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)

EXCERPTS OF RECORD
VOLUME 14 OF 18 (PAGES ER 2800 – ER 3080)

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Dated: March 6, 2019

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IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT TEAM COMMITTEE
IN THE MATTER OF Mason Dean Edmo IDOC #94691

Idaho State Correctional Institution (ISCI)
South Boise Complex, BOISE, IDAHO
August 23, 2012

REVIEW OF APPLICABLE DIRECTIVES, CARE STANDARDS and REPORTS:

1. Idaho Department of Correction, Division Directive 401.06.03.501.
2. Medical Record

PARTICIPANTS:
Maria Young AA
IDOC Note Taker

Richard Craig, Ph.D. Chief Psychologist IDOC	Rona Siegert, RN Health Services Director IDOC	Scott Eliason M.D. Psychiatrist CMS
Garrett Coburn Deputy Warden – ISCI IDOC	Shell Wamble-Fisher Clinical Supervisor IDOC	Ashley Dowell Clinical Supervisor IDOC
Susan Bajovick, RN DON Corizon	Kevin Sligar, LMSW Clinician IDOC	

Name: EDMO, Mason Dean (AKA: MEEKS, Mason Dean)
IDOC #: 94691
DOB: [redacted]
Current Housing: ISCI Unit 16
Status Date: 12/19/2011
Parole Elig: 07/04/2014
Next Parole Hearing: 01/2014
Instant Disch: 07/03/2021
Crime: Drawing Checks without Funds, 1 year 6 months – 3 years; Sexual Abuse of a Child Under 16, 3 years – 10 years; Sentences running concurrent

Social/Family History:
Mason Dean Edmo (formerly Meeks) was born in Pocatello, ID on [redacted]. Early years were reportedly spent with both mother and father until approximately age 8 when the father left and his parents divorced. From then on, the mother was the primary caregiver and reportedly was able to provide adequately for her children.

JT Ex. 7-1

There appears to be a significant family history of alcohol abuse which may have contributed to this offender's use of the substance beginning at approximately age 16. Edmo's father has been incarcerated for alcohol-related offenses and both he and Ms. Edmo consumed alcohol regularly during their marriage. The availability of alcohol on the Fort Hall Reservation may also have contributed to the issues this offender has experienced with intoxication and alcohol-related crimes. This offender has never really established a relationship with the father, although Edmo apparently attempted to form a relationship after his release from prison in 2008, but this offender reported that, "... [he] could not accept that Mason is gay." Edmo reportedly does enjoy a good relationship with one sister.

Currently, Edmo indicates a close relationship with Ms. Edmo. Reportedly, Ms. Edmo had been clean and sober for 18 months at the time the latest pre-sentence report was written in July 2011. She was reportedly very upset when she learned that alcohol was involved in the latest charge and was "embarrassed" by the crime.

During the 2011 PSI process, Edmo reported to the investigator that there was previously unreported sexual abuse that began shortly after Ms. Edmo remarried a man who had a 14 year old son. That son reportedly began playing "games" with Edmo that eventually led to sexual intercourse. Ms. Edmo was married for 6 years before divorcing this man, but this offender never told either the mother or step-father about the abuse.

This offender reports having had a sporadic work history primarily due to periods of incarceration and probation/parole violations. During the last PSI process, Edmo reported having been enrolled at Idaho State University and only needed 20 clinical hours to complete the CNA course. In 2005, Edmo obtained a GED through ISU and wanted to become a Registered Nurse; however, dropped out of college in 2007 because of incarceration.

Gender History:
This offender is a self-reported homosexual from a very early age. Edmo reported during the 2009 PSI process, "During my teen years I knew I was 'different' from other guys, which led to my choice of lifestyle now." There was reportedly "...a lot of negativity towards me because of it, so I got into a rebellious stage and started drinking..."

Edmo was reportedly involved with 1 partner from May 2008 through June 2010. The relationship ended due to, "infidelity, alcohol abuse, domestic abuse, jealousy." There was one prior relationship that only lasted about 4 months and ended for similar reasons.

Regarding the gender identity disorder (GID) evaluation process, it is noted that this offender reported feeling "feminine" as far back as memory goes. Reporting to Scott Eliason, M.D. (Corizon) offender indicated it was a mistake being born

JT Ex. 7-2

male, being sexually oriented toward males and having thought that "...coming out homosexual was really what I needed to feel like me but now I think it is that I am not a gay man, but actually a woman." Edmo continued by indicating there was the feeling of shame and embarrassment about being a male. Dr. Eliason said that he believes "that this inmate's Dysphoria is related to transgender issues and meets the definition of Gender Dysphoria."

Medical History:
The PSI completed in November 2011 noted that Edmo's physical health was generally good. Offender Edmo told the presentence investigator about having gallbladder surgery at Portneuf Medical Center in February 2011. Additionally, Edmo claimed suffering extreme depression and anxiety. There have been documented suicide attempts by cutting on arm (8/2010), overdose on alcohol and pills (9/2010 & 5/2011) reportedly because of past failed relationships and difficulty dealing with family and alcohol problems.

Recently this offender has been placed into close observation related to a recent relationship loss and reported being fearful about being a sex offender; returned to unit one day later and showed much improvement the day after.

Current Status:
Dr. Lake noted in her evaluation dated July 19, 2012 that this offender was cooperative and presented well. Edmo is currently housed at ISCI in Unit 16, but was briefly housed in the mental health acute unit for the purposes of evaluation. Dr. Lake noted that there did not seem to be any disturbance by internal stimuli, responding to questions clearly and fairly directly; affect was feminine and exhibited appropriate emotional response and eye contact.

Edmo was administered the Personality Assessment Inventory (PAI) and Dr. Lake noted there is "no indication of significant clinical psychopathology." It should also be noted that in times of stress, behavior may become maladaptive. This offender is generally self-confident, but in times of trouble will become filled with self-doubt. Offender is genuine and outgoing preferring harmony in relationships with others.

Diagnosis:

Axis I:	GID with a history of Gender Dysphoria Mood Disorder NOS Alcohol Dependence
Axis II:	None
Axis III:	Deferred
Axis IV:	Incarceration
Axis V:	GAF 70

MTC Recommended Management Plan:

- Remain housed in Unit 16 (BHU)

- Evaluation by physician for suitability for hormone therapy within 30 days
- Gender Dysphoria is at a manageable level
  - Clinician contact twice per week
  - Re-evaluate after 90 days
- Parole Eligibility Date July 2014
  - Move into high risk sex offender treatment group in the next available opening

Meeting adjourned at 12:00.

Approved by:

Richard Craig, Ph.D.
Chief Psychologist
IDOC

IDAHO DEPARTMENT OF CORRECTION

ADMINISTRATIVE REVIEW COMMITTEE
IN THE MATTER OF Mason Dean Edmo IDOC #94691

CENTRAL OFFICE, BOISE, IDAHO
September 12, 2012

REVIEW PARTICIPANTS

Richard Craig, Ph.D. Chief Psychologist IDOC	Rona Siegert, RN Health Services Director IDOC	Scott Eliason M.D. Psychiatrist CMS
Garrett Coburn Deputy Warden – ISCI IDOC	Shell Wamble-Fisher Clinical Supervisor IDOC	Ashley Dowell Clinical Supervisor IDOC
Susan Bajovick, RN DON Corizon	Kevin Sligar, LMSW Clinician IDOC	

REVIEW OF APPLICABLE DIRECTIVES AND CARE STANDARDS

1. Idaho Dept of Correction Division Directive 401.06.03.501.
2. Management Treatment Committee recommendations/minutes from meeting held at (facility and date)

RECOMMENDED MANAGEMENT PLAN REVIEW

- Remain Housed in Unit 16 (BHU)
- Physician evaluation within 30 days for Hormone Therapy suitability
- Clinician contact 2 times per week for 90 days
- Re-evaluate after 90 days
- Move into High Risk Sex Offender Treatment Program

Kevin Kempf
Chief, Operations

Shane Evans
Chief, E T & R

Mark Kubinski
Attorney, Legal

Jeff Zmuda
Deputy Chief, Prisons

Brent Reinke, Director

Approved ✓
Denied ____

IDAHO DEPARTMENT OF CORRECTION
"Protecting You and Your Community"

C.L. "BUTCH" OTTER
Governor

BRENT REINKE
Director

February 12, 2013

Edmo, Mason
IDOC #94691
ISCI U16 B 34 A

RE: Unit Move

At the meeting of the Management and Treatment Committee on February 7, 2013 your request to be moved to another unit was discussed.

The MTC agreed that for your safety and to ensure ease of access to clinical services, you should remain in Unit 16.

Please continue with your groups and to meet with your case manager and/or clinician as needed.

Regards,

Richard Craig, Ph.D.
IDOC
Chief Psychologist

1299 NORTH ORCHARD · SUITE 110 · BOISE · IDAHO · 83706 · PHONE (208) 658-2000 · FAX (208) 327-7433

JT Ex. 7-6

IDAHO DEPARTMENT OF CORRECTION

ADMINISTRATIVE REVIEW COMMITTEE

IN THE MATTER OF Mason Dean Edmo IDOC #94691

CENTRAL OFFICE, BOISE, IDAHO
November 6, 2013

REVIEW PARTICIPANTS

Name:	Position:	
Richard Craig, PhD	Chief Psychologist	IDOC
Scott Eliason, MD	Psychiatrist	Corizon
Garrett Coburn	Deputy Warden	ISCI
Shell Wamble-Fisher, CMSW	Clinical Supervisor	IDOC
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
Kimel Limon, Pys D	Psychologist	Corizon
Tina Bossolono-Williams	Health Services Admin	Corizon
Will Wingert	Director of Nursing	Corizon
Kim Pilote	Asst Director of Nursing	Corizon

REVIEW OF APPLICABLE DIRECTIVES AND CARE STANDARDS

1. Idaho Dept of Correction Division Directive 401.06.03.501.
2. Management Treatment Committee recommendations/minutes from meeting held at ISCI, October 16, 2013

RECOMMENDED MANAGEMENT PLAN REVIEW

Offender Edmo was moved to ICI-O on August 12, 2013 as a precautionary measure after receiving a Disciplinary Offense Report for sexual activity and increased acting-out while housed at ISCI.

Offender Edmo was placed into the Sex Offender Treatment Program at ICI-O, but signed a refusal to program.

This offender will remain at ICI-O and behavior will continue to be monitored.

Kevin Kempf
Chief, Prisons

Shane Evans
Chief, E T & R

Karin Magnelli
Attorney, Legal

Brent Reinke, Director

Approved ✓
Denied ____

JT Ex. 7-7

IDAHO DEPARTMENT OF CORRECTION

ADMINISTRATIVE REVIEW COMMITTEE
IN THE MATTER OF EDMO, Mason IDOC 94691

CENTRAL OFFICE, BOISE, IDAHO
February 2014

MTC REVIEW PARTICIPANTS

Name:	Position:	
Richard Craig, PhD	Chief Psychologist	IDOC
Scott Eliason, MD	Psychiatrist	Corizon
Kimel Limon, PsyD	Psychologist	Corizon
Shell Wamble-Fisher, LCSW	Clinical Supervisor	IDOC
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
Garrett Coburn	Deputy Warden	ISCI
Kim Pilote, RN	ADON	Corizon
Will Wingert, RN	DON	Corizon

REVIEW OF APPLICABLE DIRECTIVES AND CARE STANDARDS

1. Idaho Dept of Correction Division Directive 401.06.03.501.
2. Management Treatment Committee recommendations/minutes from meeting held at Idaho State Correctional Institution, Business Manager's Conference Room.

RECOMMENDED MANAGEMENT PLAN

1. Reaffirm gender dysphoria Tx plan
2. Reported to be presently adjusting well at ICI-O
3. Has re-engaged with SOTP group
4. Underwear concerns – Medical will have to determine appropriateness

Jeff Zmuda
Chief, Prisons

Shane Evans
Chief, E T & R

Karin Magnelli
Attorney, Legal

Brent Reinke, Director

Approved ✓
Denied ____

JT Ex.
7-8

ADREE EDMO
IDOC# 94691
P.O. BOX 14
Boise, Idaho 83707

March 02, 2015

Richard Craig, Ph.D.
Idaho Department of Corrections
1299 North Orchard Street, Ste 110
Boise, Idaho 83706

Re: False Indications w/ ARC

Dr. Craig:

Previously, I had asked you to clarify that the meeting minutes in the Administrative Review Committee on or around September 2013, that I had been moved because of alleged "sexual DOR" that resulted from the PREA investigation prior to my facility move in August 2013 from ISCI to ICI-O.

Additionally, in the beginning months of 2014, you and I had a meeting together, where you had stated "I needed to get you out of that environment", not necessarily specific of which environment you had been referring to.

As I have stated to you previously, I have never recieved a sexual DOR stemming from any PREA investigation, more specifically in August of 2013.

I am respectfully asking that this be clarified and removed from my records to prevent further misleading indications.

I look forward to reading your reply very soon.

Respectfully Submitted,

Adree Edmo

Adree M. Edmo

Cc: File

IDAHO DEPARTMENT OF CORRECTION
ADMINISTRATIVE REVIEW COMMITTEE
IN THE MATTER OF MASON EDMO #94691
CENTRAL OFFICE, BOISE, IDAHO
MARCH 25, 2015

MTC REVIEW PARTICIPANTS

Name:	Position:	
Richard Craig, PhD	Chief Psychologist	IDOC
Scott Eliason, MD	Psychiatrist	Corizon
Shell Wamble-Fisher, LCSW	Clinical Supervisor	IDOC
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
Garrett Coburn	Deputy Warden	ISCI
Jeremy Irvin, LMSW	Clinician	IDOC

REVIEW OF APPLICABLE DIRECTIVES AND CARE STANDARDS

1. Idaho Dept of Correction Division Directive 401.06.03.501.
2. Management Treatment Committee recommendations/minutes from meeting held at Idaho State Correctional Institution, Business Manager's Conference Room.

RECOMMENDED MANAGEMENT PLAN

- Move to SICI
- Concern would have to start his time over again if he moves

Jeff Zmuda, Chief of Prisons

Shane Evans, Chief of ET&R

Karin Magnelli, Attorney Legal

Henry Atencio
Kevin Kempf, Director

Approved ____
Denied X

Please provide more information, rationale or justification As to why this offender is being moved.

Henry Atencio

JT Ex. 7-10

Memorandum

Idaho Dept of Correction *Education & Treatment Division*

***DATE**: 30 March 2015*

***TO:** Edmo #94691*

***CC:** MTC file*

***FROM**: Richard Craig, Ph.D.*

***RE:** Corrective addendum to MTC minutes dated*

In a correspondence to my office dated March 1, 2015, offender Edmo expressed a concern that the minutes of an Administrative Review Committee (ARC) meeting held on or around September 2013, contained an entry alleging that the offender had a sexual DOR resulting from a PREA investigation held prior to August 2013. To address the offender's concerns I reviewed the inmate's file and discovered in the ARC records dated November 6, 2013 the management plan noted that the offender had received "…. a Disciplinary Offense Report [DOR] for sexual activity and increased acting-out while housed at ISCI".

In reviewing the available C-notes and disciplinary records, as well as speaking to staff at ISCI and ICI-O, it was determined that the entry in the ARC minutes was, in fact, inaccurate. There was no indication of a DOR for sexual activity or any notation indicating that a PREA investigation had occurred.

This memorandum serves to acknowledge the incorrect entry made in the November 6, 2013 ARC minutes and is also placed in the file to serve as a correction of that error.

JT Ex.
7-11

Memorandum

Idaho Dept of Correction *Education & Treatment Division*

DATE: *7 April 2015*

TO: *Henry Atencio*

CC: *File*

FROM: *Richard Craig, Ph.D.*

RE: *Addendum/correction to ARC approval form (Edmo #94691)*

A clerical error appeared on the recently submitted ARC form which led to the denial of Offender Edmo's (94691) plan. Please consider the following as a correction to that original submission.

Edmo was diagnosed with GD several years ago and at that time began hormone replacement treatment under the direction of the medical department. During our MTC meetings we routinely receive a verbal update on the progress of the offenders who have been diagnosed with gender dysphoria. These updates occur every six months.

In discussing Offender Edmos' progress, the question was raised as to whether or not the offender could be referred to SICI at some time in the near future. The basis for this discussion was in anticipations of the offender possibly receiving a eligibility date. In the recommendations submitted for ARC review and approval, the entry should have read "explore a move to SICI".

Approved: Henry Atencio Date: 4/7/15
Henry Atencio

JT Ex. 7-12

Cases for consideration:

- [redacted]

Bi-annual reviews

- [redacted]

Additional discussion

- [redacted]
- Edmo, M -94691 recent self-injury
- [redacted]
- [redacted]

JT Ex.
7-13

Management and Treatment Team Committee Minutes

October 7, 2015
Idaho Department of Correction
Idaho State Correctional Institution
Business Manager's Conference Room

REVIEW PARTICIPANTS

Name:	Position:	
Richard Craig, PhD	Chief Psychologist	IDOC
Scott Eliason, MD	Psychiatrist	Corizon
Debbie Davis-Johnson	Psychologist	Corizon
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
Garrett Coburn	Deputy Warden	ISCI
Jeremy Irvin, LMSW	Clinician	IDOC

Others Present:
Janelle Catlin, IDOC Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06.03.501, the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Dr. Richard Craig called the meeting to order at 14:33 p.m. at ISCI in the Business Manager's Conference Room.

Recently, requests have been received from currently-designated Gender Dysphoria offenders asking to be allowed to move into general population. The SOP does not preclude general population housing, and offenders should be allowed the opportunity to be housed in accordance with their assigned custody level. A definite criteria will be published that includes, at a minimum, the written request from the offender wishing to move, a review by clinical staff for suitability, and documented counseling of the concerns and potential hazards of such a request. Each individual requesting general population must receive counseling and that counseling must be documented. Offenders should be allowed the opportunity to continue groups that focus on gender dysphoria.

Five new requests for review were received within the last quarter: Two prior request underwent further evaluation per recommendation of the MTC

Cases for Consideration:

[redacted]

Bi-annual Reviews:

[redacted]

Additional Discussion:

[redacted]

- Edmo, M – 94690

[redacted]

Cases for Review and Discussion:

1. **Edmo, M – 94690**
    a. Has concern forms to review
        i. Not receiving medical assistance
            1. Assessment for surgery
            2. Hormone surgery
            3. Medical has tracked all medication
        ii. Clinician Irvin met with Edmo the week of 10.5.2015
            1. Self-harm in the week of 10.5.2015 with minor cuts on testicles
            2. Edmo has continued to report a desire to cut off his testicles
        iii. To reduce risk it is recommended to return offender to the BHU
    b. **Treatment Plan:**
        i. Return Offender to BHU for additional monitoring and support
        ii. Routine contact with GD group
        iii. Some indications that estrogen was not being received on regular basis. This was brought to the attention of medical and will be resolved

2. [redacted]

c. [redacted]

3. [redacted]

4. [redacted]

5. [redacted]

4. [redacted]

IDOC_L_pg.16

JT Ex. 7-16

6. [redacted]

Meeting adjourned at 16:00 p.m

Approved by:

_____
Richard Craig, Ph.D.
Chief Psychologist
IDOC

Submitted by: J.Catlin, AA

JT Ex. 7-17

6. [redacted]

7. [redacted]

IDOC_L_pg.18

JT Ex. 7-18

IDOC_L_pg.19

JT Ex. 7-19

i. [redacted]

Department of Correction – Division of Prisons

Memo

To: **Edmo # 94691**

From: Ashley Dowell, Deputy Chief of Prisons

Date: February 22, 2016

Re: Letter Dated January 30, 2016

I appreciate your correspondence with Director Kempf regarding your request for a Management Treatment Committee meeting. Director Kempf provided me with your letter and asked that I respond. I agree that it is appropriate for the Management Treatment Committee to review all aspects of an inmate's case, to include a review of medical concerns, security concerns and the individual concerns of the inmate. As such, I have forwarded a copy of your letter to Clinician Jeremy Irvin and Clinical Supervisor Jeremy Clark and asked that they schedule a Management Treatment Committee meeting to discuss the specific concerns you have outlined in your letter and to make a recommendation to the Administrative Review Committee regarding your placement.

I trust that the consultation and discussion between your providers and the Management Treatment Committee will determine an appropriate plan of care, to include a housing recommendation, and believes this resolves the matter until a recommendation by that committee occurs.

_____

Ashley Dowell, LCPC, CCHP-MH

Deputy Chief, Division of Prisons

IDOC

IDOC_L_pg.21

JT Ex. 7-21

IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT TEAM COMMITTEE
IN THE MATTER OF Mason Edmo
ISCI, South Boise Complex, BOISE, IDAHO
3/2/16

REVIEW OF APPLICABLE DIRECTIVES, CARE STANDARDS and REPORTS

1. Idaho Dept of Correction Division Directive 401.06.03.501.
2. Medical Record

Participants:
Kathleen Wilson, AA
IDOC Note Taker

Jeremy Irvin, LMSW, MEd. Clinician ISCI	Garett Coburn Deputy Warden – ISCI IDOC	Scott Eliason, M.D. Psychiatrist Corizon
David Agler, MD. Medical Corizon	Jeremy Clark, LCPC Clinical Supervisor ISCI	Gen Brewer, RN Medical Corizon

Name: Mason Edmo
IDOC #: 94691
Current Housing: ISCI Unit 16
Current Offence: Sexual Abuse of a Child Under 16

Offender History

See attached report

Relevant Considerations

1. Edmo requested to be allowed to move to PWCC due to safety concerns.
   a. Edmo stated that Edmo has heard from many correctional staff that Edmo is at an increased safety risk associated with being in a male prison, and requests to be moved to a female prison since staff believe Edmo is unsafe in current prison.
      i. Edmo denied being fearful for safety and denied any safety concerns of Edmo's own involving staff or inmates.
   b. MTC discussed safety concerns that other inmates at PWCC may experience as a result of having a biological male be housed at PWCC. Per current policy 401.06.03.501 inmates shall be housed by their primary physical sexual characteristics.
2. Edmo requested be allowed to move from the BHU at ISCI to SICI.
   a. Edmo stated that Edmo would like to be able to move out of the BHU without meeting the MTC housing criteria that was put into place last year. Edmo has met the criteria once before and believes that this should qualify for Edmo to no longer have to meet the requirements in the future.
   b. MTC discussed Edmo's request, but the MTC recommended that Edmo be required to meet the MTC housing requirements that were established last year before being allowed to move out. Edmo does not currently meet these requirements at this time as Edmo has received three Class B DORs in the last six months. Additionally, Edmo's current custody level, which is classified as medium, precludes Edmo from

☒ Recommendations Approved

☐ Recommendation NOT approved further information needed

☐ Recommendation NOT approved consultant required

Director: Henry Mencio

IDOC_L_pg.23

JT Ex. 7-23

ER 2822

April 27, 2016

Inmate Edmo #94691

Inmate Edmo has made several requests to me moved out of Unit 16 as well as moved to other facilities. Edmo as stated that there has been a criteria that is keeping Edmo placed in Unit 16 such as being free of a DOR for 6 months. Inmate Edmo has continually stated in concern forms there is a criterion that is keeping Edmo at ISCI. Upon looking into this issue, and trying to find a criterion that give specific factors that would keep Inmate Edmo at ISCI, I was unable to find any criteria in the current Gender Dysphoria policy or in any field memorandums. Based on the current Gender Dysphoria policy all housing decisions will be address through the Management and Treatment Committee (MTC) or the Chief Psychologist. This issue will be something that is addressed in the current policy update.

Jeremy Clark, LCPC
Clinical Supervisor, ISCI
MTC Member

IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT TEAM COMMITTEE
IN THE MATTER OF Mason Edmo
ISCI, South Boise Complex, BOISE, IDAHO
06/01/16

REVIEW OF APPLICABLE DIRECTIVES, CARE STANDARDS and REPORTS

1. Idaho Department of Correction Division Directive 401.06.03.501.
2. Medical Record

Participants:
Kathleen Wilson, AA
IDOC Note Taker

Morgan Hahn, LMSW Clinician ISCI IDOC	Garett Coburn Deputy Warden – ISCI IDOC	Scott Eliason, M.D. Psychiatrist Corizon
Yolanda Ponder, LSCW Clinician ISCI IDOC	James Barry, Ph.D. IMSI Psychologist Corizon	Murry Young, M.D. Medical Corizon
David Agler, MD. Medical Corizon	Jeremy Clark, LCPC Clinical Supervisor ISCI	

Name: Mason Edmo
IDOC #: 94691
Current Housing: ISCI Unit 16
Current Offense: Sexual Abuse of a Minor under 16

Relevant Considerations

Inmate Edmo requested to have the MTC consider about the possibility of moving out of Unit 16 into the general population at ISCI. Edmo has requested several times in the past year saying Edmo is uncomfortable with living in Unit 16 as well as some struggles interacting with some of the staff. Edmo feels that the MTC and IDOC are discriminating Edmo because Edmo has been made to live in Unit 16.

The committee discussed the possibility of Inmate Edmo moving into general population, and several concerns were noted. One concern was Inmate Edmo's current behaviors. Edmo recently received a DOR for receiving a tattoo, Edmo consistently has verbal confrontations with staff, and Edmo has a history of inappropriate sexual behaviors with other inmates who live in general population. The committee was concerned that these behaviors would lead to interactions with other staff members who have less exposure to and training with working with inmates with Gender Dysphoria, and this would increase Inmate Edmo's dysphoria. The committee also felt this would also place Inmate Edmo in more high-risk situations that could lead to more disciplinary issues. The committee felt Inmate Edmo would receive the best services for Edmo's need in Unit 16 where Edmo will have clinical support as well as other staff members who are accustomed to working with inmates who have Gender Dysphoria. The committee is open to reevaluating Inmate Edmo's request to move into general population if Edmo can demonstrate more consistent prosocial behaviors and have less disciplinary issues that could place Inmate Edmo into high-risk situations in the general population.

IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT COMMITTEE (MTC)
IN THE MATTER OF Mason Edmo
ISCI, South Boise Complex, BOISE, IDAHO
08/10/16

REVIEW OF APPLICABLE DIRECTIVES, CARE STANDARDS and REPORTS

1. Idaho Department of Correction Division Directive 401.06.03.501.
2. Medical Record
3. CIS

Participants:

Morgan Hahn, LMSW Clinician ISCI IDOC	Garett Coburn Deputy Warden – ISCI IDOC	Amanda Benton Medical Corizon
Yolanda Ponder, LSCW Clinician ISCI IDOC	James Barry, Ph.D. IMSI Psychologist Corizon	David Agler, MD. Medical Corizon
Jeremy Clark, LCPC Clinical Supervisor ISCI	Jeremy Clark, LCPC Clinical Supervisor ISCI	

Name: Mason Edmo
IDOC #: 94691
Current Housing: ISCI Unit 09
Current Offense: Sexual Abuse of a Minor under 16

Relevant Considerations

The Administrative Review Committee (ARC) requested that the MTC reconvene to provide a more detail explanation of the MTC's recommendation made on 06/01/16 that Inmate Edmo remain housed in Unit 16 when Inmate Edmo had requested to be moved into general population. Below are the responses to the inquiries made by the ARC.

1) Inmate Edmo requested to be moved out of Unit 16 based on Edmo feeling uncomfortable being housed in Unit 16. The MTC's concerns were:
    a. Inmate Edmo's past behavioral issues:
        i. In the past year and a half, Inmate Edmo has had 14 DORs to include 2 Battery DORs, 2 DORs for sexual activity (the most recent in December of 2015), 2 DORs for tattooing, 4 DORs for Disobedience to Orders, and some property DORs.
        ii. Inmate Edmo has a history of being the perpetrator of inappropriate sexual activity.
    b. The MTC has a general concern that if the inmate is consistently misbehaving in Unit 16, this could pose a more significant issue for the inmate if they move into general population.
        i. The security staff in Unit 16 has more exposure with working with the GD population and has a better understanding of the dynamics of the

GD population in comparison to other staff who work in the general population.

i. The MTC has concerns that this lack of exposure may affect the interactions between staff and the inmate with gender dysphoria which may cause the inmate's gender dysphoria to increase along with other mental health issues leading to more incidents of possible DORs and incidents of inmate going on suicide watch. The MTC felt the Unit 16 would respond to these issues in a more consistent and appropriate manner.
ii. The MTC recognizes a need for a more comprehensive training program for staff statewide, and will be formalizing a plan to provide this training.

Since the recommendation on 06/01/16 for Inmate Edmo to remain housed in Unit 16, there have been some incidents that have taken place that change the status of Inmate Edmo. On 07/13/16, Inmate Edmo physically assaulted another inmate with Gender Dysphoria and that inmate did not fight back. This was the second time that Edmo physically assaulted the same inmate with the first incident taking place on 11/15/15. Inmate Edmo received two Class B DORs for Battery for these incidents. Based on the security concerns and the victim's feelings of not being safe around Inmate Edmo, Clinical Supervisor Clark authorized that Inmate Edmo be housed in general population. Inmate Edmo's situation was then address with some of the members of the MTC on 08/10/16.

Recommendations

1. Based on the security issues and the safety of the victim of the physical assault, it's recommended that Inmate Edmo be housed in general population.
2. Based on the security issues, the safety of the victim of the physical assault, and non-compliance with the expectations of the transgender group and treatment program, Inmate Edmo will be suspended from attending the transgender group for at least 90 days. The MTC will review the status of Inmate Edmo during the MTC meeting in December. Inmate Edmo with be expected to demonstrate through Inmate Edmo's behaviors, that Edmo will be appropriate to return to the transgender group by being DOR free and accepting responsibility for Edmo's behaviors towards the victim of the physical assault.
3. Inmate Edmo will have access the mental health service through Edmo's assigned clinician, and can attend other mental health or programming groups as needed.

Approved by:

Jeremy Clark, LCPC.
Clinical Supervisor, ISCI
IDOC

ARC Review: Date 10/18/16

Jeffery Zmuda:

Ashley Dowell

Karin Magnelli

☐ Recommendations Approved

☑ Recommendation NOT approved (detail reason or desired action)

recommendation not approved for ISCI based on updated UTC recommendation on 9/7/16 to move Edmo to ICIO.

Director's Review: Date 11-2-16

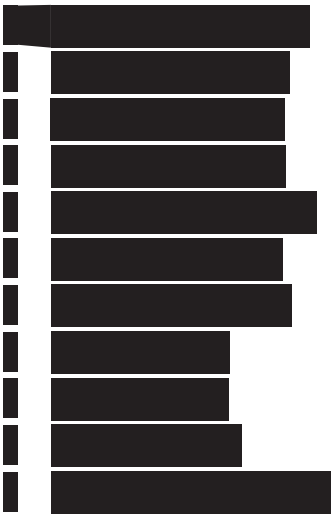
☐ Recommendations Approved

☒ Recommendation NOT approved further information needed

☐ Recommendation NOT approved consultant required

Director:

Cases for consideration:



Additional discussion

- Edmo, M. – 94691
    - Requesting Protective Custody
        - Housing Options?
- Set MTC Dates for Upcoming Year
    - December

JT Ex. 7-29

IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT COMMITTEE (MTC)
IN THE MATTER OF Mason Edmo
ISCI, South Boise Complex, BOISE, IDAHO
09/07/16

REVIEW OF APPLICABLE DIRECTIVES, CARE STANDARDS and REPORTS

1. Idaho Department of Correction Division Directive 401.06.03.501.
2. Medical Record
3. CIS

Participants:

Morgan Hahn, LMSW Clinician ISCI IDOC	Garett Coburn Deputy Warden - ISCI IDOC	Amanda Benton Medical Corizon
Yolanda Ponder, LSCW Clinician ISCI IDOC	James Barry, Ph.D. IMSI Psychologist Corizon	David Agler, MD. Medical Corizon
Jeremy Clark, LCPC Clinical Supervisor ISCI		

Name: Mason Edmo
IDOC #: 94691
Current Housing: ISCI Unit 16
Current Offense: Sexual Abuse of a Minor under 16

Relevant Considerations

On 09/05/16, the inmate requested to be placed into Protective Custody due to being threatened to be sexually assaulted by another inmate. During the investigation period, the inmate changed their mind saying that ISCI was not going to help them and they desired to move out of ISCI to another facility. The MTC was scheduled to meet on 09/07/16, and discussed the possible housing that would be appropriate for the inmate. There were two options for facilities if the inmate was granted protective custody, and those facilities were ISCC and ICI-O. The MTC felt that ISCC would not be an appropriate facility for the inmate. The MTC felt more comfortable with ICI-O as the inmate was housed there before, and moving to ICI-O may separate the inmate from the dynamics of the inmate's current situation.

Recommendations

1. If the inmate is granted Protective Custody, the MTC recommends the inmate be housed in the Protective Custody housing at ICI-O
2. If it's determined there will be a security issue for the inmate at ISCI, then the MTC recommends the inmate be moved to ICI-O in general population as the inmate has experience residing at ICI-O. They can also complete their assigned sex offender specific programming at ICI-O

3. If the inmate is not granted Protective Custody and there are not significant security issues at ISCI, the MTC still recommends working with the placement staff to move the inmate to ICI-O to place some separation from the current dynamics the inmate is in

Approved by:

Jeremy Clark, LCPC
Clinical Supervisor, ISCI
IDOC

ARC Review: Date 10/18/2016

Jeffery Zmuda:

Ashley Dowell

Karin Magnelli

☑ Recommendations Approved

☐ Recommendation NOT approved (detail reason or desired action)

Director's Review: Date 11-21-16

☑ Recommendations Approved

☐ Recommendation NOT approved further information needed

☐ Recommendation NOT approved consultant required

Director:

IDAHO
DEPARTMENT OF CORRECTION

Department of Correction
Division of Prisons

Memo

To: Jeremy Clark and Members of the Management Treatment Committee (MTC)

From: Ashley Dowell and Members of the Administrative Review Committee (ARC)

Date: 11/23/2016

Re: MTC Recommendations for Edmo #94691

The ARC reviewed the recommendations of the MTC on July 14th, 2016 and as a result, are requesting clarification and additional information about those recommendations. In the case of Edmo, it is noted that Edmo wanted to move out of the Behavioral Health Unit after becoming uncomfortable with that housing placement. It is not clear to the ARC why the MTC would deny this request.

It is noted that a concern exists regarding Edmo's current behaviors, to include tattooing, verbal confrontations with staff and a history of inappropriate sexual behaviors while in general population. It is not clear what relationship verbal confrontations and tattooing have with Gender Dysphoria and the related safety concerns. Furthermore, there is no information as to what the history of sexual behavior entails, how long ago the events occurred, and whether the concern is that Edmo would be a potential victim or abuser. The MTC also notes the potential for Edmo to be placed in "more high risk situations that could lead to more disciplinary issues", though it is unclear how this would occur or what these situations would be. The ARC requests additional information on these concerns prior to making a decision on the recommendation.

The MTC also notes that having Edmo work with staff members with less training in Gender Dysphoria could potentially increase Edmo's dysphoria. It is unclear as to why the MTC believes that potential for increased dysphoria may exist. The ARC believes that all staff need to be appropriately trained in the management of inmates with Gender Dysphoria but doesn't believe that a lack of training should be a factor in placement decisions. The training of staff is an IDOC responsibility and if the MTC believes training is lacking, that concern should be addressed. The ARC requests additional information on this concern prior to making a decision.

The ARC is asking that the MTC reconvene to clarify these concerns and answer additional questions that developed in the course of the ARC review. The ARC will reconvene to review updated housing and placement recommendations after receiving additional information from the MTC.

1

JT Ex. 7-32

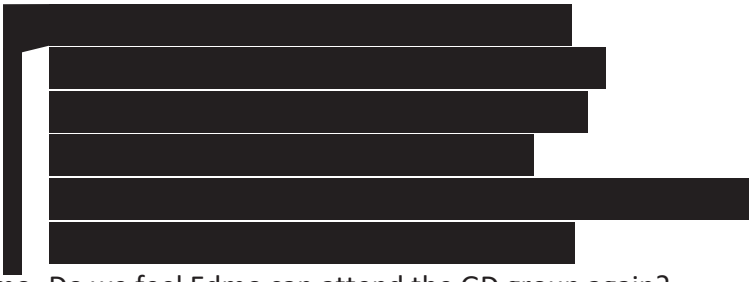
Introduction of New Members

Cases for consideration:

Additional discussion:

- Assessment Group Update- Hahn
    - Referrals for HRT

- GD Group Update- Ponder
- Groups
    - Split them up to have more experienced inmates in both groups?
    - Do we need an "assessment" group?
- Placements
    - Do we want to default initial placement into the BHU? Another Unit?



- Edmo- Do we feel Edmo can attend the GD group again?
- Can we provide the female commissary list to the inmates?
- Need for monthly MTC meetings
- Shower accommodations in GP (PREA)
- Staff Training
- Policy Update- Dr. Campbell

IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT COMMITTEE
IN THE MATTER OF Edmo
ISCI, South Boise Complex, BOISE, IDAHO
03/15/17

REVIEW OF APPLICABLE DIRECTIVES, CARE STANDARDS and REPORTS

1. Idaho Department of Correction Division Directive 401.06.03.501.
2. Medical Record
3. CIS

Participants:

Morgan Hahn, LMSW Clinician ISCI IDOC	Garett Coburn Deputy Warden – ISCI IDOC	Walter Campbell Chief Psychologist IDOC
Krina Stewart, LPC Clinician ISCI IDOC	James Barry, Ph.D. IMSI Psychologist Corizon	Jeremy Clark, LCPC Clinical Supervisor ISCI IDOC
Kathleen Wilson Administration Assistant ISCI	Scott Eliason Psychiatrist Corizon	Laura Watson, LCSW Clinical Supervisor ISCI IDOC
Jonathon Dehahn Resident Corizon		

Name: Edmo
IDOC #: 94691
Current Housing: ISCI Unit 09
Current Offense: Sexual Abuse of a Child Under 16

Relevant Considerations

1. Inmate Edmo was removed from any Gender Dysphoria group due to assaulting another member of those groups
2. The MTC reported they would review Edmo's eligibility to return to a Gender Dysphoria group after 6 months
3. Edmo has been non-consistent with Edmo's assigned mental health clinician, and has refused to participate in any other mental health groups
4. Edmo has been provided assignments associated with gender dysphoria during the past 6 months, but has not been consistent with completing them and reviewing them with Edmo's assigned clinician
5. Edmo expresses a desire to return to the Gender Dysphoria group

The committee concluded that Inmate Edmo is appropriate to be eligible to be moved into one of the Gender Dysphoria groups

Recommendations

1. The MTC feels it is appropriate for Inmate Edmo be eligible to return to one of the Gender Dysphoria groups that does not have the other inmate who Edmo assaulted as a participant
2. The MTC also would like to see Inmate Edmo participate in a Social Skills group
3. The MTC recommends that Inmate Edmo remain in general population
4. The inmate will be able to access mental health services through the IDOC clinical staff in the BHU as needed

Housing/Security

(Update on 05/08/17) Edmo currently resides in Unit 9 at ISCI and is Medium custody. Edmo has three safety concerns with other inmates. One of those inmates currently resides at ICI-O and Edmo cannot be housed in the same unit as this inmate due to sexual activity. One currently resides at ISCC and Edmo cannot reside in the same living unit due to past sexual activity. The third inmate resides at ISCI and they have been diagnosed with Gender Dysphoria. Edmo cannot reside in the same housing unit as this inmate due to Edmo assaulting this inmate on two occasions. This inmate resides in Unit 16 at ISCI. Edmo will attend a different group for gender dysphoria, so they will not have any contact via the group process. Edmo has 28 DORs with 6 DORs happening in the last year. Those DORs were for such behaviors as battery, tattooing or piercing, disobedience to orders, destruction of property and sexual activity.

Approved by:

Jeremy Clark, LCPC.
Clinical Supervisor, ISCI
IDOC

ARC Review: Date 8/28/17

Ross Castleton: Ross Castleton

Ashley Dowell: Ashley Dowell

☐ Recommendations Approved

☒ Recommendation NOT approved (detail reason or desired action)

The ARC met 8/28/17 + approved the 6/7/17 recommendations.

Director's Review: Date 11/19/2017

☐ Recommendations Approved

☐

☒ Recommendation NOT approved further information needed

☐ Recommendation NOT approved consultant required

Director: Hunter Haines

Introduction of New Members

Cases for consideration:

- Edmo #94691- Edmo is refusing to attend a Social Skills group as directed as part of Edmo's MTC treatment plan
- [redacted]

Additional discussion:

- GD Group Update- Hahn
- GD Group Update- Stewart
- Referrals for HRT?
- Placements
  - [redacted]
  - [redacted]
- Shower accommodations in GP (PREA)
- Policy Update- Dr. Campbell

JT Ex.
7-37

Introduction of New Members

Cases for consideration:

[redacted]

Additional discussion:

- GD Group Update- Hahn
- GD Group Update- Stewart
- Referrals for HRT?
  [redacted]
- [redacted]
- Edmo #94691- Edmo is refusing to attend a Social Skills group as directed as part of Edmo's MTC treatment plan
- Placements
  [redacted]
- Policy Update- Jeremy

JT Ex. 7-38

IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT COMMITTEE
IN THE MATTER OF Edmo
ISCI, South Boise Complex, BOISE, IDAHO
6/7/2017

REVIEW OF APPLICABLE DIRECTIVES, CARE STANDARDS and REPORTS

1. Idaho Department of Correction Division Directive 401.06.03.501.
2. Medical Record
3. CIS
4. Collateral Information (if applicable)

Inmate Name: Edmo **IDOC#:** 94691 **Current Housing:** ISCI-Unit 9
Current Offense: Sexual Abuse of a Child under 16

Participants: Jeremy Clark, IDOC Clinical Supervisor; Morgan Hahn, ISCI Clinician; Krina Stewart, ISCI Clinician; Jazmin Garibay-Arredondo, ISCI AA; Randy Valley, ISCI Deputy Warden; Janell Clement, IDOC Clinical Supervisor; Scott Eliason, Corizon Psychiatrist

Relevant Considerations: Approximately one year ago, Inmate Edmo was removed from the therapeutic groups for the inmates who have gender dysphoria due to Edmo assaulted another inmate with gender dysphoria for the second time. The MTC removed Edmo from the therapeutic groups for six months. When it was recommended that Edmo return to the therapeutic groups, the MTC also requested that Edmo attend a social skills group to help Edmo to avoid getting into future altercations. According to Clinician Krina Stewart, Edmo's assigned clinician, Edmo initially accepted attending a social skills group but has since refused stating the group has nothing to do with Edmo's gender dysphoria. Edmo has been attending the therapeutic groups for gender dysphoria.

Housing/Security Considerations: Inmate Edmo is Medium Custody and currently resides in the general population at ISCI. Edmo has three safety concerns with other inmates. One of those inmates resides at ICI-O and another one resides at ISCC. The third safety concern is with the inmate at ISCI who Edmo has assaulted, and the safety concern states that Edmo and this inmate should not reside in the same housing unit. The clinical staff has also taken precautions not the have Edmo and the other inmate attend the same groups for Gender Dysphoria. Edmo has twenty eight DORs with four being in the last year. The last DOR was for sexual activity in January of 2017. Edmo has several other sexual activity, battery, tattooing, property, and disobedience to orders DORs.

Recommendations: The MTC recognizes they are unable to force Edmo to attend a social skills group. The MTC recommends that Edmo continue to attend the therapeutic groups for gender dysphoria, and address any interpersonal struggles that Edmo may have with others.

Approved by:

Jeremy Clark, LCPC	Clinical Supervisor	08/28/17
	Title	Date

ADMINITRATIVE REVIEW COMMITTEE

Date of Review: 8/28/17

Reviewer: Ashley Dowell, Chief of Prisons

Reviewer: Ross Castleton: Deputy Chief of Prisons

☑ Recommendations Approved

☐ Recommendations NOT Approved

Detail Reason or Desired Action:

DIRECTOR'S REVIEW

Date of Review: 11/19/2017

☒ Recommendations Approved

☐ Recommendations NOT Approved- Further information is needed

☐ Recommendations NOT Approved- Consultant required

Henry Atencio: IDOC Director

IDOC_L_pg.41

JT Ex.
7-41

ER 2840

Introduction of New Members

Cases for consideration:

[redacted]

Additional discussion:

- GD Group Update- Hahn
- GD Group Update- Stewart
- Referrals for HRT?
- [redacted]
- Placements
    - Edmo #94691- Edmo is requesting to move to another facility to include PWCC

      [redacted]
- Setting consistent meeting date at the beginning of the month to help the ARC to schedule consistent meetings
- Policy Update- Wally

JT Ex. 7-42

IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT COMMITTEE
IN THE MATTER OF Edmo
ISCI, South Boise Complex, BOISE, IDAHO
9/13/2017

REVIEW OF APPLICABLE DIRECTIVES, CARE STANDARDS and REPORTS

1. Idaho Department of Correction Division Directive 401.06.03.501.
2. Medical Record
3. CIS
4. Collateral Information (if applicable)

Inmate Name: Edmo **IDOC#:** 94691 **Current Housing:** ISCI Unit 09 C-77A
Current Offense: Sexual Abuse of a Minor Under 16

Participants: Dr. Walter Campbell, IDOC Chief Psychologist; Jeremy Clark, IDOC Clinical Supervisor; Laura Watson, IDOC Clinical Supervisor, Bryan Gimmeson, IDOC Clinical Supervisor, Krina Stewart, IDOC Clinician; Morgan Hahn, IDOC Clinician; Breonna Krafft, IDOC Clinician; Scott Eliason, Corizon Psychiatrist; James Barry, Corizon Psychologist; Kristina Waldram, IDOC AA

Relevant Considerations: Edmo has requested to have Edmo's mental health hold removed so Edmo can be transferred to another facility. Edmo made a separate request to Dr. Campbell to be moved to PWCC. The MTC felt that Edmo has maintained the ability to reside in a male facility, and manage Edmo's Gender Dysphoria. The MTC has concerns with Edmo's history of violence and sexual activity, and whether those behaviors can be addressed in a female facility. Edmo has attended the groups for inmates with Gender Dysphoria for several years. The MTC does recommend that Edmo be moved to another male facility based on Edmo's request.

Housing, Management, & Security Considerations: Edmo is Medium Custody and currently resides at ISCI. Edmo has three security concerns with other inmates. One of these inmates resides at ISCI, and Edmo is not to reside with this other inmate in the same living unit. Edmo had two security concerns with inmates who reside at ISCC, and Edmo is not supposed to reside in the same facility with one of the inmates, and cannot reside in the same living unit as the other. Edmo has 28 DORs, with 2 being in the last year for sexual activity and Destruction of Property. The inmate current resides in general population, and can be managed in a general population setting based on the inmate's security needs. Due to the inmate's status of having Gender Dysphoria, the inmate should be offered different times to shower to afford Edmo privacy. If possible, it would be appropriate to house Edmo with another inmate who has Gender Dysphoria to accommodate both inmates' needs.

Recommendations: The inmate has a current Level of Care that is CMHS-1. Edmo's mental health and needs associated with Gender Dysphoria will be addressed based on that Level of Care. It's the MTC's recommendation that Edmo be moved to ICI-O, as this is the only facility that can accommodate Edmo's custody level and safety concern needs. Another option would be to have the inmate at ISCC that Edmo cannot be in the same facility with move to another facility. Then Edmo could reside at ISCC.

Approved by:

Webb Cockrell, PhD — Click here to enter text.

Psychologist — Title

9-13-17 — Date

ADMINITRATIVE REVIEW COMMITTEE

Date of Review: 11/13/17

Chief of Prisons: [signature] — Signature

Jeffrey Dowell — Printed Name

Deputy Chief of Prisons: [signature] — Signature

Tess Castleton — Printed Name

Deputy Attorney General Present? Yes ☑ No ☐

☑ Recommendations Approved

☐ Recommendations NOT Approved

Detail Reason or Desired Action:

As of this review Edmo is housed at ISCI.

DIRECTOR'S REVIEW

Date of Review: 11/19/2017

☑ Recommendations Approved

IDOC_L_pg.44

JT Ex. 7-44

ER 2843

☐ Recommendations NOT Approved- Further information is needed

☐ Recommendations NOT Approved- Consultant required

IDOC Director Signature

IDOC Director Printed Name

IDOC_L_pg.45

JT Ex. 7-45

ER 2844

IDAHO
DEPARTMENT OF CORRECTION

Department of Correction
Division of Prisons

Memo

To: Edmo #94691

From: Walter Campbell, IDOC Chief Psychologist

Date: 11/24/2017

Re: Administrative Review Committee decision

Recently, you requested to have your mental health hold removed so that you could be moved to another facility. The Management and Treatment Committee (MTC) met on 09/13/17 to review your assessments, history, and other behaviors to determine if your request could be met. The MTC made the following recommendations, which have been reviewed and accepted by the Administrative Review Committee and the IDOC director:

1) The ARC has approved that your mental health hold be lifted so you can be moved to another facility. Since you have recently requested specific housing changes within ISCI, I will ask staff to seek the most appropriate placement.

2) The MTC encourages to continue to work with your assigned clinician concerning your mental health needs

3) You can schedule to meet with a clinician by submitting a Health Service Request (HSR)

Walter Campbell, PhD

Cc: file
Laura Watson, ISCI Clinical Supervisor
Jeremy Clark, ISCI Clinical Supervisor

IDAHO
DEPARTMENT OF CORRECTION

Department of Correction
Division of Prisons

Memo

To: Edmo #94691

From: Walter Campbell, IDOC Chief Psychologist

Date: 11/24/2017

Re: Administrative Review Committee decision

Recently, you requested to have your mental health hold removed so that you could be moved to another facility. You also previously requested to be reinstated to Gender Dysphoria groups. The Management and Treatment Committee (MTC) met on 09/13/17 to review your assessments, history, and other behaviors to determine if your request could be met. The MTC made the following recommendations, which have been reviewed and accepted by the Administrative Review Committee and the IDOC director:

1) The ARC has approved that your mental health hold be lifted so you can be moved to another facility in General Population. Since you have recently requested specific housing changes within ISCI, I will ask staff to seek the most appropriate placement.

2) You are approved to participate in Gender Dysphoria groups again. The MTC also recommended that you participate in Social Skills groups, which was also approved.

3) The MTC encourages to continue to work with your assigned clinician concerning your mental health needs

4) You can schedule to meet with a clinician by submitting a Health Service Request (HSR)

Walter Campbell, PhD

Cc: file
Laura Watson, ISCI Clinical Supervisor
Jeremy Clark, ISCI Clinical Supervisor

MTC Meeting 1/3/2018

Attendance:

Walter Campbell, chief psychologist

Laura Watson, ISCI clinical supervisor

Morgan Hahn, ISCI clinician

Krina Stewart, ISCI clinician

Breanna Kraft, ISCI clinician

Josie Boggs, ISCI clinician

Assessments for consideration-

[redacted]

JT Ex. 7-48

[redacted]

Group Update-

Clinician Hahn: Group going well- Inmate [redacted] wants to restart group. Clinician Hahn will send an email to Krafft of group expectations for [redacted] prior to being reenrolled.

Clinician Stewart: All is going well in group. [redacted] reports wanting to restart group, [redacted] was told that [redacted] needs to work with assigned clinician prior to being enrolled in group.

Groups Request: Stewarts group is requesting GAFFS to be into the new policy. (GAFF memo)

Placements and Requests-

[redacted]

Other GD Discussion:

[redacted]

- [redacted]
- [redacted]
- [redacted]

Notes-

- When meeting inmates for assessments, put documentation in a SOAP that they were met with.

JT Ex.
7-50

IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT COMMITTEE
IN THE MATTER OF Edmo
ISCI, South Boise Complex, BOISE, IDAHO
02/07/18

REVIEW OF APPLICABLE DIRECTIVES, CARE STANDARDS and REPORTS

1. Idaho Department of Correction Division Directive 401.06.03.501.
2. Previous GD evaluations
3. Medical Record
4. CIS

Participants:

Walter Campbell, PhD Chief of Psychology	Krina Stewart Clinician, ISCI	Breonna Kraft, Clinician, ISCI
Randy Valley Deputy Warden, ISCI	Timothy McKay Deputy Warden, ISCC	Jeremy Clark, LCPC Clinical Supervisor ISCI IDOC
Adrea Nicodemus Clinical Supervisor, ISCC	Janell Clement (via telephone) Clinical Supervisor, PWCC	Brian Gimmeson (via telephone) Clinical Supervisor, OCIO
Scott Eliason Regional Director of Psychiatry Corizon	Morgan Hahn Clinician, ISCI	Laura Watson Clinical Supervisor, ISCI
Kaylene Hartt Clinician, ISCC	Steven Menard Regional Medical Director Corizon	Amanda Weed Administrative Assistant
Shellie Munoz Clinician, ICIO		

Name: Edmo
IDOC #: 94691
Current Housing: ISCI, Unit 11
Current Offense: Sexual Abuse, Drawing checks without funds

Relevant Considerations

1. Inmate Edmo was moved from Unit 11 to Unit 15 (ISCI), due to behavioral problems in Unit 11.
2. MTC noted that there are numerous verbal reports of Edmo's misbehavior, but this has not been documented in CIS. DW Valley said staff will be notified to ensure proper documentation of behavioral problems.
3. Inmate Edmo has also requested a transfer to a different facility. ISCC is not an option due to cautions related to another inmate with whom Edmo should not be housed near.
4. ICIO is an option for Edmo's placement. The MTC did not determine that this move is necessary for any aspect of mental health or placement necessity, however, there is no contraindication that ICIO would be an inappropriate placement, should facility staff decide

this is an appropriate transfer. CS Gimmeson (ICIO) stated appropriate mental health services can be offered at ICIO.

Recommendations

1. Inmate is appropriate to remain in current housing environment with current care, however a transfer to ICIO is not contraindicated and would be supported by the MTC should such a move be decided at the facility level.

Approved by:

_____
Walter Campbell, PhD
Chief Psychologist, IDOC

ARC Review: Date _____

Randy Blades: _____

Ashley Dowell: _____

☐ Recommendations Approved

☐ Recommendation NOT approved (detail reason or desired action)

_____

_____

Director's Review: Date_____

☐ Recommendations Approved

☐ Recommendation NOT approved further information needed

☐ Recommendation NOT approved consultant required

Henry Atencio: _____

JT Ex. 7-52

Attendance:

- Walter Campbell, Chief of Psychology, IDOC
- Steven Menard, Regional Medical Director, PWCC
- Randy Valley, Deputy Warden (operations), ISCI
- Tim Richardson, Deputy Warden (security), ISCI
- Gretchen Woodland, Captain, PWCC
- Laura Watson, Clinical Supervisor, ISCI
- Adrea Nicodemus, Clinical Supervisor, ISCI
- Janell Clement (via phone), Clinical Supervisor, PWCC
- Breonna Kraft, clinician, ISCI
- Krina Stewart, clinician, ISCI
- Morgan Gruhot, clinician, ISCI

Introduction of New Members

Assessments for consideration:

- [redacted]

[redacted]

JT Ex. 7-53

[redacted]

- [redacted]

- [redacted]

IDOC_L_pg.54

JT Ex.
7-54

[redacted]

Additional discussion:

- GD Group Update- Hahn
  -Edmo may be returning to group. Edmo works at CI and was given a letter from assigned clinician about being able leave work and go to group.
- GD Group Update- Stewart
  [redacted]
- New Requests for Assessment
  [redacted]
- Referrals for HRT evaluation: [redacted]
- Placements and Requests
  - [redacted]
  - [redacted]
  - [redacted]

JT Ex. 7-55

- o [redacted]
- Policy Update- Wally

IDOC_L_pg.56

JT Ex.
7-56

IDAHO DEPARTMENT OF CORRECTION

To promote a safer Idaho by reducing recidivism

C. L. "BUTCH" OTTER
Governor

BRENT D. REINKE
Director

Management and Treatment Team Committee Minutes

January 15, 2014
Idaho Department of Correction
Idaho State Correctional Institution
Business Manager's Conference Room

REVIEW PARTICIPANTS

Name:	Position:	
Richard Craig, PhD	Chief Psychologist	IDOC
Scott Eliason, MD	Psychiatrist	Corizon
Kimel Limon, PsyD	Psychologist	Corizon
Shell Wamble-Fisher, LCSW	Clinical Supervisor	IDOC
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
Garrett Coburn	Deputy Warden	ISCI
Kim Pilote, RN	ADON	Corizon
Will Wingert, RN	DON	Corizon

Also Present: Maria Young, IDOC Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06.03.501, the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Dr. Richard Craig called the meeting to order at 14:40 p.m. at ISCI in the Business Manager's Conference Room.

Two new requests for review were received within the last quarter: [redacted]

[redacted]

a. Dr. Craig

[redacted]

JT Ex. 7-57

IDOC_L_pg.58

JT Ex.
7-58

[redacted]

b. Dr. Eliason
   i. Concur with Dr. Craig

c. **Treatment Plan:**

[redacted]

2. [redacted]

a. Dr. Craig

[redacted]

b. Dr. Eliason:

[redacted]

c. **Treatment Plan:**

[redacted]

3. Reviews:
   a. [redacted]

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JT Ex.
7-60

b. [redacted]

c.

d.

e.

f. Edmo #94691
   i. Doing better
   ii. Has reengaged with SOTP Treatment
   iii. Underwear concerns – Medical will have to make the decision

g. [redacted]

h.

i.

- All reviews – with noted exceptions – were reaffirmed

Meeting adjourned at 15:22 p.m

Approved by:

Richard Craig, Ph.D.
Chief Psychologist
IDOC

Submitted by: M. Young, AA

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7-62

IDAHO DEPARTMENT OF CORRECTION

To promote a safer Idaho by reducing recidivism

C. L. "BUTCH" OTTER
Governor

BRENT D. REINKE
Director

Management and Treatment Team Committee Minutes

July 16, 2014
Idaho Department of Correction
Idaho State Correctional Institution
Business Manager's Conference Room

REVIEW PARTICIPANTS

Name:	Position:	
Richard Craig, PhD	Chief Psychologist	IDOC
Scott Eliason, MD	Psychiatrist	Corizon
Murray Young, MD	Regional Medical Director	Corizon
Shell Wamble-Fisher, LCSW	Clinical Supervisor	IDOC
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
Garrett Coburn	Deputy Warden	ISCI
Jeremy Irvin, LMSW	Clinician	IDOC

Also Present: Maria Young, IDOC Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06.03.501, the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Dr. Richard Craig called the meeting to order at 14:33 p.m. at ISCI in the Business Manager's Conference Room.

Some offenders have requested to move out of Unit 16. In light of that, and because to date there has been none, we have drafted some proposed criteria. Once this group has agreed to the criteria, we will make copies of the letter available to affected offenders. All members of the MTC agree on the following and the guidelines are attached:

- Request in writing
- CMHS-1
- No Class A or B DOR's within last 180 days
- No Class C DOR's within the last 60 days
- Documented contact with clinician regarding benefits/risk
- Treatment plan devised for clinical contact
- Now specific location
- All plans for moves will be coordinated with facility management

All members present voted in favor of distributing these guidelines.

Three (3) offenders initially reviewed during the April 23, 2014 meeting were deferred for 90 days for further evaluation.

1. [redacted]

2. [redacted]

3. [redacted]

b. [redacted]

c.

4. [redacted]

5. [redacted]

IDOC_L_pg.65

JT Ex. 7-65

[redacted]

6. Offender Edmo has again requested to be allowed to move out of Unit 16
    a. Currently CMHS-1
    b. Medication was stable at 150 mg Zoloft; offender requested lower dosage; dosage lowered to 100 mg for 3 months – seems stable at this point
    c. Consult with facility management

7. ISCI management has received a grievance regarding "feminine hair styles"
    a. As defined in IDOC policy, the definition is determined by the facility head; however, in these cases, it is not just the hair, it's the entire package
    b. There have been several DOR's for "feminine hair styles"

8. IDOC Policy dictates GD offenders be addressed by "offender" and the individual's last name, or simply by last name.
    a. Using pronouns confuses security as they are following policy, and others within the units use feminine pronouns thereby causing the potential for harm to the offenders to which are being referred
    b. Ms. Wamble-Fisher indicates that all clinicians have been instructed to use last name
    c. Caution to all staff that interact with GD offenders to be sensitive to the use of pronouns and only refer to them as "Offender XXX" or simply use the last name

9. Medical
    a. Hormone dosages are only for managing dysphoria symptoms

    b. Dr. Young:
        i. Dosages will remain at maintenance levels
        ii. Will talk to all the providers at the provider meeting

Meeting adjourned at 15:15 p.m

Approved by:

Richard Craig, Ph.D
Chief Psychologist
IDOC

Submitted by: M. Young, AA

IDAHO DEPARTMENT OF CORRECTION

To promote a safer Idaho by reducing recidivism

C. L. "BUTCH" OTTER
Governor

BRENT D. REINKE
Director

To All IDOC Offenders designated with Gender Dysphoria

The following is the Management and Treatment Committee guidelines for Gender Dysphoria offenders who want to explore a move into General Population.

- Offender must submit a concern form to the IDOC Chief Psychologist stating their interest in moving to general population
- Once received, the Chief Psychologist will consider the request within 30 calendar days
- The following criteria must be met:
  - LOC of at least CMHS-1
  - Stable on hormone treatment for 60 days
  - No class A or B DOR's within the last 180 days
  - No Class C DOR's within the last 60 days
  - Documented contact with the offender's assigned clinician stating the possible benefits/risk of residing in general population have been discussed and understood
- Treatment plan is to be devised indicating the level of clinical contact to be maintained
- Moves to general population will be dependent on space availability with no specificity for housing
- All potential unit or facility moves will be reviewed and agreed upon with the MTC and facility management prior to initiating

Richard Craig, Ph.D.
IDOC Chief Psychologist

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JT Ex.
7-68

IDAHO DEPARTMENT OF CORRECTION

To promote a safer Idaho by reducing recidivism

C. L. "BUTCH" OTTER
Governor

BRENT D. REINKE
Director

Management and Treatment Team Committee Minutes

October 15, 2014
Idaho Department of Correction
Idaho State Correctional Institution
Business Manager's Conference Room

REVIEW PARTICIPANTS

Name:	Position:	
Richard Craig, PhD	Chief Psychologist	IDOC
Scott Eliason, MD	Psychiatrist	Corizon
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
Jeremy Irvin, LMSW	Clinician	IDOC

Also Present: Jenni Florendo, IDOC Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06.03.501, the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Dr. Richard Craig called the meeting to order at 14:25 p.m. at ISCI in the Business Manager's Conference Room.

1. [redacted]

2. [redacted]

[redacted]

3. [redacted]

4. [redacted]

[redacted]

5. [redacted]

Meeting adjourned at 15:15 p.m

Approved by:

Richard Craig, Ph.D
Chief Psychologist
IDOC

Submitted by: J. Florendo, AA2

IDAHO DEPARTMENT OF CORRECTION

MANAGEMENT TREATMENT TEAM COMMITTEE

ISCI, South Boise Complex, BOISE, IDAHO
July 16, 2014

Agenda

I. Discussion
   a. Edmo 94691

II. Review and updates for:
[redacted]

III. Review information for:
[redacted]

IV. Final Discussion

V. Adjournment

IDOC_L_pg.71
JT Ex. 7-71

IDOC_L_pg.72

JT Ex.
7-72

Management and Treatment Team Committee Minutes

March 2, 2016
Idaho Department of Correction
Idaho State Correctional Institution
Business Manager's Conference Room

REVIEW PARTICIPANTS

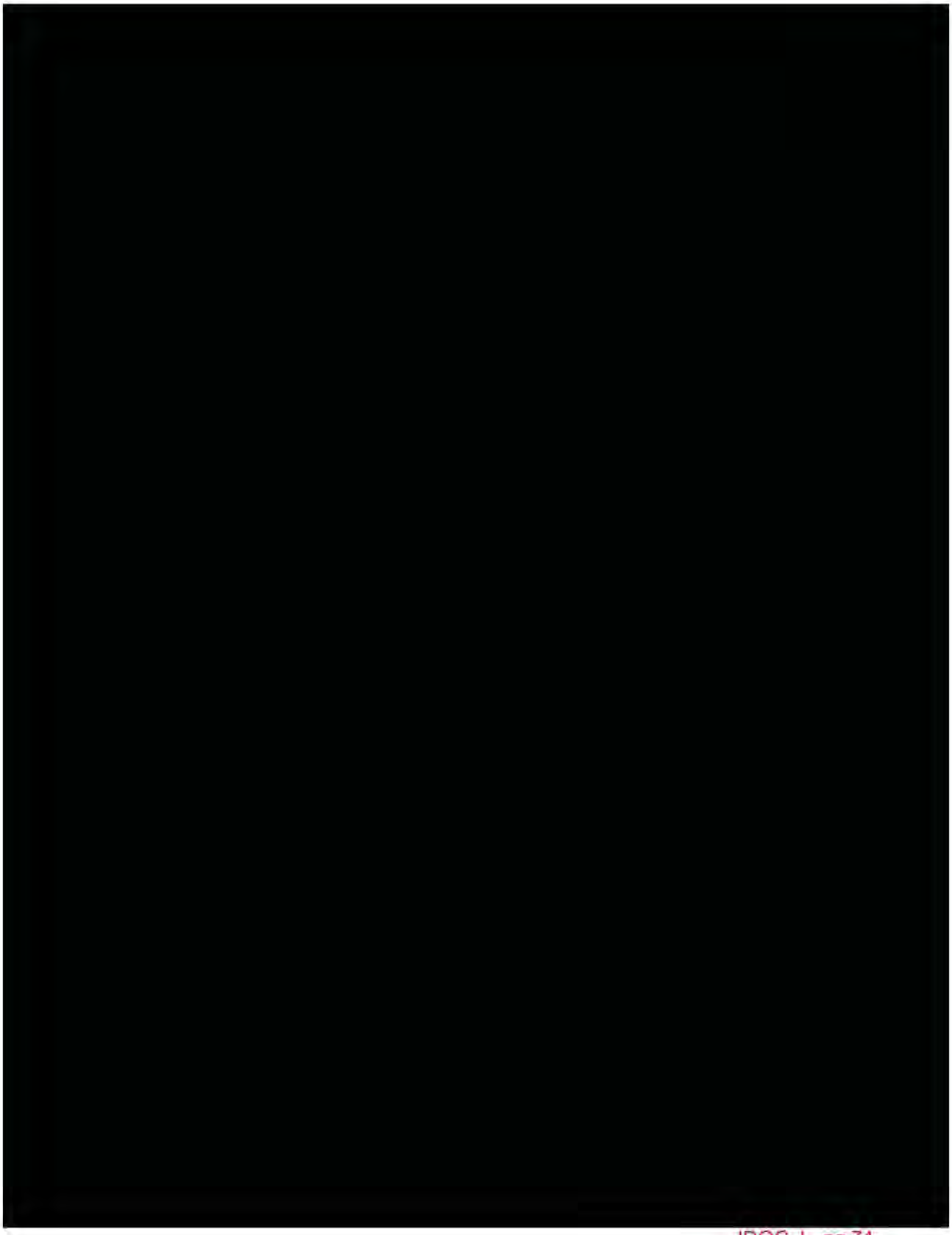
Name:	**Position:**	
Scott Eliason, MD	Psychiatrist	IDOC
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
Jeremy Irvin, LMSW	Clinician	IDOC
David Agler, MD		Corizon
Gen Brewer, RN		Corizon
Michael Grace, RN		Corizon
Amanda Benton, LPN		Corizon
Pat Cash, RN		ISCI
Garrett Coburn	Deputy Warden	ISCI
Morgan Hahn		

Others Present:
Kathleen Willson, ISCI Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06/03/501 the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Dr. Eliason called the meeting to order at 14:30 pm at ISCI in the Business Manager's Conference Room.

