

THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
NO. 3:22-cv-191

KANAUTICA ZAYRE-BROWN,)
)
 Plaintiff,)
)
 v.)
)
 NORTH CAROLINA DEPARTMENT OF)
 PUBLIC SAFETY, et al.,)
)
 Defendant.)

**DEFENDANTS’
RESPONSE TO MOTION FOR
PRELIMINARY INJUNCTION**

Plaintiff’s motion for preliminary injunction fails for two reasons. First, Plaintiff argues for the application of a standard that is not consistent with the constitutional deliberate indifference standard for evaluating the provision of prison medical care. The prison is already providing the gender-affirming medical care that the Constitution requires, including hormone therapy and mental healthcare. Adopting Plaintiff’s position, however, would change the scope and standard of care in prisons for all cases. Second, Plaintiff’s request is premature because the Court has not yet had the opportunity to fully consider the serious and complex issues in this case.

STATEMENT OF THE FACTS

Defendants have described the complaint’s allegations in their motion to dismiss. (DE 10 at 1-5) In addition, Defendants provide the following facts for purposes of this response.

Plaintiff’s Incarceration

For her most current term of incarceration, Plaintiff entered the custody of the North Carolina Department of Public Safety (“the Department”) on October 10, 2017. (Mingo Aff. ¶ 3) She was sentenced to a minimum term of 7 years and 5 months and a maximum term of 9 years and 11 months based on convictions for obtaining property by false pretenses, two counts of

insurance fraud, and being a habitual felon. Plaintiff is scheduled to be released no later than November 2, 2024 (or sooner if she receives available credits).¹

From October 10, 2017, until August 15, 2019, Plaintiff was housed in male facilities. (Mingo Aff. ¶¶ 3-8) She was transferred to an all-female unit at Anson Correctional Institution on August 15, 2019, where she is currently incarcerated. (*Id.* ¶ 9) The Department’s records do not indicate that Plaintiff has ever reported any physical or sexual assault. (Mingo Aff. ¶ 12; Richardson Aff. ¶ 10)

Incidents During Incarceration

On March 2, 2019, while housed at Harnett (an all-male facility), Plaintiff was transported to the local emergency room after she was discovered in her bunk yelling and screaming that she was going to die. (Mingo Aff. ¶ 13) Plaintiff was taken to the sergeant’s office where she vomited, and then became combative with staff as they took her to the medical unit. (*Id.*) During a medical screening, Plaintiff mentioned, more than once, being high – stating that she smoked something out of a pipe. (*Id.* ¶ 14) The on-call physician ordered Plaintiff transferred to the local emergency room. (*Id.* ¶ 14)

During transport, EMS personnel reported that Plaintiff was hysterical, kicking, and screaming. (Mingo ¶ 15) At the emergency room, Plaintiff was given a sedative, at which point medical records indicate that she reported that she was “only doing this to get” transferred to a female facility. (*Id.*) Plaintiff then refused a medical work up, including a blood test, signed an “against medical authorization” and demanded to be sent back to the facility. (*Id.*) Upon her return to Harnett, Plaintiff denied any suicidal ideation. (Mingo Aff. ¶ 16) Plaintiff was charged with

¹ This information is publicly available at <https://www.ncdps.gov/dps-services/crime-data/offender-search>.

multiple serious prison disciplinary offenses—she pled guilty to the charge of possession of a substance and the other charges were dismissed. (*Id.*)

On August 6, 2019, Plaintiff was again sent to the local emergency room after she was found in her bunk unresponsive but breathing. (Mingo Aff. ¶ 17) Staff at the facility suspected that Plaintiff may have been using an illicit substance known as K2. (*Id.*) At the medical unit, Plaintiff appeared to have vomited and reported that her mind was gone. (*Id.*) Medical staff ordered her taken to the local emergency room. (*Id.*)

At the local emergency room, Plaintiff reported that she was more stressed than normal, and connected that stress to an impending transfer to a female facility. (*Id.* ¶ 18) The hospital staff surmised that Plaintiff had passed out after an episode of nausea and vomiting and discharged her back to the facility after evaluation. (*Id.*) Upon her return from the emergency room, Plaintiff threatened self-harm due to not wanting to be placed in restrictive housing since staff had suspected her of using K2. (*Id.* ¶ 19) Thus, Plaintiff was placed on self-injurious behavior precautions. (*Id.*) Plaintiff was taken off self-injurious behavior precautions the next day, after she reported that she had a breakdown due to her impending transfer, attributed her increased emotionality to her “hormones,” and affirmed that she never attempted suicide and values her life. (*Id.*)

On December 8, 2020, Plaintiff was placed in restrictive housing after an apparent assault on another incarcerated person. (Mingo Aff. ¶ 21; Richardson Aff. ¶ 7) On December 11, 2020, Plaintiff was sent to an inpatient mental health unit at the North Carolina Correctional Institute for Women (“NCCIW”) following a voluntary transfer form executed by Plaintiff and one of her mental health providers. (*Id.* ¶ 22) Plaintiff reported that she felt bad and was trying to mutilate herself. (*Id.*) Plaintiff’s mental health provider noted that a recent episode had increased Plaintiff’s dysphoria, which had been getting worse since August. (*Id.*) Plaintiff reported isolating from others

and having thoughts of self-harm. (*Id.*) Within one day of being admitted to the inpatient mental health unit, Plaintiff denied thoughts of self-harm. (Mingo Aff. ¶ 23) Suicide watch was discontinued on December 14, 2020. (*Id.*) Thereafter, Plaintiff remained in the inpatient unit until December 30, 2020, during which time her medical records contain no reports of distress. (*Id.*) Plaintiff described her major stressor as feeling bullied by staff and other inmates at Anson. (*Id.*)

When Plaintiff learned that she would be sent back to Anson (an all-female facility) because she was not an appropriate candidate for long-term admission into the inpatient mental health unit, she began to threaten to kill herself if she was transferred back to Anson. (Mingo Aff. ¶ 24) Plaintiff articulated her desire to remain at NCCIW or be transferred to a different male facility rather than go back to Anson. (*Id.*) Plaintiff repeatedly threatened self-harm if she was forced to go back to Anson. (*Id.*) Plaintiff was transferred back to Anson on January 5, 2021. (*Id.*) There is no record of that Plaintiff attempted to harm herself upon her return to Anson. (*Id.*) Moreover, Anson has taken steps to ensure Plaintiff is treated appropriately at Anson. (Richardson Aff. ¶¶ 4-10)

Plaintiff's Gender Dysphoria

In July 2017 (prior to the most recent incarceration), Plaintiff had an orchiectomy—surgical removal of the testes. (DE 1 ¶ 52; DE 13-2 ¶ 15) Plaintiff was incarcerated just over two months later, on October 10, 2017, at which time she advised correctional staff of her situation, and medical staff confirmed her diagnosis of gender dysphoria. (DE 1 ¶¶ 64-5; DE 13-2 ¶ 16) When Plaintiff entered custody, she was not presently on hormone replacement therapy (“HRT”). (Junker Aff. ¶ 13) Under the then applicable policy, Plaintiff initiated her request to begin HRT on December 21, 2017. (*Id.*) Plaintiff’s request for HRT was ultimately approved and she began

HRT on June 29, 2018. (*Id.*) Plaintiff continues to receive HRT and regularly meets with an endocrinologist who monitors her hormone levels and manages the HRT.² (*Id.*)

Plaintiff first requested transfer to a female facility on January 11, 2019. (Junker Aff. ¶ 14) That request was denied by the Facility Transgender Accommodation Review Committee (“FTARC”) and forwarded to the Division Transgender Accommodation Review Committee (“DTARC”) for further consideration. (*Id.*) Because such a housing assignment had never been made, the Department had to study the issue and take security and other factors into consideration. (*Id.*) Ultimately, the request to transfer Plaintiff to a female facility was approved and she was transferred to an all-female unit on August 15, 2019. (*Id.*)

Plaintiff has had access to mental and behavioral health services at each facility in which she has been housed. (Junker Aff. ¶ 15) Plaintiff has been on the mental health caseload since November 11, 2017. (*Id.*) As a patient on the mental health caseload, Plaintiff regularly sees a licensed mental health provider. (*Id.*) Plaintiff has also had access to, and on occasion has utilized, emergency mental health services. (*Id.*)

Plaintiff’s Request for Surgery

Plaintiff’s request for surgery was evaluated by the DTARC. (Junker Aff. ¶ 17 & Ex. A thereto) Ultimately, the DTARC recommended against approving the request for surgery as it determined that the surgery was not necessary at that time. (Ex. A to Junker Aff. at 2-3) Defendants Junker and Harris agreed with the recommendation. (Junker Aff. ¶ 19)

Making an informed and well-considered determination on the type of request at issue in this litigation takes time and consideration from many high-level Department stakeholders who

² Any delay in initiating HRT, or gaps in providing access to certain hormones or specialists appointments, were at most due to inadvertent oversights, communication issues, challenges due to the COVID-19 pandemic, and staffing shortages. Such circumstances, however, cannot support a deliberate indifference claim, and would at most support allegations of negligence. Moreover, there are no allegations that these issues currently remain a concern.

have substantial responsibilities within the prison system. (Junker Aff. ¶ 16) The DTARC meets quarterly. (*Id.* ¶ 9) Additionally, when the DTARC does meet it reviews and considers multiple requests by other incarcerated individuals. (*Id.* ¶ 16) Thus, requests, particularly novel requests such as the one at issue in this case, require significant deliberation, may require additional information, and time. (*Id.*)

Plaintiff's Request for Preliminary Injunctive Relief

On April 28, 2022, two days after receiving the denial from DTARC for the requested surgery, Plaintiff filed her complaint. On June 28, 2022, exactly two months after filing this action, and after Defendants moved to dismiss the same, Plaintiff first filed this motion for preliminary injunction. Plaintiff submits two declarations in support of her request – one from herself and one from a retained expert, Randi Ettner, Ph.D., an advocate for transgender persons and longtime WPATH board member who regularly testifies on behalf of transgender plaintiffs.

