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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

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

Plaintiff,

v.

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

Defendants.

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

PLAINTIFF'S REPLY IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION [DKT. 62]

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

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INTRODUCTION

All parties to this litigation agree that Plaintiff Adree Edmo has gender dysphoria, a medical condition constituting a serious medical need under the Eighth Amendment. By definition, gender dysphoria is characterized by clinically significant distress and/or impairment of functioning. Yet, Defendants refuse to provide Ms. Edmo available and well-established treatment demonstrated to alleviate "the severe and unremitting pain" associated with the medical condition of gender dysphoria. Ettner Decl. ¶ 35 (ECF 62-1). Denial of necessary treatment for a serious medical condition is cruel and unusual punishment violating the Eighth Amendment. Defendants' arguments for denying Ms. Edmo the recognized treatment for her condition are based on contrived and post-hoc justifications that are, at their core, based on outdated stereotypes and prejudices that the mainstream medical community has repeatedly rejected. Defendants also substantially mischaracterize the factual record in this case—particularly regarding their own policies and discipline of Ms. Edmo—to attempt to minimize the harm they have inflicted upon her. As Plaintiff will demonstrate during the evidentiary hearing, Defendants have deliberately refused to provide her appropriate and necessary medical treatment, have compounded her distress by punishing her for behaviors related to gender dysphoria and expressing her gender identity, and continue to subject her to needless pain and suffering by failing to treat her serious medical condition.

STATEMENT OF FACTS

Defendants' Refusal To Provide Necessary Treatment to Ms. Edmo

Defendants diagnosed Ms. Edmo with gender dysphoria in July 2012, and, in September 2012, began providing her with cross-sex hormone therapy, one of the medically recognized treatments for gender dysphoria. Edmo Decl. ¶ 12 (ECF 62-2); Exhibit ("Exh.") 2.[1] While hormone therapy was a partial treatment for Ms. Edmo's gender dysphoria, she continued to experience clinically significant distress as a result of severe gender dysphoria, and, particularly, related to her male genitalia.[2] Ettner

[1] Unless otherwise noted, all exhibit references are to exhibits attached to the Declaration of Lori Rifkin in Support of Plaintiff's Reply, filed herewith.

[2] Plaintiff also claims that Defendants were deliberately indifferent to her serious medical needs by providing inadequate hormone therapy, but that claim is not the focus of her motion for preliminary injunction, which seeks access to surgery.

Decl. ¶ 61 (ECF 62-1). As early as February 2014, Ms. Edmo requested sex reassignment surgery to treat her ongoing medical need, but this request—as with each of her subsequent requests for surgery—was denied. Exh. 3. On September 29, 2015, Ms. Edmo attempted self-castration for the first time. Exh. 4; Edmo Decl. ¶ 31 (ECF 62-2). In response, Defendants placed her on suicide watch, and instructed her to "use coping skills to manage distress related to dysphoria" and "work on improving self-esteem." Exh. 5.

Ms. Edmo's medical records for April 20, 2016 reflect Defendants' first and only consideration of sex reassignment surgery for her since she entered IDOC custody in 2012. Exh. 6 at 1. Corizon psychiatrist Dr. Eliason completed this two-paragraph "assessment," concluding Ms. Edmo "does not meet criteria for medical necessity for sex reassignment surgery" and "the combination of hormonal treatment and supportive counseling is sufficient for her gender dysphoria." *Id*. Dr. Eliason further noted three examples that

> [C]ould meet medical necessity: 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 as well. 3) Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage.

Id. Dr. Eliason found Ms. Edmo "does not meet any of those above criteria." *Id.*

These examples provided by Dr. Eliason do not accord with any written standards of care for treatment of gender dysphoria, and, in deposition, Dr. Eliason could not recall the basis for his use of these examples. Eliason Dep. 118:8-119:23. Plaintiff's expert Dr. Gorton explained that "Dr. Eliason's examples of 'medical necessity' are far afield from the medical standards," and the "standard for surgery is not 'severe and devastating gender dysphoria that is primarily due to the genitals,' as Dr. Eliason contends . . . the standard is 'persistent, well documented gender dysphoria,' among other criteria." Gorton Decl. at ¶ 87 (ECF 62-1). Dr. Gorton concluded "Dr. Eliason's standard for surgery is wholly unsupported." *Id*. However, even under Dr. Eliason's gross misunderstanding of the medical criteria for surgery, Dr. Eliason admitted that attempted self-castration could meet the second scenario of "severe and devastating dysphoria," and was unable to provide any other examples of situations

meeting severe and devastating dysphoria. Eliason Dep. 119:8-120:2.

Despite Ms. Edmo's report of continuing severe distress resulting from gender dysphoria, and her attempt to auto-castrate, Dr. Eliason made no changes to Ms. Edmo's treatment plan. Exh. 6 at 1; Eliason Dep. 120:3-9. Subsequently, Dr. Eliason met with Ms. Edmo on May 18, 2016 "to explain that the decision regarding SRS has not yet been determined," and "it has been determined that we will form a committee of physicians to determine the medical necessity of SRS" that would occur within the next few weeks to months. Exh. 6 at 2. However, this committee never met, and Ms. Edmo's request for surgery was never re-visited after April 20, 2016. Eliason Dep. 122:4-25, 124:6-18.

Since Dr. Eliason's "assessment" of Ms. Edmo for surgery in April 2016, Ms. Edmo has continued to experience acute distress linked to gender dysphoria, resulting in another attempt to castrate herself nine months later, on December 31, 2016. Exh. 7. Even after Ms. Edmo's second attempt at self-surgery, Defendants refused to re-evaluate her for surgery, dismissing Ms. Edmo as being "confused about her gender . . . confusion happens a couple of times a year." Exh. 8. Until Ms. Edmo moved for a preliminary injunction, Defendants refused to provide her with any other evaluation for surgery to treat gender dysphoria.

Defendants' New Justifications For Refusing Surgery to Treat Ms. Edmo's Gender Dysphoria

Now, following Ms. Edmo's motion, Defendants have suddenly "discovered" a host of purported reasons that she cannot have surgery, none of which formed the basis of any of Defendants' treatment decisions for Ms. Edmo in the six years prior to her motion. Primarily, these newly-formed rationalizations for denying surgery imply that Ms. Edmo does not "deserve" surgery for a variety of reasons, including: 1) her attempts at self-surgery, and, more recently, cutting her arm in an attempt to avoid additional attempts to auto-castrate, demonstrate that she has not developed "appropriate coping mechanisms" for addressing the distress resulting from the severe gender dysphoria Defendants refuse to adequately treat; 2) Ms. Edmo has received various disciplinary violations, and therefore has not "appropriately adjusted" to incarceration; 3) Ms. Edmo has not "properly" engaged in psychotherapy treatment opportunities Defendants have purportedly provided to her, largely for diagnoses Defendants have never actually made for Ms. Edmo in the six years she has been in their care; and 4) although

there is no dispute that Ms. Edmo has persistently presented herself as feminine in her six years in IDOC custody, even despite repeated discipline, threats, and harassment for doing so, and all parties agree that Ms. Edmo authentically identifies as female, Defendants' experts "have questions" about her presentation of gender identity prior to incarceration.

These are not medically accepted criteria for withholding treatment for the medical condition of gender dysphoria. Defendants' experts acknowledge that there is no serious dispute that surgery is an effective treatment for gender dysphoria, and that surgery must be available to incarcerated persons for whom it is medically indicated. Just as chemotherapy to treat cancer, insulin to treat diabetes, or psychotropic medication to treat schizophrenia, cannot be withheld from a prisoner based on purported "maladaptive behaviors" such as "co-dependency, disobedient behaviors, and sexually acting-out," ECF 99 at 3, Defendants may not deny Ms. Edmo surgery to treat her medical condition based on the argument that she has not adequately conformed her behavior to their expectations or demands. Defendants' claims that Ms. Edmo "must develop healthy tools to manage her . . . GD" in the absence of surgery, *id.* at 10, are akin to demanding that cancer patients must stop their tumors from growing while denying them chemotherapy or radiation.

Furthermore, contrary to Defendants' representations, Ms. Edmo has regularly participated in medical and mental health treatment during her incarceration. She has been fully compliant with prescribed hormone treatment since 2012 as well as being fully compliant with prescribed medication for depression. Ms. Edmo attends the gender dysphoria treatment group and has generally done so since 2013, with lapses due to scheduling conflicts and disciplinary charges. Edmo Dep. 122:23-123:4. Ms. Edmo also accepted referrals for other recommended groups, including Depression, Anxiety, Mindfulness, PTSD, and Healthy Relationship groups, although she was on the waitlist for several of these groups for extended periods of time and was unable to attend others due to housing transfers.

Defendants' new claim that Ms. Edmo has "significant uncontrolled mental health concerns" including PTSD and borderline personality disorder that she must address prior to qualifying for surgery for gender dysphoria, is belied by the fact that, in the six years of Ms. Edmo's incarceration, neither IDOC nor Corizon providers have ever diagnosed her with PTSD or borderline personality

disorder, nor have they ever found her to be psychotic, unable to appreciate reality, or incapable of providing informed consent for medical treatment due to mental illness. Nor have Defendants offered any evidence to support such statements as "[t]hese underlying mental health issues have complicated Ms. Edmo's resolution of her GD." ECF 99 at 9. This statement in fact demonstrates Defendants' lack of understanding of the medical condition of gender dysphoria and the treatments for this medical condition; there is no evidence establishing that treatment of depression, anxiety, PTSD, or borderline personality disorder alleviates gender dysphoria, and, indeed, Ms. Edmo is already on the highest dose of antidepressants. The widely-accepted standard of care, set forth by the World Professional Association for Transgender Health (WPATH), is clear that psychotherapy is not a substitute for surgery to treat gender dysphoria. Ettner Decl. ¶ 44 (ECF 62-1). Defendants' suggestion that Ms. Edmo's gender dysphoria will be alleviated by something other than surgery (despite Defendants' simultaneous statement that IDOC has already provided her with the other types of treatment recommended by WPATH, ECF 99 at 7, is simply unsupported by medically accepted evidence. Further, Defendants' contention that Ms. Edmo has such significant uncontrolled mental health concerns that she cannot have surgery is directly contradicted by their simultaneous assertion that she is "functional and is not exhibiting symptoms of a person whose condition is so extreme that a mandatory injunction is required." ECF 99 at 17.

With respect to Defendants' claims that Ms. Edmo is somehow ineligible for surgery because her pre-incarceration medical records allegedly do not corroborate her statements that she presented as female prior to 2012, there is no evidence that Dr. Eliason or any other IDOC or Corizon treatment provider based denial of surgery on these records. *See* Eliason Dep. 110:8-15. Indeed, Defendants subpoenaed these records after Ms. Edmo moved for a preliminary injunction and there is no evidence that they ever requested or obtained them in the prior six years of treating Ms. Edmo.

Defendants' Refusal to Provide Surgery is Consistent with Their Training

In April 2016, around the same time he found surgery was not medically necessary for Ms. Edmo, Dr. Eliason organized a gender dysphoria training for IDOC and Corizon staff led by an outside consultant, Dr. Steven Levine. Eliason Dep. 35:24-36:12; Menard Dep. 56:22-57:8; Exhs. 9, 10. Dr.

Levine's training included information that has been repudiated by the professional medical community and contradicts the WPATH Standards of Care, as well as the positions of the American Medical Association, the American Psychiatric Association, the American Psychological Association, the World Health Organization, the Endocrine Society, the National Commission on Correctional Health Care, and other professional organizations endorsing these standards.[3] For example:

- SRS is not conceived as lifesaving as is repairing a potentially leaking aortic aneurysm but as life enhancing as is providing augmentation for women distressed about their small breasts.
- Most pre-operative trans females have learned to ignore their penis most of the time even though its functions remind them of their maleness.
- It is difficult to quantify or compare this type of pain. Is it exaggerated by lawyers? By inmates? Or by lawyers counseling their clients how to speak about it?
- To date, most GD inmates in American prisons have not had any major complications other than frustration and the sense that the DOC does not care about their suffering.

Exh. 10 at 43-45.

Corizon providers, including Dr. Eliason, then incorporated this information from Dr. Levine's presentation into internal Corizon training materials regarding gender dysphoria. Exh. 11 at 1-2, 28-29. Consistent with the approach espoused by this training—which contradicts the established standard of care and is not based on any peer-reviewed studies or evidence—neither Dr. Eliason nor any other health care provider has ever found surgery medically necessary to treat a patient with gender dysphoria in IDOC. Eliason Dep. 43:13-22; Dowell Dep. 59:20-60:9; Menard Dep. 39:7-15. Moreover, Corizon admits it has declined to adopt any written policy or guidelines governing the provision of surgery to treat gender dysphoria or the standards providers should apply in assessing the medical necessity of such surgery for a patient. ECF 100 at 14; Menard Dep. 79:8-23. In fact, the only guidelines issued by Corizon to assist its providers in treating gender dysphoria do not even mention surgery as a treatment option. Menard Dep. 38:10-39:6; Exh. 12.

[3] A federal court also afforded Dr. Levine's expert opinions regarding surgery as treatment for gender dysphoria "very little weight" after determining there were significant weaknesses in his expert report, including misrepresentations of the Standards of Care, overwhelming reliance on generalizations about gender dysphoric prisoners, and illogical inferences. *Norsworthy*, 87 F. Supp. 3d at 1188. The court also noted that it appeared to be Levine's "opinion that no inmate should ever receive SRS . . . ." *Id.*

Further, as Plaintiff will demonstrate during the evidentiary hearing, the "experts" Defendants have retained to opine that surgery is not medically necessary to treat Ms. Edmo's gender dysphoria are unqualified to provide expert opinions in this area. Neither have directly treated patients for gender dysphoria, and neither has ever treated or assessed a patient with gender dysphoria who has had sex reassignment surgery. Rather, both obtained their severely limited experience with gender dysphoria directly under the tutelage of Dr. Levine in the Massachusetts Department of Corrections. Like Dr. Levine, they are outliers in the professional treatment community, refusing to apply the internationally-accepted standards of care to the medical treatment of incarcerated persons.

By Policy and Practice, IDOC Defendants Punish Ms. Edmo for Feminizing in Accordance with Her Gender Identity

IDOC Defendants mislead this Court by making repeated references to an "updated" gender dysphoria policy, which they assert permits "inmates with GD to wear appropriate makeup, style their hair in traditionally female hairstyles, and present as female," as well as "access commissary items, such as bras, underwear, female makeup, and grooming items." ECF 99 at 13; *see also id.* at 3, 15. However, IDOC's *current* policy regarding treatment of inmates with gender dysphoria was adopted on October 31, 2002. Dowell Dep. 17:12-18:15; Exh. 13 at 1. IDOC's 30(b)(6) designee testified that the purported "updated" policy exists only in draft form, and has not been approved or implemented. Dowell Dep. 20:19-25, 92:10-20; Exh. 14 at 23-35; ECF 101-10, Exh. D at 25-33;

IDOC Defendants further claim that "IDOC's focus has not been with precluding Ms. Edmo from feminizing, but rather with her repeated attempts to sexualize her appearance in a male facility," ECF 99 at 12. Ms. Edmo's disciplinary record clearly shows that Defendants have applied IDOC policies to punish her for feminizing her appearance. IDOC Defendants have imposed eleven formal disciplinary offense reports ("DORs") on Ms. Edmo, as well as placing her in restraints and segregation, explicitly for wearing makeup, styling her hair in a traditionally feminine style, and altering her male-issued underwear to more closely resemble female panties. *See* Exh. 1. The written justifications for these DORs directly contradict IDOC's claim that she was disciplined for "provocative or sexually charged clothing and behavior," rather than her efforts to feminize. ECF 99

at 13; *see* Exh. 1. For example:

- "I reminded offender Edmo that if this hairstyle continues and previous warnings were going to be ignore [sic] to comply with direction and orders regarding the feminine hair styles, offender Edmo would be subjected to the disciplinary process." Exh. 15 at 1.
- "I asked Offender Edmo #94691 to remove Edmo's hairstyle to a style that appeared less feminine gender specific per section 4 of PREA policy 325.02.0 l .001." Exh. 15 at 5.
- "Offender Edmo 94691 was wearing makeup and his hair was in a high pony tail which violates policy 325.02.01.002 . . . . I then gave Edmo a direct order to fix the issue . . . . Edmo refused at which point Edmo was placed in restraints and taken to unit 8 [segregation]." Exh. 15 at 6.
- "Your condition does not allow you to wear makeup. Staff were within our policy to issue you a disciplinary infraction for violating this rule." Exh. 15 at 12.
- "The DOR is affirmed because you know you're not authorized to alter property regardless of the reasons." Exh. 15 at 24.

This violates the WPATH Standards of Care, which establish that the ability to feminize one's appearance is a "critical component of treatment" for gender dysphoria. Ettner Decl. ¶ 45 (ECF 62-1).

LEGAL ARGUMENT

Through the testimony of Plaintiff and her retained experts, Drs. Gorton and Ettner, as well as other evidence submitted during the hearing on Plaintiff's motion for preliminary injunction, Plaintiff will establish "that [s]he is likely to succeed on the merits, that [s]he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [her] favor, and that an injunction is in the public interest." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2009); *Pimentel v. Dreyfus*, 670 F. 3d 1096, 1105 (9th Cir. 2012).

I. Plaintiff Will Succeed on the Merits of her Claims

A. Eighth Amendment Claim

Defendants do not dispute that Ms. Edmo suffers from a serious medical condition, but make three arguments that their repeated denial of medically necessary treatment for Ms. Edmo is not deliberately indifferent: (1) Defendants' treatment decisions, including Dr. Eliason's April 2016 denial of surgery, were based on "professional judgment" and therefore cannot constitute deliberate indifference; (2) Defendants' treatment decisions are consistent with the opinions of Defendants' "experts" that surgery is not medically necessary for Ms. Edmo; and (3) Defendants have no "blanket policy" prohibiting surgery.

1. Defendants' choice of a medically unacceptable course of treatment constitutes deliberate indifference

Defendants' contention that their providers exercised "professional," or their "best medical judgment" in treating Ms. Edmo does not preclude a finding of deliberate indifference. ECF 99 at 7; ECF 100 at 15. While difference of opinion between two medically acceptable courses of treatment does not automatically constitute deliberate indifference, a provider's choice of a medically *unacceptable* course of treatment can be a basis for Eighth Amendment liability. *See, e.g.*, *Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996) (summary judgment improper where jury could find course of treatment was medically unacceptable under the circumstances and was chosen in conscious disregard of excessive risk to plaintiff); *Hamilton v. Endell*, 981 F.2d 1062, 1067 (9th Cir. 1992) ("By choosing to rely upon a medical opinion which a reasonable person would likely determine to be inferior, the prison officials took actions which may have amounted to the denial of medical treatment, and the 'unnecessary and wanton infliction of pain.'"), *overruled in part on other grounds as recognized in Colwell v. Bannister*, 763 F.3d 1060, 1069 (9th Cir. 2014). Plaintiff's experts have opined that Defendants failed to provide Ms. Edmo appropriate treatment and did not provide her access to medical professionals qualified to assess and treat her gender dysphoria, and thus have not exercised proper medical judgment.[4] ECF 62 at 5-6.

In *Norsworthy v. Beard*, 87 F. Supp. 3d 1164 (N.D. Cal. 2015), a case brought by an incarcerated person with gender dysphoria seeking access to surgery, the court found the plaintiff likely to succeed on her Eighth Amendment claim in part because the prison's stated reasons for denying her surgery were pretextual. *Id.* at 1190. The *Norsworthy* Court reasoned that the psychologist's evaluation was "designed to support the denial of SRS" because it "omitted several important indicators of medical necessity," "reached conclusions that are at odds with the Standards of Care," and the psychologist "had attended a training at which [Dr. Steven] Levine instructed participants that SRS should never be provided to incarcerated patients." *Id.* at 1190; *see also Hicklin v. Precynthe*, 2018

[4] Defendants' reliance on *Mintun v. Corizon Med. Servs.*, 2018 U.S. Dist. LEXIS 29831 (D. Idaho Feb. 22, 2018), is misplaced. There, this Court found that the pro se plaintiff failed to establish his mental health condition presented a serious medical need and the only evidence of deliberate indifference was the plaintiff's own belief that he required further testing. *Id.* at *13-15.

U.S. Dist. LEXIS 21516, at *38 (E.D. Mo. Feb. 9, 2018) ("The denial of [treatment] based on a blanket rule, rather than an individualized medical determination, constitutes deliberate indifference in violation of the Eighth Amendment."). The *Norsworthy* Court also relied upon Dr. Ettner's expert declaration detailing the psychologist's misunderstanding of treatment for gender dysphoria. *Id.*

The facts here are strikingly similar. Plaintiff's experts have explained not only that Dr. Eliason lacked the requisite understanding and qualifications to treat gender dysphoria, but also, that Dr. Eliason's assessment that surgery was not medically necessary for Ms. Edmo was based on unsupported criteria lacking any connection to internationally-recognized standards of care. Ettner Decl. ¶ 64 (ECF 62-1); Gorton Decl. ¶¶ 85-87 (ECF 62-1). Just as in *Norsworthy*, Dr. Eliason was trained by Dr. Levine—attending Levine's training *the very same month* he denied surgery for Ms. Edmo. Moreover, while Dr. Eliason claimed that Ms. Edmo's request for surgery would be re-assessed by a committee, this never occurred. Eliason Dep. 122:4-25, 124:6-18. Rather, Dr. Eliason applied made-up criteria (which he admitted in deposition Ms. Edmo satisfied) in order to reach the conclusion that surgery was not medically necessary to treat Ms. Edmo's gender dysphoria, in direct contradiction to the accepted standard of care. This decision to follow a medically unacceptable course of treatment based on pretextual reasons constitutes deliberate indifference. *See Norsworthy*, 87 F. Supp. 3d at 1190.

Further, contrary to Defendants' contention, *see* ECF 99 at 7, their provision of some treatment for Ms. Edmo's gender dysphoria does not insulate them from Eighth Amendment liability for failing to provide medically necessary treatment. *See Hicklin v. Precynthe*, No. 4:16-cv-02357-NCC, ECF 176, at 6 (E.D. Mo. May 22, 2018) ("providing [only] counseling and/or psychotropic medication to a severely gender dysphoric patient whose condition warrants medical intervention is a departure from the [WPATH] standards of care . . . [and] puts a person at serious risk of psychological and physical harm"); *Norsworthy*, 87 F. Supp. 3d at 1187 ("Just because defendants have provided a prisoner with some treatment consistent with the Standards of Care, it does not follow that they have necessarily provided her with *constitutionally adequate* treatment.") (internal alterations and quotations omitted).

2. Defendants' experts cannot cure their failure to provide treatment with post hoc justifications

Defendants next assert that they are not deliberately indifferent to Ms. Edmo's serious medical needs because Dr. Eliason's April 20, 2016 assessment is consistent with the current opinions of Ms. Edmo's treating clinicians, IDOC's Chief Psychologist, MTC members, and Defendants' retained experts, Drs. Garvey and Andrade, "all of whom agree that SRS is not appropriate for Ms. Edmo at this time, due to her significant uncontrolled mental health concerns." ECF 99 at 8-9. However, neither Dr. Eliason nor anyone else who treated Ms. Edmo cited these alleged concerns—which appear to encompass depression, anxiety, and so-called "maladaptive behaviors"—as a basis for denying Ms. Edmo surgery prior to her motion for a preliminary injunction. Indeed, in arriving at this newfound conclusion, Defendants' experts rely upon a variety of information Dr. Eliason never documented that he even considered at the time he assessed Ms. Edmo for surgery, such as Ms. Edmo's pre-incarceration medical records and her disciplinary history. Eliason Dep. 114:25-115:23. Additionally, IDOC Defendants now claim that surgery is not medically indicated for Ms. Edmo at this time because she exhibits symptoms of PTSD and borderline personality disorder—despite their own clinicians never having diagnosed Ms. Edmo with either of these conditions at any time in the past six years.

Not only are these post hoc rationalizations by Defendants' experts for the purposes of litigation unsupported by evidence and contradicted by the standards of care, but they also cannot be used retroactively to establish that Dr. Eliason's 2016 decision to deny Ms. Edmo surgery was not deliberately indifferent. *See Layton v. Bannister*, 2012 U.S. Dist. LEXIS 158359, at *6 (D. Nev. Nov. 5, 2012) (Eighth Amendment inadequate medical care claim is evaluated based on facts available to Defendant when he made the decision to deny surgery); *Funderburke v. Canfield*, 2016 U.S. Dist. LEXIS 25456, at *21 (W.D.N.Y. Feb. 29, 2016) ("[A]lthough Defendants now argue that Voltaren and Indocin were sufficient to treat Plaintiff's nerve pain, a reasonable jury could easily conclude that this argument is simply a post hoc rationalization . . . .").

3. Defendants have a *de facto* policy of refusing to provide surgery as treatment for gender dysphoria

While Defendants' written policies do not explicitly bar surgery as treatment for gender

dysphoria, Defendants' manner of implementing existing policies and training provided to staff constitutes a *de facto* ban of surgery as treatment for gender dysphoria. In *Norsworthy*, the court concluded that the prison had a blanket policy prohibiting surgery based on (1) evidence that the prison's guidelines for treating transgender inmates did not mention surgery as a treatment option, and (2) Dr. Levine's training to prison staff, which indicated that surgery should never be provided to incarcerated patients. 87 F. Supp. 3d at 1191. As in *Norsworthy*, the evidence here also suggests that Defendants have implemented a *de facto* ban. An internal IDOC policy analysis document acknowledged that IDOC's policy does not currently address surgery as a treatment intervention. Exh. 14 at 7 ("[O]ur current SOP only discusses one intervention: hormone replacement therapy. . . allowing for at least the possibility of surgical intervention would be in keeping with accepted practices."); Dowell Dep. 61:7-62:2. Dr. Levine's training, which was provided to Corizon and IDOC staff in April 2016 and then incorporated in Corizon's own training materials, in effect instructs Corizon and IDOC staff not to assess surgery as medically necessary for inmates with gender dysphoria. Exh. 10; Exh. 11 at 1-2, 28-29. Further, the Corizon gender dysphoria policy treatment does not include surgery as a treatment option, nor provide any guidelines for assessing a patient's medical necessity for surgery. Indeed, the practical effect of such policies and training is that no IDOC or Corizon employee has ever recommended that an IDOC prisoner receive surgery to treat gender dysphoria.

4. Defendants' Punish Ms. Edmo for Feminizing in Accordance with Her Gender Identity

While Ms. Edmo's ability to feminize her appearance through her manner of dress and grooming is a critical component of her treatment for gender dysphoria, IDOC Defendants have routinely stated that such conduct violates IDOC policy and disciplined her accordingly. Indeed, Ms. Edmo has been disciplined numerous times for feminizing her appearance.[5] Exh. 1. Moreover, although mental health staff could have recommended that disciplinary charges be reduced or dismissed because Ms. Edmo's conduct was directly related to gender dysphoria, no medical provider

[5] Defendants' characterization of Ms. Edmo's efforts to feminize her appearance as "repeated attempts to sexualize her appearance in a male facility," ECF 99 at 12, further illustrates their misunderstanding of and prejudices regarding gender dysphoria and its treatment.

did so. *See, e.g.*, Exh. 16 (clinician found Ms. Edmo's mental illness was not a mitigating factor in her July 26, 2016 DOR offense "destruction of property under $25" for altering underwear).

B. Fourteenth Amendment Claim

In response to Plaintiff's Fourteenth Amendment claim that Defendants' denial of treatment for gender dysphoria is discrimination based on sex, Defendants repeat the assertion that they do not have a policy prohibiting surgery, and claim that their denial of surgery to Ms. Edmo is based on legitimate penological interests.[6] These arguments ignore the basis for Plaintiffs' Fourteenth Amendment claim and apply the wrong legal standard. Plaintiff contends that Defendants' denial of medically necessary treatment is "based on their belief that a transgender person should not receive certain medical treatment such as sex reassignment surgery and access to traditionally female underwear, despite this treatment being the accepted standard of care for treating gender dysphoria." ECF 62 at 13. Defendants' post hoc attempt to impose requirements on Ms. Edmo that she behave "properly" in accordance with Defendants' "expectations" in order to receive necessary and accepted treatment for a medical condition constitutes the exact evidence that proves Ms. Edmo's Fourteenth Amendment claim.

Defendants have pointed to no other medical condition for which they deny medically necessary treatment on the basis that a patient exhibits "maladaptive behaviors." Similarly, Defendants' disciplining of Ms. Edmo for appearing feminine by wearing a ponytail or makeup that they now newly characterize as "appearing or acting sexual in prison" is further evidence that their treatment of Ms. Edmo is rooted in impermissible discrimination against transgender people, equating presenting as feminine in a male prison as creating a "sexually-charged environment."

As explained in Plaintiff's motion, heightened scrutiny is applied to her Fourteenth Amendment claim, requiring that Defendants show that their policy of denying surgery and other medically necessary treatment to transgender people is substantially related to an important government interest. *See, e.g., Martin v. Barron*, 286 F. Supp. 3d 1131, 1142 (D. Idaho 2018). The

[6] Defendants further cite their "updated GD policy," which has neither been approved nor implemented.

asserted governmental justification must be "exceedingly persuasive" and it must be "genuine, not hypothesized or invented post hoc in response to litigation." *United States v. Virginia*, 518 U.S. 515, 533 (1996). Defendants have made no showing to meet this burden.

C. Affordable Care Act Claim

Defendants incorrectly argue that Section 1557 of the ACA does not apply to IDOC by mis-quoting the definition of a "health program or activity" in the Department of Health and Human Services regulations. The regulations state, "[h]ealth program or activity means the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage." 45 C.F.R. § 92.4 (2016). IDOC incorrectly asserts that "an entity qualifies as participating in a 'health program or activity' if it is principally engaged in the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage." ECF 99 at 16. However, the regulation does not require an entity to be principally engaged in providing or administering health services to qualify as a health program or activity.

The ACA's anti-discrimination protection applies to Ms. Edmo because IDOC is a covered entity under the ACA. *See* 45 C.F.R. § 92.4 (covered entity is "[a]n entity that operates a health program or activity, any part of which receives Federal financial assistance").

II. Plaintiff Will Suffer Irreparable Harm Absent Relief

Defendants argue, without citing to any authority, that injunctive relief is not warranted because Ms. Edmo "is not exhibiting symptoms of a person whose condition is so extreme that a mandatory injunction is required." ECF 99 at 17. This argument is unsupported by evidence, and also misstates the law. Ms. Edmo can establish irreparable harm by virtue of the fact that her gender dysphoria has not been "properly treated over a period of years." *Norsworthy*, 87 F. Supp. 3d at 1193. Her need for surgery is "a matter of long-standing, not sudden, urgency. The continuation of this suffering constitutes irreparable injury, whether this is the first month she has suffered it or the hundredth." *Id.*; *see also McNearney v. Wash. Dep't of Corr.*, 2012 U.S. Dist. LEXIS 115802, at *14 (W.D. Wash. 2012). The suffering that Ms. Edmo continues to endure is not "speculative," but

well-documented in Ms. Edmo's medical record and the reports of Plaintiff's experts. Further, Defendants' attempts to discredit Ms. Edmo's extreme anguish, as well as risk of future self-castration or other self-harm, arising from their failure to provide her medically necessary treatment again demonstrates Defendants' refusal to view gender dysphoria as a legitimate and serious medical condition requiring medical treatment. Indeed, it is striking that Defendants appear to blame Ms. Edmo for her ongoing gender dysphoria, suggesting that if she developed better "coping tools" and participated in programming for other mental health conditions and even sex offender treatment, this would somehow relieve her gender dysphoria. ECF 99 at 18.

III. The Balance of Equities and the Public Interest Favor Granting Injunctive Relief

Defendants essentially argue that the public interest requires that they must be accorded deference to determine what treatment is medically necessary, or the needs of all inmates will be harmed. This is a nonsensical and illogical argument unsupported by any evidence. Requiring Defendants to provide medical treatment in accordance with widely-accepted standards of care does not injure other incarcerated persons, nor does it contravene the public interest. Rather, "the public has a strong interest in the provision of constitutionally adequate health care to prisoners." *McNearney.*, 2012 U.S . Dist. LEXIS 115802, at *44 (quoting *Flynn v. Doyle*, 630 F. Supp. 2d 987, 993 (E.D . Wis. 2009)); *see also Melendres v. Arpaio*, 695 F. 3d 990, 1002 (9t h Cir. 2012) ("[I]t is always in the public interest to prevent the violation of a party's constitutional rights.").

CONCLUSION

For the foregoing reasons, Plaintiff requests that the Court issue a preliminary injunction requiring Defendants to provide her necessary treatment, including surgery, to alleviate ongoing and needless pain and suffering from her serious, but treatable, medical condition of gender dysphoria.

Dated: September 28, 2018

Respectfully Submitted,
HADSELL STORMER & RENICK LLP

By: /s/ - Lori Rifkin
Lori Rifkin
Shaleen Shanbhag
Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 28th 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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Attorney for IDOC Defendants

/s/ - Lori Rifkin
Lori Rifkin

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Email: AWhelan@NCLRights.org
jwilensky@nclrights.org

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

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

Plaintiff,

v.

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

Defendants.

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

DECLARATION OF LORI RIFKIN AND EXHIBITS IN SUPPORT OF PLAINTIFF'S REPLY TO MOTION FOR PRELIMINARY INJUNCTION

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

DECLARATION OF LORI E. RIFKIN

I, Lori E. Rifkin, hereby declare and state:

1. I am a partner at the law firm of Hadsell Stormer & Renick, LLP. I am an attorney licensed to practice law in the state of California and am admitted *pro hac vice* before this Court, and am counsel of record for plaintiffs in this action. The information contained herein is based on my personal knowledge, or upon review of files and documents generated or received and regularly maintained by my office in connection with this case. If called upon, I could testify in a court of law to the accuracy of the matters set forth herein.

2. Attached hereto as **Exhibit 1** is a chart titled "Selected Disciplinary Offense Reports (DORs)," prepared by my office at my direction based upon the information contained in Exhibit 15.

3. Attached hereto as **Exhibit 2** are Plaintiff's Medication Administration Records for the period September-December 2012, produced by Defendant Corizon Inc. in the course of discovery as CORIZON 0768-0772.

4. Attached hereto as **Exhibit 3** are two Health Services Request forms signed by Plaintiff on February 8, 2014 and produced by Defendant Corizon Inc. in the course of discovery as CORIZON 0061-0062.

5. Attached hereto as **Exhibit 4** is a Nursing Encounter Tool form regarding Plaintiff dated September 29, 2015, produced by Defendant Corizon Inc. in the course of discovery as CORIZON 0160-0161.

6. Attached hereto as **Exhibit 5** is an IDOC Suicide Risk Assessment form regarding Plaintiff dated October 1, 2015, produced by Defendant Corizon Inc. in the course of discovery as CORIZON 0493-0494.

7. Attached hereto as **Exhibit 6** are a series of Psychiatric Progress Notes pertaining to Plaintiff dated April 20, 2016 and May 18, 2016, produced by Defendant Corizon Inc. in the course of discovery as CORIZON 538 and 543.

8. Attached hereto as **Exhibit 7** is a Nursing Encounter Tool form regarding Plaintiff

dated December 31, 2016, and an Emergency Department Referral form regarding Plaintiff dated December 31, 2016, produced by Defendant Corizon Inc. in the course of discovery as CORIZON 0174-0176 and 725.

9. Attached hereto as **Exhibit 8** is a January 26, 2017 Psychiatric Progress Note pertaining to Plaintiff, produced by Defendant Corizon Inc. in the course of discovery as CORIZON 0605.

10. Attached hereto as **Exhibit 9** is a document titled "Attendance for Lecture with Dr. Levine," produced by Defendant Scott Eliason at his August 14, 2018 deposition as PBL 0047.

11. Attached hereto as **Exhibit 10** is Dr. Stephen Levine's PowerPoint presentation entitled "Medical Necessity for Transgender Inmates: In Search of Clarity When Paradox, Complexity and Uncertainty Abound" and produced by Defendant Scott Eliason at his August 14, 2018 deposition as PBL 1383-1445.