[redacted]



IDOC_L_pg.74

JT Ex.
7-74

[redacted]

Additional discussion

[redacted]

- **Edmo, M -94691**
  a. Requests to move out of unit without meeting MTC housing criteria
  b. Has not been DOR free for 16 months.
  c. Wants to move to PWCC
  d. PWCC placement denied per policy.

[redacted]

Regarding SRS eval requests:

- Medical provider to assess
- If already on psych meds. refer to Dr. Eliason. Send Dr. a summary of what patient is going through, history etc.
- If there is an emergency for sexual assignment surgery, call Dr. Eliason.

- Put offender on Call Out to see Dr. Eliason

Evaluator requirements for offender who request evaluation after being initially denied:

- Process for appeal
- How to avoid same person denying evaluations
- Who does second evaluation
- Irvin and Clark will come up with a proposal

Dr. Eliason confirmed estrogen level/all pill call, all single dose

Medically cleared to wear a bra:

- Commissary bras allowed to be purchased
- DW Coburn will put out a memo next week, medical memo will be attached to this

Next MTC meeting

- Irvin will send out invitations

Meeting adjourned at 16:05 p.m.

Approved by:

_____

Jeremy Clark
LCPC
Clinical Supervisor
IDOC

Submitted by: K Willson, AA

MTC Agenda – 03/15/16

Introduction of New Members

Cases for consideration:

[redacted]

Additional discussion:

- Assessment Group Update- Hahn
  - Referrals for HRT?
- GD Group Update- Ponder
- Groups
  - Split them up to have more experienced inmates in both groups?
  - Do we need an "assessment" group?
- Placements
  - Do we want to default initial placement into the BHU? Another Unit?

[redacted]

- Edmo- Do we feel Edmo can attend the GD group again?
- Can we provide the female commissary list to the inmates?
- Need for monthly MTC meetings
- Shower accommodations in GP (PREA)
- Staff Training
- Policy Update- Dr. Campbell

JT Ex. 7-77

Management and Treatment Team Committee Minutes

June 1, 2016
Idaho Department of Correction
Idaho State Correctional Institution
Business Manager's Conference Room

REVIEW PARTICIPANTS

Name:	Position:	
Scott Eliason, MD	Psychiatrist	IDOC
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
David Agler, MD		Corizon
Murray Young, MD		Corizon
Yolanda Ponder	Clinician	ISCI
Morgan Hahn	Clinician	ISCI
Garrett Coburn	Deputy Warden	ISCI

Others Present:

Kathleen Willson, ISCI Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06/03/501 the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Dr. Eliason called the meeting to order at 14:00 pm at ISCI in the Business Manager's Conference Room.

Cases for consideration:
N/A

Additional discussion

- **Edmo, M-94691**
    a. Request to move out of Unit 16 into GP
        1. Wants shower curtains
        2. GP would not accommodate

The Committee's Role

- Diagnose Disorder
- Housing recommendation
- Clothing/Makeup
- Open to move to female facility
- Surgery
    - Second committee with physicians for surgery
- Reassessment
    - Initial assessment
    - Decision made
    - Appeals
        - Second Assessment
        - Brought to MTC committee
        - Final Decision

Regarding Bras: Defined process of a "measurement" development of breast tissue

- Educate inmates to measure themselves
- A policy would need to be written
- Just sports bras-SM, M, L
-

Next MTC meeting

- Clark will send out invitations

Meeting adjourned at 16:00 p.m.

IDAHO STATE CORRECTIONAL INSTITUTION
13500 PLEASANT VALLEY RD, KUNA, ID 83634
PO BOX 14, BOISE, ID 83707
(208) 336-0740 FAX: (208) 334-2748

Approved by:

_____

Jeremy Clark

LCPC

Clinical Supervisor

IDOC

Submitted by: K Willson, AA

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**JT Ex.
7-80**

Management and Treatment Team Committee Minutes

September 7, 2016
Idaho Department of Correction
Idaho State Correctional Institution
DW Coburn's Office

REVIEW PARTICIPANTS

Name:	Position:	
Scott Eliason, MD	Psychiatrist	IDOC
James Barry		
Jeremy Clark, LCPC	Clinical Supervisor	IDOC
David Agler, MD		Corizon
Yolanda Ponder	Clinician	ISCI
Morgan Hahn	Clinician	ISCI
Garrett Coburn	Deputy Warden	ISCI
Alisson Krause	Guest	

Others Present:

Kathleen Willson, ISCI Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06/03/501 the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Dr. Eliason called the meeting to order at 14:00 pm at ISCI in the DW Coburn's Office.

Cases for consideration:

[redacted]

[redacted]

[redacted]

IDAHO STATE CORRECTIONAL INSTITUTION
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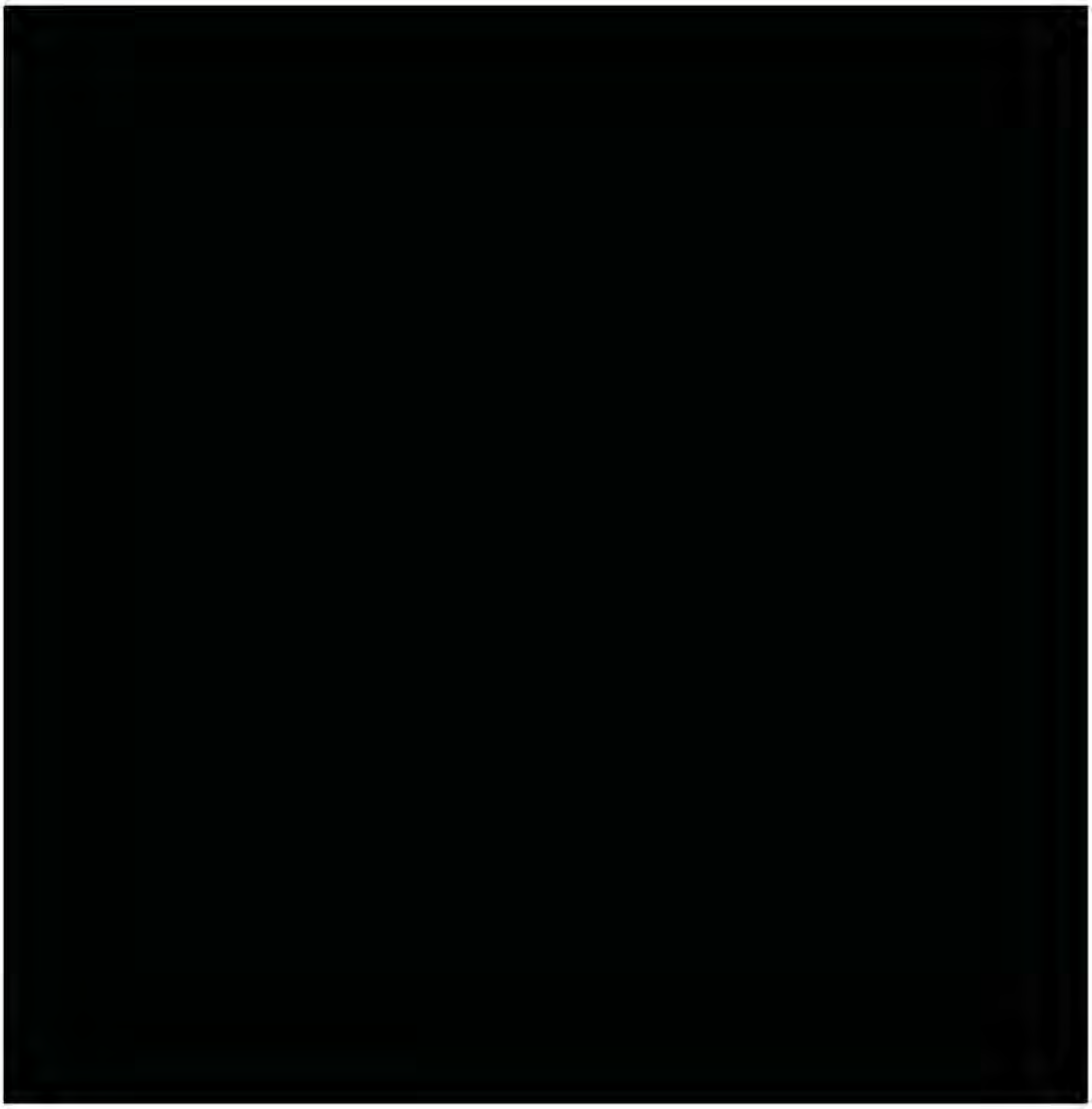
PO BOX 14, BOISE, ID 83707
(208) 336-0740 FAX: (208) 334-2748

**JT Ex.
7-82**

[redacted]

IDAHO STATE CORRECTIONAL INSTITUTION
13500 PLEASANT VALLEY RD, KUNA, ID 83634
PO BOX 14, BOISE, ID 83707
(208) 336-0740 FAX: (208) 334-2748

**JT Ex.
7-83**



Additional discussion

- **Edmo, M-94691**
  a. Requesting Protective Custody

IDAHO STATE CORRECTIONAL INSTITUTION
13500 PLEASANT VALLEY RD, KUNA, ID 83634
PO BOX 14, BOISE, ID 83707
(208) 336-0740 FAX: (208) 334-2748

JT Ex.
7-84

- Forced sexual acts
- Does not want to go to U-8
- Wants to go back to GP
    1. Housing Options
        - Concerned housing in BHU
        - PC placement
            - First option ICIO-GP
            - Second option ISCI-GP

[redacted]

Discussion of components to 6 month reassessment

- Continued assessment, re-evaluate
- Attending groups
- Living role
- Review PSI
- Sign release of information to talk to family, wife, etc.
- Placed in BHU
- More informed decision to start hormones

Clinician Clark suggested splitting groups; Assessment group, treatment group. Concerned there is hormone seeking to get hormones free in groups.
Clinician Clark will propose the following to Leadership:

- Recommendation of how GD population wants them to be referred as.
- Minimal make-up
- Panties

Clarification was given regarding who is responsible for approving panties. Medical is responsible; at this time panties are not medically necessary.

Next MTC meeting

- Jeremy Clark will send out invitations

Meeting adjourned at 16:00

Approved by:

IDAHO STATE CORRECTIONAL INSTITUTION
13500 PLEASANT VALLEY RD, KUNA, ID 83634
PO BOX 14, BOISE, ID 83707
(208) 336-0740 FAX: (208) 334-2748

Jeremy Clark
LCPC
Clinical Supervisor
IDOC

Submitted by: K Willson, AA

IDAHO STATE CORRECTIONAL INSTITUTION
13500 PLEASANT VALLEY RD, KUNA, ID 83634
PO BOX 14, BOISE, ID 83707
(208) 336-0740 FAX: (208) 334-2748

JT Ex.
7-86

Management and Treatment Team Committee Minutes

December 7, 2016
Idaho Department of Correction
Idaho State Correctional Institution
DW Coburn's Office

REVIEW PARTICIPANTS

Name:	Position:	
Scott Eliason, MD	Psychiatrist	IDOC
Walter Campbell, MD	Psychiatrist	IDOC
James Barry		Corizon
Jeremy Clark, LCPC	Clinician	IDOC
Laura Watson,	Clinical Supervisor	IDOC
Aaron Hofer		Corizon
Rebekah Haggard		Corizon
Yolanda Ponder	Clinician	ISCI
Morgan Hahn	Clinician	ISCI
Garrett Coburn	Deputy Warden	ISCI

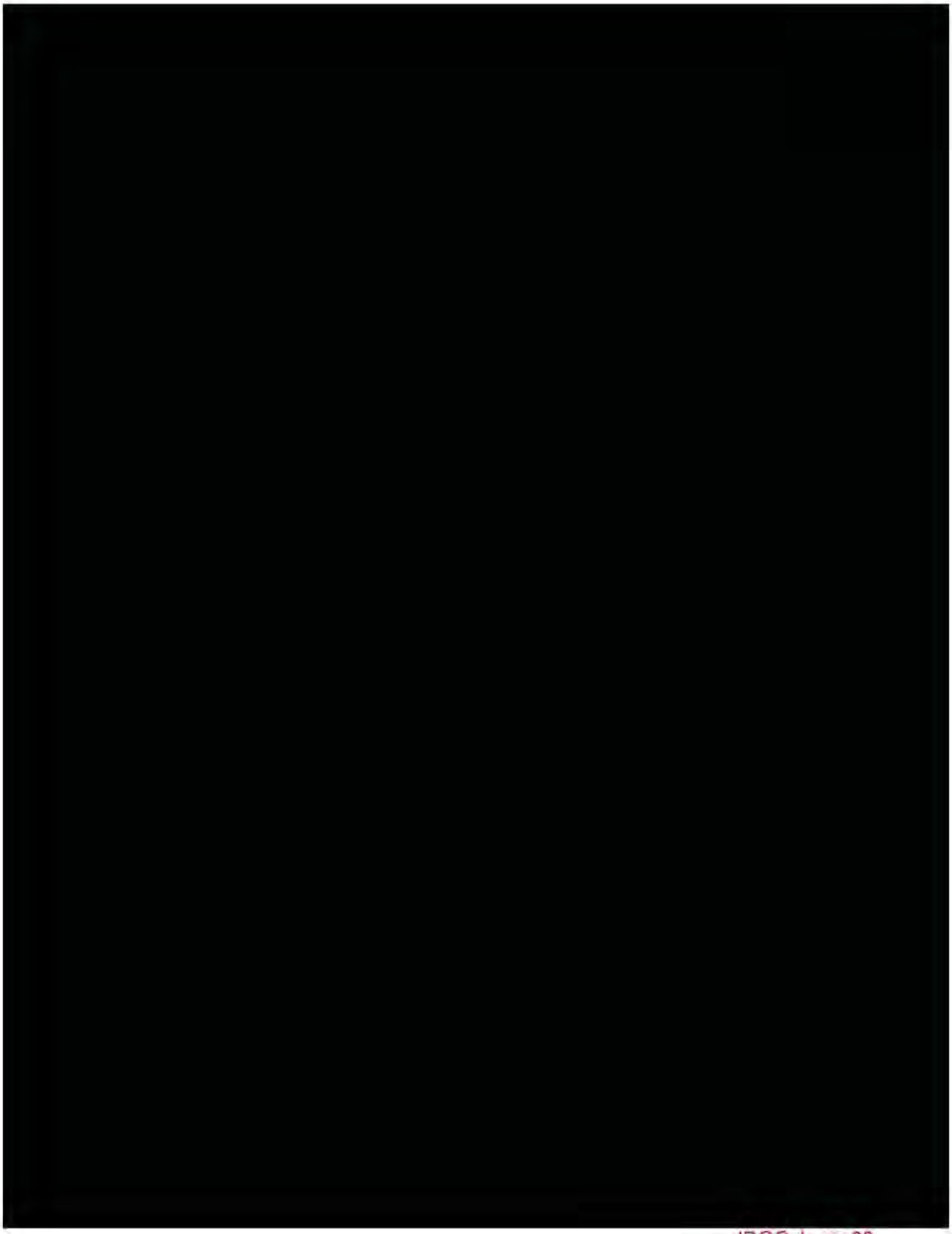
Others Present:

Kathleen Willson, ISCI Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06/03/501 the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Jeremy Clark called the meeting to order at 14:05 pm at ISCI in the Business Manager's Conference Room.

[redacted]



IDOC_L_pg.88

JT Ex.
7-88

[redacted]

GD group update-Ponder:

There are a lot of changes/dynamics within the group. Offenders are not picking on policy issues. They are working on dysphoria living. There's a mixture of forming, storming, norming in the group. The group is more comfortable with new group attendees. Offender [redacted] is mentoring an offender who is paroling out. He is requesting offender [redacted] to room with him; there are some concerns regarding this.

[redacted]

Edmo, M. 94691-Removed from group because of behaviors

-3 months until his next assessment

-Still getting treatment

All in group are on hormone treatment, overall group doing well.

[redacted]

New policy requires that housing for GDs needs to be reviewed by ARC.

Regarding returning inmates; paperwork is not put in medical file, it is being filed at central office. This history will not follow inmate if he returns. A follow up is not documented.

Policy update – Dr. Campbell

- Recommending Treatment plans
- Offering feminine items

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JT Ex. 7-89

- Panties, bras, make-up
  - In cell only?
  - Higher PREA risk with make-up?

Policy will be in place by next meeting in March.

Next MTC meeting

- March 2017
- Jeremy Clark will send out invitations

Meeting adjourned at 16:00

Approved by:

_____

Jeremy Clark
LCPC
Clinician
IDOC

Submitted by: K Willson, AA

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JT Ex. 7-90

IDAHO DEPARTMENT OF CORRECTION

IDAHO DEPARTMENT OF CORRECTION

Protect the public, our staff and those within our custody and supervision

C. L. "BUTCH" OTTER
Governor

HENRY ATENCIO
Director

Management and Treatment Team Committee Minutes

March 15, 2017
Idaho Department of Correction
Idaho State Correctional Institution
Small Business Conference Room

REVIEW PARTICIPANTS

Name:	Position:	
Scott Eliason, MD	Psychiatrist	IDOC
Walter Campbell, MD	Chief Psychologist	IDOC
James Barry, Ph.D	Psychologist	Corizon
Jeremy Clark, LCPC	Clinician	IDOC
Laura Watson	Clinical Supervisor	IDOC
Aaron Hofer, HSA		Corizon
Patricia Cash, RN	RN	ISCI
Krina Stewart	Clinician	ISCI
Morgan Hahn	Clinician	ISCI
Garrett Coburn	Deputy Warden	ISCI

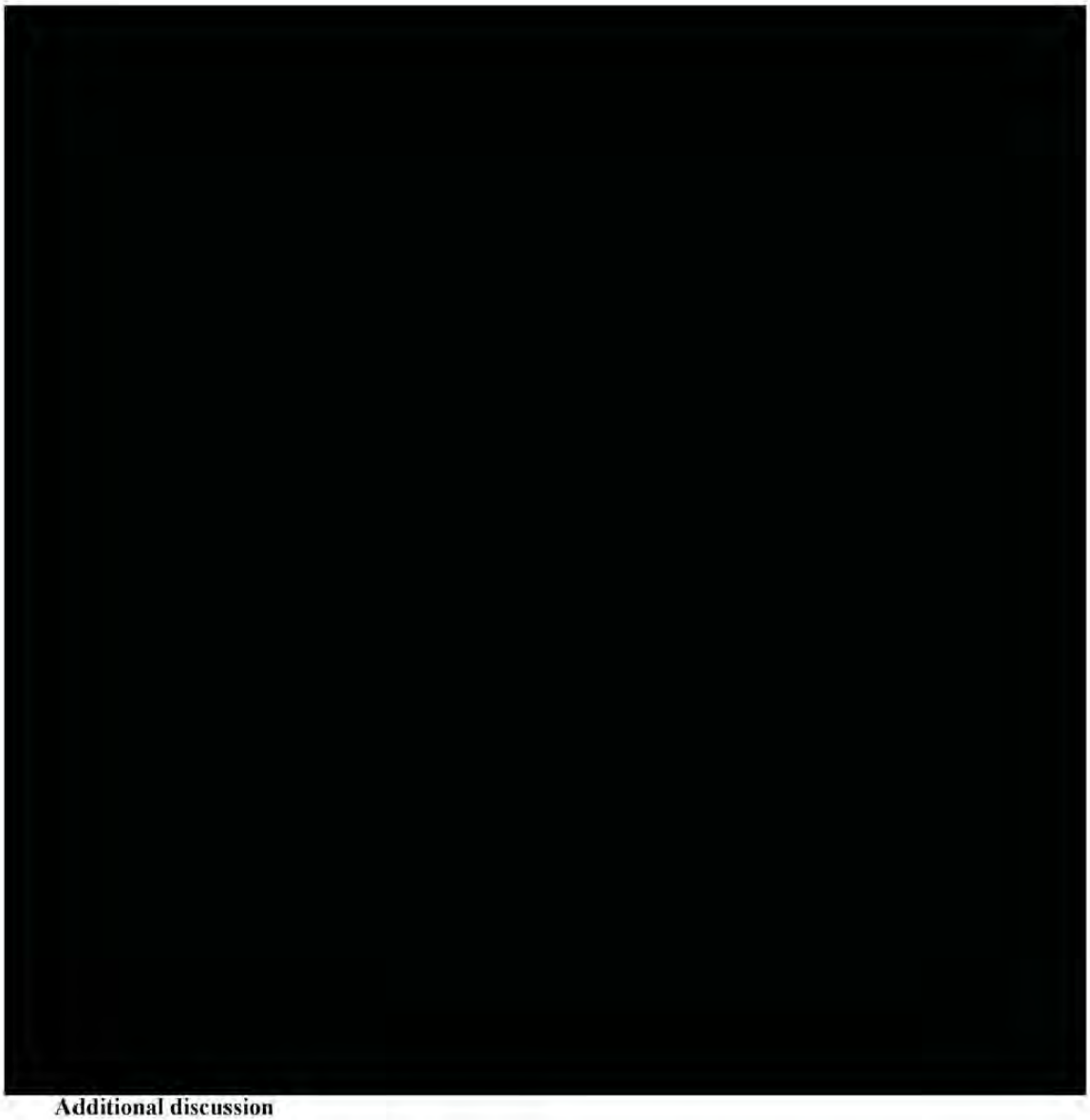
Others Present:
Kathleen Willson, ISCI Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06/03/501 the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Jeremy Clark called the meeting to order at 14:05 pm at ISCI in the Business Manager's Conference Room.

[redacted]

JT Ex.
7-91



Additional discussion

Assessment group update-Hahn:

Groups have improved as far as structure. Members of this group have approved diagnosis, but are not taking hormones yet.

- MTC agrees that the group needs:
  - Boundaires
  - Guidelines
  - Certain levels of functioning
  - Mirror what community resources are available when they are released
  - A curriculum/Topic
  - Keep groups as they are?
    - How to split group?

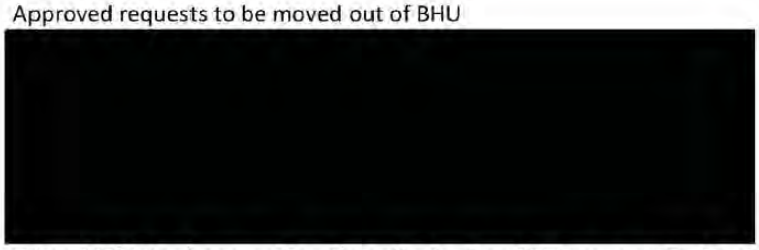
GD group update-Ponder:

This group is on hold; Krina Stewart will be taking over the group. Concerns by inmates brought up:

- Housing –Privacy
  - Open dorms reduced privacy for changing, restroom use and showers
  - Gym/Pendyne: Units 9,11,15 are on "blue" side. All other units on "yellow" side
    - GD feel there is a divide on the yard , difficult to reach out to each other for support
- Medical-
  - HRT: Dissolve under tongue vs. crushed/swallowed
  - Blood clotting-GD inmates who are prone to blood clots able to undergo HRT
- GD group-What happens after GD inmates complete 6 month assessment group
  - Have two groups?
- Mentorship program-Connecting current incarcerated GDs with GDs who have topped or released from prison
  - No topped or released GDs
  - Outside speaker approved
  - Has to coincide with prison values
  - Staff will monitor
- Products to reduce Dysphoria-
  - Request to see the list of women's commissary products

Placements-

Approved requests to be moved out of BHU



Edmo 94691 has been waiting 6 months to attend GD group again. An opportunity will be given to him to go back into group with the agreement to: set boundaries, require to attend process group/social skills. A reminder that anytime you are in contact with Edmo please document.

A female commissary list will be provided to the inmates.

Shower curtains will be ordered in GP.

Inmates starting hormones are required to be placed in BHU. Then may be placed in GP, or BHU.

There is a need for a monthly meeting for 1 hour to update groups, BHU housing issues. Those attending will be Jeremy Clark, Laura Watson, Garrett Coburn, Morgan Hahn.

There is a Webinar on the 29th on transgenders –Morgan Hahn and Krina Stewart will attend.

Dr. Campbell- MTC needs to be very clear on what we are meeting for

- Careful not to put transgender and GID in mental health

Providing feminine products

- Difficulty managing- C/Os not knowing who is diagnosed
- Set up to be victims-PREA
- Security-distinguishing self with make-up
- Provide panties? Are they medically necessary?
- Feminine hairstyles

Evals

- Template/format?
- Supporting documentation-previous records
- Can more staff do evals
- Can Dept. hire an expert in field?

Next MTC meeting

- TBD
- Jeremy Clark will send out invitations

Meeting adjourned at 16:00

Approved by:

_____

Jeremy Clark
LCPC
Clinician
IDOC

Submitted by: K Willson, AA

IDAHO DEPARTMENT OF CORRECTION

IDAHO DEPARTMENT OF CORRECTION

Protect the public, our staff and those within our custody and supervision

C. L. "BUTCH" OTTER
Governor

HENRY ATENCIO
Director

Management and Treatment Team Committee Minutes

April 4, 2017
Idaho Department of Correction
Idaho State Correctional Institution
Deputy Warden Coburn's Office

REVIEW PARTICIPANTS

Name:	Position:	
Jeremy Clark, LCPC	Clinician	IDOC
Janell Clement	Clinical Supervisor	PWCC
Randy Valley	Deputy Warden	ISCI
Krina Stewart	Clinician	IDOC
Morgan Hahn	Clinician	IDOC
Scott Eliason	Psychiatrist	ISCI

Others Present:
Jazmin Garibay-Arredondo, ISCI Administrative Assistant

In accordance with Idaho Department of Correction Standard Operating Procedure 401.06/03/501 the above persons were present and participated in the discussion for the review and recommendations of requests involving Gender Dysphoria.

Jeremy Clark called the meeting to order at 14:09 pm at ISCI in the small conference room.

Cases for consideration:

[redacted]

JT Ex. 7-95

[redacted]

Additional discussion

- **Hahn GD Group Update:** 3 people are coming, Edmo, [redacted]
- **Stewart GD Group Update:** Inmates are boycotting her group. If everyone showed up there would be 6-7 in the group.
- **Referrals for HRT:**

[redacted]

- **Edmo #94691:**
  - Edmo assaulted for the second time.
  - Was taken out of groups for 6 months.
  - Was told in order to attend group needed to attend a different class which doesn't want to attend.

JT Ex. 7-96

- Edmo will be able to attend group since we cannot keep him from attending.

[redacted]

Valley would like a process for these inmates. For example, he said [redacted] was with shirt off on yard and was asked to put shirt back on. Valley believes if they want to be able to purchase bras off commissary than they shouldn't be able to remove their shirt on yard.

Next MTC meeting

- Jeremy Clark will send out invitations

Meeting adjourned at 1535

Approved by:

_____

Jeremy Clark
LCPC
Clinician
IDOC

Submitted by: J Garibay-Arredondo, AA

MTC Agenda – 09/13/17

Introduction of New Members

Cases for consideration:

[redacted]

Additional discussion:

- GD Group Update- Hahn
- GD Group Update- Stewart
- Referrals for HRT?

[redacted]

- Placements
  - Edmo #94691- Edmo is requesting to move to another facility to include PWCC

[redacted]

- Policy Update- Wally

JT Ex.
7-98

MTC Meeting

September 14, 2017
1400-1600
ISCI-Small Conference Room

Meeting called by:	Walter Campbell	**Type of meeting:**	MTC Meeting
Facilitator:	Walter Campbell	**Note taker:**	Kristina Waldram

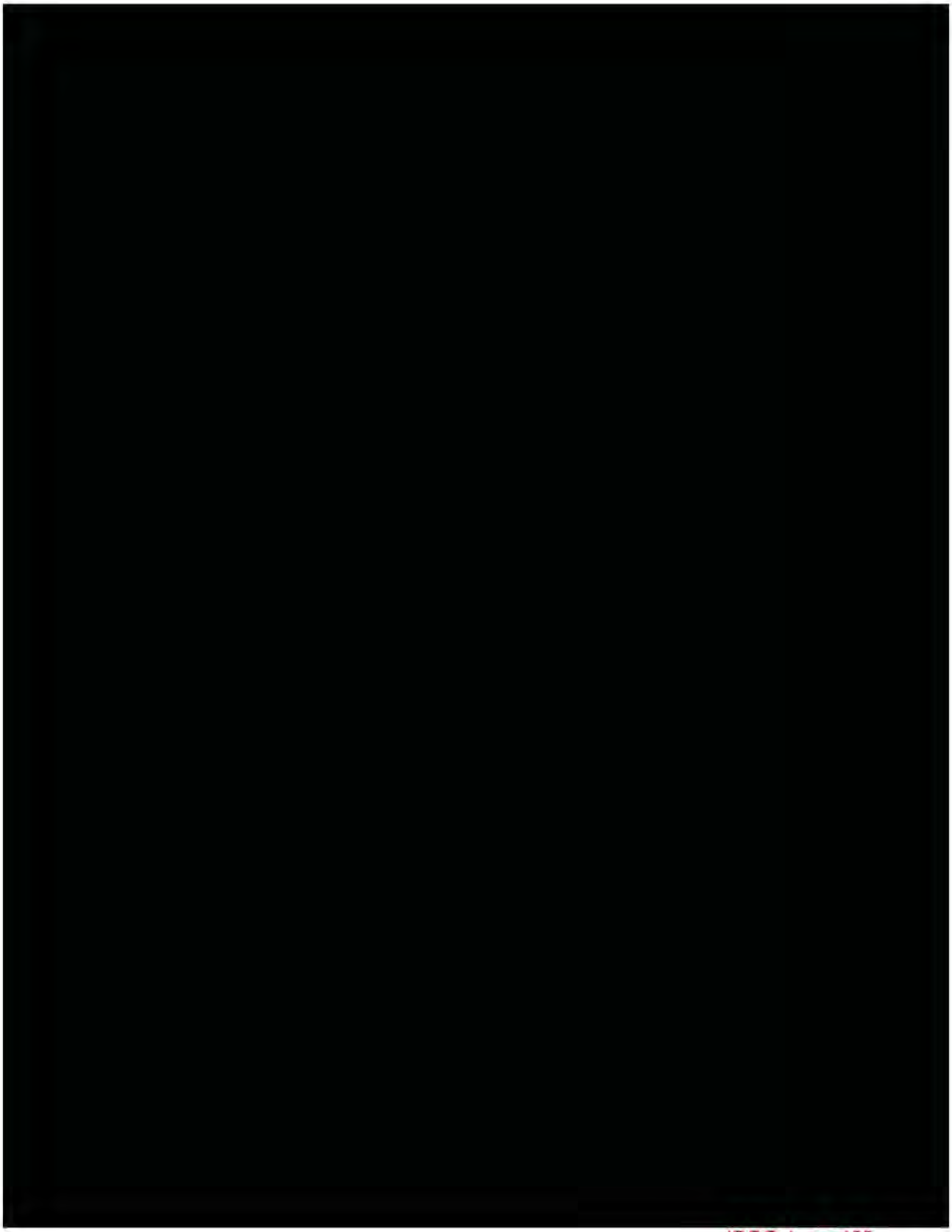
Attendees:

Name:	Position:	Institution:
Walter Campbell, MD	Chief Psychologist	IDOC
Jeremy Clark, LCPC	Clinician Supervisor	IDOC
Laura Watson	Clinician Supervisor	IDOC
Bryan Gimmeson	Clinician Supervisor	
Krina Stewart	Clinician	ISCI
Morgan Hahn	Clinician	
Breonna Krafft	Clinician	
Scott Eliason	Corizon Psychiatrist	
James Berry	Corizon Psychiatrist	

Cases for Consideration (New Diagnosis)

[redacted]

JT Ex.
7-99



IDOC_L_pg.100

JT Ex.
7-100

[redacted]

Cases for Review (Already Diagnosed)

Placements:

- Edmo 94691
  - Housing situation discussed
  - Unit 15 is not appropriate housing
  - Unit 9 does not appear to be inherently unsafe for gender dysphoria inmates
  - No issues with moving to different facility
  - As long as mental health services are available
  - Recommend removing mental health hold for movement

[redacted]

Additional Discussion

GD Group Update-Hahn:

- 4 on a regular basis
- Group is going well

GD Group Update-Stewart:

- Shaken with [redacted] suicide
- Concerns are being processed and addressed
- Moves have shaken up the group
- [redacted] is graduating from group

JT Ex. 7-101

[redacted]

Policy Update:

- Policy is under review.
- Goal is to publish by end of calendar year

IDOC_L_pg.102

JT Ex. 7-102

MTC Meeting

November 1, 2017
1400-1600
ISCI-Small Conference Room

Meeting called by: Walter Campbell
Type of meeting: MTC Meeting
Facilitator: Walter Campbell
Note taker: Kristina Waldram

Attendees:

Name:	Position:	Institution:
Walter Campbell, MD	Chief Psychologist	IDOC
Krina Stewart	Clinician	ISCI
Breonna Krafft	Clinician	ISCI
Randy Valley	Deputy Warden	ISCI
Adrea Nicodemus,	Clinician	Corizon/ISCC
Janell Clement	Clinical Supervisor	PWCC

Cases for Consideration (New Diagnosis)

[redacted]

[redacted]

[redacted]

JT Ex.
7-103

Cases for Review (Already Diagnosed)

[redacted]

Placements:

- Edmo 94691
  - Placed in Unit 15
  - Was placed in Unit 11; however he caused drama and was moved to Unit 15
  - All issues need to be documented

[redacted]

Additional Discussion

GD Group Update-Stewart:

- Smaller group
- Sent notices to group memebers notifiying them if they didn't attend they would be removed from group
- None of the inmates showed when scheduled but one. This inmate has a conflict with an inmate in the other group; therefore the groups were not joined together.
- Stewart and group members are excited about smaller group.

Referrals for HRT:

[redacted]

MTC Meeting

February 7, 2018
1400-1600
ISCI-Small Conference Room

Meeting called by: Walter Campbell
Type of meeting: MTC Meeting
Facilitator: Walter Campbell
Note taker: Amanda Weed

Attendees:

Name:	Position:	Institution:
Walter Campbell, MD	Chief Psychologist	IDOC
Krina Stewart	Clinician	ISCI
Breonna Krafft	Clinician	ISCI
Randy Valley	Deputy Warden	ISCI
Adrea Nicodemus	Clinician	Corizon/ISCC
Janell Clement	Clinical Supervisor	PWCC
Scott Eliason	Psychiatrist	Corizon/ISCI
Morgan Hahn	Clinician	ISCI
Tim Mckay	Deputy Warden	ISCC
Laura Watson	Clinical Supervisor	ISCI
Kaylene Hartt	Psych Tech	Corizon/ISCC
Steven Menard	Regional Medical Director	Corizon/ISCI
Bryan Gimmeson (on call)	Clinical Supervisor	ICIO
Amanda Weed	Management Assistant	IDOC

Cases for Consideration (New Diagnosis)

[redacted]

[redacted]

JT Ex.
7-105

[redacted]

[redacted]

Cases for Review (Already Diagnosed)

[redacted]

Placements:

- Edmo 94691
  - Placed in Unit 15
  - Was placed in Unit 11; however he caused drama and was moved to Unit 15
  - All issues need to be documented by correctional staff, as behavioral concerns do not appear to have been consistently documented

[redacted]

JT Ex. 7-106

Additional Discussion

[redacted] went to group twice. Inmate is being told by inmate Edmo not to attend group. Edmo wrote a grievance in [redacted] name to help support Edmo's lawsuit.
[redacted] requested to be housed with GD inmate. Wanted moved in with Edmo and staff believe this is a manipulation attempt. ISCI will discuss who to live with. MTC will support it but not required.

- Clinician Stewart stated group was rough today and the trigger was her telling inmates if they attend group in makeup they would be asked to remove it then come back. Stewart stated she will not do that anymore because of conflict. This should be a security concern to address.
- Get upper management involved in the issues facilities are facing.
- 245 Group updates
- EDMO stopped going to group. [redacted] is a new comer.
- Start putting diagnosis in EOMIS so clinical staff can access this if inmate is moved from facility to facility. In drop down have GD evaluation as a selection option. Wally and I will go through paper files. Put most recent decision in EOMIS.
- [redacted]
- Medical consideration needs to say only house with another GD inmate. "Transgender inmate" in all facilities. Jeremy will do this.

Referrals for HRT:

- Pashall: sent multiple concern forms wanting HRT. Been on HRT previously.

JT Ex. 7-107

MTC Meeting

July 11, 2018
1400-1530
ISCI-Small Conference Room

Meeting called by: Walter Campbell
Type of meeting: MTC Meeting
Facilitator: Walter Campbell
Note taker: Amanda Weed

Attendees:

Name:	Position:	Institution:
Walter Campbell, PhD	Chief Psychologist	IDOC
Randy Valley	Deputy Warden	ISCI
Adrea Nicodemus	Clinician	Corizon/ISCC
Tim Mckay	Deputy Warden	ISCC
Laura Watson	Clinical Supervisor	ISCI
Steven Menard, MD	Regional Medical Director	Corizon
Amanda Weed	Management Assistant	IDOC

Cases for Consideration (New Diagnosis)

[redacted]

IDOC_L_pg.108

JT Ex.
7-108

DECISION

Cases for Review (Already Diagnosed)

Updates:

Gruhot – Edmo is coming back consistently.

[redacted]

[redacted]

[redacted]

[redacted]

Placements:

[redacted]

[redacted]

[redacted]

Additional Discussion

Policy update: No change on policy but met with attorneys on Edmo lawsuit. One commissary for all inmates and can't sexualize appearance is what Ashley is talking about and the Board of Corrections was on board. It's just discussion at this point.

[redacted]

New curtains for showering are too short. Randy Valley will look into this.

JT Ex. 7-109

Referrals for HRT:

[redacted]

IDOC_L_pg.110

JT Ex.
7-110

Idaho Department of Correction	Standard Operating Procedure Operations Division Operational Services	**Control Number:** 401.06.03.501	**Version:** 3.2	**Page Number:** 1 of 9
		Title: Gender Identity Disorder: Healthcare for Offenders with		**Adopted:** 10-31-2002 **Reviewed:** 12-21-2011

This document was approved by Shane Evans, director of the Education, Treatment, and Reentry Bureau, on 12/21/11 (signature on file).

Open to the general public: ☒ Yes

BOARD OF CORRECTION IDAPA RULE NUMBER 401

Medical Care

POLICY CONTROL NUMBER 401

Clinical Services and Treatment

DEFINITIONS

Standardized Terms and Definitions List

Administrative Review Committee (ARC)—GID: A committee comprised of the chief of the Operations Division; a deputy chief of the Prisons Bureau; the director of the Education, Treatment, and Reentry Bureau; and a deputy attorney general who is assigned to the Idaho Department of Correction (IDOC) and will act as legal advisor. The committee reviews recommendations of the Management and Treatment Committee (MTC). The ARC may, in its discretion retain a consultant versed in the treatment, management, and placement of persons with gender identity disorder (GID). The ARC makes recommendations regarding the classification, management and security of persons with GID. Recommendations of the ARC, together with the recommendations of the MTC, shall be submitted to the director of the IDOC for final consideration.

Chief Psychologist: The Idaho Department of Correction (IDOC) employee who is primarily responsible for overseeing or managing the IDOC's mental health services.

Consultant—GID: A medical or mental health professional, qualified by virtue of their training and experience to make non-binding recommendations regarding the diagnosis and treatment of offenders with gender identity disorder (GID). Any consultant involved with the diagnosis of GID must be a qualified GID evaluator.

Cross-sex Hormonal Therapy: Medical treatment in which an anatomically male person is prescribed feminizing medications or an anatomically female person is prescribed masculinizing medications for the purpose of generating either or both psychological or physical changes determined to be medically necessary.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The standard manual of psychiatric diagnoses, as published and amended by the American Psychiatric Association from time to time.

Facility: A building or residence (including the property and land where the building or residence is located) owned, leased, operated, or managed by the Idaho Board of Correction or Idaho Department of Correction (IDOC).

Facility Head: The person primarily responsible for overseeing, managing, or operating an Idaho Department of Correction (IDOC) facility.

Gender Identity Disorder (GID): A psychiatric disorder that includes gender identity disorder (GID) and gender dysphoria, as defined in the most current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. A person with this condition is dissatisfied and sometimes seriously dysphoric with his or her own biological sex and desires to be considered and treated as a member of the opposite sex. In general, this condition is a stable nonviolent condition and not due to psychosis but it may accompany other mental disorders.

Health Authority: The Idaho Department of Correction (IDOC) employee who is primarily responsible for overseeing or managing the IDOC's medical services. (The health authority is commonly referred to as the health services director.)

Hormonal Replacement Treatment: A medical treatment in which male or female hormones are prescribed to a patient as a result of his/her inability to produce an adequate amount of these hormones internally. Persons who have undergone sexual reassignment surgery may require this therapy to treat medically significant side effects.

Level of Care (LOC): A system utilized by the Idaho Department of Correction (IDOC) in which offenders with mental health issues are assigned a LOC based upon the severity of their mental illness and degree of treatment needs.

Management and Placement Plan: A written plan devised by the Management and Treatment Committee (MTC) implementing the treatment plan, by addressing mental health services, facility placement, and other needed support services for individuals diagnosed with gender identity disorder (GID). The Management and Placement Plan is forwarded to the Administrative Review Committee (ARC) for their review and approval.

Management and Treatment Committee (MTC): A committee composed of the health authority, chief psychologist, psychiatrist, psychologist, medical director, and facility head. Other mental health, medical, human services, and security staff may be requested to attend in a recommendational capacity by the health authority.

Medical Director: A physician either employed by the Idaho Department of Correction (IDOC) or contracted through privatized services (i.e., the physician in charge if medical services are privatized).

Offender: A person under the legal care, custody, supervision, or authority of the Idaho Board of Correction, including a person within or out of the state of Idaho pursuant to an agreement with another state or contractor.

Primary Physical Sexual Characteristics: Genitalia and reproductive organs.

Psychiatrist: A psychiatrist, who meets the definition of a qualified gender identity disorder (GID) evaluator, employed by the Idaho Department of Correction (IDOC) or a private contractor and charged by their employer with oversight of delivery of psychiatric services to offenders.

Psychologist: A psychologist, who meets the definition of a qualified gender identity disorder (GID) evaluator, employed by the Idaho Department of Correction (IDOC) or a

private contractor and charged by their employer with oversight of delivery of psychological services to offenders.

Qualified Gender Identity Disorder (GID) Evaluator: 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.

Reception/Diagnostic Unit (RDU): Initial housing for newly committed offenders (except those under sentence of death) where orientation, screening, assessment, and classification occur.

Sexual Reassignment Surgery: The surgical alteration of a person's physical appearance so that the person appears more like the opposite gender.

Sexual Reassignment Treatment: Treatment for a person diagnosed with gender identity disorder (GID) in which hormonal medications, surgical procedures, or both are utilized to alter a person's physical appearance so that the person appears more like the opposite gender. While these surgical procedures are available within the community, sexual reassignment surgery will not be considered for individuals incarcerated within the Idaho Department of Correction (IDOC), unless determined medically necessary by the GID evaluators.

Treatment Plan: A series of written statements specifying a patient's particular course of therapy and the roles of qualified healthcare professionals in carrying it out.

PURPOSE

The purpose of this standard operating procedure (SOP) is to establish guidelines for the diagnosis, treatment, management, and placement of offenders diagnosed with gender identity disorder (GID) to ensure offender safety and access to appropriate and necessary medical and mental health treatment. This SOP defines the extent and general limits of healthcare services provided to offenders identified as meeting the criteria for diagnosis of GID as outlined within the most current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

SCOPE

This SOP applies to all Idaho Department of Correction (IDOC) offenders who request or are evaluated for and/or diagnosed with GID; Education, Treatment, and Reentry Bureau administrators, employees, contract medical providers and subcontractors; and limited IDOC staff such as facility heads, security staff, deputy attorneys general (DAG) who represents the IDOC, and the director of the IDOC.

RESPONSIBILITY

The director of the Education, Treatment, and Reentry Bureau **and** deputy chief of the Prisons Bureau shall be jointly responsible for the implementation of this SOP and for designating appropriate personnel to develop and implement procedures in conjunction with this SOP.

Table of Contents

GENERAL REQUIREMENTS

1. Initial Reporting

Information about all services available within the correctional system, including those to meet the needs of offenders with GID, will be made available to offenders while in the Reception/Diagnostic Unit (RDU). Upon the offender's request, information about all services will be available throughout the offender's incarceration. Until an offender who is suspected of having GID completes the RDU process, security staff and other relevant staff shall review whether to escort and transport the offender separately to avoid the risk of physical or sexual assault by other offenders in transit.

Offenders may be evaluated for GID at any point during their incarceration. When the offender has a prior diagnosis or is suspected of having GID or accompanying/supporting information (i.e., collateral information) is received pertaining to the suspicions of GID, any of the following may request an initial or subsequent evaluation for GID:

- **Offender** – Requests (in writing) health assistance in accordance with SOP 401.06.03.037, *Non-emergency Healthcare Requests and Services* **or** SOP 401.06.03.087, *Healthcare for Offenders Housed in Non-Idaho Department of Correction Facilities*.

- **Healthcare staff** – Prepares a referral in accordance with SOP 401.06.03.037 **or** 401.06.03.087 and forwards to the chief psychologist.

Subsequent Evaluations

Also see section 11.

2. Referral and Placement of the Offender for Evaluation Purposes

The chief psychologist will take the necessary action to transfer an offender who is scheduled to be evaluated for GID to the appropriate facility for evaluation as follows:

- **Male offenders**—will be housed within the Secure Mental Health Unit (located within the Idaho Maximum Security Institution [IMSI]). Offenders who are believed to pose a security risk may be placed in more secure housing following consultation with the IMSI warden's office.
- **Female offenders**—will be housed at the Pocatello Women's Correctional Center (PWCC) following consultation with the warden of PWCC.

Note: The chief psychologist must be a doctoral level psychologist licensed in the state of Idaho and employed by the IDOC. The chief psychologist reports directly to the director of the Education, Treatment, and Reentry Bureau, should be a qualified GID evaluator, and shall be responsible for overseeing the delivery of all IDOC mental health services provided by state of Idaho and/or contract providers. If the chief psychologist is not a qualified GID evaluator, he must engage and rely upon a consultant who must be a qualified GID evaluator.

When determining appropriate placement, the chief psychologist will consider factors such as the offender's diagnostic needs, prior institutional adjustment, and safety and/or security concerns. Upon reviewing these and other relevant factors, the chief psychologist may exercise the option to place the offender in a facility other than those listed above in this section. In consultation with the warden, unless there are overriding security and/or safety concerns for the offender, the chief psychologist will place the offender (who either requests a GID evaluation **or** is diagnosed with GID) in a correctional facility consistent with the offender's primary physical sexual characteristics.

The transfer will occur as soon as practicable, subject to variables such as bed and transportation availability, and security considerations. The evaluation process will commence within 30 days from the date a written request, **or** referral from medical staff for evaluation, is received by the chief psychologist.

3. Evaluation of the Offender

Once the offender has been moved to the appropriate housing unit, the offender will be evaluated by the psychologist and/or psychiatrist. The chief psychologist, at his discretion, may require that a consultant perform this initial evaluation.

Note: Any consultant involved with the diagnosis of GID must be a qualified GID evaluator.

This evaluation shall include a comprehensive history, mental status evaluation, and clinical interview. Documentation of any claim by the offender of prior GID diagnosis, treatment, or transgender lifestyle shall be obtained as part of the evaluation process. An offender's

refusal to provide written authorization to access medical records relating to prior diagnosis or treatment of GID may be considered a factor for a non-GID finding by the evaluators.

The diagnosis of GID shall be based on the most current *Diagnostic and Statistical Manual of Mental Disorders*. If the evaluators believe it is necessary, they may contract a medical **or** mental health consultant to assist in the evaluation process. Any diagnoses by the evaluators should include consideration of the consultant's report.

Throughout the evaluation process, the chief psychologist shall monitor the progress of the evaluation to ensure the GID evaluation is completed as soon as practicable. Absent extenuating circumstances, the GID evaluation—including the chief psychologist's review and report (see section 5)—will be completed within 60 days from the date the evaluation process commences as described in section 2.

4. Evaluator Findings, Diagnosis, and Reporting

The psychologist (and/or psychiatrist) or consultant conducting the evaluation shall prepare independent written reports detailing their findings, diagnosis, and recommended treatment options. These independent written reports shall include dates of contact, instrumentation utilized, collateral data obtained, and the consultant's report, if applicable. The reports shall also include a multiaxial diagnosis **and** a summary of the information and impressions that support the diagnosis and recommended treatment options. These written reports shall be forwarded to the chief psychologist for consideration.

In cases where an offender was receiving (prior to incarceration) feminizing **or** masculinizing hormones from a licensed medical professional as treatment for GID, the prior treatment will be continued and incorporated into the offender's individualized treatment plan, unless hormone therapy is—for medical reasons—subsequently contraindicated.

5. Chief Psychologist's Review of Findings

Upon receipt of the evaluators' reports, the chief psychologist shall review the findings. If the chief psychologist agrees with the findings, he shall issue a report stating his agreement and basis for his decision and finalize the portion of the treatment plan involving GID. The chief psychologist may, in his discretion, request an additional evaluation by a consultant who will provide an independent diagnosis and report. The chief psychologist shall—based upon his review of all available information, including the reports of the evaluators and any consultant—issue a report resolving any differences of opinions concerning diagnosis and/or treatment, including his own findings. In all cases in which an evaluation is performed, the chief psychologist will determine an appropriate level of care (LOC) based on the resulting multiaxial diagnosis. All reports generated by the evaluators, consultants, or the chief psychologist will be placed in the offender's medical file.

Note: The LOC system utilized by the IDOC requires that each offender with a major 'axis I' and/or 'axis II' diagnosis for a disorder, which includes behaviors that may prove a significant risk, be assigned to one (1) of three (3) LOCs. The resulting LOC establishes defined parameters including, but not limited to, the required time frame for treatment plan reviews. These time frames can vary based upon the needs of the individual offender, but will occur no less than one time per year.

Findings

Supported: If a diagnosis of GID is supported by the evaluation process. The chief psychologist will then convene the full Management and Treatment Committee (MTC) within 15 working days after the diagnosis has been finalized. (See section 6.)

Not supported: In incidences in which the diagnosis of GID is not supported by the evaluation process, the chief psychologist may, in his sole discretion,

- Request an additional evaluation by a consultant who will provide an independent diagnosis, **or**
- Issue a report detailing that finding and refer the offender to the Prisons Bureau for housing in a suitable facility based on the offender's security and treatment needs.

Note: The IDOC has a comprehensive, uniform, and objective offender classification system that is used to place offenders in facilities that the offer the appropriate security and programs. See SOP 303.02.01.001, *Classification: Offender*.

Re-evaluation of Findings Initially Not Supported

See section 11.

6. Management and Treatment Committee (MTC) Meeting

When convened, the MTC shall develop and recommend a plan for the management and placement of the offender. Copies of all reports authored by the psychologist, psychiatrist, or consultant(s)—as well as the chief psychologist's report—will be provided to the MTC.

The MTC (in coordination with team case management) shall develop and recommend an individualized *Management and Placement Plan* for each offender diagnosed with GID, which implements the treatment plan approved by the chief psychologist.

The medical director may also initiate cross-sex hormonal therapy when such therapy has been prescribed as part of the treatment plan. When initiated by the medical director, the cross-sex hormonal therapy may commence prior to and independent of the Administrative Review Committee's (ARC) review. The chief psychologist may initiate mental health services prescribed as part of the treatment plan prior to and independent of the ARC review.

Management and placement recommendations for offenders with GID will take into account both treatment **and** security needs, with a goal of least restrictive placement. As provided in section 2, facility placement will be based upon the offender's primary physical sexual characteristics.

The MTC shall forward its recommendation for management and placement to all ARC members within 15 working days of the MTC meeting.

7. Administrative Review Committee (ARC) Meeting

Convening Responsibility

As soon as possible after receiving the MTC's report and recommendation, the deputy chief of the Prisons Bureau shall convene a meeting of the ARC.

Review of Management and Placement Plan

The ARC shall review the *Management and Placement Plan* recommended by the MTC and, at its discretion, consult with members of the MTC in an effort to address concerns and/or questions related to the proposed plan.

Upon approval of the MTC's proposed *Management and Placement Plan*, the ARC shall submit its recommendation for management to the director of the IDOC within 15 working days of meeting.

8. Final Approval of the Management and Placement Plan

The director of the IDOC shall review the ARC's recommendation, and in his sole discretion:

- Take into consideration existing security concerns within the facility **and** available space in the facility identified in the *Management and Placement Plan*; **and either**
- Send the recommendation back to the ARC **or** the MTC for additional findings or information, **or**
- Retain consultants to address any concerns or questions with the recommendation.

After completing all of the above and as soon as practicable, the director of the IDOC may accept (in writing) the ARC's recommendation. If the director of the IDOC accepts the ARC's recommendation, the ARC will approve implementation of the *Management and Placement Plan*, and implementation shall begin within four (4) months of approval.

9. Implementation of the Management and Placement Plan

Offenders diagnosed with GID shall be:

- Managed pursuant to the *Management and Placement Plan* approved by the director of the IDOC, and
- Treated in accordance with their treatment plan (see section 6).

Offenders requesting evaluation for (or diagnosed with) GID will not be placed in administrative segregation based solely upon their request or diagnosis. During their evaluation for GID, offenders will be transferred to housing in accordance with section 2. Once a diagnosis is complete, offenders may be returned to a correctional facility consistent with their security classification.

Hormone replacement treatment **and** cross-sex hormonal therapy shall be provided as needed but only when medically indicated and consistent with the offender's treatment plan. An offender who was receiving hormonal medications (related to cross-sex hormonal therapy) at the time of incarceration will continue on such hormonal medications, unless current medical providers determine there is a medically compelling reason to discontinue treatment. An offender who is initially diagnosed with GID while incarcerated at the IDOC will be eligible to receive hormonal medications as provided herein. The offender shall be required to provide their informed consent (see SOP 401.06.03.070, *Informed Consent*) to ensure the offender understands and accepts the risks associated with any prescribed treatment for GID.

10. Moral and Ethical Treatment of Offenders Diagnosed with GID

Offenders diagnosed with GID:

- Shall be addressed by their last name (e.g., offender Smith),
- Will not be harassed because of their condition, and
- Will be treated by staff in a manner consistent with policy 201, *Respectful Workplace*. (I.e., Staff members must maintain a respectful and professional demeanor, and refrain from harassing offenders due to their gender/sex, etc.)

Offenders diagnosed with GID shall be provided access to the full range of services and programs available within the IDOC to the same extent as other offenders including, but not limited to, mental health services tailored to the offender's individual needs. Referral to such services or programs will be dependent on factors such as admission criteria (generally applied), availability within the facility or housing unit, and security considerations.

Strip searches of offenders diagnosed with GID will be conducted in a manner that is consistent with SOP 317.04.02.001, *Searches of Offenders*.

11. Subsequent Reviews and Evaluations for GID

The evaluation process includes the assignment of a LOC (see section 5) in all cases in which an offender is assessed to have a major mental illness and dictates the minimum frequency in which the offender's resulting treatment plan must be reviewed.

In the event that additional observations **or** information concerning the offender's purported GID becomes available, a subsequent evaluation (i.e., a re-evaluation) may be requested as described in section 1.

The decision to allow a re-evaluation shall be within the discretion of the chief psychologist based upon his review of all available information. If a re-evaluation is denied, the basis for the denial must be documented in the offender's healthcare record.

REFERENCES

Idaho Department of Correction Manual, *Correctional Mental Health Service System*

IDAPA 06.01.01, *Rules of the Board of Correction*, Section 302.05, Medical, Dental, Psychological and Psychiatric Care

IDAPA 06.01.01, *Rules of the Board of Correction*, Section 401, Medical Care

Policy 201, *Respectful Workplace*

Standard Operating Procedure 303.02.01.001, *Classification: Offender*

Standard Operating Procedure 317.04.02.001, *Searches of Offenders*

Standard Operating Procedure 401.06.03.037, *Non-emergency Healthcare Requests and Services*

Standard Operating Procedure 401.06.03.070, *Informed Consent*

Standard Operating Procedure 401.06.03.087, *Healthcare for Offenders Housed in Non-Idaho Department of Correction Facilities*

– End of Document –

Idaho Department of Correction	Standard Operating Procedure	Title: **Gender Dysphoria: Healthcare for Inmates with**		Page: 1 of 9
		Control Number: **401.06.03.501**	Version: **4.0**	Adopted: 10/31/2002

Ashley Dowell, chief of the division of prisons, approved this document on 10/05/2018.

Open to the public: ☒ **Yes**

SCOPE

This standard operating procedure (SOP) applies to all Idaho Department of Correction (IDOC) inmates who request or are evaluated for and/or diagnosed with Gender Dysphoria; Prisons Division administrators, employees, contract medical providers and subcontractors; and limited IDOC staff such as facility heads, security staff, deputy attorneys general (DAG) who represents the IDOC, and the director of the IDOC.

Revision Summary
Revision date (10/05/2018) version 4.0: Reformatted, updated terminology; provided clarification regarding inmates with gender dysphoria including how they are to be addressed, appearance, commissary, and various other issues.

TABLE OF CONTENTS

BOARD OF CORRECTION IDAPA RULE NUMBER 401

Medical Care

POLICY CONTROL NUMBER 401

Clinical Services and Treatment

PURPOSE

The purpose of this standard operating procedure (SOP) is to establish guidelines for the diagnosis, treatment, management, and placement of inmates diagnosed with Gender Dysphoria (GD) to ensure inmate safety and access to appropriate and necessary medical and mental health treatment. This SOP defines the extent and general limits of healthcare services provided to inmates identified as meeting the criteria for diagnosis of GD as outlined within the most current *Diagnostic and Statistical Manual of Mental Disorders (DSM).*

RESPONSIBILITY

The chief of Prisons Division is responsible for the implementation of this SOP and for designating appropriate personnel to develop and implement procedures in conjunction with this SOP.

STANDARD PROCEDURES

1. Initial Reporting

Information about all services available within the correctional system, including those to meet the needs of inmates with GD, will be made available to inmates while in the Reception/Diagnostic Unit (RDU). Upon the inmate's request, information about all services will be available throughout the inmate's incarceration. Until an inmate who is suspected of having GD completes the RDU process, security staff and other relevant staff will review whether to escort and transport the inmate separately to avoid the risk of physical or sexual assault by other inmates in transit.

Inmates may be evaluated for GD at any point during their incarceration. When the inmate has a prior diagnosis, or is suspected of having GD or accompanying/supporting information (i.e., collateral information) is received pertaining to the suspicions of GD, any of the following may request an initial or subsequent evaluation for GD:

- **Inmate** – Requests (in writing) health assistance in accordance with SOP 401.06.03.037, *Non-emergency Healthcare Requests and Services* or SOP 401.06.03.087, *Healthcare for Inmates Housed in Non-Idaho Department of Correction Facilities*.
- **Healthcare Staff** – prepares a referral in accordance with SOP 401.06.03.037 or 401.06.03.087 and forwards to the chief psychologist.

Subsequent Evaluations

Also see section 11.

2. Referral and Placement of the Inmate for Evaluation Purposes

The chief psychologist will take the necessary action to transfer an inmate who is scheduled to be evaluated for GD to the appropriate facility for evaluation if a move is needed.

When determining appropriate placement, the chief psychologist will consider factors such as the inmate's diagnostic needs, prior institutional adjustment, and safety and/or security concerns. In consultation with the warden, unless there are overriding security and/or safety concerns for the inmate, the chief psychologist will place the inmate (who either requests a GD evaluation or is diagnosed with GD) in a correctional facility consistent with the inmate's primary physical sexual characteristics.

The evaluation process will commence within 30 days from the date a written request, or referral from medical staff for evaluation, is received by the chief psychologist.

3. Evaluation of the Inmate

Once the inmate has been moved to the appropriate housing unit, the inmate will be evaluated by the Qualified GD Evaluator. The chief psychologist, at his direction, may require that a consultant perform this initial evaluation.

Note: Any consultant involved with the diagnosis of GD must be a qualified GD evaluator and contracted by the IDOC.

This evaluation will include a comprehensive history, mental status evaluation, and clinical interview. Documentation of any claim by the inmate of prior GD diagnosis, treatment, or transgender lifestyle will be obtained as part of the evaluation process. An inmate's refusal to provide written authorization to access medical records relating to prior diagnosis or treatment of GD may be considered a factor for a non-GD finding by the evaluator.

The diagnosis of GD will be based on the most current *Diagnostic and Statistical Manual of Mental Disorders*. If the IDOC evaluator believes it is necessary, they may contract a medical or mental health consultant to assist in the evaluation process. Any diagnoses by the evaluators should include consideration of the consultant's report.

Throughout the evaluation process, the chief psychologist or clinical supervisor will monitor the progress of the evaluation to ensure the GD evaluation is completed as soon as practicable. Absent extenuating circumstances, the GD evaluation will be completed within 60 days from the date the evaluation process commences as described in section 2.

4. Evaluation Findings, Diagnosis, and Reporting

The GD evaluator conducting the evaluation will prepare independent written reports detailing their findings, diagnosis, and recommended treatment options. These independent written reports will include dates of contact, instrumentation utilized, collateral data obtained, and the consultant's report, if applicable. The reports will also include a diagnosis and a summary of the information and impressions that support the diagnosis and recommended treatment options. These written reports will be forwarded to the chief psychologist.

In cases where an inmate was receiving (prior to incarceration) feminizing or masculinizing hormones from a licensed medical professional as treatment for GD, the prior treatment will be continued and incorporated into the inmate's individualized medical treatment plan, unless hormone replacement therapy is subsequently contraindicated based on the assessment and findings by the inmate's treating physician.

5. Chief Psychologist's Review

Upon receipt of the evaluators' reports, the chief psychologist reviews the findings and convenes the Management and Treatment Committee (MTC). The chief psychologist may, at his discretion, request an additional evaluation by a consultant who will provide an independent diagnosis and report. If differences in opinions between evaluators exist, the chief psychologist will—based upon his review of all available information, including the reports of the evaluators and any consultant—issue a report resolving any differences of opinions concerning diagnosis and/or treatment, including his own findings. All reports generated by the evaluators, consultants, or the chief psychologist will be placed in the inmate's medical file.

Findings Not Supported

In incidences in which the diagnosis of GD is not supported by the evaluation process, the chief psychologist may, at his sole discretion:

- Request an additional evaluation by a consultant who will provide an independent diagnosis.
- Refer concerns about the inmate's security or housing needs to the operations and security staff at the inmate's assigned facility so they can determine appropriate housing.

6. Management and Treatment Committee (MTC) Meeting

When convened, the MTC will develop and recommend a plan for the management and placement of the inmate. Copies of all reports authored by the evaluators will be provided to the MTC.

The MTC will develop and recommend an individualized Management and Placement Plan for each inmate diagnosed with GD, which implements the treatment plan developed by the treating medical and mental health providers.

The treating physician may also initiate hormone replacement therapy when such therapy has been prescribed as part of the treatment plan. When initiated by the treating physician, the hormone replacement therapy may commence prior to and independent of the Administrative Review Committee's (ARC) review. The chief psychologist may initiate mental health services recommended as part of the treatment plan prior to and independent of the ARC review.

Management and placement recommendations for inmates with GD will take into account both treatment and security needs, with a goal of least restrictive placement. As provided in section 2, facility placement will be based upon the inmate's primary physical sexual characteristics.

The MTC will forward its recommendation for management and placement to all ARC members.

7. Administrative Review Committee (ARC) Meeting

Convening Responsibility

After receiving the MTC's report and recommendations, the chief of the Prisons Division will convene a meeting of the ARC.

Review of Management and Placement Plan

The ARC will review the *Management and Placement Plan* recommended by the MTC and, at its discretion, consult with members of the MTC in an effort to address concerns and/or questions related to the proposed plan.

Upon approval of the MTC's proposed *Management and Placement Plan*, the ARC will submit its recommendation for management to the director of the IDOC within 15 working days of meeting.

8. Final Approval of the Management and Placement Plan

The director of the IDOC will review the ARC's recommendation, and in his sole discretion take into consideration existing security concerns within the facility and available space in the facility identified in the *Management and Training Plan* and either:

- Send the recommendation back to the ARC or the MTC for additional findings or information, or
- Retain consultants to address any concerns or questions with the recommendation, or
- May accept (in writing) the ARC's recommendation.

9. Implementation of the Management and Placement Plan

Inmates diagnosed with GD will be:

- Managed pursuant to the Management and Placement Plan approved by the director of the IDOC.
- Treated in accordance with their medical and mental health treatment plan.

Inmates requesting evaluation for (or diagnosed with) GD will not be placed in administrative segregation based solely upon their request or diagnosis.

Hormone replacement therapy will be provided as needed, but only when medically indicated and consistent with the inmate's treatment plan. An inmate who was receiving hormone replacement therapy at the time of incarceration will continue on those medications, unless current treating medical providers determine there is a medically compelling reason to discontinue treatment. An inmate who is initially diagnosed with GD while incarcerated at the IDOC will be eligible to receive hormone replacement therapy if medically necessary and as identified in their treatment plan. The inmate will be required to provide their informed consent (see SOP 401.06.03.070, *Informed Consent*) to ensure the inmate understands and accepts the risks associated with any prescribed treatment for GD.

