowledge or beliefs became more “gender sensitive”
- Negative results indicate response became less “gender sensitive”

Training Does Work!



Consider These Specific Training Topics When You Develop Your Training

- Intake Procedures
- Medical Clinic Procedures
- Medication Procedures
- Follow Up Procedures After Denial of Therapy
- Evaluating Procedures for Unsafe Behavior
- Procedures for Reporting Unsafe Behavior
- Confidentiality
- Chronic Care Procedures
- Wellness Programs for ***Intact*** Gender Specific Genitalia
- Holistic Care
- Available Items on Commissary
- **Update demographic forms and electronic health records to recognize transgender identities.**
- **Educate all staff members on appropriate communication with transgender patients**

PLEASE RETURN BY 3:30 PM

Managing Gender Dysphoria From An Administration Perspective

Important Areas For Consideration

A GLOBAL APPROACH WILL CONTRIBUTE TO SUCCESSFUL OUTCOMES

ER 477

JT Ex. 20-44

PBL 0442

Department or Agency Viewpoint

- What is the stance of the overall Department or Agency?
  - What does the current literature suggest?
  - Past management practices verses future management practices
- Important to review current case laws surrounding the management and treatment of individuals with Gender Dysphoria
  - Specific to the environments one is working in

- It is necessary for Executive Level Leadership to become educated on how to appropriately manage the environments in which offenders reside.
  - Who do we treat?
  - How do we treat?
  - How are we going to overall manage this population?
  - Whose job is this anyways?

Policy Reviews Are a Must

- Policy Reviews
  - Departmental
  - Divisional
  - Institutional
  - Facilities
- Review past perspective with current perspective.
  - Are enhancements needed?

ER 480

- Who should be included in the policy review process?
- A Transdisciplinary Approach should be utilized:
  - Department/Agency Leadership
  - Facility Administration
  - Custody and Case Management staff
  - Healthcare staff
  - Legal staff
  - Others….who would that be?

ITEMS IMPORTANT TO BE ADDRESSED IN POLICY

Items Worthy of Consideration

- Definitions
  - It is important to educate staff on the appropriate terminology
- Placement
  - Facility and Housing Assignments
    - Health and safety considerations
    - Completed surgical sexual reassignment therapy prior to incarceration
    - Self–inflicted genital mutilation
    - How often should placement considerations be reviewed?

ER 483

- Accommodations
  - What name should be used when addressing the offender?
  - Property and Clothing
    - What property will be allowed?
    - How will property be accessed?
  - How should offender be addressed?

ER 484

JT Ex. 20-51

PBL 0449

- Showering
- Make-up
- Pat Searches
  - Will staff be allowed to physically examine offenders for the purpose of determining the offenders genital status?
- Placement in Restrictive Housing
  - Hair removal –are razors allowed?

CONSIDERATION SHOULD BE GIVEN AS TO THE BENEFIT OF HAVING A "COMMITTEE"

ER 486

JT Ex. 20-53

PBL 0451

Items to be Considered When Developing a Committee

- What is the purpose of the Committee?
  - Reviews cases
    - Records
    - Treatment Plans
  - Approves treatment plans
  - Approves external referrals for assessment and treatment
  - Makes recommendations for treatment
  - What other purposes can you think of?

What Should The Name of Committee Be?

- Examples of Various Names Used:
  - Gender Identity Disorder, Management and Treatment Committee
  - Therapeutic Level of Care Committee
  - Gender Identity Disorder Clinical Supervision Group
  - Transgender Committee
  - Gender Identity Disorder Treatment Overview Committee
  - Gender Dysphoria Treatment Team
  - Gender Dysphoria Clinical Supervision Group

Committee Members… Who Might this Include…

- Might vary due to the systems in which individuals with Gender Dysphoria are being managed
- Department and Agency representation
- Local facility staff representation
- Healthcare staff representation
- Outside specialty healthcare consultant
- Others who you might think could be a benefit to include?

Other Committee Activities to Consider

- How often should the Committee convene?
- Are minutes taken at Committee meetings and if so where are the meeting minutes stored?
  - Who would have access to the meeting minutes?
- Is the Committee required to report to any one? If so, who is that and how often should the Committee report?
- Is the Committee involved in any activities connected to the offender grievance process?

CLOSING POINTS TO REMEMBER

The Time Has Come When….

- We must review how we are currently managing offender diagnosed with Gender Dysphoria.

- We can not operate in silos as we attempt to successfully manage this population. We will fail.

- Systems must lead from the top down as policy and procedures are reviewed and enhanced to ensure a consistent message is being given to staff and offenders.

- Policies and Procedures must flow in a manner that mirrors a “Continuum of Management” from intake through discharge.

- We must assess where in our systems training for staff is needed.
  - Department/ Agency Leadership staff
  - Administration staff
  - Custody staff
  - Classification and case manager staff
  - Healthcare Staff
- Identify what type of staff training is needed and how often training should occur.
  - Clinical
  - Operations

- We must develop the necessary processes and relationships within the community to ensure we have forged the way for successful reentry back into the community for individuals diagnosed with Gender Dysphoria.
  - Discharge medications
  - Discharge healthcare appointments
  - Release of healthcare records

for
ATTENDING

THANK YOU.....

DO YOU HAVE ANY QUESTIONS ?

ER 496

JT Ex. 20-63

PBL 0461

Managing Gender Dysphoria From A PREA Perspective

Important Areas For Consideration

What is

LGBTIQ?

LGBTIQ

- LESBIAN
- GAY
- BI-SEXUAL
- TRANSEXUAL
- INTERSEX
- GENDERQUEER

PREA—What you need to know

- Standards impacting this population.
- Prevention planning
- Training and Education
- Screening for risk of sexual victimization
- Placement

Standards Related to LGBTI

- 115.13 Supervision and Monitoring
- 115.15 Cross-gender Searches
- 115.31 Zero Tolerance for Sexual Abuse and Harassment and Employee Training
- 115.41 Screening
- 115.42 Use of Screening--Housing, job assignments, education, etc.
- 115.86 Sexual Abuse Incident Reviews

§ 115.13
Supervision and Monitoring

- Proper visual access
- Adequate number of staff
- Unannounced supervisory checks on nights and days to deter the occurrence and opportunity for staff sexual abuse and harassment—Make sure you document this is happening in pod log books.

ER 502

§ 115.15
Limits to Cross-Gender Viewing and Searches

- No cross-gender strip searches or visual body cavity searches except in extreme situations or by medical staff.
- Cross-gender searches shall not occur on a female facility and shall not restrict access to programming to do so.
- Any female cross-gender searches will be documented.
- Policies and Procedures will be implemented to allow for showers, change clothing, etc. without cross-gender observation.
- No transgender or intersex inmate will be searched to determine genital status. Interviews, medical records and medical exam will be used.
- Staff will be trained on proper searches of transgender and intersex inmates.

§ 115.31
Employee Training

- Zero tolerance for sexual abuse and harassment
- Staff responsibility to report and detect, etc.
- Inmate's right to be free from sexual abuse and harassment
- Right of inmates and employees to from retaliation for reporting sexual abuse and harassment.
- The dynamics of sexual abuse and harassment in confinement.
- Common reactions to sexual abuse and harassment
- Detection and response to signs of sexual abuse and harassment
- How to avoid inappropriate relationships with inmates
- Proper communication with inmates, including LGBTI inmates
- Complying with mandatory reporting laws
- Facility specific training
- One year time frame and 2 year refresher training
- Documentation of training

§ 115.41
Screening for risk of victimization and abusiveness

- Intake and transfer screening with an objective measure within 72 hours of arrival at the facility to determine risk of victimization or abusiveness
- Factors to consider:
  - History of mental, physical, or developmental disability
  - Age
  - Physical build
  - Previous incarcerations
  - Violent or not criminal history
  - Sex offenses against adult or child
  - Whether the inmate is or is perceived to be LGBTI
  - Previous sexual assault victim
  - Inmate's own perception of vulnerability
  - Housed solely for immigration purposes
- Determination is made on these factors within 30 days
- Re-evaluate as necessary
- Inmates may not be disciplined for refusal to answer
- This information may not be exploited and used to the detriment of the inmate

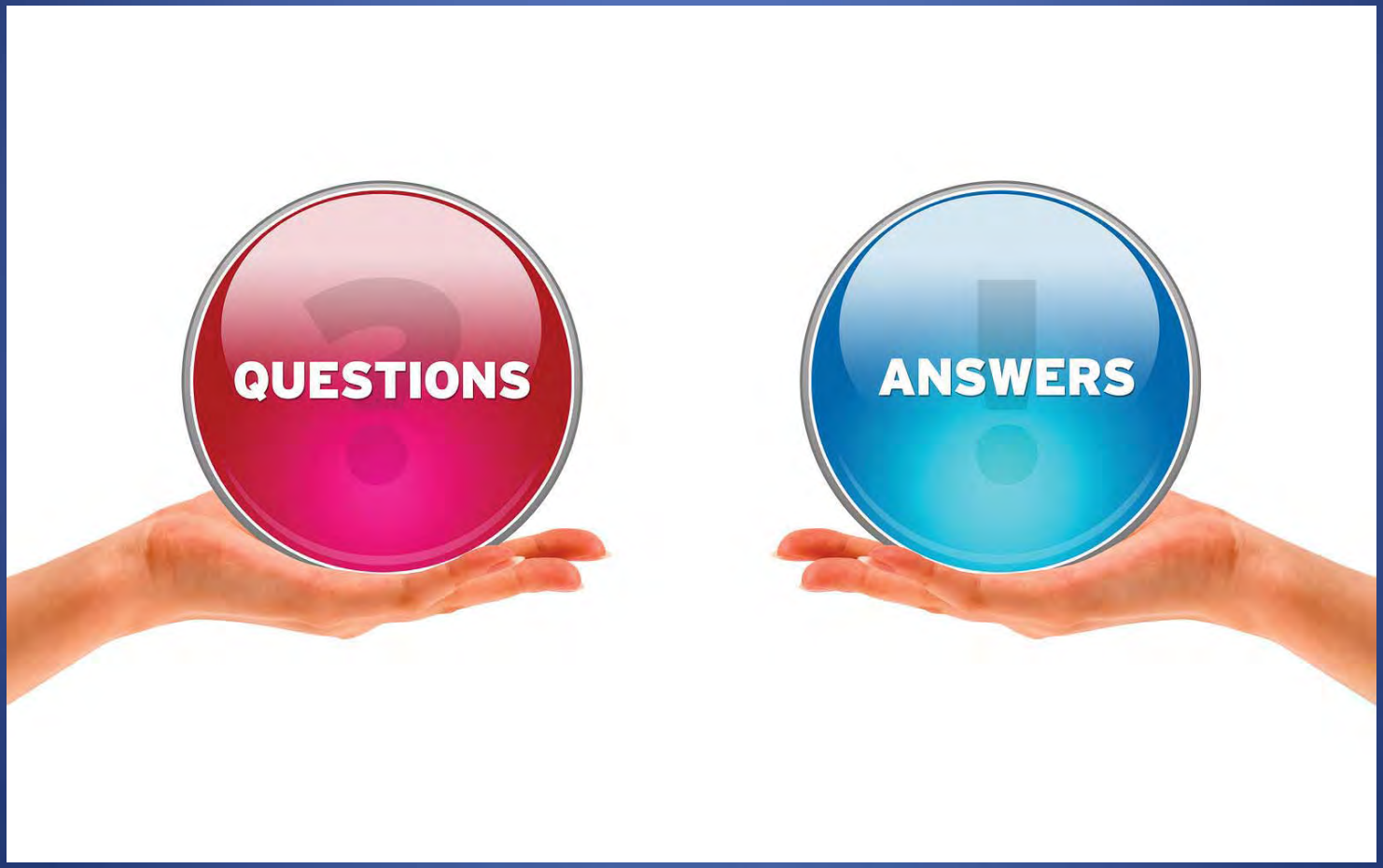
§115.42
Use of screening information

- Information is used to protect inmates in housing, work, education and programming
- Each inmate will have an individual plan
- Placement at male or female facility will be determined on an individual basis
- Housing and programming placement will be reviewed 2 times a year
- Transgender and intersex inmate's own views about safety will be given serious consideration
- Transgender and intersex inmates shall be given the opportunity to shower separately
- LGBTI inmates will not be housed in a dedicated facility, unit or wing unless it was established in a consent decree or other legal process.

§115.86
Sexual Abuse Incident Reviews

- An incident review is conducted at every investigation, even when the claim is not substantiated, unless unfounded.
- This occurs within 30 days of the concluded investigation.
- The team shall:
  - Consider need for change in policy
  - Consider motivation, i.e., race, gender identity, gang affiliation
  - Consider physical barriers that contributed
  - Consider Staffing levels
  - Consider any modern technology assists that could help prevent this in the future
  - Prepare a report of findings
  - Implement recommendations of report

PANEL DISCUSSION



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THANK YOU
for coming!

Transgender, Transsexual, and Gender Nonconforming Health Care in Correctional Settings

‹ Back to Position Statements

INTRODUCTION

Transgender people face an array of risks to their health and well-being during incarceration, and are often targets of physical assault and emotional abuse. They are commonly placed in correctional facilities according to their genitals and/or sex assigned at birth, regardless of their gender presentation. The health risks of overlooking the particular needs of transgender inmates are so severe that acknowledgment of the problem and policies that assure appropriate and responsible provision of health care are needed.

Sex refers to the biological and physiological characteristics that define males and females. *Gender* refers to the socially constructed roles, behavior, activities, and attributes that a given society considers appropriate for men and women. *Transgender* is an umbrella term used to describe people with gender identities and/or expressions not traditionally associated with the sex that they were assigned at birth. Transgender women are individuals whose birth sex was male but who understand themselves to be, and desire to live their lives as, women. Transgender men are individuals whose birth sex was female but who understand themselves to be, and desire to live their lives as, men. Transgender people may identify as men, women, neither, both, or another gender. They can be of any race, sexual orientation, age, religion, body type, socioeconomic background, or national origin. Transgender does not imply any specific form of sexual orientation; transgender persons display a range of sexual orientations similar to those who are not transgender. Individuals may identify their gender in different ways over the course of a lifetime.

Transsexual is an older term that originated in the medical and psychological communities. It is still preferred by some people who have permanently changed-or seek to change-their bodies through medical interventions (including but not limited to hormones and surgeries). Transsexual is not an umbrella term. It is best to ask which term an individual prefers. For the purposes of this statement, the term transgender includes those who identify as transsexual as well as gender nonconforming individuals.

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex. *Gender dysphoria* refers to discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Only some gender nonconforming people experience gender dysphoria at some point in their lives. Transgender individuals are at risk for mental health issues, such as gender dysphoria, depression, and anxiety, if gender expression is suppressed. These issues can be exacerbated when transgender individuals are in correctional environments.

The National Commission on Correctional Health Care publishes *Standards* for jails, prisons, and juvenile confinement facilities that address board-approved recommendations for an adequate health care delivery system, including issues such as patient confidentiality, discharge planning, health professional qualifications, medication availability and delivery, and staff training. Position statements are intended to provide information on the management of specific problems not addressed in the *Standards*.

POSITION STATEMENT

Because jails, prisons, and juvenile confinement facilities have a responsibility to ensure the physical and mental health and well-being of inmates in their custody, correctional health staff should manage transgender patients in a manner that respects their biomedical and psychological needs. The National Commission on Correctional Health Care recommends that the following principles guide correctional health professionals in addressing the needs of transgender patients:

Health Management

1. All inmates, including those who are transgender, must be treated with fairness, dignity, and respect.

2. Medical screening should include inquiries about an individual's sexual activity, sexual orientation, and gender identity.

3. Confidential HIV and STD testing and care should be provided to all transgender patients.

4. Gynecological and obstetrical care should be provided when indicated.

5. The management of medical or surgical transgender care should follow accepted standards[1] developed by professionals with expertise in transgender health. Determination of treatment necessary for transgender patients should be on a case-by-case basis. Ideally, correctional health staff are trained in transgender health care. Alternatively, they should have access to other professionals with expertise in transgender health care to help determine appropriate management and provide training on gender-related care.

6. Because transgender patients may be under different stages of care prior to incarceration, there should be no blanket administrative or other policies that restrict specific medical treatments. Policies that make treatments available only to those who received them prior to incarceration or that limit transition and/or maintenance are inappropriate and out of step with medical standards and should be avoided.

7. Mental health evaluations that assess an array of mental health issues, including those related to sexual orientation and gender identity, should be provided.

8. Counseling should be provided to patients who are experiencing or have experienced sexual trauma.

9. Accepted treatments for gender dysphoria should be made available to people with gender dysphoria. Providing mental health care, while necessary, is not sufficient.

10. Medical staff should ensure that commissary items consistent with an individual's gender identity are available.

11. Psychotherapy such as "reparative" or "conversion" therapy or attempts to alter gender identity should never be employed.

12. Transgender patients who received hormone therapy with or without a prescription prior to incarceration should have that therapy continued without interruption pending evaluation by a specialist, absent urgent medical reasons to the contrary. Hormone therapy should not be discontinued precipitously as this will likely cause depression and anxiety.

13. Gender dysphoric patients who have not received hormone therapy prior to incarceration should be evaluated by a health care provider qualified in the area of gender-related health care to determine their treatment needs.

14. When determined to be medically necessary for a particular patient, hormone therapy should be initiated and regular laboratory monitoring should be conducted according to community medical standards.

15. Sex reassignment surgery should be considered on a case-by-case basis and provided when determined to be medically necessary for a patient.

16. Treatment for genital self-harm or for complications arising from self-treatment should be provided when medically necessary.

17. Medical housing should be provided as long as necessary postoperatively.

18. Transgender patients should have access to services that address self-acceptance, disclosure of sexual orientation or gender identity, family relationships, healthy intimate relationships, and sexual decision making.

19. Correctional health care providers should provide transgender patients with patient education materials on treatments and transitioning.

Patient Safety

20. Since transgender individuals are common targets for violence, health care staff should work with custody staff to ensure that appropriate safety measures are taken in matters of housing, recreation, and work assignments.

21. Vulnerable inmates should be placed in the least restrictive environment necessary to ensure safety. Isolation or segregation should not be exclusively relied on to ensure safety. Inmates cannot be placed in involuntary segregated housing unless (a) an assessment of all available alternatives is made and (b) it has been determined that no alternative means of separation is available (this determination must be made within the first 24 hours of involuntary segregation). Involuntary segregated housing should generally not exceed 30 days[2].

22. Medical staff should assess the safety of transgender patients. Staff must report all observed or self-reported incidents of harassment, discrimination, and abuse.

23. Correctional staff shall not search or physically examine a transgender inmate for the sole purpose of determining genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner[3].

Discharge Planning

24. Transgender inmates receiving hormone therapy should receive a sufficient supply upon release to last until a community provider assumes care. Referrals should be made to community-based organizations with sensitive and inclusive services for transgender people.

25. Correctional policies for management of transgender inmates should be developed and implemented in partnership with local transgender communities, particularly current and former inmates, and transgender service providers when possible.

Adopted by the National Commission on Correctional Health Care Board of Directors
October 18, 2009|
April 2015 — reaffirmed with revision

NOTES

1. *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7,* available from the World Professional Association for Transgender Health

2. Prison Rape Elimination Act, 28 C.F.R. § 115.43 (a)

3. Prison Rape Elimination Act, 28 C.F.R. § 115.15 (e)

ADDITIONAL RESOURCE

PREA Standards and Policy Development Guidelines for Lesbian, Gay, Bisexual, Transgender and Intersex Inmates

EXHIBIT A

LAWRENCE G. WASDEN
ATTORNEY GENERAL
STATE OF IDAHO

BRADY J. HALL (ISB No. 7873)
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MARISA S. CRECELIUS (ISB No. 8011)
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Moore Elia Kraft & Hall, LLP
Post Office Box 6756
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Telephone: (208) 336-6900
Facsimile: (208) 336-7031

Attorneys for Defendants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, vs. IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15; Defendants.	Case No. 1:17-cv-151-BLW **EXPERT REPORT AND DECLARATION OF JOEL T. ANDRADE, PH.D. LICSW CCHP-MH**

EXHIBIT A

I, Joel T. Andrade, Ph.D., LICSW, CCHP-MH, hereby declare and state as follows:

1. I am over the age of eighteen and am competent to testify to the matters herein. I have personal knowledge regarding the matters referenced in this report and reserve the right to supplement or amend it based on any additional, facts, testimony, documents, records, or information provided to me after the date of this report.

2. I have been retained by counsel for Defendants Idaho Department of Correction ("IDOC"), Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert (hereinafter collectively "IDOC Defendants"), in connection with the above-captioned litigation.

3. This report incorporates the opinions and conclusions contained in my Gender Dysphoria Clinical Assessment of Plaintiff Adree Edmo ("GD Assessment"), a true and correct copy of which is attached hereto as **Exhibit 1.**

4. I have received and considered the following documents and information:

a. Plaintiff's Expert Witness Disclosure

b. The Declarations and Expert Reports of Drs. Ettner and Gorton

c. IDOC Gender Dysphoria Policy, SOP 401.06.03.501

d. Presentence Investigation Reports regarding Ms. Edmo

e. Shoshone-Bannock Tribes Counseling and Family Services records

f. Fort Hall Indian Health Service records

g. Portneuf Medical Center records

h. Bannock County Jail medical records

i. Idaho Department of Corrections and Corizon medical and mental health records

j. Discussions with treatment staff including Lead Clinician Krina Stewart, LPC and Laura Watson, LCSW, CCHP-MH, Clinical Supervisor at ISCI

k. Clinical interview with Ms. Edmo lasting approximately 1 hour and 35 minutes

l. Discussion with Keith Yordy, Warden of Idaho State Correctional Institution (ISCI)

m. Documents produced by the IDOC Defendants to Plaintiff's discovery requests

n. Publications, articles, and texts identified in the document attached hereto as **Exhibit 2**.

5. In preparing the GD Assessment, I also relied upon my knowledge and experience as a mental health clinician, director of clinical operations, manager and director of clinical programs, clinical operations specialist, director of assessment, and clinical social worker in the correctional setting, including providing care and supervising the care provided to prisoners who have been diagnosed with Gender Dysphoria.

6. My qualifications, along with the publications that I have authored over the last ten years are attached hereto as **Exhibit 3**.

7. I am being compensated at an hourly rate of $250.00 for expert work on this matter, including court and deposition testimony, report writing, reviewing records, and telephone contacts. I am being compensated at a rate of $125.00 per hour for travel time not actively spent working on the case. I will also be compensated for my related travel expenses and other reasonable expenses incurred. My compensation does not depend upon the outcome of this litigation, my opinions or conclusions, or the content of the testimony I provide.

EXHIBIT A

8. I have not testified as an expert at trial or deposition in the last four years.

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

DATED this 30th day of August, 2018.

Joel T. Andrade, Ph.D., LICSW, CCHP-MH

EXHIBIT 2

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EXHIBIT 3

Joel T. Andrade, Ph.D., LICSW, CCHP-MH

617.620.3664
joeltandrade@gmail.com

EDUCATION

Doctor of Philosophy in Social Work, Boston College Graduate School of Social Work, Chestnut Hill, MA, April 2009.

Dissertation Title: *Psychosocial Precursors of Psychopathy in a Psychiatric Sample: A Structural Equation Model Analysis.*

Dissertation Chair: Thomas O'Hare, Ph.D.

Master of Social Work, Boston College Graduate School of Social Work, Chestnut Hill, MA, May 1998, with a concentration in Forensic Social Work.

Bachelor of Arts in Psychology and Social & Rehabilitation Services, Assumption College, Worcester, MA, May 1996.

Licensure/Certifications

- Licensed Independent Clinical Social Worker—Massachusetts & Florida
  MA License Number—110161; FL License Number—SW13904
- Certified Correctional Healthcare Professional—Mental Health (CCHP-MH) by the National Commission on Correctional Health Care

FUNDED RESEARCH

R01 MH095230 (Principal Investigator: Jennifer Johnson, Brown University)
Role: Co-Principal Investigator 7/1/11 – 6/30/14
NIH/NIMH $360,587 (DC Yr1)
Effectiveness of Interpersonal Therapy for men and women prisoners with major depression

- To conduct the first fully-powered effectiveness study of major depressive disorder in an incarcerated population, along with cost and pilot implementation data.

Research Fellowship

9/2002-8/2003: Boston College Graduate School of Social Work/Cash & Counseling Program
Principal Investigator: Kevin Mahoney

- Worked as a member of a team conducting initial interviews regarding the Cash and Counseling program with health administrators in all 50 States.
- Worked as a member of a team to create a database to analyze data gathered from interviews.

EXHIBIT 3

Professional Experience

MHM Correctional Services, Inc.
Vienna, Virginia
Director of Clinical Operations—Mental Health
March 2015 to Present

- Provide clinical supervision to statewide mental health directors for MHM contracts nationwide.
- Develop treatment programs, staff training modules, and group psychoeducational curriculum for clinical staff.
- Develop policies and procedures related to clinical operations for MHM contracts.
- Monitor compliance of MHM contracts based on contract compliance indicators and national standards (NCCHC, ACA).
- Provide consultation and training for all MHM contracts in the areas of violence risk assessment and risk management; suicide risk assessment; clinical evaluation; forensic issues; sex offender issues; psychopathy; gender dysphoria, etc.
- Direct and oversee the treatment of all inmates diagnosed with gender dysphoria in the Massachusetts Department of Correction.
- Conduct statistical analysis for company-wide research projects.
- Provide behavior management consultation for behaviorally disturbed inmates.
- Provide clinical support during implementation phase of a contract and when needed thereafter.

MHM Correctional Services, Inc.
Norton, Massachusetts
Program Manager & Director of Clinical Programs
March 2010 to March 2015

- Direct and oversee statewide mental health services provided to the Massachusetts Department of Correction Prisons and medical and mental health services at Bridgewater State Hospital.
- Clinical and administrative oversight of over 350 clinical staff including social workers, psychiatrists, psychologists, nurse practitioners, nurses, and internists.
- Ensure compliance with accrediting bodies such as the American Correctional Association (ACA), the National Commission on Correctional Health Care (NCCHC), and the Joint Commission (TJC).
- Conduct clinical evaluations for complex cases.
- Develop behavior management plans as required for inmates or patients who engage in significant self-injurious and/or violent behavior.
- Supervise the criteria development and process management for all residential and special mental health programs throughout the Massachusetts Department of Correction.
- Implement and manage the Mental Health Classification designation process.
- Develop, approve and maintain policies and procedures specific to mental health services.

EXHIBIT 3

MHM Correctional Service, Inc.
Vienna, Virginia
Clinical Operations Specialist
August 2008 to March 2010

- Develop treatment programs, staff training modules, and group psychoeducational curriculum for all MHM contracts nationwide.
- Develop policies and procedures related to clinical operations for all MHM contracts nationwide.
- Provide clinical support for medical directors, CQI managers and psychologists.
- Provide consultation and training for all MHM contracts in the areas of violence risk assessment and risk management; suicide risk assessment; clinical evaluation; forensic issues; sex offender issues; psychopathy; etc.
- Conduct statistical analysis for company-wide research projects and present findings at conferences and meetings.
- Provide behavior management consultation for behaviorally disturbed inmates.