12. Attached hereto as **Exhibit 11** is a Corizon Inc. PowerPoint presentation entitled "Gender Dysphoria: A Comprehensive Approach to Treatment and Policy Management," produced by Defendant Scott Eliason at his August 14, 2018 deposition as PBL 0399-0474.

13. Filed under separate cover and proposed to be filed Under Seal as **Exhibit 12** is a document produced by Defendant Corizon Inc. in the course of discovery.

14. Attached hereto as **Exhibit 13** is IDOC's Standard Operating Procedure entitled "Gender Identity Disorder: Healthcare for Offenders with," adopted October 31, 2002 and produced by Defendant IDOC in the course of discovery as IDOC_V_pg. 1 - pg. 9.

15. Attached hereto as **Exhibit 14** are a series of internal IDOC policy documents and a draft policy related to IDOC's Standard Operating Procedure "Gender Identity Disorder: Healthcare for Offenders with," produced by Defendants in the course of discovery as IDOC_EE_pg. 1-pg. 35.

16. Attached hereto as **Exhibit 15** are a series of IDOC Disciplinary Offense Reports issued to Plaintiff from 2012-2017, produced by Defendant IDOC in the course of discovery as

IDOC_C_pgs. 8- 9, 21-22, 25, 27-28, 33-34, 41-43, 48-57, and 62-64.

17. Attached hereto as **Exhibit 16** is a July 26, 2016 Mental Health DOR Recommendation for Plaintiff, produced by Defendant Corizon Inc. in the course of discovery as CORIZON 0556.

18. Attached hereto as "**Dowell Dep.**" are excerpts from the deposition of Ashley Dowell, taken August 31, 2018.

19. Attached hereto as "**Edmo Dep.**" are excerpts from the deposition of Adree Edmo, taken August 24, 2018.

20. Attached hereto as "**Eliason Dep.**" are excerpts from the deposition of Scott Eliason, M.D., taken August 14, 2018.

21. Attached hereto as "**Menard Dep.**" are excerpts from the deposition of Steven Menard, taken August 27, 2018.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed September 28, 2018 in Emeryville, California.

/s/ - Lori E. Rifkin
Lori E. Rifkin

INDEX OF EXHIBITS

Exhibit	Description
1	Chart titled "Selected Disciplinary Offense Reports (DORs)"
2	Plaintiff's Medication Administration Records for the period September-December 2012
3	Health Services Request forms signed by Plaintiff on February 8, 2014
4	Nursing Encounter Tool form regarding Plaintiff dated September 29, 2015
5	IDOC Suicide Risk Assessment form regarding Plaintiff dated October 1, 2015
6	Psychiatric Progress Notes pertaining to Plaintiff dated April 20, 2016 and May 18, 2016
7	Nursing Encounter Tool form regarding Plaintiff dated December 31, 2016, and an Emergency Department Referral form regarding Plaintiff dated December 31, 2016
8	Psychiatric Progress Note pertaining to Plaintiff, dated January 26, 2017
9	Attendance for Lecture with Dr. Levine
10	Dr. Stephen Levine's PowerPoint presentation entitled "Medical Necessity for Transgender Inmates: In Search of Clarity When Paradox, Complexity and Uncertainty Abound"
11	Corizon Inc. PowerPoint presentation entitled "Gender Dysphoria: A Comprehensive Approach to Treatment and Policy Management"
12	Document produced by Defendant Corizon Inc. **[Proposed to be filed under seal]**
13	IDOC's Standard Operating Procedure entitled "Gender Identity Disorder: Healthcare for Offenders with," adopted October 31, 2002
14	Internal IDOC policy documents and a draft policy related to IDOC's Standard Operating Procedure "Gender Identity Disorder: Healthcare for Offenders with"
15	IDOC Disciplinary Offense Reports issued to Plaintiff from 2012-2017
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Dowell Dep.	Excerpts from the deposition of Ashley Dowell, taken August 31, 2018
Edmo Dep.	Excerpts from the deposition of Adree Edmo, taken August 24, 2018
Eliason Dep.	Excerpts from the deposition of Scott Eliason, M.D., taken August 14, 2018
Menard Dep.	Excerpts from the deposition of Steven Menard, taken August 27, 2018

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 28th 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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deaton@parsonsbehle. com

J. Kevin West
kwest@parsonsbehle. com

Attorneys for Corizon Defendants

Brady James Hall
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Marisa S. Crecelius
marisa@melawfirm.net

Attorney for IDOC Defendants

/s/ - Lori E. Rifkin
Lori E. Rifkin

Selected Disciplinary Offense Reports (DORs)

Date	IDOC Offense Category	IDOC Staff's Description of Offense
7/12/13	Disobedience to orders 3	"Offender Edmo" wearing "a feminine hair style" and "refused to change his hair" to "comply with direction and orders regarding the feminine hair styles."
2/23/14	Disobedience to orders 3	"Offender Edmo [sic] hair was in a high pony tail and styled in a feminine fashion . . . . I ordered Offender Edmo to take the feminine hair style out. Offender Edmo stated I am sorry that this is the way you feel, but I am allowed per my treatment plan."
2/24/14	Disobedience to orders 3	"Offender Edmo 94691 was wearing makeup and his hair was in a high pony tail which violates policy 325.02.01.002 . . . . I then gave Edmo a direct order to fix the issue . . . . Edmo refused at which point Edmo was placed in restraints and taken to unit 8."
7/8/14	Disobedience to orders 3	"I asked Offender Edmo #94691 to remove Edmo's hairstyle to a style that appeared less feminine gender specific per section 4 of PREA policy 325.02.01.001 . . . . Edmo left the officers [sic] station without changing Edmo's hair."
2/7/15	Disobedience to orders 2	"I gave Edmo a direct order to stay within policy with his hair style," which was "in a bun that was above ear line which violates policy 325.02.01.002" but "[Edmo] openly disobeyed the orders that I gave him."
9/27/15	Possession of unauthorized property	"I was conducting a random search of Offender Edmo's (#94691) Cell . . . . I found an eye drop container with what appeared to be a skin-toned substance that looked like makeup" and "a container of black eyelash makeup with an eyelash applicator."
3/28/16	Disobedience to orders 3	"I warned Edmo that wearing makeup was not allowed and that the makeup needed to be removed . . . . Edmo refused my direct orders to remove the makeup."
5/6/16	Disobedience to orders 3	"[H]e admittedly said he had eyeliner on. I told him I don't want to see him with it on again . . . . Because he was given previous verbal warnings and disciplinary sanctions, I decided that disciplinary action would be ideal."
7/26/16	Destruction of property under $25	"All items had been altered by the cutting and removal of material and sewing to create patterns in the bra straps and to turn the briefs into thong underwear."
11/28/16	Destruction of property under $25	"I found three green state underwear briefs that were altered into thongs."
12/3/17	Destruction of property under $25	"I found three green state underwear briefs that were altered into thongs, three orange cloth thongs made from some unknown cloth."

MEDICATION ADMINISTRATION RECORD

Facility: 6349 ISCI IDAHO STATE CORRECTIONAL INSTITUTION ID **Month:** SEPTEMBER 2012

Init. | Drug - Dose - Mode - Interval | HR | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

EDMO, MASON 94691
CALCIUM CARB 1250MG (500 CALC) TAB (OSCAL-D 1.5 Rx: 26491789
WHINNERY, CATHERINE OD: 08/31/12 DC: 02/27/13
TAKE 1 TAB DAILY FOR 180 DAYS
9/1/12 [signature] 6340-

EDMO, MASON 94691
ASPIRIN EC 81 MG TBEC (ECOTRIN (ASA-EC)) Rx: 26491790
WHINNERY, CATHERINE OD: 08/31/12 DC: 02/27/13
TAKE 1 TAB DAILY WITH FOOD FOR 180 DAYS - DO NOT CRUSH
9/1/12 [signature] 6340-

Estrace 0.5mg po BID x90D
Prescriber Whinnery approved NFdone
Order Date 8-30-12 Start Date 9-21-12 Stop Date 11-29-12
AM HS

Zoloft 150mg. po QHS x120D
Prescriber Sleeper
Order Date 9-19-12 Start Date 9-19-12 Stop Date 1-18-13
HS

Prescriber
Order Date Start Date Stop Date

Prescriber
Order Date Start Date Stop Date

Diagnosis:
Allergies: NKDA
[redacted] DOB/Inmate #: 94691
Location: 6340 MAIN
Name: EDMO, MASON

#3150 REV 4/10

CORIZON 0768

Exhibit 2
Page 1

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
S. Bajevich, RN, DON	T. Lee, RN			E. Reed, LPN		
K. Batista, RN	C. Lujan, RN			J. Revard, CMS		
D/C - Discontinued Order	S. Mallet, LPN			D. Richardson, LPN		
C. Bonilla	C. Marria, LPN			C. Rigdon, LPN		
A. Beshears, RN	J. Maxey, LPN			T. Robertson, RN		
G. Blackburn, LPN	C. McDonald, RN			M. Scifres		
L. Brown, LPN	P. McDonald, LPN			K. Shearer, RN		
E. Camillo, LPN	S. McGrew, LPN			E. Smith LPN		
DC - Other	J. Melchor, LPN					
T. Castello, HST	K. Murray, RN			J. Smith, LPN		
J. Dixon, LPN	C. Newby, CMS			B. Van Sickle, LPN		
B. Dunkee, LPN	B. Olson, LPN			D. Wallace, LPN		
Eastman, RN	S. Patterson, LPN			L. Whitworth, RN		
A. Gage, RN	S. Phillips, LPN			T. Williams, HAS		
E. Goodman, LPN	B. Pierce, LPN			C. Wilson, LPN		
L. Hill	H. Pierce, LPN			C. Young, LPN		
M. Howard, RN	D. Rainier, LPN			C. Zimmerman, RN		
D. Jensen, LPN	C. Ralston, RN					
M. Jordan, RN						

Date/Time	NOTES

CORIZON 0769

Exhibit 2
Page 2

Pg:306
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M **6340-** IDAHO STATE CORR INST (ISCI) ID **Month:** October 2012

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	ASPIRIN EC 81 MG TBEC ~ECOTRIN ~ TAKE 1 TAB DAILY WITH FOOD FOR 180 DAYS >> DO NOT CRUSH << 9/22 #30 Prescriber WHINNERY,CATHERINE Rx#26491790 Order Date 08/31/12 Start Date 9/1/12 Stop Date 02/27/13	K O P																															
	CALCIUM CARB 1250MG/VIT D 1250 MG TABS ~OSCAL-D 500~ TAKE 1 TAB DAILY FOR 180 DAYS 9/22 #30 Prescriber WHINNERY,CATHERINE Rx#26491789 Order Date 08/31/12 Start Date 9/1/12 Stop Date 02/27/13	K O P																															
	ESTRADIOL 0.5 MG TABS ~ESTRACE~ TAKE 1 TAB BY MOUTH TWICE DAILY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#26604130 Order Date 09/21/12 Start Date 9/21/12 Stop Date 12/20/12	AM HS																															
	SERTRALINE HCL 50 MG TABS ~ZOLOFT~ TAKE 3 TABS (150MG) AT BEDTIME FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#26592615 Order Date 09/20/12 Start Date 9/20/12 Stop Date 01/18/13	HS																															
	SPIRONOLACTONE 25 MG TABS ~ALDACTONE~ TAKE 1 TAB TWICE DAILY FOR 180 DAYS >> MAY CAUSE DIZZINESS << 9/22 #60 Prescriber WHINNERY,CATHERINE Rx#26491788 Order Date 08/31/12 Start Date 9/1/12 Stop Date 02/27/13	K O P																															
	Prescriber Order Date Start Date Stop Date																																

Diagnosis:

No Known Drug Allergy

Allergies:

[redacted] 94691 DOB/Inmate #:

6340- MAIN Location:

EDMO, MASON Name:

#3150 REV 4/10

PharmaCorr

CORIZON 0770

Exhibit 2
Page 3

Medication Administration Record

Documentation Codes	Staff Signature	Date	Initials	Staff Signature	Date	Initials
	S. Bajovich, RN, DON	C. Lujan, RN		E. Reed, LPN		
	K. Batista, RN	S. Mallet, LPN		~~J. Revard, CMS~~		
D/C - Discontinued Order	~~A. Beshears, RN~~	C. Marria, LPN		D. Richardson, LPN		
R - Refused	G. Blackbur , LPN	J. Maxey, LPN		C. Rigdon, LPN		
	L. Brown, LPN	~~C. McDonald, RN~~		~~T. Robertson, LPN~~		
A - Absent	E. Camillo, LPN	P. McDonald, LPN		M. Scifres		
	T. Castello, HST	S. McGrew, LPN		K. Shearer, RN		
O - Other	J. Dixon, LPN	J. Melchor, LPN		E. Smith, LPN		
	B. Durkee, LPN	K. Murray, RN		H. Smith, LPN		
	E. Eastman, RN	C. Newby, CMS		~~J. Smith, LPN~~		
	A. Gage, RN	B. Olson, LPN		B. Van Sickle, LPN		
	G. Goodman, LPN	S. Patterson, LPN		D. Wallace, LPN		
	L. Hill	~~S. Phillips, LPN~~		L. Whitworth, RN		
	M. Howard, RN	B. Pierce, LPN		T. Williams, ~~HAS~~ HSA		
	D. Jensen, LPN	H. Pierce, LPN		C. Wilson, LPN		
	M. Jordan, RN	D. Rainier, LPN		~~C. Young, LPN~~		
	T. Lee, RN	C. Ralston, RN		~~C. Zimmerman, RN~~		
	LRDC LPN	JPrudhomme LPN		T. Koch, RN		

Date/Time	NOTES

CORIZON 0771

Exhibit 2
Page 4

Pg:324
Form: H6/31

MEDICATION ADMINISTRATION RECORD

Facility: M 6340- IDAHO STATE CORR INST (ISCI) ID

Month: November 2012

Init.	Drug - Dose - Mode - Interval	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	~~ASPIRIN EC 81 MG TBEC ~ECOTRIN~~ TAKE 1 TAB DAILY WITH FOOD FOR 180 DAYS >> DO NOT CRUSH << Prescriber WHINNERY,CATHERINE Rx#26491790 Order Date 08/31/12 Start Date 9/1/12 Stop Date 02/27/13	K.O.P.																															
	~~CALCIUM CARB 1250MG/VIT D 125~ MG TABS ~OSCAL-D 500~~ TAKE 1 TAB DAILY FOR 180 DAYS Prescriber WHINNERY,CATHERINE Rx#26491789 Order Date 08/31/12 Start Date 9/1/12 Stop Date 02/27/13	K.O.P.																															
	~~ESTRADIOL 0.5 MG TABS ~ESTRACE~~ TAKE 1 TAB BY MOUTH TWICE DAILY FOR 90 DAYS **APPROVED** Prescriber WHINNERY,CATHERINE Rx#26604130 Order Date 09/21/12 Start Date 9/21/12 Stop Date 12/20/12	AM HS																															
	~~SERTRALINE HCL 50 MG TABS ~ZOLOFT~~ TAKE 3 TABS (150MG) AT BEDTIME FOR 120 DAYS >> MAY CAUSE DROWSINESS << Prescriber ELIASON,SCOTT PSY Rx#26592615 Order Date 09/20/12 Start Date 9/20/12 Stop Date 01/18/13	HS																															
	~~SPIRONOLACTONE 25 MG TABS ~ALDACTONE~~ TAKE 1 TAB TWICE DAILY FOR 180 DAYS >> MAY CAUSE DIZZINESS << Prescriber WHINNERY,CATHERINE Rx#26491788 Order Date 08/31/12 Start Date 9/1/12 Stop Date 02/27/13	K.O.P.																															
	Prescriber Order Date Start Date Stop Date																															

Diagnosis:
No Known Drug Allergy
Allergies:

94691
DOB/Inmate #:

6340- MAIN
Location:

EDMO, MASON
Name:

PharmaCorr

#3150 REV 4/10

CORIZON 0772

Exhibit 2
Page 5

628252

CORIZON™
Promote a culture of safety

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$_____
OTC (med)	x_____	Med(s)	$_____
Rx (med)	x_____	Total	$_____

Print Name: A Mason Edmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O B2 A01B

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A Edmo Date: 02-08-14

Nature of Complaint/Problem: Need to see G.I.D specialist for appropriate, necessary medical care ASAP!

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED
FEB 09
Mariah Cunningham, CMS
By_____

Subjective:

Objective: BP _____ P _____ R _____ T _____ Wt _____

Assessment:

Emailed request to Health Director 2/10/14 [illegible]

Plan:

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: _____ Title: _____ Date: _____ Time: _____

TRIAGED
FEB 09 2014
INITIALS

CP7166ID
Revision 09/2012

628253

CORIZON
Promote a culture of safety

HEALTH SERVICES REQUEST
CO-PAY FORM

Medical Dept. Use Only		Accounting Dept. Use Only	
☐ Inmate Initiated Visit		Visit	$_____
OTC (med)	x_____	Med(s)	$_____
Rx (med)	x_____	Total	$_____

Print Name: A. Mason Eclmo Initials: AME Inmate ID: 94691

Date of Birth: [redacted] Housing Location: ICI-O B2 A013

I consent to be treated by health staff for the condition described below. I understand my requesting health services may result in having my account charged for health care received.

Inmate Signature: A. Eclmo Date: 02-08-14

Nature of Complaint/Problem: Need ~~[redacted]~~ Sex reassignment Surgery ~~[redacted]~~ ASAP.

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA Do Not Write Below This Line

Original-Inmate file Yellow – DOC Pink-Accounting Goldenrod- Patient

HEALTH CARE DOCUMENTATION

RECEIVED
FEB 09
Mariah Cunningham, CMS
By _____

Subjective:

Objective: BP _____ P _____ R _____ T _____ Wt _____

Assessment:

Plan:

Emailed request to Health Director 2/10/14 Hernandez

☐ Inmate Education Sheet Given

☐ Use of Nursing Protocols Refer to: ☐ PA/NP/Physician ☐ Nurse/Corizon ☐ Mental Health ☐ Dental ☐ Optometry

Signature: _____ Title: _____ Date: _____ Time: _____

TRIAGED
FEB 09 2014
INITIALS MC

P7166ID
Revision 09/2012

CORIZON 0062

CORIZON
Promote a culture of safety

Nursing Encounter Tool
Abrasions and Laceration

HSR#

Facility Name	Location Seen	Date seen	Time Seen
ISCI/SICK CALL	Unit 15	10/29/15	1830 ○ AM ☑ PM

Patient's Name	Last	First	MI	ID Number	Birth date
	Edmo	Mason		94691	[redacted]

Medication Allergies ☑ N ○ Y If Yes List:

Chronic Care Clinic(s) ○ N ☑ Y GID

☐ Seizures ___/___/___	☐ Asthma ___/___/___	☐ CAD ___/___/___	Last seen in Sick Call: ___/___/___ ☐ N/A
☐ DM ___/___/___	☐ COPD ___/___/___	☐ HTN ___/___/___	☐ Dyslipidemia ___/___/___
			☐ Other ___/___/___

SUBJECTIVE

Chief complaint with onset: medical emergency called to Unit 15 pt cutting himself. pt

History of chief complaint: was attempting to remove scrotum c razor blade

Location of injury: ® posterior side of scrotum Date of injury: 9/29/15

Describe: laceration to ® posterior side of scrotum

Injury sustained in altercation with custody staff or other inmate: ☑ N ○ Y: (May require custody staff notification.)

Exchange of body fluids ☑ N ○ Y: Describe

Loss of sensation or movement ☑ N ○ Y: Describe

Other injuries reported ☑ N ○ Y: Describe

New medications or change in last 30 days ☑ N ○ Y: List: pt GID

Past medical history: ☐ Diabetes ☐ PVD / impaired circulation ☐ Anticoagulation meds ☐ MRSA ☐ HIV ☐ HCV

Tetanus booster > 5 years: ○ N ○ Y ☑ Unknown

OBJECTIVE

Response: AVPU (Choose one) ☑ Awake ○ Responds to Voice ○ Responds to Pain ○ Unresponsive

General appearance: Acute distress ○ N ☑ Y: Describe pt shaken up, covered in blood, medical Ferro c Hoffman

Vital Signs: T 97.9 P 109 RR 18 BP 133/85 Wt. 200 reported Pulse Ox 98 RA %

Skin: Cool ☑ N ○ Y ○ Clammy ☑ N ○ Y Pale ☑ N ○ Y

Wound location: ® posterior side of scrotum Approximate wound size: 1.5cm

Approximate depth of wound: ☑ Superficial ☑ Other:

Active bleeding: ○ N ☑ Y: Describe bleeding controlled c pressure

☑ Bleeding controlled ○ Bleeding uncontrolled

Wound Description: ☐ Abrasion ☐ Avulsion ☑ Laceration ☐ Puncture

○ Uncomplicated - Clean without foreign body or signs of infection

○ Uncomplicated - Superficial debris, dirt, or crusting requiring wound cleansing

☑ Complicated: Describe area irrigated c 1500cc NS, steri-strips applied, dressing placed.

Embedded foreign material: ☑ N ○ Y: Describe

Signs of infection: ☑ N ○ Y: Describe

Additional examination: pt reported that he "hates it." referring to his penis/scrotum. "When I saw how much blood, I stopped." pt placed on suicide watch in Unit 15.

Nurse's Signature	Print/Stamp Name	Title
K Larsen	Kelly Larsen, LPN	LPN

CORIZON
Promote a culture of safety

Nursing Encounter Tool
Abrasions and Lacerations

Patient's Name	Last Edmo	First mason	MI	ID Number 94691

☑ **Emergent intervention not required.** ○ **Emergent intervention required due to:**

Notify practitioner after EMS activation due to
Describe: _____

EMS process activated Time:_____ ○ AM ○ PM
EMS Arrival Time:_____ ○ AM ○ PM
EMS Transport Time:_____ ○ AM ○ PM

☐ Other:_____

Practitioner notified:_____ Time:_____ ○ AM ○ PM

○ **Urgent intervention not required.** ☑ **Urgent intervention required due to:**

Practitioner contact required due to: (check all that apply)
☐ Vital signs:_____
☐ Diabetes or impaired circulation
☐ Unimproved or worsening symptoms
☐ Last tetanus booster unknown or >5 years (non-superficial)
☐ Avulsion ☐ Uncontrolled bleeding
☐ Loss of sensation/movement
☐ Exchange of body fluids ☐ Signs of infection
☐ Embedded foreign material
☐ Eye/mouth/perineum/joint involvement
☑ Other: tetanus shot unknown

○ Seen by Practitioner ☑ Contacted practitioner
Name: J. Mitchell PA

Time:_____ ○ AM ○ PM

☑ See physician orders

Disposition:
☐ Same day practitioner visit/consult
☐ Monitor:_____
☐ Admit to:_____
☑ Other: pt placed on Suicide watch in 16
☐ Sick call follow up ○ Practitioner ○ Nurse
☐ Transport via:_____ to_____

Time:_____ ○ AM ○ PM

○ **Routine intervention**

Disposition:
Medical referral required for: (check all that apply)
☐ Recurrent complaint(2 x 72 hours) without urgent findings
☐ Medication Review
☐ Other:_____

○ Practitioner referral completed
○ Chart designated for practitioner review
○ No Medical Referral Required

Interventions: (check all that apply)
☐ Bleeding stopped with pressure
☐ Wound cleansed with mild antiseptic/soap & water
☐ Foreign materials removed
☐ Topical ointment applied
☐ Sutureless product used
☐ Dressing applied _____/issued #_____
OTC medication given per guidelines ○ N ○ Y
☐ Medication:_____ ☐ KOP
☐ Other:_____

Contact a practitioner or nursing supervisor if you have any concerns about the status of the patient.

Patient Education	Follow Up / Follow Through
☑ Patient educated to contact medical if symptoms develop or worsen ☑ ~~Written~~ Verbal information provided ☑ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care.	Nurse follow up scheduled ○ N ○ Y Custody notified of special needs ○ N ○ Y

K Larsen	Kelly Larsen, LPN	LPN
Nurse's Signature	Print/Stamp Name	Title

IDAHO DEPARTMENT OF CORRECTION
"Protecting You and Your Community"

OFFENDER LAST NAME	OFFENDER FIRST NAME	IDOC#	DOB	DATE OF REPORT
Edmo	Mason	94691	[redacted]	10/1/15

PROTECTIVE FACTORS

Inmate Edmo will be reduced to close observation with razor restriction. Once released from close observation, Inmate Edmo will have 3 days of clinical follow-up. Inmate Edmo will be moved to the BHU for continued clinical services.

EVALUATION OF RISK POTENTIAL *(It should be noted that precise prediction of suicide and other self-injurious behavior is difficult, of limited reliability, and diminishes significantly over time. However, based upon the historical information, an individual interview, existing environmental conditions, and other information available at the time of the review, inmate's current level of risk probably of suicide is indicated below. This level of risk will change over time and should be modified as circumstances change.)*

The offender is currently a moderate risk for self harm

RECOMMENDATIONS

It is recommended inmate Edmo be reduced to close observation today with continued razor restriction until determined otherwise.

Inmate Edmo appears to be a moderate risk for self-harm, but low risk for attempting to kill self intentionally.

RISK REDUCTION/TREATMENT PLAN ADDENDUM

RISK REDUCTION PLAN

PROBLEM *(The problem(s) should be specific to the offender's current reporting issues)*	GOAL *(There should be two (2) types of goals for each Problem: 1) Immediate goal(s) and 2) Short-term goal(s))*	INTERVENTION *(The interventions need to be specific and measurable to each of the two types of goals and relate to the presenting problem(s) of the offender)*
Inmate Edmo cut Edmo's testicles due to gender dysphoria. Inmate Edmo acknowledged focusing too much on the external self and not enough on the internal self; and acknowledged needing to improve self-esteem.	1. Inmate Edmo will refrain from harming or cutting on self. 2. Inmate Edmo will use coping skills to manage distress related to dysphoria. Inmate Edmo will work on improving self-esteem.	1. Inmate Edmo was placed on suicide watch, then reduced to close observation with daily clinical contact. Inmate Edmo will demonstrate and voice stability. 2. Inmate Edmo will be referred to groups, given homework and work with assigned clinician to improve self-esteem. Homework given on 10/1/15.

CORIZON 0493

Exhibit 5
Page 1

IDAHO DEPARTMENT OF CORRECTION

"Protecting You and Your Community"

OFFENDER LAST NAME	OFFENDER FIRST NAME	IDOC#	DOB	DATE OF REPORT
Edmo	Mason	94691	[redacted]	10/1/15

RISK REDUCTION PLAN CON'T

CHANGE IN LOC REQUIRED?	NEW LOC IF APPLICABLE (enter in CIS if LOC has changed)
No	Not Applicable

NATURE OF INCIDENT	DEGREE OF MEDICAL INTERVENTION
Cutting	In-house medical
OFFENDER'S STATED INTENT	**LAST SUICIDE WATCH**
Other: Remove testicles	1-6 months

TREATMENT PLAN UPDATE

The offender will return to their previous treatment plan upon stabilization

ADDITIONAL COMMENTS

According to records, Inmate Edmo was last on suicide watch 8/18/15.

REPORT COMPLETED BY	CREDENTIAL	DATE	SIGNATURE
T. Ruth, 9282	LMSW	10/1/15	

Edmo, Mason IDOC#: 94691 Psychiatric Progress Note ISCI-BHU

4/20/16

S: Inmate reports that she is "doing alright." Is eligible for parole but this has not been granted due to multiple DORs related to use of makeup and feminine appearance. Feminine appearance is subjective, which is very frustrating to the inmate. Wants to discuss sexual reassignment surgery. Has been on hormone replacement for the last year and a half, but feels that she needs more. Cites an improvement in gender dysphoria on hormone replacement, though has ongoing frustrations stemming from current anatomy. Cites that she made attempts to mutilate her genitalia this past fall because of the severity of distress. Also requests to be assigned to a different housing unit, emphasizes need for intact genitalia for successful SRS as a deterrent to self-mutilation. I spoke to prison staff about the inmate's behavior; which is notable for animated affect and no observed distress. I have also personally observed the inmate in these settings and did not observe significant dysphoria. Medications: Effexor XR 150mg AM, Remeron 7.5mg hs Wt 195 (-13)
O: MSE: Hygiene good. Eyebrows colored in with black pencil, wearing foundation. Appears feminine in his demeanor and interaction style. Thoughts logical and linear. Denied any SI/HI. No overt delusions. Affect full range, euthymic, frustrated. Speech regular in rate, rhythm, and volume. Mood "doing allright."
A: 27 year old male to female with Gender Dysphoria, Alcohol Use disorder, and Depression. Will continue current medications. Inmate has been observed to be functioning well in the correctional setting. Does not meet criteria for medical necessity for sex reassignment surgery. I staffed this case with Dr. Jeremy Stoddart, Dr. Murray Young, Jeremy Clark LCPC (clinical supervisor and WPATH member) and they agreed with my assessment. That being said I will continue to monitor and assess this inmate for the medical necessity of SRS throughout there stay here- For the time being it is my opinion that the combination of hormonal treatment and supportive counseling is sufficient for her gender dysphoria. Medical Necessity for Sexual Reassignment Surgery is not very well defined and is constantly shifting but the following situations could meet medical necessity: 1) Congenital malformations or ambiguous genitalia would likely required sexual reassignment or reparative surgery. 2) Severe and devastating dysphoria that is primarily due to genitals could potentially meet criteria for gender reassignment surgery as well. 3) Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage. There may also be other situation which could be determine as medically necessary as more information becomes available. This inmate does not meet any of those above criteria. MDD Gender dysphoria Alcohol Use disorder
P: Cont meds RTC 3 months

Edmo, Mason IDOC#: 94691 Psychiatric Progress Note ISCI-BHU

5/18/16

S: I met with the inmate to explain that the decision regarding SRS has not yet been determined. In a previous visit I had told the inmate that SRS was not medically necessary. Since that time it has been determined that we will form a committee of physicians to determine the medical necessity of SRS. I informed the inmate that this will occur within the next few weeks to months. The inmate understood this.
Chart note
A: 27 year old female with Gender Dysphoria, Alcohol Use disorder, and Depression. MDD, GDD Alcohol Use disorder

CORIZON
Promote a culture of safety

Nursing Encounter Tool
Abrasions and Lacerations

HSR #

Facility Name	Location Seen	Date seen	Time Seen
ISCI/SICK CALL	U15	12/31/16	○ AM ☒ PM 1715

Patient's Name	Last	First	MI	ID Number	Birth date
	Edmo	Adree		94691	[redacted]

Medication Allergies ☒ N ○ Y If Yes List:

Chronic Care Clinic(s) ○ N ☒ Y — Last seen in Sick Call: ___/___/___ ☒ N/A

☐ Seizures ___/___/___	☐ Asthma ___/___/___	☐ CAD ___/___/___	☐ Dyslipidemia ___/___/___
☐ DM ___/___/___	☐ COPD ___/___/___	☐ HTN ___/___/___	☐ Other ___/___/___

Chief complaint with onset: Laceration to Scrotum / exposed testicle

SUBJECTIVE

History of chief complaint: NA

Location of injury: Scrotum Date of injury: 12/31/16

Describe

Injury sustained in altercation with custody staff or other inmate: ☒ N ○ Y: (May require custody staff notification.)

Exchange of body fluids ☒ N ○ Y: Describe

Loss of sensation or movement ☒ N ○ Y: Describe

Other injuries reported ☒ N ○ Y: Describe

New medications or change in last 30 days ○ N ☒ Y: List: ↑ spironolactone,

Past medical history: ☐ Diabetes ☐ PVD / impaired circulation ☐ Anticoagulation meds ☐ MRSA ☐ HIV ☐ H

Tetanus booster > 5 years: ○ N ○ Y ☒ Unknown

OBJECTIVE

Response: AVPU (Choose one) ☒ Awake ○ Responds to Voice ○ Responds to Pain ○ Unresponsive

General appearance: Acute distress ☒ N ○ Y: Describe 8/10 pain reported

Vital Signs: T 97.7 P 104 RR 16 BP 124/87 Wt. 175 Pulse Ox 97 % RA

Skin: Cool ☒ N ○ Y ○ Clammy ☒ N ○ Y Pale ☒ N ○ Y

Wound location: Scrotum Approximate wound size:

Approximate depth of wound: ○ Superficial ☒ Other: exposed testicle

Active bleeding: ☒ N ○ Y: Describe

☒ Bleeding controlled ○ Bleeding uncontrolled

Wound Description: ☐ Abrasion ☒ Avulsion NF ☐ Laceration ☐ Puncture

○ Uncomplicated - Clean without foreign body or signs of infection

☒ Uncomplicated - Superficial debris, dirt, or crusting requiring wound cleansing

○ Complicated: Describe

Embedded foreign material: ○ N ○ Y: Describe Unknown

Signs of infection: ☒ N ○ Y: Describe A+O x3, PERRLA, testicle pink in color ☒ Signs of infection or circulation loss. EMS notified ☒ Signs of blood loss, bleeding controlled.

Additional examination: Pt BID states they no longer want her testicles"

Nurse's Signature	Print/Stamp Name	Title
N. Hoffman	Nicholas Hoffman, LPN	

NA6200
Issued 1/15/2013

CORIZON
Promote a culture of safety

Nursing Encounter Tool
Abrasions and Laceration

Patient's Name	Last Edmo	First Adree	MI	ID Number 94691

Emergent intervention not required. ○ **Emergent intervention required due to:**

Notify practitioner after EMS activation due to
Describe: _____

EMS process activated Time:_____ ○ AM ○ PM
EMS Arrival Time:_____ ○ AM ○ PM
EMS Transport Time:_____ ○ AM ○ PM

☐ Other:_____

Practitioner notified:_____ Time:_____ ○ AM ○ PM

○ **Urgent intervention not required.** **Urgent intervention required due to:**

Practitioner contact required due to: (check all that apply)
☐ Vital signs:_____
☐ Diabetes or impaired circulation
☐ Unimproved or worsening symptoms
☐ Last tetanus booster unknown or >5 years (non-superficial)
☒ Avulsion ☐ Uncontrolled bleeding
☐ Loss of sensation/movement
☐ Exchange of body fluids ☐ Signs of infection
☐ Embedded foreign material
☐ Eye/mouth/ perineum /joint involvement
☐ Other:_____

○ Seen by Practitioner ☒ Contacted practitioner
Name: Daniel Dellwo PA-C
Time: 1730 ○ AM ☒ PM

☐ See physician orders

Disposition:
☐ Same day practitioner visit/consult
☐ Monitor:_____
☐ Admit to:_____
☐ Other:_____
☐ Sick call follow up ○ Practitioner ○ Nurse
☐ Transport via: Ambulance to St. Als
Time: 1800 ○ AM ☒ PM

per Dellwo

○ **Routine intervention**

Disposition:
Medical referral required for : (check all that apply)
☐ Recurrent complaint(2 x 72 hours) without urgent findings
☐ Medication Review
☐ Other:_____

○ Practitioner referral completed
○ Chart designated for practitioner review
○ No Medical Referral Required

Interventions: (check all that apply)
☐ Bleeding stopped with pressure
☐ Wound cleansed with mild antiseptic/soap & water
☐ Foreign materials removed
☐ Topical ointment applied
☐ Sutureless product used
☐ Dressing applied _____/issued #_____
OTC medication given per guidelines ○ N ○ Y
☐ Medication:_____ ☐ KOP
☐ Other:_____

Contact a practitioner or nursing supervisor if you have any concerns about the status of the patient.

Patient Education	Follow Up / Follow Through
☒ Patient educated to contact medical if symptoms develop or worsen ☒ Written information provided ☒ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care.	Nurse follow up scheduled ○ N ○ Y Custody notified of special needs ○ N ○ Y

Nurse's Signature	Print/Stamp Name	Title
B. H.	Nicholas Hoffman	LPN

NA6200
Issued 1/15/2013

CORIZON HEALTH

Nursing Encounter Tool
Return from Off-Site

Facility Name: ISCI	Location Seen: Infirmary		Date Seen: 12-31-16		Time Seen: 2240		
Patient Name: Last EDMO	First [illegible]	MI	ID # 94691	DOB: [redacted]	Age: 29		
Vital Signs: *Call Practitioner	*T>100 T: 98.5	*P>100 P: 95	R: 16	*SBP<100 BP: 128/86	Pulse Ox: 98 % ☒RA ☐ O_2: /lpm	Wt: 175	☐ Actual ☒ Reported
Allergies: NKDA							
Chronic care clinic: ☒ Y ☐ N	What Clinic(s): gender care						

Return from

Time of return: 2240.