LEGAL STANDARD

“A preliminary injunction is ‘an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief’ and may never be awarded ‘as of right.’” *Mt. Valley Pipeline, LLC v. W. Pocahontas Props. Ltd. P’ship*, 918 F.3d 353, 366 (4th Cir. 2019) (citing *Winter v. NRDC, Inc.*, 555 U.S. 7, 22, 24 (2008)). The test for issuance of a preliminary injunction turns on the balance of the four *Winter* factors: likelihood of success on the merits; irreparable harm in the absence of an injunction; equities to the parties; and the public interest.

Plaintiffs have the burden of proof on each factor. *Winter*, 555 U.S. at 20. Additionally, a plaintiff must show that success on the merits is likely regardless of whether the balance of hardships weighs in his favor. *The Real Truth About Obama, Inc. v. F.E.C.*, 575 F.3d 342, 346

(4th Cir. 2009), *vacated on other grounds*, 559 U.S. 1089 (2010). This burden requires more than simply showing that “grave or serious questions are presented.” *Id.* at 347.

The demanding standard outlined above becomes even more exacting when a plaintiff seeks a preliminary injunction that mandates action, as contrasted with the typical form of preliminary injunction that merely preserves the status quo pending trial. *See E. Tenn. Natural Gas Co. v. Sage*, 361 F.3d 808, 828 (4th Cir. 2004) (*quoting Wetzel v. Edwards*, 635 F.2d 283, 286 (4th Cir. 1980)) (noting that “mandatory preliminary injunctions . . . normally should be granted only in those circumstances when the exigencies of the situation demand such relief”). Accordingly, mandatory injunctions are disfavored. *Mt. Valley Pipeline, LLC v. 6.56 Acres*, 915 F.3d 197, 216 n.8 (4th Cir. 2019). The more exacting standard applies in this case because Plaintiff seeks to alter the status quo by requiring Defendants to provide her with gender-affirming surgery prior to a full determination on the merits.

ARGUMENT

I. PLAINTIFF IS NOT LIKELY TO SUCCEED ON THE MERITS.

A. The Issue Before the Court is Whether Plaintiff is Likely to Succeed on the Merits of Her Claim that Denying Her Requested Gender Affirming Surgery Constitutes Deliberate Indifference.

Plaintiff’s complaint and affidavit contain multiple allegations regarding the provision of care, including alleged lapses in hormone therapy (including at the outset of the pandemic) and a change in her mental health provider. But there is no dispute that Plaintiff has received and is currently receiving hormone therapy and mental health counseling. (DE 13-2 ¶ 45) Thus, these issues do not provide any basis for injunctive relief. Accordingly, Plaintiff’s request for injunctive relief centers solely on the decision to not approve her requested surgery at this time, and that is the issue for the Court. (DE 14 at 2)

B. Defendants' Pending Motion to Dismiss Demonstrates that Plaintiff is Not Likely to Succeed on the Merits.

Defendants have moved to dismiss Plaintiff's claims. For the reasons set forth in detail in Defendants' motion to dismiss memorandum ("MTD Memo") (*see* DE 10, which is expressly incorporated herein), Plaintiff's claims fail on multiple grounds. First, Plaintiff filed this action before completing the grievance process; thus, her claim is barred by the Prison Litigation Reform Act. Second, the Eleventh Amendment bars any claim against the Department for a federal constitutional violation and against State officials for damages. Third, Plaintiff's state constitutional claim under *Corum* fails because there are other adequate state remedies. Fourth, Plaintiff fails to state a claim for relief under the Eighth Amendment or equivalent provision of the North Carolina Constitution, because she cannot establish objectively unreasonable harm or subjective deliberate indifference through the denial of surgery. While Plaintiff does not appear to base her request for injunctive relief on her claim for disability discrimination, that claim also fails.

C. Plaintiff Cannot Make a Clear Showing of Likelihood of Success on the Merits with No Controlling Precedent or Consensus of Authority in Her Favor.

The Fourth Circuit has not held that the denial of gender affirming surgery constitutes deliberate indifference in the Eighth Amendment context. In *De'Lonta v. Johnson*, 708 F.3d 520, 521 (4th Cir. 2013), the Fourth Circuit reversed the dismissal of an Eighth Amendment claim based on the denial of evaluation for gender affirming surgery under different facts (including known self-mutilation), but it expressly declined to decide on the merits whether the plaintiff had a valid claim for deliberate indifference based on the denial of surgery. *Id* at 526. Since *De'Lonta*, the Fourth Circuit has not decided the issue.

As discussed in Defendants' MTD Memo, multiple circuits that have directly addressed a deliberate indifference claim premised on the decision to not approve surgery and have found that

the provision of other treatment short of surgery is constitutionally adequate. *See Kosilek v. Spencer*, 774 F.3d 63 (1st Cir. 2014) (en banc) (holding that the state’s decision to continue treating the plaintiff’s gender dysphoria through other treatments, rather than authorizing surgery was a choice between two alternatives and thus cannot support a deliberate indifference claim); *Lamb v. Norwood*, 899 F.3d 1159 (10th Cir. 2018) (finding no error in granting summary judgment to prison officials on the claim of deliberate indifference for not approving surgery because the combination of existing treatment and the sparseness of the summary judgment record precluded an inference of deliberate indifference); *Gibson v. Collier*, 920 F.3d 212 (5th Cir. 2019) (affirming summary judgment because it was indisputable that the necessity and efficacy of surgery was a matter of significant disagreement within the medical community, and it could not be cruel and/or unusual to deny treatment that no other prison had ever provided). *See also Campbell v. Kallas*, 936 F.3d 536, 537 (7th Cir. 2019) (reversing the district court’s denial of qualified immunity because at the time of the inmate’s request for surgery, no case clearly established a right to gender-dysphoria treatment beyond hormone therapy).³

The only circuit to reach a different result is the Ninth Circuit in *Edmo v. Corizon, Inc.*, 935 F.3d 757 (9th Cir. 2019), *cert. denied*, 141 S. Ct. 610 (2020). There, the Ninth Circuit affirmed injunctive relief directing the state of Idaho to provide the plaintiff with surgery because the inmate established that such treatment was medically necessary and that in failing to provide the surgery, the correctional facility authorities were deliberately indifferent to her serious medical needs. *Id.* at 767. However, as discussed in Defendants’ MTD Memo, *Edmo* is distinguishable from the

³ Other decisions support the denial of injunctive relief here. *See, e.g., Doe v. Snyder*, 28 F.4th 103 (9th Cir. 2022) (affirming the denial of injunctive relief in the form of gender affirming surgery where plaintiff failed to establish medical necessity); *Baker v. Aetna Life Ins. Co.*, 260 F. Supp. 3d 694 (N.D. Tex. 2017) (finding that an insurance company correctly determined that breast augmentation surgery as part of gender transition was not medically necessary).

instant case including because it involved multiple known self-castration attempts and other psychical forms of self-harm.

Plaintiff also cites a handful of district court cases, none of which are controlling here. At least two of the cited cases also are factually distinguishable. *Hicklin v. Precynthe*, No. 4:16-cv-01357-NCC, 2018 U.S. Dist. LEXIS 21516, at *50 (E.D. Mo. Feb. 9, 2018), for instance, did not involve gender affirming surgery at all. There, the district court granted an injunction requiring hormone therapy, access to permanent body hair removal, and access to gender-affirming canteen items – interventions that are not at issue in the instant case. *Iglesias v. Fed. Bureau of Prisons*, No. 19-CV-415-NJR, 2021 U.S. Dist. LEXIS 245517 (S.D. Ill. Dec. 27, 2021), also involved different facts. There, the district court granted injunctive relief where the prison had provided no hormone therapy for twenty years, transferred the plaintiff to a female facility only after the lawsuit was filed, provided no response to plaintiff on a surgery request, and had categorical requirements for authorizing surgery that did not appear to be medically based.

Overall, without any controlling authority or at least a strong consensus of authority, Plaintiff cannot make a clear showing of likelihood of success on the merits. Thus, preliminary relief is not appropriate.

D. Plaintiff is Not Likely to Succeed Because She Has Not Established that the Decision to Not Approve Surgery at the Current Time Deprives Her of Constitutionally Required Medical Care.

Plaintiff and her expert contend that because Plaintiff continues to experience dysphoria, and because the surgery is an intervention that may provide some relief, the intervention is medically necessary. Thus, Plaintiff argues, the State is constitutionally obligated to provide for the intervention. (DE 14 at 19) Plaintiff appears to define medical necessity as something that has “a therapeutic effect” and is not experimental. (DE 13-1 ¶¶ 49, 57-58) The Court should reject

Plaintiff's argument because it is legally unsupported and fails to consider practical implications, like the creation of an unworkable standard moving forward. Simply put, it cannot be the case that a prison system is deliberately indifferent anytime it does not approve a course of treatment where therapeutic benefits are questionable, particularly when reasonable providers may disagree about necessity under the circumstances.