10. Respectful and Safe Conduct Related to Appearance

Inmates diagnosed with gender dysphoria will be allowed to maintain their appearance in a way that is consistent with their identified gender. This means that inmates housed in a male facility, who identify as female and have been diagnosed with gender dysphoria, will be allowed to wear makeup and wear their hair in traditionally feminine hairstyles and present as female. Similarly, inmates housed in a female facility, who identify as male and have been diagnosed with gender dysphoria, will be allowed to wear their hair in traditionally male hairstyles and present as male.

However, to avoid a sexually charged atmosphere in IDOC facilities, and to foster an environment of respect for all persons housed there, the following guidelines will be in place:

- No provocative or sexually charged clothing or behavior will be permitted.
    - Examples of inappropriate clothing include, but are not limited to: clothing that is too tight, too short, transparent, shows cleavage or the midriff.
    - Examples of inappropriate behavior include but are not limited to: gestures or mimicking of sexual behavior, behavior or actions that are provocative, kissing, or similar conduct.
- A single commissary list will be used for inmates who have been diagnosed with gender dysphoria. There will be no distinction or restriction of products by gender as to what can be ordered.
    - This includes undergarments such as male/female underwear and bras.
    - Inmates who are indigent, and diagnosed with gender dysphoria, and do not have the funds to purchase undergarments will be provided state issued undergarments per SOP 320.02.01.001, *Property: State-issued and Inmate Personal Property*.
- Gender neutral references will be used by IDOC staff when speaking to or referring to inmates diagnosed with gender dysphoria.
    - For example: Use the inmate's name or use gender neutral pronouns for reference such as "they, them, or their".
- Medical and mental health staff will refer to inmates diagnosed with gender dysphoria by their preferred pronoun.
- Inmates diagnosed with gender dysphoria will be treated by staff in a manner consistent with policy 201, *Respectful Workplace*. (i.e., Staff members must maintain a respectful and professional demeanor, and refrain from harassing inmates due to their gender/sex, etc.)
- Inmates diagnosed with GD will be provided access to the full range of services and programs available within the IDOC to the same extent as other inmates.

Searches of inmates diagnosed with GD will be conducted in a manner that is consistent with SOP 317.02.02.001, *Searches: Cell/Living Unit, and Inmate*.

11. Subsequent Reviews and Evaluations for GD

In the event that additional observations or information concerning the inmate's purported GD becomes available, a subsequent evaluation (i.e., a re-evaluation) may be requested. Inmates who have requested to be evaluated for gender dysphoria, and who have not been assessed as meeting criteria for that diagnosis, may reinitiate the evaluation process via a *Health Services Request* one year after the date of the initial evaluation.

The decision to allow a re-evaluation will be within the discretion of the chief psychologist based upon his review of all available information. If a re-evaluation is denied, the basis for the denial must be documented in the inmate's healthcare record.

DEFINITIONS

Administrative Review Committee (ARC): A committee comprised of the chief of the Prisons Division; a deputy chief of the Prisons Division; and a deputy attorney general who is assigned to the Idaho Department of Correction (IDOC) and will act as legal advisor. The committee reviews recommendations of the Management and Treatment Committee (MTC). The ARC may, in its discretion retain a consultant versed in the treatment, management, and placement of persons with gender dysphoria (GD). Recommendations of the ARC, together with the recommendations of the MTC, will be submitted to the director of the IDOC for final consideration.

Chief Psychologist: The chief psychologist must be a doctoral level psychologist licensed in the state of Idaho and employed by the IDOC and will be responsible for overseeing the delivery of all IDOC mental health services provided by state of Idaho and/or contract providers. If the chief psychologist is not a qualified GD evaluator, he must engage and rely upon a consultant who must be a qualified GD evaluator.

Consultant – GD: A medical or mental health professional, qualified by virtue of their training and experience to make non-binding recommendations regarding the diagnosis and treatment of inmates with gender dysphoria (GD). Any consultant involved with the diagnosis of GD must be a qualified GD evaluator.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The standard manual of psychiatric diagnoses, as published and amended by the American Psychiatric Association from time to time.

Facility: A building or residence (including the property and land where the building or residence is located) owned, leased, operated, or managed by the Idaho Board of Correction or Idaho Department of Correction (IDOC).

Facility Head: The person primarily responsible for overseeing, managing, or operating an Idaho Department of Correction (IDOC) facility.

Gender Dysphoria (GD): A psychiatric disorder that is defined in the most current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. A person with this condition reports marked incongruence between the gender they were born with and their identified or expressed gender causing clinically significant distress or impairment in functioning.

Hormone Replacement Therapy: A medical treatment in which hormonal medications are administered to individuals diagnosed with gender dysphoria for the purpose of more closely

aligning their physical characteristics with their gender identity. The goal of this treatment is feminization or masculinization.

Level of Care (LOC): An acuity based system utilized by the Idaho Department of Correction (IDOC) in which inmates with mental health issues are assigned a LOC based upon the severity of their mental illness and degree of treatment needs.

Management and Placement Plan: A written plan devised by the Management and Treatment Committee (MTC) that includes a review of the treatment plan from the treating medical and mental health providers, outlines referrals for treatment and includes recommendations regarding facility placement and housing and special accommodations or support services. The Management and Placement Plan is forwarded to the Administrative Review Committee (ARC) for their review and approval.

Management and Treatment Committee (MTC): A multidisciplinary committee that is composed of representatives from the medical, mental health, security and operations staff. This committee reviews the treatment plan from the treating medical and mental health providers and generates a management and placement plan. The committee is led by the IDOC Chief Psychologist.

Inmate: A person under the legal care, custody, supervision, or authority of the Idaho Board of Correction, including a person within or out of the state of Idaho pursuant to an agreement with another state or contractor.

Primary Physical Sexual Characteristics: Genitalia and reproductive organs.

Qualified Gender Dysphoria Evaluator: A trained mental health professional who is either an IDOC or contract medical employee, with competence to work with adults with gender dysphoria and has:

1. A master's degree, or more advanced degree, in a behavioral health field and appropriate licensure in or credentials
2. Competence in using the DSM for diagnostic purposes
3. The ability to recognize and diagnose coexisting mental health concerns
4. Documented supervised training and competence in counseling
5. Is knowledgeable about gender non-conforming identities and expressions and the assessment and treatment of gender dysphoria
6. Continuing education in the assessment and treatment of gender dysphoria
7. Cultural competence to facilitate work with individuals with gender dysphoria

Reception/Diagnostic Unit (RDU): Initial housing for newly committed inmates (except those under sentence of death) where orientation, screening, assessment, and classification occur.

Sexual Reassignment Surgery: The surgical alteration of the physical appearance of an individual's genitalia so the person's genitals more closely match that of their identified gender. Sexual reassignment surgery will not be considered for individuals incarcerated

within the Idaho Department of Correction (IDOC), unless determined medically necessary by the treating physician.

Sexual Reassignment Treatment: Treatment for a person diagnosed with gender dysphoria (GD) in which hormone replacement medications, surgical procedures, or both are utilized to alter a person's physical appearance so that the person appears more like their identified gender.

Treatment Plan: A series of written statements specifying a patient's particular course of treatment and the roles of qualified healthcare professionals in carrying it out.

REFERENCES

IDAPA 06.01.01, *Rules of the Board of Correction*, Section 302.05, Medical, Dental, Psychological and Psychiatric Care

IDAPA 06.01.01, *Rules of the Board of Correction*, Section 401, Medical Care

Policy 201, *Respectful Workplace*

Standard Operating Procedure 317.04.02.001, *Searches of Inmates*

Standard Operating Procedure 401.06.03.037, *Non-emergency Healthcare Requests and Services*

Standard Operating Procedure 401.06.03.070, *Informed Consent*

Standard Operating Procedure 401.06.03.087, *Healthcare for Inmates Housed in Non-Idaho Department of Correction Facilities*

Standard Operating Procedure 327.02.01.001, *Mental Health Services System*

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From: Dowell, Ashley
Sent: Wednesday, September 26, 2018 1:34 PM
To: Castleton, Ross <RCASTLET@idoc.idaho.gov>; Doan, Marissa <mdoan@idoc.idaho.gov>; Waldram, Kristina <krwaldra@idoc.idaho.gov>; Everyone ISCC <Everyone_ISCC@idoc.idaho.gov>; Trobock, Stephanie <strobock@idoc.idaho.gov>; Everyone SICI <Everyone_SICI@idoc.idaho.gov>; Everyone NICI <Everyone_NICI@idoc.idaho.gov>; Everyone PWCC <Everyone_PWCC@idoc.idaho.gov>; Everyone ICIO <Everyone_ICIO@idoc.idaho.gov>; Noble, Zachary <znoble@idoc.idaho.gov>; Kimmel, Bret <bkimmel@idoc.idaho.gov>; Everyone SAWC <Everyone_SAWC@idoc.idaho.gov>; Cochran, Jem <jemcochr@idoc.idaho.gov>; Everyone IMSI <Everyone_IMSI@idoc.idaho.gov>; Gardner-Hale, Elizabeth <ehale@idoc.idaho.gov>; Everyone SBWCC <Everyone_SBWCC@idoc.idaho.gov>; McDonald, Cindy <CMCDONAL@idoc.idaho.gov>; Everyone ISCI <Everyone_ISCI@idoc.idaho.gov>; Weed, Amanda <aweed@idoc.idaho.gov>; Fraser, John "Jack" <jfraser@idoc.idaho.gov>; Baldridge, Terressa <tbaldrid@idoc.idaho.gov>; Hess Smith, Jamie <jamismit@idoc.idaho.gov>; Oye-Johnson, Julie <jujohnso@idoc.idaho.gov>; Campbell, Walter <wcampbel@idoc.idaho.gov>; Lowe, Theo <tlowe@idoc.idaho.gov>; Yordy, Nicholas <nyordy@idoc.idaho.gov>; Beltran, Kathryn <kbeltran@idoc.idaho.gov>; Blades, Randy <rblades@idoc.idaho.gov>
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Subject: Gender Dysphoria Policy Update

Hi all,

Today you will see a training come out in Relias that is related to updates we have made to our Gender Dysphoria (GD), formerly Gender Identity Disorder (GID), Standard Operating Procedure (SOP). These updates have been in the works for some time and are needed within our system. Legal, social and medical issues surrounding the treatment of Gender Dysphoria are rapidly evolving, and these policy changes are a reflection of IDOC's commitment to ensure that the constitutional rights of all inmates are protected.

I want to reiterate that our policies require, and my expectation is, that you will treat all inmates with the same level of respect and dignity regardless of their gender identity. There are several changes in the updated policy that you'll need to familiarize yourself with. There is a distinction between someone who identifies as transgender and those who are diagnosed with gender dysphoria. Gender dysphoria is a mental health diagnosis. For those diagnosed with Gender Dysphoria (GD):

- If an inmate reports to you that they are transgender, you need to encourage them to send a Health Services Request (HSR) to mental health to be evaluated for GD
- Security staff will be required to use last names or gender neutral pronouns (they/them)
- Medical and mental health staff will be required to use the pronoun preferred by the person (he/she)
- Those with a GD diagnosis will be allowed to have the appearance (hair, makeup, etc.) of the gender of their choice regardless of the gender of the facility they are housed at
- Those with a GD diagnosis will be allowed to order off of either the male or female commissary list with no restrictions (to include undergarments)

I want to remind your that as a correctional agency we are required to provide constitutionally adequate care for medical and mental health issues. These changes will assist us with ensuring appropriate care and treatment is offered in our prisons. Inmates will continue to be housed, per the SOP, at the facility that is consistent with their biological characteristics (genitalia).

Please remember that inmates with GD are not allowed to engage in sexual or provocative behavior or have clothing that is inappropriate; the same as any other inmate in our system. Those behaviors need to be addressed and all inmates should be consistently held accountable for them. You must follow the disciplinary policy and the search policy the same as you would for the rest of the population.

Please ensure that you understand all of the changes to the policy. I'm asking that you remain professional and respectful, follow our SOP and as always seek guidance from your supervisor or shift commander if you are not sure what to do.

Thank you so much for your hard work and for helping us to successfully implement these changes in our prisons.
Ashley

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Memo

To: IDOC Inmates Diagnosed with Gender Dysphoria

From: Ashley Dowell, Chief of Prisons

Date: October 5, 2018

Re: Changes to the SOP 401.06.03.051, *Gender Dysphoria, Healthcare for Inmates with*

Effective today, we have made changes to our Gender Dysphoria (GD), formerly Gender Identity Disorder (GID), Standard Operating Procedure (SOP). There are several changes in the updated policy that you'll need to familiarize yourself with. There is a distinction between someone who identifies as transgender and those who are diagnosed with gender dysphoria. Gender dysphoria is a mental health diagnosis.

For those diagnosed with Gender Dysphoria (GD):

- Staff will be required to use last names or gender neutral pronouns (they/them)
- Medical/Mental Health staff will be required to use pronouns preferred by the person (he/she)
- Those with a GD diagnosis will be allowed to have the appearance (hair, makeup, etc.) of the gender of their choice regardless of the gender of the facility they are housed at
- Those with a GD diagnosis will be allowed to order off of either the male or female commissary list with no restrictions (to include undergarments)

This information will be placed in CIS so staff can determine who can order off of both commissary lists and what your preferred pronoun is. A mental health clinician will be meeting with you soon to discuss your preferred gender pronouns with you. Inmates will continue to be housed, per the SOP, at the facility that is consistent with their biological characteristics (genitalia).

Please remember that inmates with GD are not allowed to engage in sexual or provocative behavior or have clothing that is inappropriate; the same as any other inmate in our system. Those behaviors will be addressed and all inmates will be consistently held accountable for them. The disciplinary policy and the search policy will be followed the same as it is for the rest of the population.

From: Dowell, Ashley
Sent: Friday, October 05, 2018 12:35 PM
To: Campbell, Walter <wcampbel@idoc.idaho.gov>
Subject: GD SOP Change memo and Clinician Contact

Hi Wally,

As the updated GD SOP will post today, I need the clinicians to meet with each inmate diagnosed with Gender Dysphoria to discuss what their preferred pronoun is and give them the attached memo. Below is the language that will need to be placed in each inmate's medical considerations section in CIS (the bold will obviously need to be individualized).

Per SOP 401.06.03.051, Gender Dysphoria, Healthcare for Inmates With:
Staff are to refer to the inmate by last name or use gender neutral pronouns (they/them/their)
Inmate may order and possess items from both the male and female commissary lists
Medical/mental health staff must use **female** pronouns **(Ms./she/her)**

Thanks!
Ashley

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WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version

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7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

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Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is 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) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

III

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

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 (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is 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) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions.* These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. 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; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional

1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

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 (if younger, follow the *Standards of Care* outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fact compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[C]	variable
Increased muscle mass/strength	6-12 months	2-5 years[D]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

[A] Adapted with permission from Hembree et al.(2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[C]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society*.
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	**Venous thromboembolic disease**[A] Gallstones Elevated liver enzymes Weight gain **Hypertriglyceridemia**	**Polycythemia** Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	**Hypertension** Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes **Hyperlipidemia**
Possible increased risk with presence of additional risk factors[B]	**Type 2 diabetes**[A]	**Destabilization of certain psychiatric disorders**[C] **Cardiovascular disease** **Hypertension** **Type 2 diabetes**
No increased risk or inconclusive	**Breast cancer**	Loss of bone density **Breast cancer** **Cervical cancer** **Ovarian cancer** **Uterine cancer**

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignances that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;
2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

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 (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

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 (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

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. If 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).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

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. If 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 a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a 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, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII

Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. 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 (Brown, 2009). 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 non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). 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 *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

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APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones: Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is 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) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing**,** may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

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 (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

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 (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

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 (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

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. If 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).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

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. If 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 a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iteratations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the *SOC* and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the *SOC*.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

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Arch Sex Behav (2016) 45:1649–1663
DOI 10.1007/s10508-016-0700-z

ORIGINAL PAPER

Male Prison Inmates With Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?

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Received: 14 September 2015 / Revised: 12 January 2016 / Accepted: 18 January 2016 / Published online: 15 March 2016

Abstract Gender dysphoria (GD), a feeling of persistent discomfort with one's biologic sex or assigned gender, is estimated to be more prevalent in male prison inmates than in nonincarcerated males; there may be 3000–4000 male inmates with GD in prisons in the United States. An increasing number of U.S. prison systems now offer gender dysphoric inmates diagnostic evaluation, psychotherapy, cross-sex hormone therapy, and opportunities, albeit limited, to enact their preferred gender role. Sex reassignment surgery (SRS), however, has not been offered to inmates except in response to litigation. In the first case of its kind, the California Department of Corrections and Rehabilitation recently agreed to provide SRS to an inmate and developed policy guidelines for its future provision. In other recent cases, U.S. courts have ruled that male inmates with GD are entitled to SRS when it is medically necessary. Although these decisions may facilitate the provision of SRS to inmates in the future, many U.S. prison systems will probably remain reluctant to offer SRS unless legally compelled to do so. In this review, we address the medical necessity of SRS for male inmates with GD. We also discuss eligibility criteria and the practical considerations involved in providing SRS to inmates. We conclude by offering recommendations for physicians, mental health professionals, and prison administrators, designed to facilitate provision of SRS to inmates with GD in a manner that provides humane treatment, maximizes the likelihood of successful outcomes, minimizes risk of regret, and generates data that can help inform future decisions.

Keywords Gender dysphoria · Transsexualism · Medical necessity · Sex reassignment surgery · Standards of care

Introduction

Gender dysphoria (GD) is a psychiatric disorder in which affected persons experience severe, persistent discomfort with their biologic sex or assigned gender (American Psychiatric Association [APA], 2013). GD was previously called gender identity disorder (GID; APA, 2000).

The most extreme form of GD is transsexualism (Blanchard, 1993), which is characterized by the intense desire to live as a member of the other sex and (usually) to undergo hormonal and surgical treatment to make one's primary and secondary sex characteristics resemble those of the other sex (World Health Organization, 1992). The term transgender defines a broader category of persons who experience cross-gender identification or display significant gender-variant behaviors but who may or may not meet diagnostic criteria for GD or transsexualism (Lawrence & Zucker, 2014). Cross-sex hormone treatment and sex reassignment surgery (SRS) are widely accepted treatments for GD or transsexualism in community-dwelling patients.

In Western countries, the estimated prevalence of male-to-female (MtF) transsexualism in community-dwelling adults is about 1 in 10,000 to 1 in 12,000 (e.g., Arcelus et al., 2015; De Cuypere et al., 2007; Judge, O'Donovan, Callaghan, Gaoatswe, & O'Shea, 2014). Among male prison inmates in the United States, the prevalence appears to be significantly higher (Glezer, McNeil, & Binder, 2013). In a study conducted in the California prison system, Sexton, Jenness, and Sumner (2010) interviewed

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332 male inmates with transgender identification, out of a reported total male inmate population of 146,360; this represented a prevalence of about 1 in 440, albeit some of the inmates may not have met full diagnostic criteria for GD. More recently, Mintz (2015) reported that 385 California inmates, presumably both males and females, were receiving cross-sex hormone therapy, a strong indicator of GD. In 2013, the most recent year for which figures are available, there were 135,981 inmates, 95 % of whom were male, in state and federal prisons in California (Carson, 2014); this suggests a prevalence of cross-sex hormone therapy in California inmates of about 1 in 350. The first author, who has served as a consultant to the prison system of a large midwestern state, calculated a prevalence of transgender identification of about 1 in 500 in male inmates, based solely on the transgender inmates she had personally evaluated. Given that over 1.4 million male inmates were confined in U.S. state and federal prisons in 2013 (Carson, 2014), there could easily be 3000–4000 males with GD in U.S. prisons.

Following diagnostic evaluation, the recommended elements of treatment for GD include psychotherapy, cross-sex hormone therapy, adopting the desired gender role in everyday life, and SRS to make the individual's primary and secondary sex characteristics resemble those of the desired sex (Byne et al., 2012; Coleman et al., 2011). For males, SRS typically consists of orchiectomy, penectomy, and vaginoplasty. Not all persons with GD seek all of these treatments, but some persons with GD may need them all, including SRS, if their GD is to be effectively treated (Coleman et al., 2011).

Prison systems in the United States increasingly recognize the diagnosis of GD, provide psychological evaluation for it, and offer psychotherapy to inmates who have been diagnosed with GD. Many now offer feminizing hormone therapy to male inmates with GD, and some allow them to wear women's clothing and hairstyles and use women's cosmetics (Brown, 2014; Brown & McDuffie, 2009; Glezer et al., 2013; Sumner & Jenness, 2014). But providing SRS for male inmates with GD has been more controversial. We are aware of only one instance in which a U.S. prison system has agreed to provide SRS for an inmate (see *Quine v. Beard*, 2015). Nevertheless, the California Department of Corrections and Rehabilitation (CDCR) subsequently issued formal *Guidelines for Review of Requests for Sex Reassignment Surgery* (California Correctional Health Care Services [CCHCS], 2015), suggesting that it is prepared to provide SRS to some inmates with GD. Further, despite public and political objections to using taxpayer dollars to fund SRS for inmates, U.S. courts are now consistently ruling that prison polices that de facto prohibit SRS are unconstitutional. Accordingly, prison authorities have been forced to consider whether provision of SRS is medically necessary for some inmates with GD, which inmates should be eligible for it, and what the probable outcomes of providing SRS would be, including implications for prison assignment and security.

These questions and the conflicting opinions they evoke were recently brought into focus by four legal decisions. Two were in the case of *Kosilek v. Spencer* (2014a, 2014b). In January 2014, a three-judge panel of the U.S. Court of Appeals for the First Circuit ruled 2–1 (*Kosilek v. Spencer*, 2014a) that the Massachusetts Department of Correction (MDOC) was obliged to provide SRS for inmate Michelle (formerly Robert) Kosilek, a biologic male with a long history of GD who was serving a life sentence without possibility of parole for the strangulation murder of his wife. In December 2014, the entire Court of Appeals for the First Circuit ruled 3–2 (*Kosilek v. Spencer*, 2014b) to reverse that decision, effectively denying SRS to Kosilek. The U.S. Supreme Court subsequently declined to hear an appeal. A third decision was in the case of *Norsworthy v. Beard* (2015): In April 2015, the U.S. District Court for the Northern District of California ruled that the CDCR was obliged to provide SRS for inmate Michelle (formerly Jeffrey) Norsworthy, another biologic male with a long, well-documented history of GD who had been serving a sentence of 17 years-to-life for murder since 1987. This decision was rendered moot in August 2015 when Norsworthy was paroled ("Transgender California inmate," 2015). Also in August 2015, in a settlement agreement (*Quine v. Beard*, 2015), the CDCR agreed to provide SRS to inmate Shiloh (formerly Rodney James) Quine, a biologic male who is serving a life sentence for murder, kidnapping, and robbery (St. John, 2015), and to transfer Quine to a women's prison after SRS. If this agreement is carried out, it will represent the first instance we know of in which a U.S. prison system has actually provided SRS to an inmate.

In this article, we address the medical necessity of offering SRS to male inmates with GD within U.S. prisons, eligibility criteria for SRS, and related practical considerations. Our analysis reflects our experience in evaluating and treating community patients with GD, a review of the relevant literature, and the experience of the first author in evaluating more than 65 incarcerated or civilly committed males with known or suspected GD in three U.S. states.

Standards of Care

To meaningfully discuss the question of SRS for inmates, it is essential to examine the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (SOC; Coleman et al., 2011), the most recent guidelines promulgated by the World Professional Association for Transgender Health (WPATH), and how these guidelines apply to correctional populations. The SOC have been widely adopted by physicians and mental health professionals who treat community-dwelling persons with GD, and they have been regarded as authoritative by U.S. courts in cases involving prisoners with GD (e.g., *Kosilek v. Spencer*, 2012, 2014a, 2014b; *Norsworthy v. Beard*, 2015). But the SOC are not without controversy. Although they were formulated by experienced clinicians and scholars, most SOC recommendations are based on low-quality

evidence, such as case series and expert opinion (Byne et al., 2012; De Cuypere & Vercruysse, 2009). The SOC also do not represent the experiences and practices of all GD experts, and some provisions of the SOC seem to reflect political considerations rather than scientific evidence or clinical experience (Zucker, Lawrence, & Kreukels, 2016; see also Levine & Solomon, 2009).

Moreover, the SOC were not developed based on extensive clinical experience with incarcerated persons, many of whom have histories, characteristics, and vulnerabilities that differ substantially from community-dwelling persons with GD. The earliest version of the SOC was published in 1979 by WPATH's predecessor, the Harry Benjamin International Gender Dysphoria Association (HBIGDA; Walker et al., 1990); subsequent versions were published in 1980, 1981, 1990, 1998, 2001, and 2011 (Coleman et al., 2011; HBIGDA, 1998, 2001; Walker et al., 1990). But the SOC only began to explicitly address the treatment of prisoners in the 1998 version, nearly 20 years after the original publication, and this was only to recommend that persons who had been treated with cross-sex hormones before incarceration continue to receive them in prison. In the 2001 version, this recommendation was expanded to include other treatments begun before incarceration (e.g., psychotherapy); housing considerations for prisoners were also briefly addressed.

The situation changed dramatically in the 2011 version of the SOC, which explicitly asserted that all provisions of the SOC were applicable to all persons in prisons and other institutions:

> The SOC in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation…All elements of assessment and treatment as described in the SOC can be provided to people living in institutions…Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the SOC, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria…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 SOC. (Coleman et al., 2011, pp. 206–207)

We have no disagreement with the aspirations set forth in this statement: We accept the ethical principle that living in prison or another institution does not, in and of itself, justify withholding medically necessary treatments that are available to community-dwelling persons. We also concur that, despite the complexities involved, prisons must make reasonable efforts to provide medically necessary treatments, including SRS, to inmates, and we would further emphasize that U.S. courts have consistently so ruled. Nevertheless, the unqualified statement that "all elements of assessment and treatment as described in the SOC can be provided to people living in institutions" (Coleman et al., 2011, p. 206) does not reflect extensive clinical experience. Indeed, it is fair to say that this assertion, while admirable in principle, remains to be demonstrated in practice in correctional environments. Its confident simplicity may not adequately take account of the clinical and contextual complexities that inmates with GD present.

Many inmates who seek treatment for GD in prison never sought treatment in the community. Many have lived troubled, chaotic lives characterized by early family and economic instability, substance abuse and other psychiatric problems, failed school and employment experiences, and early involvement in crime. Inmates who seek treatment for GD typically display little resemblance to the patients who present for treatment in the community, and prison life bears little resemblance to life in the community. The SOC were not developed with the complexities, vulnerabilities, and life circumstances of incarcerated persons in mind.

Is Sex Reassignment Surgery Medically Necessary for Some Inmates With Gender Dysphoria?

The medical necessity of SRS is a fundamental issue, because U.S. courts have consistently ruled that failure to provide inmates with necessary medical treatment, deliberate indifference to their medical needs, and disregard for the suffering resulting from unmet medical needs constitute violations of the Eighth Amendment's prohibition of cruel and unusual punishment (Glezer et al., 2013). We concur with the SOC's contention that SRS can be medically necessary for some, though not all, persons with GD, including some prison inmates.

In explicating our position, we emphasize four points. First, a determination of medical necessity reflects the exercise of professional judgment, but professionals sometimes disagree about the medical necessity of certain treatments—particularly SRS as a treatment for GD. Second, SRS is a safe, effective, and widely accepted treatment for GD; disputing the medical necessity of SRS based on assertions to the contrary is unsupportable. Third, SRS can be judged medically necessary for some persons with GD, especially males, when their GD reflects intense distress about the incongruence between their external genitalia and their gender identity; this incongruence can only be corrected through genital surgery. Finally, other grounds for asserting the medical necessity of SRS, such as treating suicidality or depression, are more problematic.

Determining Medical Necessity

In the United States, the term "medical necessity" is most commonly encountered in the context of the obligations of third-party payers (e.g., private health insurance companies, Medicare, and Medicaid) to cover the costs of medical treatment. The definition of medical necessity has effectively become standardized in the United States in recent years; here is one common definition:

> "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are
>
> (a) in accordance with generally accepted standards of medical practice;
> (b) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
> (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.
>
> For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment. (Kaminski, 2007, p. 3)

Thus, a recommended treatment is considered medically necessary if a qualified professional, exercising prudent clinical judgment, determines that it is necessary. But professionals sometimes disagree about the medical necessity of certain treatments, and this has been particularly true of SRS as a treatment for GD. Disagreements about the medical necessity of SRS have historically involved most of the fundamental issues mentioned previously: Whether a recommendation of SRS is consistent with the exercise of prudent clinical judgment; whether such a recommendation is consistent with accepted standards of practice; whether SRS constitutes an effective treatment for GD, or at least some types of GD; and whether alternatives to SRS would be as likely to produce equivalent therapeutic results. Accumulated evidence has demonstrated that for all but the last of these issues, objections to the medical necessity of SRS are difficult to sustain, and arguments based on them have increasingly been rejected in U.S. court cases. At present, most challenges to the medical necessity of SRS seem to rely on opinions by some professionals that alternatives to SRS can provide equally effective, or at least adequately effective, treatment for GD.

Safety, Efficacy, and Acceptance of Sex Reassignment Surgery

Efforts to contest the medical necessity of SRS on the grounds that it is unsafe, ineffective, or inconsistent with accepted standards of practice are unsupportable. SRS has been an accepted treatment for GD in every version of the SOC from their initial publication in 1979 (Coleman et al., 2011; HBIGDA, 1998, 2001; Walker et al., 1990). SRS, in conjunction with cross-sex hormone therapy, has repeatedly been demonstrated to be associated with substantial reduction in GD symptoms, high levels of patient satisfaction, few significant complications, and minimal instances of regret (Dhejne, Öberg, Arver, & Landén, 2014; Gijs & Brewaeys, 2007; Heylens, Verroken, De Cock, T'Sjoen, & De Cuypere, 2014; Kuiper & Cohen-Kettenis, 1988; Lawrence, 2003; Mate-Kole, Freschi, & Robin, 1990; Monstrey, Vercruysse, & De Cuypere, 2009; Murad et al., 2010; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005).

The Departmental Appeals Board of the United States Department of Health and Human Services (DHHS) reached these same conclusions when it determined that transsexual surgery was eligible for coverage under the Medicare program (DHHS Departmental Appeals Board, 2014), reversing the conclusions of a 1981 report that had questioned the safety and efficacy of SRS. Based on expert medical testimony and a review of the published literature, the Appeals Board stated that "We have no difficulty concluding that the new evidence, which includes medical studies published in the more than 32 years since issuance of the 1981 report… demonstrates that transsexual surgery is safe and effective and not experimental" (DHHS Departmental Appeals Board, 2014, p. 8).

We would caution, however, that these favorable conclusions are derived from experience with community-dwelling patients. Although it is reasonable to assume that they would also apply to prison inmates, empirical evidence to support this assumption is lacking. SRS remains untested in incarcerated persons, who often differ in significant ways from community patients.

Sex Reassignment Surgery for Dysphoria Related to Genital Anatomy

GD typically reflects intense distress about both one's anatomic sex characteristics and assigned gender role, but sometimes distress about anatomic sex is particularly intense. This is recognized in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; APA, 2013), which states that the diagnostic criteria for GD can be fulfilled solely on the basis of distress related to "a strong desire to be rid of one's primary and/or secondary sex characteristics" and "a strong desire for the primary and/or secondary sex characteristics of the other gender" (p. 452). The four previous editions of the DSM also emphasized the importance of distress related to anatomic sex characteristics, especially the external genitalia, in the earlier diagnoses of GID (APA, 1994, 2000) and transsexualism (APA, 1980, 1987). For clarity, we refer to GD that reflects intense distress about one's genital anatomy as *genital anatomic GD*. Genital anatomic GD, like other GD symptoms, can vary in intensity over time and can sometimes remit, temporarily or permanently. But when genital

anatomic GD has been unremitting and intense over a long time period, treatment becomes necessary.

The phenomenon of severe, persistent genital anatomic GD thus explains why SRS can sometimes be medically necessary for gender dysphoric males. Only SRS can eliminate what many of these individuals find particularly distressing: their male external genitalia, which act as powerful and incontrovertible indicators of maleness. SRS constitutes a specific and singularly effective treatment for unremitting genital anatomic GD, one that offers what no alternative treatment can provide. For males in whom this type of GD is intense and persistent, including some inmates, SRS can sometimes be medically necessary, and no alternative treatments are likely to be equally or adequately effective.

Much of the resistance to offering SRS to inmates with genital anatomic GD appears to reflect doubts about the legitimacy of the GD diagnosis itself or whether the distress that these inmates report is genuine. Such skepticism is not surprising: The phenomenon of genital anatomic GD is so inconsistent with ordinary experience that it is almost impossible to adequately comprehend. Consequently, there is a tendency to minimize the distress that inmates with genital anatomic GD report or to attribute their complaints to hysteria, psychosis, malingering, or exaggeration, especially given that these phenomena are prevalent in correctional environments. It is particularly hard to comprehend reports of genital anatomic GD by males whose appearance and behavior are not recognizably feminine, because their feelings of "wrong embodiment" (Prosser, 1998) appear so inconsistent with their physical and behavioral presentations. Such inconsistency does not, however, make their distress any less real. Only the repeated experience of hearing persons with genital anatomic GD describe their anguish is likely to help others understand the psychological reality of this condition and the medical necessity of SRS as a treatment for it.

Medical Necessity of Sex Reassignment Surgery to Treat Associated Psychiatric Conditions

SRS is demonstrably effective in treating GD, especially genital anatomic GD, in community populations (Heylens, Verroken, et al., 2014) and plausibly also in prison populations. But health professionals and attorneys commonly argue that the reason SRS is medically necessary for inmates is to prevent or treat other psychiatric conditions, such as depression or suicidality, which are assumed to be consequences of GD. Such arguments make intuitive sense, but they are problematic for several reasons.

Unfortunately, SRS is not very effective in treating associated psychiatric conditions. Community-dwelling persons with GD display an elevated prevalence of comorbid mental health problems, including mood disorders, anxiety disorders, and suicidality (Guzmán-Parra et al., 2015; Heylens, Elaut, et al., 2014), and these comorbid conditions do not significantly improve after SRS (Dhejne et al., 2011; see also Asscheman et al., 2011). Comorbid psychiatric conditions usually do improve, at least initially, after cross-sex hormone therapy. But while subsequent SRS usually ameliorates GD and increases overall life satisfaction, it appears to confer little or no additional improvement in other psychiatric symptoms (Heylens, Verroken, et al., 2014; see also Gómez-Gil et al., 2012; Udeze, Abdelmawla, Khoosal, & Terry, 2008).

The tendency to couch arguments for the medical necessity of SRS in terms of treating depression and suicidality is understandable: These conditions are familiar, and there is little disagreement that they deserve to be treated. In contrast, GD, especially genital anatomic GD, is unfamiliar, the distress it causes is often assumed to be feigned or exaggerated, and many citizens and lawmakers believe that inmates with GD simply do not deserve SRS (Leonard, 2014). But the argument that SRS is medically necessary primarily to treat or prevent depression or suicidality is not supported by empirical evidence, and it is also problematic for other reasons.

Such an argument invites the counterargument that inmates' complaints of depression or suicidal threats or gestures can simply be manipulative and that prison authorities cannot acquiesce to them without inviting further manipulation. For example, the decision in *Kosilek v. Spencer* (2014a) contains this summary of the MDOC's position: "providing Kosilek with [sex reassignment] surgery in response to her threats of suicide would be contrary to well-established correctional practices. Inmates should not be permitted to manipulate the system utilizing a 'do it or else' theory" (p. 48; some internal quotation marks omitted). Moreover, arguing that SRS is medically necessary to prevent suicide could establish an unhelpful precedent, with suicidal threats or gestures becoming de facto prerequisites for SRS. We were encouraged to note that both expert consultants in *Quine v. Beard* (2015) considered relief of GD to be the primary basis for recommending SRS for Quine, with reduced risk of suicidality a secondary consideration.

Eligibility Requirements for Sex Reassignment Surgery

According to the SOC, persons for whom SRS has been determined to be medically necessary must still satisfy certain eligibility requirements before SRS can be performed. These can be either the usual or "standard" eligibility requirements or requirements that have been modified pursuant the provisions of the SOC that permit flexibility when indicated. The six standard eligibility requirements for SRS 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) If 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 hormones are not clinically indicated for the individual);
(6) 12 continuous months of living in a gender role that is congruent with the patient's identity. (Coleman et al., 2011, p. 202)

For most male inmates, fulfillment of all of these standard eligibility requirements should be a precondition for SRS. We believe that many inmates can satisfy all of these requirements without undue difficulty, although their ability to fulfill the requirement of living for 12 months in a gender role congruent with their gender identity remains contentious. For a few inmates, we believe that the 12-month living requirement could legitimately be relaxed or waived. For all inmates, however, we believe it would be prudent to initially impose some additional eligibility requirements, given the current lack of experience in providing SRS to prisoners.

Of the six standard eligibility requirements, two—age of majority and 12 months of continuous cross-sex hormone therapy, the latter with some exceptions permitted—are neither complicated nor controversial. Hormone therapy is recognized to be an effective treatment for GD and one that typically would already have been provided to inmates who were being considered for SRS. The other standard eligibility requirements involve more complicated considerations as they relate to prison populations.

Persistent, Well-Documented Gender Dysphoria

Evaluating the genuineness, severity, and persistence of GD in inmates can be challenging, especially in persons who have significant comorbid mental health problems. Moreover, the phenomena to which inmates' complaints of GD are often attributed—psychosis, hysteria, malingering, and manipulative exaggeration—plausibly do account for some of these complaints. Deciding the genuineness, severity, and persistence of GD is ultimately an individual professional judgment, one that should be rendered by practitioners who are experienced in assessing both GD and comorbid psychopathology in correctional populations.

The importance of conducting a thorough evaluation of GD symptoms and comorbid conditions in inmates seeking SRS cannot be overstated. But assessment is not a quick or simple process in either community or correctional settings. In the community, mental health professionals who make primary recommendations for SRS typically see their patients on multiple occasions over several months or years in a process that often involves dozens of hours of face-to-face contact (Lawrence, 2003). In inmates seeking SRS, evaluation of GD symptoms and comorbid conditions is ordinarily conducted by outside consultants, because prison-based mental health providers rarely have the necessary expertise and experience. In the first author's experience, evaluations for SRS in correctional settings tend to be comparatively brief. Consultants often base their conclusions primarily on self-reported symptoms of GD elicited in a single interview and seldom engage in longitudinal assessment, even though inmates typically present greater diagnostic complexity than their community counterparts.

When conducting an initial evaluation for either hormone therapy or SRS, the first author spends an average of 6 hr face-to-face with an inmate, often with follow-up telephone interviews if additional information is required. If there are inadequate grounds for making a confident diagnosis of GD, she will defer diagnosis and recommend a year or more of psychotherapeutic treatment, followed by re-evaluation if the inmate's symptoms and requests for treatment persist. The evaluation process also includes a review of records, sometimes involving thousands of pages of clinical, institutional, and legal files. The author commonly recommends formal psychological testing, and she consults extensively with clinical providers and prison staff who are familiar with the inmate's day-to-day functioning. Whenever possible, she also consults with family members and other external informants to verify the inmate's self-reported history.

Although thoroughly documenting the severity and persistence of GD in inmates is a time-consuming and often difficult process, some features of inmates' medical and psychiatric histories can contribute to greater diagnostic confidence. Foremost among these would be documented evidence (not just self-report) of GD symptoms prior to entering prison, especially if there is also evidence of previous medically supervised hormone therapy; such evidence, however, is rarely available. Other features that can contribute to diagnostic confidence include a documented history of intense and unremitting GD symptoms in prison, an absence of significant comorbid psychopathology that could complicate differential diagnosis (e.g., schizophrenia or bipolar disorder), and evidence of a positive response to cross-sex hormone therapy and whatever elements of identity-congruent living (e.g., clothing, makeup, hairstyle) have been permitted.

Capacity to Give Informed Consent

Providing meaningful informed consent can be difficult for an incarcerated person. Inmates have limited access to current information and lack opportunities to learn about SRS from persons who have undergone it themselves. A few learn about GD, transsexualism, and SRS for the first time in prison; some are highly impressionable and are easily influenced by other inmates. Many have a simplistic or inaccurate understanding of the typical results of SRS, are unaware of potential com-

plications, and do not understand what will be required of them in terms of postoperative care and medical follow-up. Due to intellectual limitations, emotional immaturity, or severe personality disorders, some inmates have unrealistic expectations concerning life in a female gender role, either in prison or following release.

Providing informed consent for SRS does not require that candidates anticipate and consider every possible consequence of the sex reassignment process. For male inmates, however, one foreseeable consequence that deserves careful consideration is the likelihood of being assigned to a women's prison following SRS. Most inmates with GD would probably welcome this, but some might not, and a few might even decide to forgo SRS if this were a predictable consequence. A change in prison assignment after SRS could also adversely affect relationships with family members and friends. Assignment to a women's prison provides unequivocal evidence of having undergone sex reassignment. If family members and friends had not previously been aware of an inmate's desire for sex reassignment—and inmates sometimes attempt to conceal this—then assignment to a women's prison would make the inmate's circumstances obvious. While many inmates who have been incarcerated for years have lost all connections to family and community, some still have fragile threads of connection to a parent, a sibling, or a child. Disclosure could strain these tenuous but significant connections to the outside world, making inmates more vulnerable to feelings of isolation and hopelessness. The first author has observed that many inmates with GD can effectively face the challenge of disclosure to family members and friends and sometimes discover unexpected understanding and support for their desire to live as women. In other cases, however, they experience rejection. This variability in response is not unlike what nonincarcerated persons with GD encounter, but the risk of irreparable isolation is greater for inmates. On a purely practical level, transfer to a women's prison could also make visitation more challenging: Because there are comparatively few women's prisons, most inmates would probably be reassigned to a location more distant from their community of origin after SRS.

Satisfactory Control of Comorbid Mental Health Problems

Eligibility for SRS is conditional on satisfactory control of comorbid mental health conditions for three principal reasons: to guarantee that candidates have met the minimal prerequisites for providing meaningful informed consent (i.e., that their reality testing is unimpaired), to establish that they have the capacity to cooperate in preoperative and postoperative care, and to ensure that they possess sufficient mental and emotional stability to cope with the changed life circumstances they will face after SRS, which will usually include transfer to the unfamiliar environment of a women's prison. All of these rationales are explicitly set forth or strongly implied by language in the SOC (Coleman et al., 2011, pp. 202–203, 205). Fulfillment of this standard eligibility requirement implies satisfactory management of psychoses, significant mood and anxiety disorders, dissociative disorders, and severe personality disorders.

Antisocial personality disorder (ASPD) and its most extreme manifestation, psychopathy (Hare & Neumann, 2008), deserve specific consideration. These conditions are prevalent among inmates and constitute enduring aspects of personality that are difficult or impossible to modify and challenging to manage. Some clinicians would argue that these conditions are so resistant to treatment that they can never be considered "well controlled." It is also important to consider whether symptoms that appear to be adequately controlled in the structured environment of prison will remain so when inmates are released into the community, where sustained functional stability depends on internalized skills rather than external control. Inmates with psychopathy often engage in repeated patterns of aggression and conflict with staff and peers; they are difficult to manage and are frequently placed in disciplinary segregation for rule violations. They are commonly defiant, provocative, and litigious. Accordingly, we consider severe psychopathy a contraindication to SRS.

However, some inmates with ASPD and relatively mild psychopathy arguably can give valid informed consent and cooperate in their own care when it is in their interest to do so. A sustained history of compliance with recommended psychiatric and psychological treatment, cooperation with clinicians and prison officials, and a satisfactory disciplinary record should serve as reasonable indicators that their comorbid personality disorder does not dominate their affective, behavioral, or interpersonal functioning or impair their ability to cooperate in their own care.

As noted previously, inmates with GD not uncommonly experience depressive symptoms or suicidal ideation when treatment for GD is unavailable or when expression of their gender identity is constrained. Deciding whether these symptoms imply that comorbid mental health problems are not satisfactorily controlled is always an individual professional judgment. Eligibility for SRS does not require that comorbid mental health symptoms be completely absent, only that they do not interfere with the ability to provide informed consent, to cooperate in preoperative and postoperative care, and to face with some likelihood of success the changed life circumstances that will result from SRS. Some persons with GD who think about suicide or who are despondent about their inability to obtain treatment or express their gender identity can do all of these things.

Twelve Months of Living in a Gender Role Congruent With One's Gender Identity

This is the most misunderstood and contentious of the standard eligibility requirements for SRS. Requirements of this type were first adopted over 40 years ago at the Stanford University Gender

Reorientation Program. The Stanford clinicians recognized that providing SRS was controversial, and they "were avowedly seeking candidates who would have the best chances for success so that the overall program could or would be continued" (Fisk, 1974, p. 7). They might have preferred to offer SRS only to persons who could be diagnosed as "true transsexuals"—a diagnostic category no longer considered meaningful—but this proved impossible, because candidates for SRS often misrepresented or distorted their histories, confounding accurate diagnosis. Consequently, the Stanford clinicians chose to deemphasize diagnosis per se as an eligibility criterion and instead focused on whether prospective candidates could successfully live full-time in the gender role of the other sex for an extended period—typically 1 to 3 years. Laub and Fisk (1974) argued that:

> Indeed, for prognosis, it is probable that the diagnostic category is of much less importance than the patient's preoperative performance in a one- to 3[sic]-year therapeutic trial of living in the gender role of his choice—with demonstrable economic, social, psychological, and sexual success during that period. (pp. 401–402)

Five years later, in 1979, successfully living full-time "in the social role of the genetically other sex" (Walker et al., 1990, p. 5) for 12 months became a standard eligibility requirement for SRS in the first version of the SOC. A similar requirement has been included in all subsequent versions, including the present one. Although formal descriptions of this requirement have become increasingly ambiguous over the years, language explaining the rationale and suggested parameters of this requirement actually became more detailed in the most recent version of the SOC, implying that the requirement is not considered a mere formality.

The fifth version of the SOC (HBIGDA, 1998) introduced the term *real-life experience* to describe this 12-month period of living in the desired gender role; the term also appeared in the sixth version (HBIGDA, 2001), but not in the seventh and most recent version (Coleman et al., 2011). Nevertheless, the term continues to be widely used. The current version of the SOC merely states that candidates for SRS are required to live for 12 months "in a gender role that is congruent with the patient's identity" (p. 202). This formulation "would seem to be almost entirely open to individual interpretation" (Lawrence, 2014, p. 702) but is usually interpreted to mean living in a gender role typical of the other biologic sex.

We contend that some male inmates with GD can and do live in a gender role typical of the other biologic sex within men's prisons and therefore can technically fulfill this standard eligibility requirement. Inmates with GD often display remarkable tenacity and resourcefulness in their attempts to live in something resembling female-typical gender roles in men's prisons. They adopt female-typical names, vocal mannerisms, and ways of moving; they wear female-typical garments when these are obtainable and improvise them when they are not; they modify their bodies by shaping their eyebrows and shaving their faces and bodies; and they avail themselves of permanent epilation and feminizing hormone therapy when these treatments are made available. Moreover, inmates with GD often band together in informal groups for social and emotional support, thereby receiving validation of their cross-gender identities. Within the relative safety of these groups, they can practice behaving in a more overtly feminine manner, thereby enacting the gender role that is congruent with their gender identity. Their efforts to live in something resembling a female-typical gender role often equal or exceed those of males with GD who are not in prison.

However, we question whether this standard eligibility requirement has much practical or prognostic relevance for inmates. Whether or not one believes that fulfilling this requirement contributes to greater postoperative satisfaction or avoidance of regret in community-dwelling patients—and the evidence is slim to nonexistent (Bockting, 2008; Levine, 2009)—it at least provides community patients an opportunity to experience what their lives after SRS might be like before undergoing irreversible surgery. This would not be the case for inmates with GD who attempt to live in female-typical gender roles within men's prisons. If they were to undergo SRS, they would almost certainly be assigned thereafter to women's prisons, where their lives would immediately become dramatically different. Living in a female-typical role in a men's prison could not effectively prepare them for this. There is no way for inmates to know, first hand and in advance, what life in a women's prison would be like. Inmates who would eventually be released from prison similarly would have no way of knowing what life as a woman outside of a correctional environment would be like. Recognizing these facts, some prison officials have argued that inmates with GD cannot have a meaningful experience in a gender role typical of the other sex in men's prisons and therefore cannot fulfill this standard eligibility requirement (e.g., *Kosilek v. Spencer*, 2014a, pp. 31–32; *Kosilek v. Spencer*, 2014b, pp. 24–25, 27; *Norsworthy v. Beard*, 2015, p. 15). Other commentators (e.g., Alexander & Meshelemiah, 2010) have expressed similar opinions. In our view, their position reflects a misinterpretation of this standard eligibility requirement of the SOC; but the concerns they raise nevertheless deserve to be taken seriously.

Because inmates who undergo SRS will almost always be assigned to a women's prison thereafter, the immediate social consequences of SRS will be far greater for inmates than for their community counterparts. The first author has observed that most candidates she has evaluated for SRS appear to have realistic expectations concerning postoperative life in a women's prison, albeit acknowledging some anxiety and recognizing that they will face interpersonal challenges. But if an inmate were to regret assignment to a women's prison after SRS, returning to life in a men's prison would probably be difficult or impossible; the risk of psychological deterioration in such circumstances makes it essential to proceed cautiously.

The future availability of SRS for other inmates could be imperiled if early recipients were to experience regret or psy-

chological decompensation; therefore, it is crucial to avoid catastrophic outcomes, particularly early on. Accordingly, we believe it would be advisable for prison officials to initially impose additional eligibility requirements for SRS, at least until some clinical experience and outcome data have been acquired.

Standard Eligibility Requirements for Sex Reassignment Surgery Can Be Modified

The SOC explicitly allow the standard eligibility requirements for SRS to be modified when indicated:

> The criteria put forth in this document for…surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. (Coleman et al., 2011, p. 166)

This means that additional or more stringent eligibility requirements for SRS can be imposed in certain circumstances. Some community clinics impose more stringent requirements, such as a longer period of cross-living or hormonal treatment or required participation in individual or group psychotherapy. More stringent eligibility requirements would also be allowable in correctional settings. Because clinical experience with SRS in correctional settings is currently nonexistent, we believe that initially imposing additional eligibility requirements would be advisable. These should include:

(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 the responsible practitioner; and
(5) willingness to be assigned to a women's prison after SRS.

Most of these additional requirements have parallels in the criteria for recommending SRS set forth explicitly or implicitly in the CCHCS guidelines:

> No available, additional treatments other than SRS…are likely to alleviate the distress…At least two (2) years remaining before his/her anticipated parole or release date …Expected to successfully…adjust medically and psychologically to confinement postoperatively with inmates of his/her postoperative gender…The patient is cooperative and adherent with prescribed therapies and follows provider's orders. (CCHCS, 2015, pp. 3, 7)

There are two principal reasons that we recommend initially offering SRS only to inmates for whom a long period of incarceration is expected. First, although SRS is an effective treatment for GD, it is associated with a greatly increased postoperative risk of completed suicide and comorbid psychiatric conditions requiring hospitalization (Dhejne et al., 2011). Inmates who remain in prison for a long period after undergoing SRS would have guaranteed access to psychiatric services to address these potential problems, something that might not be true after release. Second, as we will discuss later, for inmates who undergo SRS and are subsequently released, there is a risk of remission of their feminine gender identification, possibly accompanied by regret about having undergone SRS. A lengthy period of time in which to consolidate one's new gender identity and gender role in prison could plausibly mitigate these risks.

Although a satisfactory disciplinary record was not explicitly included in the CCHCS guidelines as a decision criterion, we consider this to be an important indicator of willingness to cooperate with treatment. Consequently, we believe it should be an additional eligibility requirement for SRS, at least initially. We would emphasize, however, that imposing these or other additional eligibility requirements for SRS cannot merely be a pretext for making SRS de facto unavailable to inmates.

The standard eligibility requirements for SRS can also be relaxed or waived. Consider, for example, an inmate with prominent genital anatomic GD, incarcerated for a long term or for life, who had some experience living in a female-typical gender role prior to entering prison, whose response to hormonal treatment has been positive, but who has had limited opportunities to engage in female-typical gender role behavior while in prison. This is precisely the kind of unique situation that could justify relaxing or waiving the standard requirement of living for 12 months in a gender role congruent with one's gender identity. The first author has observed that some inmates clearly meet all the standard eligibility requirements for SRS other than having unambiguously fulfilled the 12-month cross-living requirement. In such circumstances, for appropriately selected inmates, the potential benefit of a flexible approach to this requirement—relief of genital anatomic GD—would almost certainly outweigh any possible risk of regret.

Consequences of Offering Sex Reassignment Surgery to Inmates

Although it is legally and ethically obligatory to make SRS available to inmates for whom it is medically necessary, it is also important to anticipate and address the practical consequences of doing so. These include the need to develop policies for prison assignment after SRS, anticipate possible safety and security concerns, and consider post-release issues. Some of these matters loom large in the minds of prison officials, but we contend that

none of them constitute insurmountable barriers to offering SRS to carefully selected inmates.

Prison Assignment After Sex Reassignment Surgery

Routine assignment to a women's prison after SRS would be the simplest, most rational, and most therapeutically beneficial policy. Not surprisingly, it is the policy that the CDCR guidelines implicitly adopted, stating that one criterion for recommending SRS would be whether "the patient can be expected to successfully and safely transfer and adjust medically and psychologically to confinement postoperatively with inmates of his/her postoperative gender" (CCHCS, 2015, p. 3). Routine reassignment to a women's prison would maintain consistency with current policies in nearly all U.S. correctional systems, in which assignment is based on external genital anatomy (Sumner & Jenness, 2014). It would also be consistent with how the few MtF transsexuals who have undergone SRS before entering prison have been assigned (e.g., "Prison near Purdy," 2003). From a therapeutic perspective, assigning inmates to a women's prison after SRS could be expected to ameliorate GD symptoms associated with inmates' limited ability to live and be treated as women while residing in male-only facilities.

Paradoxically, a policy of routine assignment to a women's prison after SRS might deter some inmates from seeking SRS. In the California prison system, 82 % of male transgender inmates report that they are exclusively sexually attracted to men (Jenness, 2010), and these inmates often derive significant satisfaction from the social, romantic, and sexual attentions of masculine male inmates. In summarizing interviews with several hundred male transgender inmates in the California prison system, some of whom might not meet full diagnostic criteria for GD, Jenness and Fenstermaker (2014) observed:

> Throughout the interviews, transgender prisoners expressed appreciation for caring interactions with real men that served to recognize them as women. These simple, but much desired, interactions include being walked across the yard, given cuts in the chow line, and having an umbrella held over your head in the rain. (pp. 24–25)

Knowing that they would forfeit these rewarding interactions with men if they were reassigned to a women's prison might cause some inmates to forgo SRS. Moreover, a few male transgender inmates appear to dislike the company of women and would prefer not to be housed with them:

> When a transgender prisoner…was asked whether she would prefer to be housed in a men's prison or a women's prison, she immediately replied, "Men's." She added, "That's a hard one. I don't want to be with women because they are vicious. They are worse than men. Their hormones are going all the time. Imagine being around 60 women and two are on their period at the same time! God. Imagine how bad that would be?". (Jenness & Fenstermaker, 2014, pp. 16–17)

Inmates might be forced to choose between SRS, with its potential to reduce their genital anatomic GD, and the opportunity to enact a feminine gender role in relation to men, with its potential to ameliorate the social or interpersonal components of their GD. Notwithstanding these considerations, the first author has observed that all seven inmates she has evaluated for SRS over the past 18 months, whether sexually attracted to men or to women, have indicated that they would welcome the opportunity to live among women, and in many cases to be free of the sexual tension they experience in relation to male inmates.

Some male prisoners for whom SRS is medically necessary have a history of violent behavior toward women. Kosilek, the plaintiff who sued the MDOC to obtain SRS, had been convicted of murdering a woman (*Kosilek v. Spencer*, 2014a). Norsworthy, the plaintiff who sued the CDCR to obtain SRS, had a history of domestic violence against women (*Norsworthy v. Beard*, 2015). Prison officials have sometimes interpreted such histories as effectively precluding assignment to a women's prison after SRS. In the Norsworthy case, CDCR official Kelly Harrington opined that:

> Norsworthy would be "at significant risk of being assaulted or victimized by female offenders" in a women's facility because of her history of domestic violence against her girlfriend before her arrest…Harrington is also concerned that "Norsworthy might herself victimize female inmates." (*Norsworthy v. Beard*, 2015, p. 17)

However, in what is perhaps the only known case in which a MtF transsexual who had undergone SRS was sent to a women's prison after committing a violent crime against a female victim, the offender—"Jo" Shandley, convicted of murdering her sister—was housed uneventfully in the Washington Correctional Center for Women ("Prison near Purdy," 2003; see also *Kosilek v. Spencer*, 2012, p. 108; *Kosilek v. Spencer*, 2014a, p. 49).

Moreover, natal women who have been convicted of violent crimes against other women, including victims they knew personally, are assigned to women's prisons as a matter of course. The most recent information from the U.S. Department of Justice (Greenfield & Snell, 1999) revealed that over three-quarters of violent crimes committed by female offenders involved female-on-female violence and that in about 8 % of these cases the victims were intimates or relatives of the perpetrator. Consequently, women's prisons can be assumed to have experience dealing with violent offenders whose victims have been other women. Judge Jon Tigar made this point when he wrote in *Norsworthy v. Beard* (2015):

> Any suggestion that housing a female inmate with a history of violence against women would be a novel security challenge is hard to square with the fact that CDCR already houses

> many women with a history of violence, including violence against their female partners. (p. 27)

The other options for prison assignment after SRS—assignment to a special facility for transgender inmates, administrative segregation, or continued assignment to a men's prison—are more problematic. Assignment to a special unit for transgender inmates could sometimes be a reasonable option, but such facilities are not available in most states, and transfer to a unit for transgender prisoners in another state, pursuant to the Interstate Compact on Adult Offender Supervision (Interstate Commission for Adult Offender Supervision, 2014), could not be guaranteed. Moreover, some inmates would probably reject and challenge being housed in units for transgender inmates, believing such an arrangement to be discriminatory and stigmatizing. Prolonged administrative segregation would be inhumane and probably would not stand up to legal challenge (Fleischaker, 2014). Continued assignment to a men's prison after SRS would be inconsistent with current genital-based assignment policies and would probably increase an already elevated risk of sexual victimization. In addition, all of these alternative assignment options would forgo the potential therapeutic benefits of placement in a women's prison, in which inmates with GD could more freely and fully enact their desired gender role.

Security Considerations Related to Sex Reassignment Surgery

We mention security considerations for reasons of completeness, not because we think they pose serious impediments to providing SRS. We have already addressed the most significant security issues related to housing inmates in women's prisons following SRS. Prison officials have sometimes expressed concern about the risk of escape attempts if inmates were transported to a distant location to undergo SRS and then transported back to prison. We consider these objections pretextual rather than substantive. In the *Kosilek* case, the MDOC initially raised this issue, but MDOC Commissioner Harold Clarke subsequently minimized these concerns in his testimony:

> Clarke too initially opined that Kosilek posed an unacceptable risk of flight if transported out of Massachusetts in part because he had fled the state after killing his wife… However, Clarke ultimately testified that he could say "[w]ith some degree of certainty" that the DOC would "take all the precautions necessary to secure that transport, secure the place where it's going to take place, and care for [Kosilek] in terms of providing appropriate custody prior to returning [Kosilek] back to the state." (*Kosilek v. Spencer*, 2012, p. 104)

Post-Release Considerations Following Sex Reassignment Surgery

Practitioners who recommend SRS for inmates who will eventually be released from prison should think carefully about how SRS might affect these inmates' lives after release. In particular, they should consider the risk of post-release regret about having undergone SRS. Clinicians have repeatedly observed that changes in life circumstances can affect the severity of GD symptoms and the intensity of the desire for sex reassignment and SRS (Levine, 1993; Lothstein, 1979; Marks, Green, & Mataix-Cols, 2000; Roback, Fellemann, & Abramowitz, 1984). Males with only minimal or moderate GD symptoms before entering prison sometimes experience an increase in the severity of their GD symptoms after incarceration, accompanied by the onset or intensification of cross-gender identification and the desire to undergo sex reassignment and SRS. This phenomenon raises the concern that, if these inmates were to undergo SRS and were subsequently released from prison, their feminine gender identification might diminish or remit entirely and their desire to live as women might decline or disappear. Practitioners must be mindful of the possibility that inmates who avidly sought and eventually underwent SRS in prison might regret having done so after being released.

Why is the prison environment sometimes associated with an increase in the severity of GD and an intensification of the desire for sex reassignment? Several factors plausibly contribute. Before entering prison, many inmates with incipient GD lived unstable or chaotic lives, characterized by familial and interpersonal instability, childhood abuse or neglect, out-of-home placements, poverty, school failure, substance abuse, untreated mental illness, and early and chronic criminality. In prison, some of these problems may resolve or remit, allowing inmates enough stability to seriously confront their GD for the first time. Other inmates may have had little or no information about the meaning of their GD symptoms or about their options for living in a gender role more congruent with their gender identity; some may have lacked language to describe their feelings, learning terms such as transgender for the first time in prison. Transgender subcultures within prisons provide information, descriptive language, and role models for inmates who are beginning to think about these issues. Although the natural history of GD in males often involves intensification of symptoms over time, social forces in the outside world can hold GD symptoms in check and deter individuals from pursuing sex reassignment. These restraining forces can include the desire to preserve relationships with spouses, children, and friends (Blanchard, 1994) and to maintain employment, legal or otherwise. When incarceration removes these social constraints, GD can intensify. The prison environment also offers inmates opportunities to enact female-

typical social and sexual behaviors in relation to masculine men; these interactions can strengthen or consolidate cross-gender identification in males with GD and can be associated with intensification of GD symptoms. Conversely, GD can sometimes intensify in prison as a result of constraints on feminine self-expression: Inmates who had cross-dressed, engaged in prostitution, or entertained as drag queens may only experience clinically significant GD once those activities have become impossible in the context of incarceration.

After release from prison, however, inmates' circumstances may revert to the status quo ante. Their lives can once again become chaotic in the face of joblessness, homelessness, substance abuse, or untreated mental illness. Opportunities for cross-gender expression that were unavailable during incarceration may again become available to them. Social forces that once constrained cross-gender expression may again exert their influence. In males with GD who are sexually attracted to women, the opportunity to engage in new romantic relationships with women is sometimes associated with remission of GD symptoms and loss of the desire to live as a woman (Lawrence, 2013; Marks et al., 2000; Shore, 1984; Steiner, 1985); release from prison would allow such opportunities. For inmates who had undergone SRS before being released, these forces could potentially be associated with partial or complete remission of their feminine gender identification and desire to live as women; some of these individuals might come to regret SRS. We believe it is plausible that having a longer period of time to consolidate one's feminine gender identity and gender role after SRS might make these outcomes, especially postoperative regret, less likely. Consequently, until more inmates have undergone SRS and more outcome data for this population have been accumulated, we believe it would be prudent to offer SRS only to those inmates for whom a long period of incarceration is anticipated (cf. Colopy, 2012, p. 267).

Regret following SRS is a rare but recognized phenomenon in nonincarcerated MtF transsexuals. A large longitudinal study in Sweden found that 2.2 % of MtF transsexuals regretted having undergone sex reassignment and SRS, as evidenced by application to return to male legal gender status (Dhejne et al., 2014). Factors associated with an increased risk of regret following SRS include poor family support, late-onset GD, inadequate differential diagnosis, and dissatisfaction with the physical and functional outcomes of surgery. Some of these factors, especially poor family support, could potentially increase the risk of post-release regret in inmates who underwent SRS while in prison.

It is important to acknowledge, however, that if an inmate were to undergo SRS in prison and subsequently revert to living in a male gender role after release, this would not necessarily indicate that the inmate regretted SRS, that GD had been incorrectly diagnosed, or that SRS had not been medically indicated or had been provided in error. Some persons who undergo SRS outside of correctional environments report that this treatment successfully ameliorated their GD symptoms but nevertheless revert to living in their original gender role, usually for complex social reasons. Kuiper and Cohen-Kettenis (1998) described three such MtF patients and observed that:

> [Some] individuals do not live any longer in the previously desired sex, but do not express any regret. Some may even state that they are happy about their decision, and still consider themselves transsexuals, but choose to live in the original gender role again for social reasons. (p. 2)

This is consistent with the perspective that the fundamental therapeutic value of SRS lies in its ability to alleviate genital anatomic GD and that SRS can provide this therapeutic benefit even when individuals decide to revert to their original gender role after surgery.

Recommendations for Providing Sex Reassignment Surgery to Male Inmates With Gender Dysphoria

We hope that prison systems will begin providing SRS for carefully selected inmates not because they are legally compelled to do so but because they recognize that SRS is an effective and ethically obligatory treatment for the particular form of suffering that some inmates with GD experience. We recognize that to do so, prison systems will have to address policy, security, and operational complexities as well as legislative, judicial, and public relations challenges. But the status quo of waiting for legal mandates not only leaves inmates with unmet treatment needs but is also prohibitively expensive. Based on our clinical experience and review of the relevant literature, we offer the following recommendations:

(1) Prison officials and physicians and mental health practitioners who evaluate and treat inmates should recognize that SRS can be medically necessary for some male inmates with GD. Prison systems should begin offering SRS to inmates for whom it is medically necessary, even when not faced with the threat of legal compulsion.

(2) The eligibility requirements for SRS for male inmates with GD should include the first five standard eligibility requirements set forth in the SOC (Coleman et al., 2011).

(3) The SOC standard eligibility requirement of 12 continuous months of living in a gender role congruent with the patient's gender identity should either have been

   (a) satisfied in the judgment of the responsible practitioner or
   (b) explicitly waived by the responsible practitioner, as permitted by the SOC.

(4) Until greater experience is accumulated, practitioners should initially impose some additional eligibility requirements, as permitted by the SOC, in order to maximize the likelihood of successful outcomes and minimize the likelihood of regrets. These should include

(a) prominent genital anatomic GD;
(b) a long period of expected incarceration after SRS;
(c) a satisfactory disciplinary record and demonstrated capacity to cooperate with providers and comply with recommended treatment;
(d) a period of psychotherapy, if recommended by the responsible practitioner; and
(e) willingness to be assigned to a women's prison after SRS.

(5) Inmates should routinely be assigned to a women's prison after SRS, although assignment to a specialized unit for transgender inmates might be acceptable in some cases.
(6) Consistent with inmate confidentiality, practitioners and the prison systems that employ them should collect, analyze, and publish the outcome data, for their own use and for the use of other prison systems.
(7) The additional eligibility requirements suggested above should be modified as indicated, based on accumulated experience and the outcome data.