- ☒ Off site appointment
- ☒ Emergency visit
- ☐ Outpatient surgery
- ☐ Hospital admission
- ☐ Other: _____

Documentation with patient

- ☒ Discharge summary
- ☐ Discharge orders
- ☐ Other: _____

Treatment procedure expected: assess & Rx of Rt testicular injury

Treatment procedure received: same :

Current symptoms: some pain

See MAR

Current Medications: (Mark all that apply)

- ☐ Antibiotics: _____ Last dose given: _____
- ☐ Diabetes Last med: _____ Time: _____
- Last food intake _____ Time: _____

See MAR

- ☐ New medication within the past 30 days

What medications: _____

Past Medical History: see medical records.

- ☐ Other chronic condition _____

General appearance

Acute Distress ☐ Y ☒ N

Oriented to:

☒ Person ☒ Place ☒ Time

Eyes

☐ Pale ☐ Red ☒ PERRL ☐ Unequal/Abnormal ☐ Watery

Mouth

☐ Oral mucosa ☒ Moist ☐ Dry

Respiratory

☒ Normal

☐ Labored ☐ Stridor ☐ Accessory muscle use

☐ SOB ☐ Cough

Lung sounds

R Lung ☒ Clear ☐ Wheezing ☐ Diminished ☐ Wet

L Lung ☒ Clear ☐ Wheezing ☐ Diminished ☐ Wet

Skin

☐ Warm ☐ Dry ☐ Pale ☐ Cold ☐ Clammy

Wounds/incisions

Describe: Rt testicular c penrose & drsg

Tests

☐ Fingerstick result: Ø (Diabetics)

Comments: to room #2 per H.Case for medical OBS

Eileen Mitchell RN	Eileen Mitchell, RN
Nurse signature	Print/stamp

CORIZON 0176

Exhibit 7
Page 3

CORIZON HEALTH

Emergency Department Referral

From: ISCI (Site Name – Do Not Abbreviate) (Site Number) Today's Date: 2-23-16

Inmate Name: Edmo, Mason (Last, First, MI) Exam Time: 1730

PRISONERS PLAN ESCAPES!
DO NOT Inform prisoners of the date/time of revisits or possible hospitalization. 94691 (Inmate Number) Date of Birth: [redacted]

ER PHYSICIANS – If hospital admission is recommended, please notify: (208) 331-1195

REASON FOR REFERRAL: Include date of onset, present treatment, history of injury or illness, physical examination and pertinent X-rays and lab results

Onset: approx 1720 this evening.

Vital Signs: T: 97.7 P: 104 RR: 16 BP: 124/87 Pulse Ox: 97%

Present Treatment: Supportive. Keep patient warm while protecting site

Comments: Pt has "~~sexual~~ Gender dysmorphic disorder" and states "she" was trying to remove the testicle. She reported disappointment that she failed.

Current Meds: (or attach MAR)

Allergies: NKDA

Approving Practitioner: Dellwo

ER Contact: Case discussed with: Name St Al's Access Center Triage Nurse

Hospital: [x] St. Al's [ ] Other:

Mode of Transportation: ( ) Security (x) Ambulance (x) 911 ( ) Other:

[ ] Referral Form FAX to Utilization Management at: ( ) - emailed to admin

Form completed by: L Eagle RN Signature:

HOSPITAL PHYSICIAN REPORT

Significant Findings, including tests done:

Diagnosis:

Recommendations:

Physician Name: Last: First:

Signature: Date:

BILL DIRECT TO:
Corizon
P. O. Box 981639
El Paso, TX 79998

DO NOT BILL MEDICAID OR MEDICARE

UM1102

Psychiatric Progress Note

ID: 94691

Name: Edmo, Mason

1/26/17

S: Shee sent an HSR stating that she and Dr. Stoddart had discussed Remeron d/t her perseverating about his gender dysphoria. I see nothing in his note about Remeron; however, she has been on it in the past. She recently cut her scrotum as she was confused about her gender. In his note Dr. Stoddart wrote that the confusion happens a couple of times a year. She states that Dr. Stoddart thought that Remeron would be a good combination with his Effexor. She says that she hates taking it so early d/t sleeping too early. She states her environment is better now. She says she is not in unit 8 and not up in the infirmary. She feels the Remeron may be helpful. She states she hasn't slept well lately. She says her mind races at night. She says she is frustrated because she hasn't gotten into the GD group yet. She denies thoughts of hurting herself now. She says when she gets to that point she gets cloudy and has a different mentality and it happens for weeks at a time and it "finally snaps." She is getting some exercise. She says loses a couple of pounds is a boost for her. She reports that her appetite is good. She says she is stressed especially in her shoulders. She will be in prison until 2021.

Response to TX: See above
Medication Compliance: Compliant
Suicidal/Homicidal Ideation and/or Plan: Denies
Medication Side Effects: Denies
Auditory/Visual Hallucinations/Delusions/Paranoia: Denies
Medications: Effexor XR 300 mg. AM

Wt: 176

O: Alert and oriented. Speech is clear with RRR. Thoughts are coherent and goal oriented. Mood appears WNL. Attitude is cooperative. Appearance is well groomed and feminine. Good eye contact. Cognition is intact. Has been on Celexa, Remeron, Zoloft, and Effexor.

AIMS: N/A

Med Consent In Chart: Yes

A: 28 year old (GID) who reports some residual depression and anxiety. She also has problems with sleep. I will start Remeron and have Dr. Stoddart see her in a month or PRN. I have assessed for suicidal ideation and it is low.
Diagnoses Include:
GDD
Major Depressive Disorder
Alcohol Use Disorder
Prison

P: Effexor XR 300 mg. AM; Remeron 15 mg. HS
Educated regarding the risks/benefits/side effects of current medication and inmate verbalized understanding.
RTC: 8 weeks

Attendance for Lecture with Dr. Levine:

Scott Eliason (Psychiatric Director)

Jeremy Stoddart (Psychiatrist)

April Dawson (Physician)

Connie Smock (Corizon nursing director)

Tom Dolan (Corizon)

Murray Young (Regional Medical Director)

Rona Seigert (IDOC)

Laura Watson (MH)

Deputy Warden Coburn

Mark Kubinski (Legal)

Clinician Hahn (MH)

Clinician Ponder (MH)

Jeremy Clark (MH)

Ashley Dowell (Deputy Chief IDOC)

David Agler (Physician)

James Barry (Psychologist)

MEDICAL NECESSITY FOR TRANSGENDER INMATES: IN SEARCH OF CLARITY WHEN PARADOX, COMPLEXITY AND UNCERTAINTY ABOUND

Stephen B. Levine, MD

Clinical Professor of Psychiatry

Case Western Reserve University School of Medicine

PART I. THE BASICS

HUMAN IDENTITY = SENSE OF ONESELF
WHO AM I?

1. Racial
2. Sexual—gender, orientation, intention
3. Familial
4. Religious
5. Class
6. Political
7. Vocational
8. Spousal
9. Cultural
10. Dietary
11. National
12. Regional
13. Recreational
14. Illness bearer/survivor

- Each can be passionately held
- Each can be the source of one's values/energy/preoccupations/ developmental differentiation
- Each can be:
  - Irrelevant
  - Life enhancing
  - Life limiting
  - Life destroying

IDENTITIES CHANGE

- These 14 aspects of identity subtly evolve from youth to old age, predictably and unpredictably
- Some identities are more stable than others
- The declaration to oneself of a trans identity is the beginning phase of a life long evolution;
- Its natural history is not well known

- Levine SB. *Demystifying Love: Plain talk for the mental health professional.* New York, NY: Routledge; 2006.

SEXUAL IDENTITY = COMPOSITE OF THREE SELF-REFLECTIONS

- Gender identity: is based on the sense of self in terms of masculinity/femininity
- Orientation: is based on the inclination to create romantic attachments to and have sex with a class of gendered others
- Intention: is based on what one wants to do to a partner and have done to him during sexual activity; (Paraphilia= target error or unusual activity goal)

Levine SB. *Sexual Life: A clinician's guide*. New York, NY: Plenum; 1992.

EACH SEXUAL IDENTITY COMPONENT HAS AN EROTIC AND A BEHAVIORAL DIMENSION

- **Erotic**: private, psychological, subjective
  - Fantasies
  - Attractions
  - Preoccupations-interests
- **Behavioral**, observable, objective
  - Countable events
  - "Scientific"

Levine SB. *Sexual Life: A clinician's guide*. New York, NY: Plenum; 1992.

TWO CAVEATS

1. Don't confuse sexual identity with one of its components
   - ✓ Gay refers to orientation; it says nothing about gender identity or intention
2. Don't assume that the erotic and behavioral dimensions of anyone's sexual identity correspond
   - ✓ A masculine appearing man may have a feminine gender identity
   - ✓ A heterosexual man may have sex with men
   - ✓ A man's dominant erotic fantasies may be sadistic, although his sexual behavior with a partner is not

SEXUAL IDENTITY IS A MOSAIC

Everyone's sexual identity is subtly subjectively composed of bits masculine and feminine, homoerotic and heteroerotic, conventional and paraphilic desires

THE WIDE SPECTRUM OF SEXUAL IDENTITY DIVERSITY

- Academic sexology is exploring a new overarching theory of identity that takes into account these observations but emphasizes fluidity, change, influence of the intersection of different identities, and the complexity of nurturance of others vs. arousal by others
- Proposed by Sari van Anders, we are likely to hear more of the *Sexual Configurations Theory* in the future because it emphasizes diversity rather than morality, frequency, and normality

- Van Anders, SM. (2015) Beyond orientation: Integrating gender/sex and diverse sexualities via sexual configurations theory. Archives Sexual Behavior 41, 11-12. doi: 10.1007/s10508-012-9932-8

PART 2 VOCABULARY

TERMINOLOGY IS RAPIDLY EVOLVING

- Gender Dimorphic: Assumption that the world is divided into male and female elements. An inmate who wants to live as a woman endorses gender dimorphism
- Gender Diversity: Assumption that the world is comprised of a spectrum of genders; opposite of dimorphic
- Cis: living in the biological sex of assignment=gender conforming=normal
- Gender Nonconforming: individuals whose gender identity and gender role expression differ from what is expected for their biological sex
  - Gender fluid, queer, agender, gender neutral, bigender, pan gender, etc.
- Transgender: Individuals who cross or transcend culturally defined categories of gender.
- Transsexual: Individuals who seek to change or have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical intervention (hormones and/or surgery), typically accompanied by a permanent change in gender role.
- Transitioning: Process of moving from one gender expression to another

TERMINOLOGY IS RAPIDLY EVOLVING

- Gender Dysphoria—the DSM-5 dx for the ICD-10 term transsexualism
- gender dysphoria—the distress that derives from the incongruence of body with the current self-defined gender identity
- WPATH—World Professional Association for Transgender Health which has produced 7 editions of standards of care (SOC)
- SRS - sex reassignment surgery = genital conforming surgery
- Medically necessary—a qualified professional's judgment that an intervention is an indicated and useful treatment for an individual with Gender Dysphoria.

THE WORLD IS RAPIDLY CHANGING

1. When lifelong conventionality was a criterion of normality, trans phenomena were psychopathologies. This began to fade in the 1990s.
2. Six forces are shaping the change
   A. The Internet has ended the isolation of individuals and created new relationships and new communities
   B. 50 years of efforts for minority rights that have culminated in marriage equality(June 26, 2015) and antidiscrimination policies
   C. Celebrity trans people
   D. Positive national media coverage: ”transition is an act of courage”
   E. Feminism—sensitized the world to the idea that gender is political
   F. Silence of professional dissent: only prominent dissent is from Paul McHugh who views trans phenomena as a psychopathology

THE WORLD IS CHANGING

1. Dramatic increase (400%) in request for transition services worldwide in twenty years
2. Major educational and government institutions have made changes in policy, forms, terminology. APA (s) issue policy statements.
3. Some now argue that a young child who wants to change gender should be immediately supported and eventually given puberty blocking hormones, cross sex hormones and SRS by 18
4. Sissy boys and tomboys--have been long recognized to develop homosexual orientations (sissy boys at a far greater rate than tomboys)
   - Degrees of cross gender expression have always existed in the gay and lesbian communities—thus the sexual configurations theory

THE WORLD IS CHANGING

1. Trans now appears in the media as a "fact of nature"
   - Widespread personal, social, media, medical and psychiatric recognition as a separate category of gender identity
   - If an idea is repeated enough in public, it tends to be viewed as true
2. Prevalence in male inmates greater than in non-incarcerated males
3. Estimates of 3000–4000 male GD inmates in US prisons.
   - ✓ California has the most—estimated to be 1/440 to 1/500 compared to 1/10,000 in the general population
   - ✓ We in corrections must try to answer why this might be

PART 3 HIDDEN ASSUMPTIONS FOR DETERMINING MEDICAL NECESSITY

MAKING THE HIDDEN EXPLICIT WHEN MAKING CLINICAL AND LEGAL JUDGMENTS

1. Medical Illness Paradigm
2. Developmental Paradigm
3. Minority Rights Paradigm

MEDICAL ILLNESS PARADIGM: 4 ASSUMPTIONS

1. *The DSM-5 diagnosis, Gender Dysphoria, should determine the treatment just as it does with illnesses such as prostate cancer or Graves Disease*
2. The physician is to employ what is best for the patient after considering the danger of untreated condition, the effectiveness of the treatment, its short-term and long-term side effects and economic cost.
3. All treatments--facial hair removal, hormones, name change, rhinoplasty, augmentation mammoplasty, bilateral mastectomies, liposuction, remodeling the chin, lips, forehead or cricoid cartilage--may lessen the incongruence of current gender identity with form of the body
4. SRS "cures" Gender Dysphoria.

MEDICAL ILLNESS PARADIGM: 7 LIMITATIONS

1. Patient preference, not MD recommendation, is the primary determinant of SRS and cosmetic procedures. MHPs only cooperate with the patient's request for SRS or mastectomies. We are not involved in other surgeries.
2. There is no credible evidence of the genetic dictation or any biologic cause of Gender Dysphoria
   - Several fMRI studies suggest that the brains of transsexual persons are different from other males but such studies have many confounds and, like other brain imaging studies, the findings are "delicate and ephemeral"
     - Tone EB, Am.. Psych. 172 (9):822-823, 2015, editorial
     - Rahman Q. Biological Basis of Orientation. In Handbook of Clinical Sexuality for Mental Health Professionals Routledge New York, 2016.

MEDICAL ILLNESS PARADIGM: LIMITATIONS

3. Prevalence estimates vary: is this due to multifactorial influences, definition/methodological differences or political motivations
   - Two estimates among US military personnel
     - Belkin: 12,800 transgendered on active duty
     - Rand report: up to 129

Belkin A. Caring for our transgendered troops. NEJM 373(12):1089-1091, 2015
Tone EB, High stakes in small mistakes: abused youth show hypersensitivity to Errors. Am.J. Psych. 172 (9):822-823, 2015, editorial

MEDICAL ILLNESS PARADIGM: LIMITATIONS

4. Gender Dysphoria is known to resolve spontaneously in response to life processes.
5. The majority of boys diagnosed with Gender Dysphoria become homosexual adolescents.
6. Treatments do not target any biological abnormality
7. If genital surgery cures anything, it eradicates distress over natal genitalia in relationship to current gender identity; does not help other anatomic inconsistencies

MUSINGS ON THE MEDICAL PARADIGM

1. The nature of disease: Biological diseases occur within a social context that shapes outcome because of economic, cultural and familial influences. The growth of attention to Gender Dysphoria is an excellent example of how societal forces create concepts of illness and acceptable forms of treatment

2. The social-political need: to obtain insurance coverage.12 states have mandated it; 90% of those who have SRS now have insurance coverage

3. Politics masquerading as science: WPATH explains the co-morbid psychiatric problems as a consequence of familial and societal minority stress— all suffering and limitations are due to the gender problem and all will be improved by hormones, transition and SRS.

4. What is a mental illness? WPATH asserts that Gender Dysphoria is not a symptom of an illness, despite the frequent symptomatic and functional accompaniments and despite its persistence in DSM-5

THE DEVELOPMENTAL PARADIGM: 4 ASSUMPTIONS

1. *Gender Dysphoria is an adaptation to an evolving problem that was first manifested as a failure to establish a comfortable conventional sense of self in early childhood*
    a. The source and the evolution of this uncomfortable and behaviorally problematic sense of self are explained by the interaction of changing biological, social, developmental psychological and cultural forces
    b. The declaration of the self as transgendered is the latest solution
    c. Thereafter, trans individuals view their life histories as containing elements that provide conviction that they have always been that way. They now see that they have had a feminine self, struggling for expression over their false but culturally approved of male gender roles. This metaphor, the typical narrative of the trans inmate, is likely a fallacy.

THE DEVELOPMENTAL PARADIGM: 4 ASSUMPTIONS

2. During adolescence these forces create other unstable identities involving gender, orientation, paraphilia and dysfunction in partner sexual intimacies.
3. Fluidity of the person's gender identity, as well as other aspects of identity, is noted before and after SRS—trans individuals may change their ethnicity, religion, religiosity, diet, or last name
4. The diagnosis of Gender Dysphoria, per se, does not mean that hormones and surgery are medically necessary

* .

THE DEVELOPMENTAL PARADIGM: CLINICAL RESPONSES

1. Treatment is based on a compassionate understanding of the individual's history, co-morbidities and motivations for the transition. The challenge is to consider what can be done to ameliorate the patient's suffering in the cultural setting of the patient's life.
2. Clinicians urge hope, patience, and continued clarification of the forces that shape the individual's distress, current needs and behavior through ongoing psychotherapy.
3. They work with the environment to make life easier by addressing the person by her preferred name, meetings with family, environmental education and support groups.
4. Asserts that this intrapsychic problem dictates a thoughtful relationship-based process intervene between diagnosis and medical/surgical treatment

THE DEVELOPMENTAL PARADIGM: CLINICAL RESPONSES

5. Ongoing psychotherapeutic investigation can in some circumstances help the person to face past dilemmas and recognize the underlying conflicts that are being avoided through transitioning.
6. Clinicians raise the question with the patient to what extent and in what ways anyone can start their life over, inside or outside of prison
7. Clinicians attempt two particularly difficult tasks:
    a. Defining motivation for change—hard to conceptualize and admit overlapping motives
    b. Recognize and own ambivalence about female body and invention of female role
8. Psychotherapy allows a clinician to recognize the reasonableness of hormones and SRS for some individuals

THE DEVELOPMENTAL PARADIGM: 5 LIMITATIONS

1. It often conflicts with the patients' wishes. Many patients do not want to consider the impact of their past adversities, their convictions about the sources of their suffering and that they might not be correct about what is necessary to relieve their distress.

    a. Some will not establish an alliance unless the therapist supports the permanence of the current gender identity and the unquestionable need for hormones and surgery. It is simple to ally with a inmate's belief in his feminine self and his need to evolving this way

    b. This attitude is built on a pervasive distrust of others and a certainty about what would benefit them.

2. Pre-endocrine or pre-operative psychotherapy is no longer a SOC requirement

THE DEVELOPMENTAL PARADIGM: 5 LIMITATIONS

3. Understanding a developmental process does not mean that the patient's ambitions can be changed

4. Change depends in part on patient capacity to use a therapeutic relationship to grow; many do not seem to have this capacity.

5. Many psychiatrists no longer conduct psychotherapy with anyone, let alone the transgendered! Many MHPs do not want to see these by claiming that they lack of training. (Psst…trans individuals are human beings)

MINORITY RIGHTS PARADIGM: 3 ASSUMPTIONS

1. ***The*** *treatment of Gender Dysphoria should be determined by the patient's wishes because individuals have the right to express their gender as they see fit*
2. Psychiatry viewed homosexual persons as mentally ill until 1976. Homosexuality is now viewed as a developmental variation. This paradigm perceives trans people as similarly misunderstood, marginalized, diagnosed, stigmatized and cruelly ignored or inappropriately delayed in their medically necessary endocrine and surgical therapies.
3. Anyone who hesitates supporting transition and SRS is a dinosaur committed to an outgrown inherently discriminatory understanding of trans persons and needs to be defeated in court or in the public arena.

THE MINORITY RIGHTS PARADIGM: 5 PARADOXES

1. This legal political perspective borrows the medical paradigm to get patients their desired treatment but then denies that Gender Dysphoria is a form of illness.
2. SOC, which claims to be a scientific and a minority rights document, ignores the profound differences between science and advocacy.
3. WPATH assert that gender identity and orientation are two ever-distinct aspects of sexual identity denying the obvious overlap and two-way traffic between

THE MINORITY RIGHTS PARADIGM: 5 PARADOXES

4. WPATH aims to decrease stigmatization by declaring all trans individuals as normal and views trans individuals' anxiety states, suicidal preoccupations, suicide attempts, substance abuse and aggression to others as consequences of social rejection. Most MHPs find this a jarring position. APA has long fought against the stigmatization of the mentally ill without denying that patients have illnesses.

5. Judges, who are schooled in civil rights, look to professional societies like WPATH, for guidance. It is an uphill battle to convince them that a professional society is wrong and a dissenting expert in the courtroom is right.

THE MINORITY RIGHTS PARADIGM: 5 PARADOXES

6. Assumes that genital surgery will cure of the problem and withholding SRS constitutes a gross violation of the Eighth Amendment.

7. Prisoners' right to SRS overrides the fact that in the community they might not qualify because of their problematic behaviors and co-morbidiites. The argument is that they are well-enough because of maturation and institutional control. The crime for which they are incarcerated and their prior criminal career are irrelevant to the delivery of trans care. Is it irrelevant to their motivation for transitioning, however?

PART 4 MEANINGS OF MEDICAL NECESSITY

Hidden Ethical Dimensions

CRASHING OF ETHICAL STANDARDS EXPLAIN NEGATIVE COUNTERTRANSFERENCE

1. Above all do no harm
2. Respect for patient autonomy
3. Honesty/Informed consent
4. Devotion to the patient's welfare—beneficence
5. Care based on knowledge (vs. care based on personal political belief)

Jones DS, Podolsky SH, Greene JA. The burden of disease and the changing task of medicine N Engl J Med. 2012 Jun 21;366(25):2333-4

THEN THERE ARE ROLE CONFLICTS

- Medical disease paradigm creates the conviction that the diagnosis of Gender Dysphoria = support for transition, hormones, and plastic and genital surgery ASAP—”cheerleaders”
- Developmental paradigm creates the conviction Gender Dysphoria = understand the psychosocial pathways to this identity, appreciate the strengths and limitations of the patient, represent consequences of transition, and share the long term follow up information

McHugh PR, Slavney PR. Mental Illness-comprehensive evaluation or checklist? NEJM 366, 1853-1854

SCIENCE VS. ADVOCACY

A. Science provides a dispassionate view of what seem to be the facts. Science recognizes its own limitations
B. Advocacy aims at attaining a specific goal. Advocacy musters the facts that support the goal; it is disinterested in emphasizing the limitations of its position.
C. The fact that the post-operative suicide rate ten years after SRS is 19x general population is irrelevant to the minority rights paradigm

INSURANCE INDUSTRY'S CONCEPT OF MEDICAL NECESSITY

- Four elements
  - a licensed qualified health professional who evaluates and treats the patient;
  - an insurance company decides what interventions will be covered;
  - state and federal legislation that mandates specific coverage;
  - courts that rule on disputes between these parties.
- The attitude of government and insurance providers is evolving. An increasing number of plans and states are extending coverage to carefully diagnosed and prepared patients with Gender Dysphoria.
  - SRS is being covered because of the belief that it can meaningfully help the patient psychologically, if not cure the problem. Some companies have concluded SRS is a scientifically verified effective treatment
  - This represents one of the many recent gains in minority rights.
  - While patient belief alone is insufficient to justify medical necessity, patient belief in the early post operative years is one of the factors that creates the impression that SRS is effective.

TERM EASES ENDOCRINOLOGISTS' AND SURGEONS' ETHICAL DISTRESS

- The original use of "medically necessary" among gender specialists appeared in the1970's within the Harry Benjamin International Gender Dysphoria Association (the initial name of WPATH) to assuage the concerns of endocrinologists and surgeons who recognized that their interventions went against the principle of nonmalficience (do no harm).
- The employment of this term enabled surgeons to remove healthy tissues to improve the subjective quality of a person's life. They were asked to listen to the patients tell of their distress to convince themselves what the HBIGDA meant by being ethically acceptable.
- Today, if the phrase "psychologically beneficial" were substituted for medically necessary there may be considerably less confusion.

OSBORNE CS, LAWRENCE AA, MALE PRISON INMATES WITH GENDER DYSPHORIA: WHEN IS SEX REASSIGNMENT SURGERY APPROPRIATE?

ARCH SEX BEHAVIOR E PUB MARCH 2016

1. Determination of medical necessity always reflects professional judgment exercised with respect to a particular patient; Although a judgment of medical necessity can be contested, the grounds for doing so are quite limited.
2. SRS is a safe, effective, and widely accepted treatment for GD, disputing the medical necessity of SRS based on assertions to the contrary is unsupportable.
3. SRS can be judged medically necessary for some persons with GD, especially males, when their GD reflects intense distress about the incongruence between their external genitalia and their gender identity because this incongruence that can only be corrected through genital surgery.
4. Other bases for asserting the medical necessity of SRS, such as treating suicidality or depression, are more problematic.

OSBORNE AND LAWRENCE: GENERAL MEANING OF MEDICAL NECESSITY

- "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
  - a) in accordance with generally accepted standards of medical practice;
  - b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
  - c) not primarily for the convenience of the patient, physician or other health care provider
  - d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

OSBORNE AND LAWRENCE

- We would caution, however, that these favorable conclusions (widespread support for SRS as effective over 30 years of study) 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 differ in significant ways from community patients.

FOUR CRITERIA FOR MEDICAL NECESSITY THROUGHOUT MEDICINE

1. Does it prevent death?
2. Does it prevent complication?
3. Does it relieve pain?
4. Does it improve function?

PREVENTING DEATH AMONG INMATES WITH GENDER DYSPHORIA

- Individuals with Gender Dysphoria are well known to have suicidal ideation and to suicide before hormones, during hormonal treatment and after SRS
  - Suicide rate after SRS is far greater than the general population
  - Suicide rate is comparable with VA patients with chronic mental disorders
- SRS is not conceived as lifesaving as is repairing a potentially leaking aortic aneurysm but as life enhancing as is providing augmentation for women distressed about their small breasts.
- When inmates declare they will suicide without SRS, their desperation and manipulation are separately addressed.
- When experts declare a prisoner is likely to suicide without SRS, they overlook their profession's poor track record at prediction and what else can be done to deal with their depression.
- Our committee once refused SRS to a young man who had made 6 suicide attempts and told us he thought he would suicide after the operation

PREVENTING COMPLICATION AMONG GD INMATES

- Disappointment, despair, depression and suicidal ideation* are likely to follow the rejection of a request for SRS as an inmate comes to grips with the obstacles fulfilling this desire
- Some have argued that SRS will prevent genital self-mutilation. Mutilation is far more often considered than attempted, and more often attempted than completed
  - It often is a response to the inmate's sense that her identity is being ignored
  - As a result of increasing experience with trans inmates, such desperation is less frequently ignored
  - Inmates considering this act often say that they will begin the process in the hope that the doctors will finish it.
    - Corrections staff cannot provide SRS under these conditions.
- To date, most GD inmates in American prisons have not had any major complications other than frustration and the sense that the DOC does not care about their suffering

* and unacknowledged relief

RELIEVING PAIN IN GD INMATES

- Gender dysphoria is a form of psychological pain. As represented in court, gender dysphoria is a steady state of distress, often described as suffering. The pain is represented as intense, unrelenting and interfering with the ability to function well.
- It is difficult to quantify or compare this type of pain. Is it exaggerated by lawyers? By inmates? Or by lawyers counseling their clients how to speak about it?
- Most pre-operative trans females have learned to ignore their penis most of the time even though its functions remind them of their maleness.
- All psychiatric conditions have their own form of psychological pain. I do not know how to objectively compare gender dysphoria with the diverse psychiatric diagnoses that MHPs also try to ameliorate. Lawyers make judges feel this is worse than other psychic pains!
- What is unique about gender dysphoria is the clinical experience that any form of increased feminization—being acknowledged with a female name,being treated with respect by corrections officers and prescribing hormones can temporarily ameliorate it.
- SRS relieves the dysphoria caused by the presence of male genitalia and in addition pleases because of the female genital appearance, if the surgery goes well. The patient feels more genuine.

IMPROVE CAPACITY TO FUNCTION OF INMATES

- SOC leave room for case-by-case judgments and state that they are intended to be flexible guidelines.
- In prisons, ascertaining medical necessity and readiness are complicated processes.
  - Clinicians are asked to articulate why they feel their patient is ready and whether the patient has worked through ambivalence about SRS. “I have no ambivalence” is a sign that the inmate is either not being honest or is dangerously without insight. It is difficult to ethically feel one has provided informed consent when inmates are certain that nothing will go wrong and the surgery will make them complete as a woman.
  - Post-operative transsexuals report the arduousness of translating their concept of the self as a woman into living successfully in this new role. Their adaptations leave them vulnerable to decompensations.

IMPROVE CAPACITY TO FUNCTION OF INMATES

- While this has been well documented in Sweden of everyone who had SRS over thirty years, the study did not contain a control group of those with Gender Dysphoria who did not have SRS. The study used age, and gender matched controls from the general population (10 controls per subject). The researchers' conclusion was that individuals who have SRS should have post-operative lifelong psychiatric care
- This conclusion was based on the need to prevent suicide attempts and completed suicide which were 7,6 and nineteen times more frequent than in the controls.
- In prison, the inability to function well usually is reflected in the absence of segregation, job and privilege maintenance.
- Where these parameters indicate poor functioning in the environment, should consideration of SRS be delayed?
- Being happy after SRS is not to be equated with improving function. Improved function is a simple concept when it comes to incontinence after a prostatectomy, but is complicated when it applies to dealing with diverse aspects of life skills, which may not have been well developed prior to incarceration.

AN UNCERTAINTY

Assuming SRS is conceptually granted as a matter of policy in Idaho, should it only be granted to those with a long stable history of good functioning because they are assumed to have more coping skills to deal with the changes SRS will bring about or be given to those with poor functioning in the hope that their function will improve when their gender dysphoria is ameliorated?

SRS AS A CAUSE OF FUTURE PAIN—7 CONSIDERATIONS

1. Inmates who receive SRS achieve their long quest and purpose for living. Most will continue incarceration and the emptiness of a life without a sustained purpose. This may be a recipe for a new form of pain and behavioral dyscontrol.
2. The hope is to be transferred to women's prison, which is assumed to be a happy prospect of acceptance as a woman. This may pose significant security concerns in some cases. Women prisoners, many of whom have been victims of domestic violence and abuse, may be wary of a trans inmate with a history of violence and may keep the inmate feeling like an outsider. Living among women prisoners represents a different more relevant real life experience than feminizing in a male environment. Inmates may discover that they are profoundly different from natal criminal women and become unhappy with their decision to transition. They may flunk their second "real life test."
3. Many of these individuals have very poor interpersonal skills, which are not likely to improve via SRS. If they develop a romantic attachment to another female inmate, it may lead to regret for having lost their male genitalia.

? NEW PROBLEMS

4. Legal battles provide inmates with a heroic purpose because success in the courtroom will enable others to follow. The inmates attain an elevated status over other prisoners in their minds. To many peers they are weird, but to themselves they are special because of Gender Dysphoria. Over time, this will dissipate and they will be disappointed that others do not view them that way.
5. Inmates have a difficult time holding onto the idea that SRSs can create significant anatomic and functional complications. There is no guarantee of surgical cosmetic and functional success. Individuals with poor surgical outcomes are thought to have fared worse over time than those without functional and anatomic complications.
6. Not all GD inmates have told their family members (when they still are in contact) of their feminine identity and life style choices. SRS may further weaken their familial connections.
7. One or more of these problems will be occurring in relatively inarticulate individuals when it comes to subtle sources of their distress. This can only lead to need for more mental health services or increased behavioral control.

OSBORNE AND LAWRENCE'S CRITERIA FOR SRS FOR INMATES

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;
5. Willingness to be assigned to a women's prison after SRS.

ANOTHER PARADOX FROM THE SOC

- The SOC explicitly allows the standard eligibility requirements for SRS to be modified when indicated: The criteria put forth in this document for . . . surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies.

- Versus

- The SOC in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. . . . All elements of assessment and treatment as described in the SOC can be provided to people living in institutions . . . . Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the SOC, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria .Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the SOC.

PART 5 RETURNING TO THE TRANS INMATE

THEIR PARADIGM

1. Trans is my discovered true identity; Now that I know it, I want to be treated as such with respect, protected from harassment by inmates and correctional staff, and afforded privileges typically granted to cisgender inmates of the opposite sex as I come to understand them.
2. Although I have a condition that others call a disorder, I am not disordered; I am happier. But, I need the treatment that you can readily provide. The more that I am called upon to continue to behave and be regarded as a male without that treatment, the more pain and vulnerability I experience.
    a. Much of this pain is unnecessary and is born of inmate and staff attitudes toward me
    b. Even if I can not get everything that I want here and now, the fight against my keepers is valuable
        I. I may prevail and obtain what I want
        II. I may make it easier for others if I can change the environment
        III. My life now has a new purpose and goal

INMATE TRANS PARADIGM

3. My sexual attractions, behaviors, and intimate relationships are not to be regarded as homosexual because I am a woman. I am different from gay men: I always have been.
4. I can't trust
   a. You--because you are not doing what you are supposed to: advocating for me with the DOC to get me what I need.
   b. You--because you want to talk about irrelevant or superficial things
   c. Anyone in this place, including mental health staff--because you don't care about me
   d. Other trans inmates--because my sisters can be selfish, narcissistic and jealous
5. If you give me what I want now, I will be happy; I won't want more later.
6. Life will not be worth living if I can not believe I can attain my goal.
7. I live in this system; I know how it works; I am just looking out for me in the best way I know how. Don't expect me to tell you too much about me.

CONSIDERATIONS FOR EVALUATION

Can Co-exist with Gender Dysphoria

1. Psychotic symptoms
2. Depressive symptoms
3. Dissociative symptoms
4. Body dysmorphic symptoms
5. Autistic spectrum symptoms
6. Suicidal ideation/past attempts
7. Substance abuse
8. Paraphilia past and current activities
9. Mutilation of genitals or breasts
10. Anorexia bulimia symptoms

Other Vital Matters

1. Vocational and scholastic history
2. Complete criminal history including sex offenses
3. Quality of early life attachments within the family history
4. When did the current gender crystallization occur?
5. What experience and emotional state preceded it?
6. What is person's concept of its motivation?
7. What previous identities have been important?
8. Does inmate want to live among women in prison or stay among men? Why?
9. What worries does the person have about this new form of being? Do not accept "none."
10. What is the quality of thinking from magical to realistic?

IS THERE A FIFTH HIDDEN PARADIGM—A JUSTICE PARADIGM?

- The justice paradigm reminds us that the inmate is in prison as a punishment for crime, for the protection of citizens and for an opportunity for civic rehabilitation.
  1. Most inmates do not have the resources, insurance coverage or cash, to personally pay for this surgical process and its post operative surgical interventions. Going to prison, ironically, presents an opportunity for SRS
  2. Most individuals--professional, governmental officials and laypersons--do not support this surgery and express bafflement and outrage when they learn of court decisions to mandate it for inmates at public expense.
  3. This paradigm might be alternatively labeled common sense paradigm or a citizens paradigm

IS THERE A FIFTH HIDDEN PARADIGM—A JUSTICE PARADIGM?