Bridgewater State Hospital
Bridgewater, MA
Clinical Risk Assessment Coordinator
September 2007-April 2009

- Conduct violence risk assessment evaluations, including the administration of risk assessment tools such as the HCR-20, and PCL-R or PCL:SV for high-risk patients being considered for transfer from Bridgewater State Hospital (maximum-security forensic hospital) to a less secure setting.

Bridgewater State Hospital
Bridgewater, MA
Admission Coordinator
July 2003-August 2008

- In 2003 standardized and wrote the admission criteria for patients being admitted to Bridgewater State Hospital from county and state correctional facilities.
- Provide clinical consultation to all State and County correctional facilities in the State of Massachusetts regarding inmates that may require inpatient hospitalization at Bridgewater State Hospital.

Bridgewater State Hospital
Bridgewater, MA
Director of the Intensive Treatment Unit
September 2002-August 2008

- Provide clinical and administrative oversight of the Intensive Treatment Unit at Bridgewater State Hospital.
- Conduct violent risk assessment evaluations and provide expert witness testimony in commitment hearings and dangerousness hearings throughout the Commonwealth of Massachusetts.
- Provide clinical administrative services for a group of patients on the Maximum-Security Admissions unit, which includes initial diagnostic assessments, treatment

EXHIBIT 3

planning, crisis intervention, violence risk assessments, suicide risk assessments, etc.
- Member of several hospital committees including: Seclusion and Restraint Task Force; Seclusion and Restraint Performance Improvement Team; Violence Reduction Performance Improvement Team; De-escalation Performance Improvement Team; Administrative Segregation Legislative Work Group; Forensic Training Committee; JCAHO Assessment Chapter Committee; and Self-Injurious Behavior Performance Improvement Team.
- Chair of the Law & Mental Health Training Committee (2003 to 2008).

Sexual Disorders Clinic—Community Health Link
Worcester, MA
Director of Assessment
January 2004-October 2007
- In conjunction with the clinical director, developed a laboratory for physiological and psychological assessment. Evaluations included penile plethysmography, psychopathy assessments, and other clinical evaluations.
- Research topics include: Comorbid Mental Illness, Psychopathy Among Sex Offenders, and Violence Risk Assessment among Sex Offenders.

New England Forensic Associates (NEFA)
Arlington, MA
Laboratory Consultant
July 2005-September 2006
- Oversee physiological and psychological assessments conducted in the laboratory. These include the following: Penile Plethysmograph, Abel Assessment for Sexual Interest, and Millon Clinical Multiaxial Inventory—III.
- NEFA is an outpatient treatment and assessment clinic for individuals with sexually related disorders.

Bridgewater State Hospital—Correctional Medical Services
Bridgewater, MA
Forensic Clinical Social Worker
April 1999-October 2002
- Conduct violent risk assessment evaluations and provide expert witness testimony in civil commitment hearings and forensic recommitment hearings.
- Clinical administration, initial diagnostic assessments, treatment planning, crisis intervention, suicide risk assessments.
- Long term individual and group psychotherapy with committed patients.
- Discharge planning to Department of Correction facilities, Department of Mental Health facilities, and community based agencies.

EXHIBIT 3

Stoughton Youth Commission/ Boston College Graduate School of Social Work
Stoughton, MA
Clinical Supervisor
September 2001-January 2003

- Provide clinical supervision for Master's level Clinical Social Workers and Social Work Interns.
- Conduct group trainings and seminars on topics including: administering psychosocial assessments with adolescents and families, working with at-risk populations, engaging clients in court ordered treatment, and conducting suicide and violence risk assessments

South Shore Mental Health---Crisis Intervention Team
Quincy, MA
Crisis Clinician
June 1999-September 2001

- Conduct psychiatric crisis evaluations for acutely distressed adults, adolescents, children, couples, and families.
- Assess for violence risk and suicide risk, as well as acute psychiatric distress.
- Present clinical information to third party payer and advocate for the level of care needed to effectively treat the individual.

Massachusetts Correctional Institute-Concord—Correctional Medical Services
Concord, MA
Forensic Clinical Social Worker
June 1998-April 1999

- Conduct initial intake assessments immediately after sentencing, provide crisis intervention for acutely at risk inmates, conduct suicide and institutional violence risk assessments, and provide long-term individual therapy.
- Case management and treatment planning of a caseload of 50 to 75 mentally ill incarcerated men.
- Oversee clinical services at Northeastern Correctional Center, which is the minimum-security facility associated with MCI-Concord.

Clinical Internships

1997-1998, Bridgewater State Hospital	Bridgewater, MA
1996-1997, Barron Assessment and Counseling Center	Jamaica Plain, MA
1995-1996, Auburn Youth & Family Services	Auburn, MA
1994-1995, Department of Social Services	Worcester, MA

TEACHING EXPERIENCE

2007-2010—Adjunct Faculty—Bridgewater State University, Department of Social Work

- Introduction to Social Research
- Research: Evaluating Practice (2007 and 2010)
- Human Behavior in the Social Environment I
- Human Behavior in the Social Environment III: DSM-IV-TR

2004 – Teaching Assistant – Boston College Graduate School of Social Work.

- Introductory research methods and statistics course

EXHIBIT 3

PUBLICATIONS

Peer-Reviewed Journals

Johnson, J. E., Miller, T. R., Stout, R. L., Zlotnick, C., Cerbo, L., **Andrade, J. T.**, Wiltsey-Stirman, S. (2016). Study protocol: Hybrid Type I cost-effectiveness and implementation study of interpersonal psychotherapy (IPT) for men and women prisoners with major depression. *Contemporary Clinical Trials, 47, 266-274.*

Andrade, J.T. (2008). The inclusion of antisocial behavior in the construct of psychopathy: A review of the research. *Aggression & Violent Behavior, 13, 328-335.*

Kayser, K., Watson, L.E., & **Andrade, J.T.** (2007). Cancer as a "We-Disease": Examining the process of coping from a relational perspective. *Families, Systems & Health, 25*(4), 404-418.

Andrade, J.T., Vincent, G.M., & Saleh, F.M. (2006). Juvenile sex offenders: A complex population. *Journal of Forensic Sciences, 51*(1), 163-167.

Books

Andrade, J.T. (Editor, 2009). *Handbook of Violence Risk Assessment and Treatment: New Approaches for Mental Health Professionals*. New York: Springer Publishing.

Book Chapters

Pinals, D.A. & **Andrade, J.T.** (2015). Recovery in Correctional Settings: Challenges and Opportunities. In Trestman, R.L., Appelbaum, K.L., & Metzner, J.L. (Eds.), *The Oxford Textbook of Correctional Psychiatry*. New York: Oxford University Press.

Andrade, J.T. (2009). Psychopathy: Assessment, treatment, and risk management. In **J.T. Andrade** (Ed.), *Handbook of violence risk assessment and treatment: New approaches for mental health professionals.* pp. 241-290. New York: Springer Publishing.

Andrade, J.T., O'Neill, K., & Diener, R. (2009). Violence risk assessment and risk management: A historical overview and clinical application, In **J.T. Andrade** (Ed.), *Handbook of violence risk assessment and treatment: New approaches for mental health professionals.* pp. 3-39. New York: Springer Publishing.

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Blog Posts

Andrade, J.T. (2017, June 22). Mental Health Units as Alternatives to Segregation It Can Be Done [Vera Institute Blog Post]. Retrieved from https://www.vera.org/blog/addressing-the-overuse-of-segregation-in-u-s-prisons-and-jails/mental-health-units-as-alternatives-to-segregation-it-can-be-done

Webinars:

Andrade, J.T. (2018, May 31). *Medical and Mental Health Professionals' Role in Segregation: Charting Policies to Ensure Quality Care.* National Commission on Correctional Health Care. Retrieved from: https://www.ncchc.org/medical-and-mental-health-professionals-role-in-segregation

Other Publications

Andrade, J.T. (2015). Providing Care for Incarcerated Psychopathic Patients. *CorrDocs, 18*(2), 8-9.

Andrade, J. T., Wilson, J. S., Franko, E., Deitsch, J., & Barboza, S. E. (December, 2014). Developing the Evidence Base for Reducing Chronic Inmate Self- Injury: Outcome Measures for Behavior Management. *Corrections Today*.

Andrade, J.T., & Saleh, F.M. (Winter, 2007). Book Review: Patrick C.J (Editor). Handbook of Psychopathy. Guilford Press 2006. *American Society for Adolescent Psychiatry Newsletter.*

Andrade, J.T. & Saleh, F.M. (Winter, 2005). Juvenile psychopathy: What do we know? *American Society for Adolescent Psychiatry Newsletter.*

EXHIBIT 3

Conference Presentations

Wilson, J.S. & Andrade, J.T. (2018, March). *Evidence-Based Approaches to Safety Promotion and Harm Prevention for Patients in Isolation.* Presented at the American College of Correctional Physicians Spring Conference. Houston, TX.

Fagan, T., Fleming, M., & Andrade, J.T. (2017, November). *Building an Ethics Toolbox: Strategies for Correctional Health Professionals.* Presented at the National Commission on Correctional Health Care Annual Conference: Chicago, IL.

Wilson, J.S. & Andrade, J.T. (2017, November). *Evidence-Based Approaches to Safety Promotion and Harm Prevention for Patients in Isolation.* Presented at the American College of Correctional Physicians Annual Conference. Chicago, IL.

Garvey, K., & Andrade, J.T. (2017, October). *"Tax Dollars at Work": Treating Inmates with Gender Dysphoria.* Presented at the American Academy of Psychiatry and the Law: Denver, CO.

Andrade, J.T. (2017, July). *Psychopathy: Providing Treatment and Managing Risk.* Presented at the National Commission on Correctional Health Care Summer Conference: Las Vegas, NV.

Andrade, J.T. (2017, July). *Serious Mental Illness and Segregation: Recommendations for a System that Works.* Presented at the National Commission on Correctional Health Care Summer Conference: Las Vegas, NV.

Andrade, J.T., Peterson, M.S., & Norcliffe, N. (2017, April). *Mental Health Units as an Alternative to Segregation for SMI Inmates.* Presented at the National Commission on Correctional Health Care Spring Conference: Atlanta, GA.

Fagan, T., Fleming, M., & Andrade, J.T. (2017, April). *Building an Ethics Toolbox: Strategies for Correctional Health Professionals.* Presented at the National Commission on Correctional Health Care Spring Conference: Atlanta, GA.

Andrade, J.T. (2017, February). *Violence Risk Assessment in Forensic Settings: An Update on the Research Literature.* Presented at the American Correctional Association Winter Conference. San Antonio, TX.

Andrade, J.T. & Fagan, T. (2016, October). *Beyond Good and Evil: The Soul of the Psychopath.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Andrade, J.T. (2016, October). *The Science of Violence Risk Assessment.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

EXHIBIT 3

Andrade, J.T. (2016, August). *The Science of Suicide Risk Assessment Prevention in Correctional Settings.* Presented at the American Correctional Association Summer Conference. Boston, MA.

Turney, A., Williams, K., Boyd, B., Fleming, M.C., & Andrade, J.T. (2016, August). *Effective Management of Self-Injurious Behavior in the Correctional Health Care Setting.* Presented at the American Correctional Association Summer Conference. Boston, MA.

Andrade, J.T. (2016, July). *Serious Mental Illness and Segregation: How Massachusetts Resolved This Litigation.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Andrade, J.T. & Garvey, K. (2016, July). *Gender Dysphoria: Recommendations for a Successful Program.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Andrade, J.T. (2016, July). *Continuous Quality Improvement.* Roundtable Discussion at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Andrade, J.T. (2016, April). *Continuous Quality Improvement: Motivating and Measuring Change.* Preconference Workshop presented at the National Commission on Correctional Health Conference: Nashville, TN.

Andrade, J.T. (2015, October). *Gender Dysphoria: Developing and Implementing a Successful Program in the Correctional Environment.* Presented at the National Commission on Correctional Health Conference: Dallas, TX.

Andrade, J.T. (2015, October). *Continuous Quality Improvement: Strategies and Techniques to Improve Patient Care.* Preconference Workshop presented at the National Commission on Correctional Health Conference: Dallas, TX.

Andrade, J.T., & Neitlich, D. (2015, April). *Psychopathy: Providing Treatment and Managing Risk.* Presented at the National Commission on Correctional Health Conference: New Orleans, LA.

Andrade, J.T. (2015, April). *Continuous Quality Improvement: Strategies and Techniques to Improve Patient Care.* Preconference Workshop presented at the National Commission on Correctional Health Conference: New Orleans, LA.

Metzner, J., & Andrade, J.T., (2014, December). *Serious Mental Illness and Segregation: Recommendations for a System That Works.* Presented at the NYS Correctional Medical and Behavioral Health Care Workshop: Albany, NY.

Andrade, J.T., Wilson, J., & Franko, E. (2014, December). *Measuring Effectiveness of Behavior Management: Individual- and Unit-Based Outcome Data.* Pennsylvania Forensic Rights and Treatment Conference/Drexel University, Grantsville, PA

EXHIBIT 3

Andrade, J.T., & Metzner, J. (2014, July). *Serious Mental Illness and Segregation: Recommendations for a System That Works.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Denver, CO.

Andrade, J.T., & Diener, R.B. (2014, July). *Gender Dysphoria: Clinical and Legal Aspects.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Denver, CO.

Andrade, J.T. (2014, July). *Serious Mental Illness and Segregation: Clinical and Legal Aspects.* Roundtable discussion at the National Commission on Correctional Health Care Mental Health Conference: Denver, CO.

Andrade, J.T. (2014, July). *Gender Dysphoria and Correctional Mental Health.* Roundtable discussion at the National Commission on Correctional Health Care Mental Health Conference: Denver, CO.

Andrade, J.T. & Wilson, J.S. (2014, January). *Measuring Effectiveness of Behavior Management: Individual- and Unit-Based Outcome Data.* Presented at the American Correctional Association Winter Conference. Tampa, FL.

Andrade, J.T. (2013, July). *DSM-5: From Gender Identity Disorder to Gender Dysphoria.* Roundtable discussion at the National Commission on Correctional Mental Health Conference: Las Vegas, NV.

Wilson, J.S, Andrade, J.T., & Barboza, S.E. (2013, July). *Behavior Management Strategies for Individual and Group Programs.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Andrade, J.T., O'Neill, K., & Neitlich, D.P. (2013, July). *Segregation and Serious Mental Illness: Creating a System to Ensure Quality Care and Minimize Clinical and Legal Risks.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Andrade, J.T., Diener, R.B., Cohen-Kettenis, P., Levine, S.B., & Zucker, K. (2013, March) *Trends, Uncertainties, and Controversies in the Treatment of the Transgendered.* A symposium presented at the 166th American Psychiatric Association Annual Meeting. San Francisco, CA.

Andrade, J.T. (2013, April). *Alternatives to Long-Term Segregation for Inmates with Serious Mental Illness.* Presented at the Society of Correctional Physicians Spring Conference. Denver, CO.

Andrade, J.T., Bissonnette, L., Holowecki, C., O'Neill, K. (2013, January). *An Intensive Treatment Unit for Female Offenders in Massachusetts.* Presented at the American Correctional Association Winter Conference. Houston, TX.

EXHIBIT 3

Andrade, J.T., Neitlich, D.P., & Deitsch, J. (2013, January). *Maintaining a Correctional mental Health System to Ensure Quality Care and Minimize Clinical and Legal Risks.* Presented at the American Correctional Association Winter Conference. Houston, TX.

Andrade, J.T. (2012, October). *The Treatment of Psychopathic Offenders within a Correctional Setting: The Behavior Management Unit in Massachusetts.* Presented at the National Commission on Correctional Health Conference: Las Vegas, NV.

Andrade, J.T. & Franko, E. (2012, July). *Continuous Quality Improvement (CQI) to Improve Patient Care and Clinical Efficiencies, Successfully Defend Against Litigation, and more...* Presented at the National Commission on Correctional Mental Health Conference: Chicago, IL.

Andrade, J.T. (2012, May). *Treatment of Problematic Behavior in a Correctional Setting: An Analysis of Behavioral outcomes.* Presented at the National Commission on Correctional Health Conference: San Antonio, TX.

Andrade, J.T., & O'Neill, K. (2012, March). *The Behavior Management Unit: An Alternative to Long-Term Segregation.* Presented at the Academic & Health Policy Conference on Correctional Health: Atlanta, GA.

Andrade, J.T., & Neitlich, D.P. (2012, March). *A Descriptive Analysis of 2,000 Incidents of Self-Injurious Behavior.* Presented at the Academic & Health Policy Conference on Correctional Health: Atlanta, GA.

Andrade, J.T. (2011, July). *Alternatives to Long-Term Segregation for Inmates with Serious Mental Illness: Outcomes of Secure Treatment Units in Massachusetts.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Andrade, J.T., Diener, R.B., & O'Neill, K (2011, July). *Gender Identity Disorder: A Correctional Mental Health Perspective.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Masotta, M., & Andrade, J.T. (2011, March). *Suicide and Self-Harm Risk Assessment within Correctional Settings: Avoiding Common Pitfalls.* Presented at the Academic & Health Policy Conference on Correctional Health: Boston, MA.

Andrade, J.T. & O'Neill, K.L. (2011, March). *Alternatives to Segregation for Inmates with Serious Mental Illness.* Presented at the Academic & Health Policy Conference on Correctional Health: Boston, MA.

Andrade, J.T., O'Neill, K.L., Hallett, A., & Mulvey, R. (2010, November). *A Collaborative Training Model for Behavior Management Units.* International Association of Correctional Trainers: Boston, MA.

EXHIBIT 3

Andrade, J.T. (2010, July). *Behavior Management Interventions.* Roundtable discussion at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Andrade, J.T. (2010, July). *Behavior Management Strategies That Won't Reinforce Inmate Self-Injury.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Barboza, S.E., Andrade, J.T., Wilson, J.S. (2010, April). *Ending It All: Data Informed Suicide Prevention.* Presented at the National Commission on Correctional Health Care Conference: Nashville, TN.

Wilson, J.S., Barboza, S.E., & Andrade, J.T. (2009, December). *Ending It All: What the Data Tell Us About Suicide Prevention.* Presented at the Academic & Health Policy Conference on Correctional Health Linking Best Practices to Best Evidence: Fort Lauderdale, FL.

Andrade, J.T. (2009, June). *Psychopathy in Correctional Settings: Assessment & Risk Management.* Presented at the Michigan Sheriffs' Association 2009 Summer Conference: Frankenmuth, MI.

Andrade, J.T. & Barboza, S.E. (2009, April). *Taking A Chance on Change: Treating Offenders in Restricted Housing.* Presented at the Mental Health in Corrections Consortium 2009 Symposium: Kansas City, MO.

Andrade, J.T. (2009, March). *The Institutional Treatment of Psychopathy.* Presented at the American Correctional Health Services Association Conference: Orlando, FL.

Andrade, J.T., Weiner, L., Mitchell., L., Zakai, A. (2008, September). *Roundtable Discussion: Mental Health Treatment within Maximum-Security Institutions and Segregation.* Presented at the National Institute of Corrections Conference: Leominster, MA.

Andrade, J.T. & Terry, A. (2008, March). *Workshop: Violence Risk Assessment in Youthful Populations.* Presented at the American Society for Adolescent Psychiatry Annual Conference: Boston, MA.

Andrade, J.T. (2007, October). *Assessment of Inpatient Aggression and Violent Behavior.* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Miami, FL.

Dwyer, R.G., Saleh, F.M., Vincent, G.M., & Andrade, J.T. (2007, October). *Assessing and Treating Violent Women: What Do We Know?* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Miami, FL.

EXHIBIT 3

Andrade, J.T., & O'Neill, K. (2007, April). *The Forensic Assessment of Malingering*. Presented at the National Organization of Forensic Social Work Conference: Las Vegas, NV.

Andrade, J.T. (2007, April). *Juvenile Psychopathy: Assessment, Treatment, and Risk Management*. Presented at the National Organization of Forensic Social Work Conference: Las Vegas, NV.

Andrade, J.T. (2007, March). *Psychopathy within a Correctional Setting: Assessment, Treatment, and Risk Management*. Presented at the University of Massachusetts Correctional Health Program Academic and Health Policy Conference; Quincy, MA.

Saleh, F.M., & Andrade, J.T. (2006, October). *Clinical and Ethical Consideration in People with Gender Identity Disorder*. Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Chicago, IL.

Andrade, J.T., & Saleh, F.M. (2006, October). *Measurement of Treatment Outcome in Paraphilic Patients*. Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Chicago, IL.

Andrade, J.T., & O'Neill, K. (2006, July). *Beyond a Reasonable Doubt: Violence Risk Assessment and Expert Witness Testimony in Massachusetts*. Presented at the National Organization of Forensic Social Work Conference: Chicago, IL.

Andrade, J.T. (2006, July). *The Psychopathic Personality: Historical and Current Perspectives*. Presented at the National Organization of Forensic Social Work Conference: Chicago, IL.

Saleh, F.M., Kenan, J., Dwyer, R.G., & Andrade, J.T. (2006, March). *Workshop: Evaluation and Treatment of Adolescent Sex Offenders*. Presented at the American Society for Adolescent Psychiatry Annual Conference: Miami, FL.

Andrade, J.T., Vincent, G.M., & Saleh, F.M. (2005, October). *Meta-analysis of Psychopathy and Sex Offending: Preliminary Findings*. Presented at the American Academy of Psychiatry and the Law Annual Conference: Montreal, Canada.

Andrade, J.T., & Saleh, F.M. (2005, October). *The Penile Plethysmograph in the Assessment and Treatment of Sexually Offending Behavior*. Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Montreal, Canada.

Kayser, K., Watson, L., & Andrade, J.T. (2005, May). *How couples talk about their coping with breast cancer: A relational-cultural perspective*. Paper Presented as the Advances in Couples' Coping and Stress Research: Psychosocial and Clinical Perspectives Conference: Milan, Italy.

EXHIBIT 3

Andrade, J.T., & Peebles, J.L. (2005, April). *The Relationship Between Psychopathy and Sexual Aggression: A Review*. Presented at the National Organization of Forensic Social Work Conference: New Orleans, LA.

Andrade, J.T. & Caratazzola, P. (2005, April). *The Assessment of Violent Offenders: Implications of the MacArthur Violence Risk Assessment Data and Its Application to Forensic Social Work Practice.* Presented at the National Organization of Forensic Social Work Conference: New Orleans, LA.

Andrade, J.T. (2005, March). *Therapy with Juvenile Sexual Offenders.* Presented at the American Society for Adolescent Psychiatry Annual Conference: Houston, TX.

Guidry, L. & Andrade, J.T. (2004, October). *Comorbid Mental Illness Among Paraphilic Sex Offenders: Clinical Implications.* Poster Presented at the Association for the Treatment of Sexual Abusers Annual Conference: Albuquerque, NM.

Andrade, J.T., Guidry, L., Saleh, F., Vincent, G.M. & Berlin, F. (2004, October). *Comorbid Mental Illness Among Sex Offenders: A Pilot Study.* Presented at the American Academy of Psychiatry and the Law Annual Conference: Scottsdale, AZ.

Andrade, J.T. & Saleh, F.M. (2004, October). *Self-Injurious Behavior Among Incarcerated Individuals.* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Scottsdale, AZ.

Andrade, J.T., Vincent., G.M., & Saleh, F.M. (2004, October). *Psychopathy Among Sex Offenders: A Systematic Review.* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Scottsdale, AZ.

Kayser, K., & Watson, L., & Andrade, J.T. (2004, May). *Cancer as a "We-Disease:" A Relational Perspective of the Process of Coping.* Paper presented at the Fourth International Conference on Social Work in Health and Mental Health: Quebec City, Canada.

EXHIBIT 3

Reviewer Scholarly Journals
Journal of Forensic Social Work
Personality and Individual Difference
Journal of Clinical Psychology
Clinical Psychology Review
Scandinavian Journal of Psychology
Journal of Correctional Health Care

Reviewer Books
Columbia University Press

DSM 5

- Expert rater for DSM 5 Workgroup on Personality and Personality Disorders
- Provided input on the proposed Antisocial/Psychopathic type in terms of the proposed DSM-5 trait model
- Provided expert ratings on traits of Antisocial Personality Disorder and Borderline Personality Disorder

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PUBLICATIONS

Peer-Reviewed Journals

Johnson, J. E., Miller, T. R., Stout, R. L., Zlotnick, C., Cerbo, L., **Andrade, J. T.**, Wiltsey-Stirman, S. (2016). Study protocol: Hybrid Type I cost-effectiveness and implementation study of interpersonal psychotherapy (IPT) for men and women prisoners with major depression. *Contemporary Clinical Trials, 47, 266-274.*

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Books

Andrade, J.T. (Editor, 2009). *Handbook of Violence Risk Assessment and Treatment: New Approaches for Mental Health Professionals*. New York: Springer Publishing.

Book Chapters

Pinals, D.A. & **Andrade, J.T.** (2015). Recovery in Correctional Settings: Challenges and Opportunities. In Trestman, R.L., Appelbaum, K.L., & Metzner, J.L. (Eds.), *The Oxford Textbook of Correctional Psychiatry*. New York: Oxford University Press.

Andrade, J.T. (2009). Psychopathy: Assessment, treatment, and risk management. In **J.T. Andrade** (Ed.), *Handbook of violence risk assessment and treatment: New approaches for mental health professionals.* pp. 241-290. New York: Springer Publishing.

Andrade, J.T., O'Neill, K., & Diener, R. (2009). Violence risk assessment and risk management: A historical overview and clinical application, In **J.T. Andrade** (Ed.), *Handbook of violence risk assessment and treatment: New approaches for mental health professionals.* pp. 3-39. New York: Springer Publishing.

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Other Publications

Andrade, J.T. (2015). Providing Care for Incarcerated Psychopathic Patients. *CorrDocs, 18*(2), 8-9.

