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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO,

Plaintiff,

v.

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

Defendants.

CIVIL ACTION FILE

NO. 1:17-cv-151-BLW

**CORIZON DEFENDANTS' RESPONSE
TO PLAINTIFF'S MOTION FOR
PRELIMINARY INJUNCTION AND
MEMORANDUM OF POINTS AND
AUTHORITIES IN SUPPORT
THEREOF**

COME NOW Defendants, Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery ("Corizon Defendants"), by and through their counsel of record, Parsons Behle &

Latimer, and submit this response to Plaintiff's Motion for Preliminary Injunction and Memorandum of Points and Authorities in Support Thereof (Dkt. 62).

I. INTRODUCTION

With respect to Corizon Defendants, this case primarily involves the treatment and care for Plaintiff who was diagnosed with Gender Dysphoria in 2012. At the end of the day, the evidence will clearly show that Plaintiff has and continues to receive appropriate care and treatment for her Gender Dysphoria (GD) and that there has been no deliberate indifference on the part of Corizon Defendants. Plaintiff's preliminary injunction should be denied because Plaintiff is not likely to succeed on the merits of the case, not likely to suffer irreparable harm in the absence of preliminary relief, the balance of the equities does not tip in Plaintiff's favor, and the injunction is not in the public interest.

Corizon Defendants are treating this brief similar to a trial brief in which to educate the Court on some of the anticipated facts and some of Corizon Defendants' positions and defenses in this case. Corizon Defendants do not waive the right to assert other facts, defenses and arguments, however. As of the time of filing this brief, most of the parties' experts have not been deposed. Further, the Court set an evidentiary hearing for October 10-12, 2018. Accordingly, Plaintiff's Motion for Preliminary Injunction cannot be fully briefed at this time because discovery is ongoing and the evidentiary hearing related to Plaintiff's Motion has not yet occurred. Corizon Defendants anticipate there will be an opportunity for closing arguments at the hearing and will likely request an opportunity for more briefing after the facts and testimony at the hearing have been established.

II. PROCEDURAL POSTURE OF THE CASE

On April 4, 2017, Plaintiff filed her Complaint pro se.

On June 8, 2017, Plaintiff filed her First Amended Complaint.

Plaintiff subsequently retained counsel and then, on September 1, 2017, Plaintiff filed her Second Amended Complaint.

In November 2017, Corizon Defendants filed a motion seeking to limit and bar some of Plaintiff's claims in her Complaint. In early June 6, 2018, the Court issued a decision dismissing some claims, but not all.

On June 1, 2018, before the Court had ruled on Corizon Defendants' motion, Plaintiff's filed a Motion for Preliminary Injunction.

With respect to Corizon and its medical providers, Plaintiff alleges that the World Professional Association for Transgender Health (WPATH) establishes the applicable standard of care for gender dysphoria. Plaintiff argues that treatment for GD can include hormone therapy, surgery to change primary and/or secondary characteristics, and/or psychotherapy addressing the negative impact of gender dysphoria and stigma on mental health. They claim that sex-reassignment surgery (aka SRA or "gender confirmation surgery") is medically necessary for some individuals with GD. Ultimately, Plaintiff claims that Corizon Defendants have refused to provide appropriate treatment and care for her GD, including allegedly refusing to provide a sex-reassignment surgery, not adequately monitoring and adjusting her feminizing hormones, and denying her access to other medically necessary treatments for reducing her GD.

Plaintiff's Motion concludes by requesting that the Court issue a preliminary injunction:

1. Ordering Defendants to provide Edmo immediate access to necessary medical treatment, including:
 - a. Sex-reassignment surgery;
 - b. Reinstatement of spironolactone, or an equivalent type of care;
 - c. Access to gender-appropriate underwear, clothing, and commissary items;

- d. Any other treatment a medical professional qualified to assess and treat gender dysphoria determines to be medical urgent.
2. Prohibiting Defendants from:
 - a. Implementing their policy and/or practice of blanket denial of access to such treatment for transgender persons incarcerated in the Idaho Department of Corrections; and
 - b. Disciplining or retaliating against Plaintiff for expressing her gender identity, including wearing gender-appropriate underwear and clothing and adhering to female grooming standards with regards to makeup and hair styling.