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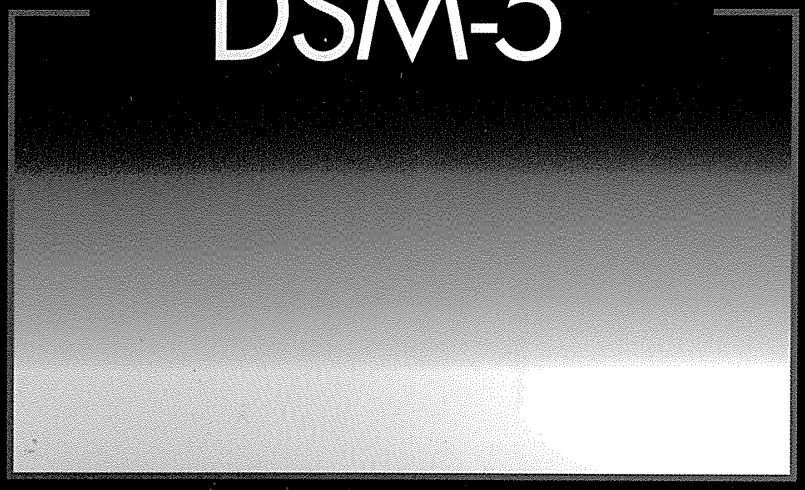

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Gender Dysphoria

In this chapter, there is one overarching diagnosis of gender dysphoria, with separate developmentally appropriate criteria sets for children and for adolescents and adults. The area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines. An additional source of confusion is that in English "sex" connotes both male/female and sexuality. This chapter employs constructs and terms as they are widely used by clinicians from various disciplines with specialization in this area. In this chapter, *sex* and *sexual* refer to the biological indicators of male and female (understood in the context of reproductive capacity), such as in sex chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia. Disorders of sex development denote conditions of inborn somatic deviations of the reproductive tract from the norm and/or discrepancies among the biological indicators of male and female. *Cross-sex* hormone treatment denotes the use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth.

The need to introduce the term *gender* arose with the realization that for individuals with conflicting or ambiguous biological indicators of sex (i.e., "intersex"), the lived role in society and/or the identification as male or female could not be uniformly associated with or predicted from the biological indicators and, later, that some individuals develop an identity as female or male at variance with their uniform set of classical biological indicators. Thus, *gender* is used to denote the public (and usually legally recognized) lived role as boy or girl, man or woman, but, in contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development. *Gender assignment* refers to the initial assignment as male or female. This occurs usually at birth and, thereby, yields the "natal gender." *Gender-atypical* refers to somatic features or behaviors that are not typical (in a statistical sense) of individuals with the same assigned gender in a given society and historical era; for behavior, *gender-nonconforming* is an alternative descriptive term. *Gender reassignment* denotes an official (and usually legal) change of gender. *Gender identity* is a category of social identity and refers to an individual's identification as male, female, or, occasionally, some category other than male or female. *Gender dysphoria* as a general descriptive term refers to an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category. *Transgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender. *Transsexual* denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery (*sex reassignment surgery*).

Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.

Gender Dysphoria

Diagnostic Criteria

Gender Dysphoria in Children 302.6 (F64.2)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

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

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Gender Dysphoria in Adolescents and Adults 302.85 (F64.1)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

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

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

Specifiers

The posttransition specifier may be used in the context of continuing treatment procedures that serve to support the new gender assignment.

Diagnostic Features

Individuals with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as *natal gender*) and their experienced/expressed gender. This discrepancy is the core component of the diagnosis. There must also be evidence of distress about this incongruence. Experienced gender may include alternative gender identities beyond binary stereotypes. Consequently, the distress is not limited to a desire to simply be of the other gender, but may include a desire to be of an alternative gender, provided that it differs from the individual's assigned gender.

Gender dysphoria manifests itself differently in different age groups. Prepubertal natal girls with gender dysphoria may express the wish to be a boy, assert they are a boy, or assert they will grow up to be a man. They prefer boys' clothing and hairstyles, are often perceived by strangers as boys, and may ask to be called by a boy's name. Usually, they display intense negative reactions to parental attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes are required. These girls may demonstrate marked cross-gender identification in role-playing, dreams, and fantasies. Contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates are most often preferred. They show little interest in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play). Occasionally, they refuse to urinate in a sitting position. Some natal girls may express a desire to have a penis or claim to have a penis or that they will grow one when older. They may also state that they do not want to develop breasts or menstruate.

Prepubertal natal boys with gender dysphoria may express the wish to be a girl or assert they are a girl or that they will grow up to be a woman. They have a preference for dressing in girls' or women's clothes or may improvise clothing from available materials (e.g., using towels, aprons, and scarves for long hair or skirts). These children may role-play female figures (e.g., playing "mother") and often are intensely interested in female fantasy figures. Traditional feminine activities, stereotypical games, and pastimes (e.g., "playing house"; drawing feminine pictures; watching television or videos of favorite female characters) are most often preferred. Stereotypical female-type dolls (e.g., Barbie) are often favorite toys, and girls are their preferred playmates. They avoid rough-and-tumble play and competitive sports and have little interest in stereotypically masculine toys (e.g., cars, trucks). Some may pretend not to have a penis and insist on sitting to urinate. More

rarely, they may state that they find their penis or testes disgusting, that they wish them removed, or that they have, or wish to have, a vagina.

In young adolescents with gender dysphoria, clinical features may resemble those of children or adults with the condition, depending on developmental level. As secondary sex characteristics of young adolescents are not yet fully developed, these individuals may not state dislike of them, but they are concerned about imminent physical changes.

In adults with gender dysphoria, the discrepancy between experienced gender and physical sex characteristics is often, but not always, accompanied by a desire to be rid of primary and/or secondary sex characteristics and/or a strong desire to acquire some primary and/or secondary sex characteristics of the other gender. To varying degrees, adults with gender dysphoria may adopt the behavior, clothing, and mannerisms of the experienced gender. They feel uncomfortable being regarded by others, or functioning in society, as members of their assigned gender. Some adults may have a strong desire to be of a different gender and treated as such, and they may have an inner certainty to feel and respond as the experienced gender without seeking medical treatment to alter body characteristics. They may find other ways to resolve the incongruence between experienced/expressed and assigned gender by partially living in the desired role or by adopting a gender role neither conventionally male nor conventionally female.

Associated Features Supporting Diagnosis

When visible signs of puberty develop, natal boys may shave their legs at the first signs of hair growth. They sometimes bind their genitals to make erections less visible. Girls may bind their breasts, walk with a stoop, or use loose sweaters to make breasts less visible. Increasingly, adolescents request, or may obtain without medical prescription and supervision, hormonal suppressors ("blockers") of gonadal steroids (e.g., gonadotropin-releasing hormone [GnRH] analog, spironolactone). Clinically referred adolescents often want hormone treatment and many also wish for gender reassignment surgery. Adolescents living in an accepting environment may openly express the desire to be and be treated as the experienced gender and dress partly or completely as the experienced gender, have a hairstyle typical of the experienced gender, preferentially seek friendships with peers of the other gender, and/or adopt a new first name consistent with the experienced gender. Older adolescents, when sexually active, usually do not show or allow partners to touch their sexual organs. For adults with an aversion toward their genitals, sexual activity is constrained by the preference that their genitals not be seen or touched by their partners. Some adults may seek hormone treatment (sometimes without medical prescription and supervision) and gender reassignment surgery. Others are satisfied with either hormone treatment or surgery alone.

Adolescents and adults with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicides. After gender reassignment, adjustment may vary, and suicide risk may persist.

Prevalence

For natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%. Since not all adults seeking hormone treatment and surgical reassignment attend specialty clinics, these rates are likely modest underestimates. Sex differences in rate of referrals to specialty clinics vary by age group. In children, sex ratios of natal boys to girls range from 2:1 to 4.5:1. In adolescents, the sex ratio is close to parity; in adults, the sex ratio favors natal males, with ratios ranging from 1:1 to 6.1:1. In two countries, the sex ratio appears to favor natal females (Japan: 2.2:1; Poland: 3.4:1).

Development and Course

Because expression of gender dysphoria varies with age, there are separate criteria sets for children versus adolescents and adults. Criteria for children are defined in a more con-

crete, behavioral manner than those for adolescents and adults. Many of the core criteria draw on well-documented behavioral gender differences between typically developing boys and girls. Young children are less likely than older children, adolescents, and adults to express extreme and persistent anatomic dysphoria. In adolescents and adults, incongruence between experienced gender and somatic sex is a central feature of the diagnosis. Factors related to distress and impairment also vary with age. A very young child may show signs of distress (e.g., intense crying) only when parents tell the child that he or she is "really" not a member of the other gender but only "desires" to be. Distress may not be manifest in social environments supportive of the child's desire to live in the role of the other gender and may emerge only if the desire is interfered with. In adolescents and adults, distress may manifest because of strong incongruence between experienced gender and somatic sex. Such distress may, however, be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence. Impairment (e.g., school refusal, development of depression, anxiety, and substance abuse) may be a consequence of gender dysphoria.

Gender dysphoria without a disorder of sex development. For clinic-referred children, onset of cross-gender behaviors is usually between ages 2 and 4 years. This corresponds to the developmental time period in which most typically developing children begin expressing gendered behaviors and interests. For some preschool-age children, both pervasive cross-gender behaviors and the expressed desire to be the other gender may be present, or, more rarely, labeling oneself as a member of the other gender may occur. In some cases, the expressed desire to be the other gender appears later, usually at entry into elementary school. A small minority of children express discomfort with their sexual anatomy or will state the desire to have a sexual anatomy corresponding to the experienced gender ("anatomic dysphoria"). Expressions of anatomic dysphoria become more common as children with gender dysphoria approach and anticipate puberty.

Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%. Persistence of gender dysphoria is modestly correlated with dimensional measures of severity ascertained at the time of a childhood baseline assessment. In one sample of natal males, lower socioeconomic background was also modestly correlated with persistence. It is unclear if particular therapeutic approaches to gender dysphoria in children are related to rates of long-term persistence. Extant follow-up samples consisted of children receiving no formal therapeutic intervention or receiving therapeutic interventions of various types, ranging from active efforts to reduce gender dysphoria to a more neutral, "watchful waiting" approach. It is unclear if children "encouraged" or supported to live socially in the desired gender will show higher rates of persistence, since such children have not yet been followed longitudinally in a systematic manner. For both natal male and female children showing persistence, almost all are sexually attracted to individuals of their natal sex. For natal male children whose gender dysphoria does not persist, the majority are *androphilic* (sexually attracted to males) and often self-identify as gay or homosexual (ranging from 63% to 100%). In natal female children whose gender dysphoria does not persist, the percentage who are *gynephilic* (sexually attracted to females) and self-identify as lesbian is lower (ranging from 32% to 50%).

In both adolescent and adult natal males, there are two broad trajectories for development of gender dysphoria: early onset and late onset. *Early-onset gender dysphoria* starts in childhood and continues into adolescence and adulthood; or, there is an intermittent period in which the gender dysphoria desists and these individuals self-identify as gay or homosexual, followed by recurrence of gender dysphoria. *Late-onset gender dysphoria* occurs around puberty or much later in life. Some of these individuals report having had a desire to be of the other gender in childhood that was not expressed verbally to others. Others do not recall any signs of childhood gender dysphoria. For adolescent males with late-onset gender dysphoria, parents often report surprise because they did not see signs of gender

dysphoria during childhood. Expressions of anatomic dysphoria are more common and salient in adolescents and adults once secondary sex characteristics have developed.

Adolescent and adult natal males with early-onset gender dysphoria are almost always sexually attracted to men (androphilic). Adolescents and adults with late-onset gender dysphoria frequently engage in transvestic behavior with sexual excitement. The majority of these individuals are gynephilic or sexually attracted to other posttransition natal males with late-onset gender dysphoria. A substantial percentage of adult males with late-onset gender dysphoria cohabit with or are married to natal females. After gender transition, many self-identify as lesbian. Among adult natal males with gender dysphoria, the early-onset group seeks out clinical care for hormone treatment and reassignment surgery at an earlier age than does the late-onset group. The late-onset group may have more fluctuations in the degree of gender dysphoria and be more ambivalent about and less likely satisfied after gender reassignment surgery.

In both adolescent and adult natal females, the most common course is the early-onset form of gender dysphoria. The late-onset form is much less common in natal females compared with natal males. As in natal males with gender dysphoria, there may have been a period in which the gender dysphoria desisted and these individuals self-identified as lesbian; however, with recurrence of gender dysphoria, clinical consultation is sought, often with the desire for hormone treatment and reassignment surgery. Parents of natal adolescent females with the late-onset form also report surprise, as no signs of childhood gender dysphoria were evident. Expressions of anatomic dysphoria are much more common and salient in adolescents and adults than in children.

Adolescent and adult natal females with early-onset gender dysphoria are almost always gynephilic. Adolescents and adults with the late-onset form of gender dysphoria are usually androphilic and after gender transition self-identify as gay men. Natal females with the late-onset form do not have co-occurring transvestic behavior with sexual excitement.

Gender dysphoria in association with a disorder of sex development. Most individuals with a disorder of sex development who develop gender dysphoria have already come to medical attention at an early age. For many, starting at birth, issues of gender assignment were raised by physicians and parents. Moreover, as infertility is quite common for this group, physicians are more willing to perform cross-sex hormone treatments and genital surgery before adulthood.

Disorders of sex development in general are frequently associated with gender-atypical behavior starting in early childhood. However, in the majority of cases, this does not lead to gender dysphoria. As individuals with a disorder of sex development become aware of their medical history and condition, many experience uncertainty about their gender, as opposed to developing a firm conviction that they are another gender. However, most do not progress to gender transition. Gender dysphoria and gender transition may vary considerably as a function of a disorder of sex development, its severity, and assigned gender.

Risk and Prognostic Factors

Temperamental. For individuals with gender dysphoria without a disorder of sex development, atypical gender behavior among individuals with early-onset gender dysphoria develops in early preschool age, and it is possible that a high degree of atypicality makes the development of gender dysphoria and its persistence into adolescence and adulthood more likely.

Environmental. Among individuals with gender dysphoria without a disorder of sex development, males with gender dysphoria (in both childhood and adolescence) more commonly have older brothers than do males without the condition. Additional predisposing

factors under consideration, especially in individuals with late-onset gender dysphoria (adolescence, adulthood), include habitual fetishistic transvestism developing into autogynephilia (i.e., sexual arousal associated with the thought or image of oneself as a woman) and other forms of more general social, psychological, or developmental problems.

Genetic and physiological. For individuals with gender dysphoria without a disorder of sex development, some genetic contribution is suggested by evidence for (weak) familiality of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria. As to endocrine findings, no endogenous systemic abnormalities in sex-hormone levels have been found in 46,XY individuals, whereas there appear to be increased androgen levels (in the range found in hirsute women but far below normal male levels) in 46,XX individuals. Overall, current evidence is insufficient to label gender dysphoria without a disorder of sex development as a form of intersexuality limited to the central nervous system.

In gender dysphoria associated with a disorder of sex development, the likelihood of later gender dysphoria is increased if prenatal production and utilization (via receptor sensitivity) of androgens are grossly atypical relative to what is usually seen in individuals with the same assigned gender. Examples include 46,XY individuals with a history of normal male prenatal hormone milieu but inborn nonhormonal genital defects (as in cloacal bladder exstrophy or penile agenesis) and who have been assigned to the female gender. The likelihood of gender dysphoria is further enhanced by additional, prolonged, highly gender-atypical postnatal androgen exposure with somatic virilization as may occur in female-raised and noncastrated 46,XY individuals with 5-alpha reductase-2 deficiency or 17-beta-hydroxysteroid dehydrogenase-3 deficiency or in female-raised 46,XX individuals with classical congenital adrenal hyperplasia with prolonged periods of non-adherence to glucocorticoid replacement therapy. However, the prenatal androgen milieu is more closely related to gendered behavior than to gender identity. Many individuals with disorders of sex development and markedly gender-atypical behavior do not develop gender dysphoria. Thus, gender-atypical behavior by itself should not be interpreted as an indicator of current or future gender dysphoria. There appears to be a higher rate of gender dysphoria and patient-initiated gender change from assigned female to male than from assigned male to female in 46,XY individuals with a disorder of sex development.

Culture-Related Diagnostic Issues

Individuals with gender dysphoria have been reported across many countries and cultures. The equivalent of gender dysphoria has also been reported in individuals living in cultures with institutionalized gender categories other than male or female. It is unclear whether with these individuals the diagnostic criteria for gender dysphoria would be met.

Diagnostic Markers

Individuals with a somatic disorder of sex development show some correlation of final gender identity outcome with the degree of prenatal androgen production and utilization. However, the correlation is not robust enough for the biological factor, where ascertainable, to replace a detailed and comprehensive diagnostic interview evaluation for gender dysphoria.

Functional Consequences of Gender Dysphoria

Preoccupation with cross-gender wishes may develop at all ages after the first 2–3 years of childhood and often interfere with daily activities. In older children, failure to develop age-typical same-sex peer relationships and skills may lead to isolation from peer groups and to distress. Some children may refuse to attend school because of teasing and harass-

ment or pressure to dress in attire associated with their assigned sex. Also in adolescents and adults, preoccupation with cross-gender wishes often interferes with daily activities. Relationship difficulties, including sexual relationship problems, are common, and functioning at school or at work may be impaired. Gender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals from resource-poor family backgrounds. In addition, these individuals' access to health services and mental health services may be impeded by structural barriers, such as institutional discomfort or inexperience in working with this patient population.

Differential Diagnosis

Nonconformity to gender roles. Gender dysphoria should be distinguished from simple nonconformity to stereotypical gender role behavior by the strong desire to be of another gender than the assigned one and by the extent and pervasiveness of gender-variant activities and interests. The diagnosis is not meant to merely describe nonconformity to stereotypical gender role behavior (e.g., "tomboyism" in girls, "girly-boy" behavior in boys, occasional cross-dressing in adult men). Given the increased openness of atypical gender expressions by individuals across the entire range of the transgender spectrum, it is important that the clinical diagnosis be limited to those individuals whose distress and impairment meet the specified criteria.

Transvestic disorder. Transvestic disorder occurs in heterosexual (or bisexual) adolescent and adult males (rarely in females) for whom cross-dressing behavior generates sexual excitement and causes distress and/or impairment without drawing their primary gender into question. It is occasionally accompanied by gender dysphoria. An individual with transvestic disorder who also has clinically significant gender dysphoria can be given both diagnoses. In many cases of late-onset gender dysphoria in gynephilic natal males, transvestic behavior with sexual excitement is a precursor.

Body dysmorphic disorder. An individual with body dysmorphic disorder focuses on the alteration or removal of a specific body part because it is perceived as abnormally formed, not because it represents a repudiated assigned gender. When an individual's presentation meets criteria for both gender dysphoria and body dysmorphic disorder, both diagnoses can be given. Individuals wishing to have a healthy limb amputated (termed by some *body integrity identity disorder*) because it makes them feel more "complete" usually do not wish to change gender, but rather desire to live as an amputee or a disabled person.

Schizophrenia and other psychotic disorders. In schizophrenia, there may rarely be delusions of belonging to some other gender. In the absence of psychotic symptoms, insistence by an individual with gender dysphoria that he or she is of some other gender is not considered a delusion. Schizophrenia (or other psychotic disorders) and gender dysphoria may co-occur.

Other clinical presentations. Some individuals with an emasculinization desire who develop an alternative, nonmale/nonfemale gender identity do have a presentation that meets criteria for gender dysphoria. However, some males seek castration and/or penectomy for aesthetic reasons or to remove psychological effects of androgens without changing male identity; in these cases, the criteria for gender dysphoria are not met.

Comorbidity

Clinically referred children with gender dysphoria show elevated levels of emotional and behavioral problems—most commonly, anxiety, disruptive and impulse-control, and de-

pressive disorders. In prepubertal children, increasing age is associated with having more behavioral or emotional problems; this is related to the increasing non-acceptance of gender-variant behavior by others. In older children, gender-variant behavior often leads to peer ostracism, which may lead to more behavioral problems. The prevalence of mental health problems differs among cultures; these differences may also be related to differences in attitudes toward gender variance in children. However, also in some non-Western cultures, anxiety has been found to be relatively common in individuals with gender dysphoria, even in cultures with accepting attitudes toward gender-variant behavior. Autism spectrum disorder is more prevalent in clinically referred children with gender dysphoria than in the general population. Clinically referred adolescents with gender dysphoria appear to have comorbid mental disorders, with anxiety and depressive disorders being the most common. As in children, autism spectrum disorder is more prevalent in clinically referred adolescents with gender dysphoria than in the general population. Clinically referred adults with gender dysphoria may have coexisting mental health problems, most commonly anxiety and depressive disorders.

Other Specified Gender Dysphoria

302.6 (F64.8)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The other specified gender dysphoria category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for gender dysphoria. This is done by recording "other specified gender dysphoria" followed by the specific reason (e.g., "brief gender dysphoria").

An example of a presentation that can be specified using the "other specified" designation is the following:

The current disturbance meets symptom criteria for gender dysphoria, but the duration is less than 6 months.

Unspecified Gender Dysphoria

302.6 (F64.9)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The unspecified gender dysphoria category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for gender dysphoria, and includes presentations in which there is insufficient information to make a more specific diagnosis.

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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 **STIPULATION GOVERNING EVIDENTIARY HEARING TESTIMONY AND EXHIBITS**

COME NOW the parties to this action, by and through their counsel of record, and hereby stipulate and agree to the following regarding testimony and exhibits presented at the upcoming evidentiary hearing on Plaintiff's *Motion for Preliminary Injunction* (Dkt. 62).

WHEREAS the parties to this action hereby stipulate that the following categories of information within the Confidential PSI Reports governed by this Court's *Protective Order* (Dkt. 88), will be the subject of testimony at the upcoming evidentiary hearing:

1. The nature of Plaintiff's underlying criminal convictions;
2. Plaintiff's family history and childhood;
3. Plaintiff's mental health history;
4. Plaintiff's history of trauma;
5. Plaintiff's history of abuse;
6. Plaintiff's sexual history;
7. Plaintiff's prior suicide attempts and mental health history;
8. Plaintiff's substance abuse history;
9. Plaintiff's statements regarding cross-dressing;
10. Mental health and substance abuse treatment recommendations for Plaintiff by evaluators;
11. Any purported absence of statements by Plaintiff, her family members, evaluators, employers, probation officers, or other persons providing information contained in the Confidential PSI Documents regarding Plaintiff's history as a transgender woman or Plaintiff dressing in female clothing, wearing makeup, styling her hair in a feminine fashion, or otherwise living full-time as a woman prior to her incarceration.

WHERAS the parties to this action also hereby stipulate and agree that, based on the testimony and evidence presented at the evidentiary hearing, counsel for any party may question witnesses about categories contained in the Confidential PSI Documents that are not listed above. However, prior to proceeding with such questioning, counsel seeking testimony outside the above-listed categories must meet and confer with the other parties before doing so.

WHEREAS the parties to this matter also hereby stipulate to the authenticity of the records thus far identified as exhibits for the upcoming hearing. No party will be required to call witnesses to authenticate a document or establish foundation for the admissibility of records pursuant to the business records exception, public records exception, and/or medical statements for purposes of diagnosis exception to the hearsay rules. For instance, the parties stipulate that pre- and post-incarceration medical and mental health treatment records, the Confidential PSI Documents, disciplinary offense reports, IR reports, grievances, SOTP progress reports, property records, concern forms, and policies are business records kept in the ordinary course of business. However, the parties also reserve the right to object to the admissibility of all or part of any of the offered exhibits on the grounds of lack of foundation, relevancy, prejudice, and/or hearsay-within-hearsay.

DATED this 9th day of October, 2018.

/s/ Lori Rifkin
Lori Rifkin
Attorney for Plaintiff

DATED this 9th day of October, 2018.

/s/ Dylan Eaton
Dylan Eaton
Attorney for Corizon Defendants

DATED this 9th day of October, 2018.

/s/ Brady J. Hall
Brady J. Hall
Attorney for IDOC Defendants

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 9th 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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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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n/a	10/10/18	Exhibit 1: Medical Records of Plaintiff Adree Edmo	ER 1193 to ER 1472

VOLUME 9
(ER 1473-ER 1752)

n/a	10/10/18	Exhibit 1: Medical Records of Plaintiff Adree Edmo	ER 1473 to ER 1752

VOLUME 10
(ER 1753-ER 2032)

n/a	10/10/18	Exhibit 1: Medical Records of Plaintiff Adree Edmo	ER 1753 to ER 2032

VOLUME 11
(ER 2033-ER 2312)

n/a	10/10/18	Exhibit 1: Medical Records of Plaintiff	ER 2033 to

		Adree Edmo	2312

VOLUME 12
(ER 2313-ER 2592)

n/a	10/10/18	Exhibit 1: Medical Records of Plaintiff Adree Edmo	ER 2313 to 2592

VOLUME 13
(ER 2593-ER 2799)

n/a	10/10/18	Exhibit 1: Medical Records of Plaintiff Adree Edmo	ER 2593 to ER 2791
n/a	10/10/18	Exhibit 4: Photographs of Plaintiff Adree Edmo	ER 2792 to ER 2799

VOLUME 14
(ER 2800-ER 3080)

n/a	10/10/18	Exhibit 7: Minutes from the Management and Treatment Team Committee (MTC)	ER 2800 to ER 2909
n/a	10/10/18	Exhibit 8: IDOC Standard Operating Procedure, Version 3.2, "Gender Identity Disorder: Healthcare for Offenders with"	ER 2910 to ER 2918
n/a	10/10/18	Exhibit 9: IDOC Standard Operating Procedure, Version 4.0, "Gender Dysphoria: Healthcare for Inmates with"	ER 2919 to ER 2927
n/a	10/10/18	Exhibit 10: Ashely Dowell email re Gender Dysphoria Policy Update	ER 2928 to ER 2930
n/a	10/10/18	Exhibit 11: Ashley Dowell email re GD SOP Change memo and clinician	ER 2931

		contact	
n/a	10/10/18	Exhibit 15: WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People	ER 2932 to ER 3051
n/a	10/10/18	Exhibit 19: "Male Prison Inmates with Gender Dysphoria: When is Sex Reassignment Surgery Appropriate" by Cynthia Osborne and Anne Lawrence	ER 3052 to ER 3066
n/a	10/10/18	Exhibit 1001: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), "Gender Dysphoria"	ER 3067 to ER 3076
130	10/09/18	Stipulation Governing Evidentiary Hearing Testimony and Exhibits	ER 3077 to ER 3080

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101-4	09/17/18	Declaration of Walter L. Campbell, Ph.D.	ER 3135 to ER 3143
101-5	09/17/18	Declaration of Cliff Cummings	ER 3144 to ER 3147
101-6	09/17/18	Declaration of Sandy Jones	ER 3148 to ER 3162
101-7	09/17/18	Declaration of Jeremy Clark	ER 3163 to ER 3168
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101-9	09/17/18	Exhibits B (Andre Edmo deposition excerpts) and C (Dr. Scott Eliason deposition excerpts) to Declaration of Counsel Marisa S. Crecelius in Support of IDOC Defendants' Response to Plaintiff's Motion for Preliminary Injunction (Dkt. No. 101-8)	ER 3209 to ER 3259
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101-12	09/17/18	Declaration of Howard Keith Yordy and Exhibits 1, 2, 3, and 4	ER 3302 to ER 3311
101-13	09/17/18	Exhibit 5 (Part One) to the Declaration of Howard Keith Yordy (Dkt. No. 101-12)	ER 3312 to ER 3354

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(ER 3355-ER 3633)

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101-17	09/17/18	Exhibit 6 to the Declaration of Howard Keith Yordy (Dkt. No. 101-12)	
100	09/14/18	Corizon Defendants' Response to Plaintiff's Motion for Preliminary Injunction and Memorandum of Points and Authorities in Support Thereof (Excerpted pgs. 1, 8-12)	ER 3383 to ER 3390
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59	04/04/18	Minute Entry regarding hearing on Defendants' First Motion for Dispositive Relief	ER 3620 to ER 3622
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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

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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

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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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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' WITNESS LIST**

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 this Court's *Order* dated September 28, 2018 (Dkt. 110), Local U.S. District of Idaho Rule 16.3(a), and Rule 26(a)(3)(A) of the Federal Rules of Civil Procedure, hereby provide the *IDOC Defendants' Witness List*.

WITNESSES THAT DEFENDANTS EXPECT TO PRESENT AT THE HEARING:

1. Joel T. Andrade, Ph.D, LICW, CCHP-MH
2. Jeremy Clark
3. Krina Stewart
4. IDOC Defendants reserve the right to call replacement witnesses in the event of the above are unable or unwilling to testify at trial.
5. IDOC Defendants reserve the right to later designate rebuttal witnesses and/or any other witnesses necessitated by the testimony presented in Plaintiff's case-in-chief.

WITNESSES THAT DEFENDANTS MAY PRESENT AT THE HEARING:

1. Defendant Keith Yordy
2. Laura Watson
3. Ashley Dowell
4. IDOC Defendants reserve the right to call any witness designated by Plaintiff and Defendant Corizon, including, but not limited to, Dr. Keelin Garvey.
5. IDOC Defendants reserve the right to call witnesses to rebut testimony adduced by Plaintiff or any other Defendant at the hearing.

DATED this 3rd day of October, 2018.

Moore Elia Kraft & Hall, LLP

/s/ Marisa S. Crecelius
Marisa S. Crecelius

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 3rd day of October, 2018, I caused to be served the foregoing document to the following parties or counsel by email.

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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 FINAL DISCLOSURE OF WITNESSES FOR OCTOBER 10-12, 2018 EVIDENTIARY HEARING**

Defendants, Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery ("Corizon Defendants"), by and through their counsel of record, Parsons Behle & Latimer, hereby identify, pursuant to the Court's Order (Dkt. 110), the following individuals whom said Corizon

Defendants intend to call to testify as witnesses at the time of any evidentiary hearing on October 10 - 12, 2018 in this case:

1. **Steven Menard, D.O**., Corizon Idaho Regional Medical Director
2. **Defendant Scott Eliason, M.D.**, Corizon Regional Psychiatric Director
3. **Keelin Garvey, M.D., CCHP**, Corizon Defendants' expert

Corizon Defendants reserve the right to not call some of the above-identified witnesses or to change the order of the above identified witnesses at the time of the evidentiary hearing.

In addition to the above-listed experts, Corizon Defendants reserve the right to call any experts and/or fact witnesses identified by the Plaintiff, if allowed, or other Defendants in this case. Such individuals may be called to testify regarding facts or opinions within their scope of knowledge, experience and/or expertise or other relevant matters to which they are competent to testify.

Corizon Defendants reserve the right to call any person necessary to authenticate or otherwise lay foundation for any exhibits which may be offered into evidence. However, based on recent meet and confer conversations among counsel in this case, such custodians of record should not be needed.

Corizon Defendants reserve the right to identify any additional witnesses necessitated by rebuttal testimony or otherwise dictated by further developments in this case.

Corizon Defendants reserve the right to call any person(s) identified by Plaintiff as a witness (by way of pleading, letter, deposition testimony or otherwise) during the course of this litigation, to discuss any matter for which they are competent to testify.

Corizon Defendants also reserve the right to supplement this disclosure in the event the individuals identified herein become unavailable to testify at evidentiary hearings or trial. Corizon

Defendants further reserve the right to supplement this disclosure as necessitated by the identification of additional witnesses, as required by the Federal Rules of Civil Procedure.

DATED this 3rd day of October, 2018.

PARSONS BEHLE & LATIMER

By: */s/ Dylan A. Eaton*
Dylan A. Eaton
Counsel for Defendants Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 3rd 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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By:_____
Dylan A. Eaton

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 ORDER

Pursuant to the informal status conference conducted on September 20, 2018, IT IS HEREBY ORDERED:

1. Final witness lists shall be exchanged and filed on or before October 3, 2018 at 5:00 p.m.
    a. Any modifications to witness lists after October 3, 2018 shall be made in good faith with a detailed explanation.
2. Final exhibit lists shall be filed on or before October 5, 2018.
    a. The parties shall meet and confer and work in good faith to reach stipulations for admitting exhibits.
    b. The parties shall also meet and confer and work in good faith to determine which exhibits they believe should be sealed, and which

testimony should be conducted in a closed courtroom. The parties shall each submit a short brief supporting the request to seal exhibits and testimony, and addressing the areas where the parties disagree.

3. Each side will be allotted 8 hours of time during the evidentiary hearing.
4. A final transcript of the hearing will be provided to counsel on or before October 19, 2018.
5. Proposed findings of fact and conclusions of law shall be filed on or before October 26, 2018.

DATED: September 28, 2018

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

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiffs, 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 **NOTICE OF ERRATA RE: IDOC DEFENDANTS' RESPONSE TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION (DKT. 99)**

COME NOW Defendants Idaho Department of Correction ("IDOC"), Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert (collectively referred to as the "IDOC Defendants"), by and through their counsel of record, Moore Elia Kraft & Hall, LLP, and submit the following Notice of Errata regarding the *IDOC Defendants' Response to Plaintiff's Motion for Preliminary Injunction* (Dkt. 99), which was originally filed on September 14, 2018.

Due to formatting errors, the attachments to the IDOC Defendants' *Response* were filed without page numbers (Dkt. 99-2 through 99-17). In addition, Exhibit F to the *Declaration of Marisa S. Crecelius* (Dkt. 99-11) was missing over 40 pages. In order to allow for a clear record, the IDOC Defendants hereby submit this Notice of the corrected versions of those attachments, which are filed contemporaneously herewith.

DATED this 17th day of September, 2018.

Moore Elia Kraft & Hall, LLP

/s/ Brady J. Hall
Attorneys for Defendants Idaho Department of Correction, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 17th day of September, 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 **SECOND DECLARATION OF KRINA L. STEWART**

I, Krina L. Stewart, hereby declare and state as follows:

1. I am over the age of eighteen and am competent to testify to the matters herein. I make this declaration based upon my own personal knowledge.

2. I am employed with the Idaho Department of Corrections ("IDOC") as the Lead Mental Health Clinician at the Idaho State Correctional Institution ("ISCI").

3. I am a Licensed Professional Counselor ("LPC") and maintain a license with the State of Idaho. I received my Master's degree in Counseling, Addictions Cognate, and my Bachelor's of Science degree, both from Boise State University.

4. As part of my duties as the Lead Mental Health Clinician at ISCI, I provide mental health assessments, treatment, and referrals for individuals incarcerated at ISCI. My duties include, but are not limited to, providing individual and group therapy to inmates diagnosed with Gender Dysphoria ("GD").

5. I have received training in the clinical treatment of inmates diagnosed with GD and I participate in the Management and Treatment Committee ("MTC") for inmates with GD, providing the MTC with my assessment of the mental health of inmates with GD and updates regarding the GD inmates' progress in group counseling sessions. I am also involved in the diagnosis of GD as part of the MTC and provide recommendations to the MTC regarding other GD-specific issues, such as housing.

6. I am Plaintiff Adree Edmo's current treating Mental Health Clinician. I have provided individualized clinical contact to Edmo since July 1, 2016. As Edmo's assigned Mental Health Clinician, I have met individually with Edmo on multiple occasions over the last two years. I have also reviewed Edmo's mental health records and clinical notes. Further, I have been involved in a number of discussions and meetings with other IDOC treatment providers with

personal knowledge of Edmo's mental health conditions, including monthly meetings of the MTC. I am familiar with Edmo's documented social, criminal, medical, institutional, and mental health history and current mental health condition, along with Edmo's attendance at group and individual clinical sessions.

7. Edmo came to be on my caseload after being discharged from the Behavioral Health Unit for physically assaulting another GD offender. It is my understanding that Edmo assaulted the same GD inmate on two separate occasions and received Disciplinary Offense Reports ("DORs") for both assaults. At that time, there was one GD processing group for GD inmates. Both Edmo and the inmate who Edmo assaulted participated in that group. After the assaults and resulting DORs, the MTC determined that Edmo was prohibited from attending the GD group for six months.

8. Edmo was later approved by the MTC to return to the GD group, so long as Edmo also completed a Social Skills group. Edmo agreed to so do at first, but later Edmo refused to attend the Social Skills group because the other inmate Edmo assaulted was not required to attend.

9. Edmo has been diagnosed with Major Depressive Disorder, Anxiety, GD, and Alcohol Dependence. During my individual clinical contacts with Edmo over the last two years, Edmo has often expressed that GD is Edmo's only mental health problem. Edmo chooses to focus solely on Edmo's GD and typically insists that Edmo has no other underlying mental health concerns. Edmo is very focused on Edmo's GD as the main cause of Edmo's depression and attempts at self-castration. However, Edmo has other stressors that contribute to Edmo's depression, including relationship issues, past trauma, and past abuse. Edmo cycles through depressive episodes, although Edmo does not or cannot separate Edmo's feelings of depression

from Edmo's GD.

10. Edmo has also demonstrated traits consistent with borderline personality disorder, including unstable relationships, self-harm, and poor sense-of-self. Edmo's self-harm, which have included attempts at self-castration and more recently, cutting on other body parts, are attempts to replace Edmo's emotional pain with physical pain. The physical pain of self-harm provides a release of Edmo's emotional pain. Edmo's cutting of other body parts is not self-surgery. Rather, cutting of other body parts is an unhealthy way to process feelings of emotional pain and depression and is common in people diagnosed with borderline personality disorder.

11. In my experience with Edmo, Edmo's dysphoria fluctuates depending on Edmo's life stressors, including Edmo's job, housing, and relationships. When Edmo experiences a stressful life event, such as a break-up with a boyfriend, Edmo's dysphoria increases and Edmo is unable to separate out when Edmo's feelings of depression are related to Edmo's Major Depressive Disorder or Edmo's GD.

12. Based on my experience counseling and meeting with Edmo, along with my participation in the MTC and my review of Edmo's medical and mental health records and PSI Reports, I have significant concerns with Edmo receiving sex reassignment surgery ("SRS"). While SRS could be very helpful in relieving Edmo's GD at some point, it is not appropriate for Edmo at this time. First, Edmo has not addressed, and at times refuses to recognize, that Edmo has other serious mental health issues that would not be resolved by receiving SRS. Edmo is placing every expectation on SRS relieving Edmo's depression, anxiety, and relationship issues. However, Edmo's failure to work through Edmo's other mental health problems by refusing to attend groups and recognize Edmo's other serious mental health issues means that Edmo will certainly have those same issues with depression, anxiety, and low self-esteem after receiving

SRS.

13. One of my biggest concerns about Edmo receiving SRS at this time is Edmo's borderline traits. Edmo uses self-harm to deal with emotional dysregulation. SRS is an irreversible procedure that will be stressful for Edmo. I do not believe that Edmo has the tools to manage the stress of the procedure itself and the life changes that will come afterward. Edmo needs to address Edmo's underlying mental health issues and have those well controlled before undergoing such a serious, life-altering procedure.

14. I am also concerned about Edmo's belief that SRS will solve all of Edmo's issues with depression, anxiety, low sense-of-self, and problems in relationships. While SRS may reduce Edmo's dysphoria, Edmo's depression will still be present and Edmo will still have dependency and other issues that may be made worse by undergoing a serious surgery. Edmo should work through and manage Edmo's underlying mental health issues before receiving SRS.

15. I have reviewed Plaintiff's Notice of Motion and Motion for Preliminary Injunction and Memorandum of Points and Authorities in Support Therefore (Document 62). I am aware that, on page 16 of that document, Edmo's attorneys assert that Edmo is at a "risk of death or imminent self-harm" and that Edmo is currently suffering "serious psychological harm" as a result of Edmo's GD. While it is my observation and opinion that Edmo has serious uncontrolled mental health issues unrelated to Edmo's GD, Edmo's clinical picture over the last year regarding Edmo's symptoms of GD and overall mental health do not support the representations advanced by Edmo's attorneys.

16. Most recently, I met with Edmo privately on May 18, 2018 during a regularly scheduled clinical visit. Edmo reported that Edmo was doing "okay" and that most things were the same since I had begun treating Edmo. Edmo denied having current suicidal ideations or

plans to self-harm. Edmo presented as functional and goal oriented. Edmo's affect and clinical picture was consistent with how Edmo had presented over the last year. Edmo did mention one change to Edmo's status. In December, Edmo became married to another inmate. Edmo had also applied to change Edmo's last name to "Retzer," the name of Edmo's husband. I noted in the computer at that time that Edmo's record included the last name "Retzer." Redacted pursuant to stipulation of the parties.

. Edmo denied any additional mental health concerns.

17. Additionally, over the last several months, Edmo was employed and lived for a time in Unit 13, which is a unit that is reserved for what I label as the high-functioning inmates who are typically employed, and do not pose a recent disciplinary risk. Edmo lost Edmo's job after a DOR for theft and was moved to Unit 10.

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

DATED this 31st day of August, 2018.

/s/ Krina L. Stewart
Krina L. Stewart

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 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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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 **DECLARATION OF RONA SIEGERT**

I, Rona Siegert, hereby declare and state as follows:

1. I have personal knowledge of the information provided in this declaration and I am over the age of 18 and am competent to testify to the facts as stated. I am employed by the Idaho Department of Corrections ("IDOC") at the Idaho State Correctional Institute ("ISCI") as the Health Services Director. I am not a medical doctor, nor do I specialize in the treatment of mental health issues.

2. Corizon, Inc. ("Corizon") is a private corporation under contract to provide medical services to inmates in the custody of all IDOC facilities. All medical decisions for the care of inmates are made by Corizon based on the exercise of the provider's medical judgment.

3. Plaintiff Adree Edmo is currently incarcerated under the custody and control of the IDOC in the ISCI.

4. My job duties as the Health Services Director include overseeing Corizon's provision of medical services at ISCI. My duties require me to accomplish several tasks, including investigating any medical-related issues or complaints I receive, discover, and/or are brought to my attention, including through concern forms and grievances.

5. As Health Services Director, I am the designated appellate authority for offender grievances concerning medical care and I am familiar with the IDOC Grievance Process. The IDOC Grievance Process consists of three steps for offenders to submit grievances concerning their medical care: (1) submit an Offender Concern Form, (2) file a Grievance, and (3) appeal the reviewing authority's response to the Grievance.

6. When I receive a concern form or grievance for appellate review and it involves a matter I do not have any prior knowledge of or dealings with, my standard practice is to fully research the issue, which may include speaking with medical staff, reviewing medical records

and speaking with the offender. When I review the medical records, I look for information that supports the inmate's claims or reveals a medical issue that needs further intervention. If that information is not in the medical record, I will refer the inmate back to the treating medical provider. When the issue involves an inmate's disagreement with the treatment he or she is receiving and there is no indication from the record that the treatment is inadequate based upon the inmate's medical needs, I will refer the inmate back to the treatment provider. I cannot and do not overrule a provider's diagnoses or treatment recommendations.

7. Pursuant to IDOC policy, grievances for review that have been previously grieved on the same issue will be returned without action even if the grievance has been written in such a manner that it appears to be a new issue.

8. As the Health Services Director, I am not responsible for nor do I provide direct patient care. I have never provided medical care to the Plaintiff. I have never spoken to Edmo. At no time did I attempt to deny, delay, or intentionally interfere with Edmo's medical treatment. My interactions with Edmo have been limited to providing appellate review on grievances.

9. I have responded to several concern forms related to Edmo's medical and mental health treatment for Gender Dysphoria ("GD"), which was also formerly referred to as Gender Identity Disorder ("GID"). I have also responded to several concern forms related to Edmo's request for property items, including the following:

a. On August 27, 2014, Edmo submitted a concern form to me, requesting an evaluation for sex reassignment surgery. I replied to Edmo's concern form, advising her that I did not have the authority to grant or deny any type of medical treatment and that her request for sex reassignment surgery must be deemed medically necessary by a medical provider. A true and correct copy of this concern form is attached hereto as **Exhibit 1.**

10. I have provided appellate review of several grievances related to Edmo's medical and mental health treatment for GD and GID and Edmo's requests for property items as they also relate to Edmo's GD and GID, including the following:

a. On March 7, 2014, Edmo filed Grievance No. II140000312, requesting gender reassignment surgery. After a review of Edmo's medical records, I noted that Edmo had been seen by ISCI providers in the Chronic Disease Program ("CDP") and had recently been seen by Dr. Whinnery. Based on my review, I determined that Edmo's request for gender reassignment surgery must be evaluated by medical staff. I requested that Edmo direct Edmo's questions to Edmo's providers in the CDP. A true and correct copy of the grievance paperwork is attached hereto as **Exhibit 2**.

b. On December 17, 2014, Edmo filed Grievance No. II140001365, requesting female "panties" as a medical necessity for the treatment of Edmo's GD. Absent a determination that female underwear is medically necessary, IDOC practices generally do not allow female underwear for offenders housed at ISCI. I had previously incorrectly informed Edmo that female underwear had been deemed medically necessary for GD offenders. After reviewing Edmo's medical records, I noted that panties had not been identified as medically necessary for Edmo by Edmo's medical providers and informed Edmo that female underpants would not be allowed without such a determination of medical necessity. A true and correct copy of the grievance paperwork is attached hereto as **Exhibit 3**.

c. On November 4, 2015, Edmo filed Grievance No. II150001187, regarding laser hair removal. Edmo's grievance relied in part on the World Professional Association for Transgender Health ("WPATH") standards of care. After reviewing Edmo's medical records and the WPATH standards, I noted that hair removal was listed as an option or alternative, not a

requirement, for treatment for GD. There was no indication in Edmo's records that any provider had deemed laser hair removal as medically necessary for Edmo. A true and correct copy of the grievance paperwork is attached hereto as **Exhibit 4**.

d. On April 4, 2016, Edmo filed Grievance No. II160000391, requesting an evaluation for sex reassignment surgery by a qualified gender identify disorder evaluator. The initial response to the grievance referred Edmo to Dr. Eliason, who is a Corizon psychiatrist. Edmo expressed her opinion that Dr. Eliason was not qualified to treat persons with gender identity disorder. The determination of whether sex reassignment surgery is medically necessary must be made by a qualified evaluator. Dr. Eliason is a board-certified physician with a specialty in psychiatry and is qualified to provide an evaluation for sex reassignment surgery pursuant to IDOC's policy regarding the treatment of offenders with Gender Dysphoria. I informed Edmo that Dr. Eliason could perform Edmo's requested evaluation. A true and correct copy of the grievance paperwork is attached hereto as **Exhibit 5**.

e. On August 14, 2017, Edmo filed Grievance No. II170000845, regarding Edmo's treatment for GD. Edmo indicated that she was being given "inferior" medical care based on her status as an inmate with GD. Edmo requested blood labs to test Edmo's hormone levels and a medical appointment with a doctor specializing in GD. The initial response to the grievance indicated that Edmo was currently being seen by Dr. Alviso, a GD specialist, who managed all medications and doses as they related to Edmo's hormone treatment. The reviewing response indicated that Edmo was also monitored every 90 days in the CDP with licensed nurses, lab work, evaluation, medication, and patient education. Edmo commented that Edmo was not receiving panties and that the CDP did not adequately staff for GD offenders. Edmo again requested to see a specialist in GD. Upon reviewing Edmo's medical records, I determined that

the prior responses to Edmo's grievance adequately addressed Edmo's concerns regarding her treatment for GD. Specifically, Edmo had been receiving hormone therapy and follow-up with Dr. Alviso, was being monitored in the CDP every 90 days for concerns related to her hormone treatment, received a bra, and had available to Edmo mental health clinicians to further address her GD. I informed Edmo that, to the extent that the issues Edmo raised in the grievance were a part of Edmo's current lawsuit, Edmo would have to address those issues in litigation. A true and correct copy of the grievance paperwork is attached hereto as **Exhibit 6**.

11. I have not received a grievance from Edmo related to a request for a "gaff" and Edmo has not separately completed the IDOC's Grievance Process regarding the request for a gaff.

12. To my knowledge, prior to June 1, 2018, no medical or mental health provider has deemed sexual reassignment surgery medically necessary for the treatment of Edmo's GD.

13. To my knowledge, prior to June 1, 2018, no medical or mental health provider has deemed makeup and feminine hairstyles as medically necessary for the treatment of Edmo's GD.

14. To my knowledge, prior to June 1, 2018, no medical or mental health provider has deemed a "gaff" and/or female underwear or "panties" as medically necessary for the treatment of Edmo's GD.

15. Based on my research into the issues raised in Edmo's grievances, I believed that Edmo's medical and mental health needs while in custody of IDOC were being appropriately addressed. At all times, when reviewing Edmo's grievances, I confirmed that Edmo was being seen by medical and mental health staff and was receiving continued attention to Edmo's medical and mental health needs.

16. I have not overruled any medical decisions made by Edmo's providers related to

Edmo's medical or mental health treatment including, but not limited to, treatment of Edmo's GID/GD.

17. None of my actions with respect to Edmo have been made with deliberate indifference. I have complied with the recommendations of Edmo's medical and mental health providers in conformance with IDOC policy and IDOC's contract with Corizon.

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

DATED this 28th day of August, 2018.

/s/ Rona Siegert
Rona Siegert

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 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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/s/ Krista Zimmerman
Krista Zimmerman

EXHIBIT 1

IDAHO DEPARTMENT OF CORRECTION
Offender Concern Form

Offender Name: Adree Edmo AKA Mason Edmo — IDOC Number: 94691
Institution, Housing Unit, & Cell: ISCI 110A02B — Date: 08-27-14

To: Rona Siegert - IDOC Health Authority
(Address to appropriate staff: Person most directly responsible for this issue or concern)

Issue/Concern: I am a transsexual offender housed at ISCI. On 07-03-14 I had asked my provider Dr. Whinnery to evaluate me as being eligible for sex reassignment surgery. Dr. Whinnery had stated she could not because of IDOC Health Authority denying this for anyone. What policy are you referring to that says a blatant "no to a serious medical need" it says S.R.S. "is medically available if a GID" Evaluator indicates "medically necessary (CMD 418.06.03.501 definitions "SRS reassignment treatment").
(Description of the issue must be written only on the lines provided above.)

Offender signature: A Edmo

Staff Section

[redacted], A953 — Collected/Received: 8-28-14
(Signature of Staff Member Acknowledging receipt) / Associate ID # — (Date collected or Received)

Reply: I do not have the authority to grant or deny any type of medical intervention or treatment. Your request for "sex reassignment surgery" must be determined as medically necessary by a medical provider.

Responding Staff Signature: R. Siegert Associate ID #: 5119 Date: 9-4-14

Pink copy to offender (after receiving staff's signature).
Original and yellow to responding staff (after completing reply, yellow copy returned to offender.)
Appendix A 316.02.01.001
(Appendix last updated 2/14/12)

PRT3NCRCF

[redacted]

IDOC_H_pg.39

EXHIBIT 2

IDAHO DEPARTMENT OF CORRECTION

Idaho Department of Correction
Grievance Form

Offender Name:	EDMO, MASON DEAN	Location:	ISCI
Offender Number:	94691	Number:	II 140000312
		Category:	MEDICAL/HEALTHCARE

Offender Grievance Information

Date Received: 03/07/2014

The problem is:

Sent concern form to HSA about issues concerning Gender Reassignment surgery. Mallet #8769 responded that Gender Reassignment surgery is unavailable. S. Mallet #8769 is not a M.D. to make this decision, nor is Regional Director Young qualified to base decisions through concern forms without seeing me personally.

I have tried to solve this problem informally by:

Submitting HSR's, talking to clinicians, submitting concern forms.

Note: Only one concern form is submitted with grievance.

I suggest the following solution for the problem:

Allowed to be seen by a GID evaluator specialist.

Level 1 - Initial Response

Date Forwarded:	03/17/2014	Date Returned:	03/17/2014
Date Due Back:	03/21/2014	Level 1 Responder:	PILOTE, KIMBERLY

The response from the staff member or person in charge of the area/operation being grieved:

Dr. Young is a qualified health care provider and is capable of making decisions regarding your care. However, gender re-assignment surgery is not medically necessary. Please submit an HSR if your have any other issues. Thanks.

EXHIBIT 2

II 140000312 EDMO, MASON DEAN 94691

Level 2 - Reviewing Authority Response

Date Forwarded:	03/17/2014	Grievance Disposition:	DENIED
Date Due Back:	03/31/2014	Level 2 Responder:	VALLEY, RYAN
Date Returned:	03/17/2014	Response sent to offender:	03/18/2014

Your grievence has been reviewed and I find:

You have been seen by medical providers that are liccensed to practice in the State of Idaho. Your gender re-assignment surgery is not medically necessary and therefore has not been recommended by our providers.

Offender Appeal

Offender Comments:

Response to Level 2 responder: I have not been seen by your providers, or anyone in medical dealing with my gender reassignment request, medical refused to schedule any appt., especially when I state gender reassignment on the HSR. Of course your providers have not recommended gender reassignment, I have not been able to see anyone in medical to address this issue. IDOC medical / Corizon is discriminating against me because of my gender. I am being denied access to medical care - when I cannot even have an appt. to address this issue. I need a specialist dealing with GID patients, as it is a serious medical need.

Level 3 - Appellate Authority Response

Date Appealed:	03/24/2014	Grievance Disposition:	MODIFIED
Date Forwarded:	03/24/2014	Level 3 Responder:	SIEGERT, RONA
Date Due Back:	04/09/2014	Response sent to offender:	03/26/2014
Date Returned:	03/26/2014		

Your appeal has been reviewed and I find:

Offender Edmo:

Your medical record shows that you have been seen by the ISCI providers in the chronic disease program (CDP). Your last visit was March 6, 2014 with Dr. Whinnery. You are followed in the CDP for GID. Please address your questions regarding gender reassignment surgery at your next CDP appointment.

Rona Siegert RN, CCHP
IDOC Health Services Director

EXHIBIT 3

IDAHO DEPARTMENT OF CORRECTION

Idaho Department of Correction
Grievance Form

Offender Name:	EDMO, MASON DEAN	Location:	ISCI
Offender Number:	94691	Number:	II 140001365
		Category:	MEDICAL/HEALTHCARE

Offender Grievance Information

Date Received: 12/17/2014

The problem is:

Not being allowed panties as a medically necessary undergarment approved by Dr. Whinnery, IDOC states, it does not allow for panties.

I have tried to solve this problem informally by:

Submitting HSR #716481, & concern form to Dr. Whinnery on 11-16-14.

I suggest the following solution for the problem:

Be given a medical memo to possess / purchase panties from commissary as approved by Director Rienke, Dr. Whinnery, and IDOC A.R.C.

Level 1 - Initial Response

Date Forwarded:	12/17/2014	Date Returned:	12/19/2014
Date Due Back:	12/31/2014	Level 1 Responder:	CARLSON LESLIE

The response from the staff member or person in charge of the area/operation being grieved:

Panties are not, " medically necessary." This is a comfort issue. Please take this issue up with Idaho Department of Corrections.

Level 2 - Reviewing Authority Response

Date Forwarded:	12/19/2014	Grievance Disposition:	DENIED
Date Due Back:	01/02/2015	Level 2 Responder:	VALLEY, RYAN
Date Returned:	12/19/2014	Response sent to offender:	12/22/2014

Your grievence has been reviewed and I find:

Edmo,
There is no medical need for you to be given panties to wear. If you would like to request panties, this needs to be made to the Idaho Department of Corrections.

EXHIBIT 3

II 140001365 EDMO, MASON DEAN 94691

Offender Appeal

Offender Comments:

As decided by A.R.C. Medical would have determine appropriateness, and Dr. Whinnery clearly states she would provide a medical memo for women's underwear on concern form dated Nov. 16. 2014. This is deliberate indifference to a serious medical need. Panties and underwear are medical necessities, IDOC allows @ SBWCC, I am a similarly situated individual. There is no substantial penological concern justifying denial of a clearly stated medical need indicated by my provider Dr. Whinnery. IDOC is contracted w/Corizon therefore both need be able to allow for such medical necessities.

Level 3 - Appellate Authority Response

Date Appealed:	12/30/2014	Grievance Disposition:	DENIED
Date Forwarded:	12/30/2014	Level 3 Responder:	SIEGERT, RONA
Date Due Back:	01/15/2015	Response sent to offender:	01/09/2015
Date Returned:	01/08/2015		

Your appeal has been reviewed and I find:

Revised Grievance Appeal Response Dated 1/8/15:

Offender Edmo:

Upon further research and discussion, the response I provided to Grievance II 40001365 is incorrect. Female underpants are only allowed when determined to be medically necessary not based on a GID diagnosis.

Rona Siegert RN, CCHP-RN
ISCI Health Services Director

EXHIBIT 4

IDAHO DEPARTMENT OF CORRECTION

Idaho Department of Correction
Grievance Form

Offender Name:	EDMO, MASON DEAN	Location:	ISCI
Offender Number:	94691	Number:	II 150001187
		Category:	MEDICAL/HEALTHCARE

Offender Grievance Information

Date Received: 11/04/2015

The problem is:

I am being denied adequate / appropriate medical care for my serious condition of GID. N.P.-C Paulson refuses to follow the WPATH standard of care in treating my GID; specifically of ordering laser hair removal electrolysis, or hair remover for my facial hair, or any further treatment on 10/20/15.

I have tried to solve this problem informally by:

Sending concern form on 10/15/15 and submitting HSR # 784404 on 10/25/15. (Both attached)

I suggest the following solution for the problem:

I should be treated according to WPATH standards of care for my serious condition of GID.

Level 1 - Initial Response

Date Forwarded:	11/04/2015	Date Returned:	11/05/2015
Date Due Back:	11/18/2015	Level 1 Responder:	WINGERT, WILLIAM

The response from the staff member or person in charge of the area/operation being grieved:

Facial hair removal for Gender Dysphoria is not an IDOC policy, nor is it medically necessary.

Level 2 - Reviewing Authority Response

Date Forwarded:	11/05/2015	Grievance Disposition:	DENIED
Date Due Back:	11/19/2015	Level 2 Responder:	VALLEY, RYAN
Date Returned:	11/06/2015	Response sent to offender:	11/06/2015

Your grievence has been reviewed and I find:

Edmo,
Hair removal is not part of our policy, nor is it medically necessary.

EXHIBIT 4

II 150001187 EDMO, MASON DEAN 94691

Offender Appeal

Offender Comments:

WPATH "SOC" PAS 171-72 explain the need for electrolysis for support in changes of gender expression in conjunction with hormone therapy. WPATH is the standard of care for treating GID. Corizon nor IDOC have any providers competent, or experienced in treating GID, including me. A competent experienced provider would note this facial hair removal medically necessary to alleviate my gender dysphoria, and help to prevent another attempt at autocastration, as I did on 09/29/15. Please refer me to a GID specialist to be evaluated by appropriate medical care of my GID. Denial based on policy or cursory health service evaluations is deliberate and indifference to my serious GID medical condition. Denial highers my depression and ideation of autocastration.

Level 3 - Appellate Authority Response

Date Appealed:	11/13/2015	Grievance Disposition:	DENIED
Date Forwarded:	11/13/2015	Level 3 Responder:	SIEGERT, RONA
Date Due Back:	11/29/2015	Response sent to offender:	11/16/2015
Date Returned:	11/16/2015		

Your appeal has been reviewed and I find:

Offender Edmo;

Per WPATH, The Standards of Care, Version 7. Hair removal is listed as an option or alternative not a requirement for GD treatment.

Rona Siegert RN, CCHP-RN
IDOC Health Services Director

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Idaho Department of Correction
Grievance Form

Offender Name:	EDMO, MASON DEAN	Location:	ISCI
Offender Number:	94691	Number:	II 160000391
		Category:	MEDICAL/HEALTHCARE

Offender Grievance Information

Date Received: 04/04/2016

The problem is:

I am not being provided timely adequate medical/mental health care, specifically a medical/mental health evaluation for the medical necessity pre-requisite of sex reassignment surgery by a qualified gender identity disorder evaluator pursuant to IDOC SOP 401.06.03.501 and NCCHC MH-A-01 Access to care, and P.-G-02 special needs.

I have tried to solve this problem informally by:

Sending concern forms to clinician Houser on 3/03/16, clinician Irvin on 2/22/16 and Dr. Scott Eliason on 3/16/16, and 3/25/16. (all attached)

I suggest the following solution for the problem:

I want to be scheduled immediately by a qualified gender identity disorder evaluator for a medical/mental health evaluation for sex reassignment surgery!

Level 1 - Initial Response

Date Forwarded:	04/07/2016	Date Returned:	04/08/2016
Date Due Back:	04/21/2016	Level 1 Responder:	BREWER, GEN

The response from the staff member or person in charge of the area/operation being grieved:

Please submit a concern form to Dr. Eliason for this request.

Level 2 - Reviewing Authority Response

Date Forwarded:	04/08/2016	Grievance Disposition:	MODIFIED
Date Due Back:	04/22/2016	Level 2 Responder:	HOFER, AARON
Date Returned:	04/13/2016	Response sent to offender:	04/18/2016

Your grievence has been reviewed and I find:

Please address any and all GID questions/concerns to Dr. Eliason. Dr. Eliason is the expert and has the decision making ability in this area. Thank you.

EXHIBIT 5

II 160000391 EDMO, MASON DEAN 94691

Offender Appeal

Offender Comments:

Dr. Eliason is not an expert in GID, does not have any substantial treatment experience in treating persons w/ GID. Dr. Eliason is restricted, restrained, land / or denied from utilizing the standard of care typically used in treating GID/ GD; wpath, Dr. Eliason further delays and / or interferes with adequate medical care of my GID by stating he is a expert and / or specialist. I still am being denied timely and adequate medical treatment for my GID by a medical / mental health provider qualified to exercise judgment about my particular medical / mental health condition of GID.

Level 3 - Appellate Authority Response

Date Appealed:	04/25/2016	Grievance Disposition:	MODIFIED
Date Forwarded:	04/29/2016	Level 3 Responder:	SIEGERT, RONA
Date Due Back:	05/17/2016	Response sent to offender:	05/19/2016
Date Returned:	05/17/2016		

Your appeal has been reviewed and I find:

Offender Edmo:

Dr. Eliason is a board certified physician with a specialty in psychiatry. If Dr. Eliason feels that it is necessary for you to be evaluated by a "qualified gender identity disorder evaluator" he will provide that service to you. If you have further questions or concerns please follow up with Dr. Eliason.

Rona Siegert RN, CCHP-RN
Idaho Department of Correction

EXHIBIT 6

IDAHO DEPARTMENT OF CORRECTION

Idaho Department of Correction
Grievance Form

Offender Name:	EDMO, MASON DEAN	Location:	ISCI
Offender Number:	94691	Number:	II 170000845
		Category:	MEDICAL/HEALTHCARE

Offender Grievance Information

Date Received: 08/14/2017

The problem is:

I am being given inferior medical care based on my status as an inmate with GD, and required to wait 5 months before seeing a GD doctor. All inmates with medical issues other than GD are provided medical care in a timely fashion, and not required to wait 5 months to see a MD for their worsening conditions.

I have tried to solve this problem informally by:

Submitting HSR#'s 979519, 979520, & 979521 on 07/11/2017. Submitting concern form to ISCI HSA on 07/24/17; and seeing corizon NP-C (15) days later.

I suggest the following solution for the problem:

Immediate blood labs for testosterone/estrogen/prolactin levels and review of these levels there after and a medical appt. w/a MD specializing in GD within 14 days to discuss SRS.

Level 1 - Initial Response

Date Forwarded:	08/23/2017	Date Returned:	08/30/2017
Date Due Back:	09/06/2017	Level 1 Responder:	BENTON, AMANDA

The response from the staff member or person in charge of the area/operation being grieved:

I apologize for the inconvenience, but Dr. Alviso is our GID specialist and he manages all medications and doses. Thank you !

Level 2 - Reviewing Authority Response

Date Forwarded:	08/31/2017	Grievance Disposition:	MODIFIED
Date Due Back:	09/16/2017	Level 2 Responder:	HOFER, AARON
Date Returned:	09/06/2017	Response sent to offender:	09/11/2017

Your grievence has been reviewed and I find:

Edmo,
In addition to the utilization of our GID specialist, you are monitored every 90 days in our Chronic Disease Program with licensed nurses and providers, to include labwork, evaluation,, medication, and patient education.Our providers collaborate with Dr. Alviso on your treatment plan.
I see that you had your Chronic Disease appointment on 8-31-17, and labs were ordered for testosterone, prolactin, and estrogen levels. You may submit an HSR to discuss labs or GID concerns @ no charge with onsite providers as needed.
Thank you!

EXHIBIT 6

II 170000845 EDMO, MASON DEAN 94691

Offender Appeal

Offender Comments:

On 8/31/2017 I "attempted" to discuss SRS w/NP-C Rogers and he said "
IDOC won't allow SRS without a court order" I am requesting SRS but IDOC interferes W@/ my medical doctors and orchestrates Corizon providers to deny requests for SRS. I requested a medical memo for panties, as I am allowed Bras and NP-C Rogers denied, again re-stating IDOC will not allow panties. Other GD offenders are allowed panties and I am not. IDOC/Corizon's Chronic Disease program does adequately staff persons w/GD (including me) and only performs cursory exams, I requested to see a medical Doctor specializing in GD so I may be provided appropriate necessary medical care. My symptoms of GD are worsening due to inadequate medical care- please help.

Level 3 - Appellate Authority Response

Date Appealed:	09/14/2017	Grievance Disposition:	MODIFIED
Date Forwarded:	09/19/2017	Level 3 Responder:	SIEGERT, RONA
Date Due Back:	10/05/2017	Response sent to offender:	10/06/2017
Date Returned:	10/06/2017		

Your appeal has been reviewed and I find:

Inmate Edmo:

The issues stated in your grievance were addressed as detailed in the first and second responses to this grievance. In addition, to the extent the issues you reference are subject matter that is in litigation you have filed, those issues will need to be addressed as part of the court process.

LAWRENCE G. WASDEN
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STATE OF IDAHO

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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 **DECLARATION OF LAURA WATSON**

I, Laura Watson, hereby declare and state as follows:

1. I am employed with the Idaho Department of Corrections ("IDOC") as the Clinical Supervisor at the Idaho State Correctional Institution ("ISCI"). I have been the Clinical Supervisor at ISCI since June, 2016.

2. I am a Licensed Clinical Social Worker and maintain a license with the State of Idaho. I am also a Licensed Clinical Supervisor and a certified Correctional Health Care Provider with a specialty in Mental Health. I received my Master of Social Work degree from Walla Walla College in 2006 and a Bachelor of Social Work from Boise State University in 2004.