1. Plaintiff's Proposed Standard is Inconsistent with the Level of Care Required By The Constitution.

At least one circuit has rejected the notion that “the Eighth Amendment requires the government—which is to say taxpayers—to fund any medical treatment that is ‘psychologically pleasing’ Necessity, not pleasure, is the constitutional standard—and no amount of massaging can make those two things the same. . . . The possibilities are endless.” *Keohane v. Florida Dep’t. of Corr. Sec’y.*, 952 F.3d 1257, 1274 n.9 (11th Cir.), *en banc review denied*, 981 F.3d 994 (11th Cir. 2020) and *cert. denied*, 142 S. Ct. 81 (2021).

In the instant case, Plaintiff, and her expert assert that provision of the surgery at this present time is “medically necessary” because there is therapeutic benefit. But that is not the standard applied when deciding whether the government is constitutionally required to provide that care.

As explained by Dr. Penn, Plaintiff's definition of “medical necessity” does not match the analysis performed by a state correctional institution when it decides whether it must provide for a particular intervention at a given time. (*See* Penn Aff. ¶¶ 35-47) In the prison context, courts have declined to find that the constitution requires the State to provide care that has the mere possibility of aiding a person's well-being, at the taxpayers' expense, regardless of cost.

“[S]ociety does not expect that [incarcerated individuals] will have unqualified access to health care.” *Hudson v. McMillian*, 503 U.S. 1, 9 (1992). Thus, “not ‘every claim by a[n

incarcerated person alleging] that he has not received adequate medical treatment” is an Eighth Amendment violation. *Thompson v. City of Charlotte*, No. 3:20-cv-370-MOC-DSC, 2020 U.S. Dist. LEXIS 223513, at *9 (W.D.N.C. Nov. 30, 2020) (quoting *Estelle v. Gamble*, 429 U.S. 97, 105, (1976). Accordingly, “[t]o find the prison officials liable, the treatment given must be so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.” *Hixson v. Moran*, 1 F.4th 297, 303 (4th Cir. 2021) (cleaned up). “Once prison officials are aware of a serious medical need, they only need to ‘respond[] reasonably to the risk.’ *Hixson v. Moran*, 1 F.4th 297, 302 (U.S. 4th Cir. 2021) (quoting *Farmer v. Brennan*, 511 U.S. 825, 844 (1994). And “a prisoner is not entitled to receive the treatment of his choice.” *Thompson*, 2020 U.S. Dist. LEXIS 223513, at *9. Moreover, as set forth in the MTD Memo, a disagreement regarding the appropriate course of treatment, as a matter of law, cannot support a deliberate indifference claim. *See* DE 10 at 16-18.

2. Plaintiff’s Standard Fails to Account for the Practical Considerations of Providing Medical Care in a Correctional Setting.

Presumably to rebut the fact that the WPATH standards do not take the correctional context into account, Dr. Ettner contends that there should be no difference between how care is provided in the community as compared to correctional settings. (*See* DE 13-1 ¶ 30) This contention ignores the realities of providing health services in the carceral setting. For this reason alone, the Court should reject Plaintiff’s proposed standard.

In the correctional setting, whether to approve a particular medical intervention turns on a host of considerations. (*See* Penn Aff. ¶¶ 35-47) Such considerations include the availability of qualified medical professionals, rates of patient satisfaction, effectiveness of alternative interventions, short and long-term continuity of care issues, risks of complications, implications of postponing the procedure, pre-operative and post-operative concerns and logistics, the costs of

the procedure, informed consent, and more. (*Id.*) These considerations take on added layers in the correctional setting that are not present in community. These considerations include the reality of recovering from procedures in a communal setting, determining informed consent, the carceral environment, and access to specialty care. (*See Id.* ¶¶ 40, 42, 46) Additionally, given these considerations, careful thought must be given to the risks and benefits of delaying treatment until it can occur outside of the prison context. (*Id.* ¶ 47) As explained by Dr. Penn, each of these factors must be accounted for and balanced when making determinations on the provision of certain medical interventions. (*See Id.* ¶ 39-47) For the particular decision here, the realities of a major surgery now—in the correctional context—as opposed to postponing the surgery for a temporary period to allow it to occur at Plaintiff’s discretion after release and other aspects of moving forward in the correctional context also must be taken into account. (*See Id.*)

Additionally, as explained by Dr. Boyd, an exploration of an individual’s expectancy of how a given intervention may impact their condition, is critical, especially when evaluating the risks and benefits of proceeding with a given intervention while in custody as opposed to waiting until after release, and when multiple procedures are contemplated by the patient. (Boyd Aff. ¶¶ 7-10, 15) Indeed, Plaintiff’s records suggest that her preferred surgical intervention was the vaginoplasty. (*Id.* ¶ 10) However, Plaintiff appears to have opted for a less desirable option, a vulvoplasty, evidently out of a sense of expediency and due to post-operative issues. (*See Id.*) Given this, there is cause for concern regarding how proceeding with the vulvoplasty now as opposed to waiting until Plaintiff is released and can pursue her preferred intervention might impact her expectancy of how the surgery would affect her dysphoria. (*See Id.* ¶¶ 10, 15) However, Plaintiff’s expert, Dr. Ettner, does not address this issue at all. (*Id.* ¶ 11)

3. Plaintiff's Contention that a Correctional System is Constitutionally Obligated to Provide any Care that Could Provide Some Therapeutic Benefit Imposes an Unworkable Standard for Correctional Systems.

In essence, Plaintiff and her expert advance a constitutional standard that would require the State to approve any medical intervention which may potentially provide a therapeutic benefit. A simple example highlights the unworkability of such a standard.

Many incarcerated persons experience depressed mood, dysphoria, anxiety, insomnia, and other DSM-V recognized disorders. (Penn Aff. ¶ 64) Research indicates that massage may provide a therapeutic effect that benefits these patients. (*Id.*) Under Plaintiff's standard, state prisons systems would be constitutionally obligated to approve and provide for massages to incarcerated persons at public expense simply because there is some evidence of a therapeutic benefit to some patients. (*Id.*) Such an outcome would make the test for a medical necessity meaningless. This example is not offered to minimize Plaintiff's experience or create false equivalencies. Rather, this example is offered to highlight the unworkable nature of the standard pressed by Plaintiff. Plaintiff's proposed standard fails to focus on the actual necessity of a given intervention (*see* Penn Aff. ¶¶ 61-68) and would dramatically expand the nature of health services required in prison systems.

Despite arguing that this case is only about one person's request for one medical intervention, it is not. Fundamentally, this case challenges the Department's decision by articulating a new (and incorrect) constitutional standard, which if accepted would have a profound impact the provision of health services in prisons across the State. Plaintiff's theory of this case, if accepted, would potentially result in constitutional violations any time a requested medical intervention that may provide some benefit is not approved. This is not and cannot be the rule.

Furthermore, there is nothing improper about accounting for other relevant considerations when determining whether to approve a particular medical intervention in a correctional setting. (*See* Penn Aff. ¶¶ 35-47) Plaintiff asserts that Defendants denied her requested surgery for “nonmedical reasons.” To the contrary, the DTARC appropriately determined the surgery was not medically necessary at the present time. (*See* DE 13-1 at 95-97 (noting that Plaintiff has received extensive treatment and finding that “[a]lthough [Plaintiff] has clearly communicated a desire for gender-affirming surgery, there is insufficient medical evidence to indicate such a complex and irreversible surgical intervention is medically necessary for her at the present time.”)). Plaintiff’s disagreement with DTARC’s conclusion, does not make the decision “nonmedical” and it cannot support a claim for deliberate indifference.

4. The Fact that There is Reasonable Disagreement in the Field on the Necessity of Gender Affirming Surgery Under the Circumstances Precludes a Finding of Deliberate Indifference.

Plaintiff relies on the fact that some of her providers recommend surgery as well as on the WPATH standards to contend that the surgery is constitutionally required. But Plaintiff ignores significant dissent within the field. (*See* Penn Aff. ¶¶ 51-60) Because there is reasonable disagreement about the necessity of surgery under the circumstances, especially in the correctional setting, Plaintiff cannot establish deliberate indifference.

As an initial matter, Plaintiff’s reference to and reliance on WPATH as determinative is unavailing. There continues to be significant debate in the medical community about WPATH’s recommendations, particularly concerning matters related to surgical interventions. (*See* Penn Aff. ¶¶ 51-60) While WPATH may set out guidance that is to be referenced in making particular determinations it does not lay down hard and fast rules, particularly, not in the correctional setting. (*See id.*) As discussed above, the provision of health services in a correctional setting requires the

consideration of factors which are not present in the community. (*See* Penn Aff. ¶¶ 35-47) Thus, while WPATH may provide helpful standards as a reference, it does not address the implications of providing such care in the correctional setting, (*see* Penn Aff. ¶¶ 51-60), and thus cannot set constitutional requirements.