III. FACTS

A. General Overview of Plaintiff's Medical Care and Treatment History at IDOC Prisons.

The following is a brief summary of the medical and mental health care at issue in this case. This summary is not all inclusive, but is intended to give the Court an overview of the facts from Corizon Defendants. These and other facts will be supported by the medical and mental health care records as well as testimony at the evidentiary hearing.

This case involves Plaintiff Adree Edmo (a.k.a. Mason Dean Edmo, a.k.a. Mason Dean Meeks) who has been incarcerated since about April 2012 and who is currently an inmate at Idaho State Correctional Institution (ISCI). Plaintiff is incarcerated for sexual abuse of a child under 16 as well as for drawing checks without funds. Plaintiff's current "sentence satisfaction date" (date when she would complete her sentence, if no early parole) is listed as July 3, 2021.

At birth, Plaintiff was assigned the gender of male and had male characteristics, including a penis and testicles. Before incarceration, Plaintiff apparently first came out as a homosexual,

but when she was incarcerated then felt that “I was not a gay man, but actually a woman.” (She has a prior history of suicide attempts.) While in prison, on or about July 19, 2012, she was diagnosed with Gender Dysphoria (formally Gender Identity Disorder (“GID”)) by Claudia Lake, a Corizon Psychologist, and also by Scott Eliason, M.D., Corizon’s Regional Psychiatrist Director. Plaintiff had numerous appointments with Dr. Eliason over the years regarding her mental health issues, such as anxiety, depression, and alcohol and substance abuse disorders.

On August 23, 2012, a team of Corizon and IDOC employees/providers met at a Management and Treatment Committee (MTC) meeting and agreed Plaintiff could start hormone therapy, among other things. Dr. Eliason was often a part of these MTC meetings, as were clinicians, psychologists, and IDOC correctional staff.

Hormone therapy was started for Plaintiff. Cathy Whinnery, M.D., who was the ISCI Medical Director at the time and a defendant in this case, ordered hormone therapy and monitored and adjusted it as she deemed appropriate in her clinical judgment. Dr. Whinnery treated Plaintiff at various times from about August 20, 2012 to January 15, 2015, including about eight chronic care visits and numerous orders adjusting Plaintiff’s hormone medications over this time period. The hormone therapy caused Plaintiff to develop breasts and the testicles shrank over time.

Medical providers completed medical memos allowing Plaintiff to get a bra. She has had access to a bra soon after she was diagnosed with GD. Medical providers ordered a jock strap and pads to help Edmo tuck her penis as she wanted. Plaintiff currently has panties at the prison.

On November 6, 2013, an MTC meeting note indicates that Plaintiff had been moved to another facility (Idaho Correctional Institution-Orofino (ICI-O)) on August 12, 2013 as a precautionary measure after receiving a Disciplinary Offense Report for sexual activity and increased acting-out while housed at ISCI. Plaintiff was placed into the Sex Offender Treatment

Program at ICI-O, but signed a refusal to participate in the program. She has not completed this program to date.

On February 11, 2014, Plaintiff submitted a Health Services Request indicating that she wanted to see Dr. Craig, IDOC's psychologist, for gender reassignment surgery.

In February and March 2014, Plaintiff was put on suicide watch because she indicated she would harm herself.

On September 29, 2015, Plaintiff attempted to remove her scrotum with a razor blade. The attempt was unsuccessful, the bleeding was controlled with pressure, the area was irrigated, and steri-strips were applied. No stitches were needed. Plaintiff was given a tetanus shot. There were subsequently no signs of infection. Plaintiff was then placed on suicide watch.

On March 24, 2016, a social worker noted that Plaintiff was struggling to remain DOR-free (a.k.a. avoiding a disciplinary write-up) and had received eight since June 2015. Some of these DORs were for fighting or sexual activity.

On April 20, 2016, Dr. Eliason indicated that Plaintiff was doing alright, but had not been granted parole because she continued receiving DORs. Plaintiff also indicated that she wanted to discuss sexual reassignment surgery. Dr. Eliason assessed Plaintiff for Sexual Reassignment Surgery (SRS) and determined that SRS was not medically necessary at that time. She did not meet criteria for SRS at that time, including:

1. Congenital malformations or ambiguous genitalia would likely require sexual reassignment or reparative surgery;
2. Severe and devastating dysphoria that is primarily due to genitals could potentially meet criteria for gender reassignment surgery;
3. Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage.