Andrade, J. T., Wilson, J. S., Franko, E., Deitsch, J., & Barboza, S. E. (December, 2014). Developing the Evidence Base for Reducing Chronic Inmate Self-Injury: Outcome Measures for Behavior Management. *Corrections Today.*

Andrade, J.T., & Saleh, F.M. (Winter, 2007). Book Review: Patrick C.J (Editor). Handbook of Psychopathy. Guilford Press 2006. *American Society for Adolescent Psychiatry Newsletter.*

Andrade, J.T. & Saleh, F.M. (Winter, 2005). Juvenile psychopathy: What do we know? *American Society for Adolescent Psychiatry Newsletter.*

KEELIN GARVEY, MD, CCHP
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Bristol, RI 02809
keelingarvey@gmail.com

MEDICAL LICENSURE

Massachusetts
Rhode Island
Minnesota
Pennsylvania
Arizona
Florida
Texas
California

BOARD CERTIFICATION

Psychiatry (May 2010)
Forensic Psychiatry (June 2011)

EMPLOYMENT

September 2017-present

Medical Director, Forensic Psychiatry
InnovaTel Telepsychiatry
Erie, PA

August 2015-September 2017

Statewide Psychiatric Medical Director,
Massachusetts Partnership for Correctional Healthcare (MPCH)

- *Coordinating all psychiatry services and recruitment/hiring of psychiatric staff for the Massachusetts prison system*
- *Providing direct clinical care to inmates with serious mental illness*
- *Facilitating weekly reviews of complex clinical cases with emphasis on risk assessment and optimizing treatment*
- *Reviewing all nonformulary medication requests*
- *Providing consultation to psychiatric staff regarding need for higher level of care or hospitalization*
- *Voting member of Pharmacy and Therapeutics committee*
- *Chair of Gender Dysphoria Treatment Committee, responsible for evaluation and treatment of all individuals in the custody of the Massachusetts Department of Correction diagnosed with or reporting symptoms of Gender Dysphoria*

August 2011-August 2015

Deputy Medical Director, MPCH

- *Coordinated psychiatry services for the Massachusetts prison system, and participated in recruiting efforts*
- *Provided clinical supervision to several advanced*

practice nurses, and consultation to all psychiatry staff on complex cases
- *Participated in the Pharmacy & Therapeutics Committee*
- *Provided direct clinical care to a large population of inmates with serious mental illness (SMI)*

July 2010-August 2011 — Psychiatrist, Old Colony Correctional Center
MHM Services, Inc.
Bridgewater, MA
- *Provided psychiatric care to a large population of inmates with serious mental illness (SMI)*
- *Provided clinical leadership to a large group of mental health professionals*

MEDICAL AND PSYCHIATRIC TRAINING

July 2009-June 2010 — Forensic Psychiatry Fellowship
University of California, Davis
Sacramento, CA
- *Performed violence/sexual violence risk assessment services at Napa State Hospital*
- *Provided clinical psychiatric care to jail inmates*
- *Conducted court-ordered and private assessments of competency to stand trial and sanity*
- *Performed psychological measures of malingering*

April 2008-April 2009 — Chief Resident, Adult Psychiatry Residency
Alpert Medical School, Brown University
Providence, RI
- *Created and managed call schedule for more than 50 residents working at six different hospitals*
- *Liaison between residents and administration*
- *Coordinated orientation for incoming residents and recruitment of new residents*

July 2005-June 2009 — Adult Psychiatry Residency
Alpert Medical School, Brown University
Providence, RI
- *Provided inpatient and outpatient clinical care*
- *Performed emergency psychiatric evaluations in both medical and psychiatric emergency departments*
- *Conducted court-ordered evaluations of competency to stand trial*
- *Provided psychiatric consultation services to medical and surgical teams*

August 2001-June 2005 — University of Massachusetts Medical School
Medical Degree
Worcester, MA

OTHER QUALIFICATIONS

Certified Correctional Health Professional (CCHP), National Commission on Correctional Health Care

Certified Buprenorphine Physician, American Society of Addiction Medicine

ADDITIONAL WORK EXPERIENCE

July 2006-June 2009 — Butler Hospital Patient Assessment Services
Providence, RI

- *Performed emergency psychiatric evaluations and admissions of adults and children in psychiatric emergency department*
- *Provided emergency medical management of 180-bed inpatient psychiatric facility*

July 2006-June 2009 — Rhode Island Hospital Acute Psychiatric Services
Providence, RI

- *Performed emergency psychiatric evaluations and admissions of adults and children in medical emergency department*

July 2006-June 2009 — Miriam Hospital Department of Psychiatry
Providence, RI

- *Performed emergency psychiatric evaluations and admissions in medical emergency department*
- *Provided acute psychiatric consultation to medical and surgical teams in tertiary care hospital*

UNDERGRADUATE EDUCATION

August 1996-June 2000 — Yale University
BA, Molecular, Cellular & Developmental Biology
New Haven, CT

AWARDS & HONORS

2008 Rappeport Fellowship Award, American Academy of Psychiatry and the Law
- *Award given to 6 Residents nationally in recognition of demonstrated interest in psychiatry and the law*

First Prize Psychiatry Residency Research Poster, 12th Annual Research Symposium on Mental Health Sciences, Alpert Medical School of Brown University, March 27, 2008.

PSYCHOLOGICAL TESTING EXPERIENCE

- Structured Interview of Reported Symptoms (SIRS)
- Miller Forensic Assessment of Symptoms Test (M-FAST)
- Structured Inventory of Malingered Symptomatology (SIMS)
- Test of Malingered Memory (TOMM)
- Violence Risk Appraisal Guide (VRAG)
- Sex Offender Risk Appraisal Guide (SORAG)
- Hare Psychopathy Checklist-Revised (PCL-R)
- Historical, Clinical, Risk Management-20 (HCR-20)

ARTICLES

Garvey K, Penn J, Campbell A, Esposito-Smythers C, Spirito A. Contracting for Safety with Patients: Clinical Practice and Forensic Implications. *Journal of the American Academy of Psychiatry and the Law 37(3): 2009.*

Recupero P, Price M, **Garvey K**, Daly B, Xavier S. Restraint and seclusion in psychiatric treatment settings: regulation, case law, and risk management. *Journal of the American Academy of Psychiatry and the Law 39(4): 2011.*

BOOK CHAPTER

Garvey K, Newring K, Parham R, Pinals D (2013). The Roles and Limitations of Evidence-Based Psychotherapy in Correctional Settings, Volume II. In O. Thienhaus & M. Piasecki (Eds.), *Correctional Psychiatry Practice Guidelines and Strategies* (pp. 1-1 to 1-29). Kingston, NJ: Civic Research Institute.

PROFESSIONAL ORGANIZATIONS

American Psychiatric Association (APA)
American Academy of Psychiatry and the Law (AAPL)
World Professional Association for Transgender Health (WPATH)
National Commission on Correctional Health Care (NCCHC)
American Correctional Association (ACA)
Rhode Island Psychiatric Society
Rhode Island Psychiatric Society, Member in Training Representative 2007-2009
Rhode Island Suicide Prevention Sub-Committee, 2007-2009

NATIONAL PRESENTATIONS

1) "Contracting for Safety with Patients: Clinical Practice and Forensic Implications," American Academy of Psychiatry and the Law, Seattle, Washington, October 2008

2) "Dissociative Identity Disorder: Disease or Drama?" American Academy of Psychiatry and the Law, Baltimore, Maryland, October 2009
3) "Assaults on an Inpatient Service: Legal, Ethical and Administrative Considerations," American Academy of Psychiatry and the Law, Baltimore, Maryland, October 2009
4) "Gender Dysphoria: Recommendations for a Successful Program," National Commission on Correctional Health Care, Boston, Massachusetts, July 2016
5) "Stepping Up the Right Way: Best Practices in the Treatment of Persons with Serious Mental Illness who have Contact with the Criminal Justice System," Webinar hosted by National Council for Behavioral Health, July 2017
6) "'Tax Dollars at Work': Treating Inmates with Gender Dysphoria," American Academy of Psychiatry and the Law, Denver, Colorado, October 2017 (*Please note that the title of this presentation is in quotes as it does not reflect the opinion of the presenters)*
7) "Gender Dysphoria: A New Challenge for Corrections and Timely Solutions," American Correctional Association, Minneapolis, Minnesota, August 2018
8) "Criminogenic Needs: Screenings and Assessments," Webinar hosted by National Council for Behavioral Health for the Criminal Justice and Behavioral Health Collaborative Group Affinity Call #1, Sept 2018

FUTURE SCHEDULED PRESENTATION:

"Forensic Telepsychiatry: Why Aren't You Doing It?" American Academy of Psychiatry and the Law, Austin, Texas, October 2018

NATIONAL POSTER PRESENTATIONS

1) "'Contracting for Safety' with Adolescents: Is this an Empirically-Based Practice?" American Academy of Psychiatry and the Law, Miami, Florida, October 2007
2) "Antipsychotic Medication Use in the Rhode Island Prison System," American Academy of Psychiatry and the Law, Seattle, Washington, October 2008
3) "Restraint & Seclusion in Psychiatric Treatment Settings: A Review & Analysis of Case Law," American Academy of Psychiatry and the Law, Baltimore, Maryland, October 2009
4) "Psychiatric Advanced Directives: A State by State Review," American Academy of Psychiatry and the Law, Baltimore, Maryland, October 2009

OTHER PRESENTATIONS AND LECTURES

- Developed and provided DSM-5 training for all mental health staff in the Massachusetts Partnership for Correctional Healthcare, and for all psychiatry and psychology staff working for MHM Services, Inc., a national provider of correctional health services
- Provided training on the treatment of Gender Dysphoria to Bridgewater State Hospital social work and psychology interns and MPCH medical and mental health providers
- Participation in didactic program for Brown University forensic psychiatry fellowship, lecturing on Gender Dysphoria in the correctional setting

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ORIGINAL PAPER

Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder

William Byne · Susan J. Bradley · Eli Coleman · A. Evan Eyler · Richard Green · Edgardo J. Menvielle · Heino F. L. Meyer-Bahlburg · Richard R. Pleak · D. Andrew Tompkins

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Abstract Both the diagnosis and treatment of Gender Identity Disorder (GID) are controversial. Although linked, they are separate issues and the DSM does not evaluate treatments. The Board of Trustees (BOT) of the American Psychiatric Association (APA), therefore, formed a Task Force charged to perform a critical review of the literature on the treatment of GID at different ages, to assess the quality of evidence pertaining to treatment, and to prepare a report that included an opinion as to whether or not sufficient credible literature exists for development of treatment recommendations by the APA. The literature on treatment of gender dysphoria in individuals with disorders of sex development was also assessed. The completed report was accepted by the BOT on September 11, 2011. The quality of evidence pertaining to most aspects of treatment in all subgroups was determined to be low; however, areas of broad clinical consensus were identified and were deemed sufficient to support recommendations for treatment in all subgroups. With subjective improvement as the primary outcome measure, current evidence was judged sufficient to support recommendations for adults in the form of an evidence-based APA Practice Guideline with gaps in the empirical data supplemented by clinical consensus. The report recommends that the APA take steps beyond drafting treatment recommendations. These include issuing position statements to clarify the APA's position regarding the medical necessity of treatments for GID, the ethical bounds of treatments of gender variant minors, and the rights of persons of any age who are gender variant, transgender or transsexual.

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Preface

After the announcement of the DSM-5 work group membership in May 2008, the American Psychiatric Association (APA) received many inquiries regarding the workgroup named to address the entities included under Gender Identity Disorder (GID) in versions III through IV-TR of the DSM. These inquiries most often dealt with treatment controversies regarding GID, especially in children, rather than issues related specifically to the DSM text and diagnostic criteria. In addition, the APA Committee on Gay, Lesbian, and Bisexual Issues had previously raised concerns about the lack of evidence-based guidelines for GID, and questions about whether such guidelines could and should be developed.

While the diagnosis and treatment of mental disorders are inextricably linked, they are separate issues and the evaluation of treatments is not addressed by the DSM work groups. The APA Board of Trustees, therefore, formed a task force on the treatment of GID under the oversight of the Council on Research. Members of the GID Task Force were appointed by the APA President, Dr. Nada Stotland, and charged by the Board of Trustees "to perform a critical review of the literature on the treatment of GID at different ages and to present a report to the Board of Trustees." The report "would include an opinion as to whether or not there is sufficient credible literature to take the next step and develop treatment recommendations."

Members of the Task Force include APA members William, Byne M.D., Ph.D. (Chair); A. Evan Eyler, M.D., MPH; Edgardo J. Menvielle, M.D., M.S.H.S.; Richard R. Pleak, M.D., and D. Andrew Tompkins, M.D. (Early Career Psychiatrist). Non APA members named as consultants include Susan J. Bradley, M.D., Eli Coleman, Ph.D., Richard Green, M.D., JD, and Heino F. L. Meyer-Bahlburg, Dr. rer. nat. The work of the Task Force was conducted by email correspondence, conference calls, and one group meeting of the APA members at the APA Annual Meeting, May 2010. Members and consultants contributed equally to the project.

The Task Force commenced its work as the DSM-5 workgroups were deliberating. Questions, therefore, arose regarding the impact of potential differences between the forthcoming DSM-5 and previous iterations of the DSM on the utility of the Task Force Report. Of particular concern was the question of whether or not the diagnostic entity designated as GID would be carried forward into the DSM-5. The Task Force concluded that most of the issues pertaining to gender variance (GV) that lead individuals (or their parents in the case of minors) to seek mental health services would remain the same regardless of any changes in DSM nomenclature or diagnostic criteria. Any such changes to the DSM should, therefore, have minimal impact on the utility of the Task Force Report. Since the DSM-5 would be published only after the Task Force completes its work, the evidence base available for consideration by the Task Force was necessarily based on prior diagnostic formulations. The Task Force chose to conduct its deliberations primarily in terms of the DSM-IV-TR formulations with reference to other formulations as necessary.

Although the charge to the Task Force was to comment on the feasibility of making treatment *recommendations*, questions arose in the initial conference calls regarding the nature of the evidence base required by the APA for development of recommendations in the specific form of *APA Practice Guidelines*. *APA Practice Guidelines* are defined as systematically developed documents in a standardized format that present patient care strategies to assist psychiatrists in clinical decision making. The APA's Steering Committee on Practice Guidelines (SCPG) both selects topics for guideline development and oversees their development. According to the APA's website (http://www.psychiatryonline.com/content.aspx?aID=58560) at the time the Task Force commenced it work in 2008 and concluded it in May 2011, two of the criteria for topic selection by the SCPG are quality of the relevant data base and prevalence of the disorder. The randomized double blind control trial is the study design that affords the highest quality evidence regarding the comparative efficacy of various treatment modalities; however, no such trials have been conducted to address any aspect of the treatment of GID. Given the very nature of GID, such trials, or even unblinded trials with random assignment to treatment groups, are not likely to be forthcoming due to a lack of feasibility and/or ethical concerns. In addition to the lack of evidence of the highest quality relevant to the treatment of GID, GID is widely believed to be a rare phenomenon (Zucker & Lawrence, 2009)[1] and likely to fall short of the SCPG's criterion for prevalence. The Task Force, therefore, decided to consider whether available evidence, together with clinical consensus, constitutes a sufficient basis to support the development the treatment *recommendations*, broadly defined, in addition to assessing the quality of evidence relevant to the potential development of APA Practice Guidelines, as defined above.

In order to address its charge, the Task Force divided itself into subgroups to address GID and related issues in four populations. Three of these populations are defined by age: children, adolescents, and adults. The fourth population comprises individuals with the desire to change their assigned gender who have a somatic disorder of sex development (DSD). The makeup of the subgroups was as follows: child (Richard R. Pleak and Edgardo J. Menvielle); adolescent (Susan Bradley and Richard Green); adult (A.

[1] Epidemiological studies are lacking so that no strong conclusions about the prevalence of GID can be drawn (Zucker & Lawrence, 2009). The DSM-IV estimates that roughly 1:30,000 natal males and 1:100,000 natal females ultimately seek SRS. These are underestimates for the prevalence of GID since not all adults who meet criteria for GID seek SRS, and GID diagnosed in childhood usually does not persist into adolescence and adulthood.

Evan Eyler, Eli Coleman, and D. Andrew Tompkins), and DSD (Heino F. L. Meyer-Bahlburg and William Byne).

Each subgroup conducted database searches and produced a document addressing the Task Force's charge pertaining to its assigned subpopulation. These documents were circulated to all members of the Task Force, discussed during conference calls, and revised until approved by group consensus. Because the consensus process involves compromise, all members of the Task Force do not necessarily agree with all views expressed within the report. The Task Force could not reach a consensus regarding the question of whether or not persistent cross-gender identification sufficient to motivate an individual to seek sex reassignment, per se, is a form of psychopathology in the absence of clinically significant distress or impairment due to a self-perceived discrepancy between anatomical signifiers of sex and gender identity. Since this question falls within the purview of the DSM Committee and is not central to the Task Force's charge of evaluating treatment, text suggesting a stand on this issue was deleted from the report. Similarly, a consensus could not be reached regarding the legitimacy of particular goals of therapy with children diagnosed with GID (e.g., prevention of transgenderism or homosexuality) even when consistent with the religious beliefs or sociocultural values of the parents or primary caregivers.

Executive Summary and Recommendations

This Task Force Report assesses the current status of evidence bearing on treatment, by mental health professionals, of the entities included under GID in the DSM (versions III through IV-TR) as well as gender dysphoria in individuals with somatic DSDs, designated as GID Not Otherwise Specified (GIDNOS) in DSM-IV-TR. The primary aim of the report is to answer the question posed by the APA Board of Trustees as to whether or not there is sufficient credible literature to support development by the APA of treatment recommendations for GID. Separate sections of the report are addressed to GID in children, adolescents, and adults, as well as to GIDNOS in individuals with somatic DSDs. The Executive Summary provides a synopsis of each of those sections (readers are referred to each primary section for full citations), together with an opinion from the Task Force regarding support for treatment recommendations in the literature. The Task Force concludes that the current credible literature is adequate for the development of consensus based treatment recommendations for all subgroups reviewed. Moreover, it is concluded that, for adults, with subjective improvement as the primary outcome measure, the existing evidence base combined with clinical consensus is sufficient for developing recommendations in the form of an APA Practice Guideline.

The case is also made that treatment recommendations from the APA are needed, even in areas where criteria are not met for selection by the SCPG for APA Practice Guideline development, and that the APA should proceed with their preparation. The Task Force recommends that additional steps be taken by the APA pertaining to issues relating to GV (Appendix 1) and to DSDs, whether or not GV is an issue (Appendix 2). These include issuing a position statement to clarify the APA's position regarding the medical necessity of treatments for GID, the ethical bounds of treatments for minors with GID, and the rights of persons of any age who are gender variant or transgender.

Evaluation of Levels of Evidence

Where possible, the Task Force Report comments on the level of evidence from research studies bearing on treatment issues. Unless otherwise specified, the levels of evidence refer to the APA evidence coding system which was in use at the time the Task Force was commissioned (http://www.psychiatryonline.com/content.aspx?aID=58560) and is specified below:

[A] *Randomized, double-blind clinical trial.* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are "blind" to the assignments.

[A-] *Randomized clinical trial.* Same as above but not double blind.

[B] *Clinical trial.* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally. Does not meet standards for a randomized clinical trial.

[C] *Cohort or longitudinal study.* A study in which subjects are prospectively followed over time without any specific intervention.

[D] *Control study.* A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.

[E] *Review with secondary data analysis.* A structured analytic review of existing data (e.g., a meta-analysis or a decision analysis).

[F] *Review.* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.

[G] *Other.* Opinion-like essays, case reports, and other reports not categorized above.

Terminology and Abbreviations

The diagnostic category, GID, was introduced by DSM-III and included the diagnoses of GID of Childhood and Transsexu-

alism. In DSM-III-R, GID of Childhood and Transsexualism were retained; GID of Adolescence and Adulthood, Nontranssexual Type (GIDAANT) was added; and "disorders in gender identity" not otherwise classified were designated as GIDNOS. Note that under GID of Childhood, physical disorders of the sex organs, when present, were noted under Axis III. This stipulation was not made explicit for transsexualism and GIDAANT, but intersex is not noted under GIDNOS in DSM-III-R. Thus, if a person with a DSD met GID criteria, s/he would be given the GID diagnosis, with the intersex syndrome listed on Axis III. In DSM-IV and IV-TR, GID of Childhood and GIDNOS (in addition to some other conditions) were retained; however, the designation GID of Adolescence and Adulthood subsumed both Transsexualism and the Nontranssexual Types.

DSM-IV-TR excludes individuals with a DSD from the diagnosis of GID. Individuals with gender dysphoria and a DSD are placed under the category GIDNOS rather than under the more specifically defined term GID. GIDNOS is commonly used also for individuals without a DSD who meet some but not all required GID criteria (often referred to as "subthreshold cases"). Thus, the DSM-IV-TR applies the term GIDNOS (apart from other examples) to three groups of individuals with gender dysphoria: (1) those without a DSD who do not meet full criteria for GID, (2) those who would meet full criteria for GID if not for the DSD exclusion, and (3) those with a DSD who do not meet the full inclusion criteria.

The criteria for the GID diagnoses, as well as the nomenclature itself, are under revision at the time of this writing. Documentation regarding the development of the DSM-5 and potential changes in nomenclature and diagnostic criteria are available through the DSM-5 website (http://www.dsm5.org) and are not addressed here.

In the present report, the abbreviations GID and GIDNOS, are used to refer to Gender Identity Disorders as defined in the DSM-IV-TR. The entities designated as GIDs by the DSM-IV-TR include only a subset of individuals for whom clinical concerns related to GV may be raised (whether by the individual or the individual's primary caregivers, educators, or healthcare providers). GV is used to refer to any degree of cross-gender identification or nonconformity in gender role behavior regardless of whether or not criteria are met for either GID or GIDNOS. The terms transsexual and transsexualism are used to refer to adults who meet diagnostic criteria for GID and have employed hormonal and/or surgical treatments in the process of transitioning gender or who plan to do so. Transgender denotes individuals with cross-gender identification whether or not hormonal or surgical treatments have been, or are planned to be, employed in transitioning gender. Natal sex is used to refer to the sex at birth of individuals who subsequently desire or undergo any degree of sex reassignment or gender transition, provided that they do not have a DSD. DSD as employed here refers to congenital conditions (formerly referred to as intersex disorders, hermaphroditism, and pseudohermaphroditism) which entail atypical development of chromosomal, gonadal and/or genital sex.

Abbreviations

AACAP	American Academy of Child and Adolescent Psychiatry
APA	American Psychiatric Association
CAH	Congenital adrenal hyperplasia
DSD	Disorder of sex development
DSM	Diagnostic and Statistical Manual
FTM	Female to male
GID	Gender Identity Disorder
GIDAANT	Gender Identity Disorder of Adolescence and Adulthood, Nontranssexual Type
GIDNOS	Gender Identity Disorder, Not Otherwise Specified
GLBT	Gay, lesbian, bisexual transgender/transsexual
GnRH	Gonadotropin releasing hormone
GRADE	Grading of Recommendations, Assessment, Development, and Evaluation
GV	Gender variance
HBIDGA	Harry Benjamin International Gender Dysphoria Association
ICTLEP	International Conference on Transgender Law and Employment Policy, Inc
MTF	Male to female
WPATH	World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association (HBIDGA)
RCT	Randomized controlled trial
SCPG	Steering Committee on Practice Guidelines
SOC	Standards of Care
SRS	Sex reassignment surgery

Synopses of Literature Reviews and Opinions with Respect to Recommendations

Children

Synopsis Children have limited capacity to participate in decision making regarding their own treatment, and no legal ability to provide informed consent. They must rely on caregivers to make treatment decisions on their behalf, including those that will influence the course of their lives in the long term. The optimal approach to treating pre-pubertal children with GV, including DSM-defined GID, is, therefore, more controversial than treating these phenomena in adults and adolescents. An additional obstacle to consensus regarding treatment of children is the lack of randomized controlled treatment outcome studies of children with GID or with any presentation of GV (Zucker, 2008b). In the absence of such studies, the highest level of evidence available for treatment recommendations for these children can best be characterized as expert opinion. Opinions vary widely among experts, and are influ-

enced by theoretical orientation, as well as assumptions and beliefs (including religious) regarding the origins, meanings, and perceived fixity or malleability of gender identity. Primary caregivers may, therefore, seek out providers for their children who mirror their own world views, believing that goals consistent with their views are in the best interest of their children.

The outcome of childhood GID without treatment is that only a minority will identify as transsexual or transgender in adulthood (a phenomenon termed persistence), while the majority will become comfortable with their natal gender over time (a phenomenon termed desistence) (Davenport, 1986; Green, 1987; Wallien & Cohen-Kettenis, 2008; Zuger, 1978). GID that persists into adolescence is more likely to persist into adulthood (Zucker, 2008b). Compared to the general population, the rate of homosexual orientation is increased in adulthood whether or not GID was treated (Green, 1987; Zucker, 2008b). It is currently not possible to differentiate between preadolescent children in whom GID will persist and those in whom it will not. To date, no long-term follow-up data have demonstrated that any modality of treatment has a statistically significant effect on later gender identity.

The overarching goal of psychotherapeutic treatment for childhood GID is to optimize the psychological adjustment and well-being of the child. What is viewed as essential for promoting the well-being of the child, however, differs among clinicians, as does the selection and prioritization of goals of treatment. In particular, opinions differ regarding the questions of whether or not minimization of gender atypical behaviors and prevention of adult transsexualism are acceptable goals of therapy.

Several approaches to working with children with GID were identified in the professional literature. The first of these focuses on working with the child and caregivers to lessen gender dysphoria and to decrease cross-gender behaviors and identification. The assumption is that this approach decreases the likelihood that GID will persist into adolescence and culminate in adult transsexualism (Zucker, 2008a). For various reasons (e.g., social stigma, likelihood of hormonal and surgical procedures with their associated risks and costs), persistence is considered to be an undesirable outcome by some (Green, 1987; Rekers, 1982; Zucker, 2008a) but not all clinicians who work in this area of practice (Brill & Pepper, 2008; Ehrensaft, 2007; Spack, 2005).

A second approach makes no direct effort to lessen gender dysphoria or gender atypical behaviors. This approach is premised on the evidence that GID diagnosed in childhood usually does not persist into adolescence and beyond (Green, 1987; Wallien & Cohen-Kettenis, 2008), and on the lack of reliable markers to predict in whom it will or will not persist. A variation of this second approach is to remain neutral with respect to gender identity and to have no therapeutic target with respect to gender identity outcome. The goal is to allow the developmental trajectory of gender identity to unfold naturally without pursuing or encouraging a specific outcome (Ehrensaft, 2011; Hill & Menvielle, 2010; Hill, Menvielle, Sica, & Johnson, 2010; Pleak, 1999). Such an approach entails combined child, parent, and community-based interventions to support the child in navigating the potential social risks. Support for this approach is centered on the assumption that self-esteem may be damaged by conveying to the child that his or her likes and dislikes, behaviors, and mannerisms are somehow intrinsically wrong (Richardson, 1999). A counter argument proposes that self-esteem can be best served by improved social integration, including positive relationships with same-sex peers (Meyer-Bahlburg, 2002b). Alternatively, proponents of this second approach suggest that the child's self-recognition of a gender variant and stigmatized status may be actively encouraged, with the goal of mastery (e.g., developing cognitive, emotional and behavioral coping tools for living as a gender variant person) (Edwards-Leeper & Spack, 2011; Ehrensaft, 2011). A third approach may entail affirmation of the child's cross-gender identification by mental health professionals and family members. Thus, the child is supported in transitioning to a cross-gendered role, with the option of endocrine treatment to suspend puberty in order to suppress the development of unwanted secondary sex characteristics if the cross-gendered identification persists into puberty (Ehrensaft, 2011). The rationale for supporting transition before puberty is the belief that a transgender outcome is to be expected in some children, and that these children can be identified so that primary caregivers and clinicians may opt to support early social transition. A supporting argument is that children who transition this way can revert to their originally assigned gender if necessary since the transition is done solely at a social level and without medical intervention (Brill & Pepper, 2008). The primary counterargument to this approach is based on the evidence that GID in children usually does not persist into adolescence and adulthood. Thus, supporting gender transition in childhood might increase the likelihood of persistence (Pleak, 2010). Furthermore, the peer-reviewed literature does not support the view that desisters and persisters can currently be reliably distinguished as children (Cohen-Kettenis & Pfäfflin, 2010; Wallien & Cohen-Kettenis, 2008; Zucker, 2007; Zucker & Cohen-Kettenis, 2008). Moreover, after transitioning gender in childhood, reverting to the natal gender may entail complications (Steensma, Biemond, Boer, & Cohen-Kettenis, 2011).