3. Prior to my position as Clinical Supervisor, I was a Clinician/Lead Clinician at ISCI for five years, from February 2010 to November, 2015. During that time, I performed mental health assessments of offenders to determine their needs for mental health and/or psychiatric services. I also provided crisis intervention and conducted assessments with offenders who verbalized or demonstrated suicidal behavior. My duties also included planning and delivery of individual and group counseling to offenders who had been diagnosed with Gender Dysphoria ("GD"), which was previously known as Gender Identity Disorder ("GID"). I also prepared psychological reports for the Commission on Pardons and Parole, the Sex Offender Board, and various Courts.

4. As the Clinical Supervisor at ISCI, I currently train and supervise Master's level clinicians as well as a psychiatric treatment coordinator. I also oversee the Behavioral Health Unit, along with mental health services for the facility. I act as a liaison between the mental health clinicians and the education, program, medical, and security staff.

5. My current duties also include performing mental health treatment and consultation for individuals incarcerated at ISCI, including those diagnosed with GD. I supervise

a multi-disciplinary team approach to the professional delivery of clinical and treatment services for inmates at ISCI. My current duties also include training new correctional officers on Managing Mental Illness (to include GD), Suicide Risk Management through Idaho's POST academy. I am also involved in with providing GD training for the officers in the Behavioral Health Unit.

6. I am a member of the Management and Treatment Committee ("MTC"), which is a multidisciplinary committee that meets monthly to discuss and evaluate the needs of inmates who have been diagnosed with GD. Those needs include issues with housing, treatment, clothing, and requests for hormone replacement therapy. The MTC also receives and reviews inmate requests to be assessed for GD. As the Clinical Supervisor and member of the MTC, I am familiar and have experience with the MTC's procedures and practices.

7. I have received training in the clinical treatment of inmates diagnosed with GD, and inmates who have experienced trauma, substance abuse issues, PTSD, and self-injurious behaviors.

8. When providing clinical counseling and mental health services at ISCI and as a member of the MTC, I can rely on and become familiar with different records and documents, including GD inmates' medical and mental health records, Disciplinary Offense Reports ("DORs"), grievances, incident reports, concern forms, and c-notes in order to gain a better understanding of the factors and experiences contributing to an inmate's overall mental health and to assess how an inmate's mental health issues may affect their housing, safety, security, and discipline. Those are records kept in the course and scope of IDOC's regularly conducted activity of supervising, housing, securing, and providing for medical and mental health treatment and counseling to prisoners in the state prison system.

9. As a Clinician and Lead Clinician, I was one of Plaintiff Adree Edmo's treating Mental Health Clinicians from 2013 to 2015. During that time, I provided individualized clinical contact to Edmo and met individually with Edmo on multiple occasions, including while Edmo was housed in the Behavioral Health Unit. During that time I facilitated the GID group for which Edmo attended 27 weeks from 1/8/13 to 8/6/13.

10. During my individual clinical sessions and in group therapy sessions, Edmo and I discussed Edmo's family history, relationship history, trauma, sexual abuse, and Edmo's suicide attempts before Edmo's incarceration. We also discussed Edmo's feelings of dysphoria, depression, anxiety, and Edmo's difficulty maintaining healthy, stable relationships. During my contacts with Edmo, I recommended tools to assist Edmo in addressing Edmo's mental health issues, including attending group and individualized counseling to work through Edmo's Fsignificant history of trauma, abuse, and relationship/dependency issues.

11. For example, on September 30, 2015, Edmo requested to meet with me specifically after already having met with the primary clinician while on suicide watch for attempting to remove Edmo's testicles. Edmo and I discussed issues with parts of Edmo that did not make Edmo feel feminine. Edmo further acknowledged struggling with wanting and needing male attention, which made Edmo feel needed, wanted, and feminine. Edmo stated that Edmo wanted Edmo's genitals gone, but Edmo also admitted that Edmo knew that removal of Edmo's testicles would not fix Edmo's long-standing mental health issues. I spent quite a bit of time with Edmo confronting Edmo's long standing maladaptive behaviors of focusing on issues outside Edmo's self, while not taking any of the time needed to focus and work on the struggles Edmo had had for a very long time, such as low self-esteem, relationship issues, being a victim of domestic violence, substance abuse, dependency, and acceptance issues. I validated the other

things Edmo focused on that were important to Edmo and that Edmo should continue to advocate for Edmo's self and work on those things, but we processed how Edmo is wrapped up in Edmo's sense of identity and uses it as an escape from having to deal with some of the long standing issues mentioned above. Edmo agreed that all of those things help Edmo refrain from dealing with Edmo's problems. We discussed how if Edmo looked exactly the way Edmo wanted (including having sex reassignment surgery), Edmo would still be broken inside if Edmo did not address Edmo's other mental health issues. Edmo agreed and we discussed ways Edmo could begin to work more on Edmo's self, along with the underlying issues that Edmo had throughout Edmo's life, rather than only focusing on the outside. A true and correct copy of the record for this encounter is attached as **Exhibit 1.**

12. Less than one week later, on October 5, 2015, during a visit with Edmo after being released from a holding cell, Edmo didn't feel like Edmo had any mental health concerns and felt that Edmo had worked through most of those struggles. During that visit, Edmo was able to recognize that the attention Edmo sought from men was similar to the way Edmo abused substances, in that both were maladaptive ways to address ongoing problems. However, Edmo was less willing to accept that Edmo had underlying issues to work on, such as self-esteem, boundaries, and self-acceptance. Edmo appeared to minimize these ongoing struggles, instead referring to them as "normal" female self-esteem issues. A true and correct copy of the record for this encounter is attached as **Exhibit 2**.

13. On October 13, 2015, I met again with Edmo after receiving a concern form. Edmo's estrogen had been increased and Edmo felt good about that. However, Edmo expressed that Edmo had struggled lately with pulling Edmo's self out of a negative mindset despite recognizing/validating all the progress Edmo had made. During that visit, we discussed how

Edmo would continue to have identity and acceptance issues outside of Edmo's gender so long as Edmo was unwilling and unable to process some of the other issues that Edmo had struggled with, including a history of trauma, issues with power and control, relationship issues, and perfection issues. A true and correct copy of the record for this encounter is attached as **Exhibit 3**.

14. I met again with Edmo on December 3, 2015, for Edmo's scheduled clinical contact. Edmo had struggled recently with relationship issues and admitted that Edmo did not do well alone. Edmo admitted that the attention of a male took Edmo's focus off Edmo's dysphoria. We discussed Edmo's pattern of unhealthy relationships and tried to identify ways in which Edmo could get healthy attention, rather than seeking attention from males in unhealthy ways. A true and correct copy of the record for this encounter is attached as **Exhibit 4**.

15. I had another clinical contact visit with Edmo on December 17, 2015, during which we discussed Edmo's recent attempts at self-harm. Edmo desired to self-castrate given that Edmo felt overwhelmingly frustrated with still having male genitalia. I worked with Edmo on ways to meet Edmo's needs to feminize without violating policy and without resorting to self-harm. At that time, we prepared a treatment plan, wherein Edmo agreed that Edmo needed to set boundaries in personal relationships and avoid giving in to impulsive self-harming thoughts. A true and correct copy of the record and treatment plan for this encounter is attached as **Exhibit 5**.

16. As a member of the MTC and as Clinical Supervisor at ISCI, I have also been involved in discussions and meetings with other IDOC treatment providers with personal knowledge of Edmo's mental health conditions. I have reviewed mental health records from prior to Edmo's incarceration, along with Edmo's Presentence Investigation Reports and clinical notes. I am familiar with Edmo's documented social, criminal, medical, institutional, and mental

health history and current mental health conditions.

17. Based on my personal clinical experiences with Edmo, including individualized clinical and group counseling contacts, along with my review of Edmo's mental health treatment records, prior medical records, and PSI Reports, it is my observation and opinion that Edmo has significant underlying unresolved mental health concerns, including depression, self-harm, suicide attempts, a history of sexual abuse, a history of domestic abuse, substance abuse, sexually-charged behaviors, dependency issues, self-esteem issues, and unhealthy relationships. Although Edmo has not been diagnosed with borderline personality disorder, it is my clinical opinion that Edmo has demonstrated borderline personality characteristics.

18. It is also my opinion that Edmo relies on sex reassignment surgery as the one and only solution to all of Edmo's current mental health concerns. However, Edmo has not sufficiently addressed Edmo's other serious mental health concerns by failing to engage in recommended individual therapy to address Edmo's traumatic past and subsequent maladaptive behaviors and the impact this has on Edmo's current mental health struggles. Edmo has also been noncompliant with clinically recommended scheduled clinical contacts and group therapy such as Mood Management and Social Skills. Edmo has also not completed sex offender programming which may also provide insight into Edmo's ongoing struggles. At times, Edmo has not been willing to acknowledge Edmo's other mental health issues and has remained fixated on obtaining SRS to "fix" Edmo, without first doing the work to explore the other potential sources of Edmo's dysphoria and depression, i.e., prior trauma and abuse.

19. As a result, it is my clinical opinion that SRS is not appropriate for Edmo, due to Edmo's underlying uncontrolled mental health issues, and because Edmo considers SRS as a cure for all of Edmo's complex mental health concerns, while refusing to acknowledge and work

through those issues using less invasive and permanent means. I believe that Edmo's unresolved sources of distress are complicating Edmo's resolution of GD and as a result, SRS would not be in Edmo's best interest at this time.

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

DATED this 31st day of August, 2018.

/s/ Laura Watson
Laura Watson

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 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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/s/ Krista Zimmerman
Krista Zimmerman

EXHIBIT 1

IDAHO DEPARTMENT OF CORRECTION
CLINICAL CONTACT NOTE

INMATE NAME (Last, First, MI)	IDOC #	DATE OF BIRTH
Edmo, Mason	94691	[redacted]

Date/Time Problem Number	Use SOAP Note Format
9/30/15 1511 Clinical contact	S: Met with Edmo today at Emdo's request while on suicide watch for attempting to remove Edmo's genitals. Edmo asked about what the plan is for Edmo. Edmo states Edmo doesn't know what the options are so Edmo doesn't know what to do. Edmo discussed issues with parts of Edmo that don't make Edmo feel feminine. Edmo spoke of struggles with wanting and needing attention from males and how this makes Edmo feel needed/wanted/feminine. Edmo admitted that this was what fueled Edmo's desire to be moved out of unit 16 as it was "easier."
	O: Edmo was Ox4 and alert. Edmo's hygiene and grooming were consistent with Edmo's placement in a holding cell and Edmo's speech was WNL. Edmo appeared relaxed and presented with direct eye contact. Edmo denied HI/SI but did state Edmo wants Edmo's genitals gone. However, through the conversation, Edmo reported that Edmo knows it won't fix everything and had no plan or intent to follow through at this moment. Edmo presented as pleasant and euthymic and indicated Edmo was feeling "alright." Edmo's thought process was logical and clear and Edmo's content of thought was appropriate. Edmo's insight and judgment were assessed as fair. Edmo did not appear to be endorsing any delusions, illusions, or hallucinations. Edmo was cooperative.
	A: Edmo appears to be stable at this point. I spent quite a bit of time with Edmo confronting Edmo's long standing maladaptive behaviors of engrossing Edmo's self in all of these other things (legal fights, males in general population, complaints over everything, outward beauty, etc.) while not taking any of the time needed to focus and work on the struggles Edmo has had for a very long time (low self-esteem, relationship issues, being a victim of domestic violence, substance abuse, dependency and acceptance issues, etc.). I validated the other things Edmo focused on were important to Edmo and that Edmo should continue to advocate for Edmo's self and work on those things. . . but we processed how Edmo's entire sense of identity is wrapped up in that and how Edmo uses it as an escape from having to deal with some of the long standing issues. Edmo agreed that all of those things help Edmo refrain from dealing with Edmo's problems. We discussed how if Edmo looked exactly the way Edmo wanted (including having surgery), Edmo would still be broken inside. Edmo agreed and we discussed ways Edmo could begin to work more on Edmo's self and the issues Edmo has had throughout Edmo's life rather than only focusing on the outside. Explored insecurities that all men and women have and how fixing things on the outside, don't fix things on the inside the way we expect them to. Edmo was very receptive and identified a plan to identify how Edmo is going to refrain from attempting to take off Edmo's genitals. Edmo agreed to do this. I also told Edmo that release from 16 requires stability and Edmo does not appear stable. Edmo agreed and requested to remain in 16 upon release.

EXHIBIT 1

	P: Edmo will be seen daily while on SW. Edmo will remain in unit 16 upon release.

L. Watson, LCSW

9/30/15
Date

ALL ENTRIES MUST INCLUDE THE WRITER'S PRINTED NAME, SIGNATURE & TITLE

(SOAP – Subjective Objective Assessment Plan)

IDOC Clinical Contact Note 3.09

CORIZON 0490

EXHIBIT 2

IDAHO DEPARTMENT OF CORRECTION
CLINICAL CONTACT NOTE

INMATE NAME (Last, First, MI)	IDOC #	DATE OF BIRTH
Edmo, Mason	94691	[redacted]

Date/Time Problem Number	Use SOAP Note Format
10/5/15 0900 3 of 3	S: Met with Edmo today for Edmo's 3 of 3 after being released from a holding Spent quite a bit of time discussing Edmo's reported need to "feminize." Edmo states that the issues seem to ebb and flow in regards to feeling like Edmo can handle it and then feeling like there is no way to handle it. Edmo expressed frustration at medical stating Edmo knows Edmo's own body and knows the meds are not where they should be. Edmo states this is partly why Edmo decided Edmo would take things into Edmo's own hands by attempting to castrate Edmo's self. Edmo stated that Edmo had time to think about our last conversation and stated that Edmo feels that Edmo doesn't really have any mental health concerns as Edmo has worked through most of these but struggles with dysphoria which Edmo attributes to lack of appropriate medical care. Edmo states Edmo only sees self as a woman and that Edmo struggles with "normal" female self-esteem issues such as worrying about how Edmo looks and how others will perceive Edmo.
	O: Edmo was Ox4 and alert. Edmo's hygiene and grooming were appropriate and Edmo's speech was WNL. Edmo appeared relaxed and presented with direct eye contact. Edmo denied HI/SI but did state Edmo wants Edmo's genitals gone. However, Edmo denied plan or intent to follow through at this moment and agreed to seek out staff if needed. Edmo presented as pleasant and euthymic and indicated Edmo was feeling "just frustrated." Edmo's thought process was logical and clear and Edmo's content of thought was appropriate. Edmo's insight and judgment were assessed as fair. Edmo did not appear to be endorsing any delusions, illusions, or hallucinations. Edmo was cooperative.
	A: Edmo appears to be stable at this point. Spent quite a bit of time problem solving and formulated a plan for medical follow up and communication. Discussed the medical treatment being separate from mental health treatment. Edmo indicated that we should work together and I agreed but also stated that I am not a medical provider so I cannot recommend more or less meds and I am happy to talk with them about Edmo's struggles with depression, anxiety, and dysphoria related to having male genitals. Edmo seemed to vacillate back and forth between what Edmo felt Edmo needed from mental health. However, Edmo was able to recognize that attention from men seems to help with the dysphoria and was able to see the similarities with attention and drug use. Edmo had a much different presentation today than last week. Today Edmo's frustration was medical and there was a significant denial of internal issues which may be leading to some of the struggles. Last week there seemed to be more of an acceptance of things Edmo needed to work on in regards to self-esteem, boundaries issues, and self-acceptance.
	P: Edmo will continue to be followed by clinical staff congruent with Edmo's LOC. Edmo can use a concern form or attend clinic to access MH staff as well.

L. Watson, LCSW

10/5/15
Date

ALL ENTRIES MUST INCLUDE THE WRITER'S PRINTED NAME, SIGNATURE & TITLE

CORIZON 0501

EXHIBIT 3

IDAHO DEPARTMENT OF CORRECTION
CLINICAL CONTACT NOTE

INMATE NAME (Last, First, MI)	IDOC #	DATE OF BIRTH
Edmo, Mason	94691	[redacted]

Date/Time Problem Number	Use SOAP Note Format
10/13/15 1310 Clinical contact	S: Met with Edmo today per Edmo's concern form. Edmo stated Edmo met with medical and the increased Estrogen by 1mg. Edmo felt good about this and felt like maybe this was a sign of good things to come. Edmo discussed historical details of Edmo's past including information regarding diagnoses. Edmo stated that recently Edmo has struggled with getting into a place where Edmo cannot see out of the tunnel vision that seems to be present. Edmo states that Edmo knows there are many good things going on and Edmo has made a great deal of progress but struggles seeing that in the moment. Edmo states Edmo is not sure how to pull Edmo's self out of that mindset. Edmo talked about not being open and honest with Edmo's significant other regarding struggles as Edmo is a "strong, independent woman who can handle these things myself." However, Edmo also admitted that Edmo manipulates to present things in a certain way order to not be vulnerable with others.
	O: Edmo was Ox4 and alert. Edmo's hygiene and grooming were consistent with Edmo's placement in a holding cell and Edmo's speech was WNL. Edmo appeared relaxed and presented with direct eye contact. Edmo denied HI/SI. Edmo states Edmo still wants to remove "that thing" (referring to penis/testicles" but denies having a plan or intent to follow through stating Edmo "just wants it gone." Edmo presented as pleasant and euthymic and indicated Edmo was feeling "okay." Edmo's thought process was logical and clear and Edmo's content of thought was appropriate. Edmo's insight and judgment were assessed as fair. Edmo did not appear to be endorsing any delusions, illusions, or hallucinations. Edmo was cooperative.
	A: Edmo appears to be stable at this point. We discussed how this clinician will be transferring to another position and the plan will be to transfer Edmo to clinician Irvin's caseload. Edmo was receptive to this. Spent time building rapport and discussing history and the impact this has on Edmo's current functioning. Explored Edmo's insight about manipulating so that other's only see what Edmo is willing to show them and pointed out how Edmo has done this recently (while in the holding cell was open about issues regarding self-esteem and acceptance and then the netx time we met identified that this wasn't a problem at all and Edmo had worked through all of this). Pointed out how Edmo will continue to have identify and acceptance issues outside of gender as long as Edmo is unwilling/unable to process some of the other issues Edmo struggles with (such as trauma history, relationship issues, issues with power and control, perfection issues, etc.). Explored ways in which Edmo can begin to identify issues as they arise and address them at that point rather than allowing them to build up (as Edmo has done recently) and then become a crisis. Used the analogy of a flat tire versus a broken engine. . . one is much easier to "fix." Edmo has great insight but needs to work on trust in regards to being vulnerable to really make progress in some of the areas Edmo struggles with.
	P: Edmo will continue to be followed by clinical staff congruent by Edmo's LOC. Edmo will use a concern form or attend clinic as needed.

L. Watson, LCSW

10/13/15
Date

ALL ENTRIES MUST INCLUDE THE WRITER'S PRINTED NAME, SIGNATURE & TITLE
(SOAP – Subjective Objective Assessment Plan)

IDOC Clinical Contact Note 3.09

CORIZON 0502

EXHIBIT 4

IDAHO DEPARTMENT OF CORRECTION
CLINICAL CONTACT NOTE

INMATE NAME (Last, First, MI)	IDOC #	DATE OF BIRTH
Edmo, Mason	94691	[redacted]

Date/Time Problem Number	Use SOAP Note Format
12/3/15 1005 Clinical contact	S: Met with Edmo today for Edmo's scheduled clinical contact. Clinician Houser was present as she will be the clinician that Edmo is transitioning to. Edmo stated that Edmo had been struggling a bit lately "because of the same old drama." Edmo stated Edmo broke up with the previous significant other but had already had one that Edmo was starting to see before breaking up with the other one. Edmo now states Edmo is in a relationship with someone else but warned them that it may not last. Edmo admitted to not doing well alone. Edmo states that the attention makes Edmo feel good and takes the focus off of things like still having a penis. Edmo stated that overall, Edmo feels better and is trying to work on being alone and setting boundaries. Edmo states Edmo's depression has been better with the increase in hormones but still feels it could be better.
	O: Edmo was Ox4 and alert. Edmo's hygiene and grooming were appropriate. Edmo appeared relaxed and presented with direct eye contact. Edmo denied HI/SI. Edmo states Edmo still has desires to self-castrate but states Edmo has been managing these well and denies plan or intent. Edmo presented as pleasant and euthymic and indicated Edmo was feeling "alright I guess." Edmo's thought process was logical and clear and Edmo's content of thought was appropriate. Edmo's insight and judgment were assessed as fair. Edmo did not appear to be endorsing any delusions, illusions, or hallucinations. Edmo was cooperative.
	A: Edmo appears to be stable at this point. Confronted Edmo on ongoing maladaptive patterns which continue to lead to issues in Edmo's life. Reviewed the challenges Edmo has with saying no and the concern Edmo has about hurting other's feelings which is why Edmo will remain in unhealthy relationships for far too long. Reviewed healthy boundaries that Edmo could set and ways in which Edmo could get healthy attention that Edmo felt Edmo needed rather than continuing to seek it from males in any way Edmo can. Spent some time reviewing Edmo's history and the things that Edmo was working on for the new clinician. Reviewed compliance towards treatment plan goals.
	P: Edmo will continue to be followed by clinical staff congruent by Edmo's LOC. Edmo will use a concern form or attend clinic as needed. Edmo was referred to healthy relationships.

L. Watson, LCSW

12/3/15
Date

ALL ENTRIES MUST INCLUDE THE WRITER'S PRINTED NAME, SIGNATURE & TITLE
(SOAP – Subjective Objective Assessment Plan)

IDOC Clinical Contact Note 3.09

CORIZON 0511

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION
CLINICAL CONTACT NOTE

INMATE NAME (Last, First, MI)	IDOC #	DATE OF BIRTH
Edmo, Mason	94691	[redacted]

Date/Time Problem Number	Use SOAP Note Format
12/17/15 1215 Clinical contact	S: Met with Edmo today for per Edmo's concern form to update Edmo's treatment plan. Clinician Houser was present as Edmo will be transferring to her caseload. Edmo stated Edmo was doing better. I had attempted to meet with Edmo last week per the concern form but Edmo stated Edmo was given the wrong medication and it made Edmo too tired to participate. Edmo reported doing well now and had recently ended a relationship Edmo knew Edmo did not want to be in. Edmo states Edmo has one person "interested" but Edmo doesn't want to jump into a relationship and wants to get to know the person. Edmo admits to liking the attention from relationships and states Edmo has been in a relationship of some sorts the entire time Edmo has been incarcerated. Edmo spoke of recent self-harm and desires to self-castrate given Edmo feels overwhelmingly frustrated with still having male "parts." Edmo states Edmo has self harmed three times in the last six months and wants to work on this.
	O: Edmo was Ox4 and alert. Edmo's hygiene and grooming were appropriate. Edmo appeared relaxed and presented with direct eye contact. Edmo denied HI/SI but did report recent self harm (denied current plan or intent). Edmo presented as pleasant and euthymic and indicated Edmo was feeling "better." Edmo's thought process was logical and clear and Edmo's content of thought was appropriate. Edmo's insight and judgment were assessed as fair. Edmo did not appear to be endorsing any delusions, illusions, or hallucinations. Edmo was cooperative.
	A: Edmo appears to be stable at this point. We spent quite a bit of time updating Edmo's treatment plan and all needed items for MDTT. Edmo took an active role in treatment plan formation but seemed focused on wanting this clinician to include Edmo's need to feminize as Edmo continued to state if Edmo gets a DOR, Edmo wants the hearing officer to know it was part of the plan and that it plays a role in Edmo's dysphoria. We spoke at length about ways in which Edmo could feel feminine though going against policy but Edmo seemed resistant to this. I was honest with Edmo that I could not write a goal that goes against policy but that I could work with Edmo on ways in which Edmo could better meet these needs while refraining from self harm. We also spent quite a bit of time processing/discussing boundary issues and ways Edmo could work on these in order to meet Edmo's own needs.
	P: Edmo will continue to be followed by clinical staff congruent by Edmo's LOC. Edmo will use a concern form or attend clinic as needed. Edmo will attend MDTT.

L. Watson, LCSW — Date: 12/17/15

ALL ENTRIES MUST INCLUDE THE WRITER'S PRINTED NAME, SIGNATURE & TITLE

(SOAP – Subjective Objective Assessment Plan)

IDOC Clinical Contact Note 3.09

CORIZON 0512

EXHIBIT 5

Mental Health Group Referral (BHU)

Inmate Name: Edmo Inmate IDOC #: 94691

Date of Referral: 12/17/15

Referring Clinician: Watson

Clinician Groups:

- ☐ Lifer's Group (CCG 1)
- ☐ Suicide Prevention (CCG 1)
- ☐ Mindfulness (CCG 4)
- ☐ Living with Schizophrenia (CCG 6)
- ☐ Living with Bipolar (CCG 7)
- ☐ Living with Depression (CCG 8)
- ☐ Living with Anxiety (CCG 9)
- ☐ PTSD (CCG 10)
- ☐ Mood Management (CCG 12)
- ☒ GD Process Group (CCG 12)
- ☐ ADHD (CCG 12)
- ☐ Grief and Loss (CCG 13)
- ☐ Co-Occurring (CCG 14)
- ☐ Self-esteem (CCG 15)
- ☐ Other

already enrolled

Psych Tech/Officer Groups:

- ☐ Community Re-entry (CCG17)
- ☐ Healthy Self (CCG 17)
- ☒ Healthy Relationships (CCG 17)
- ☐ Anger Reduction (CCG 17)
- ☐ Social Skills/ Goals (CCG 18)
- ☐ Social Roles (CCG 18)
- ☐ Assertive Communication (CCG 18)
- ☐ Current Events (CCG 19)
- ☐ History (CCG 19)
- ☐ Reading (CCG 19)
- ☐ Creative Writing (CCG 19)
- ☐ Puzzle/ Games (CCG 20)
- ☐ Riddles/ Trivia (CCG 20)
- ☐ Music (CCG 20)
- ☐ Art (CCG 20)
- ☐ Other

CORIZON 0513

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION
TREATMENT PLAN

DATE	12/17/15	INMATE NAME	Edmo, Mason		
IDOC #	94691	DOB	[redacted]	LOC	CMHS-1
PROBLEM (in operational terms)			GOAL		
1.	Edmo states Edmo struggles setting boundaries in personal relationships out of fear or hurting someone else's emotions.		Edmo will identify at least one boundary Edmo needs to set in a personal relationship and follow through within at least one week 75% of the time.		
2.	Edmo reports some struggles with attempting to self-castrate or desires to self-castrate.		Edmo will identify at least two ways Edmo could feel more feminine (within policy) and engage in these prior to giving into impulsive, self-harming thoughts.		
PREPARED BY	L. Watson, LCSW 0367			DATE	12/17/15

INTERVENTIONS Problem #	Treatment Intervention	Staff/Person Responsible	Frequency/ Duration	Date Goal Closed
1, 2	Edmo will use coping skills when struggling with mental health symptoms.	Edmo	As needed	
1, 2	Edmo will voice an understanding of how to use a concern form and/or attend drop-in clinics to access clinical support.	Edmo	As needed	
1, 2	Edmo will attend psychoeducational groups as scheduled. **Edmo is currently attending Gender Dysphoria group and has been referred to healthy relationship.**	Edmo	As scheduled	
1, 2	Edmo will take any medication prescribed by the psychiatrist or designee, as indicated, reporting any changes, concerns, or side effects.	Edmo/ Psychiatry	As prescribed	
1, 2	Edmo will notify staff right away of any suicidal or homicidal thoughts, or of any plan/intent to harm self or others.	Edmo	As needed	
1, 2	Edmo reports spending time at education and exercising as beneficial activities and is encouraged to maintain these activities so long as they continue to be helpful.	Edmo	Daily	
1, 2	Edmo will use journaling as a tool help improve self-esteem and self-image.	Edmo	Ongoing	

OFFENDER SIGNATURE — 94691 IDOC # — 12/17/15 DATE

IDOC Treatment Plan Form Rev. 5.10

CORIZON 0514

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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 **DECLARATION OF WALTER L. CAMPBELL, PH.D.**

I, Walter L. Campbell, PhD., hereby declare and state as follows:

1. I am over the age of eighteen and am competent to testify to the matters herein. I make this declaration made upon my personal knowledge.

2. I am employed with the Idaho Department of Corrections ("IDOC") as the Chief Psychologist.

3. I am a licensed psychologist and maintain a professional license with the State of Idaho. I received my Ph.D. in Counseling Psychology and my Masters of Sciences degree in Counseling and Counseling Education, both from the Indiana University. I earned two Bachelors of Arts degrees in Philosophy of Religion and Biblical Literature from Taylor University.

4. I have been the Chief Psychologist at IDOC since September 17, 2016.

5. Prior to my employment with IDOC, I was employed for three years as the Lead Psychologist for Corizon Health, Inc. and worked at three separate facilities. In 2015 and 2016, I oversaw the INSIGHT Mental Health Unit of the Pendleton Correctional Facility in Pendleton, Indiana. In 2014 and 2015, I oversaw the Special Needs Unit at the Wabash Valley Correctional Facility in Carlisle, Indiana. In 2013 and 2014, I was responsible for all mental health services at the Plainfield Correctional Facility in Plainfield, Indiana.

6. During my doctoral internship with Corizon in 2012 and 2013, I provided individual and group therapy to prisoners at the Wabash Valley Correctional Facility.

7. I am a member of the American Psychological Association and Idaho Psychological Association.

8. I am a member of the World Professional Association for Transgender Health. I attended continuing education courses at the 2017 WPATH conference.

9. I also have also received training on Gender Dysphoria ("GD") from the National Commission on Correctional Health Care ("NCCHC") at two annual conferences.

10. I have reviewed dozens of articles and publications regarding the treatment of transgendered inmates, including inmates with GD. I am familiar with the standards of care for transgender persons set forth by WPATH, along with statements and guidelines regarding GD and transgender persons set forth by the American Psychological Association and the American Psychiatric Association. I am also familiar with the guidelines regarding GD offenders and transgender inmates as provided by the National Commission on Correctional Health Care, the National Institute of Corrections, and the Federal Bureau of Prisons.

11. As the Chief Psychologist at IDOC, I am responsible for the oversight of mental health programming, including the creation and approval of policies and procedures related to mental health services for prisoners housed in general population, restrictive housing, and specialized mental health treatment units.

12. My duties as Chief Psychologist also include the administrative supervision of the master's level clinicians who provide group and individual therapy to IDOC inmates at each facility. As the chief diagnostician, I also consult with clinicians on mental health operations and services at IDOC. I am further provide input regarding revisions to the current IDOC GD Policy, SOP 401.06.03.501.

13. I serve as chair of the Management and Treatment Committee ("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. As the chair, I am familiar and have significant experience with the MTC's procedures and practices.

14. During my time as Chief Psychologist at IDOC, I have directly conducted six GD assessments. Also during that time, I have overseen the treatment and assessment of approximately fifty inmates who have requested GD evaluations, through my role as chair of the MTC and as the Chief Psychologist at IDOC.

15. Once an inmate makes a request for a GD evaluation or if a member of the healthcare staff requests that an inmate receive an evaluation for GD, I review the request and recommend that the offender be placed in the appropriate facility for the evaluation to take place.

16. Once an evaluation has been performed, the evaluator provides a report to the MTC seven days before the MTC monthly meeting. Prior to the meeting, I review the report and when the MTC convenes for the monthly meeting, I provide my assessment of the evaluator's findings, indicating whether I agree or disagree with the findings and diagnoses contained in the evaluation report, if any.

17. I then convene the MTC to develop an individualized treatment plan and recommendation for the placement and needs of the GD offender. Typically, a clinician prepares the individualized treatment plan, which is then reviewed by the MTC, taking into consideration both the treatment and security concerns involving each individual GD offender. Once a treatment plan is adopted by the MTC, recommendation for the adoption of that plan is presented to the Administrative Review Committee ("ARC").

18. The ARC then reviews our recommendations and our proposed individualized plan. The MTC consults with the ARC to answer any questions or provide further clarification of our recommendations. The ARC reviews the recommendations of the MTC and crafts its own recommendations regarding the classification, management, and security of the GD inmate. The

ARC then provides its recommendations, along with those of the MTC to the director of IDOC for final approval.

19. The MTC also convenes monthly to discuss and address the individual needs of the GD offenders, including issues related to mental health treatment, housing, property, discipline, safety, and any other issues that arise which involve the treatment and management of GD inmates.

20. The MTC does not make any individual treatment decisions regarding GD inmates. Those determinations are made by the individual clinicians or the medical staff employed by Corizon. The MTC may provide requested information and consult with Corizon providers regarding GD inmates. However, the MTC does not override any medical treatment decisions made by Corizon physicians and providers.

21. In 2012, Plaintiff Adree Edmo's ("Edmo") was diagnosed with GD, shortly after requesting and receiving an evaluation. The evaluation was performed by psychologist Claudia Lake. Also in 2012, Edmo began receiving hormone therapy. Edmo has also been provided with a bra and has been permitted to feminize appropriately. Edmo is encouraged by our staff to attend group and individualized therapy specifically for inmates with GD.

22. Edmo is one of the GD offenders whose needs have been addressed and discussed by the MTC. For instance, over the last several years, the MTC has discussed and made recommendations regarding Edmo's housing, group therapy attendance, and safety.

23. In my role as Chief Psychologist and chair of the MTC, I have reviewed Edmo's file, including Edmo's mental health treatment records, treatment plans, DORs, concern forms, and Presentence Investigation reports ("PSI"). I am familiar with Edmo's treatment for GD while Edmo has been in the custody of IDOC.

24. Edmo's individual clinicians have recommended that Edmo participate in GD group therapy and individualized clinical therapy with IDOC clinicians. Edmo's clinicians have also recommended that Edmo participate in other mental health groups, including Social Skills and Mood Management, in order to address and help Edmo manage Edmo's mental health conditions, including Edmo's GD, depression, anxiety, and unhealthy relationships. Throughout 2016, 2017, and 2018, Edmo has refused to regularly attend the individual and group therapy recommended by the mental health staff. Edmo was also barred by the MTC from attending the GD processing group for six months after Edmo twice assaulted another GD inmate who also participated in the GD group.

25. Edmo's medical and mental health records demonstrate that Edmo has significant underlying uncontrolled mental health issues. For example, Edmo has been diagnosed with Major Depressive Disorder, Anxiety, and Alcohol Dependence. Edmo also has well-documented behaviors consistent with personality disorders. Edmo also has a history of severe trauma, including sexual, domestic, and emotional abuse. Edmo attempted suicide on at least two occasions prior to Edmo's incarceration and has demonstrated poor self-worth, poor self-esteem, and unhealthy relationships while in prison. For instance, Edmo has a history of inappropriate sexual behaviors and co-dependency. Edmo has also resorted to self-harm, including continued cutting behaviors.

26. Based on my review of Edmo's mental health treatment records, it is my understanding Edmo received an evaluation for sex reassignment surgery on April 20, 2016, by psychiatrist Scott Eliason, M.D. It is my understanding that Dr. Eliason concluded after the evaluation, and in consultation with clinical supervisor Jeremy Clark, clinician Jeremy Stoddard,

and Dr. Murray Young, that sex reassignment surgery was not medically necessary or appropriate for Edmo.

27. To my knowledge, prior to June 1, 2018, no qualified GD evaluator has ever determined that sex reassignment surgery was medically necessary for Edmo. Had such a determination been made, I would have convened the MTC to discuss that determination for Edmo. I am not aware of any "blanket" prohibition to providing sex reassignment surgery if it is determined to be medically necessary for an individual inmate.

28. I have reviewed the Declarations of Randi Ettner, Ph.D. and Nicolas Gorton, M.D., who recommend that Edmo receive sex reassignment surgery.

29. I do not believe that Drs. Ettner and Gorton have fully grasped Edmo's underlying mental health issues, when they identify Edmo's GD as the root cause of Edmo's depressive symptoms and dysphoria. The clinical evidence demonstrates that Edmo's feelings of dysphoria have a very complex origin, related to trauma, relationship difficulties, and other unresolved life events, precisely as Edmo's IDOC mental health clinicians have described in treatment notes over the last several years. Furthermore, Edmo has not demonstrated a willingness to address these underlying mental health issues through treatment, making assessment of her full mental clinical difficult.

30. Edmo's clinical history provided to Drs. Ettner and Gorton is inconsistent with other reports, including the PSI and Edmo's medical records from prior to her incarceration, especially as to the reports that Edmo lived full-time as a woman prior to incarceration in 2012.This inconsistency demonstrates that there are many unanswered questions about Edmo's life events prior to incarceration. Such questions need to be explored to further evaluate the root cause of Edmo's depressive symptoms and dysphoria. What is clear is that Edmo seriously

attempted suicide several times before incarceration, was the victim of sexual and domestic abuse, and had severe substance abuse problems. Such issues should not be ignored, overlooked, or downplayed when assessing the causes of Edmo's dysphoria.

31. Edmo's medical and mental health record indicates that the etiology of Edmo's dysphoria is unclear and complex. This, coupled with Edmo's disinclination to participate in mental health treatment to address her underlying mental health issues, makes a clear clinical formulation very difficult. In short, Edmo's overall clinical picture is not fully understood and it is not clear that Edmo's GD is the sole cause of Edmo's dysphoria. Until 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.

32. IDOC mental health staff have chosen to make the clinically appropriate decision to focus on maintaining Edmo's stability and safety while compassionately extending the offer to provide therapeutic treatment to Edmo, in the case that Edmo decides to pursue it.

33. I am not convinced that there would be no adverse outcome if Edmo undergoes sex reassignment surgery, in light of the many unanswered questions posed by Edmo's complex mental health history.

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

DATED this 30th day of August, 2018.

/s/ Walter L. Campbell, Ph.D.
Walter L Campbell, Ph.D.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 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 **DECLARATION OF CLIFF CUMMINGS**

I, Cliff Cummings, hereby declare and state as follows:

1. I have personal knowledge of the information provided in this declaration and I am over the age of 18 and am competent to testify to the facts as stated.

2. I am employed as a Senior Probation/Parole Officer with the Idaho Department of Corrections ("IDOC") for District Six in Pocatello, Idaho. I have been employed as a Probation/Parole Office since June, 1991. For the last ten years, I have been a Sex Offender Supervision Officer for District Six.

3. During my time as a Probation/Parole Officer, I have supervised one transgender offender, who I understand was born biologically male, but identified as female (I will not provide that offender's identity in this declaration for privacy purposes). During my times as her probation officer, I observed this offender wearing women's clothing and makeup and wearing her hair in a feminine hairstyle. During my supervision of this offender, I used female pronouns when referring to and addressing her, as she requested.

4. From June 25, 2010, until February 8, 2011, I supervised Mason Meeks, who I understand is now known as Adree Edmo. I supervised Edmo while Edmo was on probation after completing the IDOC retained jurisdiction program following a conviction for One County Drawing a Check Without Funds in 2009.

5. As Edmo's probation officer, I met with Edmo in person fifteen times, both at Edmo's home and in my office.

6. During my interactions with Edmo, I never observed Edmo wearing women's clothing. Edmo did not appear to be wearing makeup and did not have Edmo's hair styled in a feminine way. Edmo did not present or appear as a woman in any way and Edmo did not ask that I refer to Edmo as a woman or use female pronouns.

7. During my supervision of Edmo, Edmo's physical appearance was at all times consistent with Edmo's appearance in the 2010 photograph that is attached hereto as **Exhibit 1**. I never witnessed Edmo appear or acting consistent with a gender other than male.

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

DATED this 31st day of August, 2018.

/s/ Cliff Cummings
Cliff Cummings

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 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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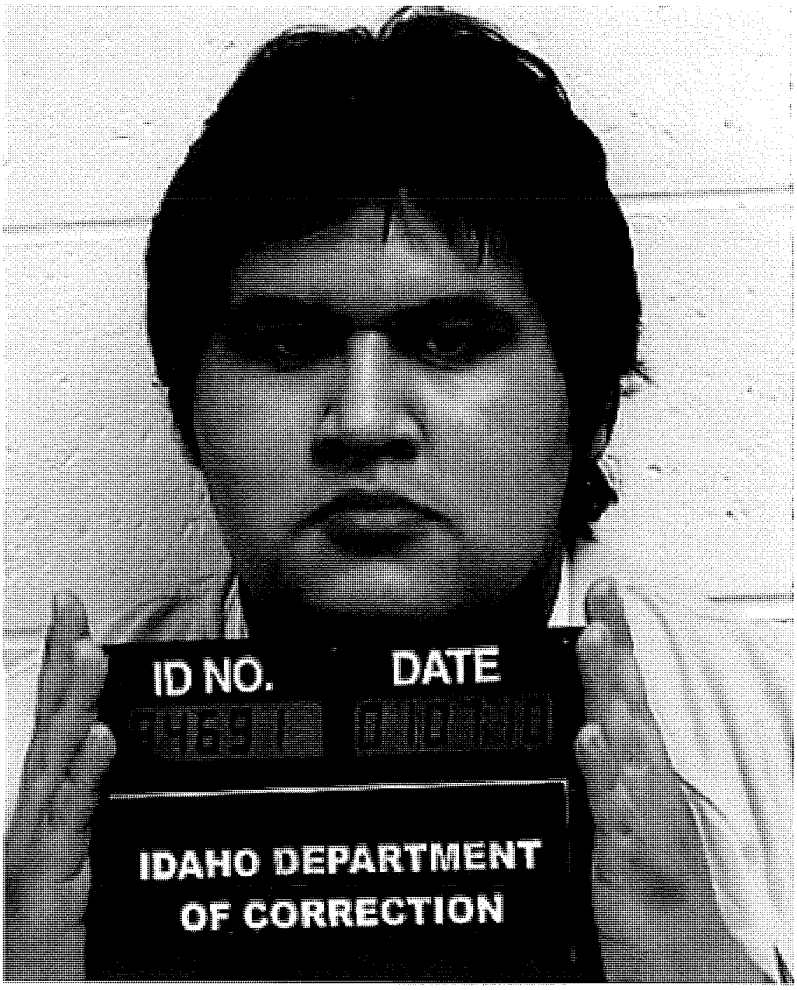
EXHIBIT 1

EDMO, MASON DEAN

IDOC#: 94691



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CIS/Facility Main/Photos/View Photos

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I, Sandy Jones, hereby declare and state as follows:

1. I have personal knowledge of the information provided in this declaration and I am over the age of 18 and am competent to testify to the facts as stated.

2. I am the Executive Director for the Idaho Commission for Pardons and Parole ("Commission"). I have served as the Executive Director for the Commission since August 2014.

3. I attend parole hearings and review proceedings in my capacity as Executive Director of the Commission and have personal knowledge of Commission proceedings involving Adree Edmo, #94691 ("Edmo"). Edmo is in prison because of Edmo's 2012 conviction for Sexual Abuse of a Minor Under the Age of 16.

4. The Commission determines whether any prisoner who is eligible for parole may be released on parole.

5. When making parole decisions with respect to inmates, the Commission considers the prisoner's current risk assessment, criminal history, institutional misconduct, and other characteristics related to the likelihood of the prisoner offending in the future, along with the prisoner's participation, compliance, and completion of offender programming.

6. As part of the Commission's regularly conducted business activities, the Commission takes minutes of its parole hearings and other proceedings. The minutes of a parole hearing constitute the official records of the proceeding, as the Commission does not utilize verbatim minutes or audio or visual recordings to document the proceedings in parole cases. In my capacity as Executive Director for the Commission, I have access to these hearing minutes and other Commission records in the ordinary course of the Commission's business, including parole hearing query reports. I have reviewed the Commission minutes and parole hearing query reports related to Edmo.

7. A regularly scheduled parole hearing for Edmo took place before the Commission on February 7, 2014. The Commission granted a tentative parole date of July 3, 2014, upon Edmo's completion of the Sex Offender Treatment Program ("SOTP"). Attached hereto as **Exhibit 1** is a true and correct copy of the minutes for the parole hearing, which constitute the official record of that hearing.

8. On January 20, 2015, the Commission conducted a Review of three Disciplinary Offense Reports ("DORs") received by Edmo, including one for Battery of another inmate and two for Disobedience to Orders. At the time of the DOR Review, Edmo had enrolled in SOTP. After reviewing the DORs, the Commission elected to void the tentative parole date of July 3, 2014, and set a new tentative parole date of June 19, 2015, set one year from the date of Edmo's battery DOR. The Commission again determined that Edmo was required to complete SOTP. Attached hereto as **Exhibit 2** is a true and correct copy of the minutes for the DOR Review, which constitute the official record of that hearing.

9. On March 3, 2015, the Commission conducted a Review of two DORs received by Edmo for Disobedience to Orders. At the time of the DOR Review, Edmo had enrolled in SOTP. After reviewing the DORs, the Commission elected to void the tentative parole date of June 19, 2015, and set a hearing to take place in March, 2016. Attached hereto as **Exhibit 3** is a true and correct copy of the minutes for the DOR Review, which constitute the official record of that hearing.

10. A regularly scheduled parole hearing for Edmo took place before the Commission on March 14, 2016. At that time, Edmo was back in SOTP but had been previously dropped from SOTP three previous times. Edmo indicated that if Edmo was not provided a parole date at the hearing, Edmo would want to "top" her time. The Commission reviewed a Sex Offender Risk

Assessment ("SORA") for Edmo and denied parole based on Edmo's failure to maintain a period of good behavior and failure to actively participate in or successfully complete Edmo's assigned programming. The Commission further denied parole based on the fact that Edmo committed Edmo's offense while on probation. The Commission scheduled another parole hearing to take place in March, 2017. The Commission determined that another DOR for Edmo would void that hearing date. Attached hereto as **Exhibit 4** is a true and correct copy of the minutes for the parole hearing, which constitute the official record of that hearing.

11. On December 8, 2016, the Commission cancelled Edmo's parole hearing date after Edmo received an additional six DORs, including another DOR for battery, two for Disobedience to Orders, one for Tattooing/Piercing, and two for Destruction of Property Under $25. Attached hereto as **Exhibit 5** is a true and correct copy of the parole hearing query report, which constitutes an official record of the Committee's decision voiding Edmo's parole hearing.

12. Based on my review of the parole proceedings and records related to Edmo, the Commission's decisions to deny parole and vacate Edmo's hearing dates are consistent with the factors set forth in paragraph 5 above, including Edmo's failure to complete SOTP and continued institutional misconduct.

13. At the time of the date of this Declaration, Edmo still has not completed SOTP.

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

DATED this 29th day of August, 2018.

/s/ Sandy Jones
Sandy Jones

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 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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PARSONS, BEHLE & LATIMER

/s/ Krista Zimmerman
Krista Zimmerman

EXHIBIT 1

THE ORIGINAL APPROVED MINUTES ARE ON FILE IN THE COMMISSION OFFICE

S T A T E O F I D A H O
COMMISSION OF PARDONS AND PAROLE

94691 EDMO, MASON DEAN

REG PAROLE HRG DATE: 02/07/2014

COMMISSIONERS:
MATTHEWS, MIKE H
DRESSEN, JANIE
SCHEIHING, GARY

CRAVEN, OLIVIA Executive Director

The Executive Director was not present at this hearing or review and these minutes were signed by the Executive Director in her official capacity only and represent the summary minutes of the proceeding that were prepared during the hearing or review by the Executive Director's designee.

INSTITUTION: ICIO

	CASE NUMBER	OFFENSE	SENT TYPE	MAX	MIN
1)	CR11-11293	SEX ABS<16	CC	10 YR	3 YR

Parole Elig Date: 1) 07/04/2014
Full Term Date: 1) 07/03/2021

Prior Hearing(s) or Reviews:

	Hearing Date	Hearing Type	Hearing Decision	Action Date
1)	01/01/2012	PRIMARY REVIEW	SCHEDULE HEARING	

History on Commitment:

NOTE: The Executive Director was not present during this hearing.

NOTE: This hearing was conducted by videoconference from PWCC to ICI-O.

The Commission had the Sex Offender Risk Assessment (SORA) prepared for this hearing.

He goes by Mason Dean Meeks too, as that is his birth name.

He is in prison because of the sex abuse case. He forged checks in 2009 but that is finished. He wrote multiple checks without funds in his account. At that time he was in a bad relationship and his substance abuse and alcohol use was at its highest. He was on probation for about 2 years for the Forgery when he committed the sex crime. He absconded from probation in 6/11, still was using alcohol and molested the victim by doing felatio. He admits he used alcohol during his entire probation.

EXHIBIT 1

The victim was a distant friend's son. It started when the boy was asleep. He understands the victim told the mother who reported it. He already had the warrant for absconding. About 2 to 3 days went by before he was arrested.

He is on the SOTP Pathway. He got back into it on 1/7/14. It is going much smoother than it did before. When he saw the Hearing Officer, he was waiting on a decision to change his programming. They are accommodating him in the Pathway there in Orofino. He believes he can complete it.

There was a PREA investigation going on but he doesn't know the result. He only knows about the August 2013 one...but did not elaborate.

He plans to live in Pocatello in his own home. He plans to work at Shoshone-Bannock Tribe in the clerical pool. He has much experience there. He will go to a doctor or to his Tribe. He will get the SO aftercare either with the doctor or with the Tribe. He will also do substance abuse treatment with the Tribe.

His family is very supportive now and in the past. They always tried to get him to stop his substance abuse even doing things such as calling police.

When out in the community, he did not have any other minor victims other than this one. He has identified two other victims he has had (in prison). He said again he only has [redacted] the one victim, in the community.

The Commission elects to grant a tentative parole date of 7/3/14 upon completion of SOTP with the following special conditions:

1. Obtain a sex offender evaluation as directed by the Commission, or supervising personnel and comply with all directives for treatment/counseling.
2. Do not associate with a minor child under the age of 18 years unless a responsible adult, approved by supervising personnel, is present
3. Do not frequent any establishments where pornographic material is the main source of income, nor possess pornographic material. You may be ordered to have no computer, or your access to the Internet may be restricted.
4. Submit to polygraph and/or plethysmographic testing at the request of the treatment providers and/or supervising personnel.
5. You must register as a sex offender as dictated by law.
6. May not enter into any relationship until the Parole Officer and treatment provider approves.
7. Remain alcohol and drug free, which includes not using marijuana and not having a medical marijuana card. Do not enter any establishment where alcohol is the main source of income.
8. Obtain a substance abuse evaluation at your own expense and comply with all directives for treatment/counseling.
9. Pay restitution as determined by the courts. You must make payment to the sentencing court for fines and other assessments, which were ordered at the

EXHIBIT 1

time of sentencing. Establish and follow a payment schedule as determined by the Parole Officer.

10. Do not associate with known felons (unless specifically allowed by the Commission or supervising personnel); persons involved in illegal activities, or other persons as identified by supervising personnel.

11. While on parole, you may drive only at times, and to and from locations, for which you have been given permission by your supervising officer, as long as you possess a valid driver's license and insurance.

Commissioner Dressen told him to read and understand the conditions of parole. That is their contract with him. They wish him luck.

EXHIBIT 2

THE ORIGINAL APPROVED MINUTES ARE ON FILE IN THE COMMISSION OFFICE

S T A T E O F I D A H O
COMMISSION OF PARDONS AND PAROLE

94691 EDMO, MASON DEAN

DOR REVIEW DATE: 01/20/2015

COMMISSIONERS:
MOORE, R. DAVID
MATTHEWS, MIKE H
DRESSEN, JANIE

JONES, SANDY Executive Director

The Executive Director was not present at this hearing or review and these minutes were signed by the Executive Director in her official capacity only and represent the summary minutes of the proceeding that were prepared during the hearing or review by the Executive Director's designee.

INSTITUTION: ISCI

	CASE NUMBER	OFFENSE	SENT TYPE	MAX	MIN
1)	CR11-11293	SEX ABS<16	CC	10 YR	3 YR

Parole Elig Date: 1) 07/04/2014
Full Term Date: 1) 07/03/2021

Prior Hearing(s) or Reviews:

	Hearing Date	Hearing Type	Hearing Decision	Action Date
1)	03/06/2014	EXEC DECISION	NO ACTION	
2)	02/07/2014	REG PAROLE HRG	TENTATIVE DATE SET	07/03/2014
COMPLETE SOTP.				
3)	01/01/2012	PRIMARY REVIEW	SCHEDULE HEARING	

Executive Director reviewed DOR #141124 on 03/06/2014 for Disobedience to Orders 3 and took no further action.

Executive Director reviewed DOR #141153 on 03/06/2014 for Disobedience to Orders 3 and took no further action.

The Commission reviewed three (3) DOR's.

The Commission reviewed DOR #143320 dated June 20, 2014 for Battery. "I (Officer D. Thornton #A746) observed Offender Edmo strike another offender with open and closed hands during a fight occurring in the Unit 16 A Tier Dayroom." The sanctions for this offense are ten (10) days detention, thirty (30) days recreation restriction, and forty (40) days property restriction.

The Commission reviewed DOR #143588 dated July 08, 2014 for Disobedience to Orders 3. "On 7/8/14 at around 10:34 I asked Offender Edmo #94691 to remove Edmo's hairstyle to a style that appeared less feminine gender specific per section 4 of PREA policy 325.02.01.001. Offender Edmo responded with "it's fine" and walked away from the officers station. A few minutes later Edmo returned with two concern forms for me to sign which I did then again requested that Edmo lower Edmo's hairstyle. Edmo requested the policy that I was referencing which I told Edmo. Edmo responded with "Lieutenant Greenland has told me I can wear my hair however I want to as long as it's not in a bun". Edmo left the officers station without changing Edmo's hair and left for Pendyne shortly after with Edmo's hair unchanged." The sanctions for this offense are fifteen (15) days recreation restriction and a behavior agreement intervention.

EXHIBIT 2

The Commission reviewed DOR #150037 dated January 02, 2015 for Disobedience to Orders 3. "On the above date and time of the offense, I was performing a Tier check on B-Tier in Unit 16. As I came up to cell #59 I noticed an extra set of legs trying to hide in the corner. The Offender originally supposed to be in the cell was standing in the cell. I then opened the cell and noticed Offender Edmo standing in the corner. I asked Edmo why Edmo was in someone else's cell. Edmo said that Edmo was waiting for another Offender. I then told Edmo to exit the cell. EOR" The sanction for this offense is fifteen (15) days recreation restriction.

Subject enrolled in SOTP on 04/07/14 and has enrolled in Clinical Care Groups and Education - Computer Literacy classes. Subject completed Education/Career Planning 12/30/14 and a CCG 10/31/14.

The Commission elected to void the tentative parole date of 07/03/2014. New tentative parole date of 06/19/2015 set one year from Battery DOR. It is noted that the same parole conditions will apply as previously ordered. Subject is to complete the Sex Offender Treatment Program.

EXHIBIT 3

After review, these minutes were approved and signed by a commissioner immediately following the hearing or review as part of the regularly conducted business activities of the Commission.

S T A T E O F I D A H O
COMMISSION OF PARDONS AND PAROLE

94691 EDMO, MASON DEAN

DOR REVIEW DATE: 03/19/2015

COMMISSIONERS:
DRESSEN, JANIE
MOORE, R. DAVID
BOSTAPH, LISA

JONES, SANDY Executive Director

INSTITUTION: ISCI

	CASE NUMBER	OFFENSE	SENT TYPE	MAX	MIN
1)	CR11-11293	SEX ABS<16	CC	10 YR	3 YR

Parole Elig Date: 1) 07/04/2014
Full Term Date: 1) 07/03/2021

Prior Hearing(s) or Reviews:

	Hearing Date	Hearing Type	Hearing Decision	Action Date
1)	01/20/2015	DOR REVIEW	TENTATIVE DATE SET	06/19/2015

REVIEWED 3 DOR'S: #143320, #143588 & #150037. VOIDED TPD OF 07/03/2014. GRANTED TPD ONE YEAR FROM BATTERY DOR. SAME PAROLE CONDITIONS APPLY AS PREVIOUSLY ORDERED. COMPLETE SOTP.

2)	03/06/2014	EXEC DECISION	NO ACTION	
3)	02/07/2014	REG PAROLE HRG	TENTATIVE DATE SET	07/03/2014

COMPLETE SOTP.

4)	01/01/2012	PRIMARY REVIEW	SCHEDULE HEARING	

The Commission reviewed one (1) DOR.

The Commission reviewed DOR #150824 dated 02/07/2015 for Disobedience to Orders 2. "On 02/07/15 at 0754 I noticed Offender Edmo #94691, have his hair in a bun that was above ear line which violates policy 325.02.01.002. I had Edmo called out to the foyer so I could address the issue. I gave Edmo a direct order to stay within policy with his hair style. Edmo did fix the issue but became upset and stating that I was threatening him. After returning to the tier Edmo went back to his cell then came out to the A-tier dayroom with his hair back in a high pony tail above the ear line which still violates policy 325.02.01.002 and openly disobeyed the orders that I gave him less than 15 minutes prior.End of report." The sanction for this offense is five (5) days detention.

The Executive Director forwarded this DOR for review. Subject has submitted a letter for consideration in this hearing. Subject has completed some Clinical Care Groups and some Education classes. He is currently enrolled in Computer Literacy classes and Career Planning Classes.

EXHIBIT 3

94691 EDMO, MASON DEAN
DATE: 03/19/2015
PAGE: 2

The Commission elected to void tentative parole date of 06/19/2015 and schedule a hearing in 03/2016. The Commission requests a SORA for the next hearing.

EXHIBIT 4

THE ORIGINAL APPROVED MINUTES ARE ON FILE IN THE COMMISSION OFFICE

S T A T E O F I D A H O
COMMISSION OF PARDONS AND PAROLE

94691 EDMO, MASON DEAN

REG PAROLE HRG DATE: 03/14/2016

COMMISSIONERS:
MATTHEWS, MIKE H
DRESSEN, JANIE
DENNIS, CORTNEY

JONES, SANDY Executive Director

INSTITUTION: ISCI

	CASE NUMBER	OFFENSE	SENT TYPE	MAX	MIN
1)	CR11-11293	SEX ABS<16	CC	10 YR	3 YR

Parole Elig Date: 1) 07/04/2014
Full Term Date: 1) 07/03/2021

Prior Hearing(s) or Reviews:

	Hearing Date	Hearing Type	Hearing Decision	Action Date
1)	03/19/2015	DOR REVIEW	SCHEDULE HEARING	
2)	01/20/2015	DOR REVIEW	TENTATIVE DATE SET	06/19/2015
3)	03/06/2014	EXEC DECISION	NO ACTION	
4)	02/07/2014	REG PAROLE HRG	TENTATIVE DATE SET	07/03/2014
5)	01/01/2012	PRIMARY REVIEW	SCHEDULE HEARING	

NOTE: The Commission reviewed a SORA that was prepared in 1/2014.

Subject prefers to be called, "Miss Edmo." She hopes to be given a parole date. She said she had received a parole date and then it was voided because of a DOR and she was scheduled for a hearing this month.

She told the hearing officer that if she were given a parole date, she would do her best to finish her programming, but if she were not given a date, she would want to just "top" her time. She said that she has extra stressors being a transgender and becomes emotional and withdrawn and constantly works on it every single day. The Commission said that she puts herself in situations that put added stress on her, and subject agreed.

The Commission said these DORs are ridiculous and she agreed, and said that the situations could definitely have been avoided and she is working on it. The Commission said that sometimes things that are worth working for are not easy to do.

Subject is back in programming and has learned a lot. She said that she knows that she will make mistakes but it has been a learning process. The Commission asked if she could come back in one year without any DORs and she said, "Most definitely."

EXHIBIT 4

Subject would like the Commissioners to know that she is only human and is learning from her past mistakes. The Commission said, "That's kind of life."

The Commission said that with her being a transgender is all the more reason for her to get out of prison because of all these extra stressors. She needs to carry a part in this, because the Commission had already given her a date and her behavior stopped it.

The Commission noted that she was dropped from the SOTP in January for the third time, and subject said that the case manager said they are trying to decide which program she will be placed in.

The Commission elects to deny parole and schedule the next hearing in 3/2017. A SORA is ordered for the next hearing. No DORs. A DOR would void the next hearing.

The Commission said that it is up to her. They told her that she is to receive no DORs and that a DOR would void the next hearing.

Reasons for denial based on the guidelines:

- You have failed to successfully maintain a continued period of good behavior.
- You committed your offense while on probation, parole, home confinement, or in prison.
- You have failed to actively participate in or successfully complete your assigned programming.

EXHIBIT 5

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= PAROLE HEARING ======= QUERY PAROLE HEARINGS ========== 08/09/2018 =
 Doc No: 94691   Name: EDMO, MASON DEAN                    ISCI/UNT13 PRES ]

           Parole Hearing Date: 03/14/2016
         Hearing Order Number:     18
           Parole Plan Number:
           Executive Director: 1   JONES, SANDY
          Hearing Agenda Type: R   REG PAROLE HRG
             Hearing Location: II  ISCI
                     Decision: D   DENIED
       Scheduled Hearing Date: 2017-03
            Next Hearing Date:
        Tentative Parole Date:
                   Psych? Y/N: Y
 Notes:  PROGRAM AS ASSIGNED. DOR WILL VOID NEXT HEARING DATE AND
         SUBJECT WILL BE PASSED TO FTRD. SORA IS REQUESTED FOR THE
         NEXT HEARING. 12/8/16 HAS HAD 6 NEW DOR'S/HRG CANCELED.CM
 Parole Hearing 1 of 6 / Offender
 XMIT to go on, RETURN to return to input
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IDOC_K_pg.94

LAWRENCE G. WASDEN
ATTORNEY GENERAL
STATE OF IDAHO

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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 **DECLARATION OF JEREMY CLARK**

I, Jeremy Clark, hereby declare and state as follows:

1. I am employed with the Idaho Department of Corrections ("IDOC") as the Clinical Supervisor at the South Idaho Correctional Institution ("SICI"). I have been the Clinical Supervisor at SICI since July, 2017. I have been the clinical supervisor of several IDOC facilities to include the Idaho State Correctional Institution ("ISCI") from April of 2015 to May of 2016.

2. I am a Licensed Clinical Professional Counselor and maintain a license with the State of Idaho. I received my Master's Degree in Counseling and Guidance from New Mexico State University in 2006 and a Bachelor's Degree in Psychology from Boise State University in 2004.

3. I have been a member of the World Professional Association for Transgender Health ("WPATH") since 2013. I have attended continuing education courses and WPATH trainings on the treatment of persons with Gender Dysphoria ("GD") from 2015 to 2017. I am also familiar with the WPATH Standards of Care, Volume 7. I am currently working toward becoming a certified WPATH GD mental health provider.

4. I have also read and reviewed approximately 12 articles and publications regarding the treatment of transgendered inmates, including inmates with GD. I have also received other training in the clinical treatment of inmates diagnosed with GD.

5. Prior to my position as Clinical Supervisor, I was a Sex Offender Treatment Program ("SOTP") Clinician for Corrections Corporation of America from November, 2009 to November, 2012. I was also a Sex Offender Clinician for adolescents at Sequel-Three Springs, Inc. in Mountain Home, Idaho from August, 2006 to November, 2009.

6. As the Clinical Supervisor at SICI, I currently train and supervise Master's level clinicians. I have also overseen the Acute Mental Health Unit and the Behavioral Health Unit,

along with mental health services for the several facilities.

7. I also provide training to IDOC clinicians on how to assess transgender inmates for GD. I also am a member of the Management and Treatment Committee ("MTC"), which is a multidisciplinary committee that meets monthly to discuss and evaluate the needs of inmates who have been diagnosed with GD. Those needs include issues with housing, clothing, treatment, and requests for hormone replacement therapy. The MTC also receives and reviews inmate requests to be assessed for GD. The MTC also reviews policies and records related to GD inmates, including disciplinary records. As a Clinical Supervisor and member of the MTC, I am familiar and have significant experience with the MTC's procedures and practices.

8. As a member of the MTC and as Clinical Supervisor, I have been involved in discussions and meetings with other IDOC and Corizon treatment providers with personal knowledge of Edmo's mental health conditions. I have reviewed Edmo's mental health records and Edmo's Presentence Investigation Reports and clinical notes. I am familiar with Edmo's documented social, criminal, medical, institutional, and mental health history and current mental health conditions.

9. The MTC regularly discusses Edmo's needs and concerns related to Edmo's GD, including issues involving Edmo's housing, security issues, and property concerns. The MTC has also discussed Edmo's request for sex reassignment surgery ("SRS").

10. In April, 2016, Dr. Scott Eliason, who was also a member of the MTC, consulted with me regarding whether SRS was appropriate for Edmo. Dr. Eliason was in the process of evaluating whether SRS was medically necessary for Edmo and sought my opinion as a WPATH member and as a member of the MTC with clinical experience related to GD and transgender inmates. At the time I consulted with Dr. Eliason, I was familiar with Edmo's mental health

treatment records from IDOC and Corizon. I was also familiar with Edmo's PSI Reports and other housing, property, and safety issues discussed in the MTC regarding Edmo.

11. I advised Dr. Eliason that I did not believe, based on my review and understanding of Edmo's complete health history, mental health records, along with my discussions with Edmo's providers and clinicians over the years, that SRS was appropriate for Edmo. First, the WPATH standards provide that a patient who wishes to undergo SRS must meet certain requirements, one of which is that significant medical or mental health concerns must be well-controlled. Mental health issues must be well controlled so that the patient is not setting themselves up for failure once SRS is complete.

12. It was and is my opinion that Edmo has significant mental health concerns that are not well-controlled. Specifically, Edmo has 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 demonstrate that Edmo is emotionally unstable. Edmo has also demonstrated borderline personality disorder traits, including sexual deviance, depression, relationship issues, and substance abuse.

13. Second, Edmo's emotional instability gave me concerns about Edmo's ability to handle the stressful process of surgery and possibly relocating to a female prison after the procedure was complete. Edmo has been noncompliant with prison rules and has refused to complete sex offender programming, both of which raise concerns about Edmo's ability to comply with the care required after surgery.

14. Third, Edmo has not addressed Edmo's underlying Major Depressive Disorder, Anxiety, and Edmo's other mental health issues. For example, Edmo has refused to attend recommended Social Skills and Mood Management Groups and has not consistently participated

in individualized counseling.

15. I discussed my opinions regarding Edmo's lack of stability and non-compliance with Dr. Eliason and shared with him my assessment that SRS was not appropriate.

16. My opinion and concerns that I relayed to Dr. Eliason still exist today. I have reviewed Edmo's medical and mental health file and have attended MTC meetings since 2014, where information was shared by Edmo's treating clinicians, medical providers, and IDOC staff, which demonstrate to me that Edmo still has issues with compliance and remains emotionally unstable and has not addressed Edmo's underlying mental health issues. As a result, I still do not believe that SRS will be appropriate for Edmo until those significant mental health issues are addressed and well-controlled.