Dr. Eliason was also treating Plaintiff's underlying mental health issues, including Major Depressive Disorder (MDD). Dr. Eliason also noted that there may also be other situations which could be determined as medically necessary as more information becomes available. He also indicated that he staffed this issue with Murray Young, M.D., Jeremy Stoddart, M.D., and Jeremy Clark, LCPC (clinical supervisor and WPATH member), who agreed with Dr. Eliason's assessment. Dr. Eliason concluded that "for the time being, it is my opinion that the combination of hormonal treatment and supportive counseling is sufficient for her gender dysphoria."

On June 10, 2016, MTC meeting minutes documented that Plaintiff consistently had verbal confrontations with staff and a history of inappropriate sexual behaviors with other inmates who live in the general population.

On August 10, 2016, the MTC reconvened to provide more information on why Plaintiff should not be moved out of Unit 16 into the general population at ISCI. Additional details were provided, including that Plaintiff recently physically assaulted another inmate with GD who did not fight back.

On December 31, 2016, Plaintiff again attempted self-castration by lacerating her scrotum with a razor blade. She was transported to St. Alphonsus hospital to address the injury. The attempt at self-castration was unsuccessful.

On April 6, 2017, Plaintiff filed her Complaint in this lawsuit.

Plaintiff has continued to receive medical and mental health care and treatment at the prison facility.

Since about December 2016, Plaintiff has also been seen by an offsite Gender Dysphoria specialist, Dr. Alviso, who, among other things, has managed her hormone therapy.

As recent as this year, Plaintiff has not been cooperative with her providers and their recommended treatment, including refusing to meet with her assigned clinician and refusing to attend recommended mental health groups. (*See* Declaration of Dylan A. Eaton, Exhibit A, expert report of Keelin Garvey, M.D., CCHP (“Dr. Garvey Report”), p. 42.)

B. Plaintiff’s history before prison.

Plaintiff claims in her declaration and to her experts that she lived full time as a woman prior to being incarcerated. However, Plaintiff has presented no evidence that she was living full time as a female prior to incarceration and she did not disclose such in her Pre-Sentencing Investigation reports that were presented to the Court before she was sentenced on her current crime. Her medical and mental health care records prior to incarceration are also silent regarding any references to her appearing to live like a female. Plaintiff’s inconsistency regarding how she lived pre-incarceration is significant for many reasons. Among other reasons, living as a female for a significant period of time (such as a year) is often one of several important criteria or factors before SRS is indicated.

Plaintiff also has a long history of mental health disorders, including major depression, anxiety, alcohol use disorder, stimulant use disorder, and opioid use disorder. (Dr. Garvey Report, pp. 19-20.)

IV. PRELIMINARY INJUNCTION STANDARD

Under the Prison Litigation Reform Act (“PLRA”):

In any civil action with respect to prison conditions, to the extent otherwise authorized by law, the court may enter a temporary restraining order or an order for preliminary injunctive relief. Preliminary injunctive relief must be narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct that harm. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system.

18 U.S.C. § 3626(a)(2).

“A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 20, 129 S.Ct. 365, 172 L.Ed.2d 249 (2008). “[S]erious questions going to the merits and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest.” *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1135 (9th Cir.2011) (internal quotation marks omitted).

“A preliminary injunction is an extraordinary remedy never awarded as of right.” *Winter*, 555 U.S. at 24, 129 S.Ct. 365. It may take two forms. “A prohibitory injunction prohibits a party from taking action and preserves the status quo pending a determination of the action on the merits.” *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 878 (9th Cir.2009) (internal alterations and quotation marks omitted). A mandatory injunction orders a party to take action. *Id.* at 879. Because a mandatory injunction “goes well beyond simply maintaining the status quo pendente lite [it] is particularly disfavored.” *Id.* (internal alterations omitted). “In general, **mandatory injunctions ‘are not granted unless extreme or very serious damage will result and are not issued in doubtful cases** or where the injury complained of is capable of compensation in damages.’ ” *Id.* (quoting *Anderson v. United States*, 612 F.2d 1112, 1115 (9th Cir.1979)) (emphasis added).