Indeed, courts have expressed skepticism about the WPATH standards, particularly as they are applied to the correctional setting. In a case decided after *Edmo*, for example, the Ninth Circuit affirmed the district court’s denial of a preliminary injunction mandating gender affirming surgery. *See Doe*, 28 F.4th at 109. In its decision, the Court acknowledged concerns raised by defense experts including that WPATH “represents a self-selected subset of the mental health professions . . . [and] does not capture the clinical experiences of others” and that WPATH’s purported professional consensus regarding standard of care “exists only within its confines.” *Id.*

Similarly, in *Kosilek*, 774 F.3d at 76, the First Circuit acknowledged defense expert testimony that many disagree with WPATH standards such that the defense expert did not consider them equivalent to “medically necessary.” In that case, the court’s independently appointed expert further testified that “WPATH is supportive to those who want [surgery] Skepticism and strong alternate views are not well tolerated.” That independent expert further testified that WPATH “aspires to be both a scientific organization and an advocacy group for the transgendered,” but that “[t]hese aspirations sometimes conflict.” 774 F.3d at 78. The expert also noted limitations in the standards caused by the lack of rigorous research in the field. *Id.*

Likewise, in *Gibson*, 920 F.3d at 222-23, the Fifth Circuit followed the First Circuit’s conclusion that “WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery.” The Fifth Circuit determined that surgery was medically controversial and reached an “unmistakable conclusion” that there is “no

medical consensus that sex reassignment surgery is a necessary or even effective treatment for gender dysphoria.” *Id.* at 223. The court noted that the WPATH standards do not reflect consensus, with WPATH itself acknowledging that “this field of medicine is evolving.” *Id.*

The Fourth Circuit has recognized the WPATH standards, but has not held that WPATH either sets the constitutional requirement under the Eighth Amendment; nor has the Fourth Circuit held that WPATH’s standards mandate gender affirming surgery under the circumstances. In *De’Lonta*, the plaintiff relied on the WPATH guidance to argue that *evaluation* for surgery was the standard of care. *Id.* 708 F.3d at 523. In holding that the plaintiff’s complaint plausibly stated a cause of action, the Court noted that the WPATH standards are “generally accepted protocols for treatment of [gender dysphoria].” *Id.* 708 F.3d at 523. More recently, the Fourth Circuit again noted that the WPATH standards “outline appropriate treatments for persons with gender dysphoria[.]” *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 596 (4th Cir. 2020). *Grimm*, involved an equal protection challenge to a school board’s bathroom policy and its impact on transgender students. *Id.* 972 F.3d at 594-95. While the Fourth Circuit has acknowledged that the WPATH standards outline appropriate treatment, these cases cannot credibly be relied on to suggest that the WPATH standards represent inflexible rules which set out the constitutional standard for medical care in prison.

Indeed, the WPATH guidance itself acknowledges the limits of its applicability as some sort of constitutional standard. “The overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment.” (*See Penn Aff.* ¶ 50). Similarly, Dr. Ettner recounts that gender affirming surgery “improves virtually every facet

of a patient's life, [including] satisfaction with interpersonal relationships and improved social functioning . . . improvement in self-image and satisfaction with body and physical appearance . . . greater acceptance and integration into the family” as well as “ability to initiate and maintain intimate relationships.” (DE 13-1 ¶¶ 54-55) While these goals are meaningful, they do not represent a constitutional medical necessity.

Plaintiff claims that her expert and WPATH's perspectives are superior, because of their expertise in transgender health. And Plaintiff critiques the DTARC and other decisionmakers for not having this specific expertise. But the DTARC members include health and medical experts, and DTARC members have made appropriate efforts to understand and give fair, good faith consideration to the issues at hand. (*See Junker Aff.* ¶¶ 10-11) Regardless, courts have rejected the concept that a correctional treatment team was incompetent without specific expertise in transgender health care. *See Keohane*, 952 F.3d at 1278 n15.

Furthermore, as described by Dr. Penn, there is genuine disagreement within the field about the medical necessity of gender affirming surgery under various circumstances. (Penn Aff. ¶¶ 51-60) Accordingly, Defendants' determination that the surgery was not medically necessary at the present time did not constitute deliberate indifference.

E. Plaintiff Cannot Justify a Preliminary Order Mandating Surgery at the Present Time.

Evaluating the appropriateness of a given medical intervention, particularly gender-affirming surgery, requires a comprehensive assessment of the patient. Dr. Ettner's evaluation appears to be lacking in several respects. First, Dr. Ettner did not probe issues related to informed consent in detail. (*Boyd Aff.* ¶ 7) Second, Dr. Ettner did not conduct collateral interviews of treatment providers, family members, friends, or other individuals who could provide observations of the Plaintiff's history, symptoms, and response to prior interventions. (*Id.*) Similarly, Dr. Ettner

did not explore the import of Plaintiff's decision as it relates to choosing vulvoplasty rather than vaginoplasty, while expressing a desire for further procedures in the future. (*Id.* ¶¶ 7, 9-11) Nor does Dr. Ettner describe a discussion with Plaintiff regarding her expectancy of the impact the surgery may have on her gender dysphoria given the many other factor which Plaintiff identifies as contributing to her distress. (*Id.* ¶¶ 16-17)

The lack of exploration whatsoever regarding Plaintiff's repeated desire for a vaginoplasty (as opposed to the vulvoplasty she now seeks) is particularly concerning. (*See Id.* ¶¶ 9-11) Plaintiff's medical records clearly indicate that vaginoplasty was and continues to be her ultimate goal. (*Id.* ¶10) However, Plaintiff chose to pursue the vulvoplasty while incarcerated due to concerns related to pre- and post-operative issues and a sense of expediency. (*Id.*) A comprehensive evaluation of the appropriateness of the requested intervention at present should have included an exploration of how the Plaintiff's decision to opt for the vulvoplasty instead of the vaginoplasty, while expressing a clear desire to pursue the vaginoplasty at a later date, affects her expectations. (*See Id.* ¶¶ 7-11) Dr. Ettner's declaration fails to mention any such discussion and does not contain any analysis of the issue. (*Id.* ¶¶ 20-1) This is especially concerning (see considering Dr. Ettner's surprising conclusion that the surgery would be curative. (*See* DE 13-1; Penn Aff. ¶ 48; Boyd Aff. ¶ 20)

Relatedly, Dr. Ettner did not discuss the relative risks and benefits of allowing Plaintiff to wait until her release in November 2024 (or sooner) to pursue her preferred surgery rather than moving forward with a less preferred surgery relatively close to the end of her incarceration,⁴ likely necessitating recovery in a far less ideal setting. (Boyd Aff. ¶ 15) The potential importance of this

⁴ Even if the Court were to order the Department to authorize the surgery now, it is possible that the surgery could not be scheduled and performed immediately. The requested procedure is highly specialized and only performed by a small number of surgeons within North Carolina. Wait times for the procedure may be many months, if not years. (*See* Penn Aff. ¶ 40)

is highlighted by the fact that Plaintiff had some post-operative healing issues when she entered custody in October 2017, within months of her orchiectomy. (*Id.* ¶ 8)

Additionally, Dr. Ettner does not appear to address two episodes of concern that warrant further evaluation. (*See* Boyd Aff. ¶¶ 12-14) Twice in 2019, Plaintiff was sent to the local emergency room following some sort of episode. (*See* Mingo Aff. ¶¶ 13-19) Custody staff suspected both instances were related to Plaintiff's use of an illicit substance. (*See* Mingo Aff. ¶¶ 17, 19) While Plaintiff reportedly admitted to smoking something out of a pipe in the first incident, and pled guilty to a related disciplinary offense, there is no definitive evidence of drug use. (Mingo Aff. ¶¶ 14, 16; Boyd Aff. ¶ 12) However, whether these two episodes were related to drugs or whether the episodes were caused by something else, the episodes and their initiating cause warrant further exploration. (*See* Boyd Aff. ¶ 13)

As explained by Dr. Boyd, if Plaintiff were self-medicating with substances, which then led to the episodes causing her to be sent to the local emergency room, this issue would need to be fleshed out through evaluation when assessing the appropriateness of a given intervention. (*Id.*) This is not necessarily because substance abuse should be considered a strict contraindication, but rather because these episodes may indicate additional contributory causes or at least exacerbating factors for the psychological symptoms that Dr. Ettner attributes exclusively to Gender Dysphoria. (*Id.*) And in the event that Plaintiff does have co-occurring mental health conditions, it will be vital to ensure that the contributing causes and major sources of exacerbation are identified. (*Id.*) And again, Dr. Ettner declaration fails to mention any such discussion and does not contain any analysis of the issue. (*Id.* ¶ 14) Given the failure to consider the issues discussed above, the court should be dubious of Dr. Ettner's assertion that the requested surgery would be curative. (*See* DE 13-1; Penn Aff. ¶ 48; Boyd Aff. ¶ 20)

In sum, Plaintiff cannot establish a likelihood of success on the merits. If her deliberate indifference claim is not dismissed, at a minimum, further discovery is necessary.

II. THE PUBLIC INTEREST, HARM ANALYSIS, AND EQUITIES WEIGH AGAINST AN INJUNCTION.

Plaintiff must make a clear showing that she will likely be irreparably harmed absent preliminary relief. *The Real Truth About Obama, Inc. v. F.E.C.*, 575 F.3d at 347. An averment that the plaintiff's harm might simply outweigh the defendant's harm is insufficient. *Id.* The showing of irreparable injury is mandatory even if the plaintiff has already demonstrated a strong showing on the probability of success on the merits. *Id.* Moreover, the Court must give "particular regard" to the "public consequences" of any relief granted. *Id.* Plaintiff fails to carry her burden on this irreparable harms and equities analysis.

There are several issues with Plaintiff's claim of irreparable harm. At least in some instances, Plaintiff's self-report of events appears to be inconsistent or incomplete when compared to the documentary record. Thus, there is material disagreement about facts related to Plaintiff's accounts of incidents she relies on to establish severe distress, and further discovery would be needed on these issues prior to any order requiring surgery.