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

DATED this 31st day of August, 2018.

/s/ Jeremy Clark
Jeremy Clark

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 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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/s/ Krista Zimmerman
Krista Zimmerman

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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 **DECLARATION OF COUNSEL MARISA S. CRECELIUS IN SUPPORT OF IDOC DEFENDANTS' RESPONSE TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION**

I, Marisa S. Crecelius, hereby declare under penalty of perjury that the foregoing is true and correct:

1. I am over the age of eighteen and am competent to testify to the matters stated herein. I make this declaration based upon my own personal knowledge or upon review of files and documents generated or received and regularly maintained by my office in connection with this case.

2. I am one of the attorneys of record for Defendants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert ("IDOC Defendants") in this action.

3. Attached hereto as **Exhibit A** is a true and correct copy of the Expert Report for retained IDOC expert, Dr. Joel Andrade, Ph.D. LISCW CCHP-MH.

4. Attached hereto as **Exhibit B** is a true and correct copy of relevant portions of the deposition transcript of Plaintiff Adree Edmo, taken under oath on August 24, 2018.

5. Attached hereto as **Exhibit C** is a true and correct copy of the relevant portions of the deposition transcript of Dr. Scott Eliason, taken under oath on August 14, 2018.

6. Attached hereto as **Exhibit D** is a true and correct copy of relevant exhibits and portions of the deposition transcript the FRCP 30(b)(6) deposition of IDOC, deponent IDOC Chief of Prisons, Ashley Dowell, taken under oath on August 31, 2018.

7. Attached hereto as **Exhibit E** is a true and correct copy of IDOC Standard Operating Procedure, 401.06.03.501, version 3.2, entitled, "Gender Dysphoria: Health Care for Inmates With."

8. Attached hereto as **Exhibit F** is a true and correct copy of the Expert Report of Dr. Keelin Garvey, M.D., CCHP. Dr. Garvey has been retained by the Corizon Defendants as an expert in this matter and her expert report was disclosed to the parties on August 31, 2018.

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

DATED this 14th day of September, 2018.

/s/ Marisa S. Crecelius
Marisa S. Crecelius

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 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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(Counsel for

/s/ Krista Zimmerman
Krista Zimmerman

EXHIBIT A

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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 **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 1

Clinical Assessment
Mason "Adree" Edmo--94691

IDAHO DEPARTMENT OF CORRECTIONS
GENDER DYSPHORIA CLINICAL ASSESSMENT
MASON "Adree" EDMO

Sources of Information

In order to complete the clinical assessment of Ms. Mason "Adree" Edmo, I relied on the following sources of information:

- Review of medical records including:
  - Shoshone-Bannock Tribes Counseling and Family Services records
  - Fort Hall Indian Health Service records
  - Portneuf Medical Center records
  - Bannock County Jail medical records
  - Idaho Department of Corrections medical and mental health records
- Discussions with treatment staff including Lead Clinician Krina Stewart, LPC and Laura Watson, LCSW, CCHP-MH, Clinical Supervisor at ISCI
- Clinical interview with Ms. Edmo lasting approximately 1 hour and 35 minutes
- Discussion with Keith Yordy, Warden of Idaho State Correctional Institution (ISCI)
- Review of IDOC Gender Dysphoria Policy, SOP 401.06.03.501

Identifying Information and Brief History

Ms. Mason "Adree" Edmo is a 30-year-old (DOB: [redacted] Native-American, transgender woman. She is currently serving a sentence of "a fixed term of three (3) years followed by a subsequent indeterminate term or seven (7) years for Sexual Abuse of a Child Under the Age of Sixteen Years. Ms. Edmo's mandatory release date is July 3, 2021. Ms. Edmo was eligible for parole in 2014, but parole has not granted on several subsequent occasions due to her disciplinary history and failure to complete the Sex Offender Treatment Program.

Ms. Edmo completed the 11th grade and later received her GED. She did not require special education classes while she was in school. Ms. Edmo reported being enrolled in a Certified Nursing Assistant (CNA) program at Idaho State University. She reported needing 20 clinical hours at a hospital to be awarded her CNA certificate.

Ms. Edmo's early life history is significant for neglect and sexual abuse. Her records indicate that her father left the home when Ms. Edmo was a child. Her mother had a significant substance abuse problem to the point that Ms. Edmo and her sister would need to bail her out of jail when she was arrested. Ms. Edmo reported being sexually victimized at 9 years of age.

Ms. Edmo began abusing substances at an early age. She began abusing alcohol by the age of 15 and other drugs by the age of 20. Ms. Edmo's records indicate that alcohol was her drug of choice and she is currently diagnosed with Alcohol Use Disorder.

Ms. Edmo has an extensive history of suicide attempts beginning at the age of 13. While in the community, these attempts resulted in several inpatient hospitalizations and outpatient mental health treatment. These pre-incarceration attempts have included overdose on pills and alcohol as well as one incident where Ms. Edmo severely lacerated her right arm with a knife. While incarcerated, Ms. Edmo's reports of suicidality have resulted in placement on suicide observation and the mental health caseload for routine follow-up. While incarcerated, Ms. Edmo has also attempted

to cut off her genitals in an act of self-surgery. She has also engaged in self-injurious behavior including cutting her arms.

Ms. Edmo's adjustment to incarceration has been tenuous. As of July 1, 2018, Ms. Edmo has incurred 30 disciplinary infractions during her current incarceration. The table below lists each disciplinary category and the number of times Ms. Edmo has been found guilty for each category:

Disciplinary Infraction	Infraction Affirmed
Disobedience to Orders	10
Destruction of Property/Possession of Unauthorized Property	6
Tattoo or Piercing	4
Sexual Contact/Physical Contact	4
Battery	3
Unauthorized Communication	2
Outside of Authorized Boundary	1

Based on a review of all available records, Ms. Edmo was first diagnosed with Gender Identity Disorder (now referred to as Gender Dysphoria) while incarcerated in the Idaho Department of Correction (IDOC). On June 25, 2012, Ms. Edmo was diagnosed with Gender Identity Disorder by Dr. Eliason. On July 19, 2012 Claudia Lake, Psy.D., also diagnosed Ms. Edmo with Gender Identity Disorder. Ms. Edmo was started on hormones, to include spironolactone and estradiol, in September 2012.

Since her admission to the IDOC, Ms. Edmo has been treated for multiple psychiatric conditions including mood and anxiety disorders. She was treated for these conditions in the community and while awaiting trial at the Bannock County Jail.

Clinical Interview and Mental Status

Ms. Edmo came to the interview unescorted and had no abnormalities in posture or gait. Ms. Edmo was informed of my role and the purpose of the interview. She appeared to understand that this interview would not be confidential and that the information would be used in her legal case. She agreed to continue the interview.

Ms. Edmo appeared her stated age of 30. She was dressed in prison clothing and presented as feminine in nature. Her hair was long and she was wearing subtle make-up. Ms. Edmo was asked about her early childhood. She reported having five siblings including two brothers (Todd and Garrett) and three sisters (Kayla, Mia, and was unsure of her youngest sister's name).

Ms. Edmo reports being born in Idaho. She reported that her early home life was "stable" and that her "mom provided" for the family. Her mother was reportedly employed as a human resources representative. When asked about her early childhood she reported playing with "Barbie's" with her sisters. In junior high and high-school she reports her friends were all girls.

When asked about her higher education Ms. Edmo reported attending Idaho State University for a period of time and receiving a "paralegal certificate" from Adams State University. She also reported plans to complete an undergraduate degree in "administration with a minor in legal studies."

When asked about her early life experience of feeling like a female she reported that she could not fully describe that period of time and stated, "It's just a feeling." When asked when she began to feminize she reported that it was in junior high-school and high-school when she would wear

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"eyeliner" and "foundation". Ms. Edmo wasn't sure whether she was fully accepted by others, but reported that there were "no hard feelings."

When asked to rate her dysphoria related to her genitalia on a scale of 0 to 10 she reported that it is a "10. All the time." When asked if she had surgery to remove her male genitalia how she thinks her dysphoria would be on a scale of 0 to 10 she initially reported it would be "less." I asked her to be more specific, and she reported that it could be reduced to 9, or 7 or 6 or 4, but it would be lower than 10.

Ms. Edmo was asked to describe her understanding of gender affirming surgery. She reported reading materials she has received from family that describe "vaginoplasty, labiaplasty and all of the others." When asked about the possible risks associated with such surgery Ms. Edmo stated, "I've never been evaluated for it", and added, "I'd have to be fully evaluated to know whether I'd take those risks."

We spent a great deal of time discussing methods to feminize. She reported that when she was in the community she would "tuck" (which is securing one's penis and testicles so they cannot be seen by others) by wearing female underwear. She reported that the female underwear that she receives in the IDOC is too baggy to effectively help her "tuck".

Ms. Edmo went on to discuss her experience of dysphoria related to her gender assigned at birth. She reported that she starts to think she can do the surgery herself. She also described a feeling of being masculine inside that results in her desire to take action. She reported that she "probably" experienced this level of dysphoria in the community but she was not completely certain. I discussed with her about my experience with some transgender women in prison who reported that if they were in the community they would opt not to have the surgery, but as they were incarcerated they felt that the surgery was the only way to feel feminine. This group of patients reported that with access to numerous methods to feminize in the community they felt complete without having the surgery. Ms. Edmo reported that she would opt to have the surgery in the community if she does not have the surgery while incarcerated.

Ms. Edmo was asked about any negative possible outcomes of surgery. She reported that she expected some people will not like you "regardless." She reported that she would not experience any internal negative outcome. When asked the chances she would regret having surgery she reported they would be "zero and below."

Ms. Edmo was asked where she believes she would live if she had the surgery while incarcerated. She stated "women's prison obviously." We then discussed her day to day activity at her current facility. She reported that she works as a production clerk approximately eight hours each day five days per week. On weekends she reported hanging out in her dormitory watching television. When asked if she feels safe in her current environment she reported that she does "most of the time." She went on to say "you can tell who is up to something."

When asked how she thinks she would feel living in a female facility, she reported being unsure as she was unfamiliar with female facilities. She also stated "I'm more likely to be open." She reported that many of the 1400 inmates at ISCI are "retards" and that she would not feel so "weary" at a female facility.

We then discussed her history of relationships and she reported being married to another inmate. Ms. Edmo reported that her husband completes his sentence in March. She reported his name is Jordan and they have been together for over a year and a half. When asked about their future plans she reported that he will be on parole so he will have to "be good." She reported that they would

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likely need to stay in the Idaho area as he has elderly parents, but reported that once her husband's parents pass away she would to move to California with her husband.

Ms. Edmo was asked her experience with the medical or mental health providers at ISCI. She reported that medical and mental health professionals have not been helpful and have not provided her with information on gender dysphoria. When asked if anyone on the treatment team has expertise in working with transgender patients she reported that none had such experience. She reported that Dr. Hutchinson is "great" with working on her depression but that this provider does not understand gender dysphoria.

Ms. Edmo went on to describe the cycle she experiences between her depression and her gender dysphoria. She reported that sometimes her "depression drives the gender dysphoria" but that other times the "gender dysphoria drives the depression."

Ms. Edmo was asked to describe her most recent attempt to perform surgery on her self. She discussed the incident of December 31, 2017 in which she attempted to remove her genitalia. She reported experiencing a high level of depression that was "beyond extreme." She also reported experiencing high levels of gender dysphoria and a "need to get rid of this right now," referring to her penis. She reported that when she gets in this place in her mind she does not weigh the medical risks, including possible death. When asked how she feels after such an event she reported feeling disappointed that "I didn't finish it."

Ms. Edmo was asked if she has recently experienced such an episode. She reported that she has not and stated, "I've been self-medicating." She then reported engaging in cutting behavior. When asked how cutting makes her feel she reported that she feels a "release" and that having physical pain is better than the mental pain. Ms. Edmo was asked how her husband would feel about this, and she reported that he is very supportive but that he does not want her to harm herself.

We then discussed her sexual relationship with her husband and whether he was supportive of her receiving surgery. Ms. Edmo reported that he understands her desire for surgery. She reported that her husband identifies as a heterosexual male and she reported that they do not use Ms. Edmo's penis during sexual activity. Ms. Edmo reported not using her penis sexually in any of her relationships.

Ms. Edmo was asked to explain her experience when her hormones were decreased. She reported that she could "feel the testosterone build." She reported feeling much better now that the hormones are being prescribed again, but that she is not mentally where she was before the hormones were decreased. She reported feeling best in November 2017 and stated "I actually felt tolerable."

Ms. Edmo was asked that if surgery were approved, but was delayed in order to identify a surgical team, etc., what things she would find helpful to feminize as she waited. She reported she would just like to be allowed to "be me." She also reported that make-up would be helpful and that other items would help and stated, "Anything at this point helps."

At the end of the interview, Ms. Edmo disclosed early life trauma in which she was sexually abused at the age of 9 by a 16-year-old boy. She proposed two possible scenarios as possible 'causes' of this sexual abuse. To paraphrase, Ms. Edmo proposed the following question "Did it happen because of who I was, or did I become who I was because of what happened?" Her question indicates that either

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(1) her feminine presentation at that age enticed the 16-year-old to sexually abuse her; or (2) the fact that she was sexually abused at 9 years of age by a 16-year-old led to her becoming a transgender woman. Ms. Edmo was adamant that her first proposal was true. She supported this by reporting that the 16-year-old young-man said things to her during the abusive episodes that indicated that her femininity led to the abuse. We briefly processed her proposals and her assertion that it was due to her feminine presentation. Although the purpose of my interview was not to provide therapy or guidance, as a mental health professional I would be remiss not to respond to Ms. Edmo's statements and propose a third proposition that neither of her two propositions were true. I proposed to Ms. Edmo that her femininity as a child was not the cause of her victimization and that the 16-year-old young man was responsible for his behavior, which was sexually abusing of a 9-year-old child. We also discussed that as a result of the trauma she may have developed mental health symptoms, such as depression and anxiety, but growing up to be a transgender female is not the result of the sexual abuse. Ms. Edmo showed some ability to grasp these complex concepts.

Ms. Edmo's propositions of the 'causes' of her early life sexual abuse are significant, and her understanding of this will have profound effects on her future ability to function as a healthy adult upon her discharge from the IDOC. She will benefit greatly from careful consideration of this topic within a therapeutic context.

At various times throughout the clinical interview Ms. Edmo was asked to identify items or interventions that would help her feel more feminine while incarcerated. The following is a list of the items we identified:

- Make-up
- Hair accessories
- Hair ties
- Tighter fitting female underwear or a "gaff" so she is able to tuck her penis
- Bras
- Female hygiene items (including soap and hair shampoo)
- Remaining on hormones
- Gender affirming surgery

Mental Status Exam: Ms. Edmo presented as her stated age of 30. She was appropriately dressed in prison clothing. Wearing a modest amount of make-up, and with her hair presented in a style typical of a woman, Ms. Edmo presented as convincingly female. She was calm, clear and cooperative throughout the interview, and was able to tolerate a lengthy interview without difficulty.

Ms. Edmo's speech was within normal rate and tone. Her thought process was logical and coherent. She was able to attend to, and focus on, abstract topics without difficulty. She did not present with any perceptual disturbances. There was no evidence of psychosis.

Ms. Edmo's mood was euthymic and her affect was appropriate to content. She was future oriented and goal directed, mostly on treatment for her gender dysphoria, her psychiatric issues and her relationship. Ms. Edmo was able to laugh appropriately throughout the interview.

Diagnostic Formulation

Based on a review of the most recent sections of Ms. Edmo's medical record she is diagnosed with the following DSM 5 diagnoses:

- Major Depressive Disorder, Recurrent, In Partial Remission

- Generalized Anxiety Disorder
- Alcohol Use Disorder, Severe
- Gender Identity Disorder (should be Gender Dysphoria)

I agree that Ms. Edmo meets clinical criteria for these disorders. The diagnosis of "Gender Identity Disorder" should be changed to "Gender Dysphoria" to be consistent with DSM 5 language.

Additionally, I recommend that the treatment team consider the following diagnoses:

- Posttraumatic Stress Disorder
- Borderline Personality Disorder

The criteria for these disorders are discussed below.

Posttraumatic Stress Disorder

Systematic assessment of PTSD symptoms was not undertaken as part of this assessment. The following discussion is offered on a preliminary basis for the team to consider. Criterion A for PTSD is "Exposure to actual or threated death, serious injury, or sexual violence in one (or more) of the following ways," and the first is "Directly experiencing the traumatic event(s). Ms. Edmo has a history of sexual abuse as a child and physical abuse by her significant other in her early adult years which meets Criterion A. There are additional criteria, Criterion B through H, which were not evaluated as part of this evaluation.

Given this information, Ms. Edmo could experience symptoms consistent with PTSD; however, I do not recommend exploring specific traumatic experiences with Ms. Edmo due to her level of behavioral and emotional instability. I do recommend that Criterion B through H be evaluated in order to determine whether she meets criteria for PTSD. This will inform staff that interacting with Ms. Edmo in a trauma-informed manner is the best course of action.

Borderline Personality Disorder.

The presence of a Borderline Personality Disorder should also be considered. *DSM 5* diagnostic criteria require at least five of the following in order to make this diagnosis:

1. Frantic efforts to avoid real or imagined abandonment (**Note:** Do not include suicidal ideation or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal ideation or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness
8. Inappropriate intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideas or severe dissociative symptoms

Based on clinical interview and record review, Ms. Edmo appears to meet criteria 2, 4, 5, 6 and 7; however, additional clinical assessment is warranted in order to ensure each criterion is fully met.

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Conclusions

Ms. Edmo meets criteria for Gender Dysphoria in Adolescents and Adults. To meet criteria for the diagnosis, an individual must show a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by meeting at least two of six criteria. Ms. Edmo meets the following criteria:

1. A marked incongruence between her experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to rid herself of the primary and/or secondary sex characteristics because of a marked incongruence with her experienced gender
3. A strong desire for female primary and/or secondary sex characteristics
4. A strong desire to be female
5. A strong desire to be treated as female
6. A strong conviction that she has the typical feelings and reactions of women

Also consistent with the DSM 5 diagnosis, Ms. Edmo's condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Ms. Edmo can best be understood as an intelligent young woman with unresolved mental health issues related to early-life trauma, substance use and gender dysphoria. In the long-term, Ms. Edmo may benefit from gender affirming surgery; however, at this time completing surgery could result in harm to Ms. Edmo. Until she is able to live for a period of time as a female, which she has not done in the community according to all available records, her hopes and expectations for the outcome of surgery are not reality based.

Ms. Edmo's reports of feminizing in the community prior to her incarceration have not been confirmed. All available records do not support her report of living full-time as a woman prior to her incarceration. It is not unusual for a transgender woman to conceal their transgender status in the community by feminizing in private due to fear of discovery and harassment or physical/sexual violence. Also, in the case of transgender women, it is not rare for the individual to present as "hyper-masculine" by taking on traditionally masculine roles to hide their transgender status from others, again to avoid alienation, harassment or physical/sexual violence. Ms. Edmo has consistently reported living full-time as a woman in the community. She reported dressing as a woman, having female style hair and using make-up consistently since early adolescence, through adolescence and into adulthood. This is not corroborated by the records reviewed. This raises clinical concern regarding her understanding of how she has presented in the past and her insight into living as a transgender woman.

An additional concern is her ability to differentiate between gender and sexuality. Based on a review of all available records, it appears that this is the first time in her life that she has feminized and the first time in her life she has been on hormones. Ms. Edmo's physical response to hormone treatment has been positive, including the development of breasts. Her feminine appearance in a male correctional facility has resulted in her receiving sexual attention from male inmates. While this has been a positive experience for Ms. Edmo as she has had several sexual encounters and relationships, including being engaged several times to heterosexual male offenders, whether such will continue in the community is not known. This is another risk for Ms. Edmo as when she enters the community she many not attract sexual partners as she has in prison, which may result in increased depression and suicide risk.

In discussions with her mental health treatment providers, it was reported that between 2014 and 2015 Ms. Edmo was working with clinical staff on understanding her history of involvement with men

who were abusive to her. Ms. Edmo was encouraged to spend some time not in a relationship as she has been in a relationship with abusive men consistently throughout her adult life. The goal was to spend some time alone to mature and grow and determine the qualities she should look for in a partner that would not be abusive. Ms. Edmo reportedly considered this, but abruptly in early 2015 told her clinicians she was not interested in doing such work in psychotherapy. Clinical staff theorize that Ms. Edmo was unable to commit to such a treatment plan as she would not be able to tolerate a period of time without attention, including physical and emotional, from a partner, even if the partner was abusive.

Some incarcerated individuals have the expectation that surgery, or other intervention, will result in an immediate transition, especially by how others treat them. This is unlikely in any environment, especially in a correctional environment.

In practice, I have worked with several incarcerated transgender women who report an experience of wanting the surgery while incarcerated, but not previously. Some have reported that this is because they were able to fully feminize in the community and felt complete as a woman without surgery; however, in prison, as the ability to feminize is often restricted to items and interventions that do not compare with the community (e.g., women's bras and underwear in correctional institutions versus such undergarments for sale in the community), this group of inmates reports that there is no other way to feel feminine without the surgery.

It is the duty of medical and mental health providers to do no harm. In correctional settings this duty is magnified as the patient is not able to simply seek another provider when her or his wishes are not fulfilled, while in the community, a provider is not scrutinized for their decisions to "deny" certain interventions they believe would create harm for the patient as the patient can simply seek out another provider willing to grant their request.

As discussed earlier, Ms. Edmo's adjustment to incarceration has been tenuous. She has had 30 disciplinary infractions, all of which have been affirmed through the IDOC disciplinary process. Of the 30 disciplinary infraction, six were property related. It is likely that these are related to her gender dysphoria as Ms. Edmo was attempting to fashion undergarments to be more comfortable. Additionally, ten were for disobeying an order. These were not considered as poor adjustment due to the fact that these could have been the result of Ms. Edmo feeling targeted by correctional staff due to her transgender status; however, Ms. Edmo also had several disciplinary infractions related to violence or sexual activity, indicating a tenuous and unstable course of incarceration. Ms. Edmo had the following disciplinary reports for aggressive or sexual behavior:

- 1/9/2017—sexual activity—found in cell with another inmate having sex.
- 7/13/2016—battery—officer observed Ms. Edmo to be punching another offender in the face with a closed fist multiple times. When ordered to stop punching the other offender Ms. Edmo threw the other inmate on the ground and kicked him multiple times in the head.
- 12/30/2015—sexual activity—admitted to sexual activity with another inmate. Letters were found in which Ms. Edmo described their sexual activity.
- 12/17/2015—physical contact—found in her cell kissing another offender.
- 11/15/2015—battery—Officer observed Ms. Edmo to have another offender pushed up against a wall while delivering body punches to the other offender.
- 6/20/2014—battery—observed by correctional officer to strike another offender with a closed fist.
- 4/21/2014—sexual activity—observed kissing another offender then walking to the chapel with the offender, but was stopped.

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At the present time, Ms. Edmo lacks general knowledge of gender affirming surgery. During the clinical interview, Ms. Edmo was unaware of the risks associated with gender affirming surgery. When asked about the possible risks associated with such surgery Ms. Edmo reported that she would need to be evaluated to know whether she would be willing to take those risks. Also, Ms. Edmo has provided very different understandings of how she believes surgery would benefit her. At times she reports that the presence of her male genitalia results in a gender dysphoria level of "ten", but when asked how her dysphoria would be after surgery she said it could be a "9, 6 or lower."

Ms. Edmo's history of suicide attempts began at the age of 16. When experiencing periods of depression or frustration throughout her life she has attempted suicide. Her risk of suicide would likely increase if there are complications with surgery, the surgery does not result as she hopes and expects or she has regret.

Ms. Edmo also has a lengthy history of having firm convictions that are later not realized. For example, in a letter from Ms. Edmo to District Judge Naftz written sometime between 2009 and 2010 based on its placement in the PSI document (page 29 of 147 of the PDF), Ms. Edmo wrote the following:

District Judge Naftz,

Since my sentence in November of last year, there has been a lot of change. Change for good. In this program-A New Direction, I've taken a good look at who I've been, who I am, and where I want to go. These books have given me essential tools to prevent myself from total relapse and the painful cruel cycle of addiction. For years I've been in denial, denial of my life. I've centered my life around alcohol, instead of true positive values. I can honestly say I lost myself in this drug and denied all means of helping myself to a better life. I've used denial to justify my use and all the consequences because of it—past DUI's and current charge. I'm 22 years old and ready to take control of my life. I know life is not easy and problems will arise, unfortunately, but that's where I need to utilize my tools of recovery and focus on positive thoughts, affirmations and give my best effort to stay in control. This program has given me the tools of sobriety and guidelines for a healthy life. I am in recovery now because I made the choice to be. I've been given a chance to go at life from a whole new angle. I've prepared myself. I've been putting in the work to show I'm committed to success. I honestly feel I am capable and ready to be a positive member of our community and productive member of our society. I am ready to be successful—no more setbacks. I can make it.

(Signed Mason Meeks)

This is an example that shows Ms. Edmo has the ability to express firm conviction in a decision but this quickly dissipates. This is not to say that Ms. Edmo's feelings and belief at the time she expresses these strong convictions are not "honest" or "true," but it illustrates the fact that despite her convincing explanation to make some type of life-change, she is often mistaken. When it comes to a desire to remain committed to sobriety or a particular relationship, these lapses (or relapses) may be frustrating but are not irreversible. In the case of gender affirming surgery, the outcome would not be reversible and could result in an increased risk for suicide.

Gender affirming surgery is not a panacea of success for all patients. As The Centers for Medicare & Medicaid Services (CMS) conclude in their study regarding gender affirming surgery, the research

literature is not conclusive regarding long-term outcomes. In the 2016 Decision Memo for Gender Dysphoria and Gender Reassignment Surgery, CMS made the following statements:

> Currently, the local Medicare Administrative Contractors (MACs) determine coverage of gender reassignment surgery on a case-by-case basis. We received a complete, formal request to make a national coverage determination on surgical remedies for gender identity disorder (GID), now known as gender dysphoria. The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population.
>
> In the absence of a NCD, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act (the Act) and any other relevant statutory requirements, will continue to be made by the local MACs on a case-by-case basis. To clarify further, the result of this decision is not national non-coverage rather it is that no national policy will be put in place for the Medicare program. In the absence of a national policy, MACs will make the determination of whether or not to cover gender reassignment surgery based on whether gender reassignment surgery is reasonable and necessary for the individual beneficiary after considering the individual's specific circumstances. For Medicare beneficiaries enrolled in Medicare Advantage (MA) plans, the initial determination of whether or not surgery is reasonable and necessary will be made by the MA plans.
>
> Consistent with the request CMS received, the focus of this National Coverage Analysis (NCA) was gender reassignment surgery. Specific types of surgeries were not individually assessed. We did not analyze the clinical evidence for counseling or hormone therapy treatments for gender dysphoria. As requested by several public commenters, we have modified our final decision memorandum to remove language that was beyond the scope of the specific request. We are not making a national coverage determination related to counseling, hormone therapy treatments, or any other potential treatment for gender dysphoria.
>
> While we are not issuing a NCD, CMS encourages robust clinical studies that will fill the evidence gaps and help inform which patients are most likely to achieve improved health outcomes with gender reassignment surgery, which types of surgery are most appropriate, and what types of physician criteria and care setting(s) are needed to ensure that patients achieve improved health outcomes.

In their 2017 article titled "Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrinology Society clinical practice guideline," the Endocrine Society Clinical Practice Guideline, stated "Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment"

Prison is an artificial environment that does not mirror the community. As such, it is extremely difficult for individuals with Gender Dysphoria and other transgender individuals to successfully integrate. Transgender women housed in male facilities are constantly identified and targeted by others with ill intent. To a lesser degree, but in some cases, transgender men housed in female facilities also experience difficulty. Although done infrequently to date, there are reports of

correctional systems transferring transgender women to female facilities prior to conducting surgery. There are no sound studies documenting the results, but based on anecdotal information, such transitions may be helpful in determining whether the individual can successfully transition. This is especially true for inmates serving lengthy or life sentences, as the female facility will likely be the only housing option for the individual post-surgery. Although I believe such a transfer is premature in Ms. Edmo's case, if the Court decides that surgery should occur, I would strongly recommend that Ms. Edmo be transferred to a female facility and allowed to completely feminize prior to the surgery.

My concern with completing surgery prior to allowing Ms. Edmo to live at a female facility is that if she has surgery first and is then unable to successfully transition to a female facility, that she will be more isolated resulting in increased depression and increased risk for suicide. If this occurs, we will have done harm to Ms. Edmo by removing her genitals and therefore her ability to safely live in a male facility as she has done during her incarceration. Allowing her to transfer to a female facility prior to genital surgery will accomplish two goals: (1) allow Ms. Edmo to determine for herself whether she will be able to function comfortably at a female facility and (2) allow clinical staff to determine whether this transition supports Ms. Edmo's functioning at her highest possible level. Again, I believe such consideration is premature. In the next section I provide recommendations that should occur prior to consideration of transfer to a female facility or gender affirming surgery.

Recommendations

As outlined above, it is my opinion based on a review of all available information and meeting with Ms. Edmo, that she is not yet ready for gender affirming surgery. It is also my opinion that if Ms. Edmo were to undergo such surgery there is the possibility of harm as she may become increasingly depressed when her expected outcomes are not realized.

However, I also recommend that the IDOC make significant changes to policy that allows Ms. Edmo, and other transgender inmates, to feminize (or masculinize) to the point possible. At a minimum, for Ms. Edmo, this should include the following:

Administrative and Policy Recommendations:

- IDOC policy should be updated to ensure that Ms. Edmo is able to:
  - Grow her hair to her desired length
  - Access and wear make-up
  - Access and use female hygiene items, such as shampoo, conditioner, deodorant, etc.
  - Access and maintain in her possession female undergarments, such as bras and female underwear
  - Ensure private shower time that occurs at a reasonable time of day and last a reasonable amount of time

Staff Interactions and Training:

- All staff should refer to Ms. Edmo by her preferred pronouns, which are "she" and "her", or no pronouns at all. Referring to her with male pronouns, either intentionally or accidentally, can cause Ms. Edmo distress and should not be tolerated.
- Medical and mental health staff should be required to refer to Ms. Edmo using female pronouns.
- While the mental health staff I spoke with were very knowledgeable of transgender health issues the method by which information is documented should be improved. For example, staff appear reluctant to refer to Ms. Edmo with female pronouns in the medical record. It

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was not rare to find a passage that read as follows: "Edmo stated that Edmo has been feeling a little more down and decided that Edmo may benefit from a Mood Mgmt group, which is why Edmo sent a concern form reporting a change of mind and requesting to be referred to that group. Edmo was informed that Edmo was added to the group recently and is on the call-out." Such language makes it apparent that female pronouns are intentionally not being used. Female pronouns should be used when talking with Ms. Edmo and in the medical record.

- Correctional Officers should be provided with meaningful and detailed training. This training should be aimed at understanding transgender health issues and the constitutional obligation to ensure that this population, and all populations with serious medical or mental health conditions, receive proper treatment.
- A correctional administrator that reports to the Warden should be assigned to oversee that the non-clinical, but operational aspects of her treatment plan are adhered to by correctional staff.

Clinical Recommendations:

- Ms. Edmo should be assigned a therapist that receives some form of supervision from a clinician with experience working with transgender inmates.
- Ms. Edmo's propositions of the 'causes' of her early life sexual abuse are significant, and her understanding of this will have profound effects on her future ability to function as a healthy adult upon her discharge from the IDOC. She will benefit greatly from careful consideration of this topic within a therapeutic context. This should be a focus in therapy.
- Psychotherapy should also focus on Ms. Edmo's understanding of how she would function in the community or a female prison were she to undergo gender affirming surgery.
- Ms. Edmo's history of suicidality, coupled with her poor frustration tolerance, is something that requires substantial monitoring and should also be a focus of treatment.
- Ms. Edmo's treatment team should evaluate her for the diagnoses of Posttraumatic Stress Disorder and Borderline Personality Disorder. This will inform methods of treatment that will be effective including Dialectic Behavior Therapy (DBT).

Joel T. Andrade, Ph.D., LICSW, CCHP-MH

EXHIBIT 2

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Veale, J.F., Clarke, D.E., & Lomax, T.C. (2011). Male-to-female transsexuals' impressions of Blanchard's autogynephilia theory. *International Journal of Transgenderism, 13*(3), 131-139.

World Professional Association for Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, 7th version (2012).

WPATH Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. (2016). https://www.wpath.org/media/cms/Documents/Web%20Transfer/Policies/ WPATH-Position-on-Medical-Necessity-12-21-2016.pdf

Zucker, K.J., Lawrence, A.A., & Kreukels, B.P.C. (2016). Gender dysphoria in adults. *Annual Review of Clinical Psychology, 12*, 217-247.

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EXHIBIT 3

Joel T. Andrade, Ph.D., LICSW, CCHP-MH

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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.

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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.

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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

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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.*

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.*

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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.

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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

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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.

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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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Andrade, J.T. & Saleh, F.M. (Winter, 2005). Juvenile psychopathy: What do we know? *American Society for Adolescent Psychiatry Newsletter.*

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, vs. IDAHO DEPARTMENT OF CORRECTIONS; 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

VIDEOTAPED DEPOSITION OF ADREE EDMO

August 24, 2018

Kuna, Idaho

Reported by: Abigail L. Manzano, RPR, CSR, SRL #1069

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VIDEOTAPED DEPOSITION OF ADREE EDMO

BE IT REMEMBERED that the videotaped deposition of ADREE EDMO was taken by the Defendants at the Idaho Department of Corrections, located at 13500 South Pleasant Valley Road in Kuna, Idaho, before Associated Reporting & Video, Abigail L. Manzano, Court Reporter and Notary Public in and for the County of Ada, State of Idaho, on Friday, the 24th day of August, 2018, commencing at the hour of 7:53 a.m. in the above-entitled matter.

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APPEARANCES (contd.)

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Also Present: Kris Coffman
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I N D E X

E X A M I N A T I O N

E X H I B I T S

EXHIBIT B

P R O C E E D I N G S

(Deposition Exhibit No. 1 was marked.)

THE VIDEOGRAPHER: So the camera is rolling. We are on the record. Today's date is October -- or I'm sorry, August 24th, 2018.

For the record, this is the video deposition of Adree Edmo, taken by the defendants in the matter of Edmo versus the Idaho Department of Corrections, et al., Case No. 17-CV-151-BLW. It is in the United States District Court for the District of Idaho.

The video deposition is being held at the Department of Corrections, located at 13500 South Pleasant Valley Road in Kuna, Idaho.

The video deposition is being recorded by Chris Ennis of Associated Reporting & Video whose business address is 1109 Main Street, Suite 220, Boise, Idaho. The deposition is being reported by Abigail Manzano of Associated Reporting & Video.

And if counsel will please state their appearances and any stipulations for the record.

MS. RIFKIN: Lori Rifkin for plaintiff.

MR. EATON: Dylan Eaton for Corizon, Dr. Eliason, Dr. Young, and Dr. Whinnery.

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MR. HALL: Brady Hall, attorney for the Idaho Department of Corrections and Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert.

THE VIDEOGRAPHER: Okay. And if the reporter will please swear the witness.

ADREE EDMO,

a witness having been first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. HALL:

Q. Good morning.

A. Morning.

Q. Would you please state your name for the record.

A. My name is Adree Edmo.

Q. What is your date of birth?

A. My date of birth is [redacted].

Q. Have you ever had your deposition taken before, Ms. Edmo?

A. No.

Q. Have you ever given any testimony under oath?

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Go off the record.

THE VIDEOGRAPHER: Okay. So the time is 9:35 a.m., and we are off the record.

(Break taken from 9:35 a.m. to 9:44 a.m.)

THE VIDEOGRAPHER: All right. So the camera is rolling. The time is 9:44 a.m., and we are back on the record.

Q. (BY MR. HALL) I want to talk with you now about your prior suicide attempts.

We've requested, in discovery, medical records from a number of different health providers, including Pocatello Portneuf Behavioral Health Unit, Indian Health Services, and from the tribe. We've provided those records to your counsel.

Have you had an opportunity to look at those records?

A. From Portneuf and my Tribal Health Center?

Q. Correct.

A. No, I have not.

Q. Prior to today, have you looked at or reviewed any medical records regarding treatment you've received prior to 2012?

A. No, I have not.

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Q. I understand that in 2010 you attempted to commit suicide.

Is that correct?

A. Yes.

Q. Okay. And do you recall how you attempted to commit suicide?

A. In 2010, I believe I cut open my right arm, right here (indicates).

Q. And you still have a pretty sizeable scar there, correct?

A. Yes.

Q. Did you cut yourself anywhere else other than your arm?

A. No, I did not.

Q. And isn't it true that you required a surgery to repair that laceration?

A. From what I remember, yes.

Q. And multiple stitches, correct?

A. From what I remember, yes.

Q. And it was pretty serious, wasn't -- wasn't it?

A. Yes.

Q. You almost died?

A. From what I remember --

I briefly remember the episode and what

EXHIBIT B

happened afterwards. I wasn't sure if that had been the case or not. I just remember it was -- I had to have surgery and stitches.

Q. Do you recall why you attempted to kill yourself in 2010?

A. I remember it was over -- if I remember correctly it was over a situation I had with Brady Summers. I think it was at the time he had cheated on me while I was coming off my retained restriction rider.

Q. And was that the first time you attempted to kill yourself?

A. No.

Q. When was the first time you attempted to kill yourself?

A. I believe in 2009.

Q. Where did that occur?

A. Physically?

Q. What location?

Was it Fort Hall? Pocatello?

A. It would have to be on my reservation at Fort Hall.

Q. Did you receive medical treatment for that?

A. I was transported to Portneuf Medical

EXHIBIT B

Center.

Q. Do you recall how you attempted to kill yourself?

A. I believe --

I remember at this one, I attempted to commit suicide by ingesting -- I think it was, like, 100 of prescription medication.

Q. Do you recall what kind of prescription medication?

A. I believe it was Amitriptyline.

Q. And do you recall why you tried to kill yourself in 2009?

A. I believe it was due to another upsetting -- upsetting event from Brady Summers. I think it was --

If I remember correctly, I think it was because of a domestic abuse issue we had during that time, one of them.

Q. And that event you just spoke about was the first time you attempted to kill yourself.

Is that correct?

A. Yes.

Q. Did you have other incidents in 2009 where you attempted to kill yourself, other than that one?

EXHIBIT B

A. Not that I can remember.
Q. Prior to -- prior to that incident in 2009 that we just spoke of, had you been depressed?
MS. RIFKIN: Objection. Vague. Overbroad.
THE WITNESS: I believe so. But I was never diagnosed prior to then. I didn't know what depression was.
Q. (BY MR. HALL) Prior to the first suicide attempt, how long had you been struggling with depression?
MS. RIFKIN: Objection. Lacks foundation. Misstates testimony.
Q. (BY MR. HALL) Go ahead.
A. Again, I didn't know what depression was exactly, but feeling, I guess, down and not feeling normal in the sense of feeling -- you know, "normal," like, as in my state of mood. It had been going on for years prior to that.
Q. So prior the 2009 suicide attempt, you had been feeling a down mood for a number of years?
A. Yes.
Q. And you felt during those number of years that things weren't right, you didn't feel normal, correct?
A. Yes.

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Q. At any time prior to the 2009 suicide attempt, did you take any antidepressant medications?

A. No.

Q. Prior to the 2009 suicide attempt, did you ever take any antianxiety medications?

A. Not that I can remember, at least not ones that were prescribed to me.

Q. Prior to the 2009 suicide attempt, did you ever receive any treatment for mental health issues?

MS. RIFKIN: Asked and answered.

THE WITNESS: No, not that I remember.

Q. (BY MR. HALL) Following the 2009 suicide attempt, did you receive any treatment for mental health?

A. Not that I can remember.

Q. When was the first time you were prescribed antidepressants?

A. I believe 2010.

Q. Was that before or after the second suicide attempt where you attempted to kill yourself by cutting your arm?

A. I don't recall if it was before or after.

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Q. Prior to the second suicide attempt, did you have any mental health treatment of any kind?

A. Not that I can remember.

MS. RIFKIN: Objection. Vague. Overbroad.

MR. HALL: Too late.

MS. RIFKIN: Belated objection.

MR. HALL: Got to be faster. Overruled.

Q. (BY MR. HALL) How many times have you attempted to commit suicide in your life?

A. I believe the two serious times were 2009, 2010.

Q. Did you attempt to commit suicide in 2011?

A. I don't recall, no.

Q. Do you recall being seen at Pocatello Portneuf Behavioral Health Unit on May 15, 2011, for an attempted suicide by overdosing on alcohol and prescription pills?

A. I believe that may have been the 2009 episode, so it may have been 2011 that it actually happened.

At those particular times, I'm not really accurate on what year it was. My substance abuse was in its most extreme during that time.

Q. Prior to your incarceration in 2012, how

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many times did you attempt suicide?

A. Two serious times were cutting my arm and alcohol and prescription pills.

Q. And you're not sure if the prescription pill overdose attempt was in 2009 or 2011.

Is that correct?

A. Yes, I would have to say 2011, 2000 --

Between 2009 and 2011. Like I said, I couldn't really give you an accurate description. I know that I was on alcohol, as I was between 2009 and 2011.

And two serious attempts were by alcohol with prescription medication, and cutting my arm open.

Q. Okay. And 2010 and 2011, you were unemployed, correct?

A. I believe so, yes.

Q. And 2010 and 2011, you had a felony conviction, correct?

A. Yes.

Q. And do you recall when you were released from the rider program stemming from your forgery convictions?

A. I recall --

I believe, I was released sometime in

EXHIBIT B

standard blue issues. I don't know what those are, but --

Q. Do you wear a smaller men's shirt in order to accentuate your breasts?

MS. RIFKIN: Objection. Argumentative. Harassing. Lacks foundation.

Q. (BY MR. HALL) You can go ahead and answer.

MS. RIFKIN: You're walking a line.

Q. (BY MR. HALL) You can go ahead and answer.

A. No, I don't wear a smaller shirt to accentuate my breasts or my curves. It's all natural.

Q. In paragraph 14 it states that you are "restricted from wearing female underwear," correct?

A. Yes.

Q. Okay. But you have been given female underwear before, correct?

A. Yes, I have while I was in Orofino in 2014.

Q. And do you currently have any of those pairs of female underwear?

A. Not from that time period. But I've

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acquired some of the female panties that have come through ISCI laundry.

Q. And currently do you have, in your possession, either on your person now or back in your cell where your property is kept, any pairs of female underwear?

A. Yes, I do.

Q. And those were given to you by commissary.

Is that correct?

A. I've ordered them through commissary and the commissary officer allowed me to keep them, yes.

Q. Okay. And are you currently wearing a pair of female underwear?

A. Yes, I am.

Q. And describe for me the type of cut of these underwear that you're currently wearing?

MS. RIFKIN: Go ahead.

THE WITNESS: They're the basic -- best description I can give you: Grandma panties, they're bigger V-cut size issue.

Q. (BY MR. HALL) And those that you're wearing now, are those from what you got off commissary or from the -- the State-issued

EXHIBIT B

property?

A. Commissary.

Q. And what color are they?

A. White.

Q. Do you know the brand?

A. Hanes.

Q. Do you know the size?

A. I believe they're a size 6.

Q. And how long have you had access to female underwear?

A. I believe I started -- was able to purchase them and allowed to have them by the commissary officer beginning of -- I believe in May. Or the end of May, beginning of June.

Q. Of 2018?

A. Yes.

Q. Now, prior to May or June of 2018, have you had female underwear while incarcerated at -- at -- well, with IDOC?

A. No. Except for 2014, in Orofino.

Q. And you've requested access to female underwear, correct?

A. Yes.

Q. And what is your understanding as to why you haven't been provided, on those prior requests,

EXHIBIT B

withdrawal from your account, or you have family or friends purchase it online. I specifically bought it through taking a withdrawal form off of my account.

Q. When was the last time you purchased makeup?

A. Okay. I think it was about a year ago, I believe.

Q. And you still have some left?

A. Yeah.

Q. Do you wear makeup every day?

A. Yes.

Q. And sounds like, from time to time, correctional officers have told you to remove your makeup.

Is that correct?

A. Yes.

Q. And there have been times, correct me if I'm wrong, where you've told them, "No"?

A. Yes.

Q. And you've received DORs for that, correct?

A. Yes.

Q. Since you've been incarcerated since 2012, have you -- have you attempted suicide?

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A. Yes, I have.
Q. And when was that?
A. 2014.
Q. In which facility?
A. Idaho -- the Orofino -- Idaho -- Idaho State Correctional Institution, Orofino.
Q. And do you remember what month?
A. Beginning of 2014, I believe.
Q. So the --
A. I don't remember what month. It'd had to have been between January or March.
Q. And how did you attempt to commit suicide?
A. I didn't have any definite plan of action to commit suicide, but I did mention to a celly at the time that I -- it didn't sound very -- It didn't sound very, like, a good idea to try it.
Like, it sounded like a good idea at the time, is what I said.
Q. So you referenced to your cellmate that you thought suicide might be good?
A. Yeah.
Q. But you didn't actually try to kill

EXHIBIT B

yourself?

A. I didn't have no plan, no.

Q. Nor did you take any actions to kill yourself?

A. No.

Q. You didn't cut yourself, you didn't try to overdose on any pills?

A. No.

Q. Correct?

A. Correct. Sorry.

Q. You did not?

A. Yes, correct. I did not try to do anything to cause -- to commit suicide.

Q. So it really wasn't a suicide attempt, then, correct?

A. No, but being that cellmate went and told the correctional officer, they took it as a suicide attempt.

Q. And they put you in protective custody?

A. Yes, suicide -- it's called a suicide cell.

Q. And how long were you in that suicide cell?

A. Two weeks, I believe.

Q. So since your incarceration, 2012, have

EXHIBIT B

A. I believe since approximately May.

Q. Do you currently have any future plans to commit suicide?

A. Not at this time, no.

Q. What are your plans upon being released from prison?

MS. RIFKIN: Objection. Vague. Overbroad.

THE WITNESS: Plans for specifically --

Q. (BY MR. HALL) When you get out, do you have plans as to what you want to do, what you are hoping to do?

A. In regards to job, family?

Q. Anything.

MS. RIFKIN: Same objection. Go ahead.

THE WITNESS: Continuing my life. Finding employment somewhere, hopefully going back to college, obtaining a degree, and continuing on in my life.

Q. (BY MR. HALL) Have you thought about what kind of job you would like to obtain when you get out of prison?

A. Being that I have a conviction of sexual assault or sexual abuse, I'm probably very limited on what type of jobs I'll be able to attain. But I haven't had a chance to really look into the

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situation.

Q. Are there any particular areas of employment that you like to explore?

A. Not that I can think of right now.

Q. Would you like to work as a paralegal someday maybe?

A. I believe that could be an option.

Q. Would you like to reunite with your husband on your release?

A. I believe that's the -- that's the plan.

Q. Are you --

A. Plans change.

Q. Are you looking forward to that?

A. At this point, yes, I am.

Q. And have you thought about where you and your husband may live when you get out of prison?

A. I believe, on the brief talks that we had, probably here in Idaho.

Q. Any particular area of Idaho that you and your husband have talked about living in once you are released?

A. Huh-uh.

Q. No?

A. No. Sorry.

Q. You mentioned that you've thought about

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going back to school when you get out of prison.

Is there a certain degree that you would like to pursue?

A. Yes. I would like to pursue a degree in --

The one that I've been really interested in, lately, epidemics, becoming an epidemiologist.

But, again, being that I have a sex crime conviction, I don't know if that'd be possible.

So like I said, I haven't really had an opportunity to really figure out what jobs, or how to be allowed to, and what jobs I wouldn't be. But that would be my goal.

Q. Do you have any future plans upon your release from prison to reconnect with your family?

A. I have the hope that I will reconnect with my family. I don't have any definite plans, just depending on how their lives are at that particular point, and mine is.

Q. I think you told Dr. Andrade that you and your husband were considering moving to California after your release.

Is that right?

A. Eventually.

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Q. And your husband's mother lives down in California.

Is that correct?

A. She did. She lives here in Idaho now.

Q. And does she own a home?

A. I believe so.

Q. Did you tell Dr. Andrade that you and your husband were thinking of living with her when you get out?

A. No, I don't believe I remember telling them that we'd live with his mother.

Q. Let's talk about sex reassignment surgery.

Do you recall the first time that you requested an evaluation for sex reassignment surgery?

A. Yes, I do.

Q. When was that approximately?

A. It would have to be in the year 2014.

Q. Do you recall what who you asked for an evaluation?

A. I believe I initially asked Dr. Craig on a health service request form.

Q. And do you recall if Dr. Craig responded to your request form?

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MS. RIFKIN: Objection. Overbroad.
THE WITNESS: At least three times.
Q. (BY MR. EATON) Have you had any recently?
A. No.
Q. When was the last time you had a migraine?
A. I can't give you an exact date.
Q. Did you have prior back and shoulder pain issues?
A. Yes, I have.
Q. Do you still have pain in your back and your shoulders?
A. Slightly.
Q. Do you know what that's related to?
A. Just recently, I went to the health -- the clinic here and they'd given me arch supports to help my walking, which would support my back.
And before that, I had had injuries from domestic abuse with Brady Summers to my back, and I've had some soreness and some -- a little bit of pain.
But I had mentioned to the providers that's what I believed it was stemming from.
Q. Okay. What other injuries did you

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sustain from domestic abuse of Brady Summers?

A. I've had multiple concussions. I've had bruises. I've had black eyes. I've had facial fractures. I've had bruises on my body.

Q. Okay. Anything else you can think of?

A. Not that I can remember.

Q. Okay. You had dry skin issues?

A. I believe once, yes. That was at the initial start of my hormone replacement therapy.

Q. Tell me about that.

A. I --

MS. RIFKIN: Objection. Overbroad. Vague.

Go ahead.

THE WITNESS: I believe maybe two or three months after starting hormone replacement therapy, I'd noticed that my skin started to feel more itchy and more dry.

Q. (BY MR. EATON) Did you have problems with that before you started the hormone therapy?

A. No.

Q. Do you have that issue now?

A. No.

Q. I thought I saw some mention that you've had asthma.

Is that true?

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(Break taken from 3:31 p.m. to 3:40 p.m.)
THE VIDEOGRAPHER: All right. So the camera is rolling. The time is 3:40 p.m., and we are on the record.
Q. (BY MR. EATON) Just a couple more questions. That's what an attorney always says, right?
Have you taken any medications today since we started the deposition?
A. I've taken my hormone replacement therapy and my Effexor.
Q. And what dose of Effexor did you take?
A. 450 milligrams.
Q. Okay. And any other medications you've taken today since we started the deposition?
A. No. I took them this morning before the deposition.
Q. Oh, okay.
A. But not during, any time.
Q. All right. So no other medications, other than those that you took this morning?
A. Yes, no other medications.
Q. Okay. I've seen some mention in the records of -- of cutting on yourself.
A. Yes.

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(Indicates.)

Q. And you're showing us your arm. Looks like there's --

A. Front part of my arm.

Q. -- marks and scars, right?

A. Yes.

Q. Okay. And why do you do that?

A. I found that cutting gave me a emotional release before I had a bad episode of gender dysphoria, relating to the cutting of my genitalia.

Q. Okay. So what do you -- did you cut with, cut yourself with?

A. A disposable razor. We get disposable razors, so I would take the blade out of the razor and use it to cut my arm.

Q. And when was the last time you cut yourself?

A. I'd say it's been about over three weeks.

Q. Okay. Is that something you've done since 2012?

A. I would say it began in -- probably after -- I believe, probably beginning of 2017.

Q. Okay. And how often would you do it in 2017?

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A. I can't give you exact -- how -- a number on how often, but it -- it started when I'd have episodes of gender dysphoria where I felt like cutting my genitalia off.

So instead of cutting my genitalia and having that mental anguish because of my genitalia, I would cut my arm, which would give me a release and not have, I guess, those immediate thoughts of cutting on my genitalia.

Q. Okay. Did you talk to any mental health providers about your cutting?

A. I've talked to Dr. Hutchinson, I've talked to my clinician, Dr. -- or not "Dr.," Clinician Stewart. And I believe that's it.

Q. What have they told you related to the cutting?

MS. RIFKIN: Objection. Compound.

Q. (BY MR. EATON) That's fair. What has Dr. Hutchinson told you about cutting?

A. She had said --

Well, she had asked me why I was cutting and, again, I told her, "Feeling physical pain versus the emotional pain of having male genitalia gives me a release, and it releases those immediate thoughts of cutting off my genitalia."

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Q. Did she talk to you about stopping or trying to stop and --

Any conversations about that?

A. She had asked me if I had any other interventions that I had tried, and specifically: Journaling, listening to music, exercising, anything else like physical activity.

And I told her, "Yes, I've done all those. I've been doing all those since 2012."

None of them work quite as effective as using a razor and causing physical pain.

Q. Any other discussions you had with Dr. Hutchinson about cutting?

A. Not that I can remember.

Q. Okay. What about with the clinician?

Tell me the name again of the clinician.

A. Clinician Stewart.

Q. What conversations have you had with Clinician Stewart about cutting?

A. It was basically the same. She had asked me when I had started, when -- the last time I had cut and if there was any other interventions that I have used or could use, specifically: Exercising, listening to music, journaling.

And, again, I told her, "I've done all

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those before."

Depending on the severity of my -- I guess my gender dysphoria episode, the only thing that's been really effective is causing physical pain.

Q. Do you feel like your cutting will continue at this point?

A. I can't say that it won't. I'm trying by best not to, but then again, I can't tell you when another severe gender dysphoria episode will happen.

Q. Aside from cutting, what helps relieve those feelings?

A. Like I said, I haven't found anything as effective, other than cutting and causing physical pain that releases that emotional torment that I have of having male genitals.

MR. EATON: Okay. I don't believe I have any other questions at this time.

EXHIBIT C

CERTIFIED COPY

UNITED STATES DISTRICT COURT

FOR THE 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

DEPOSITION OF SCOTT ELIASON, M.D.

AUGUST 14,, 2018

JEFF LaMAR, C.S.R. No. 640, Notary Public
441575

EXHIBIT C

UNITED STATES DISTRICT COURT

FOR THE 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

DEPOSITION OF SCOTT ELIASON, M.D.

AUGUST 14,, 2018

REPORTED BY:

JEFF LaMAR, C.S.R. No. 640

Notary Public

EXHIBIT C

THE DEPOSITION OF SCOTT ELIASON, M.D., was taken on behalf of the Plaintiff at the offices of Ferguson Durham, PLLC, 223 North 6th Street, Suite 325, Boise, Idaho, commencing at 10:11 a.m. on August 14, 2018, before Jeff LaMar, Certified Shorthand Reporter and Notary Public within and for the State of Idaho, in the above-entitled matter.

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EXHIBIT C

APPEARANCES (Continued):

For Defendants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert:

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EXHIBIT C

I N D E X

EXHIBIT C

I N D E X (Continued)

EXHIBIT C

SCOTT ELIASON, M.D.,

first duly sworn to tell the truth relating to said cause, testified as follows:

EXAMINATION

BY MS. SHANBHAG:

Q. Please state your full name.

A. Scott Eliason.

Q. And have you ever had your deposition taken before?

A. Yes.

Q. How many times?

A. I can't recall.

Q. When was the last time you were deposed?

A. I can't recall.

Q. Do you recall why you were deposed?

A. It was some kind of a matter about a patient who had had a side effect from a medicine and was suing the pharmaceutical company.

Q. If you had to estimate the number of times you've been deposed, would be it less than ten or more than ten?

A. Less than ten.

Q. Have you ever been a plaintiff or defendant in a lawsuit outside of this one?

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patients in Unit 8, I would write that up there.

Q. (BY MS. SHANBHAG): Okay.

A. I don't remember this encounter exactly.

Q. And do you recall what the purpose of this visit was?

A. The -- yes. The patient was referred for assessment of gender identity disorder.

Q. Do you recall who referred Ms. Edmo to you?

A. I don't recall.

Q. Would it typically have been another health care provider who would have referred Ms. Edmo to you for something like this?

A. No.

Q. Who else could have referred her to you?

A. It --

MR. EATON: Objection.

THE WITNESS: -- could have been several people.

Q. (BY MS. SHANBHAG): Can you describe who?

A. Typically these referrals came from the Idaho Department of Corrections mental health team. And usually the person on that team was Dr. Richard Craig who would send me a referral.

Q. Prior to seeing Ms. Edmo on this occasion, do you recall if you reviewed any of her records?

A. I don't recall.

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Q. Would you typically have reviewed prior records?

A. Yes.

Q. And was this progress note written contemporaneously with your examination of Ms. Edmo?

A. Partially.

Q. What do you mean by "partially"?

A. I probably wrote -- I mean I can't remember exactly, but in my normal course of things I write some of the note when I'm with the patient and some of the note after the patient leaves.

Q. Do you typically finish the note immediately after the patient leaves?

A. Typically.

Q. Can you explain the SOAP method to me.

A. The SOAP note?

Q. Yes.

A. Yes. The SOAP note is a typical format for any sort of medical encounter. And the "S" stands for subjective. It's the first portion. And that's usually what the patient says to you or another source. It's subjective information that's coming in. All right?

And then the "O" stands for objective, which is what you can see with your eyes. And in a

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a delusion might be that I have a chip implanted in my brain by the government that's recording my thoughts. And oftentimes when you're examining a patient, it's clear by their behavior that they have a delusion, even if they don't say it. And in this case I must have not noticed anything like that.

Q. Under assessment you wrote, "24-year-old male with alcohol dependence and mood d/o NOS."

What does the "d/o NOS" mean?

A. That stands for mood disorder not otherwise specified.

Q. And is this a diagnosis?

A. It was.

Q. And what was that diagnosis based on?

A. That diagnosis? I would have to speculate what that was based off of at this time.

Q. What would you typically base that diagnosis on when you're meeting with a patient?

A. On the current presentation, plus previous medical records.

Q. You also state, "In my opinion he meets criteria for GID. His subjective report and feminine demeanor would be consistent with this."

A. Yes.

Q. And was that your diagnosis of Ms. Edmo

EXHIBIT C

with gender identity disorder?

A. Yes.

Q. Do you know if Ms. Edmo had previously been diagnosed with gender dysphoria or gender identity disorder?

A. I don't believe that Ms. Edmo had, according to my memory.

Q. And what criteria were you talking about when you mentioned that he meets criteria for gender identity disorder?

A. There was a book called the Diagnostic and Statistics Manual, Version 4, that had a chapter on gender identity disorder and had criteria in there. And I based it off of that.

Q. And you also wrote, "Some dysphoria but functioning well."

Can you explain what that means.

A. Yes. Often with mental health problems, one of the criteria will be that their symptoms are affecting their level of function. And that can be a wide variety of things: occupational, social, educational functioning. So how you function in your world. And you can have a lot of mental health complaints, but yet if they don't affect your level of functioning within for a specific disorder, you might

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Q. If you did discuss it, would that have been reflected in your note?

MR HALL: Object to form.

MR. EATON: Join.

THE WITNESS: It would -- I guess it would depend if I thought it was pertinent to the note.

Q. (BY MS. SHANBHAG): And what was your treatment plan?

A. To continue medications, start Remeron 7.5 milligrams at bedtime, and return to clinic in three months.

Q. Did you do anything to address her thoughts about castrating herself?

A. I don't recall.

Q. If you did, would that have been reflected in your note?

A. It would depend.

Q. Did you --

A. If I thought it was pertinent, then I would put it in my note.

Q. Okay. Let's go to the next page, which is Corizon 538. This note is dated April 20th, 2016.

Can you read the subjective portion, please.

A. "Inmate reports that she is doing all

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right. Is eligible for parole, but this has not been granted due to multiple DORs related to use of makeup and feminine appearance. Feminine appearance is subjective, which is very frustrating to the inmate. Wants to discuss sexual reassignment surgery. Has been on hormone replacement for the last year and a half, but feels that she needs more. Cites an improvement in gender dysphoria on hormone replacement, though has ongoing frustrations stemming from current anatomy. Cites that she made attempts to mutilate her genitalia this past fall because of the severity of distress. Also requests to be assigned to different housing unit, emphasizes need for intact genitalia for successful SRS as a deterrent to self-mutilation. I spoke to prison staff about the inmate's behavior, which is notable for animated affect and no observed distress. I have also personally observed the inmate in these settings and did not observe significant dysphoria."

Q. Thank you.

Was this the first time that Ms. Edmo discussed sexual reassignment surgery with you?

A. I don't recall.

Q. What was your response to her request to discuss sexual reassignment surgery?

A. That I discussed it with her.

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Q. And what did you do in discussing it with her?

A. I assessed her, what she said, her previous medical record, and staff observations.

Q. And was this assessment something you completed while you were with her?

A. Some of it. Staff observations, I don't recall if I did that with her or not. And as part of my assessment in this note, I also staffed this case with several doctors and a WPATH member to help in my assessment.

Q. And when you staffed the case with these other doctors, does that mean that they conducted an evaluation of Ms. Edmo with you?

A. No. So what that means is I would call these doctors, present the case to them, and discuss the possible treatments and what I was recommending, and see if they thought that that sounded like a medically appropriate recommendation.

Q. So they never formally wrote down any sort of evaluation or assessment of Ms. Edmo's need for sexual reassignment surgery?

MR HALL: Object to form.

MR. EATON: Join.

THE WITNESS: I don't recall.

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Q. (BY MS. SHANBHAG): Do you recall discussing Ms. Edmo's request for sex reassignment surgery with Dr. Stoddart, Dr. Young, and Jeremy Clark?

A. I don't recall, other than what's in my note.

Q. And can you tell me what types of roles Dr. Stoddart, Dr. Young, or Jeremy Clark hold.

A. Dr. Stoddart is a psychiatrist. Dr. Young was the regional medical director. And he was a medical doctor. And Jeremy Clark was the clinical supervisor and a WPATH member and was part of the committee to treat GID -- or gender dysphoria.

Q. And is it common to consult with other treaters when evaluating whether sexual reassignment surgery is necessary for a patient?

A. You know, I think in a case like this, specifically speaking of Ms. Edmo, I had concerns and needed some help from outside colleagues to make sure I was making the right choice. And so I thought that collaborating with multiple different specialties and other outside doctors and somebody who had had more WPATH experience than I did would be helpful. So that's why I did that in this case.

Q. Do you know what concerns you had? You mentioned that you had concerns.

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A. I don't recall which concerns I had specifically. But if I were to just read this note, I was probably concerned because I had a patient who was expressing a lot of dysphoria and attempts to self-castrate, so because of that I felt like it had risen to another level. And I needed to make sure that I was doing the right thing.

Q. And in your assessment you determined that sex reassignment surgery was not necessary; correct?

A. Yes, that's correct.

Q. And what was that assessment based upon?

A. It was based upon a combination of things. My -- all the trainings that I've done, the patient's report, staff observations, consulting with these other doctors. And that's what it was based off.

Q. Earlier you mentioned a list of things that were important factors to consider when evaluating whether sex reassignment surgery is necessary, which includes the patient's current functioning.

Did you assess that here for Ms. Edmo?

A. I don't recall.

Q. Do you recall if you assessed the level of Ms. Edmo's dysphoria?

A. Well, I do comment on it in the note. I don't recall personally. But in my note there are

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comments about it.

Q. You earlier mentioned about the length of an individual's complaint was an important factor in evaluating whether the surgery is necessary.

Did you evaluate that here?

A. Yes, I did take that into account here.

Q. Can you point me to that.

A. Well, it's not like directly just the length of the complaint, but it was the length of time on hormone replacement that I documented here.

Q. And what was that time?

A. It says here for the last year and a half.

Q. And earlier you mentioned that the WPATH standards were also an important consideration in evaluating whether SRS is necessary.

Did you --

MR. EATON: Object to form. Sorry. I thought you were done.

Q. (BY MS. SHANBHAG): Did you take into account the WPATH standards in coming to your conclusion?

A. Yes.

MR. EATON: Object to the form.

THE WITNESS: Yes.

Q. (BY MS. SHANBHAG): And how did you do

EXHIBIT C

that?

A. You know, it's part of everything that I do when I treat somebody with gender dysphoria. I think the WPATH standards are very helpful to help guide treatment. They're not the only thing I rely on, but I definitely include them in what I think about.

Q. Can you point me to where in your note the standards are reflected, or your understanding of the standards are reflected.

A. Well, you find that I don't say a lot of things that I've received in trainings in my note. And that's not typical practice to reference every decision. But I did mention that I consulted with Jeremy Clark, who was a WPATH member. So that's at least an allusion to WPATH.

Q. And you earlier talked about the patient's mental health stability as another factor in evaluating whether SRS is necessary?

A. Yes.

Q. Did you evaluate Ms. Edmo's mental health stability?

A. I don't recall at this time, but I do know that as part of the committee in deciding the different treatments for Ms. Edmo that there was a lot of concern about Ms. Edmo's overall health and that she wasn't

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stable enough to receive SRS.

Q. I'm asking, in this particular assessment did you take into account Ms. Edmo's mental health stability when considering her request for SRS?

A. I don't recall.

Q. 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?

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

Q. Where in this note does it reflect that you reviewed her medical record or the notes of her therapists?

A. I don't regularly write that I reviewed past medical notes and therapist notes in my notes, because I do it as a general practice for all my patient encounters.

Q. Do you recall which prison staff you spoke to about Ms. Edmo's behavior?

A. I don't recall.

Q. And you incorporated your personal observations in the subjective portion; correct?

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A. Yes.

Q. And you state, "I have also personally observed the inmate in these settings and did not observe significant dysphoria."

What did that mean?

A. That meant that I had observed Ms. Edmo outside of the clinic appointment settings. So walking on the breezeway to the cafeteria, sitting in the dayroom, sitting in the foyer, sitting in the classroom, and hadn't observed anything that overtly looked like dysphoria in those settings.

Q. And prior to this visit you had not met with Ms. Edmo for approximately three months; correct?

A. I don't recall, but according to these chart notes, that's what it looks like.

Q. And what would be an example of significant dysphoria, in your opinion?

A. You know, dysphoria can present itself in a variety of ways. It could look like crying. It could look like a very flat affect where you're just not very gregarious. And it would kind of depend on the person too. Someone who's very extroverted who appears not to be extroverted anymore can be another sign of dysphoria.

