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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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EXHIBIT A

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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.

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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

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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: October 29, 1987) 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

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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

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- 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

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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

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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

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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.

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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

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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

EXHIBIT 3

PUBLICATIONS

Peer-Reviewed Journals

Johnson, J. E., Miller, T. R., Stout, R. L., Zlotnick, C., Cerbo, L., **Andrade, J. T.**, Wiltsey-Stirman, S. (2016). Study protocol: Hybrid Type I cost-effectiveness and implementation study of interpersonal psychotherapy (IPT) for men and women prisoners with major depression. *Contemporary Clinical Trials, 47, 266-274.*

Andrade, J.T. (2008). The inclusion of antisocial behavior in the construct of psychopathy: A review of the research. *Aggression & Violent Behavior, 13, 328-335.*

Kayser, K., Watson, L.E., & **Andrade, J.T.** (2007). Cancer as a "We-Disease": Examining the process of coping from a relational perspective. *Families, Systems & Health, 25*(4), 404-418.

Andrade, J.T., Vincent, G.M., & Saleh, F.M. (2006). Juvenile sex offenders: A complex population. *Journal of Forensic Sciences, 51*(1), 163-167.

Books

Andrade, J.T. (Editor, 2009). *Handbook of Violence Risk Assessment and Treatment: New Approaches for Mental Health Professionals.* New York: Springer Publishing.

Book Chapters

Pinals, D.A. & **Andrade, J.T.** (2015). Recovery in Correctional Settings: Challenges and Opportunities. In Trestman, R.L., Appelbaum, K.L., & Metzner, J.L. (Eds.), *The Oxford Textbook of Correctional Psychiatry.* New York: Oxford University Press.

Andrade, J.T. (2009). Psychopathy: Assessment, treatment, and risk management. In **J.T. Andrade** (Ed.), *Handbook of violence risk assessment and treatment: New approaches for mental health professionals.* pp. 241-290. New York: Springer Publishing.

Andrade, J.T., O'Neill, K., & Diener, R. (2009). Violence risk assessment and risk management: A historical overview and clinical application, In **J.T. Andrade** (Ed.), *Handbook of violence risk assessment and treatment: New approaches for mental health professionals.* pp. 3-39. New York: Springer Publishing.

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Andrade, J.T. (2017, June 22). Mental Health Units as Alternatives to Segregation It Can Be Done [Vera Institute Blog Post]. Retrieved from https://www.vera.org/blog/addressing-the-overuse-of-segregation-in-u-s-prisons-and-jails/mental-health-units-as-alternatives-to-segregation-it-can-be-done

Webinars:

Andrade, J.T. (2018, May 31). *Medical and Mental Health Professionals' Role in Segregation: Charting Policies to Ensure Quality Care.* National Commission on Correctional Health Care. Retrieved from: https://www.ncchc.org/medical-and-mental-health-professionals-role-in-segregation

Other Publications

Andrade, J.T. (2015). Providing Care for Incarcerated Psychopathic Patients. *CorrDocs, 18*(2), 8-9.

Andrade, J. T., Wilson, J. S., Franko, E., Deitsch, J., & Barboza, S. E. (December, 2014). Developing the Evidence Base for Reducing Chronic Inmate Self- Injury: Outcome Measures for Behavior Management. *Corrections Today.*

Andrade, J.T., & Saleh, F.M. (Winter, 2007). Book Review: Patrick C.J (Editor). Handbook of Psychopathy. Guilford Press 2006. *American Society for Adolescent Psychiatry Newsletter.*

Andrade, J.T. & Saleh, F.M. (Winter, 2005). Juvenile psychopathy: What do we know? *American Society for Adolescent Psychiatry Newsletter.*

EXHIBIT 3

Conference Presentations

Wilson, J.S. & Andrade, J.T. (2018, March). *Evidence-Based Approaches to Safety Promotion and Harm Prevention for Patients in Isolation.* Presented at the American College of Correctional Physicians Spring Conference. Houston, TX.

Fagan, T., Fleming, M., & Andrade, J.T. (2017, November). *Building an Ethics Toolbox: Strategies for Correctional Health Professionals.* Presented at the National Commission on Correctional Health Care Annual Conference: Chicago, IL.

Wilson, J.S. & Andrade, J.T. (2017, November). *Evidence-Based Approaches to Safety Promotion and Harm Prevention for Patients in Isolation.* Presented at the American College of Correctional Physicians Annual Conference. Chicago, IL.

Garvey, K., & Andrade, J.T. (2017, October). *"Tax Dollars at Work": Treating Inmates with Gender Dysphoria.* Presented at the American Academy of Psychiatry and the Law: Denver, CO.

Andrade, J.T. (2017, July). *Psychopathy: Providing Treatment and Managing Risk.* Presented at the National Commission on Correctional Health Care Summer Conference: Las Vegas, NV.

Andrade, J.T. (2017, July). *Serious Mental Illness and Segregation: Recommendations for a System that Works.* Presented at the National Commission on Correctional Health Care Summer Conference: Las Vegas, NV.

Andrade, J.T., Peterson, M.S., & Norcliffe, N. (2017, April). *Mental Health Units as an Alternative to Segregation for SMI Inmates.* Presented at the National Commission on Correctional Health Care Spring Conference: Atlanta, GA.

Fagan, T., Fleming, M., & Andrade, J.T. (2017, April). *Building an Ethics Toolbox: Strategies for Correctional Health Professionals.* Presented at the National Commission on Correctional Health Care Spring Conference: Atlanta, GA.

Andrade, J.T. (2017, February). *Violence Risk Assessment in Forensic Settings: An Update on the Research Literature.* Presented at the American Correctional Association Winter Conference. San Antonio, TX.

Andrade, J.T. & Fagan, T. (2016, October). *Beyond Good and Evil: The Soul of the Psychopath.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Andrade, J.T. (2016, October). *The Science of Violence Risk Assessment.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

EXHIBIT 3

Andrade, J.T. (2016, August). *The Science of Suicide Risk Assessment Prevention in Correctional Settings.* Presented at the American Correctional Association Summer Conference. Boston, MA.

Turney, A., Williams, K., Boyd, B., Fleming, M.C., & Andrade, J.T. (2016, August). *Effective Management of Self-Injurious Behavior in the Correctional Health Care Setting.* Presented at the American Correctional Association Summer Conference. Boston, MA.

Andrade, J.T. (2016, July). *Serious Mental Illness and Segregation: How Massachusetts Resolved This Litigation.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Andrade, J.T. & Garvey, K. (2016, July). *Gender Dysphoria: Recommendations for a Successful Program.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Andrade, J.T. (2016, July). *Continuous Quality Improvement.* Roundtable Discussion at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Andrade, J.T. (2016, April). *Continuous Quality Improvement: Motivating and Measuring Change.* Preconference Workshop presented at the National Commission on Correctional Health Conference: Nashville, TN.

Andrade, J.T. (2015, October). *Gender Dysphoria: Developing and Implementing a Successful Program in the Correctional Environment.* Presented at the National Commission on Correctional Health Conference: Dallas, TX.

Andrade, J.T. (2015, October). *Continuous Quality Improvement: Strategies and Techniques to Improve Patient Care.* Preconference Workshop presented at the National Commission on Correctional Health Conference: Dallas, TX.

Andrade, J.T., & Neitlich, D. (2015, April). *Psychopathy: Providing Treatment and Managing Risk.* Presented at the National Commission on Correctional Health Conference: New Orleans, LA.

Andrade, J.T. (2015, April). *Continuous Quality Improvement: Strategies and Techniques to Improve Patient Care.* Preconference Workshop presented at the National Commission on Correctional Health Conference: New Orleans, LA.

Metzner, J., & Andrade, J.T., (2014, December). *Serious Mental Illness and Segregation: Recommendations for a System That Works.* Presented at the NYS Correctional Medical and Behavioral Health Care Workshop: Albany, NY.

Andrade, J.T., Wilson, J., & Franko, E. (2014, December). *Measuring Effectiveness of Behavior Management: Individual- and Unit-Based Outcome Data.* Pennsylvania Forensic Rights and Treatment Conference/Drexel University, Grantsville, PA

EXHIBIT 3

Andrade, J.T., & Metzner, J. (2014, July). *Serious Mental Illness and Segregation: Recommendations for a System That Works.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Denver, CO.

Andrade, J.T., & Diener, R.B. (2014, July). *Gender Dysphoria: Clinical and Legal Aspects.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Denver, CO.

Andrade, J.T. (2014, July). *Serious Mental Illness and Segregation: Clinical and Legal Aspects.* Roundtable discussion at the National Commission on Correctional Health Care Mental Health Conference: Denver, CO.

Andrade, J.T. (2014, July). *Gender Dysphoria and Correctional Mental Health.* Roundtable discussion at the National Commission on Correctional Health Care Mental Health Conference: Denver, CO.

Andrade, J.T. & Wilson, J.S. (2014, January). *Measuring Effectiveness of Behavior Management: Individual- and Unit-Based Outcome Data.* Presented at the American Correctional Association Winter Conference. Tampa, FL.

Andrade, J.T. (2013, July). *DSM-5: From Gender Identity Disorder to Gender Dysphoria.* Roundtable discussion at the National Commission on Correctional Mental Health Conference: Las Vegas, NV.

Wilson, J.S, Andrade, J.T., & Barboza, S.E. (2013, July). *Behavior Management Strategies for Individual and Group Programs.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Andrade, J.T., O'Neill, K., & Neitlich, D.P. (2013, July). *Segregation and Serious Mental Illness: Creating a System to Ensure Quality Care and Minimize Clinical and Legal Risks.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Andrade, J.T., Diener, R.B., Cohen-Kettenis, P., Levine, S.B., & Zucker, K. (2013, March) *Trends, Uncertainties, and Controversies in the Treatment of the Transgendered.* A symposium presented at the 166th American Psychiatric Association Annual Meeting. San Francisco, CA.

Andrade, J.T. (2013, April). *Alternatives to Long-Term Segregation for Inmates with Serious Mental Illness.* Presented at the Society of Correctional Physicians Spring Conference. Denver, CO.

Andrade, J.T., Bissonnette, L., Holowecki, C., O'Neill, K. (2013, January). *An Intensive Treatment Unit for Female Offenders in Massachusetts.* Presented at the American Correctional Association Winter Conference. Houston, TX.

EXHIBIT 3

Andrade, J.T., Neitlich, D.P., & Deitsch, J. (2013, January). *Maintaining a Correctional mental Health System to Ensure Quality Care and Minimize Clinical and Legal Risks.* Presented at the American Correctional Association Winter Conference. Houston, TX.

Andrade, J.T. (2012, October). *The Treatment of Psychopathic Offenders within a Correctional Setting: The Behavior Management Unit in Massachusetts.* Presented at the National Commission on Correctional Health Conference: Las Vegas, NV.

Andrade, J.T. & Franko, E. (2012, July). *Continuous Quality Improvement (CQI) to Improve Patient Care and Clinical Efficiencies, Successfully Defend Against Litigation, and more...* Presented at the National Commission on Correctional Mental Health Conference: Chicago, IL.

Andrade, J.T. (2012, May). *Treatment of Problematic Behavior in a Correctional Setting: An Analysis of Behavioral outcomes.* Presented at the National Commission on Correctional Health Conference: San Antonio, TX.

Andrade, J.T., & O'Neill, K. (2012, March). *The Behavior Management Unit: An Alternative to Long-Term Segregation.* Presented at the Academic & Health Policy Conference on Correctional Health: Atlanta, GA.

Andrade, J.T., & Neitlich, D.P. (2012, March). *A Descriptive Analysis of 2,000 Incidents of Self-Injurious Behavior.* Presented at the Academic & Health Policy Conference on Correctional Health: Atlanta, GA.

Andrade, J.T. (2011, July). *Alternatives to Long-Term Segregation for Inmates with Serious Mental Illness: Outcomes of Secure Treatment Units in Massachusetts.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Andrade, J.T., Diener, R.B., & O'Neill, K (2011, July). *Gender Identity Disorder: A Correctional Mental Health Perspective.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Las Vegas, NV.

Masotta, M., & Andrade, J.T. (2011, March). *Suicide and Self-Harm Risk Assessment within Correctional Settings: Avoiding Common Pitfalls.* Presented at the Academic & Health Policy Conference on Correctional Health: Boston, MA.

Andrade, J.T. & O'Neill, K.L. (2011, March). *Alternatives to Segregation for Inmates with Serious Mental Illness.* Presented at the Academic & Health Policy Conference on Correctional Health: Boston, MA.

Andrade, J.T., O'Neill, K.L., Hallett, A., & Mulvey, R. (2010, November). *A Collaborative Training Model for Behavior Management Units.* International Association of Correctional Trainers: Boston, MA.

EXHIBIT 3

Andrade, J.T. (2010, July). *Behavior Management Interventions.* Roundtable discussion at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Andrade, J.T. (2010, July). *Behavior Management Strategies That Won't Reinforce Inmate Self-Injury.* Presented at the National Commission on Correctional Health Care Mental Health Conference: Boston, MA.

Barboza, S.E., Andrade, J.T., Wilson, J.S. (2010, April). *Ending It All: Data Informed Suicide Prevention.* Presented at the National Commission on Correctional Health Care Conference: Nashville, TN.

Wilson, J.S., Barboza, S.E., & Andrade, J.T. (2009, December). *Ending It All: What the Data Tell Us About Suicide Prevention.* Presented at the Academic & Health Policy Conference on Correctional Health Linking Best Practices to Best Evidence: Fort Lauderdale, FL.

Andrade, J.T. (2009, June). *Psychopathy in Correctional Settings: Assessment & Risk Management.* Presented at the Michigan Sheriffs' Association 2009 Summer Conference: Frankenmuth, MI.

Andrade, J.T. & Barboza, S.E. (2009, April). *Taking A Chance on Change: Treating Offenders in Restricted Housing.* Presented at the Mental Health in Corrections Consortium 2009 Symposium: Kansas City, MO.

Andrade, J.T. (2009, March). *The Institutional Treatment of Psychopathy.* Presented at the American Correctional Health Services Association Conference: Orlando, FL.

Andrade, J.T., Weiner, L., Mitchell., L., Zakai, A. (2008, September). *Roundtable Discussion: Mental Health Treatment within Maximum-Security Institutions and Segregation.* Presented at the National Institute of Corrections Conference: Leominster, MA.

Andrade, J.T. & Terry, A. (2008, March). *Workshop: Violence Risk Assessment in Youthful Populations.* Presented at the American Society for Adolescent Psychiatry Annual Conference: Boston, MA.

Andrade, J.T. (2007, October). *Assessment of Inpatient Aggression and Violent Behavior.* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Miami, FL.

Dwyer, R.G., Saleh, F.M., Vincent, G.M., & Andrade, J.T. (2007, October). *Assessing and Treating Violent Women: What Do We Know?* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Miami, FL.

EXHIBIT 3

Andrade, J.T., & O'Neill, K. (2007, April). *The Forensic Assessment of Malingering*. Presented at the National Organization of Forensic Social Work Conference: Las Vegas, NV.

Andrade, J.T. (2007, April). *Juvenile Psychopathy: Assessment, Treatment, and Risk Management*. Presented at the National Organization of Forensic Social Work Conference: Las Vegas, NV.

Andrade, J.T. (2007, March). *Psychopathy within a Correctional Setting: Assessment, Treatment, and Risk Management.* Presented at the University of Massachusetts Correctional Health Program Academic and Health Policy Conference; Quincy, MA.

Saleh, F.M., & Andrade, J.T. (2006, October). *Clinical and Ethical Consideration in People with Gender Identity Disorder.* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Chicago, IL.

Andrade, J.T., & Saleh, F.M. (2006, October). *Measurement of Treatment Outcome in Paraphilic Patients.* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Chicago, IL.

Andrade, J.T., & O'Neill, K. (2006, July). *Beyond a Reasonable Doubt: Violence Risk Assessment and Expert Witness Testimony in Massachusetts*. Presented at the National Organization of Forensic Social Work Conference: Chicago, IL.

Andrade, J.T. (2006, July). *The Psychopathic Personality: Historical and Current Perspectives*. Presented at the National Organization of Forensic Social Work Conference: Chicago, IL.