As an example, in her declaration, Plaintiff asserts that in August 2019, she was so distressed due not hearing back from the DTARC about her requested surgery that she was sent to the local emergency department and was subsequently placed on suicide watch. (DE 13-2 ¶ 29) However, Plaintiff's records indicate that in August she was sent to the local hospital after being found unresponsive following what correctional staff suspected to be the use of an illicit substance. (Mingo Aff. ¶ 18) Then, upon her return from the hospital, Plaintiff threatened to harm herself due to not wanting to be placed in restrictive housing because of her suspected use of an illicit substance. (*Id.* ¶ 20) Plaintiff was removed from self-injurious protection the next day after

reporting that she had a breakdown over her impending transfer to a female facility and affirming that she had never attempted suicide. (*Id.*)

As another example, Plaintiff and her expert have provided two different accounts of an episode in December 2020. Plaintiff reports that she expressed a desire to self-mutilate, which resulted in her admission into an inpatient mental health unit at NCCIW. (DE 13-2 ¶ 33) Dr. Ettner states that in December 2020, Plaintiff’s hospitalization “result[ed] from her attempt to amputate her penis.” (DE 13-1 ¶ 78). But there do not appear to be any custody or operational records indicating that Plaintiff had attempted to self-mutilate (Mingo Aff. ¶ 26) and Plaintiff, despite presenting some medical records, has not put forward any documenting an attempt of self-harm.

Second, Plaintiff does not link her distress to the surgery denial. Plaintiff claims that she is suffering severe mental and emotional distress, but her records challenge the causal link between the lack of surgery and the distress. Specifically, Plaintiff’s records indicate that much of her dysphoria seems to stem from what she has experienced as transphobic behavior and comments including by other incarcerated persons. (Boyd Aff. ¶16) Additionally, Plaintiff seems to be negatively affected by the sharp segregation of sexes in prison. (*Id.*) Surgical intervention, including the requested surgery, will not resolve these issues. (Boyd Aff. ¶ 16; Penn Aff. ¶ 46)

Third, Plaintiff’s two-month delay in filing for preliminary injunctive relief after bringing this lawsuit weighs against granting the relief. Plaintiff has lived as a transgender woman for many years without the surgery and without documented self-harm, and Plaintiff has not demonstrated urgency of injunctive relief now, particularly with a release date within a reasonable time frame. Notably, Plaintiff is only subject to a time-limited delay before she can pursue the desired surgery on her own upon her release from custody in or before November 2024.

On the other hand, the public has a strong interest in the proper use of public funds. While

Plaintiff attempts to characterize this as just one surgery for her that will not have a significant fiscal impact on the State, changing the standard in the manner Plaintiff proposes would have a much broader impact. Significantly, each expenditure comes at the expense of another State priority. Within the state prison system, increased expenditures in one area often require difficult tradeoffs with funding for staffing, safety and security, and other critical priorities that affect the lives of incarcerated persons.

Plaintiff ignores the impact of a loosening of standards regarding when surgeries and other accommodations will be provided at the public's expense. For instance, Plaintiff herself has had several other surgeries and procedures in order to appear or feel more feminine as part of her treatment for gender dysphoria, including "bilateral orchiectomy, breast augmentation, facial feminization, Brazilian butt lift, forehead and chin fillers." (DE 13-1 p 75) By Plaintiff's logic, any of those procedures would have to be provided by the State if requested during incarceration. WPATH concurs. (*See* DE 13-1 ¶ 29) (standards contemplate "Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring)"). Dr. Ettner also demonstrates the expansive nature of "medical care" under this standard. (DE 13-1 ¶ 64) (stating that permanent hair removal, feminine deodorant, hair care, and makeup are "accoutrements" that are "critical" to the mental wellbeing of gender dysphoric people). Under the standard Plaintiff urges, the State may be constitutionally required to financially provide these accoutrements as well.

As the Eleventh Circuit recognized in *Keohane*, reading the constitution to "require prison officials to provide every convicted inmate – at taxpayer expense – with any treatment that is 'psychologically pleasing' . . . cannot possibly be the law." 952 F.3d at 1278. The Fifth Circuit also expressed this principle in *Gibson*, explaining that "[u]nder established precedent, it can be

cruel and unusual punishment to deny essential medical care to an inmate. But that does not mean prisons must provide whatever care an inmate wants.” *Gibson*, 920 F.3d at 216.

In light of the challenging nature of these issues, the lack of clear limits and protocols, and the potential for abuse, Plaintiff cannot establish that the Department’s determination constitutes deliberate indifference. Under the circumstances, the public interest is significant, and the Court should not order Defendants to provide the surgery, and particularly not without a full hearing on the merits.⁵

CONCLUSION

For the foregoing reasons, the Defendants respectfully request that Plaintiff’s motion for preliminary injunction be denied.

Respectfully submitted this 19th day of July 2022.

JOSHUA H. STEIN
ATTORNEY GENERAL

/s/ Orlando L. Rodriguez
Orlando L. Rodriguez
Special Deputy Attorney General
Bar No. 43167
orodriguez@ncdoj.gov

Stephanie A. Brennan
Special Deputy Attorney General
Bar No. 35955
sbrennan@ncdoj.gov

Attorneys for Defendants

⁵ Defendants do not oppose Plaintiff’s request for a waiver of security.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

No. 3:22-CV-0191-MOC-DCK

KANAUTICA ZAYRE-BROWN,)

Plaintiff,)

v.)

THE NORTH CAROLINA DEPARTMENT)
OF PUBLIC SAFETY, et al.,)

Defendants.)

AFFIDAVIT OF CHRISTINA MINGO

I, Christina Mingo, am an adult over the age of 18 years, have never been judged incompetent, and testify to the following based on my personal knowledge and expertise.

1. I make this affidavit of my own free will, stating facts of which I have personal knowledge, except as to those matters stated herein upon information and belief, and as to those, I believe them to be true.

2. I serve as the Security Specialist for the North Carolina Department of Public Safety, Division of Adult Corrections. I have held this position for one (1) year. I have worked for the Department of Public Safety in the field of corrections for fourteen (14) years.

Plaintiff's Housing Assignment History

3. On October 10, 2017, Plaintiff was housed at Craven Correctional Institution ("Craven CI"), where she remained until November 2, 2017.

4. While housed at Craven CI, Plaintiff slept in a dorm that housed 34 other offenders.

5. On November 2, 2017, Plaintiff transferred to Harnett Correctional Institution ("Harnett CI"), where she remained until March 28, 2019.

6. While housed at Harnett CI, Plaintiff slept in a dorm that housed 34 other offenders from November 2, 2017, to March 2, 2019.

7. From March 2, 2019, through March 28, 2019, Plaintiff was housed in a single cell.

8. On March 28, 2019, Plaintiff was transferred to Warren Correctional Institution (“Warren CI”), where she remained until August 15, 2019. She slept in a single cell for that entire period.

9. On August 15, 2019, Plaintiff was transferred to an all-female unit at Anson Correctional Institution (“Anson CI”), where she is currently incarcerated. Since arriving at Anson, Plaintiff has slept in a single cell for the entire period.

10. On December 11, 2020, Plaintiff was briefly transferred to North Carolina Correctional Institution for Women (“NCCIW”) until January 5, 2021. While at NCCIW, Plaintiff slept in a single cell with access to a single cell shower.

11. When an incarcerated individual makes reports to correctional staff that they have been the victim of physical violence or sexual assault, Department policy requires that a staff document the report. Moreover, various Department policies require that such reports be investigated.

12. Since the beginning of her most recent incarceration, there are no documents indicating that Plaintiff has reported being the victim of physical violence or sexual assault.

Incident on March 2, 2019 (Harnett C.I.)

13. On March 2, 2019, while housed at Harnett CI, Plaintiff was transported to the local emergency room after she was discovered in her bunk yelling and screaming that she was going to die. Prior to being transported to the local emergency room, Plaintiff was taken to the sergeant’s

office where she vomited, and then became combative with staff as they took her to the medical unit.

14. During a medical screening, Plaintiff mentioned more than once being high stating that she smoked something out of a pipe. Medical staff at the facility could not take Plaintiff's vitals because she was thrashing about. The on-call physician ordered Plaintiff transferred to the local emergency room.

15. During transport, EMS personnel reported that Plaintiff was hysterical, kicking, and screaming. At the emergency room, Plaintiff was given a sedative, at which point medical records indicate that Plaintiff reported that she was "only doing this to get" transferred to a female facility. Plaintiff then refused a medical work up, including a blood test, signed an "against medical authorization" release form, and demanded to be sent back to the facility.

16. Upon her return to Harnett CI, Plaintiff denied any suicidal ideation. Plaintiff was charged with multiple serious prison disciplinary offenses. She pled guilty to the charge of possession of a substance and the other charges were dismissed.

Incident on August 6, 2019 (Warren C.I.)

17. On August 6, 2019, Plaintiff was again sent to the local emergency room after she was found in her bunk unresponsive but breathing. Staff at the facility suspected that Plaintiff might have used K2. At the medical unit, Plaintiff appeared to have vomited and reported that her mind was gone. Medical staff ordered her taken to the local emergency room.

18. Records indicate that at the local emergency room, Plaintiff reported that she was more stressed than normal, and connected that stress to an impending transfer to a female facility. The hospital staff assumed that Plaintiff passed out after an episode of nausea and vomiting and discharged her back to the facility after evaluation.