Primary modes of therapy utilized in working with children with GID include individual insight-oriented psychoanalytic or psychodynamic psychotherapy (Coates, Friedman, & Wolfe, 1991); protocol-driven psychotherapy such as behavior modification (Rekers, 1979); parent and peer-relations focused therapy(Meyer-Bahlburg, 2002b), and parent and child therapeutic groups (Ehrensaft, 2011; Menvielle & Tuerk, 2002; Pleak, 1999). Additional interventions include support groups for primary caregivers, community education through websites and conferences, school-based curricula, and specialized youth summer camps. The primary focus of intervention is sometimes the primary caregivers. Depending on the treatment approach chosen, work may include parenting support and psychoeducation, guidance in reinforcing behavior modification, and instruction in techniques for building self-acceptance and resilience in the child. Some inter-

ventions are multi-faceted and involve the school and community, as well as the child and family. These include diversity education and steps to prevent bullying.

The Task Force identified the following as the major tasks for mental health professionals working with children referred for gender concerns: (1) to accurately evaluate the gender concerns that precipitated the referral; (2) to accurately diagnose any gender identity related disorder in the child according to the criteria of the most current DSM; (3) to accurately diagnose any coexisting psychiatric conditions in the child, as well as problems in the parent–child relationship, and to recommend their appropriate treatment; (4) to provide psychoeducation and counseling to the caregivers about the range of treatment options and their implications; (5) to provide psychoeducation and counseling to the child appropriate to his or her level of cognitive development; (6) when indicated, to engage in psychotherapy with the appropriate persons, such as the child and/or primary caregivers, or to make appropriate referrals for these services; (7) to educate family members and institutions (e.g., day care and preschools, kindergartens, schools, churches) about GV and GID; (8) to assess the safety of the family, school, and community environments in terms of bullying and stigmatization related to gender atypicality, and to address suitable protective measures.

With respect to comparing alternative approaches to accomplishing the above tasks, the Task Force found no randomized (APA level A) or adequately controlled nonrandomized longitudinal (APA level A-) studies, and very few follow-up studies without a control group either with (APA level B) or without (APA level C) an intervention. The majority of available evidence is derived from qualitative reviews (APA level F) and experimental systematic single case studies that do not fit into the APA evidence grading system.

Opinion Regarding Treatment Recommendations

Despite deficiencies in the evidence base and the lack of consensus regarding treatment goals, the present literature review suggests consensus on a number of points. Areas where existing literature supports development of consensus recommendations include, but are not limited to, the following: (1) assessment and accurate DSM diagnosis of the child referred for gender concerns, including the use of validated questionnaires and other validated assessment instruments to assess gender identity, gender role behavior, and gender dysphoria; (2) diagnosis of any coexisting psychiatric conditions in the child and seeing to their appropriate treatment or referral; (3) identification of mental health concerns in the caregivers and difficulties in their relationship with the child, ensuring that these are adequately addressed, (4) provision of adequate psychoeducation and counseling to caregivers to allow them to choose a course of action and to give fully informed consent to any treatment chosen. This entails disclosing the full range of treatment options available (including those that might conflict with the clinician's beliefs and values), the limitations of the evidence base that informs treatment decisions, the range of possible outcomes, and the currently incomplete knowledge regarding the influence of childhood treatment on outcome; (5) provision of age appropriate information to the child; (6) assessment of the safety of the family, school and community environments in terms bullying and stigmatization related to gender atypicality, and to address suitable protective measures.

Adolescents

Synopsis

For purposes of this Task Force report, adolescence is defined as the developmental period from 12 to 18 years of age. Adolescents with GID comprise two groups, those in whom GID began in childhood and has persisted, and those with the onset of GID in adolescence. Only two clinics (one in Canada and one in The Netherlands) have systematically gathered data on sufficient numbers of subjects to provide an empirical "experience base" on the main issues in adolescence. Both of these teams concur that management of those in whom GID has persisted from childhood is more straightforward than management of those in whom GID is of more recent onset. In particular, the latter group is more likely to manifest significant psychopathology in addition to GID.

This group should be screened carefully to detect the emergence of the desire for sex reassignment in the context of trauma as well as for any disorder such as schizophrenia, mania or psychotic depression that may produce gender confusion. When present, such psychopathology must be addressed and taken into account prior to assisting the adolescent's decision as to whether or not to pursue sex reassignment or actually assisting the adolescent with the gender transition. Both the Canadian and Dutch groups are guided by the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) which endorse a program of staged gender change in which fully reversible steps are taken first, followed in turn by partially reversible and irreversible steps.

With the beginning of puberty, development of the secondary sex characteristics of the natal gender often triggers or exacerbates the anatomic dysphoria of adolescents with GID (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Spack, 2005). Recently, the option has become available for pubertal patients with severe gender dysphoria and minimal, if any, additional psychopathology to have puberty suspended medically in order to prevent or to minimize development of unwanted secondary sex characteristics, some of which are not fully reversible with subsequent hormonal or surgical sex reassignment therapies (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010). A practice guideline developed by the Endocrine Society (Hembree et al., 2009) suggests that pubertal suspension can be done for a period of up to several years during which time the patient, with the clinicians, can decide whether it is preferable for the adolescent to revert to living in the birth sex or to continue gender

transition with cross-sex hormone therapy. There are currently little data regarding the timing of cross-sex hormone treatment in adolescents and no studies comparing outcomes when such treatment is initiated in adolescence as opposed to adulthood, with or without prior suspension of puberty. We know, however, that many adult transsexuals express regret over the body changes that occurred during puberty, some of which are irreversible. In the absence of a DSD (addressed in a separate section), at present, sex reassignment surgery (SRS) is not performed prior to the age of 18 in the United States. It is noted, however, that one study on carefully selected individuals in the Netherlands suggests that, as assessed by satisfaction with surgery and lack of regrets, outcome was generally better in individuals who initiated sex reassignment as adolescents than as adults (Smith, van Goozen, & Cohen-Kettenis, 2001; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005a). Even in these studies, however, SRS was not initiated prior to the age of 18.

The major tasks identified by the Task Force to be germane to provision of mental health services to adolescents with the desire to transition in gender, or who are in the process of transitioning, are (1) psychiatric and psychological assessment to both assure that any psychopathology is adequately diagnosed and addressed, and to determine whether the clinicians' approach will be neutral or supportive with respect to the desire to transition in gender; (2) provision of psychotherapy as indicated by the initial assessment and as indicated by changes over time. This includes providing psychological support during the real life experience and suspension of puberty and/or the administration of cross-sex hormones; (3) assessment of eligibility and readiness for each step of treatment.

Database searches failed to reveal any RCTs related to any of these issues. The quality of the evidence is primarily individual case reports (APA level G); follow-up studies with control groups of limited utility and without random assignment, or longitudinal follow-up studies after an intervention without control groups (APA level B); and reviews of the above (APA level F). Between 2001 and 2009, over 80 adolescents selected based on conservative criteria have been treated with pubertal suspension with overall positive results in the most detailed follow-up study published to date (APA evidence level B) (de Vries, Kreukels, Steensma, Doreleijers, & Cohen-Kettenis, 2011). In a consecutive series of 109 adolescents (55 females, 54 males) with GID, the Toronto group identified demographic variables correlated with clinical decisions to recommend, or not recommend, gonadal hormone blocking therapy (Zucker et al., 2011). Follow-up data, to date, however, are not adequate for statistical analyses of outcome variables.

Opinion Regarding Treatment Recommendations

Existing literature is insufficient to support development of an APA Practice Guideline for treatment of GID in adolescence but is sufficient for consensus recommendations in the following areas: (1) psychological and psychiatric assessment of adolescents presenting with a wish for sex reassignment, including assessment of co-occurring conditions and facilitation of appropriate management; (2) psychotherapy (including counseling and supportive therapy as indicated) with these adolescents, including enumeration of the issues that psychotherapy should address. These would include issues that arise with adolescents who are transitioning gender, including the real life experience; (3) assessment of indications and readiness for suspension of puberty and/or cross-sex hormones as well as provision of documentation to specialists in other disciplines involved in caring for the adolescent; (4) psychoeducation of family members and institutions regarding GV and GID; (5) assessment of the safety of the family/school/community environment in terms of gender-atypicality-related bullying and stigmatization, and to address suitable protective measures.

Adults

Synopsis

The adult section addresses individuals 18 years and older, and thus picks up where the adolescent section leaves off in considering individuals who seek mental health services for reasons related to GV, some of whom meet diagnostic criteria for GID. For some adults, GID/GV has clearly persisted from childhood and adolescence, but for others it has arisen (or at least come to clinical attention) for the first time in adulthood. Among natal males, there tend to be a number of differences between those with an early (childhood) as opposed to late (adulthood) onset. In particular, those with late onset are more likely to have had unremarkable histories of gender nonconformity as children, and are less likely to be primarily sexually attracted to individuals of their natal gender, at least prior to gender transition (Lawrence, 2010). Age of onset may have some, albeit limited, value in predicting satisfaction versus regret following SRS (Blanchard, Steiner, Clemmensen, & Dickey, 1989; DeCuypere et al., 2006; Lawrence, 2003; Muirhead-Allwood, Royle, & Young, 1999).

The WPATH SOC (Meyer et al., 2001) and the recent Endocrine Society Guideline (Hembree et al., 2009) endorse psychological evaluation and a staged transition in which fully reversible steps (e.g., presenting as the desired gender) precede partially reversible procedures (administration of gonadal hormones to bring about the desired secondary sex characteristics), which precede the irreversible procedures (e.g., gonadectomy, vaginoplasty in natal males, mastectomy and surgical construction of male-typical chest and phalloplasty in natal females).[2] Adults who have capacity to give informed consent may receive the gender transition treatments for which they satisfy the qualifying criteria of the providers. These criteria vary among providers and clinics. A recent review graded the quality of evidence relating particular components of the WPATH SOC to outcomes and

[2] Since the completion of this report, version 7 of the WPATH SOC has been published and is available at www.wpath.org.

concluded that psychotherapy prior to initiating hormonal or surgical treatments, and staged transition (including a period of real life experience) were associated with good outcome (De Cuypere & Vercruysse, 2009). Most of the studies reviewed were case series and case reports or reviews (APA level D or lower), although some included sufficient longitudinal follow-up and standardization to meet APA level B or C.

Prior to adulthood, some individuals will have already transitioned without medical intervention, while others may have had puberty medically suspended in order to prevent the emergence of undesired secondary sex characteristics, and others may have initiated cross-sex hormone treatments. Some of these individuals may have previously formulated a plan, together with their healthcare providers, to move to the next stage of medical/surgical gender transition as soon as they reach the legal age of majority and can legally assume responsibility for themselves and give informed consent. Such individuals may seek the services of mental health professionals at this point only for the assessment of their eligibility and readiness for the desired procedures as required by the WPATH SOC or their particular provider's policy.

As is the case with GID in childhood and adolescence, and for similar reasons, there are no RCTs pertaining to any treatment intervention in adults. Nor is there universal agreement regarding treatment goals other than improving the sense of well-being and overall functioning of the individual. Recently, the greatest emphasis has been placed on subjective patient reports, particularly those of satisfaction and self-perceived improvement or regrets. Several correlates of regret have been identified, including major co-existing psychiatric issues such as psychosis or alcohol dependency; an absence of, or a disappointing, real-life experience; and disappointing cosmetic or functional surgical results (Bodlund & Kullgren, 1996; Botzer & Vehrs, 1995; De Cuypere & Vercruysse, 2009; Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Kuiper & Cohen-Kettenis, 1998; Landen, Walinder, Hambert, & Lundstrom, 1998; Lundstrom, Pauly, & Walinder, 1984; Pfäfflin & Junge, 1998; Walinder, Lundstrom, & Thuwe, 1978). Regrets are somewhat more frequent for patients with late as opposed to early onset of GID. For both early and late onset groups, a favorable outcome is more likely among individuals who were high functioning prior to transition, and who received care, including surgeries, from experienced providers, and who were satisfied with the quality of their surgical results.

As was the case for GID in children and adolescents, database searches failed to reveal any RCTs related to addressing the mental health issues raised by GID in adults. Most of the literature addressing psychotherapy with gender variant adults would be categorized as APA level G and consists of case reports and review articles without additional data analysis. This body of work, nevertheless, identifies the major issues that should be addressed in psychotherapy with these individuals. There are some level B studies examining satisfaction/regret following sex reassignment (longitudinal follow-up after an intervention, without a control group); however, many of these studies obtained data retrospectively and without a control group (APA level G). Overall, the evidence suggests that sex reassignment is associated with an improved sense of well-being in the majority of cases, and also indicates correlates of satisfaction and regret. No studies have directly compared various levels of mental health screening prior to hormonal and surgical treatments on outcome variables; however, existing studies suggest that comprehensive mental health screening may be successful in identifying those individuals most likely to experience regrets (Bodlund & Kullgren, 1996; Botzer & Vehrs, 1995; De Cuypere & Vercruysse, 2009; Eldh et al., 1997; Gijs & Brewaeys, 2007; Kuiper & Cohen-Kettenis, 1998; Landen et al., 1998; Lundstrom et al., 1984; Pfäfflin & Junge, 1998; Walinder et al., 1978).

Opinion Regarding Treatment Recommendations

The Task Force concludes that, with subjective improvement as the primary outcome measure, the existing evidence base combined with clinical consensus is sufficient for developing recommendations in the form of an APA Practice Guideline. Areas where recommendations can be made include the following: (1) assessing and diagnosing patients' gender concerns according to DSM criteria and assuring that these are appropriately addressed; (2) assessing and correctly diagnosing any co-existing psychopathology and assuring that it is addressed adequately. This may entail modification of the plans/schedule for gender transitioning; (3) distinguishing between GID with concurrent psychiatric illness and gender manifestations that are not part of GID but epiphenomena of psychopathology; (4) engaging in psychotherapy with gender variant individuals as indicated. This includes identifying the elements that should be addressed in therapy, including the impact of discrimination and stereotyping; (5) ensuring that individuals who are in the process of transitioning, or who are considering or planning to do so, receive counseling from a qualified professional about the full range of treatment options and their physical, psychological, and social implications, including both their potential benefits and the full range of potential limitations (e.g., loss of reproductive potential), risks and complications; (6) ascertaining eligibility and readiness for hormone and surgical therapy, or locating professionals capable of making these ascertainments to whom the patient may be referred; (7) educating family members, employers, and institutions about GV including GID; (8) ensuring that documentation, including preparation of letters to endocrinologists and surgeons, employs terminology that facilitates accurate communication, minimizes pejorative or potentially stigmatizing language, and conforms (when applicable) to standards for third party reimbursement and tax deductible medical expense.

Individuals with Disorders of Sex Development

Overview and Synopsis

As employed here, the term disorders of sex development (DSD) refers to congenital conditions (formerly referred to as intersex dis-

orders, hermaphroditism, and pseudohermaphroditism) which entail atypical development of chromosomal, gonadal, and/or genital sex. The gender that should be assigned may not be obvious at birth and, in many cases, the process of decision making with respect to gender assignment is complex and fraught with uncertainties. Genitoplasty is often employed to bring the appearance of the external genitalia in line with the gender assigned. Additionally, gonadectomy must be considered in a variety of DSD syndromes due to increased risk of malignancy. The multiple medical (e.g., malignancy risk) and psychological (cross-gender puberty) factors that bear on such decisions were acknowledged by the Task Force as were the current debates regarding the timing of gonadectomy and the lack of consensus regarding the multiple issues relating to genital surgeries performed on minors. Readers are referred elsewhere for various viewpoints on these controversial interdisciplinary issues (e.g., Brown & Warne, 2005; Consortium on the Management of Disorders of Sex Development, 2006a; Frimberger & Gearhart, 2005; Hughes, Houk, Ahmed, & Lee, 2006; Speiser et al., 2010; Sytsma, 2006; Wiesemann, Ude-Koeller, Sinnecker, & Thyen, 2010). Some individuals with DSDs, in a proportion that varies greatly with syndrome and assigned gender, become dysphoric in the assigned gender and may reject it. A variety of issues in the clinical care of individuals with DSDs require the expertise of mental health professionals (Consortium on the Management of Disorders of Sex Development, 2006a; Meyer-Bahlburg, 2008). This Task Force Report addresses only those issues related to gender dysphoria and gender transition in these individuals. The clinical options and decision making processes that bear on gender transition and reassignment overlap to some extent regardless of the presence or absence of a DSD. When a DSD is present, however, there are fewer barriers to legal gender reassignment, and the barriers to hormonal and surgical treatments in conjunction with gender reassignment are lower.

Major areas of involvement of mental health professionals in the care of individuals with DSDs and gender dysphoria include (1) the evaluation of gender identity and the assessment of incongruences, if present, between gender identity and assigned gender; (2) decision making regarding gender reassignment; (3) psychotherapy to address significant gender dysphoria in individuals with a DSD who do not transition gender; (4) selected psychological/psychiatric aspects of the endocrine management of puberty in the context of gender reassignment; and (5) selected psychological/psychiatric aspects of genital surgery in the context of gender reassignment.

The literature bearing on the above issues includes numerous long-term follow-up studies (APA levels B and C) of gender outcome in individuals with DSDs, including some with gender dysphoria and reassignment. These often have significant methodological weaknesses related to sample size and heterogeneity as well as inadequate control groups. There are also multiple reviews (APA level F), some of which integrate data from accessible case reports and small-group studies (e.g., Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Mazur, 2005; Meyer-Bahlburg, 2005a, b).

Opinion Regarding Treatment Recommendations

The general absence of systematic studies linking particular interventions within the purview of psychiatry to mental health outcome variables largely limits the development of practice recommendations for DSDs to their derivation from clinical consensus. For individuals with gender dysphoria and a DSD, consensus recommendations could be developed for (1) the evaluation of gender identity and assessment of incongruence between gender identity and assigned gender; (2) decisions/recommendations regarding gender reassignment based on assessment; (3) psychotherapy to address dysphoria in the context of incongruence between gender identity and assigned gender in the absence of desire for gender transition. Although recent medical guidelines emphasize the desirability of and need for mental-health service providers with expertise in this area of care it is premature to recommend detailed guidelines on their required qualifications. To do so might jeopardize existing providers rather than contribute to closing the gap in the availability of mental-health service providers. Recommendations regarding the mental health needs of individuals with DSDs and their caregivers, whether or not gender dysphoria is present are found in Appendix 2 and are not summarized here.

Why APA Recommendations are Needed for the Treatment of GID

APA recommendations are needed for the treatment of GID for a variety of reasons. First, the existing guidelines, SOC, and policy statements of other professional organizations, including the WPATH SOC, and recent reviews highlight the role of mental health professionals in a multidisciplinary team approach to providing medical services to individuals with GID (American Medical Association House of Delegates, 2008a, b; British Society for Paediatric Endocrinology and Diabetes Clinical Committee, 2009; Consortium on the Management of Disorders of Sex Development, 2006a; Di Ceglie, Sturge, & Sutton, 1998; Gooren, 2011; Hembree et al., 2009); however, to date no professional organization of mental health practitioners provides such recommendations. The Task Force on Gender Identity and GV of the American Psychological Association has recently called for guideline development by its parent organization. Exactly when such guidelines will be available remains to be determined; however, their preparation is expected to get underway shortly. A call for nominations to a "Task Force on Guidelines for Psychological Practice with Transgender and Gender Non-Conforming Clients" was issued by the American Psychological Association on April 8, 2011. Recognizing the current absence of guidelines by any professional organization of mental health professionals, the clinical practice guideline of the Endocrine Society (Hembree

et al., 2009) states that mental health professionals usually follow the guidelines set forth by WPATH. Although WPATH is not a professional organization of mental health professionals, it counts many mental health professionals among its members, including psychologists, psychiatrists, and psychiatric social workers. A limitation of the current WPATH SOC (version 6), which will be remedied in the forthcoming version 7, is that it does not cite its underlying evidence base, nor indicate the level of evidence upon which its standards are based. An appreciation of the quality of evidence upon which recommendations are based is critical for the practitioner who must judge whether or not implementation of a particular recommendation is likely to be in the patient's best interest. Version 7 of the WPATH SOC is now in preparation, and in that context numerous reviews of the supporting evidence have recently been published. In fact, all four issues of the 2009 volume of *International Journal of Transgenderism* are devoted to this topic.

Second, although the practice of psychiatry overlaps with that of other medical specialties as well as with other mental health fields, including psychology, it is distinct in many respects. In particular, the diagnosis and treatment of major mental illnesses (e.g., psychotic disorders) in which gender identity concerns may arise as epiphenomena are primarily within the purview of psychiatrists, as are the pharmacological management of psychiatric disorders that may coexist with GID (e.g., mood and anxiety disorders and the assessment of undesired psychiatric manifestations of hormonal manipulations). It is, therefore, important that the available clinical evidence be evaluated from a psychiatric perspective for the benefit of practicing psychiatrists and their patients. Third, it is likely that APA guidelines would positively impact the number of psychiatrists willing to provide services to individuals with GID as well as the development of opportunities to receive training in providing such care. Such opportunities could include continuing medical education (CME) activities as well as workshops and similar venues at national meetings such as the APA and AACAP.

Finally, recommendations from the APA would frame its position on what constitutes realistic and ethical treatment goals as well as what constitutes ethical and humane approaches to treatment. In addition to providing guidance to psychiatrists and other healthcare professionals, such a document would provide guidance to consumers of mental healthcare services, including the primary caregivers of minors with GID, in selecting among the various available approaches to treatment.

Recommendations for the APA

1. The opinion of the Task Force is that the current credible literature is sufficient to support treatment recommendations and that such recommendations are needed. The Task Force, therefore, recommends that the APA proceed with developing treatment recommendations. These recommendations should address, but not be limited to, those areas identified in this report for which recommendations are needed and substantial support is available from either research data or clinical consensus within the literature. With the possible exception of GID in adults, it is unlikely that GID/GIDNOS will meet the criteria to be prioritized by the SCPG for APA Practice Guideline development. If not, the Task Force suggests that recommendations for each of the groups discussed in this report (children, adolescents, adults, individuals with DSDs) be prepared as APA Resource Documents.

2. There is a critical need for an APA Position Statement on the Treatment of GID, and given the time it will take to develop treatment recommendations, a position statement should precede the development of recommendations. In recent years, the APA has received many requests from advocacy groups and the media inquiring about APA's position on the treatment of individuals with GID. As the APA has never had any specific component charged with directly addressing such inquiries, such questions were usually referred by default to the Committee on Gay, Lesbian and Bisexual Issues which was sunset during the restructuring of APA components in 2008. Examples of questions received include: How can primary caregivers best nurture a child with GID? Does any APA documentation define what is considered humane and ethical treatment of individuals, especially children, with GID? What constitutes medically necessary treatment for individuals of different age groups who meet criteria for GID? To what level of GID-related care are individuals entitled if their care is provided, or paid for by, governmental bodies (e.g., adolescents in foster care, prisoners, military personnel and veterans)? Is SRS a standard treatment that should be routinely covered by insurance?

The APA first introduced GID as a category of diagnostic entities in 1980. Thirty years later, other than the DSM diagnoses, the APA has no official position statements pertaining to, or even mentioning, these diagnostic entities. In particular, the APA has not addressed the issue of what constitutes either ethical and humane or medically necessary treatment for the GID diagnoses. Requests for psychotherapeutic, hormonal, and surgical treatments for GID, or their reimbursement, are frequently denied because they are perceived by private and public third party payers as cosmetic or unnecessary procedures rather than medically necessary or standard medical and mental health care (Minter, 2003). A document by the WPATH board of directors and executive officers discusses the term, *medically necessary*, as it is commonly used among health insurers in the United States and lists those aspects of GID treatment that meet the definition (Whittle et al., 2008). While the existence of the diagnosis contributes to the stigma of affected individuals, the unintended result of the APA's silence is a failure to facilitate full access to care for those diagnosed with GID. The Task Force, therefore, recommends that the APA consider drafting a resolution, similar to Resolution 122 of the American Medical Association (American Medical Association House of Delegates, 2008b). This resolution concludes that medical research demonstrates the effectiveness and necessity of mental health care, hormone therapy and SRS for many individuals diagnosed with GID and resolves that the AMA supports public and

private health insurance coverage for medically necessary treatments and opposes categorical exclusions of coverage for treatment of GID when prescribed by a physician.

3. This Task Force strongly endorses recent medical and psychological guidelines that emphasize the desirability of, and need for, mental-health service providers with expertise in providing services to individuals with gender dysphoria, GID and DSDs (Consortium on the Management of Disorders of Sex Development, 2006a; Hembree et al., 2009; Hughes et al., 2006; Meyer-Bahlburg, 2008; Speiser et al., 2010). It is the opinion of this Task Force, however, that detailed restrictions on required qualifications of the mental health practitioners who provide these services are not desirable. Such restrictions might jeopardize existing providers rather than contribute to closing the gap in the availability of mental-health service providers. Instead, the Task Force recommends that the APA create opportunities for educating mental healthcare providers in this area of care. Such opportunities could include CME activities as well as workshops and similar venues at national meetings such as the APA and AACAP.

4. The Task Force recommends that a structure, or structures, within the APA be either identified or newly created and charged to follow up on the recommendations of this report, to periodically review and update resulting treatment recommendations, to identify areas where research is particularly needed to optimize treatment, and to identify means to facilitate such research.

Literature Reviews

GV in Childhood

Edgardo J. Menvielle, M.D., M.S.H.S. and Richard R. Pleak, M.D.

The optimal approach to treating pre-pubertal children with GV, including DSM-defined GID, is much more controversial than treating these phenomena in adolescents and adults for several reasons. Intervention, or the lack thereof, in childhood as opposed to later may have a greater impact on long range outcome (Crouch, Liao, Woodhouse, Conway, & Creighton, 2008); however, consensus is lacking regarding the definition of desirable outcomes. Further, children have limited capacity to participate in decision making regarding their own treatment and must rely on caregivers to make treatment decisions on their behalf. An additional obstacle to consensus is the lack of randomized controlled treatment outcome studies of children with GID or with any degree of GV (Zucker, 2008b). In the absence of such studies, the highest level of evidence currently available for treatment recommendations for these children can best be characterized as expert opinion. Such opinions do not occur in a complete vacuum of relevant data, but are enlightened by a body of literature (mostly APA level C and lower), including systematic experimental single-case trials as well as both uncontrolled and inadequately controlled treatment studies, longitudinal studies without intervention, and clinical case reports.