V. ANALYSIS

A. Plaintiff is Unlikely to Succeed on the Merits

i. Corizon Defendants are Not Deliberately Indifferent

1. Deliberate Indifference Standard

“[D]eliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ proscribed by the Eighth Amendment.” *Estelle v. Gamble*, 429 U.S. 97, 104, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976) (internal citation omitted). Such indifference may be “manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.” *Id.* In the Ninth Circuit, a plaintiff alleging deliberate indifference must first “show a serious medical need by demonstrating that failure to treat a prisoner’s condition could result in further significant injury or the unnecessary and wanton infliction of pain.” *Jett v. Penner*, 439 F.3d 1091, 1096 (9th Cir.2006) (citing *Estelle*, 429 U.S. at 104, 97 S.Ct. 285) (internal quotation marks omitted). Second, she “must show the defendant’s response to the need was deliberately indifferent.” *1186 *Id.* This second prong “is satisfied by showing (a) a purposeful act or failure to respond to a prisoner’s pain or possible medical need and (b) harm caused by the indifference.” *Id.* An inadvertent or negligent failure to provide adequate medical care does not suffice to state a claim under Section 1983. *Estelle*, 429 U.S. at 105–06, 97 S.Ct. 285. “Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.” *Id.* at 106, 97 S.Ct. 285. Moreover, mere indifference, medical malpractice, or negligence will not support a cause of action under the Eighth Amendment. *Broughton v. Cutter Labs.*, 622 F.2d 458, 460 (9th Cir.1980) (per curiam).

Additionally, there is no vicarious liability in 1983 actions. *See Monell v. Dept. of Social Services*, 436 U.S. 658, 98 S.Ct. 2018, 56 L.Ed.2d 611 (1978); *Bonner v. Lewis*, 857 F.2d 559, 565 (9th Cir.1988) (doctrine of *respondeat superior* is not applicable in prisoner's claim against Director of Arizona Department of Corrections). To assert a § 1983 claim against a private entity, such as Corizon, Plaintiff must meet the test articulated in *Monell v. Department of Social Services*, 436 U.S. 658, 690–94, 98 S.Ct. 2018, 56 L.Ed.2d 611 (1978); *see also Tsao v. Desert Palace, Inc.*, 698 F.3d 1128, 1139 (9th Cir. 2012) (applying *Monell* to private entities). Under *Monell*, the requisite elements of a § 1983 claim against a municipality or private entity performing a state function are the following: (1) the plaintiff was deprived of a constitutional right; (2) the municipality or entity had a policy or custom; (3) the policy or custom amounted to deliberate indifference to the plaintiff's constitutional right; and (4) the policy or custom was the moving force behind the constitutional violation. *Mabe v. San Bernardino Cnty.*, 237 F.3d 1101, 1110–11 (9th Cir.2001).

To create liability, an unwritten policy or custom must be so “persistent and widespread” that it constitutes a “permanent and well settled” practice. *Monell*, 436 U.S. at 691, 98 S.Ct. 2018 (quoting *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 167–168, 90 S.Ct. 1598, 26 L.Ed.2d 142 (1970)). “Liability for improper custom may not be predicated on isolated or sporadic incidents; it must be founded upon practices of sufficient duration, frequency and consistency that the conduct has become a traditional method of carrying out policy.” *Trevino v. Gates*, 99 F.3d 911, 918 (9th Cir.1996). Further, a municipality or private entity performing a state function “may be held liable under § 1983 when the individual who committed the constitutional tort was an official with final policy-making authority or such an official ratified a subordinate's unconstitutional decision or

action and the basis for it.” *Clouthier v. County of Contra Costa*, 591 F.3d 1232, 1250 (9th Cir.2010).

2. Analysis

Plaintiff focuses solely on the World Professional Association for Transgender Health (WPATH) manual in an attempt to establish the standards of care for treating individuals with Gender Dysphoria, including for SRS. While WPATH is one resource that practitioners can consider when treating GD patients, it does not establish the applicable standard of care. Indeed, some providers consult with WPATH guidelines and others have created their own criteria and requirements for surgery, which they think are best suited for their patients. WPATH even recognizes that its guidelines should be flexible. Further, as an example, the evidence, trials and peer reviews are low or non-existent in supporting WPATH guidelines, especially as to incarcerated individuals. (Dr. Garvey’s Report, pp. 27-30; 40-42.) The cases cited by Plaintiff’s counsel that relied on WPATH standards did not address these deficiencies. Accordingly, Corizon Defendants dispute that the WPATH establishes the applicable standard of care in treating GD patients and, more specifically, in treating Plaintiff. WPATH is no substitute for clinical judgment.