Saleh, F.M., Kenan, J., Dwyer, R.G., & Andrade, J.T. (2006, March). *Workshop: Evaluation and Treatment of Adolescent Sex Offenders.* Presented at the American Society for Adolescent Psychiatry Annual Conference: Miami, FL.

Andrade, J.T., Vincent, G.M., & Saleh, F.M. (2005, October). *Meta-analysis of Psychopathy and Sex Offending: Preliminary Findings.* Presented at the American Academy of Psychiatry and the Law Annual Conference: Montreal, Canada.

Andrade, J.T., & Saleh, F.M. (2005, October). *The Penile Plethysmograph in the Assessment and Treatment of Sexually Offending Behavior.* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Montreal, Canada.

Kayser, K., Watson, L., & Andrade, J.T. (2005, May). *How couples talk about their coping with breast cancer: A relational-cultural perspective.* Paper Presented as the Advances in Couples' Coping and Stress Research: Psychosocial and Clinical Perspectives Conference: Milan, Italy.

EXHIBIT 3

Andrade, J.T., & Peebles, J.L. (2005, April). *The Relationship Between Psychopathy and Sexual Aggression: A Review.* Presented at the National Organization of Forensic Social Work Conference: New Orleans, LA.

Andrade, J.T. & Caratazzola, P. (2005, April). *The Assessment of Violent Offenders: Implications of the MacArthur Violence Risk Assessment Data and Its Application to Forensic Social Work Practice.* Presented at the National Organization of Forensic Social Work Conference: New Orleans, LA.

Andrade, J.T. (2005, March). *Therapy with Juvenile Sexual Offenders.* Presented at the American Society for Adolescent Psychiatry Annual Conference: Houston, TX.

Guidry, L. & Andrade, J.T. (2004, October). *Comorbid Mental Illness Among Paraphilic Sex Offenders: Clinical Implications.* Poster Presented at the Association for the Treatment of Sexual Abusers Annual Conference: Albuquerque, NM.

Andrade, J.T., Guidry, L., Saleh, F., Vincent, G.M. & Berlin, F. (2004, October). *Comorbid Mental Illness Among Sex Offenders: A Pilot Study.* Presented at the American Academy of Psychiatry and the Law Annual Conference: Scottsdale, AZ.

Andrade, J.T. & Saleh, F.M. (2004, October). *Self-Injurious Behavior Among Incarcerated Individuals.* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Scottsdale, AZ.

Andrade, J.T., Vincent., G.M., & Saleh, F.M. (2004, October). *Psychopathy Among Sex Offenders: A Systematic Review.* Poster presented at the American Academy of Psychiatry and the Law Annual Conference: Scottsdale, AZ.

Kayser, K., & Watson, L., & Andrade, J.T. (2004, May). *Cancer as a "We-Disease:" A Relational Perspective of the Process of Coping.* Paper presented at the Fourth International Conference on Social Work in Health and Mental Health: Quebec City, Canada.

EXHIBIT 3

Reviewer Scholarly Journals
Journal of Forensic Social Work
Personality and Individual Difference
Journal of Clinical Psychology
Clinical Psychology Review
Scandinavian Journal of Psychology
Journal of Correctional Health Care

Reviewer Books
Columbia University Press

DSM 5

- Expert rater for DSM 5 Workgroup on Personality and Personality Disorders
- Provided input on the proposed Antisocial/Psychopathic type in terms of the proposed DSM-5 trait model
- Provided expert ratings on traits of Antisocial Personality Disorder and Borderline Personality Disorder

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PUBLICATIONS

Peer-Reviewed Journals

Johnson, J. E., Miller, T. R., Stout, R. L., Zlotnick, C., Cerbo, L., **Andrade, J. T.**, Wiltsey-Stirman, S. (2016). Study protocol: Hybrid Type I cost-effectiveness and implementation study of interpersonal psychotherapy (IPT) for men and women prisoners with major depression. *Contemporary Clinical Trials, 47, 266-274.*

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Books

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Pinals, D.A. & **Andrade, J.T.** (2015). Recovery in Correctional Settings: Challenges and Opportunities. In Trestman, R.L., Appelbaum, K.L., & Metzner, J.L. (Eds.), *The Oxford Textbook of Correctional Psychiatry*. New York: Oxford University Press.

Andrade, J.T. (2009). Psychopathy: Assessment, treatment, and risk management. In **J.T. Andrade** (Ed.), *Handbook of violence risk assessment and treatment: New approaches for mental health professionals.* pp. 241-290. New York: Springer Publishing.

Andrade, J.T., O'Neill, K., & Diener, R. (2009). Violence risk assessment and risk management: A historical overview and clinical application, In **J.T. Andrade** (Ed.), *Handbook of violence risk assessment and treatment: New approaches for mental health professionals.* pp. 3-39. New York: Springer Publishing.

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Other Publications

Andrade, J.T. (2015). Providing Care for Incarcerated Psychopathic Patients. *CorrDocs, 18*(2), 8-9.

Andrade, J. T., Wilson, J. S., Franko, E., Deitsch, J., & Barboza, S. E. (December, 2014). Developing the Evidence Base for Reducing Chronic Inmate Self-Injury: Outcome Measures for Behavior Management. *Corrections Today*.

Andrade, J.T., & Saleh, F.M. (Winter, 2007). Book Review: Patrick C.J (Editor). Handbook of Psychopathy. Guilford Press 2006. *American Society for Adolescent Psychiatry Newsletter.*

Andrade, J.T. & Saleh, F.M. (Winter, 2005). Juvenile psychopathy: What do we know? *American Society for Adolescent Psychiatry Newsletter.*

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

EXHIBIT B

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.

APPEARANCES:

For the Plaintiff:
HADSELL STORMER & RENICK LLP
By: Lori Rifkin, Esq.
4300 Horton Street, #15
Emeryville, California 94608
Telephone: (415) 685-3591
Facsimile: (626) 577-7079
lrifkin@hadsellstormer.com

For the Defendants Corizon, Inc., Scott Eliason, Murray Young, and Catherine Whinnery:

PARSONS, BEHLE & LATIMER
By: Dylan Eaton, Esq.
800 West Main Street, Suite 1300
Boise, Idaho 83702
Telephone: (208) 562-4900
Facsimile: (208) 562-4901
deaton@parsonsbehle.com

EXHIBIT B

APPEARANCES (contd.)

For the Defendants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, Rona Siegert:

MOORE ELIA KRAFT & HALL, LLP
By: Brady J. Hall, Esq.
Special Deputy Attorney General
Marisa S. Crecelius, Esq.
Post Office Box 6756
Boise, Idaho 83707
Telephone: (208) 336-6900
Facsimile: (208) 336-7031
brady@melawfirm.net
marisa@melawfirm.net

The Videographer: Chris Ennis

Also Present: Kris Coffman
Mark A. Kubinski, Esq.

EXHIBIT B

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.

EXHIBIT B

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 October 29th, 1987.

Q. Have you ever had your deposition taken before, Ms. Edmo?

A. No.

Q. Have you ever given any testimony under oath?

EXHIBIT B

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.

EXHIBIT B

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.

EXHIBIT B

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.

EXHIBIT B

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

EXHIBIT B

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

EXHIBIT B

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

EXHIBIT B

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

EXHIBIT B

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

EXHIBIT B

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

EXHIBIT B

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.) Case No.
IDAHO DEPARTMENT OF CORRECTION;) 1:17-cv-00151-BLW
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.)
_____)

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.

APPEARANCES:

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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

EXHIBITS

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?

EXHIBIT C

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.

EXHIBIT C

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

EXHIBIT C

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

EXHIBIT C

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

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.

EXHIBIT C

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.

EXHIBIT C

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

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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

EXHIBIT C

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.

APPEARANCES:

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APPEARANCES (Continued):

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Also Present:
Mark A. Kubinski

I N D E X

EXHIBITS

I N D E X (Continued)

EXHIBITS PAGE

(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)

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**
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

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
+	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

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
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

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
+	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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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
+	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 (commissa ry 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

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
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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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

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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
*	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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	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

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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**
* 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

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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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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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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

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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

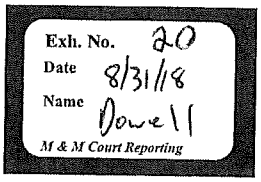
Standardized Terms and Definitions List

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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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

EXHIBIT D

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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EXHIBIT D

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.

EXHIBIT D

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,

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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**

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- 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*

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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.

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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

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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*

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EXHIBIT F

KEELIN GARVEY, MD, CCHP

August 31, 2018

Dylan A. Eaton
Parsons Behle & Latimer
800 West Main Street, Suite 1300
Boise, Idaho 83702

Re: *Edmo v. Corizon, et al.*
PBL File No. 20382.116

Dear Mr. Eaton:

At your request, I performed a psychiatric evaluation and reviewed mental health, medical and security records and associated legal filings for the purpose of providing an opinion on Corizon providers' treatment of inmate Adree Edmo since she has been in the custody of the Idaho Department of Correction (IDOC), and on the medical necessity of Gender Confirmation Surgery (GCS, also referred to as Sex Reassignment Surgery or SRS). In forming my opinion, I considered the following sources of information:

1. Clinical Interview with Ms. Adree Edmo on 08/10/2018 at Idaho State Correctional Institution (ISCI) , for two hours and 35 minutes; (audio-recorded)
2. Second Amended Complaint;
3. Corizon Medical Records (Corizon 0001-1599);
4. IDOC Standard Operating Procedure 401.06.03.501: Gender Identity Disorder: Healthcare for Offenders with;
5. IDOC Management Treatment Committee (MTC) and Administrative Review Committee (ARC) files pertaining to Ms. Edmo;
6. Plaintiff's Expert Disclosure (includes Ryan Gorton, MD and Randi Ettner, Ph.D.'s Declarations);
7. Plaintiff's Motion for Preliminary Injunction (and corresponding pleadings);
8. Plaintiff's responses to IDOC's Interrogatories;
9. Plaintiff's responses to IDOC's Requests for Production of Documents;
10. Plaintiff's corresponding document production (AE 0001-0153);
11. Plaintiff's responses to Corizon's Interrogatories;
12. Plaintiff's responses to Corizon's Requests for Production of Documents;
13. Plaintiff's corresponding document production (AE 0154-0593);
14. IDOC's responses to Edmo's Requests for Production of Documents;
15. IDOC's corresponding document production;
16. IDOC's supplemental responses to Edmo's Requests for Production of Documents;
17. IDOC's corresponding document production, including:
    a. Presentence Report dated 11/19/2009, authored by Nicole Osborn;
    b. Addendum to the Presentence Investigation dated 06/01/2010, authored by Keith Greenwalt;
    c. Presentence Report dated 11/23/2011, authored by Nicole Osborn;

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d. Psychosexual Evaluation dated 11/14/2011, authored by Dr. Linda Hatzenbuehler, Ph.D.;
e. Bannock County Sheriff's Office Detail Incident Report dated 06/29/2011;
f. Sho Ban Tribe Records, dated 11/26/2003 through 05/24/2011;
g. Indian Health Services Records, dated 06/02/2008 through 06/01/2011;
h. Portneuf Medical Center Records, dated 08/05/2010 through 08/07/2010 and 05/15/2011 through 05/19/2011;
i. Bannock County Jail Records, dated 08/21/2011 through 04/18/2012;

18. Corizon's responses to Plaintiff's Requests for Production;
19. Corizon's corresponding document production;
20. PBL 1449-1498 Dr. Alviso PowerPoint;
21. PBL 1499-1521 Handout with Alviso PowerPoint: Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, published in the Journal of Clinical Endocrinology and Metabolism in September 2009;
22. PBL 1522-1720 Handout with Alviso PowerPoint: Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, published by the Center for Excellence for Transgender health in June 2016.

Qualifications:

1. I am a physician, licensed in the states of Massachusetts, Rhode Island, Pennsylvania, Minnesota, Arizona, Florida, Texas and California. I am board certified in general adult psychiatry and in forensic psychiatry. I earned my Doctor of Medicine (M.D.) degree at the University of Massachusetts Medical School in 2005. I completed a general psychiatry residency at Brown University in 2009, serving as Chief Resident during my fourth year. I completed a forensic psychiatry fellowship at the University of California, Davis, in 2010.
2. The majority of my career has been spent providing direct psychiatric care to inmates and detainees within correctional systems. I have provided psychiatric care to inmates and detainees within the states of Rhode Island, California, and Massachusetts. I was given administrative and supervisory responsibilities as the Deputy Medical Director for psychiatric services within the Massachusetts Department of Correction (MADOC) in 2011, and served as the Chief Psychiatrist for this system from 2015-2017. I am currently employed by InnovaTel Telepsychiatry as the Medical Director for Correctional and Forensic Psychiatry. My opinions in this case are my own, and are provided outside of my role with InnovaTel.
3. I provided direct psychiatric treatment to multiple inmates with Gender Identity Disorder/Gender Dysphoria within MADOC between 2010 and 2015.
4. I began performing evaluations of inmates with gender concerns within MADOC in 2013, presenting my findings to the Gender Identity Disorder Supervision Group.
5. I became Chair of the Gender Dysphoria Treatment Committee within MADOC in August of 2015 and continued in this role until I departed MADOC in August of 2017. In this role, I evaluated every individual entering or already in the custody of MADOC who reported gender identity concerns and/or gender dysphoria, for the purposes of diagnostic clarification and treatment planning. During this time period, I evaluated over

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30 incarcerated individuals with reported gender issues. In collaboration with other policy-specified members of the Gender Dysphoria Treatment Committee, I formally considered the treatment requests and clinicians' recommendations for all established and newly diagnosed gender dysphoric individuals within MADOC, and made referrals to outside specialists for specific treatments I deemed medically necessary. These referrals included endocrinology consultation from Dr. Joshua Safer at Boston Medical Center, and dermatology consultation when individuals expressed severe dysphoria related to facial hair. The treatment committee also discussed the medical necessity of gender confirmation surgery on a case-by-case basis.

6. I have provided psychiatric treatment to individuals with Gender Dysphoria in the community, including at an outpatient mental health center and at a partial hospital program.
7. I attended a WPATH-sponsored conference entitled "Transgender Health: Best Practices in Medical and Mental Health Care" in Atlanta, Georgia in January 2016.
8. I have given formal lectures on the subject of treating and evaluating Gender Dysphoria in the correctional environment at three different national conferences: The National Commission on Correctional Health Care (NCCHC) in Boston, MA, in July of 2016; The American Academy of Psychiatry and the Law (AAPL) in Denver, CO, in October of 2017, and at the American Correctional Association (ACA) in Minneapolis, MN in August of 2018. I have also provided numerous trainings on Gender Dysphoria to mental health and medical staff within MADOC, and have given a lecture on Gender Dysphoria in the correctional system as part of the Brown University forensic fellowship didactic series.
9. I received monthly formal consultation from Dr. Stephen B. Levine, chairperson of the 5th version of the Harry Benjamin International Gender Dysphoria Association's (HBIGDA- now known as WPATH) Standards of Care, from July 2015 through August 2017, plus additional extended in-person training.
10. I have attended lectures by other presenters on the topic of Gender Dysphoria in the correctional environment at various conferences.

Publications during the last 10 years:

Articles:

1. Garvey K, Penn J, Campbell A, Esposito-Smythers C, Spirito A. Contracting for Safety with Patients: Clinical Practice and Forensic Implications. *Journal of the American Academy of Psychiatry and the Law 37(3): 2009.*
2. Recupero P, Price M, Garvey K, Daly B, Xavier S. Restraint and seclusion in psychiatric treatment settings: regulation, case law, and risk management. *Journal of the American Academy of Psychiatry and the Law 39(4): 2011.*

Book Chapter:

Garvey K, Newring K, Parham R, Pinals D (2013). The Roles and Limitations of Evidence-Based Psychotherapy in Correctional Settings, Volume II. In O. Thienhaus & M. Piasecki (Eds.), *Correctional Psychiatry Practice Guidelines and Strategies* (pp. 1-1 to 1-29). Kingston, NJ: Civic Research Institute.

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Compensation:
I am compensated $600.00 per hour of time spent on this case, including reviewing records, research, performing examinations, interviews/contact with collateral sources, preparing reports, consulting with attorneys, phone calls, travel time, preparing for depositions and testimony, depositions, and testifying in court. For portions of the case that require driving more than two hours or 100 miles total in one work day, or require air travel, I receive a flat rate of $6000 per calendar day plus travel expenses.