Opinions vary widely among experts depending on a host of factors, including their theoretical orientation as well as their assumptions and beliefs (including religious) relating to the origins, meanings, and fixity/malleability of gender identity. For example, do gender variations represent natural variations, not assimilated into the social matrix, or pathological mental processes? Even among secular practitioners there is a lack of consensus regarding some of the most fundamental issues: What are indications for treatment? What outcomes with respect to gender identity, gender role behaviors, and sexual orientation are desirable? Is the likelihood of a particular outcome altered by intervention? What constitutes ethical treatment aimed at bringing about the desired changes/outcomes? Adding to this complexity, service seekers as well as providers differ in their religious and cultural beliefs as well as in their world-views regarding gender identity, appropriate gender role behaviors, and sexual orientation. Primary caregivers may, therefore, seek out providers for their children who mirror their own world views, believing that goals consistent with their views are in the best interest of their children.

We begin by examining the natural history of GID as defined by outcome without treatment. We then discuss the goals of interventions in treating these children and the factors that influence clinicians in goal selection. Next, we describe various interventions that have been proposed. The empirical data available to inform the selection of goals and interventions are then reviewed and an opinion is offered regarding the status of current credible evidence upon which treatment recommendations could be based.

Outcome Without Treatment

The natural history or outcome of untreated children with GID is that a minority will identify as transsexual or transgender in adulthood (a phenomenon termed *persistence*), while the majority will become comfortable with their natal gender over time (a phenomenon termed *desistence*) (Davenport, 1986; Green, 1987; Wallien & Cohen-Kettenis, 2008; Zuger, 1978). As reviewed by Wallien and Cohen-Kettenis (2008), the rate of persistence into adulthood was initially reported to be exceedingly low, but more recent studies suggest that it may be 20 % or higher. In one recent study of gender dysphoric children (59 boys, 18 girls; M age, 8.4 years; age range, 5–12 years), 27 % (out of 54 who agreed to participate in the follow-up study) remained gender dysphoric at follow-up 10 years later. At follow-up, nearly all male and female participants in the persistence group reported having a homosexual or bisexual sexual orientation. In the desistance group, all of the girls and half of the boys reported having a heterosexual orientation. The other half of the boys in the desistance group had a homosexual or bisexual sexual orientation.

A more recent study (Drummond, Bradley, Peterson-Badali, & Zucker, 2008) assessed 25 girls in childhood (M age, 8.88 years; range, 3–12 years) and again as adolescents or adults (M age,

23.24 years; range, 15–36 years). At the assessment in childhood, 60 % of the girls met the DSM criteria for GID, and 40 % were subthreshold for the diagnosis. At follow-up, 3 participants (12 %) were judged to have GID or gender dysphoria. Regarding sexual orientation, 8 (32 %) participants were classified as bisexual/homosexual in fantasy, and 6 (24 %) were classified as bisexual/homosexual in behavior. The remaining participants were classified as either heterosexual or asexual. At follow-up, the rates of GID and bisexual/homosexual sexual orientation were substantially higher than base rates in the general female population derived from epidemiological or survey studies.

Desistence develops gradually over the preadolescent period (primarily between 8 and 12 years) for unknown reasons which have been postulated to include social ostracism, early pubertal hormonal changes, and cognitive development (Wallien & Cohen-Kettenis, 2008). It has also been noted that, compared to "persisters," "desisters" may experience less gender dysphoria in childhood (Wallien & Cohen-Kettenis, 2008). The reliability of adult transsexuals' reports of childhood gender nonconformity has been discussed by Lawrence (2010). A substantial proportion of adult transsexuals retrospectively report that, as children, gender conformity and/or gender dysphoria that were kept private, never leading to clinical referral (Cole, Denny, Eyler, & Samons, 2000; Denny, 1992). Some may also reinterpret childhood memories in light of later life events and recall greater degrees of gender non-conformity than were apparent in childhood, thereby making the decision to transition gender more easily explicable to self and others (Bancroft, 1972). Some patients report exaggerating the history of gender non-conformity in order to be regarded by mental health and other professionals as appropriate candidates for medical services related to gender transition (Fisk, 1974).

In Green's (1987) longitudinal study of gender-referred boys, psychotherapy as children did not appear to have any effect on gender identity or sexual orientation in young adulthood, but the numbers of boys in various types of therapy were too small to draw strong conclusions. To date, no long-term follow-up data have demonstrated that any modality of treatment has a statistically significant effect on later gender identity or sexual orientation.

Treatment Goals and Objectives

The overarching goal of psychotherapeutic treatment for childhood GID is to optimize the psychological adjustment and well-being of the child. The literature reflects a broad consensus regarding several other goals, including appropriate diagnosis and treatment of concomitant psychopathology as well as disorders or conflicts whose manifestations may be confused with GID, and building the child's self-esteem (Hembree et al., 2009; Meyer-Bahlburg, 2002b; Perrin, Smith, Davis, Spack, & Stein, 2010; Richardson, 1999; Zucker, 2008a). Although the child is the designated patient, there is also consensus regarding the need for parental psychoeducation, assessment, and adequate attention to parental psychopathology and parent–child conflicts (Coates et al., 1991; Zucker, 2008a).

What is viewed as essential for optimizing the well-being of the child differs among clinicians, as does the manner in which the various potential goals of treatment should be prioritized relative to one another. For example, should re-shaping the child's gender behaviors (e.g., increasing gender-conforming behaviors and/or decreasing gender non-conforming behaviors) be a primary therapeutic goal? Some have argued against directly targeting non-conforming behaviors (Ehrensaft, 2011; Hill et al., 2010; Pleak, 1999), while recognizing that some forms of co-existing psychopathology in children with GID (e.g., depression) may be secondary to poor peer relations resulting from peer rejection due to the cross-gender identification. Modifying the child's cross-gender behaviors has been suggested by others to alleviate short term distress by improving peer relations and perhaps preventing the development of other psychopathological sequelae (Zucker, 1990).

Opinions also differ regarding the question of whether or not prevention of adult transsexualism should be a goal of therapy. Zucker concludes that "there is little controversy in this rationale, given the emotional distress experienced by gender-dysphoric adults and the physically and often socially painful measures required to align an adult's phenotypic sex with his or her subjective gender identity" (Zucker, 1990). Given the absence of any evidence that therapy is effective in preventing transsexualism in adulthood together with concerns that therapy with that aim may be damaging to self-esteem, others challenge prevention as an acceptable goal. Among clinicians who share this second view, some endorse allowing the child to live in their preferred gender role to the extent that it is deemed safe to do so (Edwards-Leeper & Spack, 2011; Ehrensaft, 2011). Some children may choose to present in the gender congruent with their biological sex in most social settings in order to avoid teasing and ridicule, but may present as their preferred gender at home and in other "safe" environments. Other children may become extremely depressed and even suicidal if not permitted to live in their preferred gender in all settings. Thus, some clinicians endorse childhood gender transition in at least some cases (Edwards-Leeper & Spack, 2011; Ehrensaft, 2011).

The rationale for supporting transition before puberty is based on the belief that in some children a long term transgender outcome is to be expected and that these children can be identified so that primary caregivers and clinicians may opt for early social transition. An additional argument is that children who transition this way can always revert to their originally assigned gender if necessary, since the transition is only done at a social level and without medical intervention (Brill & Pepper, 2008) although this may not be without complications (Steensma et al., 2011). The main counterarguments to this approach hinge on the finding that GID in children usually does not persist into adolescence and adulthood. Thus, supporting gender transition in childhood might hinder the child's development or perhaps increase the likelihood of persistence (Pleak, 2010). Furthermore, the peer-reviewed literature

does not support the view that desisters and persisters can currently be distinguished reliably as children (Cohen-Kettenis & Pfäfflin, 2010; Wallien & Cohen-Kettenis, 2008; Zucker, 2007, 2008b).

Yet another approach to working with children with GID is to remain neutral with respect to gender identity and to have no goal with respect to gender identity outcome. Instead, the goal is to allow the developmental trajectory of gender/sexuality to unfold naturally without pursuing or encouraging a specific outcome (Ehrensaft, 2011; Hill et al., 2010; Pleak, 1999). The position in favor of supporting free gender expression is centered on the assumption that self-esteem may be damaged by conveying to the child that his/her likes and dislikes as well as mannerisms are somehow intrinsically wrong. The counter argument proposes that self-esteem can be best served by improved social integration, including the ability to make same sex friendships. Here the assumption is that the derived psychological benefits brought about by conforming to social expectations outweigh the benefits of expressing the putative "true gender self" (Ehrensaft, 2011) freely when it deviates significantly from social gender norms. Alternatively, the child's self-recognition of a gender variant and stigmatized status may be actively encouraged with the goal of mastery (e.g., developing cognitive, emotional and behavioral coping tools) (Ehrensaft, 2011). As reviewed by Zucker (1990), there is currently widespread recognition among mental health professionals that homosexuality is not inherently related to general psychopathology or mental disorders. Nevertheless, it has been suggested that treatment of gender variant children for the prevention of homosexuality can be justified on other grounds, including parental values (Green, 1987) as well as religious values (Rekers, 1982). Given the absence of evidence that any form of therapy has an effect on future sexual orientation, however, such efforts are presently controversial, and this point should be addressed in the psychoeducation of primary caregivers. Further, it has been argued that offering therapy aimed at preventing homosexuality could have the effect of labeling homosexuality as an inferior and undesirable condition, thereby increasing prejudice and discrimination towards lesbians and gay men (Byne & Stein, 1997). Parallel arguments could be made regarding attempts aimed at preventing transsexualism.

Types of Interventions

A variety of intervention modalities has been proposed to achieve the above goals. Therapeutic approaches to work with children with GID include individual insight-oriented psychoanalytic or psychodynamic psychotherapy (Coates et al., 1991); protocol-driven psychotherapy such as behavior modification (Rekers, 1979); parent and peer-relations focused therapy (Meyer-Bahlburg, 2002b), and parent and child therapeutic groups (Ehrensaft, 2011; Menvielle & Tuerk, 2002; Pleak, 1999). Other proposed interventions are best characterized as self-advocacy and educational: support groups for primary caregivers; community education through websites and conferences; school-based curricula; and specialized youth summer camps. As in other disorders, the recommendation for a particular therapy often hinges on the therapist's preferences and training. This is especially true for GID, however, in light of the lack of consensus on the goals for therapy, the malleability of gender identity, and the controversies surrounding the ethics of aiming to influence identity development.

Even though the child should be the ultimate beneficiary of treatment, the primary focus of intervention is sometimes the primary caregivers (e.g., via parenting support and psychoeducation as well as guidance in reinforcing behavior modification, and building self-acceptance and resilience in the child) and often multi-pronged interventions are necessary that involve, not only the child and family, but the community (e.g., via bullying prevention and diversity education). Some approaches may center on the primary caregivers to minimize therapist contact with the child in order to avoid placing the child squarely in the clinical spotlight which can be stigmatizing (Ehrensaft, 2011; Meyer-Bahlburg, 2002b). This is particularly true of work with very young children in which the primary caregivers may be targeted with the aim of empowering them with the understanding and skills necessary for optimally parenting their child with GID (Ehrensaft, 2011). Additionally, psychodynamic theories have sometimes focused on the primary caregivers (Stoller, 1985) or parent–child conflict (Haber, 1991) as possible causal factors in GID, providing a different rationale for primary caregivers as the target(s) of intervention. Problems in parent–child attachment interacting with temperamental dispositions in the child have been suggested to be causally implicated in GID and have been cited as a focus for psychodynamic therapy of the child (Coates et al., 1991). Zucker and Bradley (1995) observed higher levels of psychopathology in clinical samples of primary caregivers and suggested that parental psychological abnormalities may contribute to GID. These observations, however, do not distinguish between cause and effect. Whatever the directionality of the cause and effect relationship, parental distress and psychopathology should be assessed and appropriately addressed as part of a comprehensive treatment approach.

Outcome Research

Very few studies have systematically researched any given mode of intervention with respect to an outcome variable in GID and no studies have systematically compared results of different interventions. Some of the earliest treatment studies of children with GID were done in the 1970s by Rekers and colleagues in individual and small case series using behavioral methods (Rekers, 1977; Rekers, Rosen, Lovaas, & Bentler, 1978). These authors tested behavior modification in boys through contingency management, including punishment [e.g., "response cost" procedures (Rekers & Lovaas, 1974)] of feminine behaviors with a stated goal being prevention of later homosexuality and transsexualism. Short-term treatment success was reported with a decrease in gender non-conforming behaviors. Long term follow-up studies, however, were not reported so there is no evidence that these effects were enduring or that

intervention influenced either gender identity or sexual orientation. Although Rekers' reports were widely criticized (Morin & Schultz, 1978; Pleak, 1999; Wolfe, 1979) for using punishment and religious persuasion with the goal of prevention of homosexuality, his general goals for interventions with children with GID have been shared by a few other clinicians (e.g., Nicolosi & Nicolosi, 2002; Socarides, 1995) and endorsed by controversial mental health organizations such as the National Association for Research and Therapy of Homosexuality (www.narth.org).

A parent-and peer-relations focused protocol for boys with GID was tested by Meyer-Bahlburg (2002b). The treatment focused on the interaction of the child with the primary caregivers and with the same-gender peer group. The goals were developing a positive relationship with the father (or father figure), developing positive relationships with male peers, developing gender-typical skills and habits, fitting into the male peer group, and feeling good about being a boy. To minimize the child's stigmatization, only the primary caregivers attended treatment sessions which focused on such issues as parents' gender attitudes, changing family dynamics when the father increases positive interaction with the boy, selection of appropriate same-sex peers for play dates, selection of summer camp, supporting artistic interests and talents, etc. The therapy also involved ignoring rather than prohibiting or bluntly criticizing the boy's cross-gender behaviors and distracting him in contexts typically leading to cross-gender behaviors, while giving him positive attention when he engaged in gender-neutral or masculine activities.

The sample consisted of 11 boys. Age at evaluation ranged from 3 years, 11 months to 6 years with a median of 4 years, 9 months. Eight boys were diagnosed as having GID of childhood and three as having GIDNOS. Treatment was terminated in most cases when the goals stated above were judged to have been fully reached. Ten of the 11 cases showed such marked improvement; only one did not and was, therefore, judged to be unsuccessful. The total number of treatment visits per family ranged from 4 to 19 (with a median of 10). In some cases, treatment for other family problems, such as marital conflict or individual psychiatric problems of the primary caregivers, continued after treatment of the child's GID was completed. Follow-up was done mostly by telephone. The duration of follow-up was left to the primary caregivers and varied up to several years. There was no significant recurrence of GID or GIDNOS in the 10 successful cases, although several primary caregivers reported occasional recurrence of some cross-gender activities, especially during the first winter following treatment when the children were homebound and peer contacts diminished.

Some therapists, including the present authors, modify Meyer-Bahlburg's (2002b) parent- and peer-centered approach. This entails working with the family in a psychoeducational and supportive approach, promoting the child's self-esteem and decreasing family dysfunction, while assisting the family with the child's positive adaptation regardless of gender identity. This approach involves much work with the primary caregivers and other family members, as well as with the school or other facilities, and can include support groups for the primary caregivers (Hill et al., 2010; Menvielle, Perrin, & Tuerk, 2005; Pleak, 1999). The goals are to allow the child to have a variety of experiences and to promote positive adaptation to whatever gender identity and sexual orientation the child will have as an adolescent and adult, and to assist the family in accepting and supporting their child regardless of outcome. The present authors (unpublished) have observed improved self-esteem, decreased behavioral disturbance, improved family functioning, and generally less cross-gender behavior using this approach. One of the authors (Pleak, unpublished) has followed up 10 boys with GID who were in treatment between ages 3 and 12 years old. In young adulthood, 7 identify as gay men, 1 as bisexual; 1 has undergone sex reassignment and is now a woman; and 1 who has Asperger's disorder, has no romantic or sexual relationships with other people, but identifies entirely as male and reports sexual fantasies about women. As adults, all acknowledge their previous GV in behavior and identity, and the 9 who did not become transsexual say they have not felt cross-gendered since adolescence.

Conclusions

Web-based literature searches failed to reveal any randomized controlled studies related to any of the issues germane to treatment of children with GID. The majority of studies would be categorized as APA evidence category G, such as individual case reports, and APA evidence category C, such as longitudinal follow-up studies without any specific intervention (Green, 1987). A few reports might be categorized as APA level B (clinical trials); however, these lacked control groups (or an adequate control group) and/or the follow-up interval was brief (Meyer-Bahlburg, 2002b; Rekers, 1979; Rekers & Mead, 1979). In light of the limited empirical evidence and disagreements about treatment approaches and goals among experts in the field and other stakeholders, recommendations supported by the available literature are largely limited to the areas of consensus identified above and would be in the form of general suggestions and cautions. One such caution would be to inform primary caregivers and children (in an age-appropriate manner) of the realistic therapeutic goals, available treatment options, and the lack of rigorous evidence favoring any particular treatment over another for attaining a particular goal. Families should be informed about potential outcomes, including the possibility that the child's experience/perception of the gendered self may change as they mature. The range of possible long-term outcomes discussed should include homosexuality, heterosexuality, varying degrees of comfort/discomfort with sex of birth, and variance in gender expression in relation to stereotypes, including the pursuit of medical/surgical interventions for sex reassignment. Clinicians should be sensitive to the primary caregivers' values and wishes but also be alert to the possibility of parental decisions being driven by a wish to normalize the child through therapy intended to increase gender conformity (or heterosexuality) or through premature gender role transition. At the same time, clinicians should be cautioned against wholesale rejection of gender role transition when this may be in the best interest of the

child, even if in a relatively small number of cases (Steensma & Cohen-Kettenis, 2011). Clearly, therapy cannot be offered with the promise of preventing either transsexualism or homosexuality. Even offering treatment with such aims raises ethical concerns and these have been addressed elsewhere (Dreger, 2009; Pleak, 1999).

GV in Adolescence

Susan J. Bradley, M.D. and Richard Green, M.D., J.D.

For the purpose of this report, adolescents will be defined as youth between the ages of 12 and 18. Problems of gender identity present as a spectrum with some adolescents having long-standing gender dysphoria and wishes to be the other sex (typically evident in childhood) while others present with a more recent onset of gender dysphoria, sometimes in the context of more broad identity confusion and less clear definition of their identity as the other sex. For example, we have seen several adolescent females with recent onset of a wish for SRS following a sexual assault. Other adolescents may present with clear body dysmorphic disorder, psychosis, severe depression, and Asperger's disorder, with the wish for SRS appearing almost as a secondary phenomenon. Those adolescents whose GID symptoms were clearly present in childhood and have continued into adolescence are generally less complicated to manage. According to Cohen-Kettenis and van Goozen (2002), this "persistent" group may have less overt psychopathology. Those whose GID symptoms emerge later, often with pubertal changes and/or in the context of a psychiatric disorder or following Transvestic Fetishism, present with a more complicated management picture. Although many of the same issues arise for both early and later onset groups, the timing at which particular issues arise and how they are managed clinically may vary between the two groups. The consensus among the clinicians with the most experience in this area is that it is important to address major co-occurring psychiatric issues prior to the gender issues in both early and later onset groups (de Vries & Cohen-Kettenis, 2009; Zucker & Cohen-Kettenis, 2008). In the absence of other contributory issues, as is more common with the early onset group, supportive work towards transition may be appropriate (de Vries & Cohen-Kettenis, 2009; Zucker & Cohen-Kettenis, 2008).

Searches of PubMed and PsychInfo databases failed to reveal any randomized controlled trials (RCTs) related to any of the issues germane to treatment of adolescents with GID. The majority of studies would be categorized as APA evidence category G, such as individual case reports (Babinski & Reyes, 1994), APA evidence category C, such as longitudinal follow-up studies without a control groups, (e.g., Cohen-Kettenis & van Goozen, 1997; McCauley & Ehrhardt, 1984; Smith et al., 2005a), APA evidence category B, such as follow-up studies with control groups of limited utility and without random assignment (e.g., Smith et al., 2001; Steensma et al., 2011), and APA evidence category F, such as reviews of the above, some of which were exhaustive (e.g., Cohen-Kettenis et al., 2008; Tugnet, Goddard, Vickery, Khoosal, & Terry, 2007; Zucker, 2007; Zucker & Cohen-Kettenis, 2008). There are two clinics (The Gender Clinic at the Vrije University Medical Center, Amsterdam, The Netherlands, and the Gender Identity Service at the Centre for Addiction and Mental Health, Toronto, Canada) that have sufficient numbers of subjects and where there is systematic data collection to act as an "experience base" from which to guide both the inquiry and possibly expert opinion on the main issues in adolescence. Unfortunately, additional studies to either corroborate or challenge the findings of these clinics are not available.

This report will begin by considering the assessment of individuals presenting with a wish for gender reassignment, and then consider the evidence for psychotherapy, the real life experience, medical suspension of puberty, and cross-sex hormones. An assessment of the evidence base regarding each of these issues is given as well as an opinion regarding the development of treatment recommendations. SRS is not performed on adolescents in the United States and is, therefore, not addressed in detail.

Assessment

Follow-up studies of adolescents and adults from the Dutch clinic emphasize the importance of good assessment with respect to comorbid psychopathology (Cohen, de Ruiter, Ringelberg, & Cohen-Kettenis, 1997; de Vries, Steensma, & Cohen-Kettenis, 2011; Smith et al., 2001, 2005a; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005b). Better outcomes from SRS were seen in female-to-male transsexuals (FTMs) and male-to-female transsexuals (MTFs) who were primarily erotically attracted to individuals of their natal sex than in MTFs who were not primarily attracted to individuals of their natal sex. MTF individuals in the latter category with more psychopathology and cross-gender symptoms in childhood, yet less gender dysphoria at initial consultation, were more likely to drop out from follow-up prematurely. Such clients with considerable psychopathology and body dissatisfaction reported the worst post-operative outcomes. As described below, the most systematic information is available on the adults ($N = 162$) while the adolescent samples were smaller ($N = 22$ and $N = 20$).

Although the studies from the Dutch clinic are suggestive, the predictors are hardly either well-tested or strong enough to use alone in assessing prospective candidates for SRS. Generally, both clinics believe that those adolescents with higher levels of psychopathology, less gender dysphoria, and/or more recent onset of their wish for sex reassignment should be followed over a period of time in order to treat the more obvious psychopathology (e.g. depression, psychosis, body dysmorphic disorder) and to see if treatment of the psychopathology will lead to a reduction in the wish to proceed to SRS (see case reports of change in wish for SRS with treatment of comorbid psychopathology (Caldwell & Keshavan, 1991; Coleman & Cesnik, 1990; Marks & Mataix-Cols, 1997; Puri & Singh, 1996).

The position of the Toronto clinic has been to aim for neutrality with respect to the issue of gender transition in those situations in

which the GID is of recent onset and accompanied by more obvious psychopathology. With those adolescents where there is long-standing GID and the adolescent is already engaged in the "real life experience" or prepared to do so, the Toronto clinic tends to be more positive with respect to supporting transition. Both groups may, however, be offered pubertal suspension as a way of delaying puberty and/or the development of secondary sex characteristics in order to allow more time either for psychotherapy or for planning for the future. Future planning issues include how to present oneself socially as the other sex, how to change one's name, who to tell, and similar issues. Clearly, for the younger adolescent, this means agreement of the primary caregivers. In some cases older, "emancipated" adolescents may proceed without parental agreement.

The Dutch group supports full gender transition, assisted by hormone administration for adolescents who are generally well-adjusted and functioning socially in the preferred gender role, are older than 12 years of age, and have reached Tanner stage 2–3. In a follow-up study of such individuals (N = 20), they reported that with cross-sex hormone treatment in adolescence and SRS at age 18, or shortly thereafter, the outcomes were overall quite positive (as assessed by satisfaction with surgery and lack of regrets) and generally better compared to individuals who underwent SRS later in adulthood (Smith et al., 2001). They also followed a group of adolescents who were refused SRS or chose not to pursue it (N = 21). The reasons for refusal were elevated levels of psychopathology, lack of clarity or consistency regarding the nature and extent of the gender identity concerns resulting in diagnostic uncertainty, and gross psychological instability. Those who did not have SRS showed reductions in gender dysphoria but continued to have more social and emotional difficulties than the SRS group. The difficulty in interpreting this study is that the subjects who were refused or not encouraged to proceed generally had higher levels of psychopathology to begin with. Although there were reductions in psychopathology across all groups, it is impossible to draw conclusions about the efficacy of SRS in reducing comorbid psychopathology because the groups were not matched for level of psychopathology at the outset. Unfortunately, there are no controlled studies with matching of subjects at the outset and random assignment to SRS or supportive therapy. Overall, those who were refused did not regret not being able to pursue SRS. The investigators emphasize the importance of careful evaluation as the initial step in SRS and referral for comorbid psychopathology in those who do not meet careful criteria for gender dysphoria. Clearly, clinical judgment is involved with it being easier to assess and evaluate those with long-standing GID as opposed to the later onset group who tend to present not only with more psychopathology but more uncommon requests such as the desire for drugs to reduce testosterone levels with no overt desire to pursue SRS.

In the Toronto sample, there is significant psychopathology in the adolescent sample, particularly in the late onset group (Zucker et al., 2012). As indicated above, many of these adolescents also present with a shorter duration of cross-gender feelings and less clarity or consistency regarding the nature of their gender concerns as well as histories of trauma, psychosis, body dysmorphic disorder, and severe depression that seem related to their cross-gender feelings. Despite these observations, often these adolescents are very certain that SRS is the "only" solution to their dilemmas and because of this may become very pressuring of doctors in their quest for SRS. Access to internet sites that uncritically support their wishes appears to facilitate their intense desire for hormones and surgery. In order to deal with these issues, both the Dutch and the Toronto groups generally insist on some form of involvement in supportive psychotherapy with a focus on comorbid psychopathology and family issues as well as support around pursuing or not pursuing SRS. Some of these adolescents and their families, however, are reluctant to proceed with psychotherapy or family therapy.

Based on the above, it is important to do a thorough assessment of adolescents presenting with a wish for SRS. This should include an assessment for comorbid psychopathology, particularly any disorder that may have as a secondary phenomenon a tendency to produce gender confusion, such as schizophrenia or psychotic depression, or emergence of the SRS wish in the context of trauma.

Psychotherapy

As indicated above, psychotherapeutic involvement is used not only to explore issues related to the individual's commitment to living in the cross-gender role but also to explore whether the individual has fully explored other options, such as living as a homosexual person without SRS. Attempts to engage the individual in more in-depth psychotherapy to "cure" them of their gender dysphoria are currently not considered fruitful by the mental health professionals with the most experience working in this area (de Vries & Cohen-Kettenis, 2009; Zucker & Bradley, 1995). Instead of psychotherapy aimed at "curing" gender dysphoria, supportive therapy and psychoeducation seem justified on the basis of ensuring that the individual understands and is committed to a long and difficult process and has considered alternatives to SRS. Generally, some time is devoted to supporting the individual's efforts to live and present oneself as the other sex. There have been no systematic studies of the effects of this supportive psychotherapy.