Corizon Defendants do not contest that Plaintiff has Gender Dysphoria. Corizon’s psychologist, Dr. Lake, and its psychiatrist, Defendant Dr. Eliason, appropriately evaluated Plaintiff and determined in 2012 that Plaintiff had Gender Identity Disorder (now called Gender Dysphoria). Corizon’s expert also opines that Plaintiff has Gender Dysphoria. (Dr. Garvey Report, pp. 17-18.)

Contrary to Plaintiff’s representations, however, Corizon Defendants provided appropriate care and treatment to Plaintiff for her Gender Dysphoria. Plaintiff was quickly assessed and diagnosed with GD and then timely started receiving hormone therapy. The hormone therapy

provided was appropriate and within the applicable standard of care. Further, Plaintiff has been satisfied with her hormone therapy. (Dr. Garvey Report, pp. 23-26.)

Additionally, her psychiatric treatment was appropriate and within the applicable standard of care. (Dr. Garvey Report, pp. 21-23.)

Plaintiff also apparently seeks Sex Reassignment Surgery, which can include a complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation ... including breast prostheses if necessary, genital reconstruction (by various techniques which must be appropriate to each patient ...) and certain facial plastic reconstruction. It is not entirely clear what SRS Plaintiff wants, but it appears she may want a vaginoplasty. **Such a surgery is permanent and irreversible.** Therefore, medical providers and the Court, for that matter, should be extremely careful and hesitant to order such a procedure. In this case, SRS is not indicated at this time for Plaintiff.

WPATH guidelines list the following criteria for vaginoplasty:

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

Even if WPATH guidelines are followed, Corizon Defendants' expert opines that Plaintiff does not meet criteria 1, 4 and 6 above. (Dr. Garvey Report, pp. 26-40.)

Additionally, because clinical experience with SRS in correctional setting is non-existent, there are other factors beyond those in WPATH that can be considered for SRS, such as:

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

Corizon Defendants' expert also opines that Plaintiff meets criteria 5 above and may meet criteria 2, but does not meet the remainder of these criteria. (Dr. Garvey Report, pp. 40-42.)

Corizon does not have policies regarding treatment and care for GD. (It currently has some guidelines regarding hormone therapy.) Corizon providers are to work with the IDOC Standard Operating Procedure regarding Gender Identity Disorder and Gender Dysphoria and to exercise their medical judgment regarding the treatment and care of GD patients.

Corizon and its providers have not been negligent as to treatment and care of Plaintiff and their actions or inactions have not been deliberate indifference. (Dr. Garvey report, pp. 42-44.) Indeed, the medical providers diagnosed Plaintiff with GD and have provided appropriate treatment and care, including hormone therapy, ordering bras and types of underwear that could help her, and treating her mental health conditions, including Major Depressive Disorder.

Even if Plaintiff could show that Corizon Defendants violated the WPATH standards, it is still insufficient to prove deliberate indifference under the Eighth Amendment. Treatment and care for GD has been evolving over the years and there still are not clear and well-established guidelines (even with WPATH), especially regarding Sex Reassignment Surgery, which are supported by adequate medical evidence, trials and peer reviews. This is particularly true

regarding treatment and care for inmates with GD. Therefore, it is not deliberate indifference for Corizon's medical providers to exercise their best medical judgment in treating Plaintiff. Moreover, Corizon and its providers were not negligent in treatment of Plaintiff, but even if they were, such is not enough to establish deliberate indifference. *Broughton*, 622 F.2d at 460.

Additionally, Plaintiff's experts do not establish deliberate indifference. At most, Plaintiff's experts disagree with Corizon's qualified treatment providers (and qualified expert) regarding the care provided. But, mere disagreement among providers is insufficient to establish deliberate indifference. *See Mintun v. Corizon Med. Servs.*, No. 1:16-CV-0037-DCN, 2018 WL 1040088 at *5.

At a minimum, there is clearly enough doubt about whether Corizon Defendants are deliberately indifferent and if SRS (a permanent and irreversible surgery) is appropriate for Plaintiff at this time and that Plaintiff's preliminary injunction should be denied. *Marlyn Nutraceuticals, Inc.*, 571 F.3d at 878 (holding mandatory injunctions – orders for a party to take action - should not be issued in doubtful cases).

ii. Corizon Defendants are Not Discriminating Against Plaintiff on the Basis of Sex.