Psychiatric Evaluation, 08/10/2018
I performed an Independent Medical Examination on Adree Edmo on 08/10/2018. I met with Ms. Edmo in a private attorney room within the visiting room of ISCI for approximately two hours and 35 minutes. Ms. Edmo was offered the opportunity to take a break at any time during the interview but did not choose to do so. Jacqueline Franolich, a paralegal representing the law firm of Stoel Rives, LLP, was present for the entire evaluation but did not participate in the interview. The interview was audio-recorded. Prior to beginning the evaluation, Ms. Edmo was advised that I am a psychiatrist retained by Corizon defense counsel for the purpose of conducting an Independent Medical Examination pertaining to her litigation against several Corizon healthcare providers. I explained to Ms. Edmo that the content of our evaluation would not be confidential and that I would be submitting a report to the court based on my findings. I also explained that I was not entering a doctor-patient relationship with Ms. Edmo and would not be providing direct treatment to her. I informed her that I would be asking many questions, and that she was welcome to decline answering a question at any time. Ms. Edmo stated her understanding of this and agreed to proceed with the interview.

At the time of our evaluation, Ms. Edmo listed her current medications as:
Estradiol 4 mg BID
Spironolactone 50 mg BID
Calcium Carbonate 1250 mg daily
Finasteride 10 mg daily
Vit B complex with biotin
Effexor XR 450 mg daily (Note: it appears that this dose was actually decreased on 05/18/2018)

Social History:
Ms. Edmo reported that she was born in Pocatello, Idaho, and raised on the Fort Hall Indian Reservation. She said she was the youngest of four siblings until another half-sister on her father's side was born two and a half years ago. She indicated that all of her siblings are half-siblings and that she does not have any full-siblings. Ms. Edmo told me that she grew up with two older sisters and one older brother. She reported that her parents were married, but divorced when she was about nine or ten years old. She described her childhood as "stable, to a point." She said that her family had all of the necessities but described the environment as "not nurturing." She explained that her mother was her primary caretaker, but also worked a lot in human resources for the tribal business department, and at a local casino. Ms. Edmo reported that her father worked as an autobody mechanic prior to his parents' divorce. She recalled seeing her parents drink to intoxication on a regular basis, and indicated that both had alcohol

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and drug problems. She said that her parents are both still living; her mother lives in Pocatello and she has not had any contact with her father for 10-11 years.

Ms. Edmo described her relationships with her siblings growing up as "good." Her brother was the oldest, and she was closest to the younger of her two older sisters. She said that they were all one to two years apart in age. She indicated that she has regular contact with the closer of her two sisters, but speaks with her brother and other sister only "here and there" now. Ms. Edmo reported that her family was very active in traditional religious practices on the reservation, and well-connected to her community.

Ms. Edmo reported that she attended elementary school at the Native American school on her reservation. She was not certain on the exact timing, but said that she transferred off the reservation to public school in early adolescence, for middle school and high school. She described her experience at the Native American school as "pretty positive," but she was unable to recall what grades she received at that time. She stated that her transition into the public school system was "different," and that she experienced "a lot of bias toward me" due to presenting as "feminine" and due to her Native American heritage. She said that she was not bullied physically but received many "snide comments" aimed in her direction. She reported that she was the first of her siblings to attend public school, as the rest of them had finished school on the reservation. She reported never having required special education services.

After her early difficulties fitting in at public school, Ms. Edmo said that things improved for her socially in high school. Ms. Edmo indicated that some of her old friends from the reservation transferred to public school at that time, and she was able to expand her social network and feel more accepted. She recalled earning B's and C's in her classes. Despite this reported adjustment, Ms. Edmo said that she opted to drop out of school in the 12th grade and complete a GED immediately thereafter, explaining that this actually resulted in her completing her schooling one year earlier than expected. When asked why she chose to stop going to school, Ms. Edmo indicated that she "wanted to get out of the house." At that time, her siblings had all moved out and she was living with only her mother. She said that she had a "good" relationship with her mother at that time and there was no conflict; she felt "ready to start my own life."

Ms. Edmo reported that she began working for the Indian Health Service as a contract health representative soon after high school. She eventually moved to Pocatello and lived in an apartment with a friend. She described this time period, from about 2005-2010, as a "good time" in her life, but also reported that she had begun to drink alcohol and use drugs by that time. She said that her drug and alcohol use became heavy at the end of this time period, and she began "bouncing around" between Idaho, Utah and Washington state, going "wherever the drugs were." She stated, "I lost everything." Ms. Edmo said that she did not have any clean/sober time prior to her arrest in 2009.

Abuse History:
Ms. Edmo described her home life as "not nurturing," describing some elements of emotional neglect, but reported she had never been physically or sexually abused by anyone in her

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immediate family. She told me that when she was nine or ten years old, she was sexually abused repeatedly over the course of one year by a 16 year old male cousin. Ms. Edmo said that she had never reported this abuse to anyone until 2012, when she told her mother. (Note: Ms. Edmo's records indicate that she has also reported sexual abuse by a stepbrother).

Substance Abuse History:
Ms. Edmo reported that she was raised in a home with significant alcohol and drug use, and witnessed her parents becoming intoxicated frequently when she was very young. She recalled that her own substance abuse began with alcohol around age 16. Initially, she drank 1-2 nights per week, always on weekends and in the context of partying with her friends, up to five to ten beers at a time. Ms. Edmo reported that she eventually began drinking every day, from around age 19 to 22. She said that her drinking lessened as she got further into her drug addiction and began replacing alcohol with drug use. She could not clearly recall the volume of alcohol she drank on a daily basis when drinking daily. She said that she last drank in 2011, prior to her incarceration.

Ms. Edmo indicated that she began smoking methamphetamines at age 18, and started injecting it soon thereafter. She reported that she used methamphetamines daily until age 22, stopping when she was incarcerated. She reported no use of methamphetamines since prior to her incarceration.

Ms. Edmo said that she began using opioids at age 19, initially in the form of oral opioids but progressing quickly to intravenous use as she had already been injecting methamphetamines at that time. Ms. Edmo reported her last use of heroin took place in 2011, before her incarceration.

Ms. Edmo stated that she experienced significant withdrawal symptoms when she first entered Bannock County Jail on her current charges. Her symptoms included headache, nausea, hot and cold sweats, and stomach cramps. She said that she has never gone to an inpatient facility for detoxification or rehabilitation from alcohol or drugs.

Ms. Edmo reported that she tried marijuana "a couple of times" around age 16, but never used it regularly. She reported no other use of illicit drugs or abuse of prescription medications. Ms. Edmo indicated that she was a lifetime nonsmoker and that she had never abused any substances while incarcerated. She acknowledged occasional cravings for drugs and said that these are triggered by seeing needles and having blood drawn.

Legal History:
Ms. Edmo reported that her controlling offense is sexual abuse of a minor under age 16. She indicated that she was detained on this charge on 07/11/2011 at Bannock County Jail. She said that she pleaded guilty and was sentenced in December 2011, and transferred to state prison (ISCI) in April of 2012. Ms. Edmo reported that this charge is related to sexual activity with a 16-year-old male peer she met at a house party when she was 21 years old. She said that they were both drinking and using methamphetamines, and that she does not remember much

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about the incident. She reported that she has never been sexually attracted to children or prepubescent adolescents. She was asked about current sex offender treatment requirements and said that she is not required to complete any further programming prior to release in 2021, and that she is not sure if she has to register as a sex offender upon release. Of note, Ms. Edmo's records appear to indicate that she will be required to register as a sex offender upon release.

Ms. Edmo reported a history of four misdemeanor DUI charges, at age 16, 18 and two at age 19. She indicated that prior to the controlling offense, she had also been convicted on fraud and forgery charges related to writing checks from a closed account, which she attributed to her drug addiction at that time. Ms. Edmo said that she served six months in a diversion program at North Idaho Correctional Institution, which she believes to be a medium security men's prison. She indicated that she was released on "felony probation" for three years after completion of that program. Ms. Edmo reported that she was charged with violating this probation in 2011 in addition to her new felony charge of sexual abuse of a minor under age 16.

Ms. Edmo reported that she went before the parole board in 2014 and was given an "automatic open date" that included release on parole pending completion of her substance abuse and sex offender treatment programs. She stated that she was soon "kicked out" of both programs, however, due to a physical altercation with a gender dysphoric peer. She indicated that she was told at that time that she would see the parole board again one year after this fight and subsequent release from programs. Ms. Edmo said that she then got into a second physical altercation with the same peer, and subsequently received a letter from the parole board indicating that she would not be considered for parole again, and would instead have to serve her sentence to its completion date on 07/03/2021.

Work History:
Ms. Edmo reported she got her first job at age 17 as a representative for the Indian Health Service. She said that she stayed in this job for about six or seven months, and then became a floor attendant at a casino for a year. She indicated that she also worked as a legal secretary and as a cashier at a casino. She reported that she worked consistently up until her drug and alcohol use became heavier around age 19 or 20. She said that she had never received Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

Ms. Edmo indicated that she received her first prison job approximately six months prior to our evaluation, taking work orders for prison manufacturing. She said that she worked at that job until the week prior to our interview, when approximately 80% of the workers in this division were reportedly terminated due to evidence that someone was tampering with accounts. She stated that she hoped to return to this position once the investigation is complete.

Relationship History:
Ms. Edmo reported that she has always been exclusive attracted to males, and has never been attracted to or involved with a female. She recalled having had about three serious relationships during her life, beginning with her first relationship at age 16, with a 17 year old

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male peer. She described this relationship as "not very intimate ... emotionally intimate but not physically." When asked why they were not physically intimate, Ms. Edmo explained that they were more interested in "living like teenagers," and that she believed they were sexually active "I think a couple times." Ms. Edmo indicated that this partner identified as a heterosexual male attracted to women, and that this relationship lasted for about one year.

Ms. Edmo said that she was next in a serious relationship from age 20 to 22, with a man named Brady whom she had known in high school. She indicated that this relationship began at a time when she was heavily involved in drug and alcohol addiction, and that Brady was also abusing substances. Ms. Edmo reported that Brady was extremely physically abusive toward her. She described incidents in which Brady would punch, kick, and hit her, resulting in numerous criminal charges. Ms. Edmo said that this relationship lasted for about two and a half years despite this abuse. When asked why she stayed with Brady, Ms. Edmo replied, "Codependency, drug abuse, depression." She said that this relationship eventually ended when she was placed in the diversion program following her fraud and forgery charges.

Ms. Edmo reported that her current relationship, with a man named Jordan, began in 2016 while they were both incarcerated. She reported having known Jordan since prior to her incarceration. She indicated that her relationship with Jordan has been a very supportive one. She said that they were legally married on 12/27/2017. Ms. Edmo reported that Jordan had been released from prison and out in the community for six months, but later returned on a probation or parole violation and is now incarcerated again in a different facility. She said that she is not allowed to have contact with Jordan currently, but is pursuing approval for inmate-to-inmate contact through letters. Ms. Edmo indicated that she has regular contact with Jordan's mother, who is supportive of their relationship.

Past Psychiatric History:

Ms. Edmo reported a history of depression since childhood, but said that she did not seek mental health treatment until age 21 or 22. When asked why she did not seek treatment earlier, she ascribed it to a lack of health and mental health resources on her reservation rather than stigma associated with mental health treatment. She said that her depression began when she started to feel "different" from her siblings in early childhood. She reported feeling more similar to her sisters than her brother. Ms. Edmo indicated that this progressed to more significant depressed feelings when she transferred to public school and became more aware of the differences between herself and her peers. She discussed the lack of stigma associated with variance in gender expression on her Indian reservation as compared with the general population, stating that her depression worsened when she began to spend time with peers who were not Native American. When asked specifically about neurovegetative symptoms associated with depression, Ms. Edmo endorsed changes in sleep, appetite and concentration when she is depressed.

Ms. Edmo also reported a long history of intermittent suicidal ideation, beginning around age 15. She said that she had attempted suicide with lethal intent on three occasions. She described the first attempt as an intentional overdose on pills in 2009, during the time when she was

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addicted to alcohol and multiple drugs. She recalled, "I believe they pumped my stomach and I was released after that." She indicated that she was not psychiatrically hospitalized at that time. Ms. Edmo reported a second suicide attempt occurring in 2010, again by overdose on pills. She said that after that attempt, she was referred to a Behavioral Health Unit in Pocatello, at the Portneuf Medical Center. She indicated that she was held for three days for "observation and evaluation," but was not committed. She stated, "I checked myself out" and was not prescribed any psychiatric medication. Ms. Edmo said that her third and most recent attempt was in early 2011, by "cutting my arm open all the way through," requiring 20-30 sutures. She recalled that she was committed to the Behavioral Health Unit at Portneuf Medical Center at that time, staying for one to two weeks. She stated she believes she was prescribed sertraline (Zoloft) and "something else," but she did not continue to take these upon release. Ms. Edmo indicated that these were her only two inpatient psychiatric admissions.

Ms. Edmo was asked whether she had ever received outpatient treatment of any kind, including by a primary care physician, prior to prison. She said that she had never received any kind of mental health or psychiatric treatment and had never had a psychiatric evaluation prior to her incarceration. She indicated that she did not see a primary care physician in the community prior to this either.

Ms. Edmo reported no other incidents of attempted suicide, but said that in 2014 while at Idaho Correctional Institution-Orofino (ICIO) she contemplated hanging herself due to "just gender dysphoria and a really bad episode of depression." She indicated that she did not tell anyone that she was contemplating hanging, but her cellmate became concerned about a change in her behavior and reported this to mental health staff, who placed Ms. Edmo on a suicide watch. She said that she never attempted to hang herself.

Ms. Edmo also reported several incidents of self-harm that did not involve suicidal intent. Ms. Edmo said that the first such incident occurred in September 2015, when she cut the right side of her scrotum with a razor blade due to "depression and gender dysphoria." She stated her intent behind this action as "to castrate my testicles" and thereby stop the production of testosterone in her body. Ms. Edmo reported that she planned this incident for about four days and did not tell anyone she was going to do it. When asked how this plan developed, she stated, "I had researched it a little bit" on the internet. She indicated that she was treated onsite with sutures and placed on a suicide watch in the behavioral health unit of ISCI for about ten days. Ms. Edmo also reported a second incident of attempting to cut off her testicles, occurring on 12/31/2016. She explained, "I cut open the same side and pulled the testicle through." She recalled that she stopped when she could no longer see what she was doing due to significant bleeding. She said that she used legally-acquired disposable razors to cut her testicles during both of these incidents. Ms. Edmo indicated that on the second occasion, in December 2016, she was taken to St. Alphonsus Regional Medical Center by emergency medical technicians, where a urologist repaired her scrotum. She said that upon return from the hospital, she spent one week in the medical infirmary and was subsequently returned to general population.

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Ms. Edmo reported that she began cutting the inside of her wrists in early 2017. She described feelings of "mental anguish" prior to cutting, and "a release of the mental anguish" when she cuts. She denied suicidal intent behind this cutting behavior. Ms. Edmo said that as of the time of our interview, she had last cut herself approximately one month earlier.

Ms. Edmo was asked about a history or current symptoms of anxiety. She endorsed "a constant feeling of anticipation, like something is about to happen," lasting up to two hours at a time, associated with physical experiences including "my heart beats fast, body gets warm, breathing more heavy." She reported this happens at random and is not associated with any clear precipitants or triggers.

Ms. Edmo reported that she was severely physically abused by her boyfriend Brady prior to incarceration. She endorsed flashbacks of this abuse occurring since that time. When asked if she experiences nightmares or flashbacks of her childhood sexual abuse, Ms. Edmo stated that she was not currently experiencing these. She indicated that around 2010, she began to experience a heightened startle response and feelings of hypervigilance in her environment. When asked if she believes her abuse history affects her current relationships, Ms. Edmo responded affirmatively.

Ms. Edmo described her current depression, at the time of this evaluation, as "not being able to enjoy everything, not being interested in anything, feeling a sense of unworthiness, not seeing everything in a positive light; everything is a dread." She expressed her belief that this is due to "a combination of the depression and gender dysphoria." When asked specifically, she indicated that she experiences both; depression unrelated to gender and depression directly related to her gender dysphoria.