19. Upon her return from the emergency room, Plaintiff threatened to harm because she did not want to be placed in restrictive housing for investigation of her suspected use of K2. As a result of those threats, Plaintiff was placed on self-injurious behavior precautions. Plaintiff was taken off self-injurious behavior precautions the next day, after she reported that she had a breakdown due to her impending transfer, attributed her increased emotionality to her “hormones,” and affirmed that she never attempted suicide and values her life.

20. On August 15, 2019, Plaintiff was transferred from Warren CI, a male facility, to Anson CI, a female facility.

Incident of December 8 – 11, 2020 (Anson C.I. and NCCIW)

21. On December 8, 2020, Plaintiff was placed in restrictive housing at Anson CI after an apparent assault on another incarcerated person.

22. On December 11, 2020, Plaintiff was sent to the inpatient mental health unit at NCCIW following a voluntary transfer form executed by Plaintiff and one of her mental health providers. Plaintiff reported that she felt bad and was trying to mutilate herself. Plaintiff’s mental health provider noted that a recent episode had increased Plaintiff’s dysphoria, which has been getting worse since August. Plaintiff reported isolating from others and having thoughts of self-harm.

23. Within one day of being admitted to the inpatient mental health unit, Plaintiff denied thoughts of self-harm. Suicide watch was discontinued on December 14, 2020. Plaintiff remained in the inpatient unit until December 30, 2020, during which time, her medical records contain no reports of distress. Plaintiff described her major stressor as feeling bullied by staff and other inmates at Anson.

24. When Plaintiff learned that she would be sent back to Anson CI because she was not an appropriate candidate for long term admission into the inpatient mental health unit, she then began to threaten to kill herself if she was transferred back to Anson CI. Plaintiff articulated her desire to remain at NCCIW or be transferred to a different male facility rather than go back to Anson CI. Plaintiff repeatedly threatened self-harm if she was forced to go back to Anson CI. Plaintiff was transferred back to Anson CI on January 5, 2021. There is no record that Plaintiff attempted to harm herself upon her return to Anson CI.

25. To the best of my knowledge and information, there are no custody or operational records indicating that Plaintiff has attempted to mutilate her genitals or harm herself in any other manner.

Pursuant to 28 U.S.C. § 1746, I declare that the foregoing is true and correct.

This the 14 day of July, 2022.


Christina Mingo
Security Specialist

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
No. 3:22-CV-0191-MOC-DCK

KANAUTICA ZAYRE-BROWN,)	
)	
Plaintiff,)	
)	
v.	)	AFFIDAVIT OF
	)	MIRANDA RICHARDSON
THE NORTH CAROLINA DEPARTMENT)	
OF PUBLIC SAFETY, et al.,)	
)	
Defendants.)	

I, Miranda Richardson, am an adult over the age of 18 years, have never been judged incompetent, and testify to the following based on my personal knowledge and expertise.

1. I make this affidavit of my own free will, stating facts of which I have personal knowledge, except as to those matters stated herein upon information and belief, and as to those, I believe them to be true.

2. I serve as the warden of Anson Correctional Institution, a correctional facility administered by the North Carolina Department of Public Safety, Division of Adult Corrections.

3. I have been a warden for eight years and more specifically have been the warden at Anson C.I. since October 2018. I have worked for the Department of Public Safety as a correctional professional for 28 years.

4. Kanautica Zayre-Brown was transferred to Anson C.I. from Warren C.I. on August 15, 2019. When she arrived, I had concerns regarding how she would be accepted by the female population given her transgender status and the publicity related to her transfer from a male facility. I met with Zayre-Brown immediately upon her arrival to discuss her expectations as well as the

facility's expectations of her. Zayre-Brown integrated into the female population here at Anson without any notable incident and she has been broadly accepted by her peers and by the staff.

5. She has accessed available programming and participated in social opportunities, including serving as emcee at the offender talent show. She has made friends, she is civil and social, and she appears to have integrated well. As far as housing, programming, and privileges are concerned, she is treated exactly like any other female offender in terms of daily management.

6. Zayre-Brown was advised upon her arrival, and has been told on many occasions since, that if she has difficulties with staff regarding her transgender identity, such as being misgendered or misnamed, she is to respectfully correct the staff and, if the behavior continues, to let us know so that it can be addressed. She has followed this process as directed and, in the nearly three years since she arrived at this facility, two staff have been informally counselled to correct their communications with her.

7. Overall Zayre-Brown is doing well at Anson C.I. She incurred a disciplinary infraction in December of 2020 for fighting, which resulted in her demotion from Medium Custody to Close Custody, but she has not incurred any infraction since then and has been promoted back to Medium Custody based on her sustained good behavior.

8. I understand that our agency's position is that transgender offenders are to be treated equally to cisgender offenders and that discrimination, harassment, or retaliation will not be tolerated. I agree with this position. Our facility discusses transgender management issues on a regular basis at staff line-up prior to shifts and during administrative meetings. Issues discussed include the importance of avoiding misnaming and misgendering. Training on transgender issues is available through the LMS system and mandatory transgender training is periodically required of all staff.

9. I take seriously any report of retaliation, harassment, or discrimination received from an offender. Such reports are promptly investigated and, if valid, they are immediately addressed and the corrective action is documented.

10. To date, while housed at Anson, Plaintiff did not report any instances of physical or sexual assault by other incarcerated persons or staff.

11. To my knowledge there are more than 20 transgender offenders currently housed at Anson C.I. The vast majority of them are doing well, including Ms. Zayre-Brown. I strive to treat all offenders with respect and consideration without regard to gender identity and I expect my staff to do the same.

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9. I take seriously any report of retaliation, harassment, or discrimination received from an offender. Such reports are promptly investigated and, if valid, they are immediately addressed and the corrective action is documented.

10. To date, while housed at Anson, Plaintiff did not report any instances of physical or sexual assault by other incarcerated persons or staff.

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Pursuant to 28 U.S.C. § 1746, I declare that the foregoing is true and correct.

This the 15 day of July, 2022.


MIRANDA RICHARDSON, WARDEN

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

No. 3:22-CV-0191-MOC-DCK

KANAUTICA ZAYRE-BROWN,)
)
Plaintiff,)
)
v.)
)
THE NORTH CAROLINA DEPARTMENT)
OF PUBLIC SAFETY, et al.,)
)
Defendants.)
)

AFFIDAVIT OF
GARY JUNKER, Ph.D.

I, Gary Junker, Ph.D., am an adult over the age of 18 years, have never been judged incompetent, and testify to the following based on my personal knowledge and expertise.

1. I make this affidavit of my own free will, stating facts of which I have personal knowledge, except as to those matters stated herein upon information and belief, and as to those, I believe them to be true.

2. I serve as the Director of Health and Wellness for the North Carolina Department of Public Safety, Division of Adult Corrections, Prisons Section. I have held this position for two years.

3. Prior to this I was the Behavioral Health Director for the North Carolina Department of Public Safety, Division of Adult Corrections, Prisons Section beginning in September 2015.

4. Prior to coming to work for the Department of Public Safety, I was employed as Regional Clinical Director on contract for the Tennessee Department of Correction.

5. Preceding this assignment, I worked in multiple capacities within the Federal Bureau of Prisons over the course of a 24-year career. I retired from the FBOP as the Chief Psychologist at the Federal Correctional Complex in Butner, NC. I have specialized in behavior health and healthcare administration and practice in corrections for 32 years.

Transgender Offender Management at DPS-Prisons

6. The *Evaluation and Management of Transgender Offenders* policy (E.4300) was created by a multidisciplinary committee in 2017-2018. I was the lead policy developer along with a team of clinical and operational staff. This policy was drafted by referencing a recently released transgender policy in the Federal Bureau of Prisons. Policies from other state correctional systems were also reviewed in addition to guidance from the World Professional Association for Transgender Health (WPATH). The *Evaluation and Management of Transgender Offenders* policy has been modified over the past five years to keep current within a rapidly changing field.

7. During 2019, NCDPS leadership staff travelled to Illinois and Massachusetts to meet with state correctional officials and to review transgender management in those jurisdictions. At that time, I was Chair of the Division Transgender Accommodation Review Committee (D-TARC). Recommendations from those visits were incorporated into the North Carolina protocol for transgender management. In late 2019, I was assigned as interim Director of Health and Wellness and in April 2020 was permanently placed in this position. As of February 2020, an interim Behavioral Health Director was named who then assumed direct responsibility for transgender management.

8. The *Evaluation and Management of Transgender Offenders* policy stipulates that each facility will have a transgender accommodation review committee (F-TARC). When an offender requests a transgender accommodation, that request is brought to the attention of the F-

TARC chair, typically a facility behavioral health staff person. The F-TARC is comprised of a multidisciplinary team including behavioral health, nursing, operations, and the facility PREA compliance manager. The F-TARC has autonomy to grant accommodations that are stipulated in policy as routine. Examples of routine accommodations include gender consistent underclothes, private showering, canteen items and continuation of hormone replacement therapy with a valid prescription. After F-TARC review and approval, routine accommodations granted will typically be communicated to the offender by a behavioral health staff person and documented in the electronic health record.

9. When an offender requests a non-routine accommodation such as medical procedures or gender-consistent housing, these requests are reviewed by the F-TARC and then forwarded with recommendations to the Division Transgender Accommodation Review Committee (D-TARC). The D-TARC is comprised of the Director of Behavioral Health, Chief Medical Officer, Chief Nursing Officer, Chief Psychiatrist, PREA Director, Director of Rehabilitation, Director of Operations and Director of Healthcare Administration. The D-TARC meets on a quarterly basis to review all referrals for non-routine accommodation. All decisions reached by the D-TARC concerning non-routine accommodations are reviewed by the Director of Health and Wellness and the Deputy Commissioner of Prisons. All D-TARC decisions are documented in the electronic health record and communicated to the offender.