4. Judicial rulings mandating SRS are based on Gender Dysphoria being a "serious medical disorder" that has wide "consensus among professionals experienced with the condition" as the standard of care in the community. Since prisons are responsible for the medical care of its inmates, withholding SRS is viewed as cruel and unusual punishment, which is a violation of the inmates' Eighth Amendment rights.
    a. The will of the people is insufficient to overcome rights guaranteed by the Constitution
    b. Judges up for re-election are, however, mindful of the will of the people.
5. It is reasonable to assume that this paradigm is operative within corrections professionals and adds to their uncertainties and sense of confusion
6. It is reasonable to assume that this paradigm is operative within inmates and affords them this one chance in a lifetime
    a. This may explain their motivation to exaggerate their distress (gender dysphoria).

TOWARDS POLICY RECOMMENDATIONS

1. Gender dysphoria is a legitimate psychiatric condition and legally and ethically cannot be ignored.
2. Every state has the right to create a policy based on its own unique inmate, geographic and political characteristics within the human rights and legal standards of adequate psychiatric care of its inmates.
3. Prisoners who declare themselves to have developed gender dysphoria symptoms while in custody should be initially evaluated in a deliberate two-step comprehensive manner over at least six months.
    a. The first step is at least a two-hour exploration of the diagnosis of Gender Dysphoria to determine if full partial criteria are met and to ascertain the history of and current presence of psychiatric and medical co-morbidities. Regardless of the findings, with the inmates' consent, they can be enrolled in the Gender Dysphoria program
    b. The second step is the continuation of the evaluation on a regular basis to establish a working relationship with the inmate and to cover the items enumerated on slide 56. At any time the inmate may withdraw participation in the program and will be declared not a gender dysphoric person. Other psychiatric diagnoses may receive mental health attention.
    c. This six-month evaluation should not be done by outside consultants unless it is part of a larger program to develop and train corrections staff to assume this role with other gender dysphoric inmates

TOWARDS POLICY RECOMMENDATIONS

3. If the inmate meets three criteria:
    I. The persistence of the wish to transition in prison over this six-month period
    II. Attends regular meetings with a mental health clinician to discuss relevant developmental and current psychological and interpersonal issues
    III. Absence of serious rule infractions during this time

these non-medical feminization (masculinization) processes should be instituted

a. A meeting shall be held with security officials to discuss increased risks of sexual assault and harassment and what the inmate and staff can do to minimize this
b. Corrections staff will be instructed to address the person by a chosen name
c. Female canteen items available in male prisons may be purchased and worn without being considered contraband
d. If desired by the inmate, accommodations should be made to allow private showering and strip searching
e. Makeshift items such as eyeliner, makeup, self-made undergarments shall not be considered contraband as long as they are known to and approved by security officials

TOWARDS POLICY RECOMMENDATIONS

4. Criteria for hormone administration
    a. Four months of non-medical feminization
    b. At least monthly cooperative meetings with the MHP have occurred
    c. No serious rule infractions have occurred
    d. No medical contraindications as assessed by medical or endocrinology staff
    e. Signing a written contract that specifies
        1) That the physician will determine the dose and specific drugs administered not the patient. Criteria for cessation of hormone treatment
        2) The treatment will be stopped if the inmate is discovered to have diverted the hormones to another inmate
        3) The inmate may stop the hormonal treatment at any time but will consult with the physician about the safest fashion to do this
        4) A new medical condition may arise that makes it medically prudent to stop the hormones
        5) The team of gender specialists within the prison may stop the hormone treatment if a consistent deterioration of the inmate's mental health ensues. This may be manifested by a new inability to vocationally function, new major interpersonal inmate problems or behavioral uncooperation with corrections staff
5. Criterion for continuation of hormone treatment is stable or improved mental and behavioral health
6. Inmate is not required to have meetings with the MHP after three months.. Inmates may see their MHP on an as needed bases thereafter

TOWARDS POLICY RECOMMENDATIONS:
NEW INMATES WHO HAVE PREVIOUSLY TRANSITIONED

7. They shall have at least a two-hour evaluation to review and begin to document their previous transition and its hormonal and surgical therapies
    a. Inmate should be evaluated by a physician to ascertain the degree of feminization (or masculinization) by physical and laboratory examinations
    b. Decisions about nonmedical feminization (masculinization) and continuation of endocrine therapies should be based both the information from the mental health professional and the non psychiatric physician
    c. It is anticipated that new inmates who have lived in the opposite gender role for many years without having genital surgery or mastectomies are likely to be housed based on their genital anatomy to their chagrin. Every effort should be made within the safety parameters of the prison to quickly accommodate to their gender identity needs.

TOWARDS POLICY RECOMMENDATIONS

8. Criteria for facial hair removal
    a. When criteria for hormone administration are met and at least three months of hormone treatment has occurred, electrolysis or laser treatment may be obtained for heavily bearded trans women.
9. Criteria for male-to-female genital surgery
    a. After twenty-four continuous months of hormone treatment (the period of maximum bodily effects), a committee will ascertain that all previous steps have been accomplished
    b. When the inmate requests SRS in a written application, resumption of regular meetings with the mental health clinician will begin to occur at least monthly. The agenda for these meetings will include motivations for SRS, quality of thinking, obstacles in inmate's path, negative aspects of moving to a women's facility, the impact of the loss of penis, the possibility of surgical complications and new chronic urinary problems and less than normal appearing insensate vagina
    c. Continued high functioning without serious disciplinary function
    d. Inmate consistently presents as a trans womanto family visitors
    e. At least five more years of incarceration after SRS without possibility of parole
    f. A committee of mental health professionals and safety officials will meet with the mental health professional first and then with the inmates to ascertain the judgment that that a successful SRS is likely to further benefit the inmate.
    g. The inmate should anticipate that prison administrators removed from the committee may delay SRS likely as long as possible any inmates SRS

Gender Dysphoria: A Comprehensive Approach to Treatment and Policy Management

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Vice President of Operations-Nashville, Tennessee

Scott Eliason, MD, CCHP-MH
Regional Director of Psychiatry-Boise, Idaho

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Mental Health Director-Rawlins, Wyoming

Jessica Lee, MSN, CCHP
Vice President of IT Customer Solutions Integration-Brentwood, Tennessee

Faculty Disclosure

"We have the following relevant financial relationship(s) with a commercial interest:" and explain….

All Presenters currently work for Corizon Health.

Educational Objectives

- Participants will learn the most up to date approaches to treating patients with gender dysphoria utilizing national standards as a guideline for treatment planning.

- Participants will learn how to create a gender dysphoria policy for a correctional environment.

- Participants will learn how to address specific issues when treating this population from six major areas including behavioral health, psychiatry, nursing, prison and jail administration and PREA

INTRODUCTIONS

Dr. Mark Fleming—
Moderator and Introduction
to Gender Dysphoria

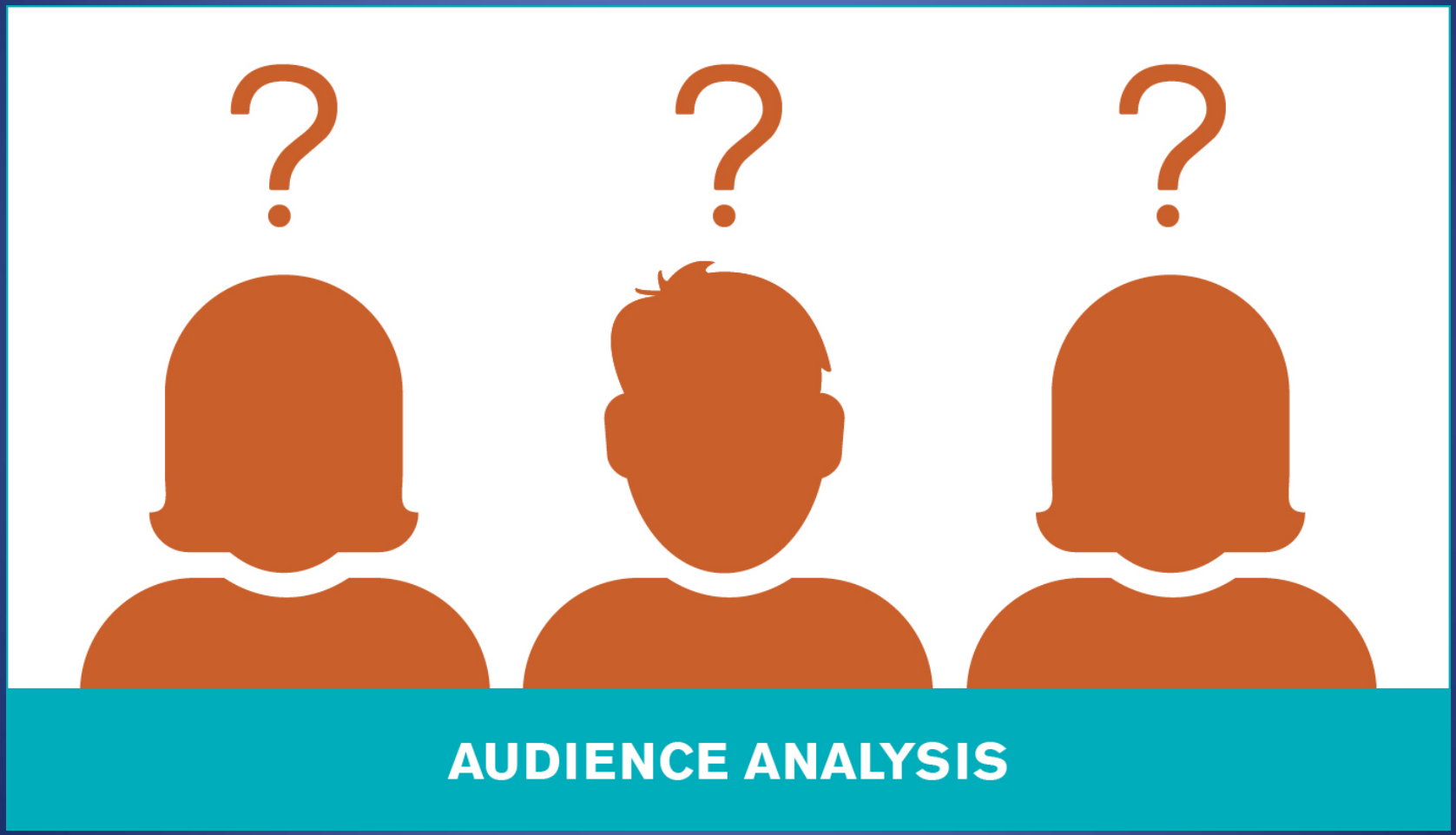
Dr. Scott Eliason-Behavioral
Health and Gender Dysphoria

Jessica Lee-Nursing

Dr. Mariann Atwell—
Administration

Laura Mckinnon--PREA

WHO IS IN THE AUDIENCE?



PRESENTATION FORMAT

SCHEDULE

1:30-1:45 PM—Introductions

1:45-2:15 PM—Introduction to Gender Dysphoria

2:15-2:45 PM—Gender Dysphoria: A Psychiatric Perspective

2:45-3:15 PM—Nursing

3:15-3:30 PM—Break

3:30-4:00—Administration

4:00-4:30 PM—PREA

4:30-5:00PM—Discussion

Managing Gender Dysphoria From A Behavioral Health Perspective

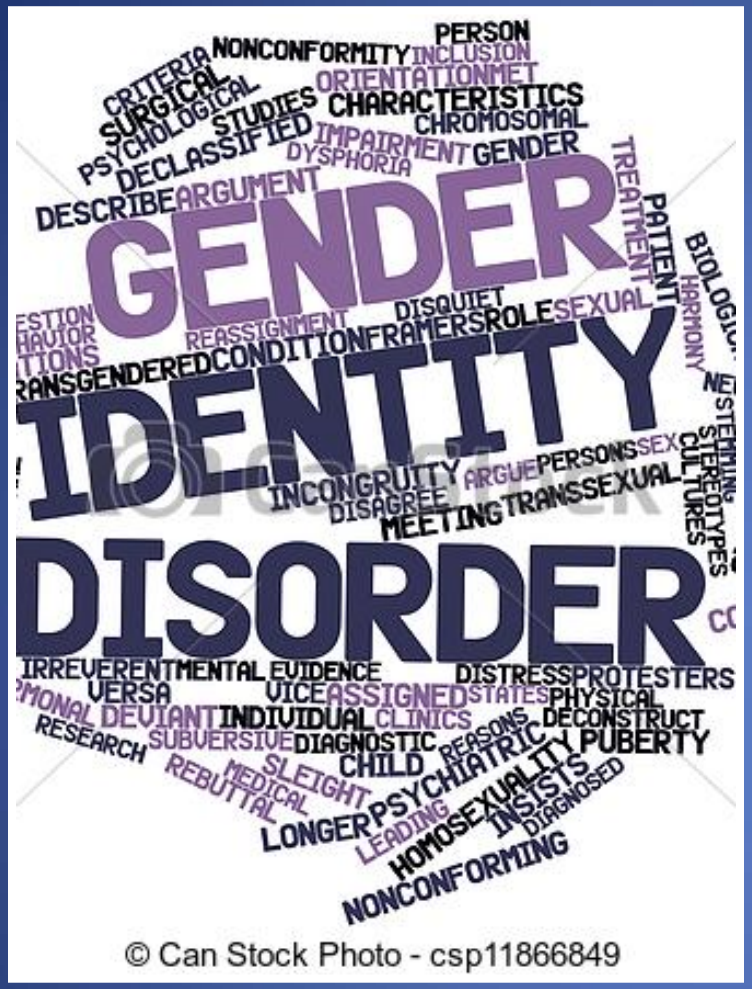
Important Areas For Consideration

WHAT IS GENDER DYSPHORIA?

- Gender Dysphoria refers to the unhappiness that some people feel with their physical sex and/or gender role.
- There is a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months.
- In children, the desire to be of the other gender must be present and verbalized.
- The condition causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

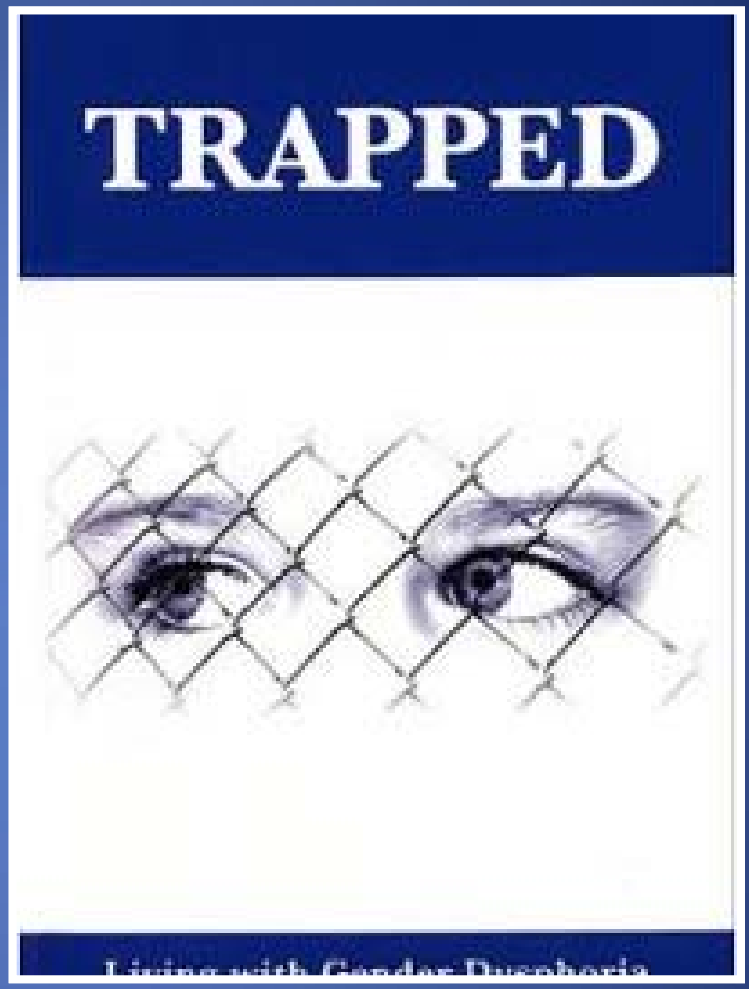
Gender Dysphoria Statistics

- It affects more males than females (On average, men are diagnosed with gender dysphoria five times more often than women) and it is estimated that 1in 11,000 people have the condition.
- The role of hormones is used to alter their physical features of the person i.e. give them a more masculine or feminine appearance with the ultimate remedy being gender re-assignment surgery.



GENDER IDENTITY DISORDER

DSM-IV



GENDER DYSPHORIA

DSM 5

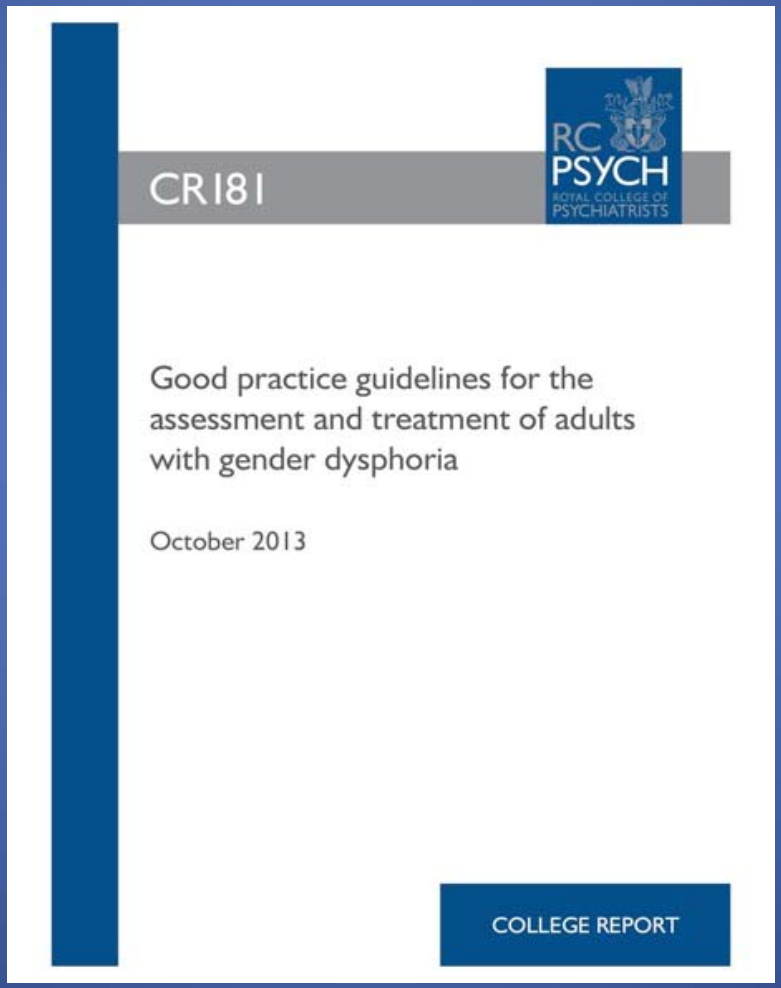
Similarities and Differences Between GID and Gender Dysphoria

- Both GID and Gender Dysphoria describe a condition in which someone is intensely uncomfortable with their biological gender and strongly identifies with, and wants to be, the opposite gender.
- GID focused on the "identity" issue-namely the incongruity between someone's birth gender and the gender with which he or she identifies.
- While this incongruity is still crucial to Gender Dysphoria, the DSM 5 emphasizes the importance of distress about the incongruity for the diagnosis of Gender Dysphoria.
- Gender Dysphoria removes the notion that the person needs to be fixed or cured and indicates the issues that need to be addressed that lie outside the individual.

Similarities and Differences Between GID and Gender Dysphoria cont…

- The DSM 5 uses the term gender rather than sex to allow for those born with both male and female genitalia to have the condition
- The shift to Gender Dysphoria reflects recognition that the disagreement between birth gender and identity may not necessarily be pathological if it does not cause the individual distress.
- As a result, those who identify with a gender different than the one they were assigned at birth and are not distressed by their cross-gender identification should NOT be diagnosed with Gender Dysphoria.

Treating Gender Dysphoria



General Treatment Guidelines

- Gender treatment should have a multi-disciplinary base, and may include a number of medical and allied health professionals.
- Patients must be offered a choice of clinically appropriate treatments.
- People with Gender Dysphoria should have access to high-quality services without undue and unnecessarily long waits.
- People with Gender Dysphoria have a right to counseling and psychotherapy as part of their overall package of care.

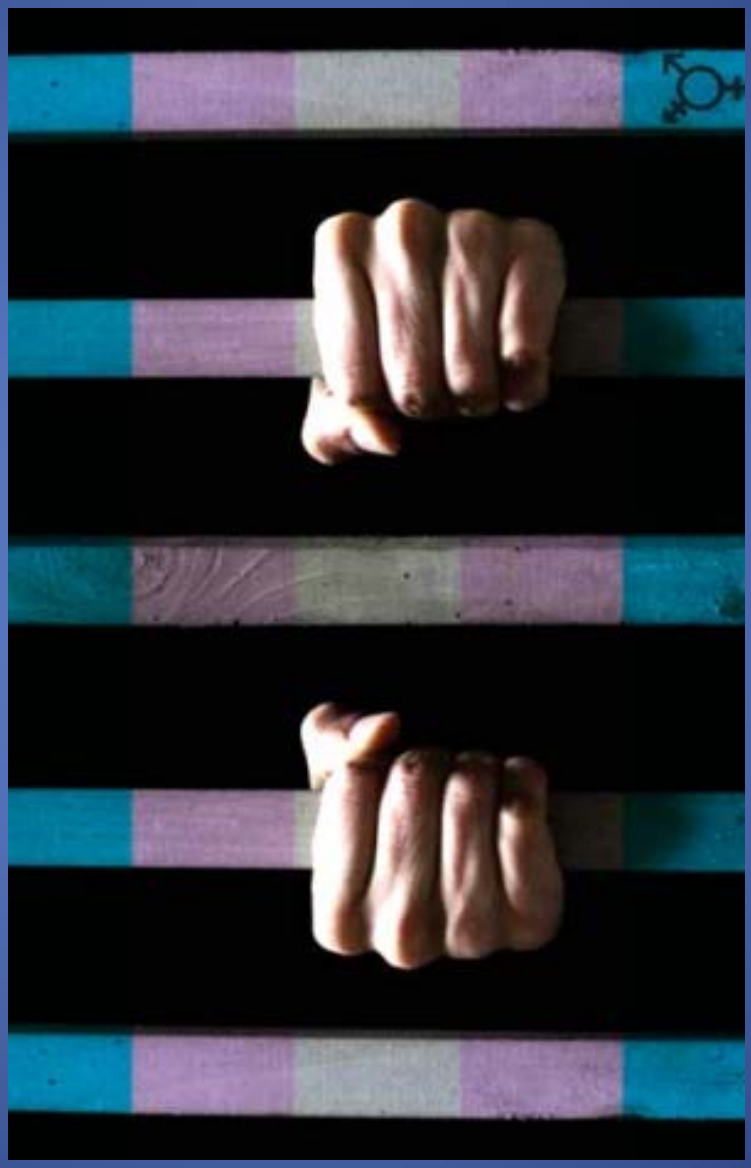
General Treatment Guidelines

- Treatment must be patient-centered and should recognize the individual's preferences, needs and circumstances.
- Treatment must not be prescriptive, and patients should be given a substantial role in determining which treatments are appropriate for them, and at what stage during the pathway of transition.
- The transfer of care of patients from adolescent to adulthood services should be managed so that treatments that have been initiated for adolescents continue without interruption.
- More research in the field should be encouraged, and funding should be set aside to offer specific grants looking at patient outcome and satisfaction with interventions and transition.

Wpath Recommendations for Treatment

- Changes in gender expression and role (which may involve living part time or fulltime in another gender role, consistent with one's gender identity)
- Hormone therapy to feminize or masculinize the body
- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring)
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of Gender
- Dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Gender Dysphoria in Prisons



Recommendations

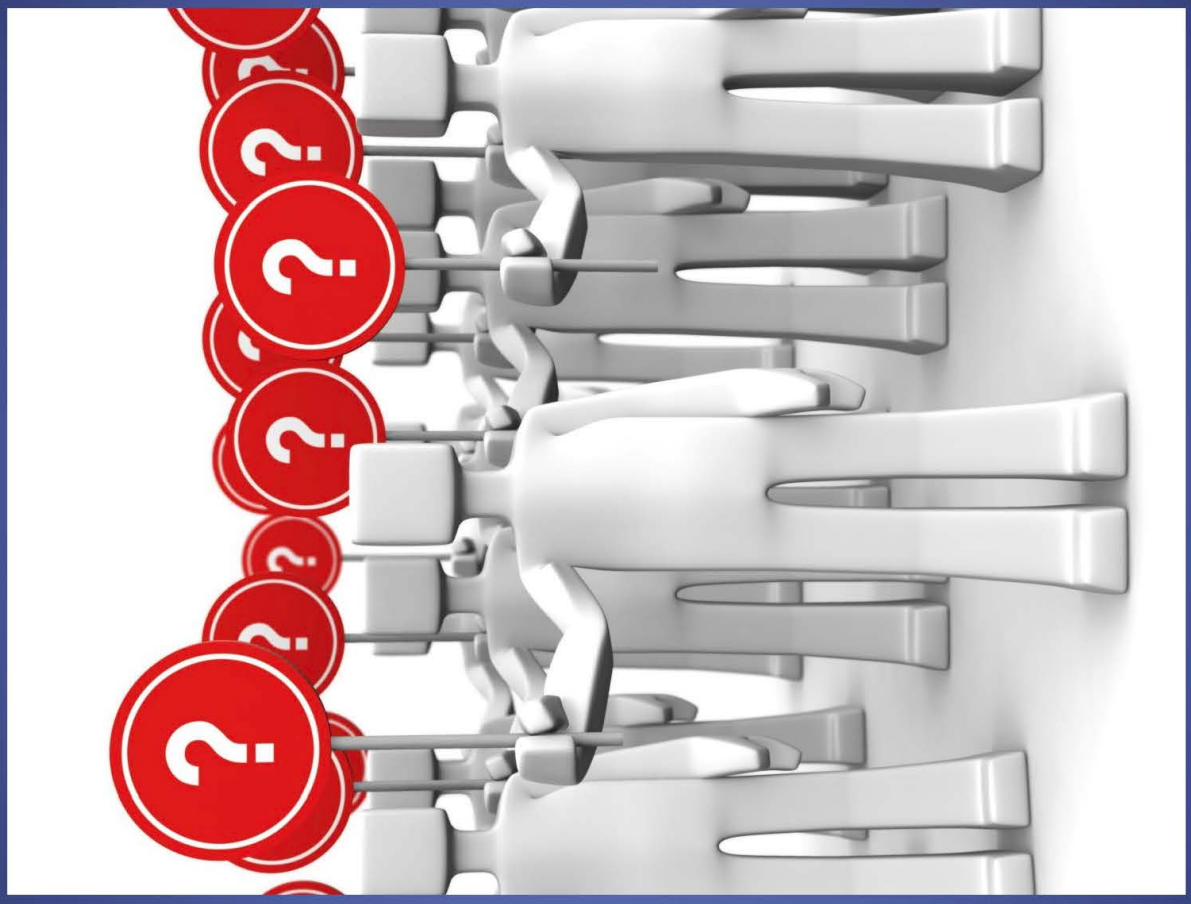
- Educate staff on appropriately identifying and recognizing differences in definitions (gender, transgender, identity, orientation).
- Designation of housing should address the "the inmate's health and safety, and whether the placement would present management or security problems" (BOP).
- Training for staff on Gender Dysphoria and how to address individuals who have Gender Dysphoria.
- Have specific guidelines on what items are allowed for someone with Gender Dysphoria so that these items are not inappropriately taken away during a cell search.

Recommendations cont…

- To the extent possible and consistent with security and safety concerns, inmates with Gender Dysphoria should be allowed to dress as the identified gender even if they are not housed with inmates of the identified gender.
- Inmates with Gender Dysphoria should be identified by qualified professionals including inmates who assert they have Gender Dysphoria.
- A treatment plan should be developed for those identified with Gender Dysphoria which promotes the physical and mental stability of the patient.

Recommendations cont…

- If an inmate is on hormone therapy, the patient should continue on these as prescribed.
- If an inmate requests hormone treatment but has never used hormones prior to their incarceration, the MDST should review the request.



Gender Dysphoria: A Psychiatric Perspective

Gender Dysphoria and Psychiatry

- Risk of Suicide
- Co-morbid/Confounding diagnosis
- Further considerations
- Requesting SRS

Suicide Attempts

- General Population 4.6%
- LGB population- 20 %
- Transgender population- 41%
- Incarcerated Population- 3X GP
- Post Op Transgender Population- 19X GP

Co-Morbid/Confounders

- Psychosis
- Depression
- Trauma
- Autism
- Body Dysmorphic
- Suicidal ideation/attempts
- Substance Abuse

Paraphilias
Self-mutilation
Anorexia and Bulimia
Personality Disorders

Important Considerations - Dr. Steven Levine

1. Vocational and scholastic history
2. Complete criminal history including sex offenses
3. Quality of early life attachments within the family history
4. When did the current gender crystallization occur?
5. What experience and emotional state preceded it?
6. What is person's concept of its motivation?
7. What previous identities have been important?
8. Does inmate want to live among women in prison or stay among men? Why?
9. What worries does the person have about this new form of being? Do not accept "none."
10. What is the quality of thinking from magical to realistic?

SRS and Suicidal Threats -Dr. Steven Levine

- Individuals with Gender Dysphoria are well known to have suicidal ideation and to suicide before hormones, during hormonal treatment and after SRS
  - Suicide rate after SRS is far greater than the general population
  - Suicide rate is comparable with VA patients with chronic mental disorders
- SRS is not conceived as lifesaving as is repairing a potentially leaking aortic aneurysm but as life enhancing as is providing augmentation for women distressed about their small breasts.
- When inmates declare they will suicide without SRS, their desperation and manipulation are separately addressed.
- When experts declare a prisoner is likely to suicide without SRS, they overlook their profession's poor track record at prediction and what else can be done to deal with their depression.

More SRS -Dr. Steven Levine

- Disappointment, despair, depression and suicidal ideation* are likely to follow the rejection of a request for SRS as an inmate comes to grips with the obstacles fulfilling this desire
- Some have argued that SRS will prevent genital self-mutilation. Mutilation is far more often considered than attempted, and more often attempted than completed
  - It often is a response to the inmate's sense that her identity is being ignored
  - As a result of increasing experience with trans inmates, such desperation is less frequently ignored
  - Inmates considering this act often say that they will begin the process in the hope that the doctors will finish it.
    - Corrections staff cannot provide SRS under these conditions.

Managing Gender Dysphoria From A Nursing Perspective

Important Areas For Consideration

"Nurses have been described as the backbone of correctional health care. Yet the complex challenges of caring for this disenfranchised population are many"- L. Schoenly

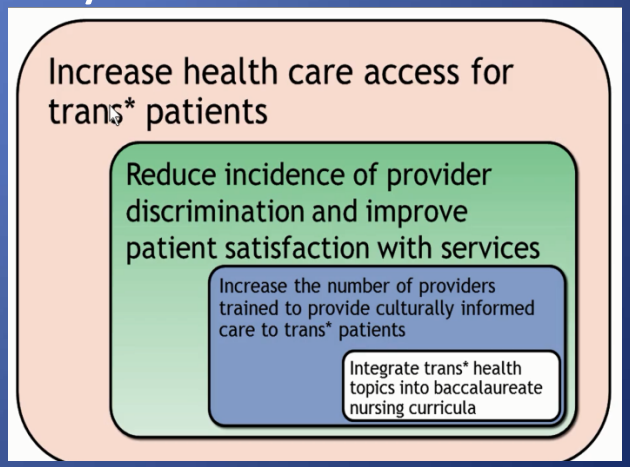
Nursing is your gatekeeper…even if you may not want them to be.

- Nursing Role in a Collaborative Healthcare Team
  - Facilitate communications within the clinical team
  - Support patients to be assertive with questions and needs.
  - Provide understanding of impact of health interventions ordered (and not ordered) for them (side effects, medication compliance and changes in condition).
  - Provide nuanced understanding of impact from the patient perspective for other members of the clinical team.
  - Support treatment adherence and know when treatment is not working; communicate to team members to make any necessary information that may be needed to consider making adjustments.

  Overall support for the patient to navigate the course of the healthcare system

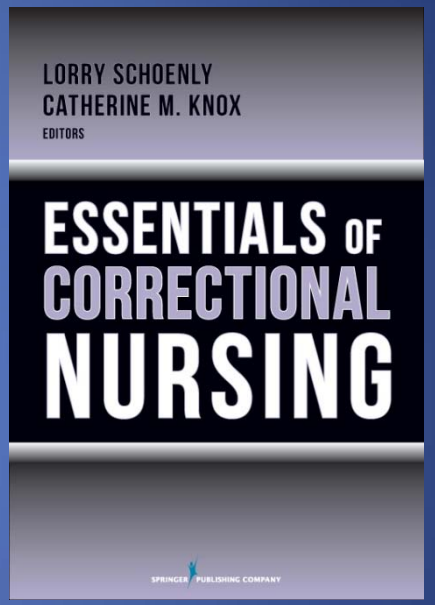
Nurses Do Not Graduate Prepared for to Discuss These Topics

- Provider education/bias (Lurie, 2005, Poteat, 2013, Sanchez, 2006, Schilder, 2001)
- Limited Access to Trained Providers (Obedin-Maliver et. Al., 2011, Solursh et al., 2003)
- Baccalaurette nursing programs dedicate a median of 2.12 total hours to LGBT – related content
- Mistreatment & Future Avoidance (Reisner et. al 2015)
- Nursing Transhealth Johns Hopkins Study



"Tell us what we need to know"- Nursing Staff Everywhere

- Patient Experience/Challenges
  - Pronouns, clothes, names
- Nurses Role
  - System Policy
  - Treatment/Therapies offered in Facility
  - Patient Education
  - Environment/Climate
  - Housing/Shower Bathrooms
- Vignettes
  - Give Permission to Be Polite- "I'd like to interact with you respectfully. What pronoun would you like me to use? What name would you like me to use?"
- Ethic Responsibility
- Manager/Supervisory Duties



SCENARIO TIME!

Consider This…

There is a new patient who is knows to identify as transgendered at door of the medical area. You overhear the patient be called the wrong name and pronoun by the officer. The other inmates that were in earshot are now laughing.

When you call the patient in for their visit, they walk up to you in tears and say they would like to refuse to be seen today..

Consider This…

You are in sick call and call your next patient. When she enters the cubicle, she tells you that she never told anyone this before today but in the community she is transitioning from female to male and just and would like to discuss her medical transition.

She asked the nurse who was at sick call yesterday and that nurse told her to put in a mental health sick call slip.

Remember the Previous Patient At Sick Call?

- The sick call nurse did the right thing and had the patient see the medical provider. In that encounter the medical provider told the patient that they would be denied hormone therapy.
- As the patient was walking out the physician's assistant hears them say, "Fine, if they do not help me, I will just do it myself".