Ms. Edmo reported that she had never experienced auditory or visual hallucinations or any other perceptual disturbances. She was asked about a variety of delusional beliefs and did not endorse any of these beliefs, and did not make any statements indicative of past or current delusional beliefs. She did not report or endorse any past episodes of mania.

Family History:
Ms. Edmo reported that her mother has depression, and her sister had depression or possibly bipolar disorder. She said that neither had ever been psychiatrically hospitalized. Ms. Edmo reported that a third cousin had just completed suicide the week before our evaluation. This cousin had been abusing drugs and alcohol.

Ms. Edmo indicated that her mother takes some kind of blood-thinning medication for uncertain reasons, and is obese. She said both of her grandmothers had diabetes.

Gender Identity History:
Ms. Edmo reported that she has always identified with her older sisters more than with her older brother. She recalled feeling closest to the younger of her two older sisters when growing up, playing Barbies and dress-up together. She indicated that she can recall these behaviors

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occurring since at least age five. She described her older brother, who was four years older than her, as "more protective than oppressive ... because he knew ... I think he knew that I was different." She added that her brother was "more like a stern protector."

Ms. Edmo reported that she began wearing her sisters' clothing, to include dresses and feminine shirts, around age five. She said that her mother and grandmother were her primary caregivers at that time and "were not opposed to it ... letting me do what I do," and that they did not force him to wear more masculine clothing. She recalled having dressed in female clothing "here and there" until about age nine, when she began wearing female clothing more consistently. Prior to age nine, she said that she still wore her own more masculine clothing outside of the house most often. She indicated that she had always hung around with female peer groups, and had never had any close male friends, adding, "I was just considered one of them." Despite her reported difficulties fitting in at public school initially, Ms. Edmo indicated that she eventually developed strong female peer groups in high school as well and felt accepted by her female friends as "one of them." Ms. Edmo described her preferred style of dress as feminine jeans and shirts. She indicated that she had never really liked wearing dresses, which she indicated were not her style. She said that she began wearing makeup at age 15, initially consisting of mascara and foundation, and later progressing to other kinds of eye makeup.

Ms. Edmo reported that after high school, her style of dress and grooming "stayed the same," which included dressing in women's clothing and wearing makeup, but that she became "more into the whole female presentation" as she got older. She said that she began wearing female underpants and bras and brought breast prostheses around age 18 or 19. She indicated that she still dressed somewhat masculine on occasion, providing example of wearing "a shirt and sweats" if she was hungover. She reported that she wore "solid basic colors" including a lot of black feminine clothing to work at her Indian Health Services job at that time. She indicated that she went to a salon for facial hair waxing and eyebrow grooming while in the community.

Ms. Edmo was asked about her preferred hairstyle. She said that she had always had long hair, since childhood. She was asked if she had ever had short hair and stated she had not. Ms. Edmo was asked again whether she had ever had short hair and replied, "They made me shave my head" at the diversion program she attended in 2009. She added that had she pointed out her Native American heritage she would have been allowed to keep her long hair, but stated, "They thought I was Mexican" and she was forced to shave it. When asked how she felt about having short hair, she stated, "It was different ... a lot more convenient."

When asked about her bathroom preferences, Ms. Edmo indicated that she had been sitting down to urinate since childhood. When asked which bathroom she used when out in public, she stated "it depended."

Ms. Edmo stated that she first became aware that she was different from her sisters when they went through puberty and developed feminine sex characteristics. She described it as "kind of depressing" to learn that she was not going to develop the way they were; that her masculine

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features would only become more masculine. Ms. Edmo reported that she had never used her penis for sexual activity. She stated that she had never used it to penetrate a partner, and that she did not use her penis for masturbation. She was asked to elaborate on how she feels about her penis, and stated, "It's gross." She said she began to feel this way around age 15, and that "it's gotten worse." She reported thinking about her penis and testicles "constantly." She was asked about other parts of her body that she wants to change and indicated that she is primarily focused on being rid of her penis and testicles and having a vagina.

Ms. Edmo reported that her family and Native American community did not question or condemn her feminized appearance and behavior. She said that her mother asked her if she liked girls when she was about 14 years old, and she told her mother she did not. She indicated that her mother accepted this readily.

Ms. Edmo was asked whether she had ever sought or received treatment for gender dysphoria prior to her incarceration. She reported that she did not understand what it meant to be transgender until she entered county jail on the controlling charge and met a transgender woman. She recalled having been "labeled as a gay man" previously, explaining that this did not completely resonate with her but she did not know there was an alternative explanation to how she felt. She recalled knowing bisexual and homosexual peers, but never anyone else who identified as transgender. She stated that she remembered feminized men on her Indian Reservation, but she never spoke to them about their gender identity and now realizes they may have been transgender.

Ms. Edmo indicated that a transgender detainee at Bannock County Jail befriended her in 2011 and advised her to seek contact with mental health professionals and physicians at the jail so she could request cross-gender hormone treatment. She said that prior to meeting this individual, she did not really know what it meant to be transgender, and had never heard of cross-gender therapy. However, at another point in the interview she reported that she had started to discuss her gender identity with a correctional professional at the diversion program in 2009 but that she had been told "just not to mention it," so she never brought it up again. Ms. Edmo reported that she received minimal psychiatric care while in county jail awaiting transfer to state prison, so elected to wait until she got to state prison to discuss her gender identity. She was asked if she had had or sought contact with any outside agencies, penpals, etc. prior to seeking an evaluation of her gender issues, and she said she had not.

<u>Past and current GD treatment</u>

Regarding her current treatment, Ms. Edmo reported that she was diagnosed with Gender Identity Disorder in July 2012 by Dr. Lake, and started hormone therapy in September 2012, with estrogen and spironolactone. She indicated that the hormone therapy "helped me mentally ... more a clearing of my mind," explaining that she felt like her thinking became clearer. She listed physical changes including weight loss, breast growth, a decrease in skin oiliness, a change in body odor, and changes in fat distribution. She said that the mental changes began about six months into hormone treatment, and the physical changes happened

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over the course of a year. She indicated that she stopped noticing any further changes about one year prior to our appointment.

Ms. Edmo reported that she first saw gender dysphoria consultant Dr. Alviso in December 2015, and sees him annually. She said that the first time she saw Dr. Alviso, he increased her estrogen dose, continued spironolactone, and started progesterone. She indicated that this did not result in much additional change, other than "like a mental clearness" and modest additional breast growth. She reported having experienced weight gain and fatigue from the medroxyprogesterone so she stopped this medication by her own choice. She was asked about her experience with spironolactone including her history of elevated liver function tests. She reported that she had been restarted on spironolactone in mid-June 2018 and felt "a lot better," with a decrease in skin oiliness and "gritty" sensation she experienced when not taking it.

When asked about her current level of satisfaction with her gender dysphoria treatment, Ms. Edmo replied, "I feel it's maintenance ... for me I feel like I've hit the most I'll ever get from the hormones." She reported feeling "content" but not satisfied with her response to hormone therapy, stating, "I think the treatment plan I'm on now ... it's pretty much the same as I would get outside of prison." She clarified that she was referring only to her hormone therapy, and not to her whole gender dysphoria treatment plan. When asked what additional treatment she is seeking, she stated, "the whole thing." She was asked to clarify and indicated that she was primarily interested in genital gender confirmation surgery. She said that she was also interested in breast augmentation and laser hair removal and/or electrolysis specifically for facial hair, but these are lower priority to her than genital surgery. She added that her facial hair has become thinner since starting hormone therapy but she still shaves her face daily.

Ms. Edmo reported that she is not allowed access to anything that is not on the male property list, other than bras that are ordered by her medical providers. She reported that she had ordered female underpants from the commissary several months ago, however, and that she had received these without incident. She was unsure if there had been a policy change that allowed this, as she had previously not been allowed to have female underpants. Ms. Edmo reported that she was not allowed to purchase her own makeup, but that her family was allowed to buy her care packages that included makeup.

Ms. Edmo was asked to discuss her requests for transfer to the women's prison. She explained, "For me, that would be more comfortable, that's who I would get along with." She explained that her close friends had always been women, and that she had very few close male friends. When asked how she believes she would be received by peers at a women's prison, she stated, "Probably the same as here," explaining that she believes she would still be treated as different and something of an outcast, but that she would feel less "in the spotlight" and would not have to deal with unwanted attention from some male inmates. She was asked about any history of violence toward women and recalled having been in one physical altercation with a natal woman around age 21, due to the woman's reported jealousy when she was talking with the woman's boyfriend. She reported she has no history of violent charges against women. When

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asked about the Department of Correction's concerns about her transferring to a women's prison, she stated, "I think their number one concern was if I was sexually attracted to women." She stated her belief that women are allowed to have limited makeup and some hair styling products at the women's facility.

Ms. Edmo was asked if she was participating in therapy for her mental health issues and gender dysphoria, and said that she does not. She indicated that she is assigned to "Clinician Stewart," but elected not to meet with her because "I feel like she doesn't understand me as a transgender." When asked to explain further, Ms. Edmo said that she does not agree with Clinician Stewart's recommendations to attend groups for depression and PTSD. She indicated that while she acknowledges having symptoms of depression and PTSD, her castrating thoughts are prominent. She was asked whether she has ever developed a good working relationship with a mental health clinician in prison and said that she worked well with Clinician Gruhot. She indicated that she had met with this clinician in group settings and in drop-in clinics but had never been assigned to work with her individually. She added that this clinician has since left IDOC.

Ms. Edmo reported that she reached out to several surgeons who do gender confirmation surgery and received information from the office of Dr. Marci Bowers. She indicated that the materials sent provided information on vaginoplasty, labioplasty and clitoroplasty surgeries, with detailed pictures. She was asked to explain her understanding of the surgical procedures, acknowledging awareness that the penis is most commonly used to create a neovagina. She expressed some understanding of the need to use dilators following surgery. She stated her awareness of risks of the procedure, including "a tear or something" and having the vagina be "not deep enough." We also discussed risks of bleeding and infection and she stated her understanding of this.

Ms. Edmo was asked how she would respond to a poor surgical outcome, and stated "It would be horrible ... I hope I never have to deal with that." She indicated that she has learned from WPATH, however, that the complication rates of sex reassignment surgeries are very low, and that the regret rate is also very low. When asked if she would feel worse from never having surgery or from having surgery end in a bad outcome, she indicated that never having surgery would be worse for her.

Ms. Edmo reported that she speaks with her mother and one older sister regularly. She described them as supportive of her pursuit of gender confirmation surgery, but added, "I really haven't heard their actual opinions." When asked to clarify this statement, she explained that she is only able to speak with them by phone as they live about five or six hours away and do not visit. She said that they had not expressed a strong opinion in either direction about her pursuit of gender confirmation surgery.

Ms. Edmo was asked about her husband's opinion about her pursuit of gender confirmation surgery. She stated, "He's supportive more than anyone else ... he's more concerned about my health," explaining that her husband's primary concern about the surgery was that she would

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have a complication that put her health in jeopardy. She was asked how her husband would react if she never had the surgery, and stated, "It wouldn't affect our relationship but it would be my ultimate decision."

Ms. Edmo said that she would "definitely" pursue gender confirmation surgery if she is released without having this done. She said that she is not familiar with resources and insurance coverage, but her health care is covered by Indian Health Services and she believes this might help improve her chances of getting the surgery covered. She was asked if she would first seek to have an orchiectomy, and responded that she is seeking to have complete genital gender confirmation surgery and does not wish to have an orchiectomy without a penectomy and vaginoplasty.

Past Medical History:
Ms. Edmo reported that she did not have any active medical issues. She indicated that she has tested negative for Hepatitis C. She endorsed a history of multiple incidents of head trauma, some with loss of consciousness, resulting from domestic abuse during a two-and-a-half year relationship prior to her incarceration. Ms. Edmo said that she had to go to the hospital on several occasions due to severe beatings and head trauma during that relationship, and also experienced seizures "a couple times" following these incidents, most recently in 2009. She stated that she had never been prescribed medication to control seizures, and these resolved on their own.

Ms. Edmo was asked whether she has ever experienced a blood clot or any similar issue, and stated that she had not.

Prison past/current functioning:
Ms. Edmo reported that she had been working from 8 am to 4 pm Monday through Friday for six months prior to our evaluation, taking work orders for prison manufacturing, until her termination last week as described above. She indicated that her days were "pretty boring" since she stopped working. She reported attending a gender dysphoria process group with three other transgender women but opined that the group is "pretty shallow ... it's just a process group, so you go in and say, 'This is how I feel today' and then you leave." Ms. Edmo said that she has been enrolled in other mental health groups recommended by clinicians, including groups for anxiety and for posttraumatic stress disorder, but has not been participating in them consistently.

Ms. Edmo reported a few physical altercations with transgender peers, including the two fights described above that negatively impacted her parole opportunities. She described these fights as being about "just catty stupid stuff."

Ms. Edmo reported that at the time of our evaluation, she was living in a cell with one cellmate. She said that she had just changed cellmates six days prior, and had been with her previous cellmate for one month. She indicated that it was common for the correctional staff to change their cellmates frequently, and that she had not been having difficulty with cellmates.

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Regarding her current cellmate, she stated, "I've known him for a few years so we're pretty close." Ms. Edmo said that she feels safe in her current environment ("As safe as I can be—it's prison"), but reported having been raped by a male inmate in August of 2016 when housed on a tier that reportedly had a lot of gang activity. She indicated that this incident was reported at the time and the alleged perpetrator was moved to another facility. She reported that she had not been sexually assaulted any other times in jail or prison. (Note: Incident reports indicate that Ms. Edmo reported that on 08/21/2016, a male peer "grabbed Edmo by the head and placed his penis against Edmo's mouth until it penetrated him [sic] orally," and that the peer had also stated on 08/31/2016 that he would be back the next day to engage in anal sex with Ms. Edmo.)

Ms. Edmo reported that she received a Disciplinary Offense Report (DOR) the week prior to our evaluation due to suspected misconduct by an unknown offender at her job, but that she had previously not received a DOR for one year. She indicated that her past DORs were all for feminizing, including wearing her hair "too feminine," wearing makeup and modifying her underwear to look more like women's underwear. She said that she had also received DORs for two separate fights with the same transgender peer, and that she had also received one DOR related to sexual activity with her now-husband. She reported never having had a PREA investigation initiated against her, and said she had no other DORs for sexual activity or violence (Note: Ms. Edmo received a DOR on 04/21/2015 for sexual activity with a peer other than her husband. She also received a DOR on 01/15/2016 after she reportedly "admitted ... 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 ... 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." It is unclear whether this incident involved her husband, as she reported to me that she began her relationship with her husband in 2016).

Ms. Edmo reported that she while she no longer feels suicidal, she struggles with chronic intermittent "castrating thoughts," approximately four days per week. She was asked how she manages these and responded, "It depends on how severe." She explained that if the thoughts are not severe, she can "talk myself out of it" using distraction techniques, but if they are severe, she has taken to cutting her wrists, which she reported having most recently done one month prior to our interview. When asked about the strength of her "castrating thoughts" at the time of our evaluation, she responded, "I guess, pretty moderate ... not as bad as when I'm in an episode, but not completely gone." She reported she does not experience any thoughts of harming others or homicidal thoughts.

At the conclusion of our evaluation, I asked visiting room officers Gomes and Archer to have Ms. Edmo evaluated briefly by mental health staff to ensure that she did not have any acute mental health concerns.

Mental Status Exam:
Ms. Edmo presented with a feminized appearance, with long curly hair, painted nails, eyeliner and groomed eyebrows. She was alert and grossly oriented. She was initially guarded,

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appropriate to the circumstances of the interview, but remained pleasant and cooperative and engaged in the interview. Her speech was of normal rate and volume. Her thought process was linear. Her thought content was within normal limits, with no evidence of delusional beliefs or obsessions. She reported chronic intermittent thoughts of self-castration, occurring approximately four days per week, but reported no current intent or plan to harm herself in any way at the time of our interview. She reported having no homicidal ideation or thoughts of harming others. She reported she was not experiencing any hallucinatory phenomena, including hearing voices or seeing visual hallucinations. She did not demonstrate any objective evidence of responding to internal stimuli or other signs of psychosis. Her insight appeared fair and her judgment appeared to be reasonably intact at the time of our evaluation.