10. North Carolina prisons' policy and practice for managing transgender offenders has evolved deliberately and thoughtfully over the past five years. To remain current, prisons' healthcare staff have frequently engaged with transgender specialists at the University of North Carolina for consultation and educational purposes. As a result, the North Carolina transgender care model exceeds procedures provided in many other correctional systems in the United States.

11. Presently, the members of the DTARC committee are listed below. Most, if not all, of these professionals participated in a UNC Transhealth Training Webinar in October 2021.

- Lewis “Jon” Peiper, PhD, Chair. Dr. Peiper is NCPDS-Prisons Behavioral Health Director and a licensed psychologist who has 13 years’ experience in correctional healthcare.
- Arthur L Campbell III, MD. Dr. Campbell is NCDPS-Prisons Chief Medical Officer. He is board-certified in Family Medicine and is a former U.S. Army flight surgeon. Dr. Campbell has 25 years in the practice of medicine and two years of prison healthcare experience.
- Terri Catlett. Ms. Catlett is NCDPS-Prisons Director of Healthcare Administration. Ms. Catlett has been a Physician Assistant since 1986 and has over 32 years’ experience working in correctional healthcare and correctional healthcare administration. Ms. Catlett attended the NCDPS training for the DTARC conducted by Katherine Croft, UNC Transgender Health Program Manager. She has also attended several ACA trainings and CCHA trainings specifically targeting the management of transgender offenders.
- Valerie Langley, RN. Ms. Langley is a Registered Nurse and the NCDPS-Prisons Director of Nursing. She has been licensed to practice nursing for 27 years and has 26 years’ experience working in correctional nursing and correctional nursing administration.
- Abhay Agarwal, MD. Dr. Agarwal is NCDPS-Prisons Deputy Medical Director. He is board-certified in Internal Medicine. Dr. Agarwal has 24 years in the practice of medicine and 24 years of prison healthcare experience.
- Brian Sheitman, MD. Dr. Sheitman is NCDPS-Prisons Chief Psychiatrist. He is board-certified in psychiatry and has over 30 years’ experience as a psychiatrist. He has worked

in the field of corrections since 2015 and has been an Adjunct Professor of Psychiatry at UNC Chapel Hill since 2018.

- Charlotte Jordan Williams. Ms. Williams is NCDPS PREA Director. She has worked 23 years in the field of corrections, 15 years specializing in PREA issues. Ms. Williams has been a member of the national PREA Coordinator's Working Group Board since 2020.
- Joshua Panter. Mr. Panter is the Director of Operations for NCDPS-Prisons. Mr. Panter has 22 years of experience in the field of corrections. He has attended annual PREA trainings on “Understanding the LGBTI Offender” and “Sexual Abuse and Sexual Harassment 101” since the trainings were introduced.
- Sarah Cobb. Ms. Cobb is the Director of Rehabilitative Services for NCDPS-Prisons. She has over 29 years’ experience in the field of corrections, with a focus on programs and rehabilitation.

12. There are currently 128 individuals who have self-identified as either transgender (120) or intersex (8) in the North Carolina state prison system. These 128 individuals are housed across 34 different facilities.

Management of Ms. Zayre-Brown

13. When Plaintiff entered custody, she was not presently on hormone replacement therapy (“HRT”). (MR 2002.) Under the then applicable policy, Plaintiff initiated her request to begin HRT on December 21, 2017. (MR 2572.) Plaintiff’s request for HRT was ultimately approved and she began HRT on June 29, 2018. (MR 2322.) Plaintiff continues to receive HRT and regularly meets with an endocrinologist who monitors her hormone levels and manages the HRT.

14. Upon information and belief, Plaintiff first requested transfer to a female facility on January 11, 2019. The facility F-TARC denied this request and, per policy, it was forwarded to the D-TARC for further consideration. Because such a housing assignment had never been made, the Department had to study the issue, take various factors into consideration, and determine how best to proceed in light of operational concerns. Ultimately, it was decided to transfer Plaintiff to a female facility and she was transferred to an all-female unit at Anson on August 15, 2019.

15. Plaintiff has been on Prisons' mental health caseload since November 11, 2017. She has had access to mental and behavioral health services at every facility in which she has been housed. As a patient on the mental health caseload, Plaintiff sees a licensed mental health provider at least once every 45 days, and more frequently if needed. Plaintiff has also had access to, and on occasion has utilized, emergency mental health services.

16. Making an informed and well-considered determination on the type of request at issue in this litigation takes time and consideration from many Department stakeholders. The DTARC includes individuals holding high-level medical, behavioral health, operational, and administrative positions throughout the Department. All committee members have fulltime responsibilities and duties in addition to the work the DTARC presents. When the DTARC meets, it reviews and considers accommodation requests from multiple incarcerated individuals. Decision-making in every case requires due a significant investment of time and resources from every member, who is required to make the best decision possible in every case, taking into account the best interests of the incarcerated person in light of the operational need to ensure safety and good order within all adult correctional facilities.

17. On March 28, 2022, I met with Assistant Commissioner Harris to discuss three cases forwarded to us from a recent DTARC meeting. This is consistent with Policy & Procedure

F.4300, which states that “All accommodation requests for surgical intervention or gender-identity consistent facility transfer shall be reviewed by the Division TARC with recommendations referred to the Assistant Commissioner of Prisons and Director of Health & Wellness Services for review and determination.”

18. One of the cases reviewed on March 28th involved an accommodation request from Plaintiff. Plaintiff requested gender affirmation surgery and specifically a vulvoplasty procedure. In preparation for my meeting with Commissioner Harris, I reviewed documentation related to the case, including but not limited to the DTARC’s written recommendation, which is attached hereto as Exhibit A.

19. Assistant Commissioner Harris and I met and reviewed the case documentation in order to reacquaint ourselves with specifics of this case. We reviewed and discussed the DTARC recommendation in detail. After review and discussion, Assistant Commissioner Harris and I agreed that the requested accommodation should not be supported.

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Pursuant to 28 U.S.C. § 1746, I declare that the foregoing is true and correct.

This the 15 day of July, 2022.


GARY JUNKER, Ph.D.

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Division Transgender Accommodation Review Committee (TARC) Report

Offender Name: [REDACTED] (Kanautica Zayre-Brown)

OPUS Number: 0618705

Facility TARC Date: review by DTARC

Division TARC Date: 2/17/2022

Names and Titles of TARC Members Present: Dr. Lewis Peiper, Behavioral Health Director; Dr. Arthur Campbell, Chief Medical Officer;
Dr. Brian Sheitman, Chief of Psychiatry; Terri Catlett, Dir. Health Services Admin; Charlotte Williams, PREA Director; Sarah Cobb, Dir. Rehabilitative Svcs;
Josh Panter, Director of Operations

Transgender Accommodation Request(s) Under Review: Gender Affirmation Surgery/ Vulvoplasty

Approved Accommodation(s): _____

Accommodation(s) Not Approved and Rationale: _____

Accommodation(s) Referred for Final Determination: DTARC does not recommend Gender Affirmation surgery. This surgery is not medically necessary.

Other: _____

Final Determination of Referred Accommodation(s)

The Deputy Commissioner and Director of Health and Wellness reviewed documents related to this accommodation request. After review and discussion we concur with the DTARC recommendation. The requested accommodation is not supported.

Scan Type: "TARC/Division Report."
Attach: "Division Transgender Accommodation Committee Report."

This form is not to be amended, revised, or altered without approval of the Behavioral Health Documentation Committee.
DC – 411D (05/20)

**North Carolina Department of Public Safety
Division Transgender Accommodation Committee Report**

Offender Name:	██████████	Off #:	0618705
Date of Birth:	██████████ 1981	Sex:	F
Date:	04/26/2022 12:00	Facility:	ANSO
		Provider:	Peiper, Lewis J Ph.D Dir. of

Comment

The following note is a summary of related input and considerations from the 2/17/2022 Division Transgender Accommodation Review Committee and concludes with a medical analysis from the Division of Prisons Medical Authority related to ██████████ (Kanautica Zayre-Brown, 0618705), referred to as Offender Brown and/or patient below with she/her pronouns used where applicable.

Offender Brown was admitted to prison 10/10/2017 with a current projected release date of 11/2/2024. She is currently housed at Anson CI where she was transferred from Warren CI on 8/15/2019. Offender Brown is currently assigned to Medium Custody after being promoted from Close Custody on 1/4/2022.

In response to Offender Brown's request for vaginoplasty or vulvoplasty surgery, the DTARC recommended receiving a consult from a surgical specialist experienced in performing vaginoplasty surgeries to obtain information to further evaluate treatment options and proposed course going forward. Offender Brown participated in a telehealth appointment with Kristia Vasilof from the UNC Transhealth Program as part of the initial review for consult and Katherine Croft (UNC Transhealth Program Manager) completed a telehealth consult with Offender Brown as part of the planned surgical consult with the UNC Transhealth program. An in-person consultation with Dr. Figler from the UNC Transhealth Program on 7/12/2021 indicated the patient's desire for vulvoplasty (versus vaginoplasty) and the need for weight loss from the recorded weight of 288 at the time down to a maximum of 250 with an identified weight goal of 210.