Q. And in concluding that Ms. Edmo did not

EXHIBIT D

UNITED STATES DISTRICT COURT

FOR THE 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

RULE 30(B)(6) DEPOSITION OF IDAHO DEPARTMENT OF CORRECTIONS, TESTIMONY OF ASHLEY DOWELL

AUGUST 31, 2018

REPORTED BY:

JEFF LaMAR, C.S.R. No. 640

Notary Public

EXHIBIT D

THE RULE 30(B)(6) DEPOSITION OF IDAHO DEPARTMENT OF CORRECTIONS, TESTIMONY OF ASHLEY DOWELL, was taken on behalf of the Plaintiff at the offices of the Idaho Department of Correction, North 1299 Orchard Street, Boise, Idaho, commencing at 8:17 a.m. on August 31, 2018, before Jeff LaMar, Certified Shorthand Reporter and Notary Public within and for the State of Idaho, in the above-entitled matter.

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Also Present:
Mark A. Kubinski

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EXHIBITS

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(Exhibit 18 was not marked at this deposition.)

EXHIBIT D

ASHLEY DOWELL,
first duly sworn to tell the truth relating to said cause, testified as follows:

EXAMINATION
BY MR. DURHAM:
Q. Could you tell us your name and spell your last name for the record.
A. Ashley Dowell, D-o-w-e-l-l.
Q. And, Ms. Dowell, have you had your deposition taken before?
A. I have.
Q. Okay. So you're probably familiar with the rules, but I'll go over just a couple of preliminary things just so we're on the same page.
A. That would be great.
Q. Okay. There's a court reporter taking down testimony today. So if you can wait until after I finish my question until you answer, and I'll try to wait until you answer and then I'll ask another question, that way we can make sure the record is clear.
If I say something or ask you something that's unclear, which I'm sure I probably will do, just ask me to repeat it, and I'll try to clarify it for

you.
A. Okay.
Q. Have you reviewed any materials today before your deposition?
A. I have.
Q. Okay. What have you reviewed?
A. Well, it won't be an exhaustive list, but lots of documents: IDOC standard operating procedures, grievances, C-notes from our offender management system, the presentence investigation report, internal documents that were generated by our chief psychologist. I'm sure there's a lot more than that that I'm not recalling at the moment. Property sheets, commissary lists, things of that nature.
Q. I just want to ask you a couple questions about a few specific categories that you mentioned.
A. Sure.
Q. So you said SOPs or standard operating procedures.
Would those have been specific to gender identity disorder or gender dysphoria, or broader than that?
A. I'm sorry. Can you repeat the question?
Q. You said SOPs. I think that's one of the first things you said.

A. Yes.
Q. What you reviewed, was that specific to gender dysphoria or gender identity disorder and those subjects, or something broader than that?
A. The gender identity disorder SOP, the mental health SOP, the property SOP, the disciplinary SOP, the PREA SOP. I could be missing a few.
Is it okay if I refer to that?
MR. HALL: Craig, I have a list of all the documents which we have produced, which have been made available to Ms. Dowell. Perhaps, if it's okay, she could look at this and it would refresh her memory as to what she's reviewed.
MR. DURHAM: That's fine.
Q. If that refreshes your memory, Ms. Dowell, please feel free to refer to it.
A. Thank you.
Q. Thank you, counsel.
So anyway, my next question was, so you're able to testify about those matters, the SOPs that you reviewed for today's deposition; is that correct?
A. Yes.
Q. Okay. And then you mentioned grievances.
Were those grievances specific to Ms. Edmo, or other grievances?

A. They were.
Q. And C-notes, can you explain for the record what C-notes are.
A. C-notes are a note that's put into our offender management system by IDOC staff.
Q. Could that be any IDOC staff, correctional officers, clinicians, anyone?
A. Correct.
Q. Okay. And the PSI, I assume that was a document that was generated during the criminal proceeding?
A. It was.
Q. Okay. Ms. Dowell, can you give us your current title.
A. I'm the chief of prisons.
Q. And what are your responsibilities with the DOC as chief of prisons?
A. Sorry, Craig, can I ask you one quick question?
Q. Yes.
A. Do you want me to review this and tell you if there's other things that I've reviewed, or is this sufficient?
Q. Yeah, please review it. And if there are things on here, if that refreshes your memory, yeah,

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MR. HALL: Is there nine pages on that?
THE WITNESS: Yes.
Q. (BY MR. DURHAM): You have nine pages?
A. I do.
Q. And Bates number, it looks like at the bottom, IDOC underscore V underscore and then the page numbers?
A. Yes.
Q. Okay. Does that appear to you to be the current written policy about which you just testified?
A. This is the current policy that's in place, yes.
Q. When was that adopted?
A. The note on the SOP indicates that it was adopted 10/31 of 2002.
Q. And do you know why it was adopted?
A. My understanding is that it was adopted after a lawsuit that was filed against the IDOC.
Q. Thank you.
And since you gave us the dates of your employment, I assume you weren't involved in the drafting of that document; is that correct?
A. I was not.
Q. Do you know who was?
A. I don't know.

Q. When was it last reviewed?
A. The SOP indicates that it was reviewed 12/21 of 2011.
Q. Do you know when it's scheduled to be reviewed again?
A. This SOP has been under review for quite some time.
Q. You say "quite some time."
Can you be a little more specific?
A. When Dr. Campbell joined our staff in the fall of 2016, it was something I discussed with him at that point. And we've had discussions about review consistently throughout that time.
Q. And when you had that discussion with Dr. Campbell in 2016, what was the nature of that discussion?
A. The nature of the discussion was that the SOP needed to be updated and revised.
Q. Did you initiate that discussion with Dr. Campbell?
A. I did.
Q. And was there anything specific that prompted you to initiate that discussion with him?
A. Not specifically. I'm sorry. Let me rephrase that.

He was new in his role at that time, and this is a policy that would fall directly within his area of responsibility. So there was no specific event that triggered that, but it was discussed as part of his role and oversight.
Q. When did Dr. Campbell come on board?
A. In the fall of 2016.
Q. And you said he's the chief psychologist?
A. He is.
Q. Who was the chief psychologist before him?
A. Dr. Richard Craig.
Q. And if you know, how long had he been the chief psychologist?
A. Prior to Dr. Campbell?
Q. Correct.
A. I don't know offhand.
Q. Okay. Was it more than five years?
A. I'm not sure.
Q. Okay. So you testified that the SOP is in the process of being updated; is that correct?
A. Correct.
Q. When is that scheduled to be completed?
A. That SOP is in a finalized draft form. We need to work out a training plan prior to approving and releasing it.

Q. So can you give me an estimate as to how long that will take before it's adopted or implemented?
A. Well, I would likely say within the next two to three months.
Q. Is there someone in IDOC that is tasked with supervising that process?
MR. HALL: Object to form. Vague.
THE WITNESS: Supervising the process of writing the SOP?
Q. (BY MR. DURHAM): It was a bad question.
Is there somebody who is supervising the complete revision of the SOP, somebody in charge of that process?
A. So there could be several people that work on a revision of an SOP. If it is specifically related to the prisons division, I would approve it, which would mean I would have the final review and editing authority. There's a process by which it is reviewed by our deputy attorney generals assigned to our agency, and there is a policy coordinator that ensures formatting. There's an SOP related to -- to policies that she follows. So she's responsible for formatting and ensuring that that SOP is followed, that definitions are consistent, things of that nature.
Q. So if I understand your testimony

EXHIBIT D

correctly, and correct me if I'm wrong, there's somebody who's assigned to make sure that the revision process itself follows another SOP; is that right?
A. Not exactly.
Q. Okay.
A. She's a coordinator, so she coordinates the process of the revision and the eventual publishing to make sure certain steps were followed. She's a coordinator. She doesn't necessarily oversee that process.
Q. Is there a committee or a task force that is working on this revision?
A. There are several people who have worked on this, but not a committee.
Q. Who are those people?
A. I've worked on it. Dr. Campbell has worked on it. Dr. Campbell -- I'm sorry. Myself, Dr. Campbell. I've had discussions with my legal counsel.
Q. Anyone else?
A. I'm -- I believe Dr. Campbell has also had some discussions with his staff as well.
Q. Are there any Corizon providers involved in that process?
A. No.

Q. So you may have testified to this, and if you did, I apologize: Does the current SOP govern the treatment of inmates with gender dysphoria?
A. I'm not sure I understand specifically what you're asking.
Q. Does the current SOP, Exhibit 11, apply to the process through which inmates with gender dysphoria are managed and treated?
MR. EATON: Object to form.
MR. HALL: Join.
THE WITNESS: So I believe I testified earlier, this process outlines specific procedures for inmates who are requesting evaluation for gender dysphoria or have been diagnosed with gender dysphoria. But there are several other health care and mental health policies that would also govern the overall health care of that inmate population --
Q. (BY MR. DURHAM): And my question --
A. -- as a whole.
Q. And the reason I asked that question -- maybe this will be a little clearer, but does Exhibit 11 use the term "gender dysphoria"?
A. Can you give me just a second to look?
Q. Sure. Absolutely.
A. [Reviews.]

Yes, the term "gender dysphoria" is found on page 2 of 9.
Q. And in what context is it being used there?
A. On page 2, "gender dysphoria," the term, is used in the definition of "Gender Identity Disorder."
Q. Okay. Thank you.
So I'd like to kind of walk through some of the steps that this policy sets out for an inmate with gender dysphoria or gender identity disorder.
Is there an IDOC official who was initially responsible for making an evaluation to determine whether the inmate is GID or GD?
A. If you'll give me just a second to review this.
[Reviews.]
Can you ask your question again, Craig? I'm sorry.
Q. No, that's fine. And this will refresh your recollection. I'll draw your attention to page 4, bottom of page 4, and the top of page 5, and that sort of sets out the steps.
A. So I'm sorry. I understood you to say does someone do an evaluation of the inmate. I think you're referring to on page 4 and 5 how the inmate requests the initial evaluation.

Can you clarify which you're asking about?
Q. So let's skip over that step.
Once the inmate has requested the evaluation, what happens next is my question. What IDOC official is responsible for conducting that evaluation?
A. For conducting the evaluation?
Q. Correct. If any.
A. Okay. On the bottom of page 5 where it speaks specifically to the "Evaluation of the Offender," it speaks to the offender being evaluated by the psychologist and/or psychiatrist.
Q. And if you know, are those IDOC positions or Corizon positions?
A. We have a chief -- I'm sorry, we, as in IDOC, has a chief psychologist. Corizon also has psychologist positions. And psychiatrist positions are all Corizon staff.
Q. Once that evaluation has been made, is it your understanding that the psychiatrist/psychologist determination goes to the chief psychologist of the Idaho Department of Correction for review?
A. Once the evaluation has been finalized?
Q. Yes. And I direct your attention to the bottom of I guess it's page 6, section 5.

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So that is training specific to the management of gender dysphoria and gender identity disorder in a correctional setting, at POST, what you just testified to?
A. So at POST there is training specific to gender dysphoria under the umbrella of a section of training that's called managing offenders with mental illness, something to that effect.
Q. Okay.
A. Managing mental illness. That -- broadly that topic. There is a section specifically related to gender dysphoria, yes.
Q. Okay. And I interrupted you. You were going to give me some other examples, I think, after POST.
A. Sorry. Now I've lost my train of thought. So there's the training at POST. There is specifically training provided in the Behavioral Health Unit at ISCI to officers every year that has encompassed gender dysphoria. There is training that has been provided to clinicians statewide related to gender dysphoria. There is initial training that's provided to new hire clinicians related to gender dysphoria. And there is training specifically that was provided on assessment and evaluation of inmates with gender dysphoria.

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Q. Do you know when that training was provided?
MR. HALL: Object to form.
Which one?
Q. (BY MR. DURHAM): The last one, the one on I think you said assessment of inmates for gender dysphoria.
A. I was given that information, and I don't recall offhand when that training occurred.
Q. Do you know who was the trainer?
A. Dr. Campbell and Jeremy Clark, who's an IDOC clinical supervisor.
Q. Are you aware of any training by Dr. Stephen Levine?
A. I am.
Q. Did you attend that training?
A. I did. Portions of it.
Q. And what was the purpose of that training?
MR. EATON: Object to form.
MR. HALL: I'll join. Calls for speculation, lacks foundation as well.
MR. EATON: Join.
THE WITNESS: Can you clarify in terms of purpose, what you --
Q. (BY MR. DURHAM): Well, let's start. So

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who sponsored or brought Dr. Stephen Levine in for the training?
A. I -- I don't know who sponsored the training, per se. I know that the training was held at the Corizon regional office.
Q. Okay. And do you know who attended besides yourself?
A. I don't know that I can specifically say without looking at a list of attendees.
MR. DURHAM: Do you have Exhibit 4 from the last deposition?
THE COURT REPORTER: Yeah.
Q. (BY MR. DURHAM): I'm handing you what's been marked as Plaintiff's Exhibit 4.
Do you recognize that?
A. I can tell you the title of the document. I don't recognize the document.
Q. Okay. Does that refresh your memory as to any attendees at Dr. Levine's training?
A. Some of the names on this list I recall being there. I don't recall all of them. But I do recall some of the attendees being there, yes.
Q. And do you recall what year that training was?
A. I don't.

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MR. DURHAM: Do you have a copy of what's been marked as Exhibit 20?
MR. HALL: I know we brought four copies. Did you get one, Craig?
MR. DURHAM: I think we had him mark it.
THE WITNESS: Here's 20.
Q. (BY MR. DURHAM): Okay. Great. I think we're wrapping up, so...
A. Okay.
Q. Do you have Exhibit 20 in front of you?
A. I do.
Q. And what is this document?
A. This is a draft of some revisions to a policy with a control number that begins with 401.
Q. Okay. And which policy is it a draft or a revision to?
A. The -- this is a revision to the policy that is marked as Exhibit 11 that originally was titled "Gender Identity Disorder: Health Care for Offenders with."
Q. Does it still have that title, that same title, or does it have a different title?
A. It has a different title.
Q. Has IDOC consulted with any third-party standards or policies in formulating this draft?

EXHIBIT D

IDAHO DEPARTMENT OF CORRECTION
Property Limits

(*) The item is not tracked in property logs
(+) If the inmate purchases personal items in addition to state issued, or to replace state issues; facility staff must take the extra state issued items away so that the inmate has only the total number allowed in possession. The maximum number allowed is the sum of SI and Pers quantity counts noted in the table.
(>>) This list establishes the maximum amount of certain property or commissary items for all inmates. It is not intended to be an all-inclusive list of offerings. Commissary or property items available for sale through commissary as approved by IDOC that are not listed on or limited by this list are considered authorized and are limited only by the weekly spending limit.
(***) This list restricts the quantities and/or types of property and commissary allowed in certain housing units. Access to general commissary and property offerings is not permitted for detention, pre-hearing segregation (PHS), and segregation pending investigation (SPI). Inmates in a reception and diagnostic unit (RDU) or transit or those inmates with an "unassigned" classification status have more liberal access to commissary but are still more restricted than other housing areas.

Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block, tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
* *Antenna	Pers	1 - PWCC only	1 - PWCC only	1 per room	None	1 - PWCC only	None
Address book	Pers	1	1	1	1	1	1
Alarm clock	Pers	1	1	1	None	1	None
Batteries AA	Pers	6	6	6	None	6	6
Batteries AAA	Pers	6	6	6	None	6	6

Exh. No. 19
Date 8/31/18
Name Davell
M & M Court Reporting

320.02.01.001
(Last updated on 06/06/2017)

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IDAHO DEPARTMENT OF CORRECTION
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Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
Beard or mustache trimmer (male only - battery operated)	Pers	1	1	1	None	None	None
Belt (plain) and buckle (buckle not to exceed 2" x 2")	Pers	1 - SI only	1 - SI only	1	None	None	None
+ Blankets	SI and/or Pers	2	2	2	None	2	2 - SI only
Board Games (Chess, Checkers, etc. as offered through commissary)	Pers	2	2	2	None	2	2
Books (soft and hard bound, including religious, and magazines)	Pers	20	20	20	1 - soft only	20	1 - soft only
Bowl (plastic with lid)	Pers	5	5	5	None	5	1

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IDAHO DEPARTMENT OF CORRECTION
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	Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
		State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
+	Bras (female and approved GD inmates only)	SI and/or Pers	3 - SI 2 - Pers	3 - SI 2 - Pers	3 - SI 2 - Pers	3 - SI only	3 - SI 2 - Pers	3 - SI only
	Calculator	Pers	1	1	1	None	1	None
*	Calendar (no metal binding, no sexually explicit materials - see SOP 402.02.01.001, *Mail Handling in Correctional Facilities*)	Pers	1	1	1	None	1	None
	Can opener	Pers	None	None	1	None	None	None
+	Cap [excludes uniforms] (baseball and/or knitted style [no hobby craft]) [i]	Pers	2 any combination of style	2 any combination of style	2 any combination of style	None	2 any combination of style	None
*	Cash	N/A	None	None	$30.00 maximum allowed	None	None	None

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Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
Coat or jacket [ii](no leather)	Pers	None	None	2	None	None	None
Coaxial cable (for television)	Pers	None	2	2	None	2	None
Coffee filter (plastic)	Pers	None	None	1	None	None	None
Coffee mug (plastic)	Pers.	1	1	1	None	1	None
Combination lock	Pers	2	2 (minimum and medium custody only)	2	None	None	None
* Contact lenses, case (non-colored) and solution (for new commitments only until eye glasses are provided by medical or personal Rx pair received)	Pers	6 pairs	6 pairs	6 pairs	6 pairs	6 pairs	6 pairs

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IDAHO DEPARTMENT OF CORRECTION
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	Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
		State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
+	Coveralls (if work required and approved) or facility uniform (top and bottom)	SI and/or Pers	1 pair	1 pair	1 pair - SI 1 pair - Pers	1 pair	1 pair	1 pair
	Cup - Tumbler (plastic only)	Pers	1	1	2	SI	1	1
	Curling **or** flat iron (females only)	Pers	1	1	1	None	None	None
*	Denture Cleaner	Pers	1	1	1	1	1	1
*	Denture Adhesive	Pers	1	1	1	1	1	1
*	Denture Cup	Pers	1	1	1	1	1	1
	Electronic tablet-type device w/approved accessories	Pers	1 (of each commissary type offered)	1 (one of each commissary type offered)	1 (one of each commissary type offered)	None	1	1
*	Envelopes (stamped from commissary or indigent)	Pers/SI for indigent	20 - Pers 1/wk - SI (indigent)	20 - Pers 1/wk - SI (indigent)	20 - Pers 1/wk - SI (indigent)	20 - Pers 1/wk - SI (indigent)	21 - Pers 1/wk - SI (indigent)	20 - Pers 1/wk - SI (indigent)

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	Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
		State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
+	Eyeglasses (prescription [Pers or SI] or reading)	Pers (Rx) and/or SI (through medical) and/or reading through commissary	1 of each	1 of each	1 of each	1 of each	1 of each	1 of each
	Fan (electric)	Pers	1	1	1	None	1	None
*	Fingernail clippers (no file)	Pers	1	1	1	None	None	1
*	Flyswatter	Pers	1	1	1	None	None	1
*	Fork, spoon, spork	Pers	1 of each (commissary only)	1 of each category (commissary only)	1 of each (commissary only)	1 of each (commissary only)	1 (commissary only)	1 of each (commissary only)
	Gloves; fingerless, weight lifting	Pers	None	None	None	None	None	None
	Gloves; jersey	Pers	1 pair	1 pair	1 pair	None	1 pair	1 pair
	Gloves; winter	Pers	None	None	1 pair	None	None	None

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IDAHO DEPARTMENT OF CORRECTION
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Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
Gloves; work (excludes SI or work-issued gloves)	Pers	None	None	2 pairs	None	None	None
Guitar (w/strings) and soft-sided case	Pers	None	1	1 (commissary only)	None	None	None
Guitar Picks (plastic)	Pers	None	5	5 (commissary only)	None	None	None
Guitar strap with (or without) buttons	Pers	None	1	1 (commissary only)	None	None	None
Guitar Strings (commissary only)	Pers	None	1 spare set	1 spare set (commissary only)	None	None	None
Guitar tuner	Pers	None	1	1	None	None	None
Hair blow-dryer	Pers	1	1	1	None	1	None
* Hair ties	Pers	1 unopened package plus one 1 open	1 unopened package plus one 1 open	1 unopened package plus one 1 open (commissary only)	1 unopened package plus one 1 open	1 unopened package plus one 1 open	1 unopened package plus one 1 open

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IDAHO DEPARTMENT OF CORRECTION
Property Limits

	Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
		State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
*	Hairbrush	Pers	1	1	1	1	1 - PWCC only	1
	Handkerchiefs (white, no bandanas)	Pers	5	5	5	None	None	5
*	Hangers (plastic)	Pers	5	5	10	None	5	None
	Harmonica (eight inches [8"] maximum) (not sold anymore in commissary but if an inmate has one, its grandfathered)	Pers	1	1	1	None	1	None
	Headphone adaptor	Pers	1	1	1	None	1	1
	Headphone extension cord	Pers	1	1	1	None	1	1
	Headphones splitter	Pers	1	1	1	None	1	1

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IDAHO DEPARTMENT OF CORRECTION
Property Limits

Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
Headphones: overhead (one aftermarket headphone in addition to standard accessories that come with an electronic device)	Pers	1 pair	1 pair	1 pair	None	1 pair	1 pair
Headphones; earbuds, or mini-earphones (one aftermarket earbud in addition to standard accessories that come with an electronic device)	Pers	1 pair	1 pair	1 pair	None	1 pair	1 pair
Hobby craft (if approved)	Pers	1 (incomplete)	1 (incomplete)	1 (incomplete)	None	None	None
Hot pot	Pers	1	1	1	None	1	None
Hygiene bag (clear, plastic)	Pers	1	1	1	1	1	1

320.02.01.001
(Last updated on 06/06/2017)

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IDAHO DEPARTMENT OF CORRECTION
Property Limits

Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
* Hygiene items (deodorant, lotion, shampoo, conditioner, razor, body wash, bar soap, toothpaste, etc.)	Pers (SI for indigent)	1 of each category	1 of each category	1 of each category	1 of each category	1 of each category	1 of each category
Lamp - book (clip-on) or reading (battery or electric)	Pers	1	1	1 (commissary only)	None	1	1
Laundry Bag	SI	1	1	1	1	1	1
Lunch box (for outside workers only)	Pers	None	1	1	None	None	None
* Make-up (female only) (foundation, mascara, eye shadow, blush, lip treatment as sold through commissary)	Pers	1 of each category	1 of each category	1 of each category (No glitter make-up, polish remover must be non-acetone, and no aerosol cans.)	None	1 of each category - PWCC only	1 of each category

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IDAHO DEPARTMENT OF CORRECTION
Property Limits

	Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
		State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
*	Mirror (plastic)	Pers	1	1	1 (commissary only)	1	1	1
	MP3/MP4 Digital Music Player with approved accessories (Not sold any longer but inmates can retain them)	Pers	1	1	1 (commissary only)	None	1	1
	Neck ties	Pers	None	None	1	None	None	None
	Nightshirt (females only)	SI	1	1	1	1	1	1
+	Pants (includes jeans, Dockers, scrubs, etc.)	SI and/or Pers	2 pair	2 pair (3rd pair if approved for work uniform)	2 pair (3rd pair if approved for work uniform)	1 pair (SI only) Scrubs or Coveralls	2 pair	2 pair
	Personal papers and legal materials	n/a	3 cubic feet	3 cubic feet	3 cubic feet	3 cubic feet	3 cubic feet	3 cubic feet
	Photograph album (each photograph not to exceed 5" x 8")	Pers	2	2	2	None	2	2

EXHIBIT D

IDAHO DEPARTMENT OF CORRECTION
Property Limits

Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
* Photographs not in album (not to exceed 5" x 8")	Pers	20	20	20	0	20	20
Pillow	Pers	2	2	2	None	2	2
Pillow cases	Pers	2	2	2	None	2	2
Playing cards: Pinochle	Pers	2 decks	2 decks	2 decks	None	2 decks	2 decks
Playing cards: Poker (cold case)	Pers	1 deck	1 deck	1 deck	None	1 deck	1 deck
Power strip	Pers	1	1	1	None	1	1
Prosthesis	Pers	Approved by medical	Approved by medical	Approved by medical	Approved by medical	Approved by medical	Approved by medical
Purse, clear plastic (females only)	Pers	None	None	1	None	None	None
Racquet Balls (w/cardboard or plastic containers only)	Pers	3 balls total	3 balls total	3 balls total (commissary only)	None	3 balls total	3 balls total

EXHIBIT D

IDAHO DEPARTMENT OF CORRECTION
Property Limits

Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
Radio - Walkman type with standard headphones and batteries	Pers	1	1	1	None	1	1
Radio (AC or battery powered)	Pers	1 (battery only if physical plant requires)	1	1 (commissary only)	None	1	1
Razor / Shaver (AC or battery powered)	Pers	1	1	1	None	1 - PWCC only	None
Ring (band, no stones or gems, maximum value of fifty dollars [$50])	Pers	1	1	1	1	1	1
Rug, bath	Pers	1	1	1 (commissary purchase only)	None	1	1
* Sewing kit (no scissors)	Pers	1	1	1	None	None	None
+ Sheets	SI and/or Pers	2 - SI only	2 - SI only	2 - SI 2 - Pers	None	2 - SI only	2 - SI only

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(Last updated on 06/06/2017)

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IDAHO DEPARTMENT OF CORRECTION
Property Limits

	Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
		State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
+	Shirts - dress, work, polo, or button up	SI and/or Pers	2 - SI only	2 - SI only	2 - SI 3 - Pers	2 - SI only	2 - SI only	2 - SI only
	Shirts - T-shirts, undershirts, gym, pull-overs(no sleeveless)	Pers/SI	5	5	5	2	5	2
	Shoes (tennis type)	Pers/SI	2 pairs	2 pairs	2 pairs (maximum value of $75)	None	2 pairs	2 pairs
	Shoes - house slippers (to be worn in cells and day rooms Only)	Pers	1 pair	1 pair	1 pair	None	1 pair	1 pair
	Shorts - Gym	Pers	2 pair	2 pair	2 pair	None	2 pair	2 pair
	Shower shoes/sandals	SI or Pers	1 pair	1 pair	1 pair	1 pair	1 pair	1 pair
*	Soap dish	Pers	1	1	1	1	1	1
+	Socks	SI and/or Pers	3 - SI 6 - Pers	3 - SI 6 - Pers	3 - SI 6 - Pers	1 - SI only	3 - SI 6 - Pers	3 - SI 6 - Pers

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(Last updated on 06/06/2017)

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IDAHO DEPARTMENT OF CORRECTION
Property Limits

Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
Storage container, personal property items (approximately 8" x 13" or six quarts)	Pers	3	3	3 (commissary only)	None	3	3
Sunglasses with strap	Pers	1 pair	1 pair	1 pair (commissary only)	None	1 pair	1 pair
Sweat pants and Sweat shirt	Pers	1 each	1 each	1 each	None	1 each	1 each
Television w/remote and batteries if available (sets previously purchased from commissary prior to a release are not allowed to re-enter a facility)	Pers	None	1	1 where permitted (commissary only)	None	1	None

EXHIBIT D

IDAHO DEPARTMENT OF CORRECTION
Property Limits

	Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
		State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
	Thermal underwear (top and bottom)	Pers	2 pairs -Pers	2 pairs -Pers	2 pairs -Pers	None	2 pairs -Pers	2 pairs -Pers
	Toenail Clippers (no file)	Pers	1	1	1	None	None	None
*	Toothbrush	Pers	1	1	1	1	1	1
*	Toothbrush holder	Pers	1	1	1	1	1	1
+	Towels	SI and/or Pers	2	2	2	None	2	2
*	Tweezers (round or flat tipped)	Pers	1	1	1	None	1 - PWCC only	1
	Typewriter w/one ribbon	Pers	None	1	1	None	None	None
+	Underwear - gender specific and GD approved inmates(boxer/briefs - males; panties-females)	SI and/or Pers	9 pairs	9 pairs	9 pairs	3 - SI only	9 pairs	9 pairs

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IDAHO DEPARTMENT OF CORRECTION
Property Limits

Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
Video game console with batteries (hand-held only)	Pers	None	None	1 (maximum value of $25)	None	None	None
Wallet	Pers	1	1	1	None	None	None
Washcloths	Pers	2	2	2	2	2	2
Water bottle	Pers	1	1	1	None	1	1
+ Work boots or work shoes (inmate workers or work crews only)	SI and/or Pers	1 pair	1 pair (work camps up to 3 pair, fire boots, etc.)	1 pair (work camps up to 3 pair, fire boots, etc.)	None	None	None
Wrist watch (with batteries and band / strap)	Pers	1	1	1 (commissary purchased only)	None	1	1
Storage container, ceremonial for personal religious property/items	Pers	See SOP 320.02.01.002, *Property: Religious (commissary purchased only, approximately 8" x 13" or six [6] quarts. Approved ceremonial items must be stored in the religious activity center [chapel])*					

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IDAHO DEPARTMENT OF CORRECTION
Property Limits

Authorized Items	General Property Limits - All Facilities (>>)				Restricted Housing Property Limits		
	State Issued (SI) and/or Personal (Pers)	Retained Jurisdiction (Rider)	General Population, Administrative Segregation, Death Row	CRC	(***) Detention, PHS, SPI	Acute BHU (IMSI C-Block , tiers 1 and 2;PWCC Unit 3, B-tier only)	(***) RDU/Transit Status and Unassigned Classification
Ceremonial, religious items such as religious medallion, head cover, etc.	Pers	See *Property: Religious*, SOP 320.02.01.002					

[i] During winter month, facilities may issue the following: one knit stocking cap to inmates in prison facilities.
[ii] During winter month, facilities may issue the following: one coat to inmates in prison facilities.

EXHIBIT D

Idaho Department of Correction	Standard Operating Procedure Operations Division Operational Services	Control Number: 401.06.03.501	Version: 3.2	Page Number: 1 of 9 Adopted: 10-31-2002 Reviewed: 12-21-2011
		Title: Gender Dysphoria: Healthcare for Inmates with		

This document was approved by Ashley Dowell, Chief of the Division of Prisons, on 12/21/11 (signature on file).

Open to the general public: ☒ Yes

BOARD OF CORRECTION IDAPA RULE NUMBER 401

Medical Care

POLICY CONTROL NUMBER 401

Clinical Services and Treatment

DEFINITIONS

Standardized Terms and Definitions List

Administrative Review Committee (ARC)—GD: A committee comprised of the Chief of the Prisons Division; a Deputy Chief of the Prisons Division; and a deputy attorney general who is assigned to the Idaho Department of Correction (IDOC) and will act as legal advisor. The committee reviews recommendations of the Management and Treatment Committee (MTC). The ARC may, in its discretion retain a consultant versed in the treatment, management, and placement of persons with Gender Dysphoria (GD). The ARC makes recommendations regarding the classification, management and security of persons with GD. Recommendations of the ARC, together with the recommendations of the MTC, shall be submitted to the director of the IDOC for final consideration.

Chief Psychologist: The chief psychologist must be a doctoral level psychologist licensed in the state of Idaho and employed by the IDOC and shall be responsible for overseeing the delivery of all IDOC mental health services provided by state of Idaho and/or contract providers. If the chief psychologist is not a qualified GD evaluator, he must engage and rely upon a consultant who must be a qualified GD evaluator.

Consultant—GD: A medical or mental health professional, qualified by virtue of their training and experience to make non-binding recommendations regarding the diagnosis and treatment of inmates with Gender Dysphoria (GD). Any consultant involved with the diagnosis of GD must be a qualified GD evaluator.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The standard manual of psychiatric diagnoses, as published and amended by the American Psychiatric Association from time to time.

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Date 8/31/18
Name Dowell
M & M Court Reporting

EXHIBIT D

Facility: A building or residence (including the property and land where the building or residence is located) owned, leased, operated, or managed by the Idaho Board of Correction or Idaho Department of Correction (IDOC).

Facility Head: The person primarily responsible for overseeing, managing, or operating an Idaho Department of Correction (IDOC) facility.

Gender Dysphoria (GD): A psychiatric disorder that is defined in the most current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. A person with this condition reports marked incongruence between the gender they were born with and their identified or expressed gender causing clinically significant distress or impairment in functioning.

Hormone Replacement Therapy: A medical treatment in which hormonal medications are administered to individuals diagnosed with gender dysphoria for the purpose of more closely aligning their physical characteristics with their gender identity. The goal of this treatment is feminization or masculinization.

Level of Care (LOC): An acuity based system utilized by the Idaho Department of Correction (IDOC) in which inmates with mental health issues are assigned a LOC based upon the severity of their mental illness and degree of treatment needs.

Management and Placement Plan: A written plan devised by the Management and Treatment Committee (MTC) that includes a review of the treatment plan from the treating medical and mental health providers, outlines referrals for treatment and includes recommendations regarding facility placement and housing and special accomodations or support services. The Management and Placement Plan is forwarded to the Administrative Review Committee (ARC) for their review and approval.

Management and Treatment Committee (MTC): A multidisciplinary committee that is composed of representatives from the medical, mental health, security and operations staff. . This committee reviews the treatment plan from the treating medical and mental health providers and generates a management and placement plan. The committee is lead by the IDOC Chief Psychologist.

Inmate: A person under the legal care, custody, supervision, or authority of the Idaho Board of Correction, including a person within or out of the state of Idaho pursuant to an agreement with another state or contractor.

Primary Physical Sexual Characteristics: Genitalia and reproductive organs.

Qualified Gender Dysphoria (GD) Evaluator: A trained mental health professional, who is either an IDOC or contract medical employee, with competence to work with adults with gender dysphoria and has:

1. A master's degree, or more advanced degree, in a behavioral health field and appropriate licensure in or credentials
2. Competence in using the DSM for diagnostic purposes
3. The ability to recognize and diagnose coexisting mental health concerns
4. Documented supervised training and competence in counseling
5. Is knowledgeable about gender non-conforming identities and expressions and the assessment and treatment of gender dysphoria
6. Continuing education in the assessment and treatment of gender dysphoria

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7. Cultural competence to facilitate work with individuals with gender dysphoria

Reception/Diagnostic Unit (RDU): Initial housing for newly committed inmates (except those under sentence of death) where orientation, screening, assessment, and classification occur.

Sexual Reassignment Surgery: The surgical alteration of the physical appearance of an individual's genitalia so the person's genitals more closely match that of their identified gender.. Sexual reassignment surgery will not be considered for individuals incarcerated within the Idaho Department of Correction (IDOC), unless determined medically necessary by the treating physician.

Sexual Reassignment Treatment: Treatment for a person diagnosed with Gender Dysphoria (GD) in which hormone replacement medications, surgical procedures, or both are utilized to alter a person's physical appearance so that the person appears more like their identified gender.

Treatment Plan: A series of written statements specifying a patient's particular course of treatment and the roles of qualified healthcare professionals in carrying it out.

PURPOSE

The purpose of this standard operating procedure (SOP) is to establish guidelines for the diagnosis, treatment, management, and placement of inmates diagnosed with Gender Dysphoria (GD) to ensure inmate safety and access to appropriate and necessary medical and mental health treatment. This SOP defines the extent and general limits of healthcare services provided to inmates identified as meeting the criteria for diagnosis of GD as outlined within the most current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

SCOPE

This SOP applies to all Idaho Department of Correction (IDOC) inmates who request or are evaluated for and/or diagnosed with GD; Prisons Division administrators, employees, contract medical providers and subcontractors; and limited IDOC staff such as facility heads, security staff, deputy attorneys general (DAG) who represents the IDOC, and the director of the IDOC.

RESPONSIBILITY

The director of the Education, Treatment, and Reentry Bureau **and** deputy chief of the Prisons Bureau shall be jointly responsible for the implementation of this SOP and for designating appropriate personnel to develop and implement procedures in conjunction with this SOP.

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GENERAL REQUIREMENTS

1. Initial Reporting

Information about all services available within the correctional system, including those to meet the needs of inmates with GD, will be made available to inmates while in the Reception/Diagnostic Unit (RDU). Upon the inmate's request, information about all services will be available throughout the inmate's incarceration. Until an inmate who is suspected of having GD completes the RDU process, security staff and other relevant staff shall review whether to escort and transport the inmate separately to avoid the risk of physical or sexual assault by other inmates in transit.

Inmates may be evaluated for GD at any point during their incarceration. When the inmate has a prior diagnosis or is suspected of having GD or accompanying/supporting information (i.e., collateral information) is received pertaining to the suspicions of GD, any of the following may request an initial or subsequent evaluation for GD:

- **Inmate** – Requests (in writing) health assistance in accordance with SOP 401.06.03.037, *Non-emergency Healthcare Requests and Services* **or** SOP 401.06.03.087, *Healthcare for Inmates Housed in Non-Idaho Department of Correction Facilities*.
- **Healthcare staff** – Prepares a referral in accordance with SOP 401.06.03.037 **or** 401.06.03.087 and forwards to the chief psychologist.

Subsequent Evaluations

Also see section 11.

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2. **Referral and Placement of the Inmate for Evaluation Purposes**

The chief psychologist will take the necessary action to transfer an inmate who is scheduled to be evaluated for GD to the appropriate facility for evaluation if a move is needed.

Note:

When determining appropriate placement, the chief psychologist will consider factors such as the inmate's diagnostic needs, prior institutional adjustment, and safety and/or security concerns. In consultation with the warden, unless there are overriding security and/or safety concerns for the inmate, the chief psychologist will place the inmate (who either requests a GD evaluation **or** is diagnosed with GD) in a correctional facility consistent with the inmate's primary physical sexual characteristics.

The evaluation process will commence within 30 days from the date a written request, **or** referral from medical staff for evaluation, is received by the chief psychologist.

3. **Evaluation of the Inmate**

Once the inmate has been moved to the appropriate housing unit, the inmate will be evaluated by the Qualified GD Evaluator. The chief psychologist, at his direction, may require that a consultant perform this initial evaluation.

Note: Any consultant involved with the diagnosis of GD must be a qualified GD evaluator and contracted by the IDOC.

This evaluation shall include a comprehensive history, mental status evaluation, and clinical interview. Documentation of any claim by the inmate of prior GD diagnosis, treatment, or transgender lifestyle shall be obtained as part of the evaluation process. An inmate's refusal to provide written authorization to access medical records relating to prior diagnosis or treatment of GD may be considered a factor for a non-GD finding by the evaluator.

The diagnosis of GD shall be based on the most current *Diagnostic and Statistical Manual of Mental Disorders*. If the IDOC evaluator believes it is necessary, they may contract a medical **or** mental health consultant to assist in the evaluation process. Any diagnoses by the evaluators should include consideration of the consultant's report.

Throughout the evaluation process, the chief psychologist or clinical supervisor shall monitor the progress of the evaluation to ensure the GD evaluation is completed as soon as practicable. Absent extenuating circumstances, the GD evaluationwill be completed within 60 days from the date the evaluation process commences as described in section 2.

4. **Evaluator Findings, Diagnosis, and Reporting**

The GD evaluator conducting the evaluation shall prepare independent written reports detailing their findings, diagnosis, and recommended treatment options. These independent written reports shall include dates of contact, instrumentation utilized, collateral data obtained, and the consultant's report, if applicable. The reports shall also include a diagnosis **and** a summary of the information and impressions that support the diagnosis and recommended treatment options. These written reports shall be forwarded to the chief psychologist.

In cases where an inmate was receiving (prior to incarceration) feminizing **or** masculinizing hormones from a licensed medical professional as treatment for GD, the prior treatment will be continued and incorporated into the inmate's individualized medical treatment plan,

EXHIBIT D

unless hormone replacement therapy is subsequently contraindicated based on the assessment and findings by the inmate's treating physician.

5. **Chief Psychologist's Review**

Upon receipt of the evaluators' reports, the chief psychologist shall review the findings and convene the Management and Treatment Committee (MTC)The chief psychologist may, at his discretion, request an additional evaluation by a consultant who will provide an independent diagnosis and report. If differences in opinions between evaluators exist, the chief psychologist shall—based upon his review of all available information, including the reports of the evaluators and any consultant—issue a report resolving any differences of opinions concerning diagnosis and/or treatment, including his own findings. All reports generated by the evaluators, consultants, or the chief psychologist will be placed in the inmate's medical file.

Findings Not Supported

In incidences in which the diagnosis of GD is not supported by the evaluation process, the chief psychologist may, at his sole discretion,

- Request an additional evaluation by a consultant who will provide an independent diagnosis, **or**
- Refer concerns about the inmate's security or housing needs to the operations and security staff at the inmate's assigned facility so they can determine appropriate housing..

6. **Management and Treatment Committee (MTC) Meeting**

When convened, the MTC shall develop and recommend a plan for the management and placement of the inmate. Copies of all reports authored by the evaluators will be provided to the MTC.

The MTC shall develop and recommend an individualized Management and Placement Plan for each inmate diagnosed with GD, which implements the treatment plan developed by the treating medical and mental health providers.

The treating physician may also initiate hormone replacement therapy when such therapy has been prescribed as part of the treatment plan. When initiated by the treating physician, the hormone replacement therapy may commence prior to and independent of the Administrative Review Committee's (ARC) review. The chief psychologist may initiate mental health services recommended as part of the treatment plan prior to and independent of the ARC review.

Management and placement recommendations for inmates with GD will take into account both treatment **and** security needs, with a goal of least restrictive placement. As provided in section 2, facility placement will be based upon the inmate's primary physical sexual characteristics.

The MTC shall forward its recommendation for management and placement to all ARC members.

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7. Administrative Review Committee (ARC) Meeting

Convening Responsibility

After receiving the MTC's report and recommendations, the Chief of the Prisons Division shall convene a meeting of the ARC.

Review of Management and Placement Plan

The ARC shall review the *Management and Placement Plan* recommended by the MTC and, at its discretion, consult with members of the MTC in an effort to address concerns and/or questions related to the proposed plan.

Upon approval of the MTC's proposed *Management and Placement Plan*, the ARC shall submit its recommendation for management to the director of the IDOC within 15 working days of meeting.

8. Final Approval of the Management and Placement Plan

The director of the IDOC shall review the ARC's recommendation, and in his sole discretion:

- Take into consideration existing security concerns within the facility **and** available space in the facility identified in the *Management and Placement Plan*; **and either**
- Send the recommendation back to the ARC **or** the MTC for additional findings or information, **or**
- Retain consultants to address any concerns or questions with the recommendation, **or**

- may accept (in writing) the ARC's recommendation.

9. Implementation of the Management and Placement Plan

Inmates diagnosed with GD shall be:

- Managed pursuant to the Management and Placement Plan approved by the director of the IDOC, and
- Treated in accordance with their medical and mental health treatment plan

Inmates requesting evaluation for (or diagnosed with) GD will not be placed in administrative segregation based solely upon their request or diagnosis.

Hormone replacement therapy shall be provided as needed but only when medically indicated and consistent with the inmate's treatment plan. An inmate who was receiving hormone replacement therapy at the time of incarceration will continue on those medications, unless current treating medical providers determine there is a medically compelling reason to discontinue treatment. An inmate who is initially diagnosed with GD while incarcerated at the IDOC will be eligible to receive hormone replacement therapy if medically necessary and as identified in their treatment plan. The inmate shall be required to provide their informed consent (see SOP 401.06.03.070, *Informed Consent*) to ensure the inmate understands and accepts the risks associated with any prescribed treatment for GD.

- **Respectful and Safe Conduct Related to Appearance**

EXHIBIT D

Control Number: 401.06.03.501	Version: 3.2	Title: Gender Dysphoria: Healthcare for Inmates with	Page Number: 8 of 9

- Inmates diagnosed with Gender Dysphoria will be allowed to maintain their appearance in a way that is consistent with their identified gender. This means that inmates housed in a male facility, who identify as female **and** have been diagnosed with gender dysphoria, will be allowed to wear makeup and wear their hair in traditionally feminine hairstyles and present as female. Similarly, inmates housed in a female facility, who identify as male **and** have been diagnosed with gender dysphoria, will be allowed to wear their hair in traditionally male hairstyles and present as male.
- However, to avoid a sexually charged atmosphere in IDOC facilities, and to foster an environment of respect for all persons housed there, the following guidelines will be in place:
- No provocative or sexually charged clothing or behavior will be permitted.
    - Examples of inappropriate clothing include, but are not limited to: clothing that is too tight, too short, transparent, shows cleavage or the midriff.
    - Examples of inappropriate behavior include but are not limited to: gestures or mimicking of sexual behavior, behavior or actions that are provocative, kissing, or similar conduct.
- A single commissary list will be used for inmates who have been diagnosed with Gender Dysphoria. There will be no distinction or restriction of products by gender as to what can be ordered.
    - This includes undergarments such as male/female underwear and bras
    - Inmates who are indigent, **and** diagnosed with gender dysphoria, and do not have the funds to purchase undergarments will be provided state issued undergarments per SOP
- Gender neutral references will be used by IDOC staff when speaking to or referring to inmates diagnosed with Gender Dysphoria.
    - For example: Use the inmate's name or use gender neutral pronouns for reference such as they, them, or their.
- Medical and mental health staff will refer to inmates diagnosed with gender dysphoria by their preferred pronoun.
-
- Inmates diagnosed with Gender Dysphoria will be treated by staff in a manner consistent with policy 201, *Respectful Workplace*. (I.e., Staff members must maintain a respectful and professional demeanor, and refrain from harassing inmates due to their gender/sex, etc.)
- Inmates diagnosed with GD shall be provided access to the full range of services and programs available within the IDOC to the same extent as other inmates.

Searches of inmates diagnosed with GD will be conducted in a manner that is consistent with SOP 317.04.02.001, *Searches of Inmates*.

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10. Subsequent Reviews and Evaluations for GD

In the event that additional observations **or** information concerning the inmate's purported GD becomes available, a subsequent evaluation (i.e., a re-evaluation) may be requested. Inmates who have requested to be evaluated for gender dysphoria, and who have not been assessed as meeting criteria for that diagnosis, may reinitiate the evaluation process via Health Services Request one year after the date of the initial evaluation.

The decision to allow a re-evaluation shall be within the discretion of the chief psychologist based upon his review of all available information. If a re-evaluation is denied, the basis for the denial must be documented in the inmate's healthcare record.

REFERENCES

IDAPA 06.01.01, *Rules of the Board of Correction*, Section 302.05, Medical, Dental, Psychological and Psychiatric Care

IDAPA 06.01.01, *Rules of the Board of Correction*, Section 401, Medical Care

Policy 201, *Respectful Workplace*

Standard Operating Procedure 317.04.02.001, *Searches of Inmates*

Standard Operating Procedure 401.06.03.037, *Non-emergency Healthcare Requests and Services*

Standard Operating Procedure 401.06.03.070, *Informed Consent*

Standard Operating Procedure 401.06.03.087, *Healthcare for Inmates Housed in Non-Idaho Department of Correction Facilities*

– End of Document –

EXHIBIT E

Idaho Department of Correction	Standard Operating Procedure Operations Division Operational Services	Control Number: 401.06.03.501	Version: 3.2	Page Number: 1 of 9 Adopted: 10-31-2002 Reviewed: 12-21-2011
		Title: Gender Identity Disorder: Healthcare for Offenders with		

This document was approved by Shane Evans, director of the Education, Treatment, and Reentry Bureau, on 12/21/11 (signature on file).

Open to the general public: ☒ Yes

BOARD OF CORRECTION IDAPA RULE NUMBER 401

Medical Care

POLICY CONTROL NUMBER 401

Clinical Services and Treatment

DEFINITIONS

Standardized Terms and Definitions List

Administrative Review Committee (ARC)—GID: A committee comprised of the chief of the Operations Division; a deputy chief of the Prisons Bureau; the director of the Education, Treatment, and Reentry Bureau; and a deputy attorney general who is assigned to the Idaho Department of Correction (IDOC) and will act as legal advisor. The committee reviews recommendations of the Management and Treatment Committee (MTC). The ARC may, in its discretion retain a consultant versed in the treatment, management, and placement of persons with gender identity disorder (GID). The ARC makes recommendations regarding the classification, management and security of persons with GID. Recommendations of the ARC, together with the recommendations of the MTC, shall be submitted to the director of the IDOC for final consideration.

Chief Psychologist: The Idaho Department of Correction (IDOC) employee who is primarily responsible for overseeing or managing the IDOC's mental health services.

Consultant—GID: A medical or mental health professional, qualified by virtue of their training and experience to make non-binding recommendations regarding the diagnosis and treatment of offenders with gender identity disorder (GID). Any consultant involved with the diagnosis of GID must be a qualified GID evaluator.

Cross-sex Hormonal Therapy: Medical treatment in which an anatomically male person is prescribed feminizing medications or an anatomically female person is prescribed masculinizing medications for the purpose of generating either or both psychological or physical changes determined to be medically necessary.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The standard manual of psychiatric diagnoses, as published and amended by the American Psychiatric Association from time to time.

EXHIBIT E

Facility: A building or residence (including the property and land where the building or residence is located) owned, leased, operated, or managed by the Idaho Board of Correction or Idaho Department of Correction (IDOC).

Facility Head: The person primarily responsible for overseeing, managing, or operating an Idaho Department of Correction (IDOC) facility.

Gender Identity Disorder (GID): A psychiatric disorder that includes gender identity disorder (GID) and gender dysphoria, as defined in the most current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. A person with this condition is dissatisfied and sometimes seriously dysphoric with his or her own biological sex and desires to be considered and treated as a member of the opposite sex. In general, this condition is a stable nonviolent condition and not due to psychosis but it may accompany other mental disorders.

Health Authority: The Idaho Department of Correction (IDOC) employee who is primarily responsible for overseeing or managing the IDOC's medical services. (The health authority is commonly referred to as the health services director.)

Hormonal Replacement Treatment: A medical treatment in which male or female hormones are prescribed to a patient as a result of his/her inability to produce an adequate amount of these hormones internally. Persons who have undergone sexual reassignment surgery may require this therapy to treat medically significant side effects.

Level of Care (LOC): A system utilized by the Idaho Department of Correction (IDOC) in which offenders with mental health issues are assigned a LOC based upon the severity of their mental illness and degree of treatment needs.

Management and Placement Plan: A written plan devised by the Management and Treatment Committee (MTC) implementing the treatment plan, by addressing mental health services, facility placement, and other needed support services for individuals diagnosed with gender identity disorder (GID). The Management and Placement Plan is forwarded to the Administrative Review Committee (ARC) for their review and approval.

Management and Treatment Committee (MTC): A committee composed of the health authority, chief psychologist, psychiatrist, psychologist, medical director, and facility head. Other mental health, medical, human services, and security staff may be requested to attend in a recommendational capacity by the health authority.

Medical Director: A physician either employed by the Idaho Department of Correction (IDOC) or contracted through privatized services (i.e., the physician in charge if medical services are privatized).

Offender: A person under the legal care, custody, supervision, or authority of the Idaho Board of Correction, including a person within or out of the state of Idaho pursuant to an agreement with another state or contractor.

Primary Physical Sexual Characteristics: Genitalia and reproductive organs.

Psychiatrist: A psychiatrist, who meets the definition of a qualified gender identity disorder (GID) evaluator, employed by the Idaho Department of Correction (IDOC) or a private contractor and charged by their employer with oversight of delivery of psychiatric services to offenders.

Psychologist: A psychologist, who meets the definition of a qualified gender identity disorder (GID) evaluator, employed by the Idaho Department of Correction (IDOC) or a

EXHIBIT E

private contractor and charged by their employer with oversight of delivery of psychological services to offenders.

Qualified Gender Identity Disorder (GID) Evaluator: 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.

Reception/Diagnostic Unit (RDU): Initial housing for newly committed offenders (except those under sentence of death) where orientation, screening, assessment, and classification occur.

Sexual Reassignment Surgery: The surgical alteration of a person's physical appearance so that the person appears more like the opposite gender.

Sexual Reassignment Treatment: Treatment for a person diagnosed with gender identity disorder (GID) in which hormonal medications, surgical procedures, or both are utilized to alter a person's physical appearance so that the person appears more like the opposite gender. While these surgical procedures are available within the community, sexual reassignment surgery will not be considered for individuals incarcerated within the Idaho Department of Correction (IDOC), unless determined medically necessary by the GID evaluators.

Treatment Plan: A series of written statements specifying a patient's particular course of therapy and the roles of qualified healthcare professionals in carrying it out.

PURPOSE

The purpose of this standard operating procedure (SOP) is to establish guidelines for the diagnosis, treatment, management, and placement of offenders diagnosed with gender identity disorder (GID) to ensure offender safety and access to appropriate and necessary medical and mental health treatment. This SOP defines the extent and general limits of healthcare services provided to offenders identified as meeting the criteria for diagnosis of GID as outlined within the most current *Diagnostic and Statistical Manual of Mental Disorders (DSM).*

SCOPE

This SOP applies to all Idaho Department of Correction (IDOC) offenders who request or are evaluated for and/or diagnosed with GID; Education, Treatment, and Reentry Bureau administrators, employees, contract medical providers and subcontractors; and limited IDOC staff such as facility heads, security staff, deputy attorneys general (DAG) who represents the IDOC, and the director of the IDOC.

RESPONSIBILITY

The director of the Education, Treatment, and Reentry Bureau **and** deputy chief of the Prisons Bureau shall be jointly responsible for the implementation of this SOP and for designating appropriate personnel to develop and implement procedures in conjunction with this SOP.

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GENERAL REQUIREMENTS

1. Initial Reporting

Information about all services available within the correctional system, including those to meet the needs of offenders with GID, will be made available to offenders while in the Reception/Diagnostic Unit (RDU). Upon the offender's request, information about all services will be available throughout the offender's incarceration. Until an offender who is suspected of having GID completes the RDU process, security staff and other relevant staff shall review whether to escort and transport the offender separately to avoid the risk of physical or sexual assault by other offenders in transit.

Offenders may be evaluated for GID at any point during their incarceration. When the offender has a prior diagnosis or is suspected of having GID or accompanying/supporting information (i.e., collateral information) is received pertaining to the suspicions of GID, any of the following may request an initial or subsequent evaluation for GID:

- **Offender** – Requests (in writing) health assistance in accordance with SOP 401.06.03.037, *Non-emergency Healthcare Requests and Services* **or** SOP 401.06.03.087, *Healthcare for Offenders Housed in Non-Idaho Department of Correction Facilities*.

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- **Healthcare staff** – Prepares a referral in accordance with SOP 401.06.03.037 **or** 401.06.03.087 and forwards to the chief psychologist.

Subsequent Evaluations

Also see section 11.

2. Referral and Placement of the Offender for Evaluation Purposes

The chief psychologist will take the necessary action to transfer an offender who is scheduled to be evaluated for GID to the appropriate facility for evaluation as follows:

- **Male offenders**—will be housed within the Secure Mental Health Unit (located within the Idaho Maximum Security Institution [IMSI]). Offenders who are believed to pose a security risk may be placed in more secure housing following consultation with the IMSI warden's office.
- **Female offenders**—will be housed at the Pocatello Women's Correctional Center (PWCC) following consultation with the warden of PWCC.

Note: The chief psychologist must be a doctoral level psychologist licensed in the state of Idaho and employed by the IDOC. The chief psychologist reports directly to the director of the Education, Treatment, and Reentry Bureau, should be a qualified GID evaluator, and shall be responsible for overseeing the delivery of all IDOC mental health services provided by state of Idaho and/or contract providers. If the chief psychologist is not a qualified GID evaluator, he must engage and rely upon a consultant who must be a qualified GID evaluator.

When determining appropriate placement, the chief psychologist will consider factors such as the offender's diagnostic needs, prior institutional adjustment, and safety and/or security concerns. Upon reviewing these and other relevant factors, the chief psychologist may exercise the option to place the offender in a facility other than those listed above in this section. In consultation with the warden, unless there are overriding security and/or safety concerns for the offender, the chief psychologist will place the offender (who either requests a GID evaluation **or** is diagnosed with GID) in a correctional facility consistent with the offender's primary physical sexual characteristics.

The transfer will occur as soon as practicable, subject to variables such as bed and transportation availability, and security considerations. The evaluation process will commence within 30 days from the date a written request, **or** referral from medical staff for evaluation, is received by the chief psychologist.

3. Evaluation of the Offender

Once the offender has been moved to the appropriate housing unit, the offender will be evaluated by the psychologist and/or psychiatrist. The chief psychologist, at his discretion, may require that a consultant perform this initial evaluation.

Note: Any consultant involved with the diagnosis of GID must be a qualified GID evaluator.

This evaluation shall include a comprehensive history, mental status evaluation, and clinical interview. Documentation of any claim by the offender of prior GID diagnosis, treatment, or transgender lifestyle shall be obtained as part of the evaluation process. An offender's

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refusal to provide written authorization to access medical records relating to prior diagnosis or treatment of GID may be considered a factor for a non-GID finding by the evaluators.

The diagnosis of GID shall be based on the most current *Diagnostic and Statistical Manual of Mental Disorders*. If the evaluators believe it is necessary, they may contract a medical **or** mental health consultant to assist in the evaluation process. Any diagnoses by the evaluators should include consideration of the consultant's report.

Throughout the evaluation process, the chief psychologist shall monitor the progress of the evaluation to ensure the GID evaluation is completed as soon as practicable. Absent extenuating circumstances, the GID evaluation—including the chief psychologist's review and report (see section 5)—will be completed within 60 days from the date the evaluation process commences as described in section 2.

4. Evaluator Findings, Diagnosis, and Reporting

The psychologist (and/or psychiatrist) or consultant conducting the evaluation shall prepare independent written reports detailing their findings, diagnosis, and recommended treatment options. These independent written reports shall include dates of contact, instrumentation utilized, collateral data obtained, and the consultant's report, if applicable. The reports shall also include a multiaxial diagnosis **and** a summary of the information and impressions that support the diagnosis and recommended treatment options. These written reports shall be forwarded to the chief psychologist for consideration.

In cases where an offender was receiving (prior to incarceration) feminizing **or** masculinizing hormones from a licensed medical professional as treatment for GID, the prior treatment will be continued and incorporated into the offender's individualized treatment plan, unless hormone therapy is—for medical reasons—subsequently contraindicated.

5. Chief Psychologist's Review of Findings

Upon receipt of the evaluators' reports, the chief psychologist shall review the findings. If the chief psychologist agrees with the findings, he shall issue a report stating his agreement and basis for his decision and finalize the portion of the treatment plan involving GID. The chief psychologist may, in his discretion, request an additional evaluation by a consultant who will provide an independent diagnosis and report. The chief psychologist shall—based upon his review of all available information, including the reports of the evaluators and any consultant—issue a report resolving any differences of opinions concerning diagnosis and/or treatment, including his own findings. In all cases in which an evaluation is performed, the chief psychologist will determine an appropriate level of care (LOC) based on the resulting multiaxial diagnosis. All reports generated by the evaluators, consultants, or the chief psychologist will be placed in the offender's medical file.

Note: The LOC system utilized by the IDOC requires that each offender with a major 'axis I' and/or 'axis II' diagnosis for a disorder, which includes behaviors that may prove a significant risk, be assigned to one (1) of three (3) LOCs. The resulting LOC establishes defined parameters including, but not limited to, the required time frame for treatment plan reviews. These time frames can vary based upon the needs of the individual offender, but will occur no less than one time per year.

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Findings

Supported: If a diagnosis of GID is supported by the evaluation process. The chief psychologist will then convene the full Management and Treatment Committee (MTC) within 15 working days after the diagnosis has been finalized. (See section 6.)

Not supported: In incidences in which the diagnosis of GID is not supported by the evaluation process, the chief psychologist may, in his sole discretion,

- Request an additional evaluation by a consultant who will provide an independent diagnosis, **or**
- Issue a report detailing that finding and refer the offender to the Prisons Bureau for housing in a suitable facility based on the offender's security and treatment needs.

Note: The IDOC has a comprehensive, uniform, and objective offender classification system that is used to place offenders in facilities that the offer the appropriate security and programs. See SOP 303.02.01.001, *Classification: Offender*.

Re-evaluation of Findings Initially Not Supported

See section 11.

6. Management and Treatment Committee (MTC) Meeting

When convened, the MTC shall develop and recommend a plan for the management and placement of the offender. Copies of all reports authored by the psychologist, psychiatrist, or consultant(s)—as well as the chief psychologist's report—will be provided to the MTC.

The MTC (in coordination with team case management) shall develop and recommend an individualized *Management and Placement Plan* for each offender diagnosed with GID, which implements the treatment plan approved by the chief psychologist.

The medical director may also initiate cross-sex hormonal therapy when such therapy has been prescribed as part of the treatment plan. When initiated by the medical director, the cross-sex hormonal therapy may commence prior to and independent of the Administrative Review Committee's (ARC) review. The chief psychologist may initiate mental health services prescribed as part of the treatment plan prior to and independent of the ARC review.

Management and placement recommendations for offenders with GID will take into account both treatment **and** security needs, with a goal of least restrictive placement. As provided in section 2, facility placement will be based upon the offender's primary physical sexual characteristics.

The MTC shall forward its recommendation for management and placement to all ARC members within 15 working days of the MTC meeting.

7. Administrative Review Committee (ARC) Meeting

Convening Responsibility

As soon as possible after receiving the MTC's report and recommendation, the deputy chief of the Prisons Bureau shall convene a meeting of the ARC.

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Review of Management and Placement Plan

The ARC shall review the *Management and Placement Plan* recommended by the MTC and, at its discretion, consult with members of the MTC in an effort to address concerns and/or questions related to the proposed plan.

Upon approval of the MTC's proposed *Management and Placement Plan*, the ARC shall submit its recommendation for management to the director of the IDOC within 15 working days of meeting.

8. Final Approval of the Management and Placement Plan

The director of the IDOC shall review the ARC's recommendation, and in his sole discretion:

- Take into consideration existing security concerns within the facility **and** available space in the facility identified in the *Management and Placement Plan*; **and either**
- Send the recommendation back to the ARC **or** the MTC for additional findings or information, **or**
- Retain consultants to address any concerns or questions with the recommendation.

After completing all of the above and as soon as practicable, the director of the IDOC may accept (in writing) the ARC's recommendation. If the director of the IDOC accepts the ARC's recommendation, the ARC will approve implementation of the *Management and Placement Plan*, and implementation shall begin within four (4) months of approval.

9. Implementation of the Management and Placement Plan

Offenders diagnosed with GID shall be:

- Managed pursuant to the *Management and Placement Plan* approved by the director of the IDOC, and
- Treated in accordance with their treatment plan (see section 6).

Offenders requesting evaluation for (or diagnosed with) GID will not be placed in administrative segregation based solely upon their request or diagnosis. During their evaluation for GID, offenders will be transferred to housing in accordance with section 2. Once a diagnosis is complete, offenders may be returned to a correctional facility consistent with their security classification.

Hormone replacement treatment **and** cross-sex hormonal therapy shall be provided as needed but only when medically indicated and consistent with the offender's treatment plan. An offender who was receiving hormonal medications (related to cross-sex hormonal therapy) at the time of incarceration will continue on such hormonal medications, unless current medical providers determine there is a medically compelling reason to discontinue treatment. An offender who is initially diagnosed with GID while incarcerated at the IDOC will be eligible to receive hormonal medications as provided herein. The offender shall be required to provide their informed consent (see SOP 401.06.03.070, *Informed Consent*) to ensure the offender understands and accepts the risks associated with any prescribed treatment for GID.

10. Moral and Ethical Treatment of Offenders Diagnosed with GID

Offenders diagnosed with GID:

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- Shall be addressed by their last name (e.g., offender Smith),
- Will not be harassed because of their condition, and
- Will be treated by staff in a manner consistent with policy 201, *Respectful Workplace.* (I.e., Staff members must maintain a respectful and professional demeanor, and refrain from harassing offenders due to their gender/sex, etc.)

Offenders diagnosed with GID shall be provided access to the full range of services and programs available within the IDOC to the same extent as other offenders including, but not limited to, mental health services tailored to the offender's individual needs. Referral to such services or programs will be dependent on factors such as admission criteria (generally applied), availability within the facility or housing unit, and security considerations.

Strip searches of offenders diagnosed with GID will be conducted in a manner that is consistent with SOP 317.04.02.001, *Searches of Offenders*.

11. Subsequent Reviews and Evaluations for GID

The evaluation process includes the assignment of a LOC (see section 5) in all cases in which an offender is assessed to have a major mental illness and dictates the minimum frequency in which the offender's resulting treatment plan must be reviewed.

In the event that additional observations **or** information concerning the offender's purported GID becomes available, a subsequent evaluation (i.e., a re-evaluation) may be requested as described in section 1.

The decision to allow a re-evaluation shall be within the discretion of the chief psychologist based upon his review of all available information. If a re-evaluation is denied, the basis for the denial must be documented in the offender's healthcare record.

REFERENCES

Idaho Department of Correction Manual, *Correctional Mental Health Service System*

IDAPA 06.01.01, *Rules of the Board of Correction*, Section 302.05, Medical, Dental, Psychological and Psychiatric Care

IDAPA 06.01.01, *Rules of the Board of Correction*, Section 401, Medical Care

Policy 201, *Respectful Workplace*

Standard Operating Procedure 303.02.01.001, *Classification: Offender*

Standard Operating Procedure 317.04.02.001, *Searches of Offenders*

Standard Operating Procedure 401.06.03.037, *Non-emergency Healthcare Requests and Services*

Standard Operating Procedure 401.06.03.070, *Informed Consent*

Standard Operating Procedure 401.06.03.087, *Healthcare for Offenders Housed in Non-Idaho Department of Correction Facilities*

– End of Document –

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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 **DECLARATION OF HOWARD KEITH YORDY**

I, Howard Keith Yordy, hereby declare and state as follows:

1. I am over the age of eighteen and am competent to testify to the matters herein. I make this declaration based upon my own personal knowledge.

2. I am currently employed with the Idaho Department of Corrections ("IDOC") as the Warden of the Idaho Maximum Security Institution ("IMSI"). I have been employed with the IDOC for a total of 31 years. From January 2014 until August 2018, I was the Warden of the Idaho State Correctional Institution ("ISCI") located in Kuna, Idaho. From September 2009 to January 2014, I was the Deputy Warden of Security at ISCI. Prior to my employment at ISCI, I spent eight years employed at the Pocatello Women's Correction Center ("PWCC") where I served in various roles including, but not limited to, Correctional Officer, Shift Commander, Employment Coordinator, and Acting Chief of Security.

3. Through my employment with the IDOC, I have gained a significant amount of experience and familiarity with IDOC's security and operational policies and practices. I am also familiar with, and have access to, the records that are created and maintained by the IDOC in the ordinary course of IDOC's operations regarding each of the offenders within IDOC's custody.