Future plans:
Ms. Edmo reported that she expects to release from prison in 2021, and will immediately begin looking for employment. She indicated that she completed a paralegal certificate while in prison and is slowly working toward a bachelor's degree. She would like to eventually work as a paralegal in the community. She said that she plans to live in Boise initially as her husband's parents live there and they are supportive of her relationship with their son. She expects that her husband will get out of prison soon, but stated it is possible that he will get out after she does, in 2022.

Ms. Edmo was asked to describe her plans in the event her relationship with her husband does not work out. She replied, "I would have to be single for a while," and indicated that she would still stay in Boise initially while she figured out where to go next. She acknowledged that the close friends she has in the community may still be using drugs. When asked how she planned to maintain her sobriety upon release, she stated, "Hopefully I'll have some resources closer to when I get out." She was asked to clarify which "resources" she was referring to and said that she would attend Alcoholics Anonymous meetings, seek mental health treatment and possibly trauma therapy. She indicated that she plans to initially seek Supplemental Security Income (SSI) and participate in ex-offender programs when she first gets out, but will in the meantime be looking for any job she can get.

Assessment
Diagnoses:
Gender Dysphoria in Adolescents and Adults, Posttransition
Major Depressive Disorder
Alcohol Use Disorder, severe, in full sustained remission in a controlled environment
Stimulant Use Disorder, severe, in full sustained remission in a controlled environment
Opioid Use Disorder, severe, in full sustained remission in a controlled environment

Gender Dysphoria in Adolescents and Adults, Posttransition
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for a diagnosis of Gender Dysphoria. The following evidence supports my opinion:

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1. Ms. Edmo reported experiencing a marked incongruence between her experienced gender (female) and her assigned gender (male), She indicated that she experiences this incongruence in the following ways:
    a. Ms. Edmo reported a marked incongruence between her experienced/expressed gender and her primary and secondary sex characteristics. She indicated that this began in early childhood, but worsened when she witnessed her older sisters go through puberty and develop female secondary sex characteristics. She explained that she found it "kind of depressing" to realize that she was not going to develop the same way they were.
    b. Ms. Edmo has reported and demonstrated a strong desire to be rid of her primary and secondary sex characteristics due to the incongruence she feels between these traits and her expressed gender. She has made two attempts to castrate her testicles and has reported that her intent was to rid herself of these undesirable body parts rather than to kill herself. She indicated that she believes her penis is "gross," and that she thinks about her penis and testicles "constantly."
    c. Ms. Edmo has expressed and demonstrated a strong desire for female primary and secondary sex characteristics. She reported that she wore breast prostheses prior to her incarceration, and has sought and obtained cross-gender hormone treatment for the purpose of attaining a more feminine appearance, to include breast development and fat redistribution. She also stated that her primary goal is to undergo gender confirmation surgery with penectomy/orchiectomy and vaginoplasty. She has reportedly written to surgeons who perform such procedures to gather information.
    d. Ms. Edmo has stated a strong desire to be female, as evidenced by her pursuit of cross-gender hormone treatment and gender confirmation surgery.
    e. Ms. Edmo has expressed and demonstrated a strong desire to be treated as female. She has legally changed her name to a more feminine one, and has requested that her identification card classify her as female. She has also sought permission to wear make-up and has demonstrated a preference for female hairstyles, to assist with her female gender expression.
2. Ms. Edmo's gender dysphoria has exceeded the required six months' duration necessary to meet criteria for the disorder. Ms. Edmo reported that her gender incongruence began during early childhood and became more pronounced in adolescence when she developed male secondary sex characteristics. The earliest documentation of her request for evaluation of her gender experience is found in 2012, and she has persistently maintained her female identity since that time.
3. Ms. Edmo's gender dysphoria is associated with clinically significant distress; she identified feeling depressed due to the incongruence between her assigned and expressed gender, and reported thinking about her dissatisfaction with her male body parts "constantly."

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Major Depressive Disorder, moderate, with anxious distress
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for a diagnosis of Major Depressive Disorder. The following evidence supports my opinion:

1. Ms. Edmo reported she began to experience depressed mood in early childhood, and has experienced depressed mood intermittently since that time.
2. Ms. Edmo reported she has experienced changes in her sleep habits during periods of depression.
3. Ms. Edmo reported variations in her appetite during periods of depression.
4. Ms. Edmo reported difficulty concentrating during periods of depression.
5. Ms. Edmo reported a long history of intermittent suicidal ideation beginning at age 15, and indicated that she had attempted suicide with lethal intent on three occasions.
6. Ms. Edmo reported experiencing "a constant feeling of anticipation, like something is about to happen," lasting up to two hours at a time, with associated physical sensations of "my heart beats fast, body gets warm, breathing more heavy." She indicated that this happens at random, without clear precipitant.
7. Ms. Edmo's depressive symptoms cause clinically significant distress and impairment in functioning; she has reported three suicide attempts with lethal intent, requiring medical intervention.
8. While it is likely that her depression was at times triggered or worsened by substance abuse, Ms. Edmo appears to have experienced depressive episodes in the absence of substance use as well.
9. Ms. Edmo does not appear to have a psychotic illness that might explain her depressive episodes, and does not appear to have experienced an episode of mania or hypomania.
10. When asked directly if she believes she suffers from depression or if all of her depressed feelings come from her gender dysphoria, Ms. Edmo opined that she believes she has "both," referring to a depressive disorder and Gender Dysphoria.

Alcohol Use Disorder, in sustained remission in a controlled environment
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for a diagnosis of Alcohol Use Disorder. Ms. Edmo reported a problematic pattern of alcohol use leading to clinically significant impairment and distress, involving drinking five to ten beers one to two nights per week beginning at age 16, and later progressing to daily drinking from age 19 to 22. She indicated that she began drinking larger amounts over time, but was unable to quantify the amount. She reported she last drank in 2011.

Stimulant Use Disorder, in sustained remission in a controlled environment
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for Stimulant Use Disorder. She reported she began smoking methamphetamines at age 18 and began to inject these drugs soon thereafter, despite known medical/infectious risks in doing so. Ms. Edmo reported using methamphetamines at the time of her crime, and indicated that prior to that, she "lost everything" as a result of her lifestyle chasing methamphetamines and opioids.

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Opioid Use Disorder, in sustained remission in a controlled environment
It is my opinion, with reasonable medical certainty, that Ms. Edmo meets DSM-5 criteria for Opioid Use Disorder. She reported that she began using oral opioids at age 19 and quickly progressed to intravenous use despite the known medical/infectious risks in doing so. She reported that she experienced significant withdrawal symptoms when she first entered Bannock County Jail on her current charges, including headache, nausea, hot and cold sweats, and stomach cramps. She reported having "lost everything" during the time period when she was chasing methamphetamine and opioids from state to state. She indicated that she last used opioids in 2011, prior to her incarceration.

Differential Diagnosis:
Transvestic Disorder
In forming my opinion about Ms. Edmo's diagnoses, I also considered the possibility that she meets DSM-5 criteria for Transvestic Disorder. To qualify for this diagnosis, individuals must experience recurrent and intense sexual arousal from cross-dressing for a period of at least six months, manifested by fantasies, urges or behaviors that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Ms. Edmo has engaged in a significant amount of sexual activity despite the restrictive correctional environment, with numerous incident reports documenting physical and sexual contact with several male inmate peers over the course of her incarceration, and disciplinary reports for sexual activity. She has demonstrated a preference for wearing female undergarments, and ISCI records indicate that some of these undergarments have been modified to make them more revealing, e.g. bras with v-shaped cuts and underwear crafted into thongs. She has also been opined to create "a sexually charged environment" through her use of makeup and feminine hairstyles and her mannerisms.

It is my opinion, however, with reasonable medical certainty, that based on the information available to me I cannot conclude that Ms. Edmo meets criteria for Transvestic Disorder. The following evidence supports my opinion:

1. Through her repeated incidents of sexual activity, Ms. Edmo has demonstrated that she does indeed become sexually aroused while dressed as a woman, but there is little evidence that this arousal is directly caused by her female attire or by arousal to herself as female. She denies using her penis in any sexual capacity, including to masturbate, which is often a component of transvestic disorder. I have not viewed any incident reports or other prison documentation indicating that Ms. Edmo engages in masturbation while wearing women's clothing or undergarments.
2. Ms. Edmo reports wearing female undergarments (a bra and more recently, women's underpants) at all times, and not just when engaging in sexual activity. It does not appear that wearing women's clothing is "always or often" accompanied by sexual excitement for Ms. Edmo, as required by the DSM-5 to meet this diagnosis.
3. Ms. Edmo does not report or display distress associated with her cross-dressing behaviors. She reports having dressed as a woman in the community prior to her incarceration, and feminizes to the extent she is able in the correctional environment.

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4. The majority of males with transvestic disorder identify as heterosexual[1] (as men attracted to women), and Ms. Edmo denies ever having been sexually attracted to women or involved in sexual activity with women. (Note: Ms. Edmo's psychosexual evaluation indicates that she did report sexual activity with two females in the past, but no further detail is known).
5. Gender Dysphoria and Transvestic Disorder can be comorbid, but the DSM-5 notes that "individuals with transvestic disorder do not report an incongruence between their experienced gender and assigned gender nor a desire to be of the other gender; and they typically do not have a history of childhood cross-gender behaviors, which would be present in individuals with gender dysphoria."[1] Ms. Edmo has reported strong incongruence between her experienced female gender and her assigned male gender and a strong desire to be female.

Ms. Edmo has been sexually active on multiple occasions, which is in violation of prison standards and expectations, but her sexual interest and behavior does not appear to be driven by Transvestic Disorder or another paraphilia.

Consideration of Ms. Edmo's Psychiatric Treatment

It is my opinion, with reasonable medical certainty, that Ms. Edmo's psychiatric treatment during this incarceration has been reasonable and appropriate, and does not fall below acceptable standards of care. Specifically, it is my opinion that her psychiatrists' approach to her reported gender dysphoria has been acceptable. In forming my opinion, I considered the following:

1. Time to evaluation: It is my opinion that Ms. Edmo's time to evaluation of her reported gender issues was well within acceptable standards. From available records, it appears that less than one month passed between her first documented request for evaluation of gender issues and her diagnosis, initially made by Dr. Scott Eliason. The timeline is as follows: On 06/01/2012, Ms. Edmo wrote an IDOC Offender Concern Form requesting to speak with healthcare staff about cross gender hormone medications and other issues related to reported Gender Identity Disorder. This concern form was stamped as having been received on 06/04/2012. She submitted additional, similar concern forms on 06/04/2012, 06/17/2012 ("I would like to understand why ISCI prison authorities are denying me proper medical treatment for my gender identity disorder. I have concerned this issue a number of times, put in HSR requests, but it seems to me that ISCI authorities are just being deliberately indifferent to my serious medical need in violation of the USA constitution, 8th amendment"), and 06/17/2012 (a second concern form on this date). Several Health Services Request forms were also received around that time, with the first mention of gender issues occurring on an HSR dated 06/04/2012. Of note, Ms. Edmo had been seen by Physician's Assistant Karen Barrett on 05/04/2012 and discussed issues with anxiety and depression, but documentation from this encounter

[1] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

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does not indicate that Ms. Edmo reported any gender issues at that time. On 06/25/2012, Ms. Edmo was evaluated by Dr. Scott Eliason in response to her reported gender identity issues, and was diagnosed with Gender Identity Disorder (GID). Dr. Eliason's note indicates that Ms. Edmo "said he thinks a lot of his mood problems and suicide attempts in the past were because of his unhappiness over his male gender." Dr. Eliason concluded, "In my opinion he meets criteria for GID. His subjective report and feminine demeanor would be consistent with this. Also his dysphoria relating to his gender is consistent with GID." Per policy, Ms. Edmo was subsequently transferred to Idaho Maximum Security Institution (IMSI) for the purpose of evaluating her gender issues and clarifying her diagnosis. She was evaluated by Dr. Claudia Lake, Psy.D. on 07/19/2012, who confirmed her GID diagnosis.

2. Diagnostic process: Dr. Gorton's declaration dated 05/29/2018 notes, "Prior to Ms. Edmo's first appointment with Dr. Alviso in 2016, her medical records contain no real transgender history ... I saw no notes prior to Dr. Alviso's 12/14/16 evaluation that had anything resembling a transgender history. Without knowing Ms. Edmo's history (e.g. how long she has experienced dysphoria, the focus and severity of her dysphoria, exacerbating and mitigating effects, whether she has social support, how she manages stress, the steps she has taken to transition, further medical and family history, etc.), it would be impossible to provide safe and effective care." It is my opinion that the diagnostic process used in evaluating Ms. Edmo's report of gender dysphoria met acceptable standards. The Standards of Care, Version 7 (SOC7), authored by the World Professional Association for Transgender Health (WPATH) notes that the evaluation of gender dysphoria in adults includes "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."[2] These factors were initially explored by Dr. Eliason on 06/25/2012, less than one month after Ms. Edmo submitted her first request to discuss her gender, and expanded upon by Dr. Lake in her GID clarification evaluation on 07/19/2012. Dr. Lake also attempted to gather collateral information from Ms. Edmo's mother, but had not received a return call as of when she completed her report. Ms. Edmo's case was discussed by the Management Treatment Team Committee (MTC) on 08/23/2012, and her gender identity history was again reviewed, in the presence of the Health Services Director and the Director of Nursing. As is standard practice in a prison setting, mental health and medical professionals work together to evaluate and address medical needs, and have access to documentation across disciplines. I disagree with Dr. Gorton's declaration that Ms. Edmo's gender concerns were not properly evaluated.
3. Time to treatment: It is my opinion that Ms. Edmo was provided cross-gender hormone therapy in a timely fashion once she received a diagnosis of GID. Ms. Edmo's case was

[2] E. Coleman, W. Bockting, M. Botzer, P. Cohen-Kettenis, G. DeCuypere, J. Feldman, L. Fraser, J. Green, G. Knudson, W. J. Meyer, S. Monstrey, R. K. Adler, G. R. Brown, A. H. Devor, R. Ehrbar, R. Ettner, E. Eyler, R. Garofalo, D. H. Karasic, A. I. Lev, G. Mayer, H. Meyer-Bahlburg, B. P. Hall, F. Pfaefflin, K. Rachlin, B. Robinson, L. S. Schechter, V. Tangpricha, M. van Trotsenburg, A. Vitale, S. Winter, S. Whittle, K. R. Wylie & K. Zucker (2012) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, International Journal of Transgenderism, 13:4, 165-232, DOI: 10.1080/15532739.2011.700873.

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initially discussed in a meeting of the MTC on 08/23/2012, approximately one month after her confirmatory evaluation with Dr. Lake. The MTC's recommended management plan included evaluation by a physician for suitability for hormone therapy within 30 days and clinician contact twice per week. According to records, Ms. Edmo's initial cross-gender hormone therapy was first ordered one week later, on 08/30/2012. The Endocrine Society Clinical Practice Guideline in effect at that time (published in 2009) followed the requirement described in WPATH's 6th version of the Standards of Care (SOC6) that adults applying for hormone treatment and surgery satisfy both eligibility and readiness criteria, which were stricter standards than those found in the SOC7 published in 2011. Eligibility criteria listed in these 2009 practice guidelines included a) fulfill DSM-IV-TR or ICD-10 criteria for GID or transsexualism, b) do not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment, c) demonstrate knowledge and understanding of the expected outcomes of hormone treatment, as well as the medical and social risks and benefits; and d) have experienced a documented RLE (real-life experience) of at least 3-month duration OR had a period of psychotherapy (duration specified by the MHP after the initial evaluation, usually a minimum of 3 months). The practice guidelines also listed required readiness criteria before cross-sex hormone treatment as a) has had further consolidation of gender identity during a RLE or psychotherapy, b) has made some progress in mastering other identified problems leading to improvement or continuing stable mental health, and c) is likely to take hormones in a responsible manner. The SOC7 removed the readiness requirements and eliminated the recommendation for the RLE prior to hormone treatment, but the endocrine society did not update their guidelines until 2017 to reflect this. It is my opinion that the speed with which Ms. Edmo was evaluated for and provided cross-gender hormone therapy was rather progressive for the time, and would still be within reasonably accepted standards today.

4. Other treatment considerations: In forming my opinion regarding the Corizon psychiatrists' management regarding Ms. Edmo's request for gender confirmation surgery (GCS), I considered many factors including WPATH SOC, evidence to support the benefits of GCS and limitations of available studies, additional publications regarding GCS, and Ms. Edmo's unique factors contributing to the likelihood of positive or negative outcomes following such surgery. This issue is discussed in greater detail below.