A survey of Dutch psychiatrists who did not work in GID clinics found that 49 % had treated at least one "cross-gender confused" patient. Of 584 patients reported on in the survey, GID was regarded as the primary diagnosis for 39 %. In the other 61 % of cases, cross-gender issues were comorbid with other psychiatric disorders and in the majority of those cases, the gender issues were interpreted as epiphenomena of the comorbid disorder (Campo, Nijman, Merckelbach, & Evers, 2003). The most frequently reported disorders in which "cross-gender confusion" was reported were personality, mood, dissociative, and psychotic disorders (Campo, Nijman, Evers, Merckelbach, & Decker, 2001; Campo et al., 2003), with gender confusion or cross-gender delusions occurring in up to 20 % of individuals with schizophrenia over the course of the illness

(Borras, Huguelet, & Eytan, 2007). Campo et al. (2003) concluded that the survey emphasizes the need for articulated rules to assist mental health specialists in distinguishing GID with a comorbid psychiatric disorder from gender confusion that is an epiphenomenon of another disorder. Knowledgeable clinicians can make this distinction based on the patient's history, including collateral history from friends and family members, and longitudinal follow-up. Most experienced clinicians would agree that, when the adolescent is motivated, supportive psychotherapy is very helpful either to assist in the transition to the other gender or to assist in the individual's decision as to whether to pursue SRS or not.

Expectations for a Period of Living as the Other Sex (The "Real Life" Experience)

Since the original guidelines drafted in 1979 by the Harry Benjamin International Gender Dysphoria Association (HBIGDA), now WPATH, subjects wishing SRS have been expected by the mental health professionals assessing them for suitability to live as the other gender for 1–2 years prior to being approved for surgery. These recommendations for living or presenting oneself as the other gender have been modified over time and there is no absolute agreement as to what length of time nor what aspects of real life experience are critical either to acceptance for SRS or to later outcomes. Many adolescents who have long-standing gender dysphoria may be living as the other gender at the time of assessment, some of them quite convincingly. Others, often in the late onset group, do not appear to have considered how they would begin to present themselves as the other gender and often create a sense of dissonance in the examiners between their wish and their appearance. The extent to which an individual seems engaged in presenting as the other sex often reflects the extent of anatomical gender dysphoria and commitment to hormonal and/or surgical interventions.

Although there has been some loosening in the application of the real life experience over the years and no consensus as to what is a required minimum length of time of such an experience, the majority of professionals working in this area believe that some period of real life experience is important. Further research is needed before a guideline on this issue can be established.

Issues Regarding Suspension of Puberty

Puberty is the critical developmental milestone in the continuation, or not, of GID. Associated body changes can have a negative short- and long-term impact. A person born male who is convinced that he should have the body of a female is distraught at experiencing the testosterone-mediated changes of male puberty. A person born female convinced that she should be male is distraught at the changes brought about by puberty. Assuming that the GID endures, the consequences of undesired pubertal changes are substantial. In the long-term, they are typically more troublesome for the person born male. The stigmata of pubertal body development, including height, bony configuration, hair, and voice are a substantial handicap when later attempting to integrate socially as a woman. For the person born female, there can be a height handicap as well as the need for surgery which could have been avoided by suppression of puberty. Clinicians experienced with GID in adult patients burdened by the pubertal changes of the "wrong sex" and clinicians attempting to help patients with gender who are entering adolescence recognize the need for intervention to prevent both the short- and long-term consequences of the "wrong puberty."

The gonads secrete sex steroids in response to the gonadotropins from the pituitary. These are secreted in response to hypothalamic gonadotropin releasing hormones (GnRH). Synthetic GnRH agonists bind to the pituitary so that GnRH no longer acts. Gonadal sex steroid production ceases within 4–12 weeks and, upon discontinuance, hormonal puberty is resumed within 3 months (de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006). Thus, current endocrinological sophistication provides a therapeutic strategy. Puberty, as it begins, can be suspended (Hembree et al., 2009). Administration of GnRH analogues can delay the sex steroid induced progression of body changes. During this period of "time out," the patient and clinician can explore the options available and decide on the optimal future direction of living as a man or as a woman.

The duration of pubertal suspension that can be safely implemented has been of concern. This has focused primarily on the effect of sex steroid deficiency on bone metabolism with its potential for deficient mineralization and possible osteoporosis. Research has demonstrated that a period of up to several years appears to be safe with the deficiency of progressive mineralization being remedied once sex steroids, either those expected by birth sex or those administered for cross-sex development, are available. Peak bone mass occurs at about 25 years of age and long- term treatment data have yet to be reported (Delemarre-van de Waal & Cohen-Kettenis, 2006; de Vries & Cohen-Kettenis, 2009). Significant safety issues connected with the use of hormone suppressing agents have not emerged to date; however, long term follow-up data are lacking.

Adolescence is also a developmental period of substantial brain maturation and concerns have been expressed over possible cognitive deficits consequent to pubertal suspension. There is some evidence in hamsters of a detriment to development or changes in behavior (Schulz & Sisk, 2006); however, there has been no evidence clinically of any consequence of pubertal suspension on brain functioning in humans (Delemarre-van de Waal & Cohen-Kettenis, 2006). Concerns about consequences of pubertal suspension may be tempered by the fact that there is substantial variation in the age of onset of normal puberty (e.g., between the ages of 11 and 16 years).

A critical treatment issue is the diagnostic challenge of selecting patients for whom GID is on a continuing developmental trajectory. The majority of prepubertal patients diagnosed with GID do not continue with GID into adolescence (Green, Roberts, Williams, Goodman, & Mixon, 1987). Most ultimately manifest

sexual attraction to persons of their birth sex but have no desire to modify their body to that of the other sex. However, most children whose anatomical gender dysphoria intensifies as pubertal development ensues will ultimately desire SRS. The fit is not perfect. Therefore, pubertal suspension for a year or two provides breathing space for the young person and clinician to experience and to explore the continuing evolution of gender identity.

Adolescent patient selection criteria have included an intense pattern of cross-gender identity and behavior from early childhood, and an increase in gender dysphoria with the onset of puberty in a patient otherwise psychologically stable and in a supportive family environment (de Vries & Cohen-Kettenis, 2009). Clinical experience with pubertal suspension demonstrates that with thorough clinical screening the large majority of patients whose puberty has been suspended continue to experience GID and do not want the body changes typical of their birth sex. They are then administered sex steroids to enable body changes consistent with their cross-sex identity (de Vries et al., 2010). For the small number of patients who conclude that developing along the lines expected by birth sex is preferable, GnRH analogues can be discontinued, and pubertal development as typical of their natal sex resumes (Hembree et al., 2009). On the other hand, if gender transition is desired, GnRH analogues are continued during cross-sex steroid treatment prior to gonadectomy.

In the most experienced treatment center in the Netherlands, GnRH analogues are prescribed shortly after the onset of puberty (Tanner stage 2–3). Triptorelin is administered in a dose of 3.75 mg every 4 weeks. At the introduction of treatment, an extra dose is given at 2 weeks. Gonadotrophins are suppressed after a brief period of stimulation (Delemarre-van de Waal & Cohen-Kettenis, 2006). Feminizing/masculinizing endocrine therapy in that center can begin at 16 years with recommendation of the mental health professional who has engaged with the adolescent for a minimum of 6 months. SRS for continuing GID can be performed at 18 years and must be preceded by a 2 year real life experience of full-time cross-gender living. As a 12 cm height difference is a typical sex difference, it is advantageous to retard the growth of natal males and enhance the growth of natal females. The Endocrine Society Guideline addresses management of this important issue (Hembree et al., 2009). The most extensive series of cases with pubertal suspension is reported from the Netherlands (APA level B, longitudinal follow-up after an intervention). From 2001 to 2009, 118 adolescents were treated (50 natal males and 68 natal females). Mean age was 14.3 years in 2009. None had discontinued pubertal suspension. Behavioral and emotional problems (as measured by the Child Behavior Checklist and Youth Self-Report) and depressive symptoms (as measured by the Beck Depression Inventory) decreased while general functioning (Global Assessment Scale) improved significantly during puberty suppression. Cross-sex hormone treatment had been started with 71, at a mean age of 16.6 years (de Vries et al., 2010).

The experience of the Toronto group to date has been recently published (Zucker et al., 2011). This group examined demographic, behavior problem, and psychosexual measures to see if any of them correlated with the clinical decision to recommend, or not recommend, pubertal suspension in a consecutive series of 109 adolescents (55 females, 54 males) with GID evaluated between 2000 and 2009. Of the 109 adolescents, 66 (60.6 %) were recommended for pubertal suspension and 43 (39.4 %) were not. A combination of five (of 15) demographic, behavior problem, and psychosexual measures were identified in a logistic regression analysis to significantly ($p < .10$) predict this clinical recommendation. The quantitative data were complemented by clinical case descriptions; however, follow-up data were not adequate for statistical comparison of any outcome measures between those for whom pubertal suspension was recommended compared to those for whom they were not. Other centers, in Los Angeles and Boston, have similarly instituted programs of pubertal suspension but have not yet published systematic evaluations of their case series. Because of cost, GnRH analogues are not affordable for many in the U.S. Less expensive alternatives (e.g., spironolactone) may be used in natal males (Hembree et al., 2009).

Issues Regarding the Use of Cross-Sex Hormones

The major issue with respect to use of cross-sex hormones concerns the timing of administration. There are no established criteria for use of cross-sex hormones in adolescents. Generally, however, these are now used following suspension of puberty when it is increasingly clear that the adolescent meets readiness criteria to move towards SRS and is functioning reasonably well psychologically and socially. There are no studies addressing the issue of timing. In the Dutch follow-up study (Cohen-Kettenis & van Goozen, 1997), it was their conclusion that those adolescents who transitioned earlier presented a more convincing physical appearance than did those with a later age of transition. This follows logically as there was less development of secondary sex characteristics of the natal sex as indicated above. There are currently inadequate data for development of an evidence based guideline regarding the timing of cross-sex hormone treatment.

Issues Regarding the Timing of SRS

SRS is not generally an issue for adolescent populations in the United States as surgery is normally not performed before the age of 18. However, occasionally surgery has been done during adolescence in other countries. Given the irreversible nature of surgery, most clinicians advise waiting until the individual has attained the age of legal consent and a degree of independence. In some jurisdictions (e.g., UK), there is no fixed legal age of consent to medical procedures. Instead, a comprehensive understanding of the procedure, with options, risks, and benefits must be demonstrated by the patient (Smith et al., 2001). At present, there is inadequate evidence to develop a guideline regarding the timing of SRS although medical advice is important with respect to removal of ovaries within a reasonable time after use of cross-sex hormones due to potentially increased malignant potential (Hembree et al., 2009).

GV in Adults

A. Evan Eyler, M.D., M.P.H., D. Andrew Tompkins, M.D., and Eli Coleman, Ph.D.

Here we address the care of transgender and other gender variant adults from the perspective of the practicing psychiatrist. First, the principal concerns of these individuals in a clinical context are described. Psychiatric assessment, treatment options and the processes employed in clinical decision making are discussed. The quality of evidence currently available to guide the selection of practice options and to support treatment recommendations is then evaluated using the APA coding system. The professional literature regarding treatment of adults with GID/GV is more extensive than the literature regarding the treatment of children or adolescents. This section of the report is, therefore, correspondingly longer than those sections.

Gender Identity Concerns in Adulthood

GV is sufficiently common that even adult psychiatrists whose practice does not focus on transgender care encounter patients who are transitioning gender, or contemplating gender transition. Gender variant persons choose different means to express the gendered self authentically or to attain relief of psychological distress due to lack of congruence between the psychological and socially-presented selves, or between physical characteristics and gender identity. Many seek both hormonal and surgical transition; however, some seek hormonal treatment but do not feel the need for any, or particular (e.g., genital) surgical procedures. Others may choose surgical but not hormonal treatments. Mental health services may be sought for many reasons, including a desire for professional assistance with exploring gender identity, or to gain comfort with the gendered self or preferred gender presentation. Some also seek counseling regarding the decision of whether or not to transition publicly, and, if so, to what extent. Additional concerns include preparing to initiate hormonal treatment; monitoring psychological functioning as the physical effects of the administered hormones become apparent; choosing whether or not to undergo various surgical procedures, such as breast, genital, or facial modifying surgeries; and adjusting to post-transition living in the preferred gender presentation. Psychiatrists who treat transgender adults may also be called upon to assist their patients with the legal and financial concerns associated with gender transition in the current social system. These include coding and payment of insurance claims for mental health and other medical services related to transgender care; management of identity documentation during and after transition; the treatment of transgender and transitioning persons in the military and in incarceration settings; discrimination based on gender identity or gender presentation, and many others.

Adults who conclude that transition is the best solution to the psychological discomfort they experience face different challenges than children and adolescents with strong cross-gender identification. Some individuals who publicly transition in adulthood have been aware of a sense of gender incongruence since childhood or adolescence, but have adopted a social presentation that is at least somewhat conforming to gender expectations. This may have occurred (consciously or unconsciously) in order to reduce the level of difficulty encountered in settings such as education, employment and partnered relationships (Bockting & Coleman, 2007). They may take the risks inherent in transitioning publicly when they are older and have more autonomy, or when they are naturally going through stages of individuation. Concerns regarding transgender awareness or transition may emerge during the course of treatment of some other presenting complaint. For example, some transgender adults initially seek treatment for depression, substance abuse, or other clinical problems that have developed in the context of chronic suppression, or repression, of feelings related to GV. Initial disclosure, particularly in a clinical setting, is usually a time of high emotional vulnerability for the person sharing this confidence with the psychiatrist or other professional (Bockting, Knudson, & Goldberg, 2007) and requires knowledgeable and empathic management.

Acknowledging the awareness of cross-gender identification to oneself and to others, and integrating this awareness into one's identity, is sometimes referred to as "coming out transgender" or "coming out trans." This has been described as a multi-stage process by mental health professionals with extensive clinical experience with transgender phenomena, as well as on the basis of observational or qualitative research (Bockting et al., 2007; Devor, 2004; Gagne, Tewksbury, & McGaughey, 1997; Lev, 2004; Lewins, 1995). These observations suggest a process somewhat analogous to that proposed for identity development among gay men (Cass, 1979; Coleman, 1981; Troiden, 1988, 1989), lesbian women (Diamond, 1998; Parks, 1999), and bisexuals (Savin-Williams, 1995; Weinberg, Williams, & Pryor, 1994). Though particular stages or milestones may be recognized in the process of coming out, they do not necessarily progress in the same sequence in all individuals (Troiden, 1993). Persons who come out as transgender, or who transition during the adult years, are usually in the position of balancing the drive to live in a more authentic gender presentation with the needs created by years of living a more gender conforming public and private life.

Transition Goals and Outcomes

The process of integration of transgender identity may also demonstrate substantial complexity due to the variation in outcome that individuals seek. For example, some never publicly transition gender, while some may delay openly transitioning for a variety of reasons, such as concern about the impact of disclosing the transgender identity on employment or child custody arrangements. These individuals may, nevertheless, utilize hormonal treatments to facilitate presentation in the psychological (trans)gender in private settings–sometimes for years prior to public transition.

Others find that their best sense of psychological relief and self-comfort is obtained through adopting a combination of social gender signifiers, with or without reinforcing medical treatments, to facilitate private reinforcement, though not public recognition, of the transgender identity. For example, an older male whose gender identity is female, may spend his leisure time at a club frequented by transgendered individuals, dressed as a woman, but may continue to present as male in his retirement community. He may also take a small dose of estrogen for psychological relief, even if this does not result in full physical feminization.

The range of transition goals sought has also evolved over time. Among the male-to-female (MTF) transsexual adults in Lewins' (1995) qualitative work, the final stage of transition was described as "invisibility," i.e., assimilation into the general female population. Such "invisibility," however, is not currently a desired outcome for many transgender individuals and other gender variant adults. As transgender people and groups have become more visible in society, and have gained a measure of relative acceptance, the possibility of a transgender identity as such, rather than as a transitional stage within a male–female divided social system, has become a more realistic option. The film, *Coming Out Trans* (Bockting & Kimberly, 2008), provides some first person accounts in that regard. Some individuals do hope to fully assimilate as women or as men; however, others find authenticity in presenting a blend of gendered characteristics, or of fully transitioning gender while continuing to value the earlier life experience in the other gender role, such as by maintaining interests and activities developed during the pre-transition years. The process of integration of the transgender identity can also continue after the completion of surgical transformation of the body.

The possibility of stopping the process of gender transition prior to completion, or of reversing some of the physical changes that have been attained, has gained more acceptance in recent years. Some individuals find that a measure of bodily change, without genital surgery, clarifies their understanding of their gender identity and desired gender presentation. For example, some adults who begin FTM transition discontinue androgen use after some physical masculinization has been achieved, finding that a masculine female (butch) identity is more authentically representative of the self than living as a man. Some adults who initially present with transgender concerns decide, during the process of psychotherapy, not to proceed with any form of public gender transition (Smith et al., 2005a). This can be a reasonable outcome to an exploratory psychotherapy, but elimination or "correction" of transgender identity is no longer considered a reasonable therapeutic goal. Pfäfflin (1992) (see also Pfäfflin & Junge, 1990, 1998) for example, describes the evolution in treatment of gender dysphoria from historic psychoanalytic approaches aimed at achieving gender congruence through resolution of presumed intrapsychic conflict, to a contemporary model of offering psychotherapy or mental health evaluations that are often followed by hormonal treatments and surgeries.

Diagnostic and Mental Health Needs Assessment

Adults desiring hormonal or surgical treatments in the process of transitioning gender sometimes initially seek psychotherapy to clarify their gender identity and personal goals. Some individuals present directly to a surgeon, endocrinologist or other prescribing clinician, and are referred for mental health consultation prior to initiation of hormone therapy or preparation for surgery. Exploration of the gender identity, assessment of realistic understanding of transition treatments and outcomes, and detection and treatment of any co-occurring psychiatric pathology are some of the usual goals of this process. At least brief (several months) participation in psychotherapy is recommended in many clinical settings, in order to allow sufficient time for this work to unfold prior to initiating physical treatments that produce effects that are not fully reversible. Mental health evaluation and treatment, and the medical transition treatments that may follow, are discussed in more detail below.

Psychotherapy and Mental Health Support

The skills used by mental health professionals in caring for adults who are in the process of transgender coming out are similar to those used in other clinical situations in which concerns regarding personal identity, individuation versus conformity, or adaptation to minority identification within non-affirming majority culture are involved. Decisions such as whether and when to transition publicly, whether hormonal and surgical treatments will be needed or whether some other accommodation can be reached; if, when and how to come out regarding the transgender identity or history; and how to manage the concerns associated with family, employment and education, etc. are best addressed in a supportive clinical environment, at the pace that is acceptable to the transgender individual, and in some cases, couple.

Most of the literature addressing psychotherapy with gender variant adults is descriptive in nature; case reports, review articles based on practice experience, theoretical schemas based on clinical observation or qualitative work. The vast majority would be categorized as APA levels F and G. The lack of more statistically robust forms of evidence, such as RCTs, is representative of the history of this aspect of clinical practice, and the fact that psychotherapy is often (though not always) followed by hormonal or surgical treatments. The relatively low, and apparently declining, rate of regret following gender reassignment surgery (as discussed below) in a number of studies is believed to reflect the overall effectiveness of current treatment of gender dysphoria, including psychotherapy aimed at clarifying the social and physical changes needed to achieve comfort with the gendered self. The available literature (Green & Fleming, 1990; Michel, Ansseau, Legros, Pitchot, & Mormont, 2002; Pfäfflin & Junge, 1998) suggests that adequate pre-surgical psychotherapy is predictive of good post-surgical outcomes.

Bockting et al. (2007) offer fairly comprehensive recommendations for assessment and treatment of gender concerns, concurrent mental health difficulties, and elements of general counseling that are transgender specific. Their recommendations are based on a model of "transgender–affirmative approach, client-centered care, and harm reduction." Based on the available literature, it would not be possible to recommend one particular style of psychotherapy over another for working with patients who are transgender; however, it is possible to identify the issues that therapy should address. These include concerns related to gender identity, gender expression and sexuality; social functioning and support; personal goals for public and private life, and related matters. Reasonable understanding of the effects of contemplated medical treatments and ability to adhere to a therapeutic regimen also should be assessed (Bockting et al., 2007; Meyer et al., 2001) consistent with usual principles of decision-making capacity and informed consent. Assessment of co-occurring mental illness, particularly psychopathology that may influence the transgender presentation or that may be mistaken for transgender (e.g., Skoptic syndrome, in which a person is preoccupied with or engages in genital self-mutilation, such as castration, penectomy or clitoridectomy) and psychotic disorders, etc., is paramount (Hembree et al., 2009; Roberts, Brett, Johnson, & Wassersug, 2008).

Adults with gender identity concerns have also often experienced stigmatization or victimization related to gender variant appearance or behavior, or on the basis of actual or presumed sexual orientation as documented in the Report of the National Transgender Discrimination Survey (Grant et al., 2011). In fact, some authors have concluded that such stigmatization largely accounts for mental illness among individuals with GID (Nuttbrock et al., 2010). The American Psychological Association's Task Force on Gender Identity and GV concludes that "…there is adequate research concerning discrimination and stereotyping to support the development of clinical guidelines addressing these areas specifically." As with clinical work with individuals who are lesbian, gay or bisexual identified, an open-minded and nonjudgmental psychotherapy approach that affirms the autonomy and lived experience of the individual is a fundamental part of psychiatric care of gender variant adults.

Medical Aspects of Gender Transition and Their Mental Health Implications

Mental health professionals who work with individuals who plan to transition using hormonal or surgical treatments, or who are in the process of doing so, need to be knowledgeable about these procedures and their mental health implications. These are, therefore, briefly reviewed here. Some individuals who transition, either FTM or MTF, do so without hormonal therapy. Some seek mental health services while clarifying the decision to do so, and others do not find this necessary or feasible.

FTM transition usually includes use of androgens, which produce (or enhance) male secondary sex characteristics, such as beard growth and male distribution of body hair, deepening of the voice, and often mild coarsening of the facial features and skin. Androgen supplementation also causes enlargement of the clitoris, often to the extent that metaoidoplasty (one form of masculinizing genital surgery, discussed below) becomes feasible. MTF transition often consists of both estrogen supplementation and reduction in circulating androgens through use of antiandrogen agents, such as spironolactone or cyproterone (Hembree et al., 2009). Estrogen effects include breast development and mild feminizing changes to skin and hair, though for many who transition MTF after completion of male pubertal development, depilation will be needed. Many also need surgical reduction of the laryngeal cartilage or feminizing facial surgeries. Use of hormonal preparations is much more effective in "adding" physical characteristics than in "subtracting" those that have already developed with natural puberty. Body habitus, including both fat distribution and potential for muscular development, is altered by use of cross-sex hormones. Utilization of either androgens or estrogens carries with it potential for both added health risks and, in some cases, physiologic benefits. The technical aspects of transgender hormonal treatment are discussed elsewhere (Delemarre-van de Waal & Cohen-Kettenis, 2006; Hembree et al., 2009; Moore, Wisniewski, & Dobs, 2003) as is the associated general medical and preventive care (Eyler, 2007; Feldman, 2007, 2008).

Emotional changes may occur with use of either androgen or estrogen supplementation, though these are often relatively subtle and consistent with the pre-transition personality (Eyler, 2007). Increase in libido usually occurs with androgen use (Hembree et al., 2009), though some individuals transitioning as MTF also experience a stronger interest in sex, perhaps due to the affirming aspects of attaining the bodily changes that have been desired for years, such as development of female breasts (Eyler, 2007). Individuals in transition often benefit from ongoing psychiatric care (Rehman, Lazer, Benet, Schaefer, & Melman, 1999). In addition to the psychotherapeutic work involved when individuals choose major life-changing experiences fueled by ongoing distress, monitoring the psychiatric effects of hormone use, along with the prescribing internist, family physician, gynecologist or endocrinologist, is advisable. For example, if excessive lability is noted, such as moodiness, weepiness or aggression (similar to the "steroid rage" that can accompany use of anabolic steroids by competitive male athletes and body builders), checking serum levels of circulating hormones is indicated (Eyler, 2007). Safer sex information, and instruction in self-protective negotiation in sexual settings, is often provided by the psychiatrist or other mental health professional if this has not been done by the prescribing clinician. It is important that this information be tailored to the needs and experiences of transgender persons (Eyler & Feldman, 2008; Feldman, 2007).

Surgeries for purposes of gender transition include breast and chest ("top") surgeries and genital ("bottom") procedures. It is believed that most adults who transition from FTM have chest reconstruction surgery, because the visible contours of female breasts are such a

powerful social cue and aspect of gender presentation as a woman, whereas a flatter chest facilitates presentation as a man (Monstrey, Vercruysse, & De Cuypere, 2009).Some individuals may not require breast surgery if the body habitus is more masculine. The goal of FTM top surgery is not mastectomy, as would be performed for treatment of carcinoma of the breast, but creation of a natural appearing male chest, such that some of the subcutaneous fat is retained, in proportion to the general body habitus of the individual. Some adults who transition MTF have breast augmentation surgery due to achieving minimal breast development with hormonal treatment alone, though others develop fully morphologically normal female breasts with estrogen, and sometimes progestin, use. Some also choose breast augmentation due to dissatisfaction with the level of breast development achieved, similar to some non-transsexual women.

Many adults undergoing MTF genital surgery receive penile inversion vaginoplasty with clitoroplasty, labiaplasty, and orchiectomy. FTM genial surgery can consist of either metaiodoplasty with limited scrotoplasty, or more extensive surgery, including phalloplasty with grafted tissue from another body site, urethral extension, scrotoplasty and vaginectomy. Hysterectomy and oophorectomy are performed in either case. Information regarding the rationale for surgery (Monstrey, De Cuypere, & Ettner, 2007b), as well as current information regarding specific techniques (Monstrey, Ceulemans, & Hoebeke, 2007a; Monstrey et al., 2007b), is readily available to patients and professionals in a variety of sources, including professional sources, the popular press and the internet; however, comparative outcome data among the providers and techniques are not similarly available.

Review of Literature with Respect to Support for Treatment Recommendations

Prior to considering whether the current literature provides sufficient evidence to support treatment recommendations by the APA, it is necessary to define what constitutes successful treatment and to determine the quality of evidence that compares treatment options in terms of outcome. These issues will be discussed in turn.

Outcome Criteria

The definition of treatment success is complex, because gender identity and gender dysphoria, as well as any perceived benefit of treatment of gender dysphoria are subjective experiences. Individuals seeking gender transition may also experience psychiatric symptoms or disorders that are unrelated to the gender identity concern, or that may have developed as a response to the distress of the gender dysphoria (e.g., addictive disorders) and require specific treatment.