4. Through my employment at ISCI, I have also become familiar with Plaintiff Mason Dean Edmo aka Adree Edmo. In addition to having multiple in-person interactions with Edmo, I have reviewed many of the IDOC records created during Edmo's incarceration and have had written correspondence with Edmo through Grievance Forms. I have also had numerous conversations with IDOC security and operations staff regarding Edmo during the years of Edmo's incarceration at ISCI.

5. From January 2010 until late June 2010, Edmo was in the custody of the IDOC after being convicted for felony check fraud. Attached hereto as **Exhibit 1** is a true and correct

copy of a photograph taken of Edmo on January 7, 2010. Starting in June 2010, Edmo was on probation until Edmo's arrest in June 2011 for sexually assaulting a fifteen-year-old boy. Edmo pled guilty to the felony charge and was transferred to ISCI in April 2012. Attached hereto as **Exhibit 2** is a true and correct copy of a photograph taken of Edmo on April 27, 2012. Except for a six month period in 2013 and 2014, Edmo has been continuously housed at ISCI since April 2012. Edmo is currently housed at ISCI. Edmo's sentence satisfaction date is July 3, 2021.

6. I understand that Edmo was diagnosed with Gender Identity Disorder (now known as Gender Dysphoria) in 2012 while incarcerated at ISCI. Since Edmo's diagnosis of Gender Dysphoria, IDOC has permitted and supported Edmo's transition into Edmo's preferred gender in multiple different ways. In addition to having been provided female hormone treatments and access to mental health counseling and Gender Dysphoria group since 2012, Edmo has also been provided with women's bras and underwear (referred to as "panties") that are available to female offenders at PWCC and IDOC's other women's institutions. Further, Edmo has been permitted to grow Edmo's hair long, shape Edmo's eyebrows, and generally take on a more feminine appearance. Attached hereto as **Exhibit 3** is a true and correct copy of a photograph taken of Edmo on August 14, 2013. Attached hereto as **Exhibit 4** is a true and correct copy of a photograph taken of Edmo on December 10, 2014.

7. To my knowledge, Edmo has not been precluded from undergoing any treatment related to Edmo's Gender Dysphoria that Edmo's medical providers have determined to be medically necessary. To the contrary, I understand that Edmo has been provided with all treatment determined to be medically necessary by Edmo's medical providers. I am also not aware of any actions taken by IDOC or its employees preventing Edmo from feminizing in an appropriate manner while incarcerated.

8. While Edmo has been permitted to feminize, the IDOC has firmly and consistently prohibited Edmo from sexualizing Edmo's feminine appearance and behavior in a manner that may create a sexually charged environment. No offender – regardless of his or her sex, gender, or housing – is permitted to appear or behave sexually while incarcerated under the custody of the IDOC. IDOC's policies and practices prohibiting sex and sexualizing in prison are critical to IDOC maintaining a safe and secure facility for all offenders. The IDOC has a legal and moral obligation to prevent offenders from being subject to sexual harassment and assault. Allowing offenders to appear or act sexual in prison increases the risk of inappropriate prisoner relationships, sexual harassment and assaults, and other various other serious security concerns. There also exists security concerns with offenders having access to underwear traditionally worn by the opposite gender, especially when the possibility exists for an offender who has a fetish with women's panties or bras obtaining such undergarments.

9. Over the six plus years that Edmo has been incarcerated at ISCI, Edmo has repeatedly engaged in inappropriate sexual relationships and sexually-provocative behaviors. At the same time, Edmo has also communicated Edmo's concern that Edmo's status as a transgendered offender with a feminine appearance increases the risk of sexual assault against Edmo. It is certainly true that Edmo, whether housed in a male or female prison, would be in the company of sex offenders and other offenders who prey on those that may act or appear different, weaker, or sexually appealing. Notwithstanding, and despite officers providing Edmo with many verbal warnings that have been well documented, Edmo has repeatedly allowed Edmo's feminine appearance to cross the line into what officers have determined to be inappropriate and at risk of creating a sexually charged environment. While what one officer perceives as inappropriate or provocative is admittedly somewhat subjective, correctional

officers and staff need to be afforded the discretion and independent judgment to recognize and remedy quickly the offending behavior in order to maintain order and prevent an offender from creating a sexually charged environment that could lead to the victimization of themselves or others.

10. I am familiar with Disciplinary Offense Reports ("DORs"), which are records kept in the course and scope of IDOC's regularly conducted activity of supervising and housing prisoners in the state prison system. DORs are made as part of IDOC's regular practice of issuing discipline to inmates who do not comply with the rules and regulations established to maintain the safety and security of IDOC prison facilities.

11. Attached hereto as **Exhibit 5** and **Exhibit 6** are true and correct copies of the Disciplinary Offense Reports ("DORs") that Edmo has received since 2012. Edmo has an extensive disciplinary history that totals thirty-two (32) DORs. Multiple DORs were issued for sexual or inappropriate contact with other offenders. Edmo has also received multiple DORs for destruction of state property for possessing altered female bras and underwear that were cut into female thong underwear. Thirty-two DORS is an exceptionally high number of DORs for an offender who has been incarcerated for only six years. In my experience, the vast majority of offenders will receive only 3 or 4 DORs, if any, over six years. To my knowledge, Edmo has not been disciplined for appearing feminine *per se*. Instead, Edmo has been disciplined repeatedly for being openly disobedient to correctional officers' direct orders to remedy Edmo's inappropriate or sexually provocative appearance. An offender's disobedience to a direct order presents serious security concerns separate from the offender's appearance that must be addressed and disciplined.

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

DATED this 30th day of August, 2018.

/s/ Howard Keith Yordy
Howard Keith Yordy

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 14th day of September, 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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PARSONS, BEHLE & LATIMER

/s/ Krista Zimmerman
Krista Zimmerman

EXHIBIT 1

EDMO, MASON DEAN

IDOC#: 94691

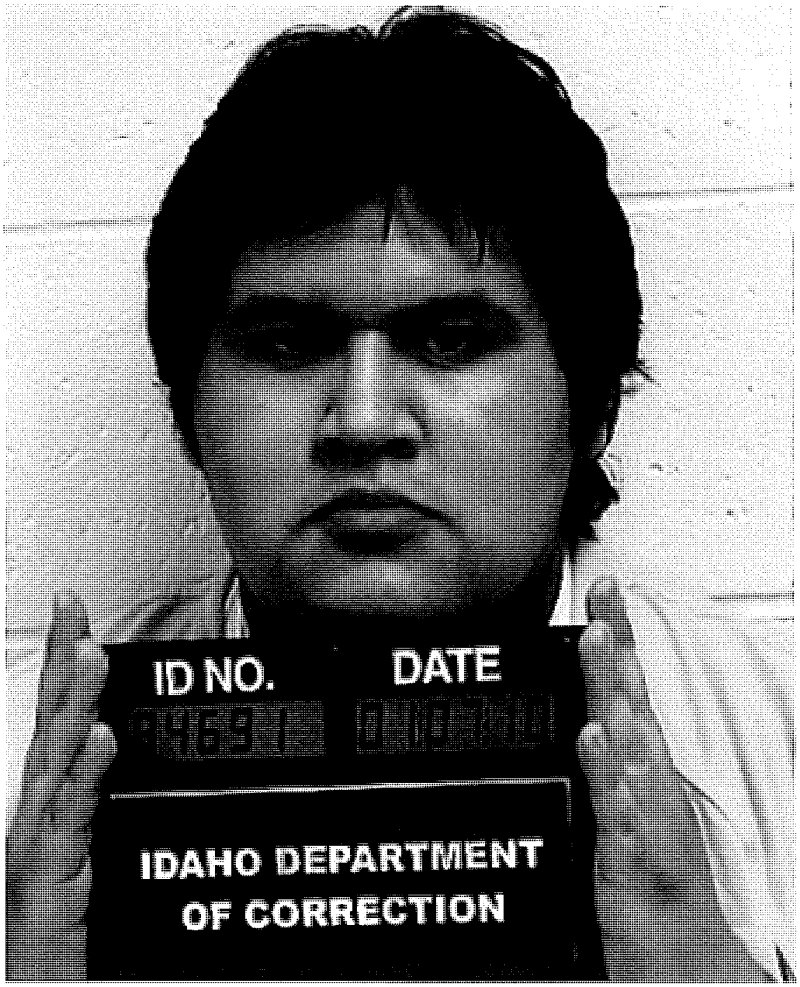


EXHIBIT 2

EDMO, MASON DEAN

IDOC#: 94691

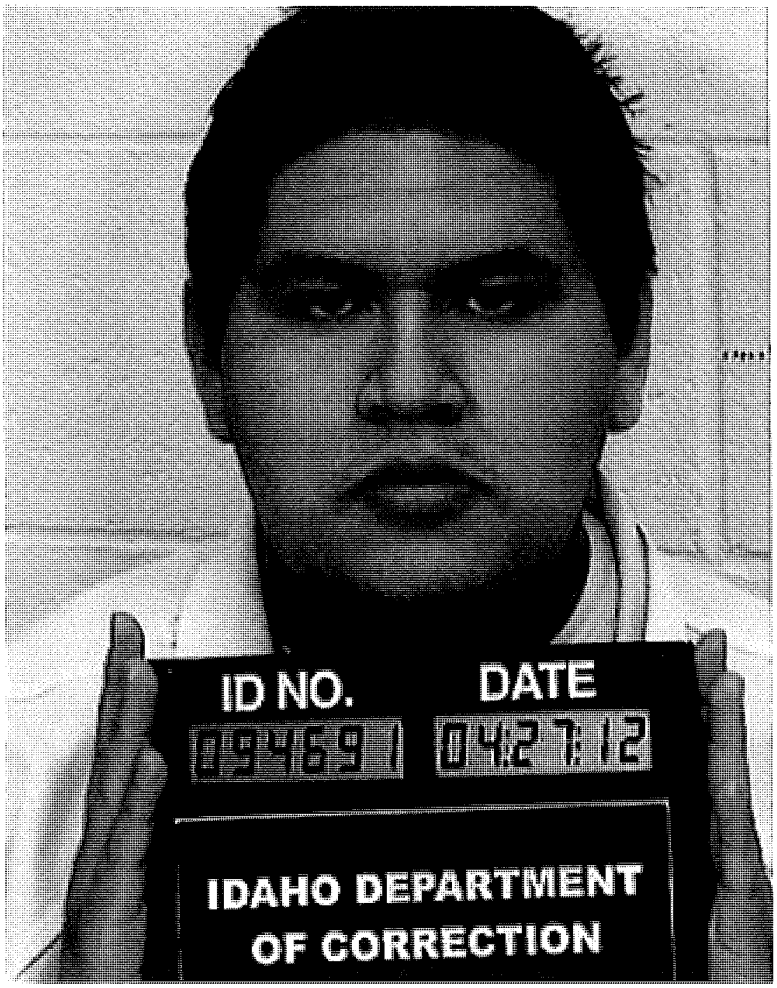
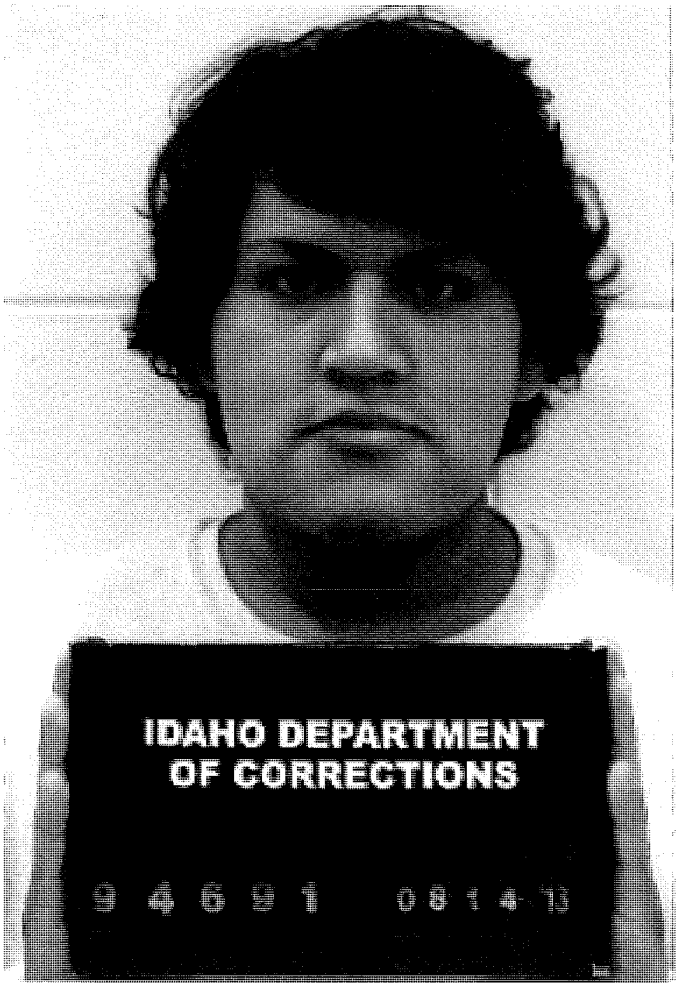


EXHIBIT 3

EDMO, MASON DEAN

IDOC#: 94691



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IDOC_A_pg.26

EXHIBIT 4

EDMO, MASON DEAN

IDOC#: 94691

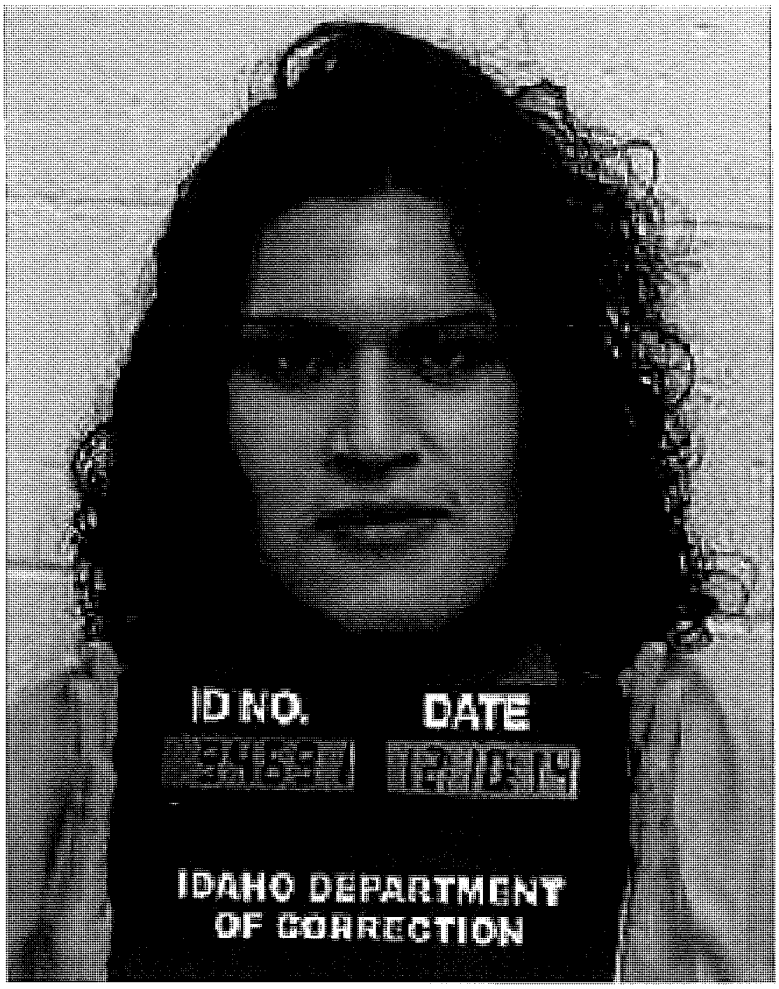

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EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Offender DOR Report

Offender Number: 94691

Name: EDMO, MASON DEAN

DOR #	Offense Date	Offense	Offense Class	Offense Facility	Sanctions	Amount	Review Results	Appeal Results
181563	03/14/2018	UNAUTHORIZED COMMUNICATION LEVEL 2	CLASS C NONE	ICC			AFFIRM	
177663	12/03/2017	DESTRUCTION OF PROPERTY UNDER $25	CLASS C NONE	ISCI	RECREATION RESTRICTION	7 day(s)	AFFIRM	AFFIRM
170267	01/09/2017	SEXUAL ACTIVITY	CLASS B NONE	ISCI	DETENTION	15 day(s)	AFFIRM	
					RECREATION RESTRICTION	30 day(s)		
					NO CONTACT ORDER	90 day(s)		
167597	11/28/2016	DESTRUCTION OF PROPERTY UNDER $25	CLASS C NONE	ISCI			AFFIRM	
164886	07/26/2016	DESTRUCTION OF PROPERTY UNDER $25	CLASS C NONE	ISCI	RESTITUTION	$8.16	AFFIRM	AFFIRM
164551	07/13/2016	BATTERY	CLASS B NONE	ISCI	DETENTION	10 day(s)	AFFIRM	
					RECREATION RESTRICTION	21 day(s)		
163300	05/22/2016	TATTOO OR PIERCING	CLASS B NONE	ISCI	COMMISSARY RESTRICTION	45 day(s)	AFFIRM	
163026	05/06/2016	DISOBEDIENCE TO ORDERS 3	CLASS C NONE	ISCI	COMMISSARY RESTRICTION	15 day(s)	AFFIRM	AFFIRM
161943	03/28/2016	DISOBEDIENCE TO ORDERS 3	CLASS C NONE	ISCI	FORMAL WARNING/WRITTEN REPRIMAND		AFFIRM	

EXHIBIT 5

DOR #	Offense Date	Offense	Offense Class	Offense Facility	Sanctions	Amount	Review Results	Appeal Results
160360	12/30/2015	SEXUAL ACTIVITY	CLASS B NONE	ISCI	DETENTION	14 day(s)	AFFIRM	
					RECREATION RESTRICTION	25 day(s)		
158094	12/22/2015	TATTOO OR PIERCING	CLASS B NONE	ISCI	PROPERTY RESTRICTION	30 day(s)	AFFIRM	
158072	12/17/2015	PHYSICAL CONTACT	CLASS C NONE	ISCI	RECREATION RESTRICTION	15 day(s)	AFFIRM	AFFIRM
					NO CONTACT ORDER	35 day(s)		
157331	11/17/2015	DISOBEDIENCE TO ORDERS 3	CLASS C NONE	ISCI			AFFIRM	
157376	11/15/2015	BATTERY	CLASS B NONE	ISCI	DETENTION	10 day(s)	AFFIRM	
					RECREATION RESTRICTION	25 day(s)		
156084	09/27/2015	POSSESSION OF UNAUTHORIZED PROPERTY	CLASS B NONE	ISCI	COMMISSARY RESTRICTION	20 day(s)	AFFIRM	AFFIRM
					RECREATION RESTRICTION	25 day(s)		
152473	04/21/2015	TATTOO OR PIERCING	CLASS B NONE	ISCI	PROPERTY RESTRICTION	30 day(s)	AFFIRM	AFFIRM
152472	04/21/2015	SEXUAL ACTIVITY	CLASS B NONE	ISCI	DETENTION	15 day(s)	AFFIRM	AFFIRM
					RECREATION RESTRICTION	45 day(s)		
					NO CONTACT ORDER	60 day(s)		
150824	02/07/2015	DISOBEDIENCE TO ORDERS 2	CLASS B NONE	ISCI	DETENTION	5 day(s)	AFFIRM	AFFIRM
150037	12/30/2014	DISOBEDIENCE TO ORDERS 3	CLASS C NONE	ISCI	RECREATION RESTRICTION	15 day(s)	AFFIRM	
143588	07/08/2014	DISOBEDIENCE TO ORDERS 3	CLASS C NONE	ISCI	RECREATION RESTRICTION	15 day(s)	MODIFY	

EXHIBIT 5

DOR #	Offense Date	Offense	Offense Class	Offense Facility	Sanctions	Amount	Review Results	Appeal Results
143320	06/20/2014	BATTERY	CLASS B NONE	ISCI	DETENTION	10 day(s)	AFFIRM	AFFIRM
					PROPERTY RESTRICTION	40 day(s)		
					RECREATION RESTRICTION	30 day(s)		
141153	02/24/2014	DISOBEDIENCE TO ORDERS 3	CLASS C NONE	ISCI	RECREATION RESTRICTION	30 day(s)	MODIFY	
141124	02/23/2014	DISOBEDIENCE TO ORDERS 3	CLASS C NONE	ISCI	DETENTION	5 day(s)	AFFIRM	
136952	11/30/2013	UNAUTHORIZED COMMUNICATION 2	CLASS C NONE	ICIO	EXTRA DUTY	14 day(s)	AFFIRM	
135819	10/07/2013	DISOBEDIENCE TO ORDERS 3	CLASS C NONE	ICIO			AFFIRM	
135363	09/09/2013	OUTSIDE OF AUTHORIZED BOUNDARIES	CLASS C NONE	ICIO			AFFIRM	
134217	07/12/2013	DISOBEDIENCE TO ORDERS 3	CLASS C NONE	ISCI	COMMISSARY RESTRICTION	10 day(s)	AFFIRM	MODIFY
					RECREATION RESTRICTION	10 day(s)		
131258	02/27/2013	TATTOO OR PIERCING	CLASS B NONE	ISCI	CELL/LIVING UNIT RESTRICTION	25 day(s)	AFFIRM	
					COMMISSARY RESTRICTION	15 day(s)		
					EXTRA DUTY	10 day(s)		
131090	02/15/2013	UNAUTHORIZED TRANSFER OF PROPERTY	CLASS C NONE	ISCI	RECREATION RESTRICTION	12 day(s)	AFFIRM	
					EXTRA DUTY	7 day(s)		
123715	10/15/2012	UNAUTHORIZED TRANSFER OF PROPERTY	CLASS C NONE	ISCI	EXTRA DUTY	6 day(s)	AFFIRM	

Total Number Of Records 30

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	123715
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	10/15/2012	EVANCHO, JOSEPH #1725
Offense:	**Class:**	**Enhancement:**
UNAUTHORIZED TRANSFER OF PROPERTY	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
10/15/2012 18:25	UNIT 15	

Description of Offense:

On October 15, 2012 at Idaho State Correctional Institution, unit 15, a-tier at approximately 1825, I observed Offender [redacted] walking around with headphones in his ear. I told [redacted] to come to the officers? station so I could speak with him. [redacted] is indigent. I asked him to show me the MP 3 player so I could look at it. He stated ?you?re going to have to take me to unit 8? I told [redacted] to go out to the foyer. Upon going out to the foyer I told [redacted] to place his hands on the wall. At that point he reached into his pocket and took out the MP 3 player out. I told him again to put his hands on the wall. The second time I told him to he complied. I conducted a clothed body search on [redacted] After conducting the clothed body search, I turned on the MP 3 player and found out it was Offender Edmo?s (94691). I told [redacted] I was going to confiscate the MP 3 player and he needed to return to the tier. He kept talking and not returning so I had to give him a direct order to return to the tier which he replied ?Fuck your direct order? and walked back onto A-tier.

This is the third time I have found Offender Edmo's MP3 player in unit 15. Either on Offender [redacted] or [redacted] Offender Edmo resides in unit 16 and his MP3 player should not even be in Unit 15. I have spoke to Offender Edmo in the past about his MP3 player and not lending it out. The last time I found the MP 3 player I took it over to unit 16 and spoke to Edmo stating if I found the MP3 player again in unit 15 it would be confiscated.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	10/23/2012 05:30
Delivering Staff:	**Date/Time Delivered:**
HILLING, DONALD EVAN #1726X	10/23/2012 08:54
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
10/24/2012	10/24/2012	RAMIREZ, SABINO J #5917
Offense:	**Offender Plea:**	**Finding:**
UNAUTHORIZED TRANSFER OF PROPERTY	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
EXTRA DUTY	6 day(s)	10/31/2012

Interventions:	End/Due Date:
DOR HEARING ITSELF	

EXHIBIT 5

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	10/26/2012	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	131090
Offense Facility:	Report Date:	Reporting Staff:
ISCI	02/15/2013	ALLEN, RYAN #0120
Offense:	Class:	Enhancement:
UNAUTHORIZED TRANSFER OF PROPERTY	CLASS C	NONE
Date/Time of Offense:	Place of Offense:	
02/15/2013 13:00	UNIT 16	

Description of Offense:
While on B-tier in unit 16, I officer R. Allen witnessed offender [redacted] stepping out of the door way of Offender Edmo?s #94691 cell with a pack of orange Ramen. When I asked offender [redacted] where he got the ramen from [redacted] admitted that he received the ramen from offender Edmo #94691.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
BULEN, PHILLIP W #1286X	02/20/2013 05:30
Delivering Staff:	Date/Time Delivered:
BONNER, SHANE R #9827	02/20/2013 10:21
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
02/22/2013	02/22/2013	RAMIREZ, SABINO J #5917
Offense:	Offender Plea:	Finding:
UNAUTHORIZED TRANSFER OF PROPERTY	DENY	CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	12 day(s)	03/06/2013
EXTRA DUTY	7 day(s)	03/01/2013

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	02/25/2013	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	131258
Offense Facility:	Report Date:	Reporting Staff:
ISCI	02/27/2013	MILLER, JARED #A060X
Offense:	Class:	Enhancement:
TATTOO OR PIERCING	CLASS B	NONE
Date/Time of Offense:	Place of Offense:	
02/27/2013 16:50	UNIT 16	

Description of Offense:
Possessing of tattooing equipment. Started cell search on Cell 34 B tier Unit 16 with Officer Lombardi, and Officer Rossel. Officer Lombardi came across tools for making a tattoo gun. In the process of the search I found that the coax wall mount was loose, after removing the wall plate, I found the tattoo motor. Delivered the motor to Cpl Craig, he talked with Offender Edmo. Offender Edmo admitted to making the tattoo gun, Offender Edmo also stated that they did not receive or give any tattoos.

Description of Evidence:
Altered alarm clock. Altered Power cord. Tattoo motor. Tools (Broken tweezers, ink pen, Modified toenail clippers, broken razor and blade, Tracing paper, Screws from modified clock)

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	02/28/2013 09:00
Delivering Staff:	Date/Time Delivered:
WAY, MARK #0721	02/28/2013 10:48
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
03/01/2013	03/01/2013	RAMIREZ, SABINO J #5917
Offense:	Offender Plea:	Finding:
TATTOO OR PIERCING	DENY	CONFIRM

Sanctions:	Amount:	End Date:
CELL/LIVING UNIT RESTRICTION	25 day(s)	03/26/2013
COMMISSARY RESTRICTION	15 day(s)	03/16/2013
EXTRA DUTY	10 day(s)	03/11/2013

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	03/04/2013	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	134217
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	07/15/2013	DOBLER, NICK #4472
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
07/12/2013 22:00	UNIT 16	

Description of Offense:
While having a conversation in the office with offender Edmo 94691 it was stated that the hairstyle that offender Edmo was a feminine hair style. I reminded offender Edmo that if this hairstyle continues and previous warnings were going to be ignore to comply with direction and orders regarding the feminine hair styles, offender Edmo would be subjected to the disciplinary process. Edmo refused to change his hair.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
BULEN, PHILLIP W #1286X	07/17/2013 05:30
Delivering Staff:	**Date/Time Delivered:**
BONNER, SHANE R. #9827	07/17/2013 13:51
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
07/19/2013	07/19/2013	RAMIREZ, SABINO J. #5917
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	DENY	CONFIRM

Sanctions:	Amount:	End Date:
COMMISSARY RESTRICTION	10 day(s)	07/29/2013
RECREATION RESTRICTION	10 day(s)	07/29/2013

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	07/22/2013	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
BLADES, RANDY E. #3431	07/22/2013	07/25/2013	MODIFY

Offender Appeal Details:

1) Sgt. Ramirez personally humiliated me about being GID (audio rec'd)
2) 20 days gym restriction / commissary restriction too severe for class C.
3) D.O.R. not specific about hairstyles "feminine" which hairstyle?
4) Time & date of D.O.R. not correct.
5) Sgt. Dobler violated SOP 401 Sec 10 (GID) "staff will not use identifiers as "she" or "him" etc. while writing

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D.O.R.
6) I use commissary approved hairspray in hair.

Appellate Comments:

1. That would be separate matter of which you can file a complaint and it will be investigated. That would not change the fact that the report states you did not comply with the order.

2. Reduced to 10 days.

3. The DOR does mention feminine hairstyle. It is the one that I was sent photos of and did not allow because it could create a sexually charged environment (as we discussed)

4. The dates and times match up chronologically.

5. The policy states that the last name is to be used. the last name was used 5 times and the word his was used only once. That meets the spirit of the policy.

6. Ok.

The bottom line is that offenders are to obey orders and then work out disagreements properly using the grievance process. Not disobey the order.

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	135363
Offense Facility:	Report Date:	Reporting Staff:
ICIO	09/15/2013	LYNCH, KRISTI NMCHG #6940x

Offense:	Class:	Enhancement:
OUTSIDE OF AUTHORIZED BOUNDARIES	CLASS C	NONE
Date/Time of Offense:	Place of Offense:	
09/09/2013 20:28	A-2	

Description of Offense:
While reviewing video footage on 09-11-13 I observed Inmate [redacted] enter cell 224 where Inmate Edmo 94691 is assigned at approximately 20:28. At 20:33 I observed Inmate Edmo close the door to his cell; Inmate [redacted] did not exit the cell. At approximately 21:00 Inmate [redacted] came to move into the cell where I observed him pause briefly when the door to the cell opened. He then entered the cell. At approximately 21:02 I saw Inmate [redacted] come from inside the cell and stand in the door. Inmate Edmo and [redacted] were in a closed cell for approximately 30 minutes.
On 08-29-13 Lt. Anderson told Inmate Edmo to not be in inmate [redacted] cell or vice versa.
On 08-31-12 CO Allen observed Inmate Edmo in Inmate [redacted] cell and gave both inmates a verbal warning.
On 09-06-13 CO Kimble observed Inmate Edmo exit cell 227 where Inmate [redacted] and Inmate [redacted] are assigned.
Inmate Edmo has been warned several times not to be in other inmates cells and to not have Inmates in his cell. By allowing Inmate [redacted] into his cell he failed to follow the rules of the living unit.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
SHRIVER, KENNETH #3773	09/15/2013 19:14
Delivering Staff:	Date/Time Delivered:
GRAHAM, HEIDI #A228	09/15/2013 20:00
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
09/20/2013	09/20/2013	HASENOEHRL, DWAINE D
Offense:	Offender Plea:	Finding:
OUTSIDE OF AUTHORIZED BOUNDARIES	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
NO RECORDS FOUND		

Interventions:	End/Due Date:
BEHAVIOR AGREEMENT	
DOR HEARING ITSELF	

Administrative Review Authority:	Review Date:	Review Finding:
KRIEGER, AARON R #4300	09/23/2013	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

Date: 04/24/2017 10:37 Created By: kosorio Page 1 of 1
CIS/Facilities/Main/Discipline/Disciplinary Offense Report

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	135819
Offense Facility:	**Report Date:**	**Reporting Staff:**
ICIO	10/10/2013	GEBHART, WENDY #8687
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
10/07/2013 14:30	B-2	

Description of Offense:
I received an IDOC concern form on 10/07/13 from I/M Edmo, which states the following: "I am removing myself from this SOTP program. Please move me back to general population or where is best please." I addressed this concern form with I/M Edmo and I/M signed a refusal to program. I/M is charged with disobedience to orders for failing to follow the IDOC's directive of completing SOTP.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
WELCH, FRANK S #3264	10/10/2013 21:15
Delivering Staff:	**Date/Time Delivered:**
DAINES, CHALKLY #1876X	10/11/2013 05:30
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
10/16/2013	10/16/2013	CURTIS, BRIAN #6146
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
NO RECORDS FOUND		

Interventions:	End/Due Date:
DOR HEARING ITSELF	

Administrative Review Authority:	Review Date:	Review Finding:
BARLOW-HUST, NOEL C #5986	10/17/2013	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	136952
Offense Facility:	**Report Date:**	**Reporting Staff:**
ICIO	12/05/2013	HECKATHORN, WESLEY #0933
Offense:	**Class:**	**Enhancement:**
UNAUTHORIZED COMMUNICATION 2	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
11/30/2013 06:30	OTHER	

Description of Offense:
On 11/30/2013 I received an outgoing letter from the mail room. The letter was addressed to Michaeline Edmo and had a return address of Mason Edmo, C-1, A-1B. Inside the envelope I saw two letters, one was addressed to Mom and the other to [redacted] (Inmate [redacted]). I read the letters and saw that Inmate Edmo instructed his mother to forward the letter addressed to [redacted] on to [redacted] who is housed at ISCI. I also saw that Inmate Edmo instructed his mother to forward letters she receives from Inmate [redacted] on to him. This is a violation of IDOC policies, as Inmates Edmo and [redacted] don't have pre-approval for inmate to inmate correspondence. Therefore, this communication is unauthorized.

Description of Evidence:
1 envelope and 5 pages that were enclosed inside.

Reviewing Supervisor:	Date/Time Reviewed:
RICCOMINI, ANTHONY #2021	12/05/2013 15:00
Delivering Staff:	**Date/Time Delivered:**
WARREN, LARRY GEOFFREY #3236	12/05/2013 16:30
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
12/10/2013	12/10/2013	CURTIS, BRIAN #6146
Offense:	**Offender Plea:**	**Finding:**
UNAUTHORIZED COMMUNICATION 2	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
EXTRA DUTY	14 day(s)	12/24/2013
Interventions:	**End/Due Date:**	
NO RECORDS FOUND		

Administrative Review Authority:	Review Date:	Review Finding:
BARLOW-HUST, NOEL C. #5986	12/11/2013	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

Date: 12/13/2013 13:07 Created By: ssummert

CIS/Facilities/Main/Discipline/Disciplinary Offense Report

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Thor DHO

IDAHO DEPARTMENT OF CORRECTION
Disciplinary Offense Report

Name: Edmo, Mason Offender #: 94691 DOR # 136752

Offense Facility: ICIO
Report Date: 12/05/2013
Reporting Staff: Cpl Wesley Heckathorn, 0933

Date & Time of offense: 11/30/2013 0630

Offense: Unauthorized Communication Level 2
Place of Offense: ICIO

Description of Offense (type in cell below):
On 11/30/2013 I received an outgoing letter from the mail room. The letter was addressed to Michaeline Edmo and had a return address of Mason Edmo, C-1, A-1B. Inside the envelope I saw two letters, one was addressed to Mom and the other to Dennis ([redacted]. I read the letters and saw that inmate Edmo instructed his mother to forward the letter addressed to [redacted] on to [redacted] who is housed at ISCI. I also saw that Inmate Edmo instructed his mother to forward letters she receives from [redacted] on to him. This is a violation of IDOC policies, as Inmates Edmo and [redacted] don't have pre-approval for inmate to inmate correspondence. Therefore, this communication is unauthorized.

Description of Evidence (type in cell below):
1 envelope and 5 pages that were enclosed inside.

FSS Ricciardi 2021 — Reviewing Supervisor and Associate # (signature)
12/5/13 15:00 — Date & Time Reviewed

Deliver Staff Steps. Ask the offender:

Do you want to request a staff hearing assistant?

Requested: Yes: ☐ No: ☑ Form Provided: Yes: ☐ No: ☑

Do you need witness statement forms? (Limit of 4 statements forms.)

Requested: Yes: ☐ No: ☑ Form(s) Provided: Yes: ☐ No: ☑ Number #: ☐

I hereby acknowledge receiving a copy of this DOR:

Mason Edmo — Offender's signature
94691 12-05-13 — IDOC # & Date

c/o Warner #3236 — Delivery Staff and Associate # (signature)
12-5-13 — Date & Time Reviewed

Additional Staff Comments:
Confirmed.

Appendix C
318.02.01.001
(Appendix last updated 9/18/12)

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IDAHO DEPARTMENT OF CORRECTION
Disciplinary Offense Report

Appendix C
318.02.01.001
(Appendix last updated 9/18/12)

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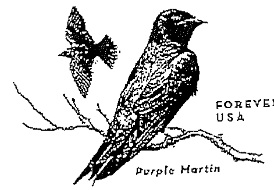
Mason Edmo
94691 CI #013
ICI-O
381 W. Hospital Dr.
Orofino ID Zip 83544



Michaeline Edmo

Happy Thanksgiving! Love you lots mom

EXHIBIT 5

NOV. 28. 2013.

Mom-

Well hello there Clarice! lol. Just Riddin Happy Thanksgiving! Happy Gobble Gobble! :)
How are you doin? Well as for me Im doin fabulous. Just chillin on my bunk, writing you a letter and watchin the tube. I've been working out hardcore! my arms & legs were killin me the other day, I could barely sit down :) how I can say everybody come and see how good I look! lol. They came out with Anchor Man 2, have you seen it yet? They let us watch movies on the weekends, they rent movies. Today, since its Turkey day we get to watch Pacific Rim. Hopefully its good. Tommorow is Spider Man 4 and then some other movie. So today another native dude, he's from north Idaho, well he said some fort dell natives were at this institution. [redacted], [redacted] and like 9 others. Dont know who. Interesting very very interesting. But yea, for the most part im doing ok. Just hangin out by myself since my other half left to Boise. Has he sent any letters there for me ([redacted])? If so, will you please PLEASE send them to me, please! There's

EXHIBIT 5

a letter to him with this one, send it to him. Very important. Use your name & address and His info is; [redacted], Boise, ID 83707. Mom please send this ASAP! Please! I really need you to send this. It means A LOT to me. This person means A LOT to me. He's helped me in so many ways. Please send it. But yea. I got a letter from baby machine Inc. (Mia) it was a good letter, very good. I'll be sending you guys a recent pic of me. I look 100% different from the last one. Better! Well mother goose, I'll end for now. I miss you & love you!

PLEASE SEND THIS LETTER TO

[redacted]

Don't forget!

Love you,
Always
Mom

EXHIBIT 5

[redacted]

NOV. 27 2013

Hey love cakes! How are you doing? I hope your doing good in there. Your almost out - two more months, then your done with IDOC; thank goodness. I bet your your excited! Im excited for you! So excited for you! So you got your plans ready for when you get out? Hopefully. Get out and get those hunnies. :) I really miss you. I miss you so much [redacted]. The last time I seen you, it was hard. I cried so hard. The next day I was so mad that they moved you, so mad. Sons of betches! lol. Nothing new here same bullshit. [redacted] was asking if you wrote me yet, I said nope. [redacted] said your probably balls deep in some man meat. lmao. funny. I hope not. But I'll definitely find out! [redacted] my promise to you still stands. Im going to be with you until you say you don't love me anymore. Just because we're seperated now does not mean shit. You promised me you will stay with me! please don't break that promise! I have your picture taped to my t.v. I see your face every night before bed and every morning I wake up - its nice! :) Your my world please don't tell me different. Please Gosh, I miss you so so much. :(I feel like half of me is missing. I've finally figured out what love is. My love for you is like

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my whole being, purpose in life. I know I love you bauz when your not here around me I miss you and long for the next time were together. It makes me so eager ~~to~~ to do what they say so I can get to be with you sooner. In psychology, it's believed that a relationship is made of passion, intimacy and commitment. We have all this, especially passion and intimacy. Please know im only yours. My heart is yours - all thats left of it. Im not going to give up on you. I love you. The time we spent together was the best time. You made my world stop. You gave me purpose again. The day we get married your not goin anywhere. Your mine!

Nov. 28. 2013

Happy Thanksgiving! I wish I could see you to tell you out not at this time cuz your not here :-. I love you [redacted] Today I sat outside & talked to [redacted] hottie. It's funny. I told him I missed you so much, it hurts. It seems like ever since you left, every time I hang out & talk to anyone, they think im trying to "hook up" with them, how lame is that? I don't want anyone but you! I can't wait to hear your voice again. I am going to call that # you gave me when you get out. So excited! I miss you so much - can't wait to hear your voice. Babe just know that im gonna send money to [redacted] or whatever that ladies

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name is. I have her address. Don't trip chicken strip, everything is gonna be OK. for sho! ☺
Well love, I guess I'll end for now ok. I miss you more than ever, your always in my dreams and Im always thinking about you.

I love you [redacted]!

always
your Sugar Tits

- they put [redacted] in jail bcuz of lame shit.
- Im "trying" to stay out of jail too!

I miss you! love you More! ♡

Don't Uget about Me!

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	141124
Offense Facility:	Report Date:	Reporting Staff:
ISCI	02/23/2014	ERBE, SAMUEL #A073
Offense:	Class:	Enhancement:
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	Place of Offense:	
02/23/2014 08:45	UNIT 16	

Description of Offense:
On 02-23-14 at 08:45 I observed Offender Edmo # 94691 walking in the day room. I observed that Offender Edmo hair was in a high pony tail and styled in a feminine fashion. I called Offender Edmo to the officer station where I told offender Edmo that per policy of the prison rape elimination that the feminine hair style was not allowed, and I ordered Offender Edmo to take the feminine hair style out. Offender Edmo stated I am sorry that this is the way you feel, but I am allowed per my treatment plan. I order Offender Edmo to take the feminine hair style out, and I would check the treatment plan. Offender Edmo replied stating I am sorry you feel that way, but I am not going to take my hair down and it is in my treatment plan; do you want me to take my breast out as well. I replied that the feminine hair style was not allowed at which time Offender Edmo walked away. I did check C.I.S., and I also checked with Unit 16 Corporal Bollman to see if anything gave such an allowance for Offender Edmo to wear a feminine hair style, and nothing was noted as such.

Description of Evidence:
Front of hair curly, and brushed up. Rear of hair was placed in a high tight pony tail. Hair styled in a feminine fashion.

Reviewing Supervisor:	Date/Time Reviewed:
BAIRD, NICHOLAS #8506	02/23/2014 23:30
Delivering Staff:	Date/Time Delivered:
BLAKE, CLINTON E. #7850	02/24/2014 07:57
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [X] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
02/26/2014	02/26/2014	LEE, BENJAMIN K. #6103
Offense:	Offender Plea:	Finding:
DISOBEDIENCE TO ORDERS 3	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	5 day(s)	03/01/2014

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	02/27/2014	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

Date: 04/24/2017 10:35 Created By: kosorio Page 1 of 1

CIS/Facilities/Main/Discipline/Disciplinary Offense Report

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	141153
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	02/24/2014	BOLLMAN, ROBERT G. #4208
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
02/24/2014 13:05	UNIT 16	

Description of Offense:

On 2/24/14 at 1305 I was notified by C/O Williams that Offender Edmo 94691 was wearing makeup and his hair was in a high pony tail which violates policy 325.02.01.002. I then asked if he had given Edmo a direct order to correct the issue. Williams stated that he had not because Edmo was getting upset in front of other offenders and was making it unsafe for officers on the tier. Edmo then made the statement "I am not changing even if you did give me a direct order and you can take me to unit 8".

After speaking with C/O Williams I had Edmo called out to the foyer of unit 16. Myself and C/O Erbe noticed as Edmo approached that he had makeup on his face. I then asked Edmo if C/O Williams had spoken to him about correcting the issue. Edmo would not answer the question and was becoming upset at me. I then gave Edmo a direct order to fix the issue that C/O Williams had pointed out. Edmo refused at which point Edmo was placed in restraints and taken to unit 8.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
DAVIS, TYRELL #6000	02/24/2014 23:39
Delivering Staff:	**Date/Time Delivered:**
CAMACHO, JUSTIN #A524	02/25/2014 09:15
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
02/26/2014	02/26/2014	LEE, BENJAMIN K. #6103
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	30 day(s)	03/31/2014

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	02/27/2014	MODIFY

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

Date: 04/24/2017 10:35 Created By: kosorio

CIS/Facilities/Main/Discipline/Disciplinary Offense Report

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	143320
Offense Facility:	Report Date:	Reporting Staff:
ISCI	06/23/2014	THORNTON, DAVID #A746
Offense:	Class:	Enhancement:
BATTERY	CLASS B	NONE
Date/Time of Offense:	Place of Offense:	
06/20/2014 12:28	UNIT 16	

Description of Offense:
I (Officer D. Thornton #A746) observed Offender Edmo strike another offender with open and closed hands during a fight occurring in the Unit 16 A Tier Dayroom.

Description of Evidence:
For more information see Information Report #06-14-271.

Reviewing Supervisor:	Date/Time Reviewed:
DAVIS, TYRELL #6000	06/24/2014 00:02
Delivering Staff:	Date/Time Delivered:
MORRISON, J #4431	06/24/2014 08:31
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
06/26/2014	06/26/2014	RAMIREZ, SABINO J #5917
Offense:	Offender Plea:	Finding:
BATTERY	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	10 day(s)	06/30/2014
PROPERTY RESTRICTION	40 day(s)	07/30/2014
RECREATION RESTRICTION	30 day(s)	07/20/2014

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	06/27/2014	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	07/02/2014	07/16/2014	AFFIRM

Offender Appeal Details:

I am appealing sanctions in this DOR. 10 days detention 30 days recreation restriction, I believe is sufficient for this offense, given circumstances. I don't believe 40 days property restriction as well as other sanctions are fair. I have a lot of legal materials, legal work, programming material, and personal property that I need, such as clothing pertaining to my gender identity dysphoria. Property restriction would limit me to wear "regular" "men" clothing and also prevent me from ordering medically necessary property items. Thanx

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Appellate Comments:
The sanctions are appropriate and within policy. We will allow any 'medically' needed items during this time.
Warden Yordy

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	143588
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	07/08/2014	WHITE, CALLIE #A521
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
07/08/2014 10:34	UNIT 16	

Description of Offense:
On 7/8/14 at around 10:34 I asked Offender Edmo #94691 to remove Edmo's hairstyle to a style that appeared less feminine gender specific per section 4 of PREA policy 325.02.01.001. Offender Edmo responded with "it's fine" and walked away from the officers station. A few minutes later Edmo returned with two concern forms for me to sign which I did then again requested that Edmo lower Edmo's hairstyle. Edmo requested the policy that I was referencing which I told Edmo. Edmo responded with "Lieutenant Greenland has told me I can wear my hair however I want to as long as it's not in a bun". Edmo left the officers station without changing Edmo's hair and left for Pendyne shortly after with Edmo's hair unchanged.

Description of Evidence:
Five C-note entries for warnings on the same policy

Reviewing Supervisor:	Date/Time Reviewed:
DAVIS, TYRELL #6000	07/09/2014 00:08
Delivering Staff:	**Date/Time Delivered:**
MORRISON, J #4431	07/09/2014 07:43
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
07/09/2014	07/09/2014	LEE, BENJAMIN K. #6103
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	DENY	CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	15 day(s)	07/24/2014

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	07/10/2014	MODIFY

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	150037
Offense Facility:	Report Date:	Reporting Staff:
ISCI	01/02/2015	HARRIS, DANIEL #1724
Offense:	Class:	Enhancement:
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	Place of Offense:	
12/30/2014 19:00	UNIT 16	

Description of Offense:

On the above date and time of the offense, I was performing a Tier check on B-Tier in Unit 16. As I came up to cell #59 I noticed an extra set of legs trying to hide in the corner. The Offender originally supposed to be in the cell was standing in the cell. I then opened the cell and noticed Offender Edmo standing in the corner. I asked Edmo why Edmo was in someone elses cell. Edmo said that Edmo was waiting for another Offender. I then told Edmo to exit the cell. EOR

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
BAIRD, NICHOLAS #8506	01/03/2015 01:30
Delivering Staff:	Date/Time Delivered:
BLAKE, CLINTON E. #7850	01/03/2015 11:10
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
01/06/2014	01/06/2014	RAMIREZ, SABINO J. #5917
Offense:	Offender Plea:	Finding:
DISOBEDIENCE TO ORDERS 3	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	15 day(s)	01/21/2014

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	01/07/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	150824
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	02/07/2015	BOLLMAN, ROBERT G. #4208
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 2	CLASS B	NONE
Date/Time of Offense:	**Place of Offense:**	
02/07/2015 07:54	UNIT 9	

Description of Offense:

On 02/07/15 at 0754 I noticed Offender Edmo #94691, have his hair in a bun that was above ear line which violates policy 325.02.01.002. I had Edmo called out to the foyer so I could address the issue. I gave Edmo a direct order to stay within policy with his hair style. Edmo did fix the issue but became upset and stating that I was threatening him. After returning to the tier Edmo went back to his cell then came out to the A-tier dayroom with his hair back in a high pony tail above the ear line which still violates policy 325.02.01.002 and openly disobeyed the orders that I gave him less than 15 minutes prior.End of report.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	02/08/2015 06:00
Delivering Staff:	**Date/Time Delivered:**
BIGELOW, MICHAEL #1778	02/08/2015 08:38
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
02/11/2015	02/11/2015	LEE, BENJAMIN K. #6103
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 2	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	5 day(s)	02/12/2015

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	02/12/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	02/14/2015	03/04/2015	AFFIRM

Offender Appeal Details:

Appeal processed on 2/19/15.

I am appealing this DOR's sanctions of five days, plus additional four days, total of 9 days of segregation for behaviors associated with my mental illness of gender dysphoria. I believe sanctions of segregation is quite

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disproportionate for the offense of disobedience to orders of not having my hair below ear level.
Appellate Comments: Staff gave you direction you refused to follow. Such open defiance of staff's orders are a serious infraction in our facility. You may challenge staff's orders but you don't have the option not to follow them because you don't agree with them. The sanctions remain. Warden Yordy

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	152472
Offense Facility:	Report Date:	Reporting Staff:
ISCI	04/21/2015	BAXTER, JORDAN #B389
Offense:	Class:	Enhancement:
SEXUAL ACTIVITY	CLASS B	NONE
Date/Time of Offense:	Place of Offense:	
04/21/2015 19:44	RECREATION	

Description of Offense:
On April 21, 2015 at 19:44 I was standing next to the balcony in recreation next to the racket ball court observing the basketball court. I heard the racket ball bouncing around in the court for some time and then I noticed that I couldn't hear it. I went to look over the balcony in the racket ball court and saw Offender Edmo (#94691) and Offender [redacted] holding each other and appeared to be open mouth kissing with the lips for approximately 5 seconds. They both had their arms around each other's waists. They were against the back wall next to the door directly below where I was standing. Soon after, Offender Edmo had looked up and made eye contact with me. As soon as Offender Edmo was aware of my presence, he slapped Offender [redacted] in the stomach as if to alert him that they had been caught. They both immediately stopped and pulled away from each other. I alerted Corporal Schaber and she asked both offenders to come to the office and informed them, they would both be receiving DORs. Lt. Clark instructed her to send them back to their units. Approximately 10 minutes later they were both seen going to the chapel at which time Cpl. Schaber notified Lt. Clark who then determined they would be going to Unit 8.

Description of Evidence:
Attached copy of Information report.

Reviewing Supervisor:	Date/Time Reviewed:
BAIRD, NICHOLAS #8506	04/22/2015 01:52
Delivering Staff:	Date/Time Delivered:
MUSIC, ALEXANDRIA #B292	04/22/2015 08:30
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
04/28/2015	04/28/2015	RAMIREZ, SABINO J. #5917
Offense:	Offender Plea:	Finding:
SEXUAL ACTIVITY	DENY	CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	15 day(s)	05/06/2015
RECREATION RESTRICTION	45 day(s)	06/12/2015
NO CONTACT ORDER	60 day(s)	06/27/2015

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	04/30/2015	AFFIRM

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Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	04/29/2015	05/08/2015	AFFIRM

Offender Appeal Details:

This DOR should be modified as a class C - inappropriate contact with 5 day segregation limit, as explained in DOR hearing that contact had been brief not 5 seconds unless the C/O actually timed the contact, which had not been the case. Neither his statement of our arms around each other. A 90 day no contact order can infringe upon my religious rights as I and [redacted] are part of the Native American religious services where interaction and communication are necessary for our goals of our religion.

Appellate Comments:

Your actions do warrant sexual activity and the DOR is affirmed.

Warden Yordy

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	152473
Offense Facility:	Report Date:	Reporting Staff:
ISCI	04/21/2015	ROMRIELL, WALTER L #3542
Offense:	Class:	Enhancement:
TATTOO OR PIERCING	CLASS B	NONE
Date/Time of Offense:	Place of Offense:	
04/21/2015 20:54	UNIT 8	

Description of Offense:
On 4-21-15 I Cpl. L Romriell observed Offender Edmo with what appeared as 2 new tattoo's Offender Edmo stated that both tattoos were new. One tattoos on the offenders left neck area and one on the offenders left wrist. Both tattoos appeared to be red and infected.

Description of Evidence:
3 photo's of the new tattoos

Reviewing Supervisor:	Date/Time Reviewed:
BAIRD, NICHOLAS #8506	04/22/2015 01:51
Delivering Staff:	Date/Time Delivered:
MUSIC, ALEXANDRIA #B292	04/22/2015 08:30
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
04/28/2015	04/28/2015	RAMIREZ, SABINO J #5917
Offense:	Offender Plea:	Finding:
TATTOO OR PIERCING	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
PROPERTY RESTRICTION	30 day(s)	05/28/2015

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	04/30/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	05/01/2015	05/08/2015	AFFIRM

Offender Appeal Details:

I do not believe 30 days restriction of property is an appropriate sanction in addition to 45 days rec. restriction. 15 days detention. Does property include hygiene items that are very necessary to remain clean and hygienic if anything I believe that my 30 days start the day I was put in 8 house 04-21-15 not on the date of my DOR hearing.

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Appellate Comments:

The restrictions are within allowable limits. Having a restriction during the time you are physically without it, such as when you're in detention, is not a restriction. For it to begin when you're released is reasonable. Additionally, offenders do not need to buy hygiene items to remain hygienic as the state provides soap, toothpaste, toothbrush, etc.

Warden Yordy

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	156084
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	09/27/2015	ELLINGTON, DUSTIN #B190
Offense:	**Class:**	**Enhancement:**
POSSESSION OF UNAUTHORIZED PROPERTY	CLASS B	NONE
Date/Time of Offense:	**Place of Offense:**	
09/27/2015 11:00	UNIT 15	

Description of Offense:
On 09/27/2015 I, Officer Ellington, was conducting a random search of Offender Edmo's (#94691) Cell. On the sink I found an eye drop container with what appeared to be a skin-toned substance that looked like makeup. In a bundle of paperwork within his assigned locker I also found a container of black eyelash makeup with an eyelash applicator. Also within some paperwork was an inmate identification card belonging to Offender [redacted] a photo of another offender, and what appeared to be a hand-made arm band. I also located a Walkman with another Offenders name and number within Offender Edmos locker.

Description of Evidence:
Body of Report, attached photos

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	09/28/2015 06:00
Delivering Staff:	**Date/Time Delivered:**
BLAKE, CLINTON E. #7850	09/28/2015 07:42
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
10/05/2015	10/05/2015	RAMIREZ, SABINO J. #5917
Offense:	**Offender Plea:**	**Finding:**
POSSESSION OF UNAUTHORIZED PROPERTY	DENY	CONFIRM

Sanctions:	Amount:	End Date:
COMMISSARY RESTRICTION	20 day(s)	10/25/2015
RECREATION RESTRICTION	25 day(s)	10/30/2015

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
COBURN, GARRETT #0455	10/07/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	10/09/2015	10/19/2015	AFFIRM

Offender Appeal Details:

The makeup applicator and container of what looked like makeup, plus the radio and ID do not pose a significant risk to the institution as described in policy. This should be modified down to a class C offense. A rehearing with an un-biased DHO.

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Sgt. Ramirez and I have a damaged rapport because he does not approve of my lifestyle as a transgender woman. He is a biased disciplinary hearing officer and intentionally bends the policies and rules to use against me. The audio will reveal the attitude and demeanor he had with from the beginning of the hearing, which supports the bias.

Appellate Comments:

The offense code that staff chose to use was appropriate given you possessed multiple property items that were not authorized. I see no reason to reduce this down to a class C.

Warden Yordy

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	157331
Offense Facility:	Report Date:	Reporting Staff:
ISCI	11/17/2015	HARTLEY, STEWART F #1892
Offense:	Class:	Enhancement:
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	Place of Offense:	
11/17/2015 15:30	OTHER	

Description of Offense:
Edmo checked out books from the Resource Center on 11/05/15 and were due on 11/10/15 per the callout. Along with those books was a memo instructing that the books be returned the following Tuesday, according to the callout. I also sent two overdue notices to Edmo on 11/10/15, and 11/13/15. It is now 11/17/15, and Edmo has not returned the books. Edmo failed or refused to comply with three written instructions to return the books. This constitutes Disobedience to Orders Level 3 -- "Failure to follow staff instruction, facility living guide, IDOC rule, behavioral agreement, work agreement, or field memorandum8230." This is the third time Edmo has failed to timely return books in less than six months. When confronted about one of these overdue incidents, he replied "what's your point?" His failure to comply with Resource Center rules has denied other inmates access legal books.

Description of Evidence:
Book Checkout Memorandum, First Overdue Notice, Second Overdue Notice

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	11/18/2015 06:00
Delivering Staff:	Date/Time Delivered:
CERRILLO, ROBERT #A074	11/18/2015 12:45
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
11/20/2015	11/20/2015	MELDRUM, JONATHAN #1145
Offense:	Offender Plea:	Finding:
DISOBEDIENCE TO ORDERS 3	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
NO RECORDS FOUND		

Interventions:	End/Due Date:
DOR HEARING ITSELF	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	11/23/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	157376
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	11/15/2015	FISHER, BRITTANY #B702
Offense:	**Class:**	**Enhancement:**
BATTERY	CLASS B	NONE
Date/Time of Offense:	**Place of Offense:**	
11/15/2015 17:25	UNIT 16	

Description of Offense:

On 11/15/2015 I was posted on A-Tier, at approximately 1725. I was walking back from the janitor's closet when I heard what appeared to be items being thrown. As I rounded cell 06 I observed Inmates Edmo #94691 and [redacted] fighting. Edmo had [redacted] pushed up against the wall. Edmo was delivering body punches to [redacted]. I radioed the emergency and gave them verbal commands to stop fighting. They continued to fight with one another. I informed them to stop or O/C will be deployed. Edmo delivered one more punch before they complied with verbal commands. At this time Officer Weinstein and Quiroz arrived at the cell and directed them to separate further. Both inmates were placed in restraints. They were escorted off the tier. Both inmates admitted to throwing punches

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	11/16/2015 06:00
Delivering Staff:	**Date/Time Delivered:**
KURDI, MIREYA #A545	11/16/2015 08:23
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
11/23/2015	11/23/2015	RAMIREZ, SABINO J #5917
Offense:	**Offender Plea:**	**Finding:**
BATTERY	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	10 day(s)	11/25/2015
RECREATION RESTRICTION	25 day(s)	12/18/2015

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	11/24/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	158072
Offense Facility:	Report Date:	Reporting Staff:
ISCI	12/17/2015	GRIFFEL, KAITLIN #B840

Offense:	Class:	Enhancement:
PHYSICAL CONTACT	CLASS C	NONE
Date/Time of Offense:	Place of Offense:	
12/17/2015 13:00	UNIT 16	

Description of Offense:
On 12/17/15 at 1300 hours, I was conducting a B tier check when I witnessed Inmate Edmo #94691 and another inmate kissing in cell 35. Edmo was sitting on the lower bunk and the other inmate was leaning over to kiss Edmo. The other inmate's hand was on Edmo's face. There were distinctive kissing noises coming from the two of them.
Brief kissing falls under the description of DOR offence #48 Physical Contact.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	12/23/2015 06:00
Delivering Staff:	Date/Time Delivered:
EASTER, KAYCEE #B778	12/23/2015 12:10
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
12/29/2015	12/29/2015	RAMIREZ, SABINO J. #5917
Offense:	Offender Plea:	Finding:
PHYSICAL CONTACT	DENY	CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	15 day(s)	01/13/2016
NO CONTACT ORDER	35 day(s)	02/02/2016

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	12/31/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	01/06/2016	01/19/2016	AFFIRM

Offender Appeal Details:

Appeal received 1.11.16.

The reviewing supervisor C/O Griffel, DHO Sgt. Ramirez and Admin. Rev. Authority Rosenthal have not thoroughly reviewed DOR. The DOR content does not identify the other offender I had been supposedly kissing. The DOR does not provide sufficient evidence. Who was I kissing? This DOR should be dropped and

EXHIBIT 5

all sanctions dropped and purged from my inmate file! I had not been kissing any offender during this time. If so, who? There is no evidence or I.R. containing such information. This is clearly a DOR of harassment.
Appellate Comments: The officer is specific in what she saw. The fact the other inmate's name is not included does not mean it didn't happen. There is some evidence to support the DOR. Warden Yordy

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	158094
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	12/23/2015	TAYLOR, TRAVIS #4679
Offense:	**Class:**	**Enhancement:**
TATTOO OR PIERCING	CLASS B	NONE
Date/Time of Offense:	**Place of Offense:**	
12/22/2015 13:00	UNIT 16	

Description of Offense:
On December 22, 2015 at approximately 13:00 I was outside of Unit 16 posted for yard movement with Sgt. Seely. During the movement I stopped Inmate Edmo #94691 and conducted a brief tattoo check of Edmo's hands. I noticed three tattooed stars on Edmo's ring finger that appeared to be fairly new. Sgt. Seely and I questioned Edmo about the stars on Edmo's ring finger and Edmo admitted that they were done recently and weren't documented. I checked the Corrections Integrated System (CIS) and was able to verify that the tattoos were in fact not documented.

Description of Evidence:
Attached pictures

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	12/24/2015 06:00
Delivering Staff:	**Date/Time Delivered:**
CERRILLO, ROBERT #A074	12/24/2015 10:15
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
12/29/2015	12/29/2015	RAMIREZ, SABINO J #5917
Offense:	**Offender Plea:**	**Finding:**
TATTOO OR PIERCING	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
PROPERTY RESTRICTION	30 day(s)	01/28/2016

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	12/31/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

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IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	160360
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	01/15/2016	MARTIN, CHESTER #8483
Offense:	**Class:**	**Enhancement:**
SEXUAL ACTIVITY	CLASS B	NONE
Date/Time of Offense:	**Place of Offense:**	
12/30/2015 09:00	UNIT 16	

Description of Offense:
On 1-13-16 Inmate Edmo admitted to Ada County Detective Weires and Officer Burroughs that while living on the same tier in Unit 16 Inmate Edmo had consensual sex on two different occasions during the evening time with another Inmate in Inmate Edmo cell 35.
Furthermore Inmate Edmo admitted to giving this other Inmate sexually explicit letters that were confiscated by staff on 12-30-15 that also admits to the sexual relationship between the two. Some quotes of the letters are as follows: "our sex was amazing", "you were the last one inside me" and " I most definitely miss your lips against mine, your hands all over my body, your cock inside me, and one day well be able 2 do it again".

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
BAIRD, NICHOLAS #8506	01/16/2016 03:08
Delivering Staff:	**Date/Time Delivered:**
EARLE II, JAMES M #5474	01/16/2016 12:28
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
01/19/2016	01/19/2016	SEELY, COREY #9918
Offense:	**Offender Plea:**	**Finding:**
SEXUAL ACTIVITY	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	14 day(s)	01/13/2016
RECREATION RESTRICTION	25 day(s)	02/13/2016

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	01/20/2016	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	161943
Offense Facility:	Report Date:	Reporting Staff:
ISCI	03/28/2016	QUIROZ, RICARDO #A365

Offense:	Class:	Enhancement:
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	Place of Offense:	
03/28/2016 20:55	UNIT 16	

Description of Offense:
On the date of 3-28-2016 at 2055 Inmate Edmo #94691 was warned by me about wearing makeup. Edmo was wearing some type of makeup that resembled eye liner. I warned Edmo that wearing makeup was not allowed and that the makeup needed to be removed. Edmo stated that the makeup will be removed and Edmo understood that makeup was not allowed. At 2055 Recall was announced and Edmo was returning from yard movement. At this time I checked Edmo's eyes again to make sure that the makeup was removed. The makeup was not removed and I again informed Edmo that the makeup needed to be removed and that Edmo refused a direct order. At this time Edmo stated, "Write me a DOR I don't care." Edmo refused my direct orders to remove the makeup.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	03/29/2016 06:00
Delivering Staff:	Date/Time Delivered:
REYNOLDS, TYLER #A132	03/29/2016 07:21
Staff Hearing Assistant:	Assistance:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
03/31/2016	03/31/2016	SEELY, COREY #9918
Offense:	Offender Plea:	Finding:
DISOBEDIENCE TO ORDERS 3	DENY	CONFIRM

Sanctions:	Amount:	End Date:
FORMAL WARNING/WRITTEN REPRIMAND		

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	04/01/2016	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

EXHIBIT 5

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	163026
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	05/12/2016	NICHOLAS, CHANCE USERNAMECHG #C077x
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
05/06/2016 17:27	PENDYNE	

Description of Offense:
On May 6th, 2016 at 1727 I caught Inmate Edmo with makeup on in Pendyne when he was on his way to throw his tray away. I asked if that was makeup on his face in which he admittedly said he had eyeliner on. I told him I don't want to see him with it on again and he replied "Ok, I won't do it again". I then looked up on his C-Notes in Unit 16 and realized that he was given a prior verbal warning and prior disciplinary sanctions for the same offense. Because he was given previous verbal warnings and disciplinary sanctions, I decided that disciplinary action would be ideal.

Description of Evidence:
Previous verbal warnings issued, C-Notes and disciplinary sanctions for the same offense.

Reviewing Supervisor:	Date/Time Reviewed:
BAIRD, NICHOLAS #8506	05/13/2016 14:37
Delivering Staff:	**Date/Time Delivered:**
SEEGER, BETHANY D #B383	05/13/2016 15:50
Staff Hearing Assistant:	**Assistance Requested:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
05/16/2016	05/16/2016	HINES, BRYAN W #8862
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	DENY	CONFIRM

Sanctions:	Amount:	End Date:
COMMISSARY RESTRICTION	15 day(s)	05/31/2016

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	05/16/2016	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	05/16/2016	06/06/2016	AFFIRM

Offender Appeal Details:

DHO Hines wrongly confirmed this DOR I had not disobeyed C/O Nicholas direct order. I followed staff's direct order to fix / correct the issue, immediately, as told to do so. I have GID, a serious mental health condition; symptoms include a persistent belief and / or desire to be the opposite sex / gender, including physical appearance. It's not a choice but a mental health issue. I deal with on a daily basis. It's a work in progress. I feel this DOR should be dropped and purged from my offender file.

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Appellate Comments:

Your condition does not allow you to wear makeup. Staff were within our policy to issue you a disciplinary infraction for violating this rule. The DOR is affirmed.

Warden Yordy