<u>Consideration of Ms. Edmo's Hormone Treatment</u>

My opinion regarding Ms. Edmo's cross-gender hormone treatment is based on my experience in evaluating gender dysphoric individuals for referral for hormone therapy, working on teams with other medical providers managing and prescribing cross-gender hormone therapy, attending a WPATH conference entitled "Transgender Health: Best Practices in Medical and Mental Health Care" in Atlanta, GA in January of 2016, and ongoing review of the literature and treatment guidelines on this topic.

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KEELIN GARVEY, MD, CCHP

Male-to-female Cross-Gender Hormone Regimen: General Concepts

The Endocrine Society Clinical Practice Guideline published in 2009[3] notes, "Most published clinical studies report the use of an antiandrogen in conjunction with an estrogen." Spironolactone's antiandrogen properties are described as working "by directly inhibiting testosterone secretion and by inhibiting androgen biding to the androgen receptor." The guideline indicates that Estrogen can be given orally as conjugated estrogens, or 17β-estradiol, as transdermal estrogen, or parenteral estrogen esters. In the Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, published by the Center for Excellence for Transgender Health in June 2016, 5-alpha reductase inhibitors including finasteride are mentioned as a "common approach" to androgen blockade in cross-gender hormone treatment. These guidelines note that finasteride "blocks 5-alpha reductase type 2 and 3 mediated conversion of testosterone to the potent androgen dihydrotestosterone." The guidelines further note that "Since these medications block neither the production nor action of testosterone, their antiandrogen effect is less than that encountered with full blockade," but that 5-alpha reductase inhibitors "may be a good choice for those unable to tolerate, or with contraindications to the use of spironolactone." Regarding progestogens, these guidelines state, "There have been no well-designed studies of the role of progestogens in feminizing hormone regimens. Many transgender women and providers alike report an anecdotal improved breast and/or areolar development, mood, or libido with the use of progestogens. There is no evidence to suggest that using progestogens in the setting of transgender care are harmful. In reality some patients may respond favorably to progestogens while others may find negative effects on mood."

Ms. Edmo's Cross-Gender Hormone Therapy

On 08/29/2012, following two separate evaluations to verify Ms. Edmo's diagnosis of Gender Dysphoria and the multidisciplinary discussion at the MTC meeting on 08/23/2012, Ms. Edmo was seen by medical provider Dr. Catherine Whinnery, MD. Dr. Whinnery prescribed Estrace 0.5 mg twice daily and spironolactone 25 mg twice daily, consistent with endocrine society guidelines of combining estrogen therapy with antiandrogen medication. On 12/03/2012, Dr. Whinnery wrote a medical memo so that Ms. Edmo was authorized to wear a bra. Dr. Whinnery's note indicates that Ms. Edmo had questions about her medications, and that she answered Ms. Edmo's questions. On 03/26/2013, Dr. Whinnery quotes Ms. Edmo as stating, "I am doing pretty good," and indicates Ms. Edmo was experiencing some breast development. Dr. Whinnery increased Ms. Edmo's spironolactone and changed her estratab to estradiol. Dr. Whinnery's 07/01/2013 note indicates that Ms. Edmo had been started on finasteride (Proscar) in the interim, and was "happy" with this, and not having issues with her medication. Subsequent notes reflect additional adjustments in Ms. Edmo's hormone medication regimen and doses in response to her feedback and requests. In the interest of brevity, I will not discuss each change here. In 2016, Ms. Edmo was referred for an evaluation with community-based

[3] Wylie C. Hembree, Peggy Cohen-Kettenis, Henriette A. Delemarre-van de Waal, Louis J. Gooren, Walter J. Meyer, Norman P. Spack, Vin Tangpricha, Victor M. Montori; Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Volume 94, Issue 9, 1 September 2009, Pages 3132–3154.

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physician Dr. Marvin Alviso, who made additional recommendations regarding her hormone regimen and has remained involved in Ms. Edmo's care since that time. Dr. Alviso also provided training to Corizon staff on 06/24/2016 entitled "Transgender Medicine."

The plaintiff's experts have voiced disagreement with the management of Ms. Edmo's cross-gender hormone treatment. In his declaration dated 05/29/2018, Dr. Gorton opines that IDOC and Corizon clinicians "failed to monitor the effect of HRT on her underlying condition." He notes that on several occasions, Ms. Edmo's laboratory values pertaining to her hormone therapy were incorrectly interpreted. While I agree with Dr. Gorton's statement that the provider (signature illegible) who indicated on 09/04/2015 that "normal female testosterone ranges from 230-189 in healthy 30 year old nonsmoker, moderate exercise" was incorrect, it is my opinion that this did not impact her treatment in a clinically significant way. Practitioner's Orders from that time period indicate that multiple changes were made to Ms. Edmo's hormone regimen over the following months, including an increase in estradiol from 3 to 4 mg on 10/09/2015 and an increase in spironolactone from 100 mg to 125 mg twice daily on 12/23/2015. It does not appear that this unknown provider's incorrect interpretation caused a significant change in the treatment plan or negatively impacted Ms. Edmo's hormone regimen to a clinically significant degree.

Dr. Gorton's strong disapproval of the way Ms. Edmo's laboratory values were interpreted invites a brief discussion of published guidelines regarding interpretation of laboratory values for cross-gender hormone therapy. The Endocrine Society guidelines "suggest" regular clinical and laboratory monitoring every three months during the first year of treatment, and then once or twice yearly. The Endocrine Society Guideline uses the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) method of weighing evidence, and indicates that this recommendation regarding lab monitoring is a "weak recommendation" based on "low quality" evidence, acknowledging that there is no evidence-based consensus regarding the appropriate laboratory monitoring schedule.

Similarly, the guidelines published by the Center of Excellence for Transgender Health in 2016 indicate that monitoring of hormone levels in response to cross-gender hormone therapy is not an exact science. These guidelines state that while physiologic hormone levels in non-transgender people are used as reference ranges, "the interpretation of hormone levels for transgender individuals is not yet evidence based." These guidelines discuss several different but acceptable approaches to the titration of estrogens and antiandrogens, and the authors state their belief that the Endocrine Society's guidelines recommending hormone level monitoring every three months are "not realistic and not likely to add value once a stable dosing has been achieved." The Center for Excellence's guidelines cite "a prospective study of transgender women taking 4 mg/day divided dose oral estradiol or 100 mcg transdermal estradiol, plus 100-200 mg/day divided dose spironolactone found that all women achieved physiologic estradiol levels, though only 2/3 of the women achieved female range testosterone levels." As of 10/09/2015, Ms. Edmo was receiving 4 mg per day of estradiol and 200 mg per day of spironolactone. The authors also note, "Once hormone levels have reached the target range for a specific patient, it is reasonable to monitor levels yearly, or only as needed as

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described below. As with other situations involving maintenance of hormone therapy (menopause, contraception), annual visits are sufficient for transgender women on a stable hormone regimen." Regarding specific monitoring of estradiol levels, the Center for Excellence's guideline notes that the Endocrine Society's 2009 guideline's recommendation to maintain estradiol levels at the mid-cycle range for non-transgender women is "based on expert opinion only and may be overly conservative, and hormone levels are often not easy to tightly control." This guideline further states, "There is no evidence that higher estradiol levels in patients with adequate androgen suppression results in additional feminization or breast development."

At the time of my evaluation, Ms. Edmo reported that her cross-gender therapy had "helped me mentally ... more a clearing of my mind," and noted she had experienced physical changes including weight loss, breast growth, a decrease in skin oiliness, a change in body odor, and changes in fat distribution. She indicated that an increase in estrogen and the addition of progesterone by Dr. Alviso had not resulted in much additional change, other than "like a mental clearness" and modest additional breast growth. When asked about her overall satisfaction with cross-gender hormone treatment, Ms. Edmo stated "I feel it's maintenance ... for me I feel like I've hit the most I'll ever get from the hormones. She reported feeling "content" but not satisfied with her response to hormone therapy, and stated, "I think the treatment plan I'm on now ... it's pretty much the same as I would get outside of prison," clarifying that by "treatment plan," she was referring solely to her hormone regimen. She indicated that she was prescribed estradiol 4 mg twice daily, spironolactone 50 mg twice daily, and finasteride 10 mg daily at the time of our evaluation. She reported having stopped medroxyprogesterone due to weight gain and fatigue, and said that she had restarted spironolactone in mid-June 2018 and felt "a lot better," with a decrease in skin oiliness and a "gritty" sensation she had experienced when not taking it.

Evaluation of the Medical Necessity of Gender Confirmation Surgery for Ms. Edmo

It is my opinion, with reasonable medical certainty, that gender confirmation surgery *is not* medically necessary for Ms. Edmo at this time. As discussed further below, it is my opinion that WPATH SOC provide a useful guideline on which to base decisions regarding transgender care, but do not override professional judgment. It is my opinion that experienced medical and mental health professionals can apply the SOC while also exercising their own professional judgment. Accordingly, it is my opinion that GCS is not medically necessary for Ms. Edmo at this time because she has not met the criteria as outlined by WPATH's Standards of Care version 7 for undergoing vaginoplasty surgery. The following evidence supports my opinion:

The WPATH SOC list the criteria for approval for vaginoplasty as follows:

1. Persistent, well documented gender dysphoria
2. Capacity to make a fully informed decision and to consent to 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

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6. 12 continuous months of living in a gender role that is congruent with their gender identity

Ms. Edmo meets criteria 2, 3 and 5, and further discussion is not needed on these topics. She is over 18 years old, demonstrates no evidence that her medical decision-making capacity is impaired, and has been taking cross-gender hormones for more than 12 continuous months. Criteria 1, 4, and 6 are not fully met, and will be discussed below.

Gender confirmation surgery: a review of the evidence

There is no doubt that gender confirmation surgery is a highly-effective, life-changing procedure or set of procedures for many individuals with gender dysphoria, and the discussion below is not intended to dispute the validity of this treatment option in general terms. Dr. Ettner's report outlines some of the positive literature supporting gender confirmation surgery and its beneficial effects on severe gender dysphoria. However, she does not provide a balanced overview of the limitations of these studies or discuss the patient-specific factors that have been found to positively or negatively affect postoperative outcomes. She also fails to acknowledge publications challenging the quality of these studies or of the body of evidence published regarding surgery. Examples include the following:

1. In her report, Dr. Ettner indicates that Medicare's policy barring coverage for transition-related surgeries was overturned in May of 2014. In follow-up, in December of 2015 the Centers for Medicare & Medicaid Services (CMS) accepted a formal request from a beneficiary to initiate a national coverage analysis (NCA) for gender reassignment surgery, and CMS undertook a thorough review of the evidence to determine whether or not gender reassignment surgery would be covered nationally.[4] CMS opined:

> Based on a thorough review of the clinical evidence at this time, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria. There were conflicting (inconsistent) study results – of the best designed studies, some reported benefits while others reported harms.

CMS found the quality and strength of evidence to be low "due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding (a situation where the association between the intervention and outcome is influenced by another factor such as a co-intervention), small sample sizes, lack of validated assessment tools, and considerable lost to follow-up."

CMS also questioned the generalizability of positive study results, both to the Medicare (generally older) population and other potentially less ideal candidates:

[4] https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282

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> Much of the available research has been conducted in highly vetted patients at select care programs integrating psychotherapy, endocrinology, and various surgical disciplines and operating under European medical management and regulatory structures ... CMS strongly encourages robust clinical studies with adequate patient protections that will fill the evidence gaps delineated in this decision memorandum.

In reaching these conclusions, CMS cites limitations of the available evidence, including that most studies were observational, non-longitudinal, or did not include concurrent controls or testing prior to and after surgery. Positive results were noted to have less strength and confidence due to design flaws. CMS identified six studies that were assessed as being done sufficiently well to provide useful information, and found that "the four best designed and conducted studies that assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies did not demonstrate clinically significant changes or differences in psychometric test results after GRS." They opined:

> We believe at minimum study designs should have a pre-test/post-test longitudinal design accompanied by characterization of all patients lost to follow-up over the entire treatment series as well as those patients who did not complete questionnaires, and the use of psychometric quality-of-life tools which are well validated with linkage to "hard" (objective) patient outcomes in this particular patient population.

In regard to the WPATH SOC, the discussion regarding this NCA indicates that "several commenters suggested that CMS should recommend the WPATH Standards of Care as the controlling guideline for gender reassignment surgery. They asserted it could satisfy Medicare's reasonable and necessary criteria for determining coverage on a case-by-case basis." CMS responded:

> Based on our review of the evidence and conversations with the experts and patient advocates, we are aware that some providers consult the WPATH Standards of Care, while others have created their own criteria and requirements for surgery, which they think best suit the needs of their patients. As such, and given that WPATH acknowledges the guidelines should be flexible, we are not in the position to endorse exclusive use of WPATH for coverage. The MACs, Medicare Advantage plans, and Medicare providers can use clinical guidelines they determine useful to inform their determination of whether an item or service is reasonable and necessary. When making this determination, local MACs may take into account physician's recommendations, the individual's clinical characteristics, and available clinical evidence relevant to that individual.

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2. The American Psychiatric Association (APA) published a report of the APA Task Force on Treatment of Gender Identity Disorder in 2012.[5] This task force was charged "to perform a critical review of the literature on the treatment of Gender Identity Disorder at different ages and to present a report to the Board of Trustees," for the purpose of determining whether or not there is "sufficient credible literature to support development by the APA of treatment recommendations for GID." The authors conclude, "The quality of evidence pertaining to most aspects of treatment in all subgroups was determined to be low; however, areas of broad clinical consensus were identified and were deemed sufficient to support recommendations for treatment in all subgroups," indicating that an APA practice guideline should, in fact, be developed. The authors also acknowledge factors that have been shown in the literature to be associated with poor outcomes and/or regret:

> Interviews with subjects who express substantial regret following genital reassignment surgery, and related case reviews, have identified several correlates of regret. These include: inadequate diagnosis of major pathology (e.g., psychosis, personality disorder, alcohol dependency), misdiagnosis, absence of or a disappointing real-life experience, and poor family support.

3. In her report, Dr. Ettner quotes the Endocrine Society's Clinical Practice Guideline from 2009: "For many transsexual adults, genital sex reassignment surgery may be the necessary step towards achieving their ultimate goal of living successfully in their desired gender role." In the updated version of these guidelines, published in November of 2017[6] and co-sponsored by WPATH, the discussion of the evidence to support gender confirmation surgery is expanded. In this latest version, the authors discuss the positive studies but also acknowledge that there are gaps in knowledge, and that not all of the data is positive, noting "Several postoperative studies report significant long-term psychologic and psychiatric pathology." In this latest version of the guidelines, the authors also acknowledge the possibility of regret and the need for better research:

> Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future 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.

4. Dr. Ettner quotes a 2005 study by Smith et al as concluding that "after surgery there was 'a virtual absence of gender dysphoria' in the cohort and 'results substantiate previous

[5] Byne, W., Bradley, S.J., Coleman, E. et al; Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. Arch Sex Behav (2012) 41: 759.

[6] Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, Guy G T'Sjoen; Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903

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conclusions that sex reassignment surgery is effective.'" While these quotes are accurate, the study's authors also emphasize that the study's purpose was two-fold; to investigate both the outcomes of sex reassignment and the prediction of favorable or poor outcomes. They listed several factors as being associated with poor outcomes, including greater psychopathology, non-homosexual orientation (with "homosexual" defined as sexual attraction to one's own natal gender), physical appearance, and inconsistencies in report of past and present gender dysphoria. Applying these findings to Ms. Edmo specifically, her risk factors include her degree of psychopathology and inconsistencies in her reported gender dysphoria history. Dr. Ettner emphasizes Ms. Edmo's degree of psychopathology in her argument in favor of gender confirmation surgery, but the Smith study actually cites psychopathology as a risk factor for poor outcomes. The study also included both male-to-female and female-to-male individuals, with the authors noting, "Comparing the sexes, the FMs showed better results, supporting the results of earlier studies," indicating that the study results may not have been quite as favorable if the sample was comprised entirely of male-to-female individuals.