DSM-IV-TR criterion D for GID states that "[t]he disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning." From this perspective, treatment can be considered successful if it relieves this distress or facilitates improvement in function in some substantive way. Some early outcome studies emphasized functional indices such as "job, education, marital, and domiciliary stability" (Meyer & Reter, 1979). However, many persons who present for medical services for transition are already functioning very well socially and occupationally. In these cases, relief of the gender dysphoria, satisfaction with treatment, and lack of regret regarding the decision to transition represent the primary measurable outcomes. (Among patients who experience some level of functional impairment, these may still be most important.) Some clinical situations are complex. For example, an individual with high levels of personality pathology and gender dysphoria may experience substantial emotional relief with transition, and yet remain disabled from employment by the co-existing psychiatric illness.

The importance of subjective satisfaction as opposed to regret on the part of the patient has gained emphasis in the literature during the last two decades (Carroll, 1999; Green & Fleming, 1990; Kuiper & Cohen-Kettenis, 1988; Lawrence, 2003; Snaith, Tarsh, & Reid, 1993). This may reflect a combination of factors, including a relaxation of prevailing biases regarding gender and sexual orientation, a greater commitment to patient autonomy in mental health and general medical services, and the emergence of transgender and gender variant persons as a recognizable political group with reasonable claims to civil rights and responsibilities, rather than a population regarded primarily as patients and clients. Cole et al. (2000) noted that treatment of gender dysphoria during the early and mid-twentieth century was based on prevailing gender stereotypes: "Transsexualism itself was considered a liminal state, a transitory phase, to be negotiated as rapidly as possible on one's way to becoming a 'normal' man or 'normal' woman." This viewpoint has gradually evolved to accommodate a greater variety of transgender experiences, and recognition of the importance of subjective outcomes as opposed to the ability to conform to majority cultural expectations. Kuiper and Cohen-Kettenis (1998) concluded, "…an evaluation of SRS can be made only on the basis of subjective data, because SRS is intended to solve a problem that cannot be determined objectively."

Evidence Regarding Effectiveness of Treatment for Gender Dysphoria in Adults

Satisfaction Versus Regret Pfäfflin and Junge (1998) reviewed the 79 available follow-up studies regarding gender transition treatment conducted between 1961 and 1991, including a total of more than 1000 MTF patients and more than 400 FTM patients. Although a variety of outcome criteria were used, when the key subjective criteria (such as general satisfaction and lack of regret) were examined, results were supportive of treatment as a means of relieving psychological distress. Most of the studies reviewed were case series, case reports or reviews (APA level D or lower) though some included sufficient longitudinal follow up and standardization to meet APA level C or B. "Big" regrets (such as reversion to the original gender role, rather than some lesser degree

of regret or ambivalence) were estimated to have occurred in only 1–1.5 % of patients. Other sizeable reviews (of numerous smaller studies, APA level F) also suggested hormonal and surgical treatments as successful therapies for gender dysphoria (Cohen-Kettenis & Gooren, 1999; De Cuypere & Vercruysse, 2009). Interpretation of these findings is limited by the analysis of nonrandom samples based on recruitment and/or response rate. One study avoided these problems by using German registry data to assess reversal of name changes following reassignment as a measure of regret (Weitze & Osburg, 1996). Only one person of 733 who applied for legal change of sex between 1981 and 1990 subsequently applied for reversal, suggesting profound regret; 57 (0.4 %) of 1,422 adults who obtained gendered changes of first name requested a second legal name change, suggesting at least some degree of regret. Though this indirect approach (APA level G) does not provide robust evidence, the results are consistent with other approaches. A recent systematic review and meta-analysis reported that 80 % experienced subjective improvement in terms of gender dysphoria and other psychological symptoms and quality of life (Murad et al., 2010).

Some relatively long-term follow up data (APA level B) are available, though sample sizes are generally modest. Smith and collaborators evaluated 162 Dutch adolescent and adult patients who were eligible for gender transition services based on "gender dysphoria, psychological stability, and physical appearance" after completion of treatment. Approximately half of the original consecutive applicants for sex reassignment completed hormonal and surgical transition (Smith et al., 2005b). Two patients had regrets; most others experienced relief of gender dysphoria and were found to be functioning well "psychologically, socially and sexually." Johansson, Sundbom, Hojerback, and Bodlund (2010) followed 42 MTF adults and 17 FTM adults, who met diagnostic criteria for GID and were accepted into treatment in a transgender treatment program, for 5 years or longer. At the time of publication, 32 had received genital reassignment surgery, 5 were anticipating surgery, and 5 had decided not to proceed. No one regretted his or her decision; 95 % of participants rated their global outcome as favorable, though only 62 % of the clinician assessments concurred. There were no differences between subgroups. Conversely, Kuhn et al. (2009) used the King's Health Questionnaire and Visual Analogue Scale to measure quality of life in 52 MTF adults and 3 FTMs, recruited from a Swiss tertiary medical center gender program. All subjects were 15 or more years post-gender reassignment surgery. Overall quality of life and life satisfaction levels were lower than matched controls, particularly in the domains of general health, role limitation, physical limitation, and personal limitation. However, the control group was chosen from the "healthy female medical staff with at least one previous abdominal or pelvic operation," rather than from a more appropriate sample, such as transgender adults who did not receive surgery. The quality of life assessments are, therefore, likely to be valid in absolute terms, but the question of whether the participants' quality of life was improved by transition (relative to having not transitioned) remains unresolved. Similarly, a recent population-based matched cohort study (APA level D) compared 191 MTF subjects and 133 FTM subjects with random controls matched by birth year and natal sex, as well as by birth year and reassigned sex (Dhejne et al., 2011). The transsexual subjects had received SRS in Sweden between the years 1973–2003. Although higher risks for psychiatric morbidity, suicidal behavior, and mortality were found in the transsexual groups, relative to non-transsexual controls, no comparison was made to transsexual persons who did not receive treatment. As with the Kuhn et al. (2009) study, questions regarding the magnitude of improvement in quality of life attributable to gender transition and SRS were not addressed, though the authors noted that the gender dysphoria had been alleviated.

Correlates of Satisfaction and Regret Much of the research literature that employs an outcome perspective has focused on identifying correlates of treatment satisfaction and lack of regret among persons seeking transition with hormonal and surgical treatments, particularly those who transition from MTF. In theory, these data could be used in the formulation of treatment recommendations, to assist clinicians in identifying individuals who are most likely to benefit from hormonal and surgical treatments as well as those most likely to have post-treatment regrets. Particularly controversial in this research, MTF psychological and social characteristics have often been dichotomized by the typology of "early onset/androphilic" versus "late onset/gynephilic" transsexual adults. Lawrence (2003) summarizes this distinction as follows:

> Many researchers have proposed that there are two types of MTF transsexuals. One category includes persons who typically transition at a younger age, report more sexual attraction to and sexual experience with males, are unlikely to have married or to have become biologic parents, and recall more childhood femininity. The other category includes persons who typically transition at an older age, report more sexual attraction to and sexual experience with females, are more likely to have married and to have become biologic parents, report more past or current sexual arousal to cross-dressing and cross-gender fantasy, and recall less childhood femininity. (p. 300)

Transgender MTF adults with early onset/androphilic characteristics have been more often found to have higher rates of satisfaction with gender transition and fewer regrets (Blanchard et al., 1989; De Cuypere et al., 2006; Muirhead-Allwood et al., 1999). However, Lawrence (2003) notes that the population of persons applying for gender transition surgeries has undergone a demographic shift, particularly in the United States and Canada. For example, at the Clarke Institute of Psychiatry in Toronto, the percentage of MTF adults seeking SRS who were "nonhomosexual relative to biologic sex," increased from 25 % (Freund, Steiner, & Chan, 1982) to 59 % (Blanchard & Sheridan, 1992) in a single decade. In a related phenomenon, the average age of MTF transgender adults presenting for gender reassignment services in

Sweden increased by 8 years during two decades (Olsson & Moller, 2003). Younger age at the time of transition had previously been found to correlate with both androphilia and better outcome satisfaction. However, rates of regret following surgery have decreased during this time, as discussed below, suggesting the possibility that co-occurring social changes, or other factors, have eroded the strength of these previously somewhat predictive relationships.

Interviews with subjects who express substantial regret following genital reassignment surgery, and related case reviews, have identified several correlates of regret. These include: inadequate diagnosis of major comorbidity (e.g., psychosis, personality disorder, alcohol dependency), misdiagnosis, absence of or a disappointing real-life experience, and poor family support (Botzer & Vehrs, 1995; Bodlund & Kullgren, 1996; De Cuypere & Vercruysse, 2009; Eldh et al., 1997; Gijs & Brewaeys, 2007; Kuiper & Cohen-Kettenis, 1998; Landen et al., 1998; Lundstrom et al., 1984; Pfäfflin & Junge, 1998; Walinder et al., 1978). Given the magnitude of the social changes associated with gender transition, these correlates are intuitively appealing, as strong family support and good emotional health are associated with positive adjustment to many other life changes. However, cases have been reported in which the individual was both suffering from severe co-occurring psychopathology, and was a "late-onset, gynephilic" MTF transgender adult, and yet experienced a long-term, positive outcome with hormonal and surgical gender transition (Brown, 2001). Several of the authors of the present TF have also treated patients with severe co-existing psychiatric illness who successfully transitioned gender and experienced improved quality of life. Delaying therapy with hormones or surgery until serious mental health difficulties are addressed may promote adherence to needed psychiatric and other mental health treatment, such that the individual experiences benefit with regard to both the gender dysphoria and the concurrent psychiatric illness. The co-occurrence of serious psychiatric pathology is further discussed below.

The quality of the surgical result, including function and appearance, has also correlated positively with patient satisfaction or other positive outcome measures among both MTF adults (Botzer & Vehrs, 1995; Eldh et al., 1997; Green & Fleming, 1990; Lundstrom et al., 1984; Pfäfflin & Junge, 1998), and FTM adults (Garaffa, Christopher, & Ralph, 2009), though it remains difficult to achieve surgically excellent results with phalloplasty (Leriche et al., 2008) relative to vulvovaginoplasty (Lawrence, 2003). In her anonymous mailed questionnaire study of 232 MTF transsexual adults operated on between 1994 and 2000 by one surgeon using a consistent technique, Lawrence (2003) found poor surgical outcome to be the strongest predictor of regret. Overall, no participants reported "consistent regret" and only 15 (6 %) were "sometimes regretful" (p. 305). Kuiper and Cohen-Kettenis (1998) recommended the use of multidisciplinary teams in order to minimize poor outcomes though lack of complete information or individual clinician bias. Although few systematic studies of suicide among gender transitioning persons have not been conducted, the case report literature suggests that this is a relatively rare outcome (De Cuypere & Vercruysse, 2009). Dhejne et al. found an increased risk of death by suicide, and of suicide attempts, among subjects who had received SRS, relative to age-matched population controls, but also noted that the difference in suicide attempts did not reach statistical significance for the most recent cohort, those who had transitioned gender during 1989–2003.

The majority of the satisfaction/regret outcome studies described above suggests that most subjects experience subjective improvement following gender transition; however, most lacked a control group. Studies assessing correlates of satisfaction through interviews or case reviews would be categorized as APA level G. For some important aspects of transgender care, it would be impossible or unwise to engage in more robust study designs. Due to ethical concerns and lack of volunteer enrollment, for example it would be extremely problematic to include a "long-term placebo treated control group" in an RCT of hormone therapy efficacy among gender variant adults desiring use of hormonal treatments.

Review of the available literature also documents a downward trend in rates of post-surgical regrets over the last three decades. Though satisfaction with transition outcome is believed to be the norm in recent years, earlier studies (Lindemalm, Korlin, & Uddenberg, 1986; Meyer & Reter, 1979) found rates of regret of 30 % or higher, and even in 1997, one study found a 6 % regret rate (Eldh et al., 1997). Reasons for this trend are not completely clear, but it is temporally correlated with fairly widespread adoption of flexible but less idiosyncratic pre-surgical criteria (the WPATH SOC); improved surgical techniques and outcomes, particularly for vulvovaginoplasty, and an improved social climate for members of sexual and gender minorities. This has been suggested as indirect evidence of the utility of the WPATH SOC in pre-surgical evaluation and treatment of gender transitioning patients (De Cuypere & Vercruysse, 2009; Meyer, 2009).

Options and Evidence for Psychiatric Evaluation and Mental Health Care

Adults who make use of conventional medical services for gender transition historically received mental health evaluation prior to beginning this process (Drescher, 2010), unless they had already been living as a member of the psychological (post-transition) gender for a significant period of time (Meyer et al., 2001). The principal area of current clinical controversy with regard to use of hormonal medications by persons in gender transition concerns the nature of, and extent of, preparation for beginning hormonal transition, particularly the mental health evaluation. Options currently in use include the following: extensive mental health evaluation or real life experience prior to beginning treatment with hormonal medications, brief evaluation by a mental health professional prior to hormonal prescription, mental health screening by the prescribing clinician, and prescription without specific evaluation. Additional possibilities, such as the creation of certified "gender specialists" who would assess readiness have been suggested (Lev, 2009).

Evaluation prior to genital surgery is similar but usually more extensive. The basis for each of these approaches is discussed below. This discussion applies only to the treatment of patients who seek medical services through licensed health care facilities in the United States and Canada. Some individuals obtain hormonal preparations without any medical or mental health contact, such as via the internet or veterinary supply. Some travel to other countries to obtain surgical treatments without specific presurgical requirements. Outcome data for treatment obtained through these routes are lacking.

Mental Health Evaluation Options Prior to Hormonal Therapy

Comprehensive Mental Health Evaluation Although some reasonable evidence supporting the clinical effectiveness of hormonal and surgical methods in the treatment of "gender dysphoria" [principally case series by Benjamin, Green, Money, and Stoller (Benjamin, 1967; Green, Newman, & Stoller, 1972; Stoller, 1967, 1973) reviewed in (Green, 1999)] had accumulated by the 1960s, the use of these physical modalities, rather than psychoanalysis or extended psychotherapy aimed at resolving the intrapsychic conflict believed to underlie the transsexualism, and its associated implicit homosexuality, remained controversial and politicized. For example, the first university affiliated transgender program, at Johns Hopkins University, was founded in the 1960s and then disbanded in an ideological sea change in 1979 (though gender identity concerns subsequently became part of the scope of practice of the Johns Hopkins Sexual Behaviors Consultation Unit). Psychiatrists and psychologists approached individuals seeking medical services for gender transition idiosyncratically, without consistency in regard to recommending, or attempting to dissuade the use of, hormonal and surgical treatments. Several recent reviews and policy papers (Drescher, 2010; Lev, 2009; Meyer-Bahlburg, 2009; Zucker, 2010) have described the intertwined clinical and political difficulties that existed in that era.

The Harry Benjamin International Gender Dysphoria Association (HBIGDA) was founded in 1979, to address the need for professional guidance in treating individuals with GID. SOC were developed by an international consensus panel, initially for the purpose of providing some protection to patients and their treating physicians (Meyer et al., 2001). These have been subsequently revised at intervals, with a seventh revision in process at the time of this writing. HBIGDA has been re-named, and is now the WPATH.

The current, sixth version (Meyer et al., 2001) of the WPATH SOC recommends evaluation by a psychiatrist, psychologist, clinical social worker, or other master's or doctoral level mental health clinician, prior to beginning treatment with hormonal medications. Areas of emphasis include identifying and beginning treatment of any pathology that may exist concurrent with the transition, and assessing readiness for hormonal treatment based on consolidation of the gender identity and demonstration of general psychiatric stability, sufficient to withstand the social or medical complications that may ensue during the physical transition process. Adults seeking treatment with hormonal medications should also have either engaged in psychotherapy (usually for 3 months or longer) or have engaged in a documented period of having lived in the psychological gender (a "real life experience") for at least 3 months. In addition, patients should experience further consolidation of the gender identity during this time, and make progress with regard to any ongoing mental health problems, such as substance abuse. They should also be considered likely to "take hormones in a responsible manner (p. 14)." In other words, the use of hormonal medications is regarded as part of an ongoing process of physical and psychosocial transition, undertaken with informed consent, in the context of mental health and general medical care.

The WPATH SOC recommends different levels of preparation for breast and genital surgeries. FTM breast surgery may be obtained at the time of beginning hormonal treatment, as the breast morphology will be minimally affected by use of testosterone, and because FTM chest reconstruction may be necessary for social presentation as a male. MTF individuals should defer breast augmentation surgery until after at least 18 months of treatment with feminizing hormones, in order to reduce the likelihood of unnecessary procedures. WPATH Standards for preparation for genital surgery are more comprehensive than those addressing hormonal treatment eligibility and readiness, and the time course is longer: 12 months of hormonal therapy unless this is medically contraindicated, and 12 months of real life experience. The current WPATH SOC (version 6) require documentation of a GID diagnosis and recommendation for surgery by two mental health professionals, at least one of whom must be a psychiatrist or doctoral level psychologist.

The Oxford Centre for Evidence-Based Medicine Level of Evidence system has been used to evaluate the evidence regarding the key components of the WPATH SOC for SRS, described as eligibility and readiness criteria (e.g., pre-treatment psychotherapy, real life experience, sequence of transition steps), as predictors of favorable post-surgical outcome (De Cuypere & Vercruysse, 2009). Overall evidence supported these components; however, the level of evidence was generally low, mostly corresponding to APA level D and lower. Some studies, however, (De Cuypere et al., 2006; Pfäfflin & Junge, 1990; Smith et al., 2005a), that tracked patients longitudinally after intervention could be categorized as APA level B. The evidence in support of gender reassignment surgery, as an "effective and medically indicated" treatment in cases of "severe GID" was similarly evaluated (Monstrey et al., 2009). Results were not uniformly supportive of surgical transition, but reports of post-surgical regret have become much less common over time; studies published since the late 1990s have been more consistently positive. Due to the lack of RCTs or large, well-designed follow-up studies most evidence is estimated to be at or below APA level C. Outcome measures varied across the studies reviewed, but were largely based on satisfaction and similar subjective measures.

In 2009, a consensus group of European and American endocrinological professional societies produced an evidence based

practice guideline (Hembree et al., 2009) based on extensive literature review using the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system (Atkins et al., 2004). Strong recommendations (based on GRADE criteria) were made regarding the involvement of mental health professionals in gender transition treatment, including that the diagnosis of GID be made by a mental health professional and that the endocrinologist and mental health professional agree on the advisability of surgical reassignment prior to surgery. The type of mental health professional was not specified. The Endocrine guideline notes that mental health professionals usually adhere to the WPATH SOC (Hembree et al., 2009).

Some other clinical guidelines, such as the Vancouver Transgender Health Program/Vancouver Coastal Health (Dahl et al., 2006) also recommend full psychological, and/or psychiatric, mental health evaluation before genital surgery. Although many, perhaps most, adults who seek transgender hormonal transition or surgical procedures may have sufficient mental and emotional well-being to manage the associated physical and experiential impacts, the smaller number who do not may be spared devastating outcomes through timely (especially pre-surgical) evaluation and treatment of co-existing psychiatric illness.

The mental health evaluation component of these guidelines is included in an effort to promote good transition outcomes through management of the psychological stress of the transition process and any accompanying Axis I or II disorders, rather than simply through assuring accurate diagnosis of the GID as such. In some cases, gender concerns or preoccupations are a manifestation of other intrapsychic conflicts (e.g., a male sex offender who covertly desires castration) or epiphenomena of other illnesses (e.g., bipolar mania or psychosis with delusional beliefs about gender). A recent Dutch study found that mental health professionals most valued consultation that provided guidance in distinguishing between transgender with concurrent psychiatric illness and psychopathology manifesting features that could be confused with GID (Campo et al., 2001, 2003). Similarly, a British psychiatrist was sanctioned by the General Medical Council for prescribing hormonal medications and recommending surgeries based on insufficient evaluation, in cases such as those described above, to the detriment of the patient; in effect, for failing to follow the WPATH SOC current at the time (Dyer, 2006, 2007).

Although clinical guidelines that restrict access to hormonal or surgical treatments may reflect a variety of implicit assumptions regarding the experience of persons who transition gender, one important basis for their development has been the finding that, although GV is not in itself evidence of medical or psychiatric pathology, neither is it protective from concurrent psychiatric illness (Cole, O'Boyle, Emory, & Meyer, 1997; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2005; Kersting et al., 2003; Wallien, Swaab, & Cohen-Kettenis, 2007). Further, Meyer (2009) notes that although some clinicians have observed that proceeding with transition planning can sometimes alleviate other Axis I related symptoms (Cole et al., 1997; Kuiper & Cohen-Kettenis, 1998; Landen et al., 1998; Olsson & Moller, 2003; Pfäfflin & Junge, 1998), others have reported lower likelihood of good long-term outcome (e.g., poor adjustment or regret) when concurrent disorders are present. It is probable that both findings have validity. Gender transition can foster social adjustment, improve self-esteem, and relieve the anxiety and mood symptoms that can accompany gender dysphoria, but significant co-occurring mental illness can mitigate against positive outcomes of any medical treatment, whether or not it is related to gender identity. Bockting et al. (2007) provide an approach to consultation regarding gender transition, including a list of co-occurring factors that should be specifically evaluated, such as associated obsessive–compulsive features, delusions about sex or gender, dissociation, personality disorders, Asperger's disorder and internalized homophobia. Their approach has substantial face validity and is consistent with general principles of psychiatric diagnosis, although it is supported primarily by low levels of evidence (generally level D and below).

Other Options Prior to Initiating Hormones Although the WPATH SOC have been utilized in clinical practice with gender transitioning persons in a variety of geographic areas and settings, their implementation presupposes significant resources on the part of the individual seeking transition. Many people who seek hormonal treatment have neither the funds to obtain a psychiatric evaluation and 3 months of psychotherapy nor insurance coverage of mental health services. However, both estrogens and androgens are available via the internet, over the counter in Mexico and other countries, without prescription in certain settings (e.g., testosterone preparations at some gyms), and through veterinary supply. Individuals who lack financial resources, or who do not wish to participate in usual medical and mental health care for other reasons, therefore, have the option of self-treatment with informally obtained hormone preparations. This entails significant medical risk. Potential problems include needle sharing (Sebastian, 1999) as well as administration of inappropriately high hormone dosages together with lack of monitoring for deleterious hormonal effects (Lawrence, 2007). Despite the apparent widespread use of nonprescribed hormonal preparations (reviewed by Lawrence, 2007), there is currently little information available concerning complications of this practice given that it occurs outside of the medical setting. Some clinicians and practices have adopted a harm reduction model of hormonal care for gender transitioning persons, consisting of hormone prescription and basic laboratory services with few additional treatment requirements on the part of the patient.

The Protocols for Hormonal Reassignment of Gender of the Tom Waddell Health Center (TWHC) note that "[t]here exists a large group of individuals self-identified as transgenders who are at high risk for HIV transmission, are homeless or nearly homeless, and who are in need of general primary care services. This group has historically been averse to accessing medical services for a number of reasons…" (Tom Waddell Transgender Team, 2006). The decision regarding hormone prescription is, therefore, left to the individual physician or nurse practitioner, based

on psychosocial evaluation, physical examination, and informed consent. However, psychiatric evaluation is required for adolescents, with family participation unless the youth is legally emancipated. Although specific data regarding measurable aspects of treatment success from this approach have not been published, the authors of the TWHC protocol documentation (2006) note that their center has treated nearly 1,200 patients, with over 400 in active medical care. Most practices that use similar treatment approaches are located in urban centers with substantial populations of high risk transgender adults and youth. Evidence regarding the effectiveness of these approaches is currently lacking with regard to treatment of gender dysphoria, though the harm reduction basis is similar to other evidence-based public health programs aimed at reducing HIV risk.

In some settings, psychiatric or psychological evaluation is not required prior to initiation of hormonal therapies, if the prescribing clinician is able to assume responsibility for the associated aspects of mental health care. For example, in the Transgender Health Program of Vancouver Coastal Health (Dahl et al., 2006) primary care providers, including family physicians and nurse practitioners, may choose to have sole responsibility for evaluating eligibility and readiness for hormone therapy, and for initiating and monitoring this treatment, if their clinical expertise and practice structure support this level of involvement. (In this protocol, nurse practitioners may prescribe estrogens but not androgens.) However, the British Columbia Medical Services Plan will not approve applications for transgender surgical coverage unless this is recommended by two psychiatrists or one psychiatrist and one Ph.D. psychologist, all of whom must be registered with the Plan (Bockting et al., 2007). Evidence regarding the efficacy of this approach is not available, though the pre-surgical criteria are similar to the WPATH SOC in some respects.

Some practices employ a modified treatment protocol, such as a medical evaluation with hormone prescription, followed by a later visit with a mental health provider, for at least some transgender patient groups. In New York City, the Callen-Lorde Community Health Center treatment protocol for hormone therapy for "men of transgender experience, hormone experienced" provides an example in that regard (Callen-Lorde Community Health Center Transgender Health Program Protocols, unpublished, 2009). Other physicians informally waive any requirement for mental health evaluation if the individual has already been using hormonal medications for a substantial length of time, even if they were obtained without prescription. Some clinicians place a very high emphasis on patient autonomy, and provide hormone prescriptions on patient request, unless a strong medical contraindication is present. This is consistent with the principles articulated by the International Conference on Transgender Law and Employment Policy, Inc. (ICTLEP) (International Conference on Transgender Law and Employment Policy, 1997). No studies comparing treatment guided by these different policies have been carried out with respect to any outcome measure.

Fraser (2009) has recommended expanded use of the internet for education and psychotherapy for transgender persons, and for clinician training in transgender mental health care. The creation of "gender specialists" among masters and doctoral level clinicians has been suggested by Lev (2009). Although the gender specialist was conceptualized as having a supportive/informed consent role, rather than acting as a "gatekeeper," letters of recommendation would be required prior to the initiation of hormonal and surgical treatments. Thus, the distinction between this role and that of gatekeeper is subtle. Evaluation by a mental health professional would still be required prior to receiving desired medical treatments. Although the informal use of the term "gender specialist" appears to be increasing among some mental-health practitioners, formalization seems unlikely in the near future given the absence of consensus regarding formal training requirements, training institutions and licensing bodies. The Task Force does not support development of specific gender specialist criteria or certification as this might inadvertently create restrictions for mental health professionals already working with patients with GV/GID.

Mental Health Evaluation Prior to Surgical Care At the time of this writing, many surgeons performing genital gender reassignment surgery in the United States utilize the WPATH SOC (version 6) as part of the pre-operative evaluation, though these are neither mandatory nor universally accepted, and some surgeons select patients through other means. In some other countries, surgical eligibility criteria are even more stringent than the WPATH SOC, such as the requirement by the British Columbia Medical Services Plan that both evaluating clinicians be of doctoral level and approved by the Plan, and at least one a psychiatrist. Waiver of the mental health evaluation has been recommended as a matter of policy (ICTLEP, 1997) or on ethical grounds (Hale, 2007) but it is not clear that either of these arguments has gained extensive support within the surgical community. No direct evidence is available to address the safety and efficacy of evaluation for suitability for surgery by the surgeon, without the assistance of mental health professionals, though Lawrence's (2003) work is somewhat related.