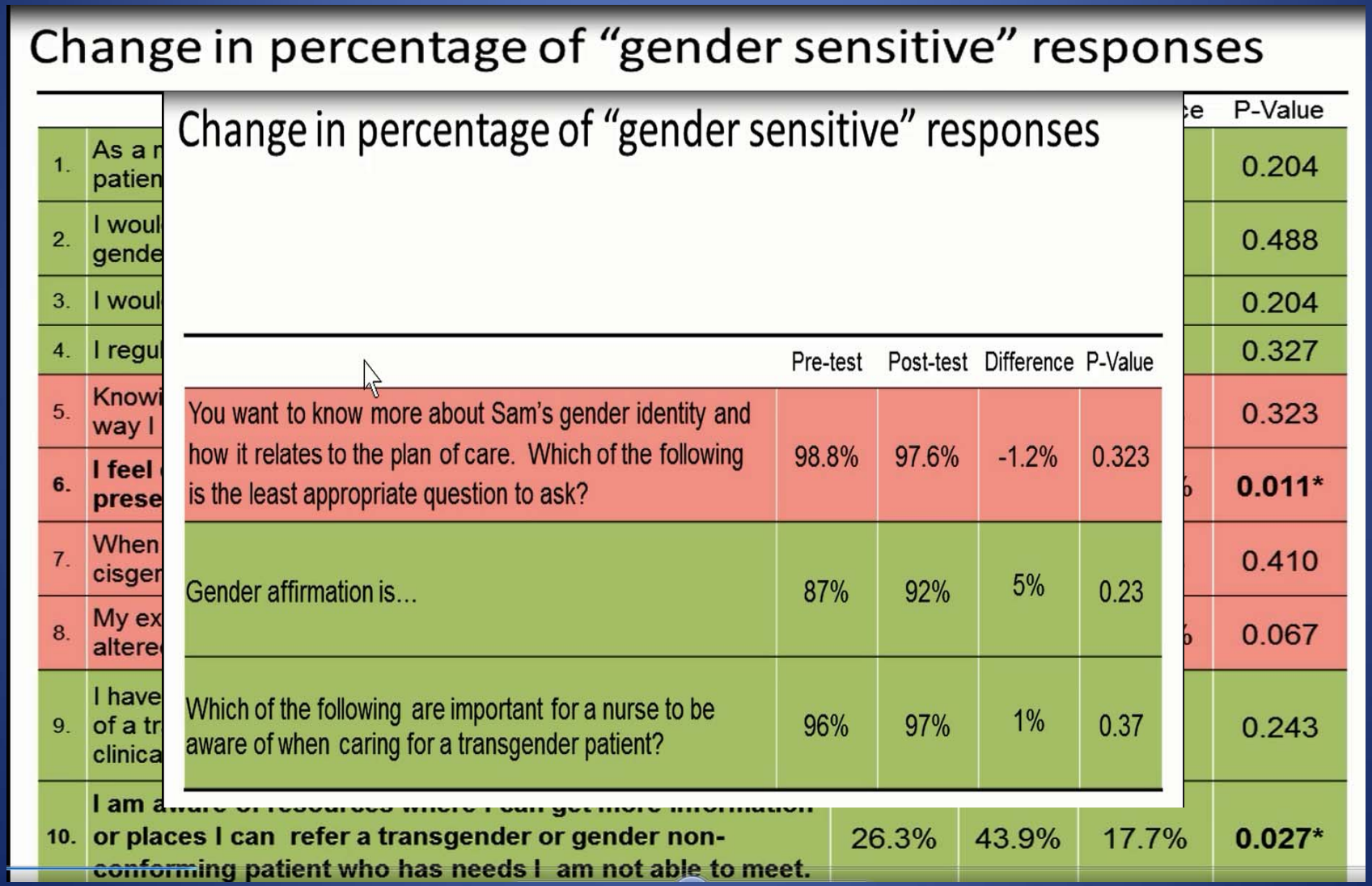
Consider This…

You are orienting a new nurse completing an intake. During the intake and assessment for a transgendered female to male patient, it is discovered that the patient has been incarcerated during their transition and has an intact uterus.

Transgender Curriculum Integration Project

- Used a student faculty partnership to develop and integrate content into the existing baccalaureate program at the Johns Hopkins University School of Nursing
- Aims to increase knowledge of trans health issues and confidence in ability to provide care to trans* patients
- 9/2014-Survey administration- data collected and analyzed at aggregate level.
- Survey finalized in 12/2015
- Positive results indicated that knowledge or beliefs became more “gender sensitive”
- Negative results indicate response became less “gender sensitive”

Training Does Work!



Consider These Specific Training Topics When You Develop Your Training

- Intake Procedures
- Medical Clinic Procedures
- Medication Procedures
- Follow Up Procedures After Denial of Therapy
- Evaluating Procedures for Unsafe Behavior
- Procedures for Reporting Unsafe Behavior
- Confidentiality
- Chronic Care Procedures
- Wellness Programs for ***Intact*** Gender Specific Genitalia
- Holistic Care
- Available Items on Commissary
- **Update demographic forms and electronic health records to recognize transgender identities.**
- **Educate all staff members on appropriate communication with transgender patients**

PLEASE RETURN BY 3:30 PM

Managing Gender Dysphoria From An Administration Perspective

Important Areas For Consideration

A GLOBAL APPROACH WILL CONTRIBUTE TO SUCCESSFUL OUTCOMES

Department or Agency Viewpoint

- What is the stance of the overall Department or Agency?
  - What does the current literature suggest?
  - Past management practices verses future management practices
- Important to review current case laws surrounding the management and treatment of individuals with Gender Dysphoria
  - Specific to the environments one is working in

- It is necessary for Executive Level Leadership to become educated on how to appropriately manage the environments in which offenders reside.
  - Who do we treat?
  - How do we treat?
  - How are we going to overall manage this population?
  - Whose job is this anyways?

Policy Reviews Are a Must

- Policy Reviews
  - Departmental
  - Divisional
  - Institutional
  - Facilities
- Review past perspective with current perspective.
  - Are enhancements needed?

- Who should be included in the policy review process?
- A Transdisciplinary Approach should be utilized:
  - Department/Agency Leadership
  - Facility Administration
  - Custody and Case Management staff
  - Healthcare staff
  - Legal staff
  - Others….who would that be?

ITEMS IMPORTANT TO BE ADDRESSED IN POLICY

Items Worthy of Consideration

- Definitions
  - It is important to educate staff on the appropriate terminology
- Placement
  - Facility and Housing Assignments
    - Health and safety considerations
    - Completed surgical sexual reassignment therapy prior to incarceration
    - Self–inflicted genital mutilation
    - How often should placement considerations be reviewed?

- Accommodations
  - What name should be used when addressing the offender?
  - Property and Clothing
    - What property will be allowed?
    - How will property be accessed?
  - How should offender be addressed?

- Showering
- Make-up
- Pat Searches
  - Will staff be allowed to physically examine offenders for the purpose of determining the offenders genital status?
- Placement in Restrictive Housing
  - Hair removal –are razors allowed?

CONSIDERATION SHOULD BE GIVEN AS TO THE BENEFIT OF HAVING A "COMMITTEE"

Items to be Considered When Developing a Committee

- What is the purpose of the Committee?
  - Reviews cases
    - Records
    - Treatment Plans
  - Approves treatment plans
  - Approves external referrals for assessment and treatment
  - Makes recommendations for treatment
  - What other purposes can you think of?

What Should The Name of Committee Be?

- Examples of Various Names Used:
  - Gender Identity Disorder, Management and Treatment Committee
  - Therapeutic Level of Care Committee
  - Gender Identity Disorder Clinical Supervision Group
  - Transgender Committee
  - Gender Identity Disorder Treatment Overview Committee
  - Gender Dysphoria Treatment Team
  - Gender Dysphoria Clinical Supervision Group

Committee Members… Who Might this Include…

- Might vary due to the systems in which individuals with Gender Dysphoria are being managed
- Department and Agency representation
- Local facility staff representation
- Healthcare staff representation
- Outside specialty healthcare consultant
- Others who you might think could be a benefit to include?

Other Committee Activities to Consider

- How often should the Committee convene?
- Are minutes taken at Committee meetings and if so where are the meeting minutes stored?
  - Who would have access to the meeting minutes?
- Is the Committee required to report to any one? If so, who is that and how often should the Committee report?
- Is the Committee involved in any activities connected to the offender grievance process?

CLOSING POINTS TO REMEMBER

The Time Has Come When….

- We must review how we are currently managing offender diagnosed with Gender Dysphoria.

- We can not operate in silos as we attempt to successfully manage this population. We will fail.

- Systems must lead from the top down as policy and procedures are reviewed and enhanced to ensure a consistent message is being given to staff and offenders.

- Policies and Procedures must flow in a manner that mirrors a “Continuum of Management” from intake through discharge.

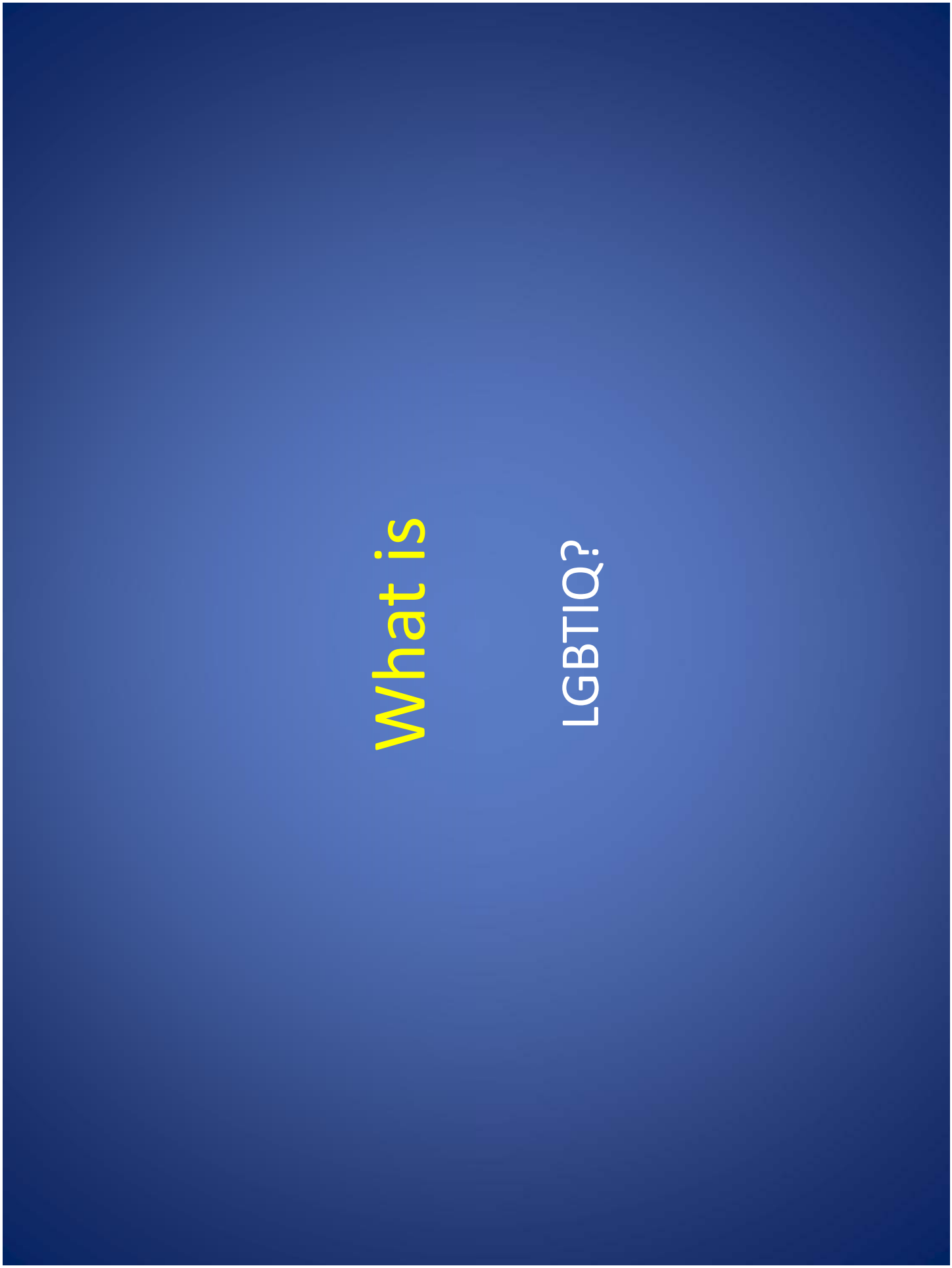
- We must assess where in our systems training for staff is needed.
  - Department/ Agency Leadership staff
  - Administration staff
  - Custody staff
  - Classification and case manager staff
  - Healthcare Staff
- Identify what type of staff training is needed and how often training should occur.
  - Clinical
  - Operations

- We must develop the necessary processes and relationships within the community to ensure we have forged the way for successful reentry back into the community for individuals diagnosed with Gender Dysphoria.
  - Discharge medications
  - Discharge healthcare appointments
  - Release of healthcare records

PBL 0461

Managing Gender Dysphoria From A PREA Perspective

Important Areas For Consideration


What is
LGBTIQ?

LGBTIQ

- LESBIAN
- GAY
- BI-SEXUAL
- TRANSEXUAL
- INTERSEX
- GENDERQUEER

PREA—What you need to know

- Standards impacting this population.
- Prevention planning
- Training and Education
- Screening for risk of sexual victimization
- Placement

Standards Related to LGBTI

- 115.13 Supervision and Monitoring
- 115.15 Cross-gender Searches
- 115.31 Zero Tolerance for Sexual Abuse and Harassment and Employee Training
- 115.41 Screening
- 115.42 Use of Screening--Housing, job assignments, education, etc.
- 115.86 Sexual Abuse Incident Reviews

§ 115.13
Supervision and Monitoring

- Proper visual access
- Adequate number of staff
- Unannounced supervisory checks on nights and days to deter the occurrence and opportunity for staff sexual abuse and harassment—Make sure you document this is happening in pod log books.

§ 115.15
Limits to Cross-Gender Viewing and Searches

- No cross-gender strip searches or visual body cavity searches except in extreme situations or by medical staff.
- Cross-gender searches shall not occur on a female facility and shall not restrict access to programming to do so.
- Any female cross-gender searches will be documented.
- Policies and Procedures will be implemented to allow for showers, change clothing, etc. without cross-gender observation.
- No transgender or intersex inmate will be searched to determine genital status. Interviews, medical records and medical exam will be used.
- Staff will be trained on proper searches of transgender and intersex inmates.

§ 115.31
Employee Training

- Zero tolerance for sexual abuse and harassment
- Staff responsibility to report and detect, etc.
- Inmate's right to be free from sexual abuse and harassment
- Right of inmates and employees to from retaliation for reporting sexual abuse and harassment.
- The dynamics of sexual abuse and harassment in confinement.
- Common reactions to sexual abuse and harassment
- Detection and response to signs of sexual abuse and harassment
- How to avoid inappropriate relationships with inmates
- Proper communication with inmates, including LGBTI inmates
- Complying with mandatory reporting laws
- Facility specific training
- One year time frame and 2 year refresher training
- Documentation of training

§ 115.41
Screening for risk of victimization and abusiveness

- Intake and transfer screening with an objective measure within 72 hours of arrival at the facility to determine risk of victimization or abusiveness
- Factors to consider:
  - History of mental, physical, or developmental disability
  - Age
  - Physical build
  - Previous incarcerations
  - Violent or not criminal history
  - Sex offenses against adult or child
  - Whether the inmate is or is perceived to be LGBTI
  - Previous sexual assault victim
  - Inmate's own perception of vulnerability
  - Housed solely for immigration purposes
- Determination is made on these factors within 30 days
- Re-evaluate as necessary
- Inmates may not be disciplined for refusal to answer
- This information may not be exploited and used to the detriment of the inmate

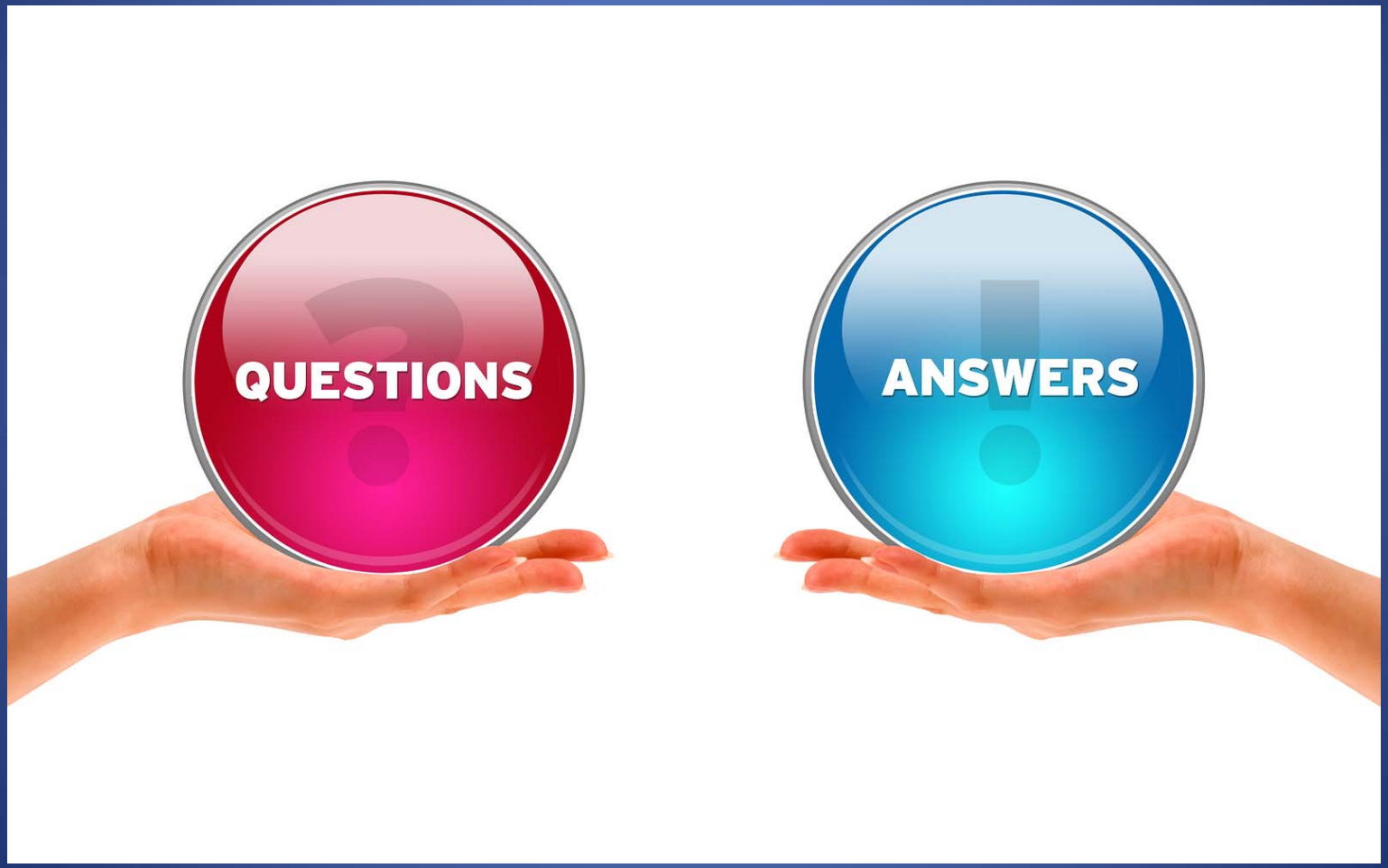
§115.42
Use of screening information

- Information is used to protect inmates in housing, work, education and programming
- Each inmate will have an individual plan
- Placement at male or female facility will be determined on an individual basis
- Housing and programming placement will be reviewed 2 times a year
- Transgender and intersex inmate's own views about safety will be given serious consideration
- Transgender and intersex inmates shall be given the opportunity to shower separately
- LGBTI inmates will not be housed in a dedicated facility, unit or wing unless it was established in a consent decree or other legal process.

§115.86
Sexual Abuse Incident Reviews

- An incident review is conducted at every investigation, even when the claim is not substantiated, unless unfounded.
- This occurs within 30 days of the concluded investigation.
- The team shall:
  - Consider need for change in policy
  - Consider motivation, i.e., race, gender identity, gang affiliation
  - Consider physical barriers that contributed
  - Consider Staffing levels
  - Consider any modern technology assists that could help prevent this in the future
  - Prepare a report of findings
  - Implement recommendations of report

PANEL DISCUSSION



PBL 0474

Exhibit 12

Proposed to be filed Under Seal

[filed under separate cover]

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

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Open to the general public: ☒ Yes

BOARD OF CORRECTION IDAPA RULE NUMBER 401

Medical Care

POLICY CONTROL NUMBER 401

Clinical Services and Treatment

DEFINITIONS

Standardized Terms and Definitions List

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Primary Physical Sexual Characteristics: Genitalia and reproductive organs.

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

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

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

Qualified Gender Identity Disorder (GID) Evaluator: A Doctor of Philosophy (PhD) level practitioner licensed by an appropriate state licensing authority as a psychologist, or a physician licensed by a state Board of Medicine, who has demonstrated an indicia of basic competence related to the diagnosis and treatment of GID and related mental or emotional disorders through their licensure, training, continuing education, and clinical experience.

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

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

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

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

PURPOSE

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

SCOPE

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

RESPONSIBILITY

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

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GENERAL REQUIREMENTS

1. Initial Reporting

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

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

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

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

Subsequent Evaluations

Also see section 11.

2. Referral and Placement of the Offender for Evaluation Purposes

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

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

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

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

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

3. Evaluation of the Offender

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

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

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

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

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

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

4. Evaluator Findings, Diagnosis, and Reporting

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

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

5. Chief Psychologist's Review of Findings

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

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

Findings

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

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

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

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

Re-evaluation of Findings Initially Not Supported

See section 11.

6. Management and Treatment Committee (MTC) Meeting

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

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

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

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

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

7. Administrative Review Committee (ARC) Meeting

Convening Responsibility

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

Review of Management and Placement Plan

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

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

8. Final Approval of the Management and Placement Plan

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

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

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

9. Implementation of the Management and Placement Plan

Offenders diagnosed with GID shall be:

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

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

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

10. Moral and Ethical Treatment of Offenders Diagnosed with GID

Offenders diagnosed with GID:

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

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

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

11. Subsequent Reviews and Evaluations for GID

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

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

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

REFERENCES

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

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

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

Policy 201, *Respectful Workplace*

Standard Operating Procedure 303.02.01.001, *Classification: Offender*

Standard Operating Procedure 317.04.02.001, *Searches of Offenders*

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

Standard Operating Procedure 401.06.03.070, *Informed Consent*

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

– End of Document –

Introduction

The goal of this proposed Standard Operating Procedure (SOP) is twofold: to provide care and treatment for the symptoms associated with the diagnosis of Gender Dysphoria (GD), and also to provide appropriate management of vulnerable transgender inmates. This document serves to provide rationale and context for the proposed changes from the current SOP. To accomplish this, this report attempts to synthesize (see reference list for complete list of sources):

1. Professional standards from related correctional and transgender-advocacy disciplines
2. Statements from advocacy, treatment, and legal organizations
3. Other state correctional system policies for comparison
4. Current research from peer-reviewed academic and relevant legal journals

The IDOC's current SOP (401.06.03.501, adopted 10/31/2002; latest review 12/21/2011) focuses on the management and treatment of inmates diagnosed with (then-current diagnostic language) Gender Identity Disorder, but does not address the correctional management issues involved with transgender inmates. Among the most striking changes to this proposed policy is the addition of management of transgender inmates, rather than solely addressing the needs of those diagnosed with Gender Dysphoria.

In keeping with current ethical, legal, and professional standards on the topic of transgender prisoners, this proposed SOP is put forth with the intention of expanding overall IDOC services to all transgender inmates, including those diagnosed with GD. Providing multidisciplinary, watchful correctional care of transgender inmates is important to the safety of the inmate and the secure management of the correctional facility for three primary reasons. First, it is important to manage transgender individuals for safety of inmates and the facilities, as transgender inmates are more vulnerable to sexual assault (Jenness et al, 2007, Wolff & Shi, 2009). Second, it is important to manage transgender inmates to comply with critical standards, as PREA guidelines specifically discuss "transgender" inmates, regardless of whether a diagnosis of Gender Dysphoria is present. Lastly, it is important to manage transgender inmates to stay in front of changing social norms, as WPATH (and other advocacy groups) have emphasized the de-pathologization of transgender inmates.

Within the IDOC, it is proposed that this management task can be accomplished through already-existing management structure. The MTC forum already exists to make multidisciplinary management and treatment decisions on a case-by-case basis for inmates diagnosed with GD. Expanding the role of the MTC to include management (but not treatment) decisions for all inmates who identify as transgender, would allow us to meet the needs of this population with only small adjustments to our current policy.

By expanding the responsibilities of MTC and by developing site-specific MTC's, the proposal suggests the IDOC will be better equipped to manage the multiple special needs of this population.

Context

This proposed policy, with its suggested changes, must be viewed in the context in which it is written. First, we must consider the specific context of the IDOC, and second, we must consider the larger social

context of this evolving issue, both of which support ongoing changes to IDOC management of the transgender population.

Idaho Department of Correction

In regard to the IDOC context, there have been previous law suits which have required the IDOC to make changes in order to provide certain evaluation and management strategies for working with the transgender population. In addition, the recent NCCHC document, Follow-Up Audit of Medical and Mental Health Services (dated October 2017), makes special notice of the steps taken by the IDOC to understand and address the concerns of inmates diagnosed with Gender Dysphoria, while encouraging IDOC to continue ensuring there is "regular, consistent, and adequate communication" (p. 33) between clinical and security staff working with this population. That document noted favorably several steps already taken by the IDOC, including working to "consider more female-based items" and "providing hormone therapy". This context reflects the importance of the IDOC continuing to adjust policy to meet the changing recognition of needs and concerns of the transgender population

Changing social context: correctional, national, and international

Beyond the context of the IDOC, large-scale social norms and understanding of transgender individuals are rapidly evolving, as is the expectations for prison systems to develop appropriate management approaches. This is seen in recent publications by the National Institute of Corrections (2013), American Psychological Association guidelines (2015), revised federal Bureau of Prisons policy (2017), federal PREA standards, and WPATH standards (2012), all of which include updated guidance for prisons officials in the management of transgender prisoners. Importantly, these standards do not solely reflect the population of persons diagnosed with Gender Dysphoria, but emphasize the importance of providing appropriate services to all transgender inmates.

Nationally, federal and state prisons systems have been a particularly problematic context for transgender individuals. Prisons have historically operated under the principle that all people are assigned a biological sex prior to birth, that one's biological sex is the same as one's gender identity, and that gender identity remains constant throughout one's life. Thus, the issue of transsexualism is particularly challenging to the assumptions on which prisons are based. In addition, prisons have often been viewed as hesitant to address the needs of this population (Etheridge, 2014). While we may disagree with this perspective, it is important to note that the overall culture of corrections has been historically viewed by many as reluctant to protect vulnerable minorities, if not outright hostile.

Transgender management guidance from outside sources, therefore, provides an important perspective on policy decisions. WPATH standards have been utilized by courts and treatment providers as a premier standard, often used in determining appropriate standards of management and care. In regard to transgender prisoners, version 7 states "Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community."

In addition, it is important to recognize this is an area that may receive additional attention in coming years. Prominent legal advocacy groups have identified incarcerated transgender prisoners as in need of legal defense. The webpages of organizations such as ACLU, Prison Law Office, and Lamba Legal emphasize the importance of transgender inmates' concerns, as seen in these documents posted prominently on these agencies' websites:

https://www.aclu.org/issues/lgbt-rights/criminal-justice-reform-lgbt-people

http://prisonlaw.com/wp-content/uploads/2017/02/Transgender-Handout-December-2016.pdf

http://www.lambdalegal.org/sites/default/files/transgender_booklet_-_incarcerated.pdf

This larger, national context suggests the need for appropriate care for the transgender population, being responsive both to the needs of the individual inmate and the changing social context in which this proposed policy is put forth.

Idaho is already following recommended guidelines in many areas. Included in this are:

- Gender identity related treatment is addressed individually
- Transgender individuals are not segregated or housed away from the general population
- Mental health assessment to determine mental health needs related to gender identity is available
- The MTC exists to provide multidisciplinary discussion and review of Gender Dysphoria treatment and management
- Hormone Replacement Therapy is available and actively used with multiple patients

Overall, it is important to note that IDOC is doing a good job in managing and providing care for this population, who can be profoundly challenging to manage.

However, this proposed SOP offers an avenue to further improve services, provide more safety to inmates, remain in good standing with agencies that offer guidance for this population, and protect the IDOC's from future legal action.

Clinical vs. management decisions

Current PREA regulations, in addition to other non-mandatory recommended standards, such as those promoted by WPATH, NIC, and the APA, require certain management practices for transgender prisoners. In the IDOC, a diagnosis of Gender Identity Disorder or Gender Dysphoria has been necessary for the extension of specialized management attention or medical/mental health care. This proposed policy modifies this to address the management concerns of all inmates who identify as transgender, and focuses on medical and mental health treatment for those diagnosed with Gender Dysphoria.

As the DSM 5 notes, individuals diagnosed with Gender Dysphoria *represent a subset of transgender individuals*. Expanding the IDOC SOP to include certain management practices of transgender inmates is in keeping with standards outlined in PREA, as well as WPATH and other advocacy and legal protection

agencies. This proposed SOP distinguishes between appropriate correctional management of transgender prisoners and medical/mental health care and treatment for those diagnosed with Gender Dysphoria.

In relation to current IDOC policy, specific concerns are noted in the following sections of the federal PREA (2012) regulations, taken from § 115.42 Use of Screening Information:

> (d) Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.
>
> (e) A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.
>
> (f) Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates.
>
> (g) The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status,

Notably, these regulations do not reserve these management considerations for those transgender inmates diagnosed with Gender Dysphoria. This proposed SOP incorporates correctional management monitoring and decision making for ALL inmates who identify as transgender. Management decisions will consist of individualized plans, which include "serious consideration" of the inmate's own preferences, for the following aspects of correctional management in the following areas:

- Consideration of special housing needs
- Special needs relating to Bathrooms/Showers
- Special considerations of Pat downs/Strip search
- Gender-specific Property allowances
- Implementation of medical Bra memos
- Use of Language (pronouns)

As noted earlier, this is in keeping with other significant policy recommendations from influential organizations. WPATH standards for transgender individuals in institutional environments provide standards for management concerns of transgender: "Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety…Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents."

Other advocacy agencies have offered clear statements on the importance of providing appropriate management of transgender prisoners. The ACLU (2015) specifically targets "Policies or practices that limit "cross-gender" expression because such expression "invites" sexual assault" and forbid "transgender, gender non-conforming and intersex individuals to access grooming items and accessories

consistent with their gender identity regardless of where they are housed" as policy that "harms" LGBTI inmates.

The Prison Law Office (2016) notes that transgender females (MtF) in male prisons must have "at least some access" to the following items that are permitted in women's institutions: pajamas/nightgowns, robes, t-shirts, scarves, chains/necklaces, walking shoes, and sandals.

The National Center for Transgender Equality (2014) states

> *…prisoners should be permitted to express and be treated according to their gender identity…issues like access to gender-appropriate undergarments and grooming items and the use of appropriate pronouns can be a medical issue. Ideally, policy provisions on these issues would be separate from medical policies and not restricted to those with a gender dysphoria diagnosis.*

The NCCHC (2015) has also published a position paper. While their scope is specific to medical care and does not address management issues, their position clearly includes both transgender prisoners, in addition to those diagnosed with Gender Dysphoria.

Taken in total, these influential groups point to the problematic position of denying ANY gender non-conforming property, appearance, or presentation without a diagnosis of Gender Dysphoria. This proposed policy allows the IDOC to conform to expectations of important agencies, such as WPATH, ACLU, Prison Law Office, APA, and NCCHC without reason to believe security will be compromised.

Management of transgender inmates

Gender specific property

Among the more difficult management aspects of transgender prisoners is that of property. Prisoners wearing cross-gender clothing or hairstyles or behaving in a non-gender conforming manner is, frankly, troubling to many. In addition, prison administrators often fear that prisoners who appear gender non-conforming place themselves at elevated risk for sexual assault.

This proposed policy attempts to work within standards and guidance proposed by various organizations while maintaining safety within the prisons, by doing away with specifications on which property items match different genders, but instead focuses on restricting the "eroticization" or "sexualization" of physical appearance. It should be noted that I was unable to find any compelling evidence that allowance for gender non-conformity within prisons increases risk of sexual assault.

WPATH SOC7 does not address the issue of property directly in its section "Transgender People Living in Institutional Environments", but it does state "all elements of assessment and treatment as described in the DOC can be provided to people living in institutions…access to these medically necessary treatments should not be denied based on the institutionalization or housing arrangements". This statement can reasonably be assumed to include cross-gender property.

The NCCHC position paper (this is not a standard of health care, but a supplemental document), point #10 states: *Medical staff should ensure that commissary items consistent with an individual's gender identity are available.*

For comparison, the federal Bureau of Prisons addresses this issue in their 2017 transgender policy. Transgender inmates "will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender." This policy goes on to state that "Additional items based on an individualized assessment of the transgender inmate may be approved by the warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate."

The ACLU PREA toolkit notes in the "what to look for" section (p. 6): Policies or practices that limit "cross-gender" expression because such expression "invites" sexual assault"

Diagnosis

Currently, the IDOC SOP allows for medical and mental health care for those individuals diagnosed with Gender Dysphoria. This section of the proposed policy remains largely consistent with current policy, however this document expounds on the difficulties in diagnosing Gender Dysphoria with a correctional population. It is important to recognize these challenges, as an appropriate diagnosis is the proposed mechanism that allows for medical intervention, in addition to supportive mental health services and management consideration.

Treatment of Gender Dysphoria exists to alleviate suffering. This proposed policy aims to make more treatment and management options available, while also acknowledging the complexity of making appropriate decisions and recognizing that some options will be provided only in exceedingly rare and extreme situations. This is designed to be in keeping with the balancing act of providing individualized care while recognizing the profound security and management concerns.

Clinically, there is very little guidance for practitioners in research literature or evidence-based assessment tools to screen for the presence of problematic claims of self-identification of a transgender identity (cite screening tools and guidance documents). In a correctional environment, this presents a difficulty due to the increased presence of sexual paraphilia, sought opportunities for sexual misconduct, or other avenues of secondary gain (Levine, 2016). In addition, many inmates themselves come from disadvantaged backgrounds, and may struggle to fully articulate differentiation between gender identity, sexual orientation, gender non-conformity, fetishistic tranvestism, Autogynaephilia (a controversial topic, but referring to sexual excitement from fantasizing about being a different gender from natal assigned), and other related dynamics.

Peer-reviewed journals that discuss difficulties of diagnosis generally come from articles that do not claim to present quantitative evidence, but rather personal reflections from seasoned practitioners. These articles, while not representing a "gold standard" of replicable, structured studies, present the best information available to the correctional practitioner.

Hakeem (2014), in discussing treatment in a community setting, states "At assessment, the clinical history includes careful detail regarding sex at birth (biological sex), gender identity and sexual and relationship history. This is essential to discern whether the presenting gender-related symptom is solely located in gender identity or is *linked primarily to sexual interests or feelings that cause the patient distress."* (Italics mine). The author's reports of his clinic also note that a significant percentage of referrals initially report transsexualism, but after assessment "are considered to be transvestites rather than transsexual".

Levine (2016), a noted expert in correctional transgender issues, highlights the practitioners' difficulty in diagnosing Gender Dysphoria among a correctional population. While he emphasizes the importance of a biopsychosocial history, he notes

> *…several points are not mentioned: the possible role played by a prisoner's prospect of a future of unending incarceration; the possibility of inmates misrepresenting their developmental histories, despite extensive experience with fabrication in the community,25 in research,26 and in medicine in general; the sexual developmental history and the patient's sexual life in prison; and the reality that SRS for a prisoner is an experiment, given the lack of research data about outcomes in this population. It is difficult to grasp that a person would sacrifice genitalia to give a new organizing purpose to life. Occasionally, however, that seems to be the case.*

Given both the difficulty and the importance of correct diagnosis, this proposed SOP requires all mental health staff who are involved in the assessment and diagnostic evaluation will meet WPATH Qualified Evaluator criteria and participate in annual gender-issue related trainings.

Treatment Interventions

When a diagnosis of Gender Dysphoria is made, our current SOP only discusses one intervention: hormone replacement therapy. While that that option is more than is available in other states (see section below), it does not address other interventions or management strategies recommended by medical and advocacy agencies. The primary areas of consideration are gender confirming surgery and cross-gender facility placement.

These are clearly extremely contentious, political issues. However, this proposed SOP attempts to place provide clarification by using already existing means of decision making to create a clear delineation of responsibility that provides both clinical judgment and administrative leadership input into the decision-making process. In short, this SOP proposes leaving the clinical evaluation and treatment plan process, the MTC, and the ARC unchanged; however, it expands the language to include other, more extreme, treatment and management options.