5. Dr. Ettner also cites a study from Monstrey et al in 2007 in support of gender confirmation surgery. In a 2009 review of the literature on follow-up studies of gender confirmation surgery, also authored by Monstrey et al, the authors acknowledge a "lack of randomized clinical trials or high-quality follow-up studies on large numbers of operated transsexuals." They conclude:

> Because the literature shows a lack of randomized clinical trials or high-quality follow-up studies on large numbers of operated transsexuals, it offers no evidence-based research above evidence level B or C. Some minor recommendations can be made at the re-writing of seventh version of the *Standards of Care* of WPATH, but although they seem intuitively appropriate, they are more based on expert opinion without explicit critical approval from peer-reviewed literature.

It is my opinion that the poor quality of studies investigating GCS should not be used to deny the effectiveness or medical necessity of this treatment for the appropriate candidate. The high satisfaction rates reported in many studies attest to the safety and effectiveness of this intervention for the appropriate candidate. However, social factors that lead an individual to be lost to follow-up, and therefore not included in analysis of outcomes in these positive studies, are likely common in individuals like Ms. Edmo, and many gender dysphoric individuals who find themselves incarcerated.

Criterion 1: Persistent, well documented gender dysphoria

As discussed above, it is my opinion that Ms. Edmo meets criteria for Gender Dysphoria, but there are significant inconsistencies in her reporting that cast doubt on the veracity of her self-report. Ms. Edmo told me that she was not aware of the concept of being transgender until she met a transgender peer at Bannock County Jail while awaiting adjudication of her current

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charges. However, she did state that she lived as a woman for years prior to her incarceration. Records have been reviewed from prior to her current incarceration and include the following:

1. North Idaho Correctional Institution (NICI): Ms. Edmo participated in the court-ordered Retained Jurisdiction Program at NICI from 02/08/2010 until 06/21/2010, at which time she was released on probation. Ms. Edmo's presentence report dated 11/23/2011 indicates that she was successful and earned positive reviews. She was noted to have "a very positive attitude" and was called "a very positive role model for other offenders." The report also indicates that she reported having "suffered from extreme depression and anxiety since he [sic] was placed on probation," and that she explained her past suicide attempts as occurring "because he was feeling upset about his past failed relationships, and he was having problems dealing with his family and alcohol problem." The report also indicated that Ms. Edmo reported he abused alcohol "because he was struggling to tell his family that he's homosexual." Ms. Edmo's 2011 explanation for her past depression and suicide attempts involved relationship stress, alcohol abuse, and her family's unwillingness to accept her sexual orientation and did not include any mention of gender issues. I did not find any discussion of Ms. Edmo's report of gender identity issues in these records, nor did these records contain any description of a feminized appearance or of dressing/presenting as a female. Male pronouns were used throughout the records.
2. Portneuf Medical Center records dated 08/05/2010-08/07/2010 and 05/16/2011-05/19/2011 (provided in response to subpoena): Ms. Edmo was admitted to PMC on 08/05/2010 following a suicide attempt by cutting her arm, and again on 05/16/2011 following a suicide attempt by overdose on amitriptyline while intoxicated. She reported at the time of these admissions that her suicide attempts were triggered by relationship issues, feelings of guilt and worthlessness, not having a job or being able to find a job, financial and legal struggles, and heavy alcohol use. I did not find any discussion of Ms. Edmo's report of gender identity issues during these two admissions. Male pronouns were used consistently throughout the records, and she was repeatedly referred to as a "gentleman." A psychiatric evaluation dated 08/05/2010 following Ms. Edmo's suicide attempt by cutting her arm included a physical description of "a 22-year-old Native American guy who has colored top of his head in a lighter color. He has painted nails." Ms. Edmo's painted nails do not appear to have been accompanied by other evidence of feminization, however, as her list of belongings on that date does not appear to include any feminine clothing: "1 brown long sleeve shirt, 3 white t-shirt [sic], 1 pair brown flip-flops, 3 pair white underwear, 1 pair blue sleeping pants, 1 brown short sleeve t-shirt, 1 black t-shirt, 2 pair khaki shorts, 1 pair black shorts, white Adidas shoes."
3. Shoshone-Bannock Tribe Counseling & Family Services Records dated 11/26/2003-07/14/2011 (provided in response to subpoena): Ms. Edmo missed an appointment scheduled on 11/26/2003 that had been scheduled in follow-up to an "apparent overdose." She missed another appointment on 12/17/2009, and then presented for a screening for alcohol and drug abuse on 07/19/2010, but missed her next four scheduled appointments on 08/13/2010, 08/19/2010, 09/30/2010, and 04/13/2011. She next presented on 05/19/2011, following her admission to Portneuf Medical Center

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for an overdose. She missed or canceled several subsequent appointments. I did not find any discussion of Ms. Edmo's report of gender identity issues in these records, nor did these records contain any description of a feminized appearance or of dressing/ presenting as female. Male pronouns were used throughout these records.

4. Not-Tsoo Gah-Nee Indian Health Service records 12/02/2008-06/01/2011: Ms. Edmo presented to IHS for various medical issues during this time period. I did not find any discussion of Ms. Edmo's report of gender identity issues, nor did these records contain any description of a feminized appearance or of dressing/presenting as a female. Male pronouns were used consistently throughout the records.
5. Psychosexual Evaluation by Dr. Linda Hatzenbuehler, Ph.D., dated 11/14/2011: This evaluation was court-ordered following Ms. Edmo's guilty plea to the charge of Sexual Abuse of a Minor Under the Age of 16. Dr. Hatzenbuehler indicated that Ms. Edmo "approached the psychosexual testing with a tendency to present himself in a socially desirable light. However, his results were valid and interpretable." She noted that Ms. Edmo was "cooperative and open about his perpetration." Dr. Hatzenbuehler described Ms. Edmo's appearance, "Mr. Edmo appeared to be a 23-year-old, Native American male." She stated, "He denied ever cross-dressing," and reported that Ms. Edmo said he masturbated once or twice every two or three weeks. She also reported that Ms. Edmo had had sexual contact with two females in the past.
6. Ms. Edmo's IDOC identification photographs taken on 01/07/2010 and on 04/27/2012 do not demonstrate any observable evidence of feminization. Although the back of Ms. Edmo's hair is not visible in the photograph dated 04/27/2012, both photographs appear to show Ms. Edmo with very short hair and ungroomed eyebrows. The first sign of a feminized appearance can be seen in the photograph dated 08/14/2013, in which Ms. Edmo's hair has grown out slightly and her eyebrows are thinner. In contrast, Ms. Edmo's photographs from 12/10/2014 show a markedly more feminized appearance, with long curly hair, well-groomed eyebrows and possible makeup (difficult to discern in photocopied black-and-white photographs). When I asked Ms. Edmo in my interview whether she had ever had short hair, she said that she had not, but then when I asked her again, she indicated that she had been made to shave her head at the NICI program. From the available records, it appears that Ms. Edmo was in the NICI program from 02/08/2010 through 06/21/2010. This does not clearly explain why her hair was short on 01/07/2010 (before she arrived at the program) or on 04/27/2012 (when she arrived in prison on her current charge).

In addition to the inconsistencies listed above, Ms. Edmo's report to me that she was not aware of the concept of being transgender until she was detained at Bannock County Jail on her current charge and met another transwoman differs markedly from her report to Dr. Gorton as noted in his declaration dated 05/29/2018:

> By early adulthood, she had learned that there were other transgender people and that she could obtain a diagnosis regarding her gender dysphoria and obtain medical and surgical treatments to alter her body to better reflect her gender identity. She reports wanting to get HRT and SRS but that "I knew that was a lengthy process," and her intent

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> to transition was interrupted both by her difficulty organizing herself due to concurrent substance abuse as well as eventually being imprisoned. She does report that a psychiatrist she had seen through the Indian Health Service mentioned the possibility of getting a diagnosis related to gender dysphoria and said that if she wanted treatment, they would have to send her to a specialist.

I was not able to find a record from a psychiatrist at IHS supporting Ms. Edmo's above statements. As noted above, my discussion with Ms. Edmo about past treatment for gender dysphoria yielded different information:

> Ms. Edmo was asked whether she had ever sought or received treatment for gender dysphoria prior to her incarceration. She reported that she did not understand what it meant to be transgender until she entered county jail on the controlling charge and met a transgender woman. She recalled having been "labeled as a gay man" previously, explaining that this did not completely resonate with her but she did not know there was an alternative explanation to how she felt. She recalled knowing bisexual and homosexual peers, but never anyone else who identified as transgender. She stated that she remembered feminized men on her Indian Reservation, but she never spoke to them about their gender identity and now realizes they may have been transgender.
>
> Ms. Edmo indicated that a transgender detainee at Bannock County Jail befriended her in 2011 and advised her to seek contact with mental health professionals and physicians at the jail so she could request cross-gender hormone treatment. She said that prior to meeting this individual, she did not really know what it meant to be transgender, and had never heard of cross-gender therapy. However, at another point in the interview she reported that she had started to discuss her gender identity with a correctional professional at the diversion program in 2009 but that she had been told "just not to mention it," so she never brought it up again.

Ms. Edmo's reported history does not match her records, and the reasons for this are known only to Ms. Edmo. There are many reasons that an individual with Gender Dysphoria might have to not dress in his/her preferred gender role, including fear of social rejection and lack of family acceptance. Gender Dysphoria can also arise later in life, or individuals with early realization of gender incongruence may not acknowledge or become fully aware of their gender dysphoria until years later. However, this is not the history Ms. Edmo provided; she indicated that despite her lack of awareness of Gender Dysphoria as a diagnosis, she was living as a woman in the community and presenting herself in a feminized fashion. The records listed above do not support this history. I did not have the records listed above prior to my evaluation of Ms. Edmo, and therefore did not have the opportunity to discuss these inconsistencies with her or ask for clarification. I have not seen documentation indicating that the plaintiff's experts reviewed the records listed above or sought to clarify these discrepancies with Ms. Edmo. While these inconsistencies do not "prove" that she does not have Gender Dysphoria, they represent important areas of exploration that should be considered prior to recommending irreversible surgery.

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Ms. Edmo's report of her family's acceptance of her lifelong attraction to men (which she initially identified as homosexuality) has varied. As noted above, Ms. Edmo's presentence report from 2011 indicates that she stated she was abusing alcohol regularly "because he was struggling to tell his family that he's homosexual." In my interview, Ms. Edmo appeared to minimize this difficulty and stated that her family and the Native American community did not question or condemn her reportedly feminized appearance and behavior. She also said that her mother asked if she liked girls when she was 14 years old, and that her mother accepted her answer readily. Similarly, Ms. Edmo's psychosexual evaluation from November 2011 notes that Ms. Edmo has "always been very comfortable with his sexuality, and he has lived in an environment that is accepting of it."

Because of the inconsistencies in her reporting, I considered sources of secondary gain that may drive Ms. Edmo's report of gender dysphoria. Her records indicate she is required to register as a sex offender, so a change in her identity may be desirable. She asked about changing her gender identity to female on the Static-99, an actuarial risk assessment instrument designed for use with adult male offenders, which may be interpreted as an effort to decrease her overall risk projection. However, I did not find evidence that either of these issues have been areas of focus for Ms. Edmo, and can therefore not conclude that Ms. Edmo is intentionally misleading her treatment providers for the purpose of impacting her legal status. Notwithstanding the reasons for the inconsistencies above, it is important that Ms. Edmo be forthcoming and transparent about her history with her treatment providers, as poor engagement with treatment providers has been associated with worse outcomes following surgery.[7]

Criterion 4: Medical/Mental health concerns must be well controlled
It is my opinion, with reasonable medical certainty, that Ms. Edmo's persistent self-injurious behavior indicates that her mental health concerns are not well controlled. As of the date of my interview, Ms. Edmo indicated that she had been cutting herself without suicidal intent, as recently as one month earlier. Regardless of the reported trigger for her self-injurious behavior, mental health and medical professionals generally consider self-injurious behavior to be a maladaptive coping strategy that indicates that mental health concerns are not well controlled.

Ms. Edmo has also consistently reported chronic intermittent urges to castrate herself, and has engaged in two such attempts. Dr. Ettner refers to Ms. Edmo's two episodes of auto-castration as "surgical self-treatment." This term appears in Dr. George Brown's 2010 article reporting on "a case series of four inmates who engaged in attempted or completed surgical self-treatment of their gender dysphoria via autocastration, autopenectomy, or a combination in the absence of concomitant psychosis, intoxication, or other comorbidities that could reasonably account for this rare behavior." Dr. Brown notes that these behaviors "occurred in the context of

[7] P.T Cohen-Kettenis, L.J.G Gooren, Transsexualism: A review of etiology, diagnosis and treatment, Journal of Psychosomatic Research, Volume 46, Issue 4, 1999, Pages 315-333.

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persistent denials of access to transgender health care in prison settings."[8] Dr. Gorton expands on this discussion to distinguish Ms. Edmo's attempts at autocastration from nonsuicidal self-injury (NSSI) done for the purpose of inflicting pain leading to emotional relief. He opines that self-surgery is a "health-seeking action." While I agree with Dr. Gorton's distinction—Ms. Edmo's attempts at autocastration differ from NSSI done for emotional relief by inflicting pain—Dr. Gorton's analysis does not acknowledge that there are other forms of self-injurious behavior that are commonly observed within the correctional environment. Self-injurious behavior within a prison or jail setting may indeed be driven by suicidal intent or by a desire to experience temporary emotional relief. It may also be manipulative in nature, a phenomenon that is well-known to experienced correctional health professionals. A 2008 article describes this as "self-mutilation through clearly planned strategies executed to manipulate desired environmental events."[9]

It is my opinion that even if the desired environmental event triggering her attempts at self-castration is truly orchiectomy/genital surgery, these incidents of self-injury should not be endorsed as "health-seeking" and should not be used as an argument in favor of gender confirmation surgery. The phenomenon of "surgical self-treatment" appears to be limited to the correctional environment, as there are few cases to be found of autocastration in the community in the absence of psychosis. Although access to appropriate transgender care has improved dramatically in recent years, it is unlikely that all individuals with severe genital anatomic gender dysphoria in the community have been able to access treatment to include orchiectomy/penectomy, thereby preventing their attempts to "surgically self-treat." This phenomenon, like several other forms of self-injury, appears to be uniquely related to the correctional environment, and not a common attribute of gender dysphoria proven to render an individual a good candidate for surgery. In my opinion, there is significant danger in referring to intentional self-harm in any form as "health-seeking," which is compounded by the plaintiff's experts' use of these gestures in support of Ms. Edmo's reported desire for surgery. The plaintiff's experts have not provided adequate evidence-based references to show that this form of "self-treatment" is later associated with positive surgical outcomes or with resolution of psychopathology following surgery, and using these incidents to support Ms. Edmo's case potentially reinforces this unsafe behavior.

Dr. Ettner further opines, "If Ms. Edmo does not receive gender confirmation surgery, she is at great risk of self-castration and other self-harm, including suicide." Cecilia Dhejne et al authored a commonly-cited cohort study of the long-term effects of gender confirmation surgery in Sweden in 2011.[10] The data available for this study provided the unique benefit of allowing interpretation of outcomes from all 324 sex-reassigned persons in Sweden from 1973-2003, and, unlike the majority of studies used to provide evidence in favor of gender

[8] George R. Brown (2010) Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder, International Journal of Transgenderism, 12:1, 31-39.
[9] Mario E. Martinez PsyD (1980) Manipulative Self-Injurious Behavior in Correctional Settings, Journal of Offender Counseling Services Rehabilitation, 4:3, 275-284.
[10] Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Långström N, Landén M (2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PLoS ONE 6(2): e16885.

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confirmation surgery, was not limited by loss to follow-up. The study matched sex-reassigned persons to random population controls matched by birth year and birth sex initially, and later by reassigned sex, and found that the overall mortality for sex-reassigned persons was higher during follow-up than for controls, particularly for death by suicide (19.1-times higher risk for completed suicide in the sex-reassigned population). It is important to note that in this study, sex-reassigned individuals were compared with general population controls, not with gender dysphoric individuals who did not undergo gender confirmation surgery. It is therefore incorrect to conclude that gender confirmation *causes* an increase in completed suicide rate. The authors conclude:

> Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behavior, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group.