Since Corizon Defendants provided appropriate care and treatment to Plaintiff within the applicable standard of care, they are not discriminating against Plaintiff. Corizon Defendants reserve for further briefing on this issue.

B. Plaintiff is Not likely to Suffer Irreparable harm in the absence of a Preliminary Injunction; the Balancing of Equities does Not Tip in Plaintiff's Favor; and Injunction is Not in the Public Interest.

Corizon Defendants join IDOC Defendants' briefing on this issue and incorporate it herein. (See Dkt. 99, pp. 17-20.) Corizon Defendants reserve further briefing on this issue.

VI. CONCLUSION

The facts and law will show that Corizon Defendants have properly treated and cared for Plaintiff and her Gender Dysphoria and that Plaintiff's Motion for Preliminary Injunction should be denied.

DATED this 14th day of September, 2018.

PARSONS BEHLE & LATIMER

By: /s/ Dylan A. Eaton

Dylan A. Eaton
Counsel for Defendants Corizon Inc.,
Scott Eliason, Murray Young, and
Catherine Whinnery

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 14th day of September, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

ADREE EDMO,

Plaintiff,

v.

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

Defendants.

CIVIL ACTION FILE

NO. 1:17-cv-151-BLW

DECLARATION OF DYLAN A. EATON

I, Dylan A. Eaton, declare as follows:

1. I am more than eighteen years of age and I am legally competent to make this declaration. I have personal knowledge of the facts set forth herein, and can testify as to the truth

of the statements contained herein if called upon as a witness at the trial of this action.

2. I am duly licensed to practice law in the State of Idaho and before this Court. I am an attorney of record for Defendants Corizon Inc., Scott Eliason, Murray Young, and Catherine Whinnery in the above-referenced action.

3. Attached hereto as Exhibit A is a true and correct copy of the expert report prepared by Keelin Garvey, MD, CCHP.

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

DATED this 14th day of September, 2018.

/s/ Dylan A. Eaton

Dylan A. Eaton

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 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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By: /s/ Dylan A. Eaton
Dylan A. Eaton

EXHIBIT A

KEELIN GARVEY, MD, CCHP

August 31, 2018

Dylan A. Eaton
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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;

KEELIN GARVEY, MD, CCHP

- 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

KEELIN GARVEY, MD, CCHP

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 (HBI-GDA- 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.

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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 exclusively 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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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.

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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.

Past and current GD treatment

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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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.

KEELIN GARVEY, MD, CCHP

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 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,

KEELIN GARVEY, MD, CCHP

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:

KEELIN GARVEY, MD, CCHP

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.”

KEELIN GARVEY, MD, CCHP

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.

KEELIN GARVEY, MD, CCHP

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.

KEELIN GARVEY, MD, CCHP

4. The majority of males with transvestic disorder identify as heterosexual¹ (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.

KEELIN GARVEY, MD, CCHP

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](https://doi.org/10.1080/15532739.2011.700873).

KEELIN GARVEY, MD, CCHP

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.

Consideration of Ms. Edmo's Hormone Treatment

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.

KEELIN GARVEY, MD, CCHP

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

The Endocrine Society Clinical Practice Guideline published in 2009³ 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 binding 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.

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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>

KEELIN GARVEY, MD, CCHP

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.

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 2017⁶ 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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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.

KEELIN GARVEY, MD, CCHP

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.

KEELIN GARVEY, MD, CCHP

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.

KEELIN GARVEY, MD, CCHP

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 Lawrence¹¹ 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: When Is Sex Reassignment Surgery Appropriate? *Archives of Sexual Behavior* 45(7): 1649-1663.

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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.”

KEELIN GARVEY, MD, CCHP

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

KEELIN GARVEY, MD, CCHP

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,

KEELIN GARVEY, MD, CCHP

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:

KEELIN GARVEY, MD, CCHP

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.

Discussion of alleged negligence and deliberate indifference by Corizon:

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

KEELIN GARVEY, MD, CCHP

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)

KEELIN GARVEY, MD, CCHP

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,

A handwritten signature in black ink, appearing to read 'K. Garvey', enclosed within a circular scribble.

Keelin Garvey, MD, CCHP