In regard to gender confirming surgery, the SOP acknowledges this is an extreme measure and should be reserved for a profoundly debilitating case of Gender Dysphoria. It would not be a decision taken lightly, but allowing for at least the possibility of surgical intervention would be in keeping with accepted practices. "Seven circuits of the U.S. Courts of Appeals have concluded that severe GID or transsexualism constitutes a "serious medical need" for purposes of the eighth amendment. No circuit court has held otherwise" (Etheridge, 2014)

The PREA regulations, incorporated into the Program Statement Sexually Abusive Behavior Prevention and Intervention Program, state in section 28 C.F.R. § 115.42 (c): "In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates…the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems."

Simonpoulos and Khin Khin (2014) state "Placement based on self-identification has been hailed by some advocates as an ideal resolution for transgender inmates. However, there are legitimate concerns surrounding this option as well: potential violence against FTM inmates in male prisons; potential violence perpetuated by MTF inmates in female prisons, especially considering the possibility that sexual predators may claim to be transgender to take advantage of the system; and violation of the rights of nontransgender inmates."

Legal Considerations

Cross gender placement decisions

PREA regulations:

115.15

(e) The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

(f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

115.31

(a) The agency shall train all employees who may have contact with inmates on (9) How to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming inmates;

§ 115.41 Screening for risk of victimization and abusiveness.

(d) The intake screening shall consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: (7) Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;

§ 115.42 Use of screening information.

(a) The agency shall use information from the risk screening required by § 115.41 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive.

(b) The agency shall make individualized determinations about how to ensure the safety of each inmate.

(c) In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.

(c) In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.

(d) Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.

(e) A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.

(f) Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates.

(g) The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

§ 115.86 Sexual abuse incident reviews.

(a) The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. (d) The review team shall (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;

Community standards: Insurance comparable guidelines

Aetna

Aetna considers gender reassignment surgery medically necessary when all of the following criteria are met:

- Requirements for mastectomy for female-to-male patients:
- Single letter of referral from a qualified mental health professional (see Appendix); and
- Persistent, well-documented gender dysphoria (see Appendix); and
- Capacity to make a fully informed decision and to consent for treatment; and
- Age of majority (18 years of age or older); and
- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.

Regence (Idaho and select counties of Washington) 2017. Policy M-MED 153

- For hormone therapy treatment of gender dysphoria:
  - Clinical records must include the following:
    - a diagnosis of gender dysphoria, as defined by the DSM-5 criteria; and,
    - Documentation to support the patient has the ability to make fully informed decisions and consent for treatment; and,
    - For 3 or more months prior to the initiation of hormone therapy, documentation of the beneficiary living as the desired gender and/or psychotherapy with a licensed mental health professional.

- For surgical treatments that may be considered medically necessary for gender dysphoria:
  - Clinical records must include all of the following:
    - Age of patient (must be at least 18 years of age);
    - Documentation to support the patient has the ability to make fully informed decisions and consent for treatment;
    - Documentation of hormonal therapy and outcomes;
    - Diagnosis of gender dysphoria by at least two (2) licensed mental health professionals; and
    - Documentation of the beneficiary living as the desired gender.

United Health Care (2017) Policy: C-007

Gender reassignment surgery may be indicated for individuals who provide the following documentation:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating gender dysphoria*, is needed for breast surgery. The assessment must document that an individual meets all of the following criteria:
    - o Persistent, well-documented gender dysphoria
    - o Capacity to make a fully informed decision and to consent for treatment
    - o Must be at least 18 years of age (age of majority)
    - o If significant medical or mental health concerns are present, they must be reasonably well controlled.
- A written psychological assessment from at least two qualified behavioral health providers experienced in treating gender dysphoria*, who have independently assessed the individual, is required for genital surgery. The assessment must document that an individual meets all of the following criteria:
    - o Persistent, well-documented gender dysphoria
    - o Capacity to make a fully informed decision and to consent for treatment
    - o Must be at least 18 years of age (age of majority)
    - o If significant medical or mental health concerns are present, they must be reasonably well controlled
    - o Complete at least 12 months of successful continuous full-time real-life experience in the desired gender
    - o Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating gender dysphoria*.

Molina Healthcare (2014) Policy: MCP-216

The treatment of gender dysphoria requires a multidisciplinary team and step-wise approach in order to promote optimal health for individuals of this diverse population. The initial assessment of a patient with transsexualism is based on psycho-diagnostic instruments and ideally should be performed by a mental health professional. Counseling is essential before initiating hormonal or surgical treatment. It is recommended that when or before hormone treatment starts, the individual should begin living in the role of the opposite gender. The World Professional Association for Transgender Health Standards of Care provides the following criteria for starting hormone therapy and for undergoing surgical procedures: diagnosis of persistent, well-documented gender dysphoria, the capacity to make a well-informed decision, the person must be of legal age; and any medical or mental issues are well-controlled. The goal of treatment in female-to-male transsexual individuals is to stop menses and induce virilization, including a male pattern of sexual hair, male physical contours, and clitoral enlargement. The principal hormonal treatment is a testosterone preparation. For male-to-female transsexual individuals the goal is elimination of sexual hair growth, induction of breast formation, and a more female fat distribution are essential. To accomplish this, a near-complete reduction of the biological effects of androgens is required.

Genital sex reassignment surgery is the final step for many transsexual individuals to live successfully in their preferred gender role. In male-to-female transsexual persons, a bilateral orchiectomy is performed to remove the main source of endogenous testosterone. In addition to gonadectomy, other procedures include penectomy, cosmetic surgery to create a clitoris, and surgical construction of a vagina. For female-to-male transsexual individuals, an oophorectomy, hysterectomy, and vaginectomy are generally performed after one to two years of androgen therapy according to practice guidelines.

1. Hormone Replacement may be considered medically necessary and may be authorized when there is a benefit for treatment of gender dysphoria and ALL of the following criteria are met 2 6:

- Age 18 years or older; and
- The individual has the capacity to make a fully informed decision and to consent for treatment; and
- A definitive diagnosis of persistent gender dysphoria has been made and documented by a qualified mental health professional such as a licensed psychiatrist, psychologist or psychotherapist and all of
- the following are present: [ALL]
    - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the
    - wish to make his or her body as congruent as possible with the preferred sex through surgery and
    - hormone treatment; and
    - The transsexual identity has been present persistently for at least two years; and
    - The disorder is not a symptom of another mental disorder; and
    - The disorder causes clinically significant distress or impairment in social, occupational, or other
    - important areas of functioning; and
- Recommendation for hormone replacement treatment has been made by an endocrinologist who has
- confirmed the diagnosis of persistent gender dysphoria by the qualified mental health professional;
- and
- Initial hormone therapy must be prescribed by an endocrinologist preceded by all of the following: [ALL]
    - Documentation that the individual has lived as their new gender full-time for 3 months or more prior to the administration of hormones; and
    - Documentation of continuous psychotherapy after the initial evaluation for a minimum of three months to identify any comorbid psychiatric diagnosis that may require treatment; and
    - Documentation that he individual has demonstrable knowledge of the risks and benefits of hormone replacement

2. Surgical Treatment* may be considered medically necessary and may be authorized when there is a

benefit for surgical treatment of gender dysphoria and ALL of the following criteria are met:

- Age 18 years of age or older; and
- The individual has the capacity to make a fully informed decision and to consent for treatment; and
- A definitive diagnosis of persistent gender dysphoria has been made and documented by a qualified
- mental health professional such as a licensed psychiatrist, psychologist or psychotherapist and all of
- the following are present: [ALL]
    - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the
    - wish to make his or her body as congruent as possible with the preferred sex through surgery and
    - hormone treatment; and
    - The transsexual identity has been present persistently for at least two years; and
    - The disorder is not a symptom of another mental disorder; and
    - The disorder causes clinically significant distress or impairment in social, occupational, or other
    - important areas of functioning; and
- Documentation of two separate written referrals for surgery or one letter signed by both qualified mental health professionals if practicing within the same office; and
- Continuous hormone therapy has been provided for 12 months under the supervision of an endocrinologist with documentation of compliance and the type, frequency, and route of the medication administered for 12 months or more unless hormones are not clinically indicated; and
- There is documentation that the individual has lived as their new gender full-time for 12 months or more; and
- There is documentation from medical and mental health providers that there are no contraindications to the planned surgery and any medical or mental issues are well-controlled; and
- The surgery must be performed by a qualified provider at a facility with a history of treating individuals with persistent gender dysphoria disorder

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PREA guidelines

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WPATH standards specific to transgender individuals in institutional environments state "Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the SOC, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria."

In determining prevalence rates, it should be noted it is unknown how many people self-identify as transgender (Winter et al, 2016). Regarding individuals diagnosed with Gender Dysphoria, the DSM 5 suggests for natal males, the prevalence rates of Gender Dysphoria is between .005 and .014. For natal females, rates are between 0.002 and .003. Given current IDOC population (12/14/2017 statistics indicate 6,333 males and 854 females), prevalence rates would suggest between 31 and 88 natal male inmates diagnosed with GD, and approximately 2 natal female inmates diagnosed with Gender Dysphoria

Proposed SOP on transgender inmates and those diagnosed with Gender Dysphoria

Summary: IDOC's current policy on Gender Dysphoria (GD) (**401.06.03.501 Gender Identity Disorder: Healthcare for Offenders with**) was scheduled for review in 2013. This review is happening now, and it is important to note there are numerous shifts in attitudes and practices in political, medical, legal, and mental health areas. This document serves as an effort to summarize current trends, and to offer explanation of some of the changes in the proposed revision to the SOP.

History: IDOC's GD policy is in part shaped by legal decisions from past law suits. According to the DAG office, the following points are a summary of the legal boundaries in which IDOC must operate to maintain compliance with these previous lawsuits:

1) An inmate can request a GD evaluation
2) The deadline to commence the evaluation process once request (or referral) received is 30 days
3) IDOC Chief Psychologist is to review the initial evaluation report and can thereafter retain an independent consultant if he/she disagrees.
4) IDOC Chief Psychologist will issue a report finalizing GD portion of treatment plan prior to convening MTC.

While our current policy meets these guidelines, other issues have arisen that should be addressed in policy:

1. Transgender vs. Gender Dysphoria
2. Management vs. Treatment
3. Individualized Treatment decisions and range of options
4. Gender identity, including appearance, property, and pronouns
5. Identifying transgender/intersex inmates
6. Management of GD related documentation

Transgender vs. Gender Dysphoria

As the DSM 5 notes, individuals diagnosed with GD *represent a subset of transgender individuals*. For clarity, transgender individuals can self-identify, the same way a homosexual individual can self-identify, while GD is a mental health disorder that requires the diagnosis of a Qualified Mental Health Professional. Expanding the IDOC SOP to include management practices of transgender inmates aligns with standards outlined in PREA, as well as WPATH and other advocacy and legal protection agencies guidelines.

Specifically, PREA (2012) regulations provide the following guidance for *Transgender* inmates (not exclusively GD), taken from "§ 115.42 Use of Screening Information":

(d) Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.

Commented [JHS1]: Is it important to distinguish between transgender and intersex in our SOP too? Or is that outside the scope of this document?

(e) A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.
(f) Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates.
(g) The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status.

Management vs. Treatment

Current policy directs management and treatment decisions through the MTC, and only inmates diagnosed with GD. The proposed revision recommends expanding this focus to provide the possibility of individualized management accommodations, in addition to medical and mental health treatment interventions for those diagnosed with Gender Dysphoria.

Management accommodations are defined as those individualized interventions that do not require a licensed provider but can be implemented by security or administrative staff (e.g. special housing, specific cell mates, gender-specific pat downs, opposite gender property), and would be considered by the MTC for all self-identified transgender inmates. Treatment decisions (such as psychotherapy or hormone replacement therapy) are those interventions that require a licensed provider (medical or mental health) and would be considered for those inmates with a diagnosis of GD.

Individualized Treatment decision and range of options

In regards to medical interventions, IDOC's current policy only addresses Hormone Replacement Therapy as an intervention. Other interventions exist, including Gender Confirming (or "reassignment") surgery or placement in a cross-gender facility. Our policy should not limit the range of management/treatment interventions at the policy level.

The SOP acknowledges these are extreme measures and should be reserved for a profoundly debilitating case of Gender Dysphoria. It would not be a decision taken lightly, but allowing for at least the possibility of surgical intervention or cross-gender placement would be in keeping with accepted practices. The IDOC already has an effective decision making process, involving the initial qualified evaluator, the MTC, and the ARC, all weighing in on decisions made with this population.

Gender Identity, including appearance, property, and pronouns

Previous PREA SOP 325.02.01.001 (Prison Rape Elimination) stated: "To foster an environment safe from sexual misconduct, offenders are prohibited from dressing or displaying the appearance of the opposite gender." This includes: Hairstyles, Shaping eyebrows, Face makeup, etc. Such language is not included in the new PREA policy.

This proposed GD policy makes a change in focus; it emphasizes that "eroticized" or "sexualized" appearance is prohibited, while non-gender-conforming appearance is not prohibited. Although this leaves significant room for interpretation, it is argued this is a more penologically-justified position.,

It should be noted this recommendation is partly based on my observations that rules governing gender-conforming appearance are enforced unevenly, and staff report anxiety about enforcing rules when transgender threaten legal action.

Concerns exist that there may be increased risk of sexual assault if male inmates are allowed to appear feminine. This writer argues that

1. there is no evidence (despite considerable searching) that sexual assaults are linked to feminized appearance (e.g. The ACLU document "END THE ABUSE" advises against "policies or practices that limit "cross-gender" expression because such expression "invites" sexual assault" are inappropriate and contrary to the needs of this population.)
2. Inmate frequently appear more feminized already. I believe it is fairly common knowledge among inmates and staff when inmates publicly identify as transgender

Identifying Transgender and Intersex inmates

The PREA policy makes reference to management requirements of transgender and intersex inmates, such as section 6 which states "transgender and intersex inmates must be given the opportunity to shower separately from other inmates. This requirement is problematic in that these inmates are not identified through any official DOC documentation, excepting the medical record which is not available to security officers who must make these accomodations.

In keeping with the Federal Government Bureau of Prison's policy, it is recommended that the DOC tracking system (CIS) create an identifier by which prison staff can identify this population for appropriate accomodations.

Management of GD-related documentation

Currently, all records of GD evaluations, MTC and ARC notes, and related documentation are kept on paper charts in "the Balla Closet" at central office. While this may have been appropriate when medical records were kept on paper charts, the implementation of the electronic medical record makes such a system problematic.

It is recommended that our policy include guidance that all medical documentation should be stored electronically in the electronic medical record. All other documentation, such as ARC and MTC notes should be stored in the inmates DOC file.

It should be noted a potential concern with including GD evaluations in the EMR is that inmates will have the right to access such data. This writer does not believe this is a problem, and is an appropriate storage solution for these records.

National Perspective from other DOCs

	Identify transgender?	Transgender management?	Offer surgery?	Cross gender placement?

Washington	Yes, via approval of medical committee	GD and	No, considered NOT medically necessary and not provided	One MtF
Oregon	Yes			
Utah	No policy currently formalized, but in development			
Montana	No policy currently formalized, but in development			
Delaware	No, only GD			"any and all medically necessary interventions are available to patients who meet the readiness criteria"
Kansas (Corizon policy)	No, only GD	No		"placed according to the inmate's biological gender presentation" Case-by-case exceptions allowed. Final decision with KDOC and facility warden.
Illinois (proposed policy draft)	Yes	GD and transgender not differentiated	Not specified,	"housed in accordance with gender-related needs"
Federal BOP	yes			

National Perspectives from non-correctional agencies

NCCHC					
NIC					
WPATH					
ACLU					
Mental health (APA)					

Community Standards

Insurance companies

Air Force

VA

Idaho Department of Correction	**Standard Operating Procedure**	Title: **Gender Dysphoria: Healthcare for Inmates with**		Page: 1 of 13
		Control Number: **401.06.03.501**	Version: **3.93**	Adopted: 10-31-2002

Jeff Zmuda, chief of the Prisons division, approved this document on _____.

Open to the public: ☒ **Yes** ☐ No

Redacted version available: ☐ Yes ☐ No

SCOPE

This Standard Operating Procedure (SOP) applies to all Idaho Department of Correction (IDOC) inmates who request or are evaluated for and/or diagnosed with Gender Dysphoria (GD); Prisons division administrators, employees, contract medical providers and subcontractors; and limited IDOC staff such as facility heads, security staff, Deputy Attorneys General (DAG) who represent the IDOC, and the director of IDOC.

Revision Summary

Revision date (__/__/2015) version 4.0: Significant rewrite to include renaming from 'Gender Identity Disorder' to 'Gender Dysphoria'.

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BOARD OF CORRECTION IDAPA RULE NUMBER 401

Medical Care

POLICY CONTROL NUMBER 401

Clinical Services and Treatment

PURPOSE

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

RESPONSIBILITY

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

GENERAL REQUIREMENTS

1. **Initial Reporting**

Information about all services available within the correctional system, including those to meet the needs of those who experience Gender Dysphoria, will be made available to inmates while in the Reception/Diagnostic Unit (RDU). Upon the inmate's request, information about all services will be available throughout the inmate's incarceration.

If an inmate reports self-identifying as transgender and believes a diagnosis of Gender Dysphoria is appropriate, that inmate should be directed to submit a concern form to the site clinical supervisor. This request may be made at any time during the inmate's incarceration.

In addition to a direct request from the inmate, staff members may refer transgender prisoners to mental health for supportive services or an evaluation for Gender Dysphoria at any time.

~~1.~~ **Inmate** – Requests (in writing) health assistance in accordance with SOP

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401.06.03.037, *Non-emergency Healthcare Requests and Services* **or** SOP 401.06.03.087, *Healthcare for Inmates Housed in Non-Idaho Department of Correction Facilities*.

~~1.~~ **Healthcare staff** – Submits a referral in accordance with SOP 401.06.03.037 **or** 401.06.03.087, to the chief psychologist.

Subsequent Evaluations

Also see section 11.

2. Placement of the Inmate for Evaluation Purposes

If necessary for the safety of the inmate or to address his or her mental health needs, the site clinical supervisor consults with facility administration to take the necessary action to transfer that inmate to an appropriate housing unit for evaluation. Although the clinical supervisor is not responsible for security-related decisions, he or she should function in the primary role of coordinating decisions in regard to transgender inmates, given the natural stressors and adjustment strains of this population in a correctional environment. Specialized placement decisions should reflect the inmate's diagnostic needs and level of distress, as well as prior institutional adjustment, inmate safety, institutional resources and existing security concerns. If a move to a different facility is indicated, the request should be forwarded to the chief psychologist or designee who shall work with IDOC staff to arrange the transfer.

Any transfer (if needed) will occur as soon as practicable, subject to variables such as bed and transportation availability, and security considerations. An inmate's identification as transgender or the experience of gender dysphoria, in itself, is not reason for placement in restricted housing. Once a diagnosis is complete, inmates may be returned to a correctional facility consistent with their security classification and treatment needs.

3. Evaluation of the Inmate

Once the inmate has been identified as appropriate for an assessment, an evaluation should be scheduled to occur within 30 days of the intake screen or of receipt of the written request. The inmate will be evaluated by a qualified evaluator, assigned by the chief psychologist or designee, who will assess for Gender Dysphoria. An outside consultant may be obtained for the evaluation, at the chief psychologist's discretion. Any diagnoses by the Management and Treatment Committee (MTC, see below) evaluators should include consideration of the consultant's report but the consultant's findings are not considered binding.

A qualified evaluator (whether IDOC mental health professional or independent consultant) is to possess credentials as defined by the World Professional Association for

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Commented [WL1]: Are you talking restrictive housing such as seg or a more restrictive environment such as the BHU?

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Transgender Health (WPATH) current Standards Of Care (SOC) document. The 2011 version 7 used here is the most current edition as of this writing, but subsequent editions of the SOC will take priority in defining a qualified evaluator.

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.
2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.
3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.
4. Documented supervised training and competence in psychotherapy or counseling.
5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.
6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

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The evaluation should be in keeping with current Standards of Care. Per current WPATH SOC, it should be psychosocial in nature and at a minimum include 1) an assessment of gender identity, 2) severity of gender dysphoria, 3) history and development of gender dysphoric feelings, 4) the impact of the stigma attached to gender nonconformity on the individual's mental health, and 5) the available support from family, friends, and peers. The evaluation process requires multiple face-to-face (minimum of two) individual sessions with the inmate.

The assessment and diagnosis of Gender Dysphoria shall be based on the most current *Diagnostic and Statistical Manual of Mental Disorders diagnostic criteria*.

The reports shall include dates of contact, instrumentation utilized (if any), and collateral data obtained. Being psychosocial in nature, the report should also include adjustment to incarceration. It should discuss any other co-occurring mental health disorders, clarify differential diagnosis when indicated, and discuss how other mental health disorders may impact Gender Dysphoria. Documentation of any claim by the inmate of Gender Dysphoria diagnosis, treatment, or transgender lifestyle prior to incarceration shall be obtained as part of the process. An inmate's refusal to provide written authorization to access medical records relating to prior diagnosis or treatment of Gender Dysphoria may be considered a factor in potentially refraining from finding Gender Dysphoria to be an appropriate diagnosis by the

evaluators. In addition to the qualified evaluator's report, a psychiatric evaluation may be requested by the evaluator, if indicated

Throughout the evaluation process, the chief psychologist, or designee, shall monitor the progress of the evaluation to ensure the Gender Dysphoria evaluation is completed as soon as practicable. Absent extenuating circumstances, the evaluation will be completed within 90 days from the date the evaluation process commences as described in section 2.

Commented [WL2]: So you have 30 days to do the evaluation but 3 months to type it? Or is this to meet the need of the MTC?

4. Evaluator Findings, Diagnosis, and Reporting

The qualified evaluator(s) and the consultant (if applicable) conducting the evaluation(s) shall prepare independent written reports. These written reports will be made available to the Management and Treatment Committee (MTC) for consideration. Whenever possible, the evaluator(s) will provide their evaluations to the MTC committee members seven (7) days prior to the quarterly MTC meeting for review. Copies of all reports authored by the qualified evaluator(s) or consultant(s) will be provided to all the members of the MTC.

In cases where prior to incarceration an inmate was receiving feminizing or masculinizing hormones from a licensed medical professional as treatment for Gender Dysphoria, the prior hormonal treatment will be continued and incorporated into the inmate's individualized treatment plan, unless current medical providers determine there is a medically or psychologically compelling reason to discontinue treatment.

5. Management and Treatment Committee (MTC) Meeting

The MTC will consist of a multidisciplinary team of staff to include, but not limited to, medical, security, administrative, and mental health staff. A designated representative for each IDOC facility should be part of the MTC to ensure the needs of the inmates with Gender Dysphoria in their facilities are represented. The facility representative will be responsible for providing the MTC needed information and updates (i.e. six-month reports) concerning the inmate(s) who identify as transgender and/or who are diagnosed with Gender Dysphoria needs and any possible housing concerns.

Commented [WL3]: We have never included security, is there a plan for this?

The MTC will convene quarterly, or more often as needed. The MTC will review and discuss the assessments and collateral information for each inmate who requested to be evaluated for Gender Dysphoria, and will make a determination whether the inmate meets the criteria for Gender Dysphoria.

If the inmate meets the criteria for Gender Dysphoria, the MTC shall develop and recommend an individualized *Management and Placement Plan* for each inmate diagnosed with Gender Dysphoria, or a provisional finding. The *Management and Placement Plan* will contain all the pertinent information needed for the inmate's treatment of

Gender Dysphoria. The plan should include, but is not limited to, 1) housing placement of the inmate, 2) recommendations for group/individual mental health treatment to provide support, maximize overall psychological well-being, and to alleviate gender dysphoria, if possible, 3) consideration of referral for an assessment for hormone treatment, and 4) any other accommodations for the inmate the MTC feels is appropriate for the treatment of Gender Dysphoria.

The MTC will notify the regional medical director of these plans, who may also assess and initiate cross-sex hormonal therapy when an assessment for such therapy is part of the *Management and Placement Plan*. Unless the inmate was previously prescribed cross-sex hormonal medications before coming to prison, the inmate will typically be required to have an approximate six-month continued evaluation period after being given the diagnosis of Gender Dysphoria where they will continue to be educated concerning issues associated with Gender Dysphoria before they will eligible to be assessed for cross-sex hormonal therapy. If the inmate was previously prescribed cross-sex hormonal medications before coming to prison, the cross-sex hormonal therapy may commence prior to and independent of the MTC and Administrative Review Committee's (ARC) review under the direction of the medical director.

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

Criteria for cross-sex hormonal administration will be as follows:

~~1.~~1) At least six (6) months of an evaluation period after an initial diagnosis of Gender Dysphoria

~~2.~~2) Having six (6) months of non-medical feminization (i.e. living as a female)

~~3.~~3) At least monthly cooperative meetings with the mental health staff (i.e. Group therapy addressing gender related issues) during those six (6) months

~~4.~~4) No medical contraindications as assessed by medical or endocrinology staff

~~5.~~5) Informed consent for treatment will be obtained, including a signed document that specifies:

~~1.~~a. The medical or endocrinology staff will determine the dose and specific drug administered rather than the inmate

~~2.~~b. Criteria for cessation of hormonal therapy

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~~3.~~c. The therapy will be stopped if it's discovered the inmate diverted the medications to another inmate

~~4.~~d. The inmate may stop the therapy at any time, but will need to consult with the medical or endocrinology staff to determine the safest manner to stop therapy

~~5.~~e. Make the inmate aware another medical condition may arise that may make it medically prudent to stop the hormonal therapy

~~6.~~f. The MTC may recommend to the medical provider the discontinuation of hormone therapy if there is a consistent deterioration of the inmate's mental health that may be manifested as an inability to vocationally function, a significant interpersonal issue with another inmate(s), or lack of behavioral cooperation with security staff

Stable mental and behavioral health, as indicated by no serious rule infractions during the period of evaluation, including diverting hormone pills to another inmate.

Management and placement recommendations for inmates with Gender Dysphoria will take into account both treatment **and** security needs, with a goal of least restrictive placement. The inmate gender dysphoria, mental health, hormone treatment, and transitioning process will be monitored through the MTC and their regular meetings. If an inmate with Gender Dysphoria is being housed outside of the general population in a more structured housing unit (i.e. BHU or ACMU), the MTC will need to convene and review the inmate's current situation before the inmate can be moved to another structured unit or general population, along with approval of the ARC. The MTC may initiate mental health services prescribed as part of the *Management and Placement Plan* prior to and independent of the ARC review, as described below. The MTC shall forward its recommendation for management and placement to all ARC members within 15 working days of the MTC meeting.

The inmate can remove themselves from the assessment process at any time, at which point they will be identified as an inmate who is not diagnosed with Gender Dysphoria.

6. Administrative Review Committee (ARC) Meeting

Convening Responsibility

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

Review of Management and Placement Plan

The ARC shall review recommendations of the Management and Treatment Committee (MTC). If the ARC agrees with the recommendations of the MTC, they will submit the *Management and Placement Plan* to the Director of the IDOC for approval. The ARC may ask the MTC to provide more clarifying information or question the recommendations concerning an inmate's *Management and Placement Plan*. If this is the case, the ARC will submit a formal request to the MTC as soon as possible so the MTC can reconvene to address

Commented [WL4]: Can we set a timeframe in this? Sometimes it is MONTHS and I think this delays care and could create some issues.

the information that needs to be clarified. The ARC may, in its discretion, retain a qualified consultant versed in the treatment, management, and placement of persons with Gender Dysphoria. The ARC makes recommendations regarding the classification, management and security of persons with Gender Dysphoria. Recommendations of the ARC, together with the recommendations of the MTC, shall be submitted to the Director of the IDOC for final consideration.

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

7. Final Approval of the Management and Placement Plan

The Director of the IDOC shall review the ARC's recommendation, take into consideration existing security concerns within the facility **and** available space in the facility identified in the *Management and Placement Plan* and in his or her sole discretion, may:

~~1.~~ Send the recommendation back to the ARC **or** the MTC for additional findings or information, or

~~2.~~ Retain consultants to address any concerns or questions with the recommendation.

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After completing all of the above and as soon as practicable, the director of the IDOC may accept, in writing the ARC's recommendation. If the Director of the IDOC accepts the ARC's recommendation, the ARC will approve implementation of the *Management and Placement Plan*, and implementation shall begin within one (1) month of the Director's approval.

8. Moral and Ethical Treatment of Inmates who identify as transgender

A diagnosis of Gender Dysphoria is protected health information and is not to be disclosed to IDOC staff without justified reasons. Inmates who identify as transgender, however, are to be treated with basic human respect, including the following:

- Shall be addressed by their last name or their preferred pronoun (i.e. "he" or "her" or "them" or "zir"),
- Will not be harassed because of their condition, and
- Will be treated by staff in a manner consistent with policy 201, *Respectful Workplace*. (i.e., Staff members must maintain a respectful and professional demeanor, and refrain from harassing inmates due to their gender/sex, etc.)

Commented [WL5]: What?

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

Garments and property that protect LGBTI individuals are to be allowed. Specifically, inmates with Gender Dysphoria are to be permitted the purchase and use of all commissary, clothing, and property items that are allowed in prisons that house the inmate's identified gender.

Commented [WL6]: I don't know what's on female commissary but what about tampons or curling irons or whatever?

Whenever possible, accommodations should be made to provide private showers and strip searches. Strip searches of inmates diagnosed with Gender Dysphoria will be conducted in a manner that is consistent with SOP 317.02.01.001, *Searches: Cell/living Unit, and Inmate*.

9. Subsequent Reviews and Evaluations for Gender Dysphoria

The evaluation process includes the assignment of a LOC (see section 5) in all cases in which an inmate is assessed to have a diagnosis of Gender Dysphoria and dictates the minimum frequency in which the inmate's resulting treatment plan must be reviewed. In all cases a review must occur at a minimum of every six months.

In the event that additional observations **or** information concerning the inmate's purported Gender Dysphoria becomes available, a subsequent evaluation may be requested as described in section 1.

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

10. Training

All IDOC staff will receive initial training concerning the procedures and treatment of inmates with Gender Dysphoria through classes provided through Peace Officer Standards & Training (POST) as well as other initial training provided to support staff. All staff will be required to complete annual continuing education training concerning the procedures and treatment of inmates who have Gender Dysphoria. This may be provided in person or by IDOC's online training programming.

Commented [WL7]: Are we going to create a training and submit it to POST?

DEFINITIONS

Administrative Review Committee (ARC): A committee comprised of the Chief of the Prisons division; a mental health professional designated by the Chief of the Prisons

division and a deputy attorney general who is assigned to the Idaho Department of Correction (IDOC) to act as legal advisor.

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

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

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

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

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

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

Gender Dysphoria: A psychiatric disorder as defined in the most current *Diagnostic and Statistical Manual of Mental Disorders (DSM 5)*. A person with this condition experiences distress in regards to his or her own biological sex. This diagnosis is not to be confused with an individual's experience of differing from their natal biological sex (see Transgender below), but refers to the internal experience of distress consequent to this difference. Not all individuals who identify as transgender experience Gender Dysphoria. In general, this condition is a stable nonviolent condition and not due to psychosis but it may accompany other mental disorders. *It should be noted the term "Gender Identity Disorder" was used for similar symptoms in the previous DSM edition (IV). This term is no longer in use, however, as identifying with a gender other than that which on was born is no longer considered a disorder in and of itself. In addition, terminology may continue to change over time.*

Gender Non-Conformity: the extent to which a person's gender identity, role, or expression differs from cultural norms prescribed for people of a particular sex. Only *some* gender-nonconforming people experience gender dysphoria at some point in their lives. (WPATH, 2012)

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

Hormonal Replacement Treatment: A medical treatment in which male or female hormones are prescribed to a patient as a result of his/her inability to produce an adequate amount of these hormones internally.

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

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

Management and Treatment Committee (MTC): A committee composed of the chief psychologist, psychiatrist, psychologist, medical director, and facility head or designee. Other mental health, medical, human services, and security staff may be requested to attend in an advisory capacity. The MTC meets on a quarterly basis.

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

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

Primary Physical Sexual Characteristics: Genitalia and reproductive organs.

Qualified Evaluator: A licensed mental health practitioner, who has demonstrated an indicia of basic competence related to the diagnosis and treatment of Gender Dysphoria

and related mental or emotional disorders through their licensure, training, continuing education, and clinical experience.

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

Sex: biological indicators of male and female, such as sex chromosomes, sex hormones, and genitals. Not to be confused with 'gender' (see above)

Sexual Reassignment Treatment: *Defined in the most current DSM, as* treatment for a person diagnosed with Gender Dysphoria in which hormonal medications, surgical procedures, or both are utilized to alter a person's physical appearance so that the person appears more like the opposite gender

Transgender: A broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender (DSM 5).

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

REFERENCES

American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, 70, 832-864.

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

IDAPA 06.01.01, *Rules of the Board of Correction*, Section 401, Medical Care Policy 201, *Respectful Workplace*

Standards of care for the health of transsexual, transgender, and gender non-conforming people. (2011). The World Professional Association for Transgender Health. (7th ed.). Chicago, IL.

Standard Operating Procedure 303.02.01.001, *Classification: Inmate*

Standard Operating Procedure 317.02.01.001, *Searches: Cell/living Unit, and Inmate*

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

Standard Operating Procedure 401.06.03.070, *Informed Consent*

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

– End of Document –

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	134217
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	07/15/2013	DOBLER, NICK #4472
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
07/12/2013 22:00	UNIT 16	

Description of Offense:
While having a conversation in the office with offender Edmo 94691 it was stated that the hairstyle that offender Edmo was a feminine hair style. I reminded offender Edmo that if this hairstyle continues and previous warnings were going to be ignore to comply with direction and orders regarding the feminine hair styles, offender Edmo would be subjected to the disciplinary process. Edmo refused to change his hair.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
BULEN, PHILLIP W #1286X	07/17/2013 05:30
Delivering Staff:	**Date/Time Delivered:**
BONNER, SHANE R. #9827	07/17/2013 13:51
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
07/19/2013	07/19/2013	RAMIREZ, SABINO J. #5917
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	DENY	CONFIRM

Sanctions:	Amount:	End Date:
COMMISSARY RESTRICTION	10 day(s)	07/29/2013
RECREATION RESTRICTION	10 day(s)	07/29/2013

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	07/22/2013	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
BLADES, RANDY E. #3431	07/22/2013	07/25/2013	MODIFY

Offender Appeal Details:

1) Sgt. Ramirez personally humiliated me about being GID (audio rec'd)
2) 20 days gym restriction / commissary restriction too severe for class C.
3) D.O.R. not specific about hairstyles "feminine" which hairstyle?
4) Time & date of D.O.R. not correct.
5) Sgt. Dobler violated SOP 401 Sec 10 (GID) "staff will not use identifiers as "she" or "him" etc. while writing

D.O.R.
6) I use commissary approved hairspray in hair.

Appellate Comments:

1. That would be separate matter of which you can file a complaint and it will be investigated. That would not change the fact that the report states you did not comply with the order.

2. Reduced to 10 days.

3. The DOR does mention feminine hairstyle. It is the one that I was sent photos of and did not allow because it could create a sexually charged environment (as we discussed)

4. The dates and times match up chronologically.

5. The policy states that the last name is to be used. the last name was used 5 times and the word his was used only once. That meets the spirit of the policy.

6. Ok.

The bottom line is that offenders are to obey orders and then work out disagreements properly using the grievance process. Not disobey the order.

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	141124
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	02/23/2014	ERBE, SAMUEL #A073
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
02/23/2014 08:45	UNIT 16	

Description of Offense:

On 02-23-14 at 08:45 I observed Offender Edmo # 94691 walking in the day room. I observed that Offender Edmo hair was in a high pony tail and styled in a feminine fashion. I called Offender Edmo to the officer station where I told offender Edmo that per policy of the prison rape elimination that the feminine hair style was not allowed, and I ordered Offender Edmo to take the feminine hair style out. Offender Edmo stated I am sorry that this is the way you feel, but I am allowed per my treatment plan. I order Offender Edmo to take the feminine hair style out, and I would check the treatment plan. Offender Edmo replied stating I am sorry you feel that way, but I am not going to take my hair down and it is in my treatment plan; do you want me to take my breast out as well. I replied that the feminine hair style was not allowed at which time Offender Edmo walked away. I did check C.I.S., and I also checked with Unit 16 Corporal Bollman to see if anything gave such an allowance for Offender Edmo to wear a feminine hair style, and nothing was noted as such.