Given the magnitude of bodily change involved, its profound social significance, and the irreversible nature of these procedures, it seems unlikely that many more surgeons in the United States and Europe will decide to perform genital reassignment surgeries without pre-operative mental health consultation, prior hormonal transition and real life experience, or some other substantial evaluative process. However, it should be noted that the ultimate decision regarding whether or not to operate in a particular case rests with the surgeon, i.e., he or she can decline to perform surgery even if the patient has been recommended according to the WPATH SOC or other evaluative means. As Green (1999) has noted, "If gender patients can procure surgeons who do not require psychiatric or psychological referrals, research should address outcomes for those who are professionally referred versus the self-referred."

GV in Persons with Somatic Disorders of Sex Development (Intersexuality)

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Overview

The process of decisions on gender assignment at birth is strongly emphasized in the clinical management of individuals with somatic disorders of sex development (DSD)—the term includes, but is not limited to, what was formerly called intersexuality. Patient-initiated gender reassignment at later ages, from late pre-school age through adulthood, varies with the specific DSD syndrome, from 0 % to about two-thirds of persons (Meyer-Bahlburg, 2005b). Among individuals who meet DSM-IV-TR criteria A and B for GID, those who have a DSD differ markedly in several respects from those who do not. These differences include variations in presentation, medical implications, and clinical context (Meyer-Bahlburg, 2009). As a consequence, the fourth edition of the DSM-IV-TR (American Psychiatric Association, 2000) placed individuals with gender dysphoria and a DSD under the category GIDNOS, rather than under the more specifically defined term, GID. GIDNOS is commonly used also for individuals without a DSD who meet some but not all required GID criteria (often referred to as "subthreshold cases"). Thus, GIDNOS is often applied to both groups of individuals with a DSD and gender identity concerns, those who meet all required GID criteria A and B, and those who meet only some of them. As the DSM-5 will be published in 2013 at the earliest and the revision process is in progress at the time of this writing, the current discussion will use the DSM-IV-TR formulations. Given the very limited literature on DSD-related GID and the fact that sex reassignment in individuals with DSD-related GID can occur at any age, we will deviate from the strictly age-defined outline of the previous sections, and will present the DSD-related issues in a more integrated fashion.

The present discussion will be limited to individuals with DSDs who present with clinically significant gender dysphoria or frank desire for gender reassignment. Clinical management of gender reassignment of such patients overlaps to some extent with that of persons with GID in the absence of a DSD. However, for individuals with a DSD, there are fewer barriers to legal gender reassignment, and the barriers to hormonal and surgical treatments in conjunction with gender reassignment are much lower. An example would be a 46,XY individual who was born with penile agenesis, assigned to the female gender and gonadectomized, although the testes were entirely normal and had provided for male-typical androgen exposure of the fetal brain, and who chooses to transition to the male gender in late adolescence (Meyer-Bahlburg, 2005a). Another example would be a 46,XX legally female individual with congenital adrenal hyperplasia (CAH) and an associated history of marked fetal masculinization and marked postnatal virilization (due to insufficient cortisol replacement therapy) who in adulthood requests reassignment to the male gender (Meyer-Bahlburg et al., 1996).

As illustrated by the above examples, several factors contribute to the lowered threshold for gender reassignment in individuals with a DSD. One is the fact that many of the underlying medical conditions require hormone administration as part of routine care. Moreover, many DSD syndromes involve infertility, which may either be congenital or due to gonadectomy performed according to past or present management guidelines (e.g., because of cancer risk) (Hughes et al., 2006). In addition, genital surgery has often been performed in infancy so that genital anatomy more closely corresponds to the assigned gender and is suitable for penile-vaginal intercourse at a later age (Hughes et al., 2006; Speiser et al., 2010). Legal and medical gender reassignment of individuals with a DSD may therefore take place at much younger ages than in persons with GID in the absence of a DSD. The evolution of clinical thinking and management guidelines concerning the indications for gonadectomy and genital surgery in infancy, and current controversies in these areas, are discussed in several recent reviews (Diamond & Beh, 2008; Frimberger & Gearhart, 2005; Hughes et al., 2006; Meyer-Bahlburg, 2009; Preves, 2003; Reiner, 2004; Speiser et al., 2010; Sytsma, 2006; Wiesemann et al., 2010). Decisions regarding hormonal and surgical procedures are complicated by the highly variable somatic presentations of the many diverse DSD conditions. A review of these syndromes is beyond the scope of the present review (see Grumbach, Hughes, & Conte, 2003). In addition, appropriate mental health care includes the often delicate task of disclosure of the medical history along with psychoeducation about the underlying biological condition (American Academy of Pediatrics, 1996; Meyer-Bahlburg, 2002a, 2008). Several major clinical management concerns that arise with patients with a DSD who experience gender dysphoria can be expected to profit from mental health interventions treatment and guidelines. These include: (1) the evaluation of gender and the respective psychiatric diagnosis, if any, in cases with incongruence between gender identity and assigned gender. This issue will be addressed largely in DSM-5 and only briefly touched upon in this report; (2) the process and validation of decisions regarding gender reassignment, including the identification and validation of the criteria on which such decisions are based; (3) the management of clinically significant gender dysphoria in individuals with a DSD who do not transition to gender change; (4) selected psychological and psychiatric aspects of the endocrine management of puberty in the context of gender reassignment; (5) selected psychological and psychiatric aspects of care involving genital surgery in the context of gender reassignment; (6) psychological implications of gonadectomy and their management; (7) disclosure of the DSD and treatment history to the patient; (8) the impact of DSD support groups; and (9) the qualifications of professionals who provide mental health services to patients with DSDs and gender-identity concerns.

Treatment of individuals with DSDs, in general, needs to address a variety of additional issues with mental health implications. Among these are the management of the gender assignment at

birth and its implications for the risk of developing gender dysphoria later; the clinical and ethical issues involved in the disclosure of medical history and biological status to the patient; the patient's self-disclosure to others; evaluation and management of any associated psychiatric conditions, especially depression and suicide risk; the management of DSD-related stigma; assessment of adherence to hormone-replacement therapy and reasons for non-adherence; providing continuity of care from childhood and adolescence into adulthood; and many others (Meyer-Bahlburg, 2008; Sytsma, 2006; Wiesemann et al., 2010).

Gender Evaluation

The assessment of gender-related behavior and identity in individuals with DSDs has been greatly improved by the development of a number of psychometrically sound questionnaires and interview schedules, based on self-report or parent report (e.g., Deogracias et al., 2007; Zucker, 2005). The evaluation procedures and related clinical considerations have been described in several publications (Consortium on the Management of Disorders of Sex Development, 2006a; Meyer-Bahlburg, 2008; Money, 1994; Uslu et al., 2007). The validation of such gender-assessment tools is based primarily on the demonstration of significant differences, preferably with large effect sizes, between: (1) males and females in general; (2) individuals with gender dysphoria who do not have a DSD versus control individuals without either gender dysphoria or a DSD (separately for males and females); and (3) later, when available, between individuals with both a DSD and gender dysphoria and controls.

Clinical experience has demonstrated that, in children and young adolescents, the evaluation of gender identity and related medical decisions regarding potential hormonal and surgical treatments requires cautious shielding of the young patient from family and peer pressures. Strong rapport building is also required by the clinician who must avoid unwittingly "leading" the child or adolescent. The process demands an extensive commitment of time. To date, no systematic studies of related techniques and their outcomes are available.

Decisions on Gender Reassignment

When an individual with a DSD meets GID criteria A and B of DSM-IV-TR, the clinician and the patient, or in the case of minors, the primary caregivers and the clinician (with the child's participation increasing with cognitive maturation), through discussion arrive at a consensus regarding a decision for or against gender reassignment. In this context, reassignment usually means "reassignment" to the "other gender" relative to the patient's natal or legal gender, although occasionally adult patients self-identify as "neither-nor," "third gender," "intersex," or some other category that implicitly rejects an exclusively binary system of gender classification. This decision is also influenced by a number of factors in addition to the A and B criteria. These include: (1) the known or assumed implications of the individual's particular DSD syndrome for genetic and hormonal effects on the sexual differentiation of the brain and behavior (Hines, 2004); (2) available knowledge regarding the long-term gender outcome of other individuals with this particular syndrome (e.g., likelihood of long term satisfaction with the new gender identity and/or gender role versus regret and request for re-transition, degree of confidence in one's gender identity, etc.); and (3) the potential benefits and risks of gender-confirming genital surgery.

Readiness criteria for the various steps of gender reassignment, for instance in terms of cognitive and emotional development, especially in children and adolescents, have not been formulated for individuals with DSDs. Clinical experience and published case reports suggest that these factors should be considered along with the duration and consistency of gender incongruence and desire for gender change. In addition, different cultures and even subcultures within a given country, may differ in the prevailing gender categories and the salience and weight of criteria used in decision making on gender assignment (Lang & Kuhnle, 2008).

A stringent evaluation of gender reassignment decisions by RCT with long-term follow-up has never been attempted. Moreover, such a study is highly unlikely to be performed for a variety of reasons. These include the distress likely to be involved when gender assignment is done randomly rather than based on what clinicians and parents decide on as best on the basis of existing information, the expected low participation rate, and the large costs of long-term follow-up. A short-term waiting-list type study design might be acceptable to an IRB, but would be logistically difficult to implement and probably not even very informative given the slow processes involved in gender development. A less stringent validation of gender reassignment decisions (without RCT) in terms of long-term gender outcome by systematic prospective follow-up studies into at least mid-adulthood has also not yet been made, because of the obvious logistical and financial problems involved.

Long-term follow-up studies of gender outcome that are available at this time include individual case reports (e.g., Meyer-Bahlburg et al., 1996; Money, 1991). There are also one-time cross-sectional studies, such as follow-up of all patients seen within a clinic starting at birth or any time later (e.g., Frisen et al., 2009; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006; Migeon et al., 2002; Schutzmann, Brinkmann, Schacht, & Richter-Appelt, 2009; Warne et al., 2005) or studies of patients recruited from support groups or from multiple sources, without analyzing systematically for patient-initiated gender reassignment (e.g., Brinkmann, Schweizer, & Richter-Appelt, 2007; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Richter-Appelt, Discher, & Gedrose, 2005). These studies typically cover a wide range of ages. Moreover, the time intervals between assignment and follow-up vary widely, and there are usually no attempts to do case–control comparisons of people with the same syndrome and the same degree of syndrome severity in terms of genital atypicality. Missing altogether is a

validation of the specific criteria upon which gender reassignment decisions in patients with DSDs have been based (e.g., which factors best predict a stable gender identity and/or quality of life).

The best available evidence is a combination of Levels [B] Clinical trial (with reassignment as the intervention for gender-dysphoric cases) and [C] Longitudinal follow-up, without any specific intervention for cases without gender dysphoria. These observational follow-up studies often have significant methodological weaknesses, including small sample sizes, syndrome heterogeneity, high attrition rates in long-term follow-ups, large variations in the follow-up intervals, and non-comparability of (reassignment) cases and (non-reassignment) controls and across syndromes in reassignment-relevant medical characteristics and/or social contexts. A few summary reports integrate data from accessible existing case reports and small-group studies and, thereby, fit the APA evidence category of [F] Review (e.g., Cohen-Kettenis, 2005; Dessens et al., 2005; Mazur, 2005; Meyer-Bahlburg, 2005a, b). The GRADE system of evidence categorization (Swiglo et al., 2008) is not applicable because a systematic analysis of the risk/benefit ratio has typically not been attempted in these reports.

Gender Dysphoria Without Transition to Gender Change

As gender roles in industrialized societies have gained flexibility and the (non-DSD) transgender spectrum has diversified, the spectrum of gender outcomes in patients with DSDs has also expanded. Gender dysphoria does not always lead to gender reassignment and, even if legal gender change is obtained, the individual may not necessarily seek to obtain all facets of available hormonal and surgical treatment. By way of self-reflection alone, or in conjunction with discussions in support groups or psychotherapy sessions, the patient may decide against a gender transition altogether or only for a partial transition. No systematic work has addressed the psychological processes underlying such decisions in patients with DSDs.

Gender Reassignment and the Endocrine Management of Puberty

In young persons with gender dysphoria who do not have a DSD, the aversive reaction to endogenous puberty is considered an indicator of cross-gender identification and recent years have seen an increase in the use of pubertal suspension, mostly by the administration of GnRH analogs, to give the early adolescent more time to come to a conclusion regarding gender reassignment, to reduce the development of unwanted secondary sex characteristics before cross-sex hormone treatment is started, and to reduce the emotional distress associated with such developments (Hembree et al., 2009).

Medical suspension of puberty is not relevant to the management of gender dysphoria in patients with DSDs who do not have functional gonadal tissue (whether congenitally or due to gonadectomy). However, such an approach could, in principle, be considered for patients with functioning gonadal tissue and a DSD such as 46,XX CAH, where the excess androgen production of the adrenal is suppressed by glucocorticoid replacement therapy, but no such study has been published to date. It is noted, however that some adult patients with 46,XX CAH have simply stopped taking glucocorticoids to self-induce somatic virilization (Meyer-Bahlburg et al., 1996). In hypogonadal or agonadal persons with a DSD, puberty is usually induced by sex-hormone treatment, and when the decision for gender reassignment has been made, the sex-hormone treatment is done in line with the gender desired by the patient. The details of sex-hormone administration (specific medication, dosing, and mode of administration) are decided by the endocrinologist. On psychological grounds, the age when the patient's peers begin noticeable pubertal development is usually recommended as the starting age for the initiation of puberty in patients with DSDs. The supporting evidence for this is clinical experience and some evidence from early observational follow-up reports of patients with Turner's syndrome or hypopituitarism and late-initiated puberty (summarized in Meyer-Bahlburg, 1980), not based on systematic study. However, such early timing might also be recommended on the basis of recent data on non-human mammals showing continued capacity of the brain for organizational effects of sex hormones which gradually diminishes from early puberty to adulthood (Schulz, Molenda-Figueira, & Sisk, 2009). A number of retrospective studies have reported past periods of gender uncertainty in patients with DSDs who at the time of later evaluation in adulthood were content with their originally assigned gender (Meyer-Bahlburg et al., 2004; Richter-Appelt et al., 2005; Wisniewski, Migeon, Malouf, & Gearhart, 2004). Whether the resolution of such transient gender uncertainties of patients with DSDs is supported by sex-hormone treatment and its timing or other factors has not been studied. The question of postnatal hormone effects is raised in this context. For example, female-assigned 46,XX individuals with CAH who transition gender at later ages tend to be those with a history of high postnatal androgen exposure. Causes of such high exposure include delayed onset of glucocorticoid treatment or prolonged interruption of treatment (usually due to the unavailability of appropriate services or a lack of money), even if their prenatal androgen exposure and their genital masculinization at birth were not extreme (Meyer-Bahlburg et al., 1996). Available evidence is yet too limited for firm conclusions regarding the role of postnatal sex-hormone exposure in gender identity development.

Gender Reassignment and Gender-Confirming Genital Surgery

Detailed case reports (e.g., Money, 1991), clinical observations (e.g., Warne & Bhatia, 2006), and the first systematic qualitative studies (Frisen et al., 2009; Karkazis, 2008; Meyer-Bahlburg et al., 2009; Preves, 2003) have documented the widespread social stigmatization in patients with DSDs, which is in part related to gender-atypical appearance, especially of the genitals. The "optimal gender policy" for the management of DSD introduced in the mid-1950s by

John Money and colleagues at Johns Hopkins included recommendations for corrective genital surgery in early childhood. The aim was to bring the genital appearance in line with the assigned gender in order to facilitate the acceptance of the child as a member of the assigned gender in the social environment. This would, in turn, facilitate gender-appropriate rearing, and, thereby minimize the occurrence of later body image problems and gender doubts on the part of the patient. An additional aim was to provide the capacity for penile-vaginal intercourse in adulthood. Because it was easier to surgically construct a vagina than a penis, this policy entailed a bias towards female assignment in 46,XY patients with a DSD and a markedly undersized phallus (an extreme example is the syndrome of penile agenesis mentioned earlier). In the last 15 years, testimonials of individuals with DSDs whose care followed the "optimal gender policy," detailed case reports, and long-term observational follow-up studies on gender outcome and sexual functioning have raised significant doubts about the policy (Meyer-Bahlburg, 2005b). Many patients initiate gender change later despite early gender-confirming surgery, especially among 46,XY patients raised female (although the frequency varies considerably with the particular DSD syndrome). Furthermore, body image problems and even stigmatization can occur despite early genital surgery, especially if the latter is not well done. Additionally, genital surgery entails a significant risk of impaired sexual functioning, which has led to a rethinking of gender assignment decisions in newborns and increased conservatism regarding genital surgery (Hughes et al., 2006; Meyer-Bahlburg, 2002a; Preves, 1998), a process that is still ongoing. In the course of this debate, numerous outcome studies of genital surgery in individuals with DSDs have been published, which increasingly evaluate not only cosmesis (i.e., quality of the anatomic outcome) but also functional outcome (Crouch et al., 2008; Gastaud et al., 2007; Karkazis, 2008; Minto, Liao, Woodhouse, Ransley, & Creighton, 2003; Sircili et al., 2006). Yet, the surgical techniques utilized are highly variable; the existing cross-sectional follow-up studies usually involve only modest sample sizes of patients with DSDs, often with considerable variability in the particular DSD syndromes represented among the subjects as well as in the ages at evaluation; RCT approaches to compare surgical techniques, even for cosmetic outcome, have not been attempted; and the existing follow-up studies commonly do not even attempt to systematically compare different surgical techniques. It is, therefore, difficult to draw conclusions sufficient for evidence-based recommendations. This applies especially to the numerous functional outcome criteria that are of clinical relevance (Meyer-Bahlburg & Blizzard, 2004). The question of optimal timing of such genital surgery runs into similar difficulties, and existing consensus recommendations are uncomfortably nonspecific (Hughes et al., 2006; Speiser et al., 2010). While many aspects of the evaluation of surgical technique fall within the purview of surgery, the indications and patient readiness for surgery as well as the impact of surgery on sexual satisfaction and psychological well-being should ideally involve mental health professionals. Considerations of the implications of a patient's present or emerging sexual orientation are also typically missing in existing discussions regarding the indications for genital surgery. The capacity for penile-vaginal intercourse may be valued differently depending on the sexual orientation of the individual, especially relative to all the difficulties that the required surgeries sometimes entail (Consortium on the Management of Disorders of Sex Development, 2006b).

Psychological Implications of Gonadectomy

Particularly in DSD syndromes involving Y chromosomes, various forms of gonadal dysgenesis, gonadal dysfunction, and/or the risk of malignant transformation, removal of the gonads may be recommended regardless of sex reassignment decisions (Brown & Warne, 2005; Hughes et al., 2006). Although there is a rich non-DSD literature on the consequences of infertility, gonadectomy, and iatrogenic and endogenous hypogonadism, there has been no systematic study of these issues in individuals with DSDs, except for the inclusion of related clinical observations in occasional case reports.

Disclosure of the DSD History

Because of the potential of DSD-related social stigmatization and self-image problems, the "optimal gender policy" of the Johns Hopkins group recommended that provision of information on the biological status and medical information about the child with a DSD be limited to a few family members along with a carefully paced disclosure to the patient him/herself and detailed suggestions on disclosure procedures (e.g., Carmichael & Ransley, 2002; Money, 1994). Although Money recommended full disclosure by the time a child completed high school unless there were significant cognitive limitations, our experience is that other clinicians frequently advised permanent withholding of disclosure from the patient, and sometimes even from the parent. This approach has been challenged on ethical grounds, is clearly at variance with the patients' rights movement of recent decades, and may entail serious medical risks. This approach may also lead to a situation when an adult discovers his/her DSD status in a setting that does not include medical supervision (e.g., self-initiated review of medical records, self-diagnosis with the aid of web-based materials or internet contacts). Moreover, many case reports and patient testimonials have documented the negative psychological outcomes of such secrecy–for example, shame, distress to the point of suicidality, and distrust of primary caregivers and doctors, the latter in some patients leads to avoidance of routine medical services altogether (Garrett & Kirkman, 2009; Money, 1991; Preves, 2003; Schutzmann et al., 2009). Yet, the questions of timing and techniques of disclosure, as described, for instance, by Money (1994) and Meyer-Bahlburg (2008), have never undergone systematic study, and formal clinical trials are highly unlikely, given the difficult logistics of such trials with patients with rare disorders as well as the complexity of clinical considerations involved. For

quite a few patients with DSDs and gender uncertainty or gender dysphoria, the disclosure of their medical information can be of help to their understanding of their behavioral gender atypicality, and may add arguments to their initiation of gender change, but this has been documented only in occasional case reports, not by systematic studies.

DSD Support Groups

Feelings of isolation are widespread among persons with DSDs, as in individuals with other uncommon medical conditions. Clinical experience and many patient testimonials have documented the tremendous beneficial effects many people experience when they are finally able to contact or meet face-to-face with others with the same or a similar condition through a DSD support group (e.g., Dreger, 1999; Garrett & Kirkman, 2009; Preves, 2003). Such groups are usually organized by persons with DSDs or their families, rather than by medical or mental health professionals. Despite the emotional relief that they can provide, support group contacts may also sometimes cause additional concerns (Meyer-Bahlburg, 2008). For instance, the composition of the group (e.g., the DSD syndromes represented within the group, the personalities of group members) may not meet the patient's expectations, and the information provided may not always be correct. Thus, patients who choose to participate in support groups should be encouraged to check back with their clinicians if they receive conflicting information or advice. Systematic research on the value of support groups in the clinical management of persons with DSDs has not yet been done.

Qualifications of Providers of Mental Health Services

The selected topics above provide a cursory overview of the issues, mental-health professionals (psychiatrists, psychologists, social workers, etc.) ought to be familiar with and able to manage clinically. Although recent medical guidelines emphasize the need for mental-health service providers with expertise in this area of care (Hembree et al., 2009; Hughes et al., 2006; Speiser et al., 2010), currently, very few mental health professionals are knowledgeable about treatment of persons with GID, and even fewer have much clinical experience with individuals with DSDs who have gender identity concerns. Given the dearth of specialized mental health service providers in this area, the gender evaluation and preparation for management decisions, including hormone treatment and genital surgery, are primarily made by endocrinologists and surgeons. Currently, there exist no formal programs for specialized training of mental-health personnel in this area. This Task Force strongly endorses the involvement of psychiatrists and other mental health professionals in the care of persons with DSDs and gender dysphoria; however, we conclude that it is premature to recommend detailed guidelines on required qualifications. To do so might jeopardize existing providers rather than contribute to closing the gap in the availability of mental health professionals in this area of clinical service.

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Appendix 1: Other APA Policy Concerns Regarding GV

In addition to the issue of treatment recommendations, several concerns regarding gender identity and the rights of persons who are gender variant are potential subjects for policy development within the APA. These include:

1. Support for treatment resources for gender variant and gender transitioning adults, and removal of barriers to care, including insurance coverage for accepted treatments, similar to AMA House of Delegates Resolutions 114 (A-08) and 122, and the American Psychological Association Council of Representatives Policy Statement regarding Gender Identity, Transgender and Gender Expression Non-discrimination.
2. Support for reasonable revision of identity documents for gender transitioning persons, including United States passports and birth certificates, which are currently difficult to correct.
3. Specific support for the marriage, adoption and parenting rights of transgender and gender transitioning persons, similar to existing APA policies regarding same gender couples.
4. Support for the rights of incarcerated persons who are gender variant or gender transitioning to personal safety and comprehensive healthcare, including transgender health services.
5. Support for transgender health services for members of the uniformed services and veterans, and opposition to the use of transgender or GV as grounds for discharge or rejection from enlistment.
6. Support for the most appropriate placement of persons who are transgender in gender-segregated treatment facilities, including inpatient psychiatric units, residential addiction treatment programs, and geriatric care centers.
7. Support for the inclusion and fair, collegial treatment of gender variant persons in all aspects of professional life, including medical schools, residency programs and fellowships in psychiatry, and the APA.
8. Support for professional and public education regarding transgender and GV, including:

(a) Scientifically sound, non-stigmatizing information about GV for patients and members of the general public.
(b) The inclusion of affirming, non-discriminatory information regarding GV and gender transition in the curricula of medical schools and psychiatric residencies and fellowships.
(c) Sponsorship of CME activities regarding transgender, such as presentations at the APA annual meeting and written materials in CME publications, particularly those used for maintenance of certification (MOC).
(d) Inclusion of questions about transgender on the ABPN certifying and MOC examinations.
(e) Tasking a specific APA Component or other group within the APA to monitor progress with regard to these activities.

Appendix 2: Other APA Concerns Regarding DSD

Because of the multiplicity of DSDs, the complex differences among them and their implications for integrated interdisciplinary care that includes mental health services; because not all DSDs are associated with either gender ambiguity or gender dysphoria; and because the needs of individuals with DSDs and gender dysphoria overlap incompletely with the needs of individuals with gender dysphoria in the absence of a DSD, the Task Force recommends that the APA create a separate mechanism for assessing the mental health needs of individuals with DSDs, whether or not gender dysphoria is present, and for working toward better integration of mental health professionals into the interdisciplinary teams that provide their care. This would include involvement with parents as soon as the DSD comes to attention, which increasingly occurs during pregnancy.

Areas identified to be addressed within this mechanism include (1) psychoeducation of parents or primary caregivers; (2) assessment of indications and readiness for gender confirming surgeries and procedures related to them; (3) age appropriate disclosure of DSD status and related medical/surgical history; (4) issues related to gonadectomy and infertility; (5) DSD-associated stigma including that related to genital anomalies and other body image issues as well as feelings of shame and guilt; (6) revealing DSD status to others, and (7) the impact of DSD status on relationship issues including sexual intimacy.

The recommendation to create a mechanism to address the mental health needs of individuals with DSDs, whether or not gender concerns are present, is not intended to exclude individuals with DSDs from APA recommendations pertaining to GID, GID-NOS or other manifestations of GV.

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EVIDENTIARY HEARING - Motion for Preliminary Injunction (Day 2)

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

Judge: B. Lynn Winmill
Case No: 1:17-cv-151
Date: October 11, 2018
Place: Boise

Deputy Clerk: Jamie Bracke
Reporter: Tammy Hohenleitner
Time: 5 hours and 57 minutes

ADREE EDMO v. CORIZON INCORPORATED, et al

Counsel for Plaintiffs: Amy Whelan, Shaleen Shanbhag, Lori Rifkin, Deborah Ferguson, and Craig Durham

Counsel for Corizon Defendants: Dylan Eaton and Kevin West

Counsel for IDOC Defendants: Brady Hall and Marisa Crecelius

WITNESSES

Plaintiff:

1) Adree Edmo
2) Dr. Ryan Nicholas Gorton

Defendants:

1) Jeremy Junior Clark
2) Scott Eliason

EXHIBITS

Plaintiff: 1002, 1004, and 1025

Defendant: 2007, 2009, 2016, 2038, 2019, and 2022

3:22 p.m. - Afternoon recess. The hearing shall resume on October 12, 2018 at 8:30 a.m. before Judge B. Lynn Winmill.