There are a variety of follow-up discussions and interviews found in various locations, some involving the primary author, that protest the citation of this study as an argument against gender confirmation surgery. Likewise, this reference is notably absent in the reports of both of the plaintiff's experts. It is my opinion, however, that it would be irresponsible not to consider the findings in this study when weighing the medical necessity of GCS for a gender dysphoric individual, particularly in regard to suicide risk. Based on these findings, individuals who undergo genital confirmation surgery are at very high risk for completed suicide compared with the general population. I am not aware that the authors of this study or anyone else have reanalyzed the data to provide a direct comparison of post-operative gender dysphoric individuals with gender dysphoric individuals who have not undergone surgery. Such a study may indeed demonstrate that gender confirmation surgery reduces the risk of completed suicide in gender dysphoric individuals. The findings of this study should instead be used to raise awareness that gender confirmation surgery does not "cure" all gender dysphoric individuals of their suicidality, and that arguing for gender confirmation surgery as a means of managing or eliminating suicidality is not evidence-based.

Cynthia Osborne and Anne Lawrence[11] also argue against asserting the medical necessity of SRS on the grounds of treating suicidality or depression. They write:

> ... 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 ... 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,

[11] Osborne S. & Lawrence A. (2016). Male Prison Inmates With Gender Dysphoria: Wen Is Sex Reassignment Surgery Appropriate? *Archives of Sexual Behavior* 45(7): 1649-1663.

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> and these comorbid conditions do not significantly improve after SRS ... while SRS usually ameliorates GD and increases overall life-satisfaction, it appears to confer little or no additional improvement in other psychiatric symptoms ... 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 ... 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.

Criterion 6: 12 continuous months of living in a gender role that is congruent with gender identity

The WPATH SOC version 7 describes the rationale for this requirement:

> 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 in 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.
>
> 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.

While the description above outlines the rationale for this real-life experience, it does not provide guidance for its interpretation in the correctional environment. The authors of the

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Standards of Care likely did not intend for this criterion to exclude detained or incarcerated individuals from receiving gender confirmation surgery; however, they did assert by expert consensus that they believe it is important that an individual considering genital confirmation surgery be faced with all of the social situations and challenges mentioned above, and did not explain how this can or should be accomplished in a correctional environment. It is a simple fact that while incarcerated, an individual who will one day be released from prison is not able to fully experience the "real life" that he or she will face in the community. He or she cannot attend family events, holidays with family and friends, vacations, work or school outside of the correctional setting when incarcerated or detained. Because of these restrictions, it is my opinion that the "real-life experience" must be considered on a case-by-case basis.

It is my opinion, with reasonable medical certainty, that Ms. Edmo has not yet met this criterion for genital surgery. The Standards of Care specifically indicate that in some situations, health professionals may request verification that this criterion has been fulfilled, recognizing that the individual's self-report may not be sufficient. As discussed above, Ms. Edmo's available outside records do not support her claim of having lived as a female in the community, and her self-report of her experience to support having met this criterion can therefore not be verified with the information available at this time.

It is also my opinion that Ms. Edmo's life was ruled by alcohol and drug use prior to her incarceration, limiting the validity of any real-life experience she may have had. Her records from prior to entering prison indicate that she voiced recognition of the profoundly negative impact of her substance abuse on her ability to live a successful life. By her own admission, the years leading up to this incarceration involved Ms. Edmo moving from state to state "wherever the drugs were," leaving room for little else in her life. If she did indeed present herself as female during the months and years leading up to her crime, the information that could be gleaned from this experience would be seriously shadowed by her admitted lack of sober time prior to her arrest. It is my opinion that the real-life experience is not valid if it occurs in the presence of heavy substance abuse, which would mask appropriate emotional responses to the difficulties of social transition and not allow for the development of healthy coping strategies in preparation for permanent transition.

As the care and treatment of gender dysphoric and gender non-conforming individuals in custody have evolved in recent years, some states and the federal system have recently begun to house individuals according to their identified rather than natal gender. Although not specifically considered for the purpose of living the real-life experience, the possibility of transferring Ms. Edmo to a women's facility has been discussed and considered by the Management Treatment Committee on several occasions. Ms. Edmo requested a transfer to Pocatello Women's Correctional Center (PWCC) and this request was considered by the MTC on 03/02/2016. The MTC notes from this date indicate that Ms. Edmo's reported reason for this request was 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." The notes also indicate, "Edmo denied being fearful for safety and denied safety concerns of Edmo's own involving staff or inmates."

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The MTC concluded, "MTC discussed safety concerns that other inmates at PWCC may experience as a result of having a biological male be housed at PWCC," and cited IDOC policy 401.06.03.501 that "inmates shall be housed by their primary physical sexual characteristics." Of note, around the same time, Ms. Edmo had also requested to move out of the Behavioral Health Unit (BHU) at Idaho State Correctional Institution (ISCI) to general population at South Idaho Correctional Institution. The MTC concluded during the March 2016 meeting that Ms. Edmo must meet the established MTC housing requirements before moving out of the BHU, which she did not meet at that time due to having received three Class B DORs in the previous six months.

Ms. Edmo made another request to transfer to PWCC, to IDOC Chief Psychologist Dr. Campbell in 2017. This request was again considered by the MTC on 09/13/2017. The notes from this meeting indicate, "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." The MTC cites considerations including "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 [sic] resides in general population, and can be managed in a general population setting based on the inmate's security needs ... 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." The 02/07/2018 MTC notes indicate that Ms. Edmo was subsequently moved from one unit to another within ISCI "due to behavioral problems in Unit 11," and that "MTC noted that there are numerous verbal reports of Edmo's misbehavior, but this has not been documented in CIS."

As described above, in addition to citing IDOC policy in support of keeping Ms. Edmo in a male prison facility, the MTC's documentation also indicates that they considered this question on an individual basis and concluded that Ms. Edmo should not be transferred to a women's facility for security reasons. Specifically, the MTC cited Ms. Edmo's history of violence and sexual activity, and each of these factors will be discussed below.

Ms. Edmo reported to me that she had been denied parole as a result of being removed from several programs due to fights with a transgender peer over "catty, stupid stuff." Disciplinary Offense Reports (DORs) were reviewed for these incidents. On 06/20/2014, Officer D. Thornton writes, "I observed Offender Edmo strike another offender with open and closed hands during a fight occurring in the Unit 16 A Tier Dayroom." Ms. Edmo appealed the sanctions that resulted from this DOR but did not dispute the incident details. On 11/15/2015, Brittany Fisher writes, "As I rounded cell 06 I observed inmates Edmo #94691 and X (redacted) fighting. Edmo had X pushed up against the wall. Edmo was delivering body punches to X. I radioed the emergency

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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 ... Both inmates admitted to throwing punches." Although I have not seen documentation that Ms. Edmo has engaged in physical fighting since the second incident described above in November of 2015, it is my opinion that the severity of these incidents and that fact that according to Ms. Edmo, these incidents both involved a transgender female rather than a male inmate, should be taken into account when considering Ms. Edmo's placement.

The MTC also cited Ms. Edmo's history of sexual activity as a contraindication to her moving to a women's facility. There are numerous incident reports documenting that Ms. Edmo has been involved in sexual activity with multiple male inmates throughout her prison sentence. I have not come across an incident report that describes Ms. Edmo using her penis for penetration or other sexual activity, and Ms. Edmo consistently reports being attracted to men exclusively. However, in her psychosexual evaluation dated 11/14/2011, Dr. Hatzenbuehler indicates that Ms. Edmo reported having been involved in sexual activity with two women in the past. Unfortunately, Ms. Edmo's psychosexual evaluation became available to me only through the process of discovery, and I did not have it at the time of my evaluation of Ms. Edmo and therefore did not have the opportunity to ask for clarification or additional information about these encounters. It is notable that Ms. Edmo had also reported having been sexually involved with two women during a pre-polygraph interview around the same time. This warrants further exploration and should be considered in future discussions of a possible move to a women's facility. While these reported incidents may not be deemed to contraindicate Ms. Edmo from such a transfer, it is significant that Ms. Edmo has consistently denied any history of sexual involvement with women and this discrepancy must be investigated.

As standards evolve, and correctional systems begin to accumulate and share data on the optimal housing of transgender inmates within the correctional environment, it is my opinion that Ms. Edmo's treatment providers, along with IDOC, should consider whether Ms. Edmo can be safely placed in a women's facility for the purposes of beginning the real-life experience. While such a placement cannot truly approximate her "real life" once she completes her sentence in 2021 and enters the community, it might provide Ms. Edmo with an opportunity to disengage from her struggle with correctional officials regarding safe feminization in a male prison, and to feminize to a greater extent. Assuming that her reported lack of sexual interest in women is accurately-reported, it might also allow her to separate her female identity from sexual opportunity, and focus more fully on herself as female and less so on relationships and sexual activity. My evaluation of Ms. Edmo did not include a comprehensive violence risk assessment or sexual violence risk assessment and does not substitute for a careful assessment of any potential security concerns, however.

Alternative and supplementary approaches to treatment of GD

While the WPATH Standards of Care are widely distributed and generally accepted by many healthcare professionals treating gender dysphoric individuals, not everyone agrees that they should be the only set of guidelines used, particularly in the prison setting. As discussed above,

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CMS stated "we are not in the position to endorse exclusive use of WPATH for coverage" in response to stakeholder input during their National Coverage Analysis in 2016. CMS cited the lack of generalizability of available data to their unique Medicare population. It is my opinion that there is a similar lack of generalizability to the correctional population. In a 2016 article authored by Cynthia S. Osborne and Anne A. Lawrence and published in the Archives of Sexual Behavior, the question of sex reassignment surgery [sic] for natal male prisoners is directly discussed. Regarding the SOC, the authors write:

> ... 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. 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.
>
> 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 ...

While agreeing that prisons must make "reasonable efforts to provide medically necessary treatments, including SRS, to inmates," the authors contest the SOC's assertion that "all provisions of the SOC are applicable to all persons in prisons and other institutions":

> ... the unqualified statement that "all elements of assessment and treatment as described in the SOC can be provided to people living in institutions" does not reflect extensive clinical experience ... 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 circumstance of incarcerated persons in mind.

In their discussion of the process of determining the medical necessity of SRS for natal male inmates, Osborne and Lawrence emphasize the determination of medical necessity reflects the exercise of professional judgment, that SRS may be considered medically necessary for natal males when "their GD reflects intense distress about the incongruence between their external genitalia and their gender identity," and that "other grounds for asserting the medical necessity of SRS, such as treating suicidality or depression, are more problematic." The authors also argue that disputing the medical necessity of SRS in general is unsupportable, but note that regarding the literature in support of SRS:

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> 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.

Osborne and Lawrence propose modification of SOC eligibility requirements when considering the medical necessity of SRS for inmates. They opine that "additional or more stringent eligibility requirements for SRS can be imposed in certain circumstances," noting that some community clinics impose more stringent requirements. The authors write, "Because clinical experience with SRS in correctional settings is currently nonexistent, we believe that initially imposing additional eligibility requirements would be advisable," including:

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.

If these proposed requirements are applied to Ms. Edmo, she appears to clearly meet the fifth requirement as she has expressed interest in transfer to a women's prison. Her sentence is set to complete in July of 2021, so she appears to meet the second requirement as well. The other proposed criteria are not clearly met, however. Many of her disciplinary issues have surrounded her attempts to feminize, but she has also received DORs for physical fights, sexual activity, and unauthorized communication. She has not demonstrated the capacity to cooperate with providers and reported to me that she refuses to meet with her assigned clinician or attend recommended mental health groups. She reports prominent genital anatomic gender dysphoria, but her self-report does not appear reliable and must be explored further. Despite her report to me that she received no treatment for her gender issues outside of prison, she has not been willing to engage in psychotherapy to explore her gender identity and associated difficulties, appearing to equate any participation in therapy with efforts to dissuade her from identifying as female.

<u>Discussion of alleged negligence and deliberate indifference by Corizon:</u>
As discussed above, it is my opinion, with reasonable medical certainty, that Corizon and Corizon providers Scott Eliason, Murray Young and Catherine Whinnery have not been negligent in their treatment of Ms. Edmo. It is my opinion that her gender issues were evaluated promptly, that she was started on appropriate cross-gender hormone therapy relatively quickly, and that the management of her hormone therapy has not fallen below acceptable standards. I agree with Dr. Gorton's declaration that lab values have not always been interpreted properly, but as discussed further above, laboratory monitoring of cross-gender hormone therapy is not evidence-based at this time. In reviewing Ms. Edmo's orders

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and the trajectory of her hormone regimen treatment, I believe she has received appropriate medications at appropriate dosages.

Further, I disagree with the second amended complaint filed by Ms. Edmo alleging that defendants "failed to enact appropriate standards and procedures that would have prevented the harm that she has experienced." When private healthcare companies are contracted to provide care for inmates in prison settings, they generally agree to practice within correctional policies and procedures. It is my opinion that Corizon and its providers working within IDOC had and have an obligation to assess and treat Ms. Edmo's gender dysphoria in a clinically appropriate manner, to include proposing policy changes if they felt unable to provide medically necessary treatment under the ruling policy. As discussed above, there is very little evidence to dictate the exact provision of Gender Dysphoria care in correctional settings, however, and policies differ substantially around the country. On a positive note, many systems are sharing information via academic and professional conferences and consultation, and continuously updating their policies to expand the treatment options available to inmates with Gender Dysphoria. Likewise, it is recommended that IDOC continue to review and update the provisions of their Gender Dysphoria policy as indicated, to include consideration of housing by preferred gender when indicated and appropriate. While there will always be room for modifications as more data becomes available, it is my opinion that IDOC's current policy has not prevented Corizon's providers from exercising professional judgment in Ms. Edmo's treatment decisions.

Accordingly, it is my opinion, with reasonable medical certainty, that Corizon and its providers Dr. Scott Eliason, Dr. Catherine Whinnery and Dr. Murray Young were not deliberately indifferent to Ms. Edmo's medical and mental health needs. Deliberate indifference occurs when a professional knows of and disregards an excessive risk to an inmate's health or safety.[12] In Ms. Edmo's case, she reported gender concerns, was evaluated in a timely fashion and started on hormone therapy relatively quickly, and her treatment has been adjusted according to her response. Her providers did not determine that gender confirmation surgery is medically necessary for Ms. Edmo, but this was an exercise in professional judgment and not a demonstration of deliberate indifference. Despite Ms. Edmo's dissatisfaction with her treatment, I believe that the defendants' assessment and treatment of Ms. Edmo met reasonable standards, and did not demonstrate disregard of a risk to her health or safety.

Conclusions:

The plaintiff's experts have an abundance of experience treating gender dysphoric individuals in the community, and should be applauded for the work they have done to expand access to care for this population. It is my strong opinion, however, that decisions regarding the care and treatment of gender dysphoric individuals in the correctional environment must also be informed by long-term experience working within the correctional setting in a treatment capacity, and by participation in multidisciplinary meetings regarding the care and treatment of inmates. Consulting in a legal context is insufficient to establish correctional expertise. The brevity of SOC7's discussion of institutional environments and cursory recommendation to provide the same treatment inside the prison setting as one would receive outside reveals a

[12] *Farmer v. Brennan*, 511 U.S. 825 (1994

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lack of appreciation for important and unique aspects of incarceration, and lack of attention to outcomes. As Osborne and Lawrence indicated in their 2016 article, there is no outcome data on gender confirmation surgery in a correctional setting. Correctional professionals would benefit from having this section expanded in a future version of the SOC, based on specific evidence rather than an uninformed perception of correctional systems. Gender confirmation surgery should not be outright prohibited in a correctional environment, but until more data is available, it is appropriate for correctional healthcare professionals to use caution in making determinations regarding gender confirmation surgery.

Decisions regarding Ms. Edmo's Gender Dysphoria treatment must be based on her own unique history and set of factors in order to optimize the likelihood that her specific treatment will be successful. These decisions should not be driven by a commitment to Gender Dysphoria as a cause, but by the individualized needs of the patient. It is notable that neither of the plaintiff's experts appear to have reviewed or made an effort to review any records predating her incarceration, and that these records were obtained only through subpoena. In Ms. Edmo's particular case, there are questions that must be answered, coping strategies that must be developed, and experiences that must be encountered before irreversible surgery can be considered medically necessary.

My opinion on this case is based on information available to me at the time of completing this report. I reserve the right to modify or change my opinion on some or all aspects of this case if additional information becomes available.

Respectfully submitted,

Keelin Garvey, MD, CCHP