Description of Evidence:

Front of hair curly, and brushed up. Rear of hair was placed in a high tight pony tail. Hair styled in a feminine fashion.

Reviewing Supervisor:	Date/Time Reviewed:
BAIRD, NICHOLAS #8506	02/23/2014 23:30
Delivering Staff:	**Date/Time Delivered:**
BLAKE, CLINTON E. #7850	02/24/2014 07:57
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [X] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
02/26/2014	02/26/2014	LEE, BENJAMIN K. #6103
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	5 day(s)	03/01/2014

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	02/27/2014	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	141153
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	02/24/2014	BOLLMAN, ROBERT G. #4208
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
02/24/2014 13:05	UNIT 16	

Description of Offense:

On 2/24/14 at 1305 I was notified by C/O Williams that Offender Edmo 94691 was wearing makeup and his hair was in a high pony tail which violates policy 325.02.01.002. I then asked if he had given Edmo a direct order to correct the issue. Williams stated that he had not because Edmo was getting upset in front of other offenders and was making it unsafe for officers on the tier. Edmo then made the statement "I am not changing even if you did give me a direct order and you can take me to unit 8".

After speaking with C/O Williams I had Edmo called out to the foyer of unit 16. Myself and C/O Erbe noticed as Edmo approached that he had makeup on his face. I then asked Edmo if C/O Williams had spoken to him about correcting the issue. Edmo would not answer the question and was becoming upset at me. I then gave Edmo a direct order to fix the issue that C/O Williams had pointed out. Edmo refused at which point Edmo was placed in restraints and taken to unit 8.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
DAVIS, TYRELL #6000	02/24/2014 23:39
Delivering Staff:	**Date/Time Delivered:**
CAMACHO, JUSTIN #A524	02/25/2014 09:15
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
02/26/2014	02/26/2014	LEE, BENJAMIN K. #6103
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	30 day(s)	03/31/2014

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	02/27/2014	MODIFY

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	143588
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	07/08/2014	WHITE, CALLIE #A521
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
07/08/2014 10:34	UNIT 16	

Description of Offense:
On 7/8/14 at around 10:34 I asked Offender Edmo #94691 to remove Edmo's hairstyle to a style that appeared less feminine gender specific per section 4 of PREA policy 325.02.01.001. Offender Edmo responded with "it's fine" and walked away from the officers station. A few minutes later Edmo returned with two concern forms for me to sign which I did then again requested that Edmo lower Edmo's hairstyle. Edmo requested the policy that I was referencing which I told Edmo. Edmo responded with "Lieutenant Greenland has told me I can wear my hair however I want to as long as it's not in a bun". Edmo left the officers station without changing Edmo's hair and left for Pendyne shortly after with Edmo's hair unchanged.

Description of Evidence:
Five C-note entries for warnings on the same policy

Reviewing Supervisor:	Date/Time Reviewed:
DAVIS, TYRELL #6000	07/09/2014 00:08
Delivering Staff:	**Date/Time Delivered:**
MORRISON, J #4431	07/09/2014 07:43
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
07/09/2014	07/09/2014	LEE, BENJAMIN K. #6103
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	DENY	CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	15 day(s)	07/24/2014

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	07/10/2014	MODIFY

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	150824
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	02/07/2015	BOLLMAN, ROBERT G. #4208

Offense:	Class:	Enhancement:
DISOBEDIENCE TO ORDERS 2	CLASS B	NONE
Date/Time of Offense:	**Place of Offense:**	
02/07/2015 07:54	UNIT 9	

Description of Offense:

On 02/07/15 at 0754 I noticed Offender Edmo #94691, have his hair in a bun that was above ear line which violates policy 325.02.01.002. I had Edmo called out to the foyer so I could address the issue. I gave Edmo a direct order to stay within policy with his hair style. Edmo did fix the issue but became upset and stating that I was threatening him. After returning to the tier Edmo went back to his cell then came out to the A-tier dayroom with his hair back in a high pony tail above the ear line which still violates policy 325.02.01.002 and openly disobeyed the orders that I gave him less than 15 minutes prior.End of report.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	02/08/2015 06:00
Delivering Staff:	**Date/Time Delivered:**
BIGELOW, MICHAEL #1778	02/08/2015 08:38
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [ ]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
02/11/2015	02/11/2015	LEE, BENJAMIN K. #6103
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 2	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
DETENTION	5 day(s)	02/12/2015

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	02/12/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	02/14/2015	03/04/2015	AFFIRM

Offender Appeal Details:

Appeal processed on 2/19/15.

I am appealing this DOR's sanctions of five days, plus additional four days, total of 9 days of segregation for behaviors associated with my mental illness of gender dysphoria. I believe sanctions of segregation is quite

disproportionate for the offense of disobedience to orders of not having my hair below ear level.

Appellate Comments:

Staff gave you direction you refused to follow. Such open defiance of staff's orders are a serious infraction in our facility. You may challenge staff's orders but you don't have the option not to follow them because you don't agree with them. The sanctions remain.

Warden Yordy

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	156084
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	09/27/2015	ELLINGTON, DUSTIN #B190

Offense:	Class:	Enhancement:
POSSESSION OF UNAUTHORIZED PROPERTY	CLASS B	NONE
Date/Time of Offense:	**Place of Offense:**	
09/27/2015 11:00	UNIT 15	

Description of Offense:
On 09/27/2015 I, Officer Ellington, was conducting a random search of Offender Edmo's (#94691) Cell. On the sink I found an eye drop container with what appeared to be a skin-toned substance that looked like makeup. In a bundle of paperwork within his assigned locker I also found a container of black eyelash makeup with an eyelash applicator. Also within some paperwork was an inmate identification card belonging to Offender Shultz(#80687), a photo of another offender, and what appeared to be a hand-made arm band. I also located a Walkman with another Offenders name and number within Offender Edmos locker.

Description of Evidence:
Body of Report, attached photos

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	09/28/2015 06:00
Delivering Staff:	**Date/Time Delivered:**
BLAKE, CLINTON E. #7850	09/28/2015 07:42
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
10/05/2015	10/05/2015	RAMIREZ, SABINO J. #5917
Offense:	**Offender Plea:**	**Finding:**
POSSESSION OF UNAUTHORIZED PROPERTY	DENY	CONFIRM

Sanctions:	Amount:	End Date:
COMMISSARY RESTRICTION	20 day(s)	10/25/2015
RECREATION RESTRICTION	25 day(s)	10/30/2015

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
COBURN, GARRETT #0455	10/07/2015	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	10/09/2015	10/19/2015	AFFIRM

Offender Appeal Details:

The makeup applicator and container of what looked like makeup, plus the radio and ID do not pose a significant risk to the institution as described in policy. This should be modified down to a class C offense. A rehearing with an un-biased DHO.

Sgt. Ramirez and I have a damaged rapport because he does not approve of my lifestyle as a transgender woman. He is a biased disciplinary hearing officer and intentionally bends the policies and rules to use against me. The audio will reveal the attitude and demeanor he had with from the beginning of the hearing, which supports the bias.

Appellate Comments:

The offense code that staff chose to use was appropriate given you possessed multiple property items that were not authorized. I see no reason to reduce this down to a class C.

Warden Yordy

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	161943
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	03/28/2016	QUIROZ, RICARDO #A365
Offense:	**Class:**	**Enhancement:**
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
03/28/2016 20:55	UNIT 16	

Description of Offense:

On the date of 3-28-2016 at 2055 Inmate Edmo #94691 was warned by me about wearing makeup. Edmo was wearing some type of makeup that resembled eye liner. I warned Edmo that wearing makeup was not allowed and that the makeup needed to be removed. Edmo stated that the makeup will be removed and Edmo understood that makeup was not allowed. At 2055 Recall was announced and Edmo was returning from yard movement. At this time I checked Edmo's eyes again to make sure that the makeup was removed. The makeup was not removed and I again informed Edmo that the makeup needed to be removed and that Edmo refused a direct order. At this time Edmo stated, "Write me a DOR I don't care." Edmo refused my direct orders to remove the makeup.

Description of Evidence:

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	03/29/2016 06:00
Delivering Staff:	**Date/Time Delivered:**
REYNOLDS, TYLER #A132	03/29/2016 07:21
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
03/31/2016	03/31/2016	SEELY, COREY #9918
Offense:	**Offender Plea:**	**Finding:**
DISOBEDIENCE TO ORDERS 3	DENY	CONFIRM

Sanctions:	Amount:	End Date:
FORMAL WARNING/WRITTEN REPRIMAND		

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	04/01/2016	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	163026
Offense Facility:	Report Date:	Reporting Staff:
ISCI	05/12/2016	NICHOLAS, CHANCE USERNAMECHG #C077x
Offense:	Class:	Enhancement:
DISOBEDIENCE TO ORDERS 3	CLASS C	NONE
Date/Time of Offense:	Place of Offense:	
05/06/2016 17:27	PENDYNE	

Description of Offense:
On May 6th, 2016 at 1727 I caught Inmate Edmo with makeup on in Pendyne when he was on his way to throw his tray away. I asked if that was makeup on his face in which he admittedly said he had eyeliner on. I told him I don't want to see him with it on again and he replied "Ok, I won't do it again". I then looked up on his C-Notes in Unit 16 and realized that he was given a prior verbal warning and prior disciplinary sanctions for the same offense. Because he was given previous verbal warnings and disciplinary sanctions, I decided that disciplinary action would be ideal.

Description of Evidence:
Previous verbal warnings issued, C-Notes and disciplinary sanctions for the same offense.

Reviewing Supervisor:	Date/Time Reviewed:
BAIRD, NICHOLAS #8506	05/13/2016 14:37
Delivering Staff:	Date/Time Delivered:
SEEGER, BETHANY D #B383	05/13/2016 15:50
Staff Hearing Assistant:	Assistance: Requested:
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
05/16/2016	05/16/2016	HINES, BRYAN W #8862
Offense:	Offender Plea:	Finding:
DISOBEDIENCE TO ORDERS 3	DENY	CONFIRM

Sanctions:	Amount:	End Date:
COMMISSARY RESTRICTION	15 day(s)	05/31/2016

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	05/16/2016	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	05/16/2016	06/06/2016	AFFIRM

Offender Appeal Details:

DHO Hines wrongly confirmed this DOR I had not disobeyed C/O Nicholas direct order. I followed staff's direct order to fix / correct the issue, immediately, as told to do so. I have GID, a serious mental health condition; symptoms include a persistent belief and / or desire to be the opposite sex / gender, including physical appearance. It's not a choice but a mental health issue. I deal with on a daily basis. It's a work in progress. I feel this DOR should be dropped and purged from my offender file.

Appellate Comments:

Your condition does not allow you to wear makeup. Staff were within our policy to issue you a disciplinary infraction for violating this rule. The DOR is affirmed.

Warden Yordy

IDAHO DEPARTMENT OF CORRECTION

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	164886
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	07/26/2016	SHERFEY, TYLER #A848
Offense:	**Class:**	**Enhancement:**
DESTRUCTION OF PROPERTY UNDER $25	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
07/26/2016 06:34	LAUNDRY	

Description of Offense:

On 7/26/16 two bras and one pair of briefs came to laundry. All items had been altered by the cutting and removal of material and sewing to create patterns in the bra straps and to turn the briefs into thong underwear. The bra was tagged with Inmate Edmo's name and IDOC # and the sizes of all of the altered items matched clothing that Inmate Edmo was issued. It is apparent that these actions are deliberate because the cuts are clean as if a pair of scissors or another sharp instrument was used to cut the fabric. Also, the area and shape of the cuts are similar to a "V" neck and the back straps sewn together in a specific pattern. All of the items listed above are completely separate from the bra that was found on 7/14/16 also altered and tagged with Edmo's name and IDOC #. Because of the alteration of these items they are no longer suitable for use and will be discarded. The cost of two new bras is $7.14 and the cost of a pair of briefs is $1.02, therefore, $8.16 is being requested as restitution.

Description of Evidence:

Picture of damaged bras and briefs attached.

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	07/27/2016 06:00
Delivering Staff:	**Date/Time Delivered:**
ROMAN, RODOLFO NMI #1736	07/27/2016 07:32
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
08/02/2016	08/02/2016	CHRISTON, BICK A #1379
Offense:	**Offender Plea:**	**Finding:**
DESTRUCTION OF PROPERTY UNDER $25	DENY	CONFIRM

Sanctions:	Amount:	End Date:
RESTITUTION	$8.16	

Interventions:	End/Due Date:
NO RECORDS FOUND	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	08/04/2016	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	08/09/2016	08/22/2016	AFFIRM

Offender Appeal Details:

This DOR should be dismissed and purged from my record because IDOC / Warden Yordy is deliberately indifferent to my serious medical condition of gender dysphoria by denying me female panties which are necessary and appropriate for my gender dysphoria symptoms. I would not have to modify my undergarments for additional support for tucking my testicles. I don't believe I should not have to pay the restitution of $8.16 without verifying that amount to receipts IDOC pays for such items. The receipt for such items was not in the DOR, therefore the restitution should be dismissed because no physical documentation was submitted.

Appellate Comments:

You clearly destroyed undergarments that had to be replaced. The cost of the items are what we pay for them and is reasonable restitution.

Warden Yordy

IDAHO DEPARTMENT OF CORRECTION
Offender Disciplinary Restitution Order

Offender Name: Edmo, Mason Offender #: 94691

Facility: ISCI Date of Offense: 7/26/16 DOR Number: 164886

It is hereby requested that the Idaho Department of Correction's Fiscal Unit garnish the offender's account until the restitution is paid in full. If the account balance does not cover full restitution, the remainder owed will be garnished at 50% of each deposit until the total cost of restitution is paid in full.

Type of Loss:

- ☒ Property Damage (IDOC or IDOC contract)
- ☐ Property Damage (other offender)
- ☐ Property Damage (private property)
- ☐ Property Damage (other government agency)
- ☐ Labor Cost (*non-IDOC agency)
- ☐ Theft (IDOC or IDOC contract)
- ☐ Theft (other offender)
- ☐ Theft (private party)
- ☐ Theft (other government agency)

Note: Restitution cannot be ordered for IDOC wages or overtime.
Restitution Amount: $8.16
Note: If the restitution is more than $250.00, it must be approved by the applicable division chief (or designee).

Description of damage or loss (type in cell below):
altered underwear

Method for determining restitution amount (type in cell below):
laundry clothing contract

Type of supporting documentation (type in cell below):
DOR

Party to be reimbursed if not IDOC or IDOC contract facility (type in cell below):

Note: Documentation must be attached to restitution order.

DHO: Sgt. B. Christon Associate Number: 1379 Date: 8/4/16

Email completed form to the department disciplinary coordinator (or designee).

Division Chief (or Designee's) Review

- ☐ Approved
- ☐ Denied
- ☐ Modified to _____

_____ _____
Division Chief (or Designee's) Signature Date

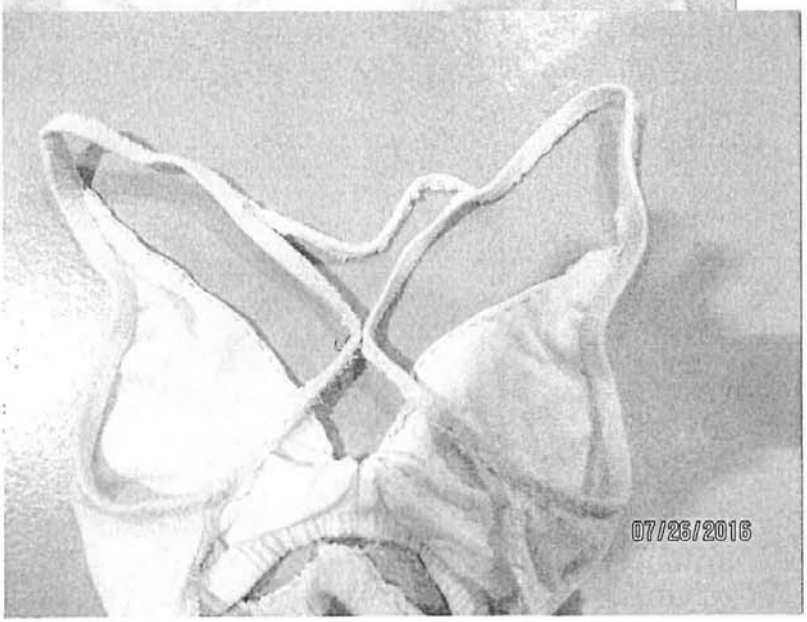
Note: After request is approved, denied, or modified, print; sign; convert to PDF, and return PDF via email to DHO. Mail original to records clerk at the offender's current facility to be attached to the *DOR* in the offender's central file.

Appendix H
318.02.01.001
(Appendix last updated 9/18/12)

IDAHO DEPARTMENT OF CORRECTION
Disciplinary Offense Report

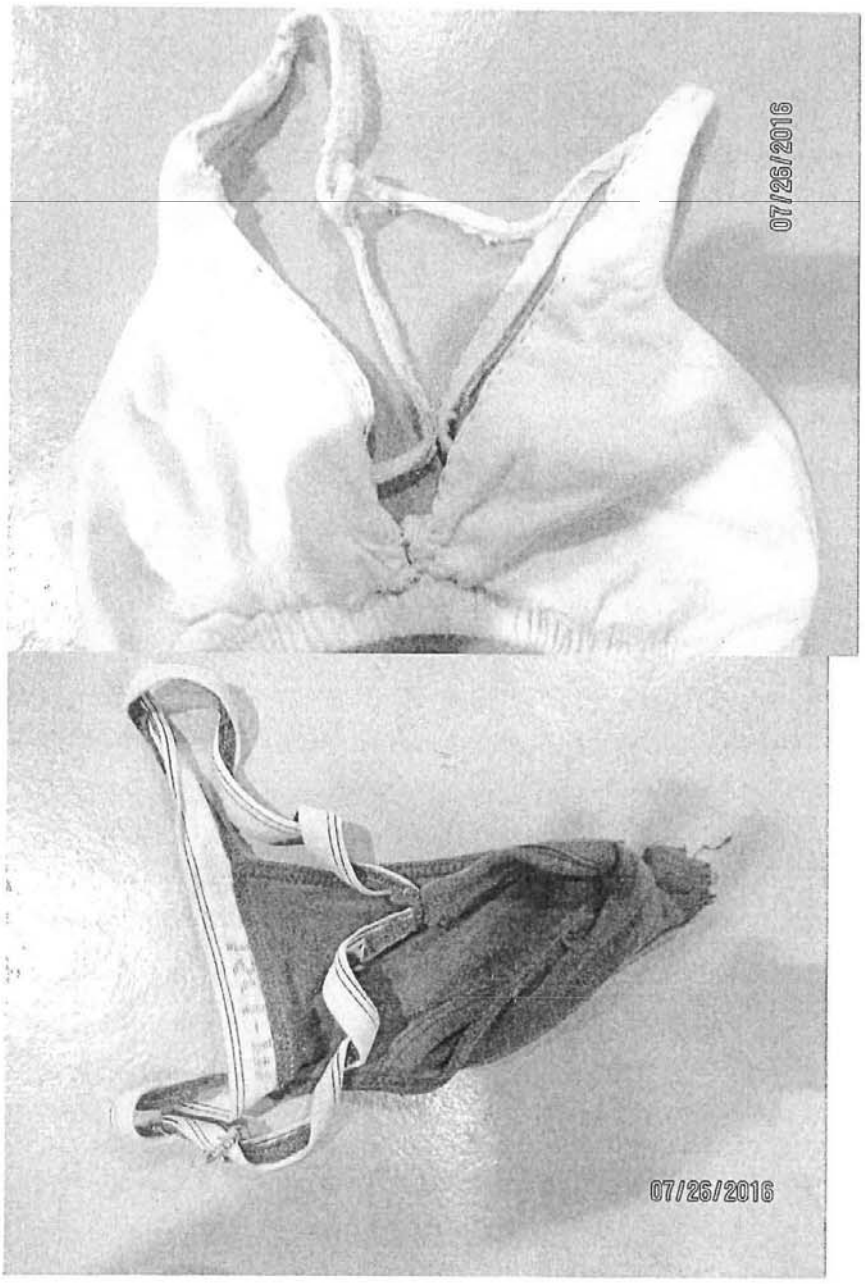
Additional Staff Comments:

Based on the fact the items arrived together in laundry. The fact the bra had yours name, and the sizes were all the same.



Appendix C
318.02.01.001
(Appendix last updated 9/18/12)

IDAHO DEPARTMENT OF CORRECTION
Disciplinary Offense Report



Appendix C
318.02.01.001
(Appendix last updated 9/18/12)

9A-54

IDAHO DEPARTMENT OF CORRECTION
Disciplinary Offense Report

Name: Edmo Offender #: 94691 DOR # 164886

Offense Facility	Report Date	Reporting Staff
ISCI	7/26/16	SHERFEY #A848

Date & Time of offense	
7/26/16	0634

Offense	Place of Offense
Destruction of Property Under $25 C	ISCI LAUNDRY

Description of Offense (type in cell below):

On 7/26/16 two bras and one pair of briefs came to laundry. All items had been altered by the cutting and removal of material and sewing to create patterns in the bra straps and to turn the briefs into thong underwear. The bra was tagged with Inmate Edmo's name and IDOC # and the sizes of all of the altered items matched clothing that Inmate Edmo was issued. It is apparent that these actions are deliberate because the cuts are clean as if a pair of scissors or another sharp instrument was used to cut the fabric. Also, the area and shape of the cuts are similar to a "V" neck and the back straps sewn together in a specific pattern. All of the items listed above are completely separate from the bra that was found on 7/14/16 also altered and tagged with Edmo's name and IDOC #. Because of the alteration of these items they are no longer suitable for use and will be discarded. The cost of two new bras is $7.14 and the cost of a pair of briefs is $1.02, therefore, $8.16 is being requested as restitution.

Description of Evidence (type in cell below): Deny

Picture of damaged bras and briefs attached.

S Hoon #2003 — 7/27/16 — 0600
Reviewing Supervisor and Associate # (signature) — Date & Time Reviewed

Deliver Staff Steps. Ask the offender:

Do you want to request a staff hearing assistant?

Requested: Yes: ☐ No: ☑ Form Provided: Yes: ☐ No: ☐

Do you need witness statement forms? (Limit of 4 statements forms.)

Requested: Yes: ☐ No: ☑ Form(s) Provided: Yes: ☐ No: ☐ Number #: ☐

I hereby acknowledge receiving a copy of this DOR:

Edmo — 94691 — 7/27/16
Offender's signature — IDOC # & Date

L Earle 5474 — 27Jul2016 — 0732
Delivery Staff and Associate # (signature) — Date & Time Reviewed

Appendix C
318.02.01.001
(Appendix last updated 9/18/12)

Confirm $8.16 restitution.

IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

RECEIVED BY
DEC 0 5 2016
ISCI RECORDS

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	167597
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	11/29/2016	DAVIS, KELSEY #B269
Offense:	**Class:**	**Enhancement:**
DESTRUCTION OF PROPERTY UNDER $25	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
11/28/2016 13:40	UNIT 15	

Description of Offense:
On November 28, 2016 at approximately 1340 while conducting a cell search in cell 58, I found three green state underwear briefs that were altered into thongs. They were found in a grey storage bin that is given to the inmates to borrow from Unit 15 while in the Unit; which had Edmo's property in it.

Description of Evidence:
Pictures of destroyed, altered underwear.

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	11/29/2016 06:00
Delivering Staff:	**Date/Time Delivered:**
LARIOS, MICHAELA #1405	11/29/2016 12:30
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

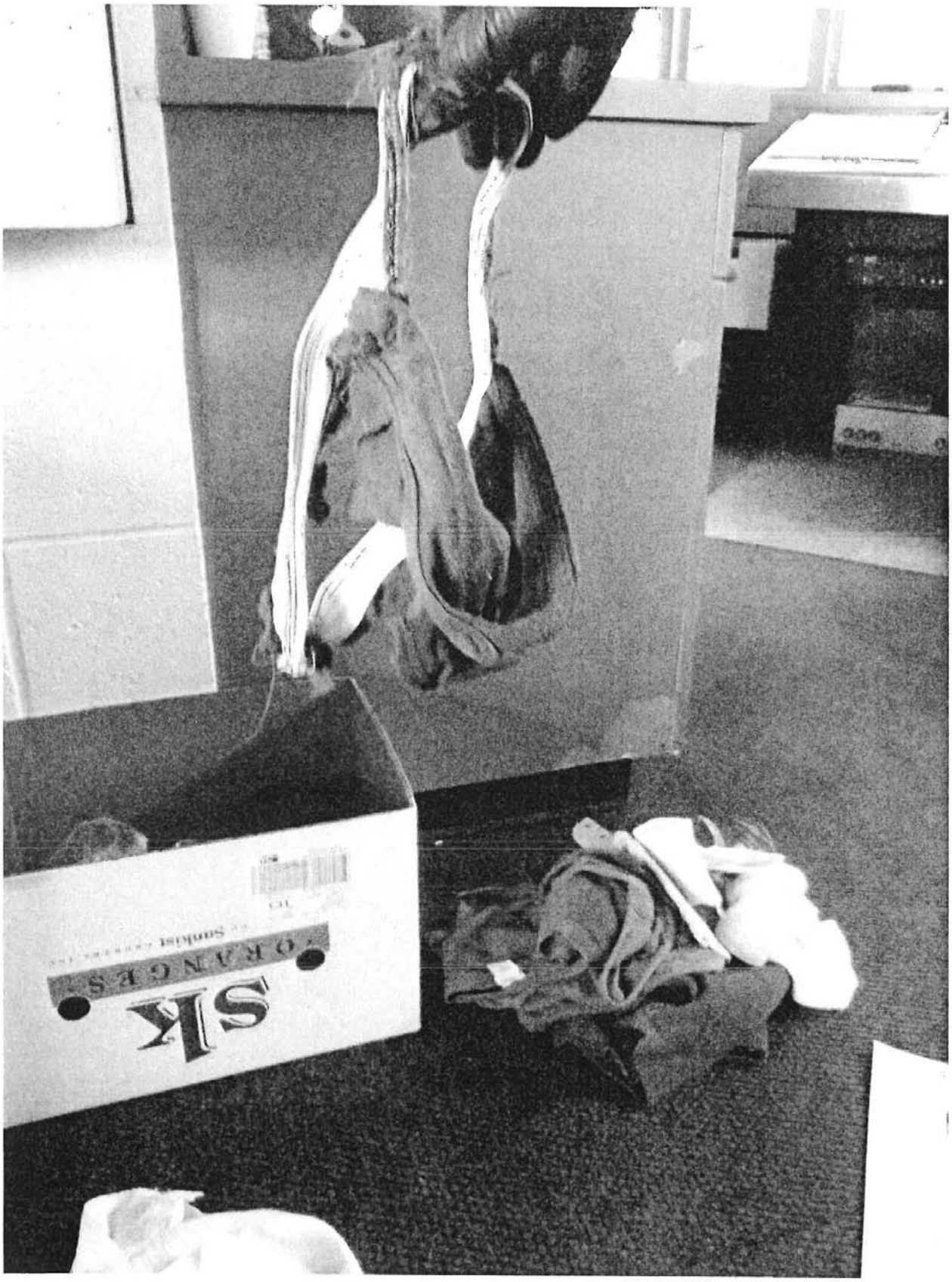
Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
11/30/2016	11/30/2016	SEELY, COREY #9918
Offense:	**Offender Plea:**	**Finding:**
DESTRUCTION OF PROPERTY UNDER $25	ADMIT	CONFIRM

Sanctions:	Amount:	End Date:
NO RECORDS FOUND		

Interventions:	End/Due Date:
DOR HEARING ITSELF	

Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	12/01/2016	AFFIRM

Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
NO RECORDS FOUND			



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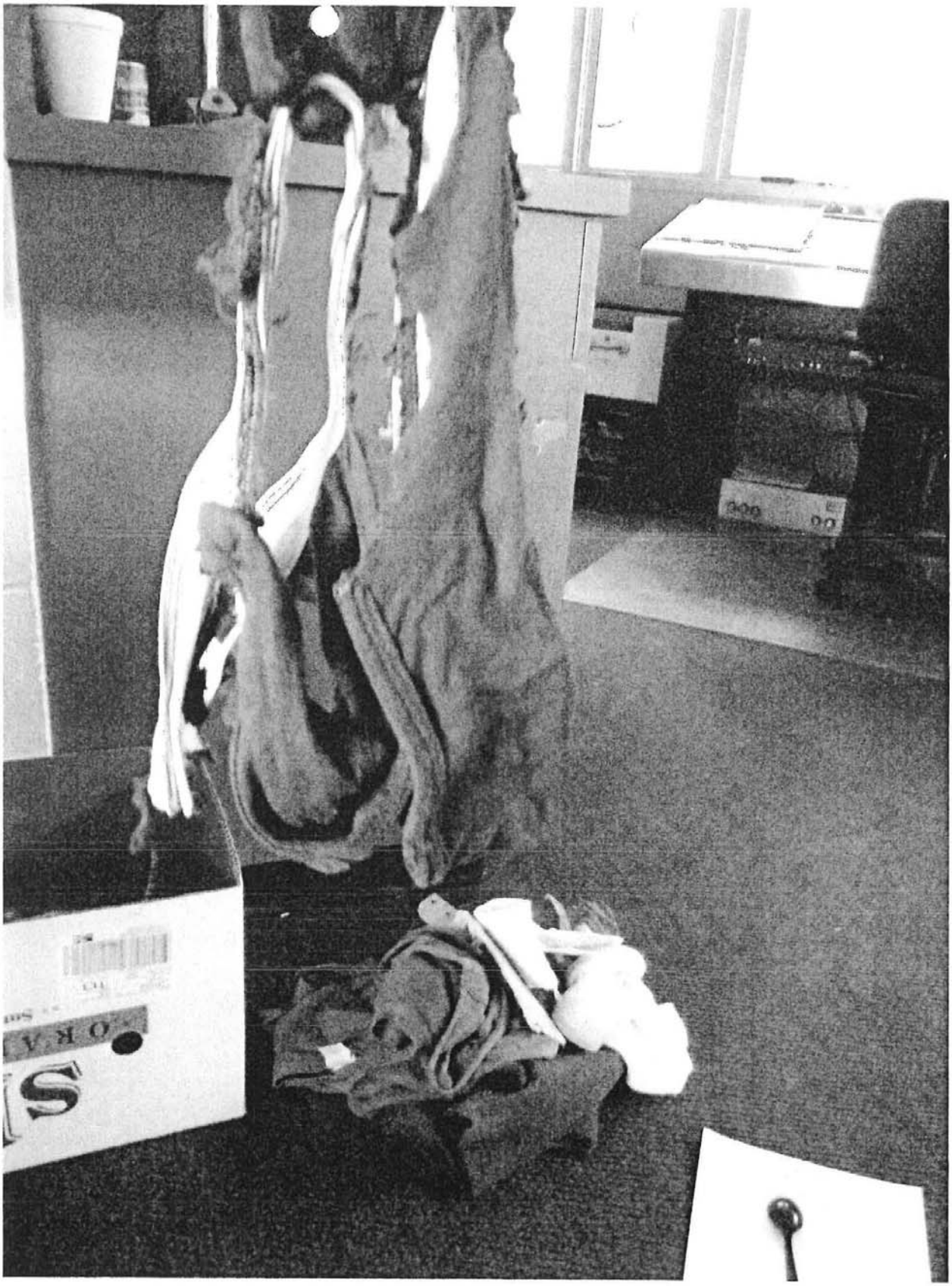

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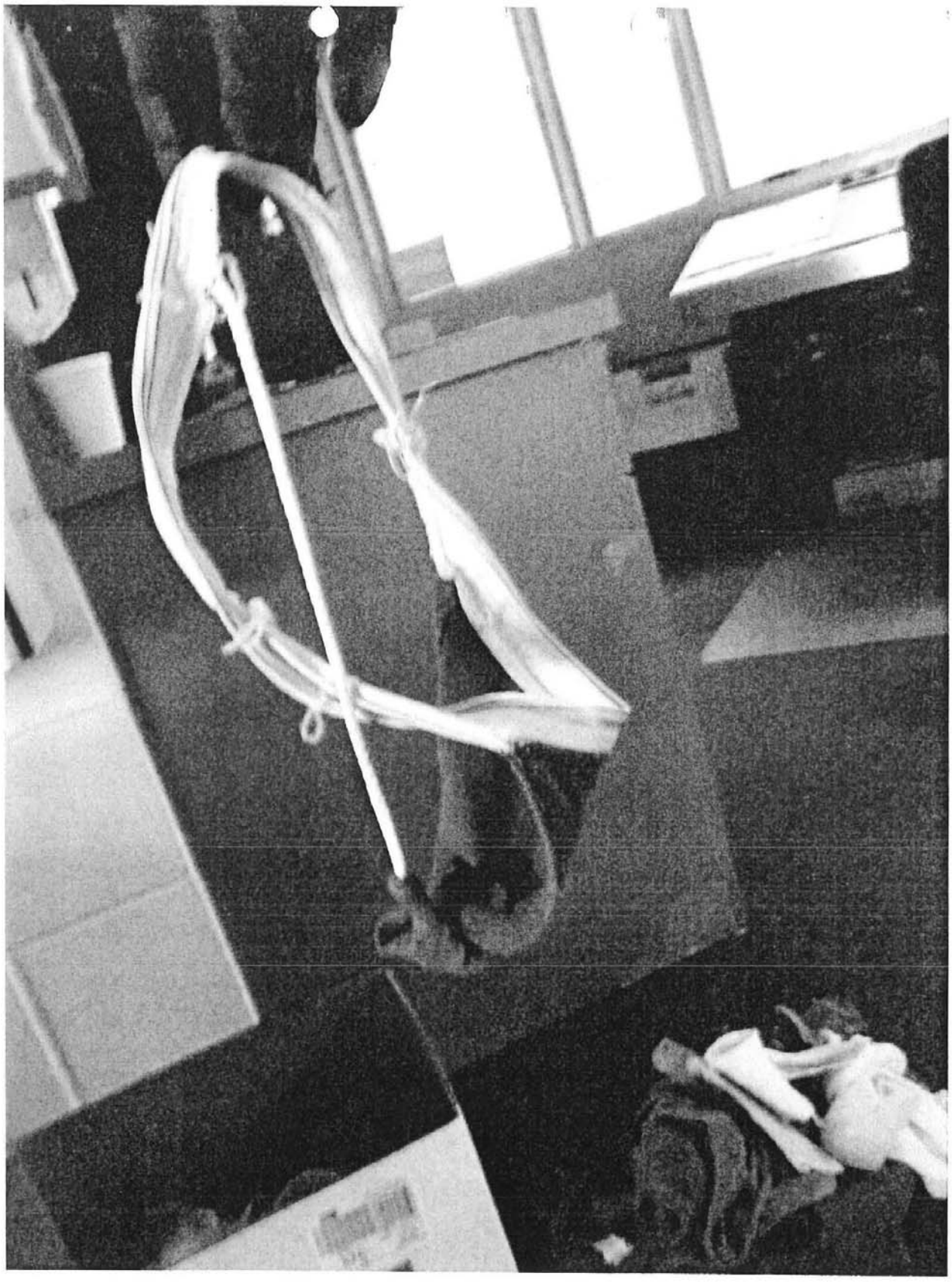


IDAHO DEPARTMENT OF CORRECTION

Disciplinary Offense Report

Offender Name:	Offender Number:	DOR #:
EDMO, MASON DEAN	94691	177663
Offense Facility:	**Report Date:**	**Reporting Staff:**
ISCI	12/03/2017	LOVELACE, BRIAN #C468
Offense:	**Class:**	**Enhancement:**
DESTRUCTION OF PROPERTY UNDER $25	CLASS C	NONE
Date/Time of Offense:	**Place of Offense:**	
12/03/2017 20:15	UNIT 15	

Description of Offense:
On December 3, 2017 at 2015 while conducting a cell search in cell 31 on Alpha Tier, I found three green state underwear briefs that were altered into thongs, three orange cloth thongs made from some unknown cloth. They were found in a hobby craft box under the bunk with Edmo's name on it.

Description of Evidence:
Photo's attached.

Reviewing Supervisor:	Date/Time Reviewed:
HOUSE, STAN #2003	12/04/2017 06:00
Delivering Staff:	**Date/Time Delivered:**
THOMPSON, RYAN #5420	12/04/2017 06:43
Staff Hearing Assistant:	**Assistance:**
Witness statements were received for this hearing:	Yes [ ] No [X]

Scheduled Hearing Date:	Final Hearing Date:	Disciplinary Hearing Officer:
12/05/2017	12/05/2017	SEELY, COREY #9918
Offense:	**Offender Plea:**	**Finding:**
DESTRUCTION OF PROPERTY UNDER $25	DENY	CONFIRM

Sanctions:	Amount:	End Date:
RECREATION RESTRICTION	7 day(s)	12/12/2017

Interventions:	End/Due Date:
NO RECORDS FOUND	

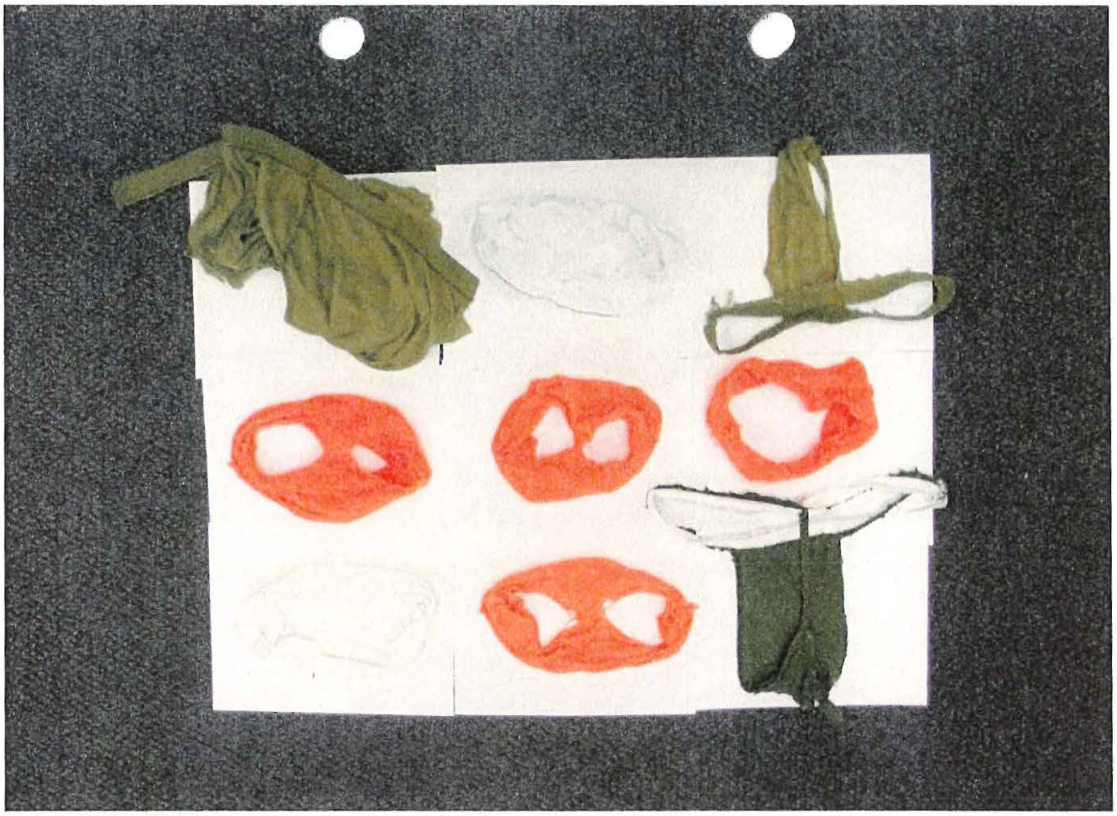
Administrative Review Authority:	Review Date:	Review Finding:
ROSENTHAL, TERRIE #3931	12/08/2017	AFFIRM

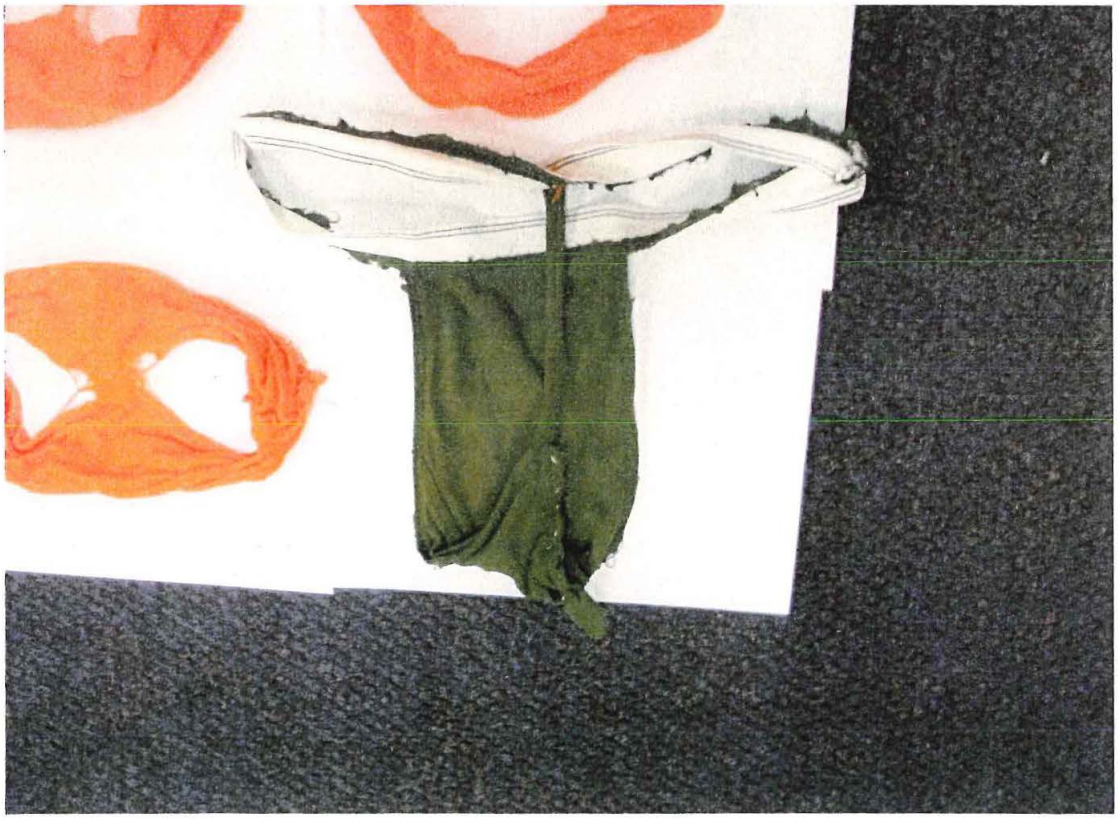
Appellate Authority:	Appeal Date:	Finding Date:	Appellate Finding:
YORDY, HOWARD KEITH #3879	12/11/2017	12/29/2017	AFFIRM

Offender Appeal Details:

I appeal this DOR and request it removed from my file based on the fact that C/O Lovelace knew and knows I am a inmate suffering from gender dysphoria. This DOR should be removed/appealed because IDOC knows and has known that I've requested to have women's panties that provide the support of my damaged testicles and a more snug fit also while providing support to my mental health of giving me a better ego syntonic state of mind of becoming female/ These exact type of DOR's as this one are examples of sex discrimination prohibited by the 14th amendment, also it is unlawful to discriminate against people like me

who have gender dysphoria pursuant to American w? Disabilities Act, and section 504 ıe Rehab Act.
Appellate Comments: The DOR is affirmed because you know you're not authorized to alter property regardless of the reasons. If there is a medical need for such underwear, it will be provided. You will never be allowed to undertake that on your own. Staff should and will continue to hold you accountable. Warden Yordy





MENTAL HEALTH DOR RECOMMENDATION

IDOC NUMBER	OFFENDER NAME	OFFENSE FACILITY
94691	EDMO, MASON	ISCI

OFFENSE DATE	OFFENSE DESCRIPTION	CLINICIAN
07/26/2016	Destruction of Property Under $25	Meyer

Documented history of significant mental illness that would/could impair decision making and/or reality testing.	Yes ☒	No ☐
Presently prescribed medication for mental health issues.	Yes ☒	No ☐
**If yes, is offender compliant?	Yes ☒	No ☐
Experienced significant increase in stressors prior to incident?	Yes ☐	No ☒
Documented increase in mental health symptoms prior to incident?	Yes ☐	No ☒
Mental Illness contributing factor in incident?	Yes ☐	No ☒

Recommendations:

Mental Illness a mitigating factor? Yes ☐ No ☒

Recommendations:

Assignment of staff assistant recommended?	Yes ☐	No ☒
Mental illness not a factor in incident - no restrictions on proceedings are recommended.	Yes ☒	No ☐

Additional Recommendations:

Inmate Edmo has a documented history of MH concerns. Medical staff reported that Edmo is prescribed MH medications and is currently medication compliant. There is no documentation within the past three months indicating a significant increase in MH symptoms that would pertain to this DOR. Therefore, Inmate Edmo's MH status is not a contributing or mitigating factor in this incident. Inmate Edmo has been housed in Unit 8 in the past and appears capable of completing any additional time in Unit 8, as determined necessary by the result of this DOR.

CLINICIAN SIGNATURE	DATE OF REPORT
R. Meyer, LCPC 2440	07/27/2016

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

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

RULE 30(B)(6) DEPOSITION OF IDAHO DEPARTMENT OF CORRECTIONS, TESTIMONY OF ASHLEY DOWELL

AUGUST 31, 2018

REPORTED BY:

JEFF LaMAR, C.S.R. No. 640

Notary Public

Q. And are you prepared to testify today topics 1 through 8 and then 11?

A. Yes.

MR. HALL: And, Counsel, for the record, those are the topics, 1 through 8 and 11, that IDOC has designated Ms. Dowell to testify on.

MR. DURHAM: Thank you, Counsel.

MR. HALL: We have another witness, Laura Watson, who will be testifying -- or made available to testify later on topics 9 and 10.

MR. DURHAM: Thank you.

Q. So let's just dive right in. Ms. Dowell, does the IDOC currently have a written standard operating procedure that governs health care for inmates with gender identity disorder?

A. Yes, there's an SOP that is specific to gender identity disorder. Those folks with gender disorder -- gender identity disorder or gender dysphoria would also be -- their health care would also fall under multiple other policies as well.

(Exhibit 11 marked.)

Q. (BY MR. DURHAM): Okay. I'm handing you -- we're going back a number. That's been marked as Plaintiff's Exhibit 11. And I'll ask you to take a look at that, if you could.

MR. HALL: Is there nine pages on that?
THE WITNESS: Yes.
Q. (BY MR. DURHAM): You have nine pages?
A. I do.
Q. And Bates number, it looks like at the bottom, IDOC underscore V underscore and then the page numbers?
A. Yes.
Q. Okay. Does that appear to you to be the current written policy about which you just testified?
A. This is the current policy that's in place, yes.
Q. When was that adopted?
A. The note on the SOP indicates that it was adopted 10/31 of 2002.
Q. And do you know why it was adopted?
A. My understanding is that it was adopted after a lawsuit that was filed against the IDOC.
Q. Thank you.
And since you gave us the dates of your employment, I assume you weren't involved in the drafting of that document; is that correct?
A. I was not.
Q. Do you know who was?
A. I don't know.

He was new in his role at that time, and this is a policy that would fall directly within his area of responsibility. So there was no specific event that triggered that, but it was discussed as part of his role and oversight.

Q. When did Dr. Campbell come on board?

A. In the fall of 2016.

Q. And you said he's the chief psychologist?

A. He is.

Q. Who was the chief psychologist before him?

A. Dr. Richard Craig.

Q. And if you know, how long had he been the chief psychologist?

A. Prior to Dr. Campbell?

Q. Correct.

A. I don't know offhand.

Q. Okay. Was it more than five years?

A. I'm not sure.

Q. Okay. So you testified that the SOP is in the process of being updated; is that correct?

A. Correct.

Q. When is that scheduled to be completed?

A. That SOP is in a finalized draft form. We need to work out a training plan prior to approving and releasing it.

what you were testifying to previously?

MR. HALL: Object to form.

THE WITNESS: Specifically what that I testified to previously?

Q. (BY MR. DURHAM): I'm sorry. Strike that.

Okay. In the third bullet point there, "If there is an emergency for sexual reassignment surgery, call Dr. Eliason," I think it is pronounced.

Do you see that?

A. I do.

Q. And who is Dr. Eliason?

A. Eliason. Dr. Eliason is a Corizon psychiatrist.

MR. EATON: Eliason.

THE WITNESS: Eliason. Did I just say Eliason?

MR. DURHAM: I had it right, didn't I?

MR. HALL: Say it say it again.

MR. EATON: Eliason.

MR. HALL: Eliason.

Q. (BY MR. DURHAM): Has any inmate in IDOC custody received a recommendation from a provider that gender confirming surgery was medically necessary?

MR. HALL: Object to form. Vague.

MR. EATON: Join.

MR. HALL: Foundation.

THE WITNESS: So to -- let me clarify. Am I aware of any inmate within IDOC's custody who has been referred for gender -- I'm sorry, sexual reassignment surgery while in our custody? in the community? prior to coming to us?

Q. (BY MR. DURHAM): Yes, in your custody. Has any inmate, while in your custody, been referred for sexual reassignment surgery?

A. Not to my knowledge.

Q. Is the current practice within IDOC to prohibit gender confirming surgery for all inmates?

MR. HALL: Object to form. Vague.

THE WITNESS: No. The policy states to sexual reassignment surgery being medically necessary as determined by a GID evaluator.

(Exhibit 15 marked.)

Q. (BY MR. DURHAM): I've handed you what what's been marked as Plaintiff's Deposition Exhibit 15. It's kind of a lengthy document. I'll give you some time to review that.

MR. HALL: I don't think --

MR. EATON: Do you want her to review the whole thing?

MR. HALL: Craig, you don't want her to review the whole thing; right?

Q. (BY MR. DURHAM): Yeah, I can draw your attention to specific parts.

I guess I'll ask you, do you recognize this document?

A. I reviewed this document in my preparation for the deposition today.

Q. There appear to be three parts to this. The first part would be Bates No. IDOC underscore EE underscore looks like page 1 to about page 17.

Do you see that?

A. I do.

Q. Okay. Do you know who authored that document?

A. In --

MR. HALL: And just for clarification, only the first 17 pages of Exhibit 15; correct?

MR. DURHAM: Of Exhibit 15, right. Right now that's all I'm asking is the first 17 pages.

MR. HALL: Thank you.

THE WITNESS: I'm sorry. Can you repeat your question?

Q. (BY MR. DURHAM): Do you know who authored this?

A. Yes. In my preparation for the deposition today, in reviewing this document, I had some

discussion with Dr. Wally Campbell, and he's the author of this document.

Q. I guess I'll just go through the other parts.

So page 18 to 22, did Dr. Campbell also author that section, if you know?

A. I don't know. I don't know offhand. This is the -- is this a document that Wally provided to you, all of it?

MR. HALL: These were documents that were produced in discovery provided by IDOC. I can't answer any further than that.

THE WITNESS: Okay. I don't know.

Q. (BY MR. DURHAM): Okay. Okay. I'd like to draw your attention to page 19 of this document, about middle of the way down where it says "Individualized Treatment decision and range of options."

Could you read that.

A. So on page 19 you want me to read the first paragraph under --

Q. Yeah, just the first paragraph.

A. So the first paragraph under "Individualized Treatment decision and range of options" says, "In regards to medical interventions, IDOC's current policy only addresses Hormone

MR. DURHAM: Do you have a copy of what's been marked as Exhibit 20?

MR. HALL: I know we brought four copies. Did you get one, Craig?

MR. DURHAM: I think we had him mark it.

THE WITNESS: Here's 20.

Q. (BY MR. DURHAM): Okay. Great. I think we're wrapping up, so...

A. Okay.

Q. Do you have Exhibit 20 in front of you?

A. I do.

Q. And what is this document?

A. This is a draft of some revisions to a policy with a control number that begins with 401.

Q. Okay. And which policy is it a draft or a revision to?

A. The -- this is a revision to the policy that is marked as Exhibit 11 that originally was titled "Gender Identity Disorder: Health Care for Offenders with."

Q. Does it still have that title, that same title, or does it have a different title?

A. It has a different title.

Q. Has IDOC consulted with any third-party standards or policies in formulating this draft?

REPORTER'S CERTIFICATE

I, JEFF LaMAR, CSR No. 640, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me.

That the testimony and all objections made were recorded stenographically by me and transcribed by me or under my direction.

That the foregoing is a true and correct record of all testimony given, to the best of my ability.

I further certify that I am not a relative or employee of any attorney or party, nor am I financially interested in the action.

IN WITNESS WHEREOF, I set my hand and seal this 6th day of September, 2018.

JEFF LaMAR, CSR NO. 640
Notary Public
Post Office Box 2636
Boise, Idaho 83701-2636

My commission expires December 30, 2023

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

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

VIDEOTAPED DEPOSITION OF ADREE EDMO

August 24, 2018

Kuna, Idaho

Reported by: Abigail L. Manzano, RPR, CSR, SRL #1069

Q. (BY MR. HALL) Well, did it help in any way with your GD?

MS. RIFKIN: Objection. Overbroad.

THE WITNESS: With the GD, as in gender dysphoria?

Q. (BY MR. HALL) Correct.

A. It gave me insight to gender dysphoria. I couldn't say it ultimately helped me. It gave me a lot more information about gender dysphoria.

Q. Gave you a lot of education about gender dysphoria?

A. At times, yes.

Q. Did it provide you with information that helped you understand why you were feeling that way about your gender dysphoria?

MS. RIFKIN: Objection. Vague.

THE WITNESS: To what I remember, I don't think it gave me a clear definition of why I was feeling the way I did.

Q. (BY MR. HALL) Did you like going to gender dysphoria group?

A. Yes, I did.

Q. Are you currently going to gender dysphoria group?

A. Yes, I am.

Q. How often does the GD group, the gender dysphoria group, meet?

A. Currently, it meets for two hours every Wednesday.

Q. And have you been going every Wednesday since January 1 of this year?

A. No, because clinicians change, and the group times change.

Q. Have you gone to -- well, let me -- let me strike that.

Are there days where, in this year, that you've decided not to go to the gender dysphoria group?

MS. RIFKIN: Objection. Vague.

THE WITNESS: Yes, there has been times. I --

Q. (BY MR. HALL) What were the reasons for not going?

A. I had a job at the Idaho Correctional Industries and my time conflicted with my job.

Q. Who's the current counselor of the gender dysphoria group?

A. I believe it's Clinician Craft.

Q. How many attend the gender dysphoria group?

REPORTER'S CERTIFICATE

STATE OF IDAHO)
) ss.
COUNTY OF ADA)

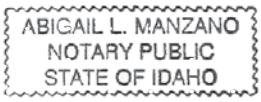
I, ABIGAIL L. MANZANO, Certified Shorthand Reporter, Registered Professional Reporter, and Notary Public in and for the State of Idaho, do hereby certify:

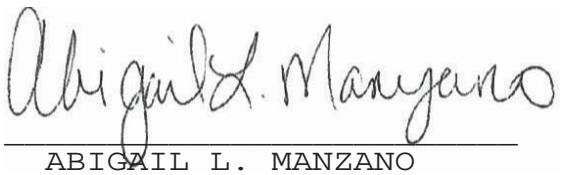
That prior to being examined, the witness named in the foregoing deposition was by me duly sworn to testify to the truth, the whole truth and nothing but the truth;

That said deposition was taken down by me in shorthand at the time and place therein named and thereafter reduced to typewriting under my direction, and that the foregoing transcript contains a full, true and verbatim record of said deposition.

I further certify that I have no interest in the event of the action.

WITNESS my hand and seal this 10th day of September, 2018.





ABIGAIL L. MANZANO
CSR, RPR, and Notary
Public in and for the
State of Idaho.

My Commission Expires: 4-13-21

CERTIFIED COPY

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO (a/k/a MASON EDMO),
Plaintiff,
vs.
IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15;
Defendants.

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

DEPOSITION OF SCOTT ELIASON, M.D.

AUGUST 14,, 2018

JEFF LaMAR, C.S.R. No. 640, Notary Public
441575

Q. Can you define that term for me.

A. Gender dysphoria describes the pain or distress that someone suffers when they're expressed or desire to express gender doesn't match their assigned gender at birth or their biologic gender at birth.

Q. And gender dysphoria was previously called another name; correct? Can you talk about that as well.

A. I think you're referring to gender identity disorder.

Q. Yes.

A. Yes. Did you want me to --

Q. Is there any difference between gender identity disorder and gender dysphoria?

MR. EATON: Object to form.

Go ahead.

THE WITNESS: Yes, there is. Gender identity disorder was thought of to be more like a mental illness. And currently we're trying to get away from pathologizing the transgender experience. And so gender dysphoria is not really thought to be a mental disorder, but more of a symptom expression that needs support and help.

Q. (BY MS. SHANBHAG): And what type of training have you received on gender dysphoria or

gender identity disorder?

A. So I've read several articles and textbooks. I've been in numerous trainings at conferences. And I did my forensic fellowship at the University of California San Francisco and there received some training. And then also I attended a training that I helped organize by Dr. Steven Levine a few years ago here to help train all the Idaho Department of Corrections and Corizon staff who were thought to be needing that training. And then I presented myself several trainings at national conferences on gender dysphoria.

Q. How many trainings have you attended regarding gender dysphoria?

A. I'd estimate six or seven.

Q. And do you recall when these trainings were?

A. I don't recall.

Q. Do you recall when the most recent training was?

A. Well, I know that Dr. Steven Levine came in the summer of 2016. And I presented a training within the last year at a national conference.

Q. Are you familiar with the World Professional Association for Transgender Health

I don't know would precisely gets credit for the order. For example, I'd be a part of the treatment committee who decided somebody was in need of hormonal treatment and recommend that they be seen by a medical provider. But I didn't actually order the hormones. The medical provider would order the hormones, so...

Q. Are there other types of treatments that you have participated in making a decision to order for a patient with gender dysphoria, outside of the hormone treatment?

A. Yes, recommended that people get put into education and supportive counseling, and undergarments.

Q. Have you ever been part of a treatment team that determined that reassignment surgery was necessary for a patient with gender dysphoria or gender identity disorder?

A. No, I haven't.

Q. Have you ever determined that sex reassignment surgery was not medically necessary for a patient with gender dysphoria or gender identity disorder?

A. Yes.

Q. Do you know about how many patients you reached that determination for?

A. I would approximate three. But at the same

A. I don't recall which concerns I had specifically. But if I were to just read this note, I was probably concerned because I had a patient who was expressing a lot of dysphoria and attempts to self-castrate, so because of that I felt like it had risen to another level. And I needed to make sure that I was doing the right thing.

Q. And in your assessment you determined that sex reassignment surgery was not necessary; correct?

A. Yes, that's correct.

Q. And what was that assessment based upon?

A. It was based upon a combination of things. My -- all the trainings that I've done, the patient's report, staff observations, consulting with these other doctors. And that's what it was based off.

Q. Earlier you mentioned a list of things that were important factors to consider when evaluating whether sex reassignment surgery is necessary, which includes the patient's current functioning.

Did you assess that here for Ms. Edmo?

A. I don't recall.

Q. Do you recall if you assessed the level of Ms. Edmo's dysphoria?

A. Well, I do comment on it in the note. I don't recall personally. But in my note there are

A. Yes.

Q. And you state, "I have also personally observed the inmate in these settings and did not observe significant dysphoria."

What did that mean?

A. That meant that I had observed Ms. Edmo outside of the clinic appointment settings. So walking on the breezeway to the cafeteria, sitting in the dayroom, sitting in the foyer, sitting in the classroom, and hadn't observed anything that overtly looked like dysphoria in those settings.

Q. And prior to this visit you had not met with Ms. Edmo for approximately three months; correct?

A. I don't recall, but according to these chart notes, that's what it looks like.

Q. And what would be an example of significant dysphoria, in your opinion?

A. You know, dysphoria can present itself in a variety of ways. It could look like crying. It could look like a very flat affect where you're just not very gregarious. And it would kind of depend on the person too. Someone who's very extroverted who appears not to be extroverted anymore can be another sign of dysphoria.

Q. And in concluding that Ms. Edmo did not

meet the criteria for sexual reassignment surgery, did you rely on any of her criminal history records? Is that something you would have?

A. No.

MR. EATON: Object to form.

THE WITNESS: No.

Q. (BY MS. SHANBHAG): Did you use or rely upon any of her DORs?

A. I guess I don't -- I'm not quite sure what you mean if I used any of her DORs. But I think her DORs are a human behavior and the consequences to a human behavior. And I use human behavior of my patients in my assessments.

And so I guess back to the criminal record, I may not have taken her charge and put it down, you know, as a reason for or against SRS, but it's definitely something that's part of Ms. Edmo and something that makes up her entirety.

Q. I guess my question is, did you look at her criminal history? Did you go through those documents? Did you go through the DOR records and evaluate her request for sexual reassignment surgery?

A. No.

MR HALL: Object to form. Vague and compound.

MR. EATON: Join.

assessment.

A. I don't recall.

Q. Do you --

A. It was an observation I made.

Q. Do you recall if this was the first time that you saw her wearing makeup?

A. I don't recall.

Q. In your assessment you mention three specific situations that could meet medical necessity for sex reassignment surgery: The first is "Congenital malformations or ambiguous genitalia." The second is "Severe and devastating dysphoria that is primarily due to genitals." And the third is "Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage."

Do you know where you got these criteria from?

A. You know, I don't remember. I don't know where I got these criteria from, but I wouldn't think of these either as an exhaustive list. But they were situations, examples I was given to the fact that, you know, this patient could meet medical necessity, and these are some examples of reasons.

Q. What are some examples of the other situations that could rise to the level of medical

necessity?

MR. EATON: Object to form.

MR HALL: Join.

THE WITNESS: I don't -- I can't give you an answer to all the reasons, because it could be an infinite amount of reasons. You know, it would just have to be necessary.

Q. (BY MS. SHANBHAG): The second scenario that you list is "Severe and devastating dysphoria that is primarily due to genitals"; correct?

A. Yes.

Q. Could attempted self-castration reflect severe and devastating dysphoria?

MR. EATON: Object to form.

THE WITNESS: It could.

Q. (BY MS. SHANBHAG): And what, in your experience, does rise to the level of severe and devastating dysphoria?

A. Dysphoria that's very bad and persistent. I mean I could find a dictionary and read what severe and devastating dysphoria mean, but bad feelings, really bad feelings.

Q. Do you have any examples of situations that you would consider to rise to the level of severe and devastating dysphoria?

A. I can't think off the top of my head. You know, I haven't experienced that, and so I'm not sure.

Q. And what was your treatment plan for Ms. Edmo based upon this visit?

A. To continue her medications and return to clinic in three months.

Q. So is it correct that you made no change to her current treatment plan?

A. That is correct.

Q. Did you determine that her current course of treatment was sufficient?

A. You know, I -- in these notes I don't say all the different treatment she's getting, because much of the gender dysphoria treatment comes through the committee. And as you've seen in all these other notes, I primarily address the medications in these notes. So just because I didn't change her medications doesn't mean that there weren't changes in her plan.

Q. Were you aware of other changes that were made in her plan as a result of this visit?

A. I don't recall.

Q. Do you recall if you spoke to other providers about her requests for sex reassignment surgery?

A. Yes, I -- I mean I documented about those

Q. And did you do anything to address Ms. Edmo's thoughts about castrating herself?

A. Did I do anything? I don't recall.

Q. Okay. Let's go to Corizon 543. This note is dated May 18th, 2016.

Can you tell me what the purpose of this visit was.

A. Yes. I remember this visit. I wanted to form a committee of physicians to determine the medical necessity of SRS. And I thought that would be a good idea, because I had heard several other states were doing things like that. And so I met with Ms. Edmo. And I told Ms. Edmo that although I had made that decision in the prior visit, that I would also be trying to form a committee of physicians to determine this, and that one of the tasks of that committee would be to consider Ms. Edmo's request.

Q. So is this visit initiated by you?

A. Yeah, by me.

Q. And was it your decision to form this committee?

A. Well, it was my -- it was my hope to form this committee, yeah.

Q. And was the committee formed?

A. The committee wasn't formed.

A. No. This was a thought that I had, an idea that I had. And after the -- it didn't work out the first time, I didn't think it was necessary, and we decided to address these decisions in the GID committee that was already formed.

Q. So what ultimately happened with Ms. Edmo's request for sexual reassignment surgery?

A. So --

MR. EATON: Object to form.

Go ahead.

MR HALL: Join.

THE WITNESS: So it was denied at that time.

Q. (BY MS. SHANBHAG): When was it denied?

A. So at this time it was denied. And so it was never brought back up.

Q. So it was denied on April 20th of 2016, and then it was not revisited?

A. Yes, not with me.

Q. And was this communicated to Ms. Edmo?

A. I don't recall.

Q. I believe we are now on the last record. So let's flip to Corizon 1305.

Did Corizon change their recording software?

A. Yes. This was a paper chart [indicating],

REPORTER'S CERTIFICATE

I, JEFF LaMAR, CSR No. 640, Certified Shorthand Reporter, certify:

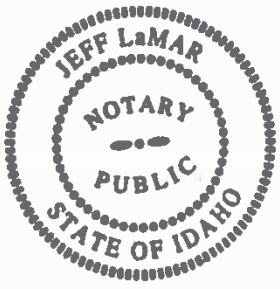
That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me.

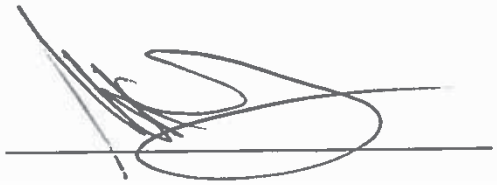
That the testimony and all objections made were recorded stenographically by me and transcribed by me or under my direction.

That the foregoing is a true and correct record of all testimony given, to the best of my ability.

I further certify that I am not a relative or employee of any attorney or party, nor am I financially interested in the action.

IN WITNESS WHEREOF, I set my hand and seal this 31st day of August, 2018.





JEFF LaMAR, CSR NO. 640
Notary Public
Post Office Box 2636
Boise, Idaho 83701-2636

My commission expires December 30, 2023

CERTIFIED COPY

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO (a/k/a MASON EDMO),
Plaintiff,
vs.
IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in his official capacity; JEFF ZMUDA, in his official capacity; HOWARD KEITH YORDY, in his official and individual capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; AND DOES 1-15;
Defendants.

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

RULE 30(B)(6) DEPOSITION OF CORIZON, INC.

TESTIMONY OF STEVEN MENARD, D.O.

AUGUST 27, 2018

REPORTED BY:

JEFF LaMAR, C.S.R. No. 640

Notary Public

441690

have any policies that guide that at all. Ultimately if you're asking for the -- you know, where that decision is being made or how we go about that, it would be at a local level.

You know, as far as corporate is concerned, that's the expectation that each place is unique, whether it's a jail or prison contract. And the expectation of providers, you know, they will be well versed to make that medical decision.

Q. (BY MR. DURHAM): Does the Clinical Pathway help providers make that decision?

MR. EATON: Object to form.

Go ahead.

THE WITNESS: Which decision?

Q. (BY MR. DURHAM): The decision whether sex reassignment surgery is medically necessary in a particular case.

A. The Clinical Pathway that Corizon has deal with just medical treatment for hormone treatment. We do not have any Pathways that would deal with sexual reassignment surgery. Again, there is a part here where it talks about indication for a specialty that would leave that open, that if -- you know, that's the next step or at the local level, that would be a decision made there. It's not something Corizon would

be able to dictate.

And again, depending on which guideline you use, whether it's the UCSF or WPATH, I think it's five different societies that provide their own similar guidelines, again, while you leave that flexibility at the local level.

Q. Has a Corizon provider in Idaho ever found that sex reassignment surgery was medically necessary for a transgender inmate?

MR. EATON: Object to form.

MS. CRECELIUS: Join.

MR. EATON: Also not covered by the scope of the notice.

MS. CRECELIUS: Join.

THE WITNESS: I am not aware. I did not research or ask that question.

Q. (BY MR. DURHAM): Okay. I think you testified earlier about the Management and Treatment Committee, the MTC?

A. Correct.

Q. You're familiar with that?

A. Yes, I am.

Q. Do you currently sit on that committee?

A. Yes.

Q. Who else from Corizon is on that committee?

Q. (BY MR. DURHAM): Does IDOC have policies that relate to health care?

MS. CRECELIUS: Object to the form.

THE WITNESS: Yes.

MR. EATON: Join.

MS. CRECELIUS: Was there an answer? I didn't hear it.

MR. EATON: He said "yes."

THE COURT REPORTER: "Yes."

Q. (BY MR. DURHAM): So let's focus specifically on training for gender dysphoria. I want to move back a few years and start with 2012.

Was there any specific training given to Corizon staff or employees related to treating inmates with gender dysphoria in that year?

MR. EATON: Object to form.

THE WITNESS: As far as Corizon, I'm not familiar with any form of that.

Q. (BY MR. DURHAM): How about 2013, was there training? Same question as to that year.

A. Not that I'm aware of.

Q. When was the first training that you're aware of?

A. I believe it was April of 2016.

Q. Was that a lecture by Dr. Stephen Levine?

A. Yes, that is correct.

Q. Okay. Who was the intended audience for that lecture?

MS. CRECELIUS: Object to form.

THE WITNESS: So to say I wasn't there, so I can only speak based on my understanding of what was presented in there. I believe it was for clinical staff and also medical staff.

Q. (BY MR. DURHAM): Have you reviewed Dr. Levine's presentation?

A. Yes, I have.

(Exhibit 4 marked.)

Q. (BY MR. DURHAM): I've handed you what's been marked as Plaintiff's Deposition Exhibits 4 and 5. We skipped one.

MR. EATON: I don't think this one's been labeled yet.

MR. DURHAM: Yeah, it doesn't have a label. I just wrote it on there. This is my copy, so...

MR. EATON: Okay. I think the witness should look at the actual exhibit.

MR. DURHAM: Yeah, it's a mistake on my part. I labeled my own copy. So let me label that one.

(Exhibit 5 marked.)

Q. (BY MR. DURHAM): Okay. Do you have those

depose Dr. Eliason in that regard.

MS. CRECELIUS: Join.

MR. DURHAM: I'm asking this witness about Corizon policy.

MR. McDUFFIE: And asked and answered.

MR. EATON: Yeah. Asked and answered as well.

THE WITNESS: Can you just restate that again?

Q. (BY MR. DURHAM): Is that what he lists there, is that Corizon policy for when sexual reassignment surgery is necessary?

MR. EATON: Same objections.

MS. CRECELIUS: Join.

THE WITNESS: So Corizon does not have, as a corporate office, any kind of policy for any of that.

Q. (BY MR. DURHAM): Okay. Thank you.

I'm assuming that the answer is the same. I'm going to ask it.

Does Corizon have a policy in Idaho regarding when a reassessment must be made as to whether sexual reassignment surgery is medically necessary?

A. Corizon, as a corporate office, does not have that.

(Exhibit 11 marked.)

Q. (BY MR. DURHAM): I've handed you what's

REPORTER'S CERTIFICATE

I, JEFF LaMAR, CSR No. 640, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me.

That the testimony and all objections made were recorded stenographically by me and transcribed by me or under my direction.

That the foregoing is a true and correct record of all testimony given, to the best of my ability.

I further certify that I am not a relative or employee of any attorney or party, nor am I financially interested in the action.

IN WITNESS WHEREOF, I set my hand and seal this 4th day of September, 2018.

JEFF LaMAR, CSR NO. 640
Notary Public
Post Office Box 2636
Boise, Idaho 83701-2636

My commission expires December 30, 2023