DTARC Review 2/17/2022:

Offender Brown has maintained the minimum weight goal identified by the UNC Transhealth program. Weight has been below 240 since 11/15/2021 and at the time of the DTARC was most recently (2/11) at 236. Patient is now eligible for review related to DTARC recommendation on requested vulvoplasty surgery.

Review of patient's related mental health and behavioral health record, and the baseline criteria identified by UNC Transhealth Program could make her a candidate for surgery. The patient has a well-documented, persistent transgender identity with a desire for "bottom surgery." The patient has been educated on the surgical interventions by the UNC Transhealth Program and identified a preference for a vulvoplasty if performed. The patient had completed other gender-affirming surgeries (orchiectomy, breast implants) prior to incarceration and has been on hormone replacement therapy since 2012. Mental health and behavioral health case reviews indicated no current evidence of any significant comorbid mental health issues. Patient continues to demonstrate emotional and psychological stability with evidence of adequate coping skills. The patient's mood and anxiety symptoms appear well-controlled by psychiatric interventions, however, recent progress notes from supportive counseling and therapy sessions indicate the patient has been heavily focused on the status of the final decision regarding her requested/desired surgery and experiencing related anxiety/frustrated mood.

Offender Brown has been housed in a female prison since 8/2019 and her adjustment to being housed in a female prison has been generally acceptable apart from a period of time in the fall / winter of 2020 related to reports of this offender having engaged in assaultive and extortive behavior against female offenders. Although she has largely adapted well to her current facility assignment, continued vigilance is necessary in order to ensure the offender's continued stability and to protect other offenders.

MEDICAL ANALYSIS:

This offender has received and continues to receive extensive treatment while incarcerated. As with all treatments in medicine, ongoing re-evaluations are conducted and regimens adjusted based on the clinical course, with further interventions based on findings from those reevaluations.

Medical analysis for this case included a comprehensive review of the offender's medical and behavioral health history, as well as a comprehensive literature review. When treatments are considered for any patient, the most important imperative for physicians is to base recommendations on evidence-based medicine and consideration of that information in the context of the individual patient. Although the offender has clearly communicated a desire for further

Offender Name: [REDACTED] Off #: 0618705
Date of Birth: [REDACTED] 1981 Sex: F Facility: ANSO
Date: 04/26/2022 12:00 Provider: Peiper, Lewis J Ph.D Dir. of

gender-affirming surgery, there is insufficient medical evidence to indicate such a complex and irreversible surgical intervention is medically necessary for her at this time.

Based on this review, it is the determination of the medical authority that gender reassignment surgery (GRS) as requested by this offender is not medically necessary.

Co-Pay Required: No **Cosign Required:** No
Telephone/Verbal Order: No
Standing Order: No

Completed by Peiper, Lewis J Ph.D Dir. of Beh. Health on 04/26/2022 12:12
Requested to be reviewed by Dula, Jennifer L MSW Clinical Social Worker.
Review documentation will be displayed on the following page.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
No. 3:22-CV-0191-MOC-DCK

KANAUTICA ZAYRE-BROWN,)	
)	
Plaintiff,)	
	)	AFFIDAVIT OF SARA BOYD, PH.D.,
v.	)	IN SUPPORT OF DEFENDANTS’
	)	RESPONSE TO PLAINTIFF’S
THE NORTH CAROLINA DEPARTMENT	)	MOTION FOR PRELIMINARY
OF PUBLIC SAFETY, et al.,	)	INJUNCTION
)	
Defendants.)	

I, Sara Boyd, Ph.D., ABPP, hereby declare the following:

1. I am a licensed clinical psychologist with experience conducting forensic mental health assessments of transgender and gender diverse people in correctional settings. As a psychologist specializing in forensic mental health assessments, I have conducted dozens of evaluations of incarcerated people housed in state and federal prisons and jails. I am familiar with procedures that departments of corrections use to assess and make determinations regarding gender-affirming treatment needs of transgender and gender diverse incarcerated people. I have conducted independent psychological evaluations related to gender-affirming care for incarcerated individuals at the request of correctional officials. I am also the co-author of a book chapter (in press) concerning psychological evaluation, management, and treatment of transgender and gender diverse people housed in correctional settings.

2. Additionally, I am a diplomate of the American Board of Professional Psychology, for the Forensic Specialty. This board-certification requires credential review, a written exam, work sample review, and a three hour-duration oral defense of work samples, in addition to ensuring that the candidate has not engaged in serious ethical and/or legal misconduct. This board

certification is one of the two post-doctoral specialty certifications recognized by the American Psychological Association Directory.

3. My qualifications and experienced are further detailed in my curriculum vita, which is attached to this declaration as Exhibit A.

4. I have not had an opportunity to personally examine the Plaintiff, Kanautica Zayre-Brown, as of the date of this declaration. However, I have reviewed her motion for preliminary injunction in case number 3:22-cv-00191, as well as the North Carolina Department of Public Safety's records for the Plaintiff. I also reviewed the declaration of Randi C. Ettner, Ph.D., which the Plaintiff included in support of her motion for preliminary injunction.

5. All statements herein are based on my education, training, and experience. Additionally, any conclusions or opinions stated herein are based upon my years of education, training, and professional experience, as well as my review of the Plaintiff's medical and mental health records, and are stated to a reasonable degree of psychological and mental health certainty.

6. It appears that Dr. Ettner personally examined the Plaintiff. In her declaration, Dr. Ettner provides information and opinions regarding a brief and recent general history of medical gender-affirming interventions, the World Professional Association for Transgender Health (WPATH) standards of care, the Plaintiff's personal history of gender-related treatment, the adequacy of treatment provided by the North Carolina Department of Public Safety to the Plaintiff, and the Plaintiff's need for surgery.

7. There were several evaluation tasks, which I expected to see referenced in Dr. Ettner's declaration, that were either not undertaken or not described in the declaration. For example, it does not appear that Dr. Ettner probed issues related to informed consent in detail, nor did Dr. Ettner conduct collateral interviews of treatment providers, family members, friends, or

other individuals who could provide observations of the Plaintiff's history, symptoms, and response to prior interventions. Likewise, Dr. Ettner did not identify what the Plaintiff's expectancies are regarding her options for medical intervention, especially her expectancies and considerations related to choosing vulvoplasty rather than vaginoplasty. Dr. Ettner did not describe how the Plaintiff had approached earlier surgical interventions in terms of her expectancies, costs and benefits, and why earlier surgical intervention proved to be inadequate for substantially mitigating her gender dysphoria symptoms.

8. This case is somewhat unusual in that the Plaintiff is relatively close to her release date, which I understand to be November 2, 2024.¹ This means that surgical interventions undertaken now could have significant implications for her ability to transition from the correctional environment to community-based care, particularly if she experiences surgical complications (as her records indicate that she did after her earlier orchiectomy surgery). Dr. Ettner does not address this factor or its possible implications.

9. Of particular significance was the absence of any discussion in Dr. Ettner's declaration of how the choice of pursuing a vulvoplasty over a vaginoplasty could have implications for the Plaintiff's ability to complete any additional surgeries in the future. This is significant because pursuing additional surgeries is something the Plaintiff's records indicate she desires.

10. The Plaintiff's records indicate that she initially requested a vaginoplasty. However, during a meeting with a nurse from the University of North Carolina Transgender Health Program, the Plaintiff opted to pursue a vulvoplasty instead. Importantly, the record from this

¹ This information is publicly available at <https://www.ncdps.gov/dps-services/crime-data/offender-search>.

meeting suggests that the choice of the vulvoplasty was not made because she believed the vulvoplasty would sufficiently alleviate her gender dysphoria, but rather because the vulvoplasty would entail less post-operative care, as compared to vaginoplasty. Additionally, during the same meeting with the nurse from the Transgender Health Program, the Plaintiff inquired about the possibility of pursuing additional surgery to create a vaginal canal after a vulvoplasty. The nurse advised her that while doing so is more difficult, operative techniques, such as robotic vaginoplasty, are available for revision at a later time. The Plaintiff also reported to one of her healthcare providers that as between the two procedures she would likely choose the vulvoplasty because she believed she could get the procedure done sooner.

11. Dr. Ettner's declaration does not contain any discussion of the potential implications of the Plaintiff choosing what appears to be her less preferred option now while intending to pursue her ultimate goal at a later date.

12. The Plaintiff's records also reflect two incidents in 2019, during which she was sent to the local emergency room following some type of crisis episode. Records indicated that correctional staff speculated that these episodes might be due to illicit drug use, specifically K2. However, the information to support this explanation was sparse in that there were no positive drug test results or contraband recovered that would shed light on (a) the likelihood that these episodes were the result of intoxication versus some other mental health issue, or (b) the type of substance, if any, that the Plaintiff ingested.

13. In any event, whether or not the episodes were caused by illicit drug use or some other cause, the records indicate that both events involved significant emotional distress for the Plaintiff, and could indicate additional contributory causes or at least exacerbating factors for the psychological symptoms that Dr. Ettner attributes exclusively to Gender Dysphoria. In the event

that the Plaintiff does have co-occurring mental health conditions, this is not necessarily a barrier for her to receive treatment. But if the objective of mental health and medical treatment for the Plaintiff is to alleviate acute mental health distress, it will be vital to ensure that the contributing causes and major sources of exacerbation are identified.

14. Dr. Ettner's report did not discuss these significant crisis events in detail and so it is not clear that Dr. Ettner considered these crisis events.

15. In the declaration, Dr. Ettner did not discuss relative benefits or disadvantages of pursuing the vulvoplasty (or as an additional option, vaginoplasty) in the community versus while incarcerated. Again, given the relatively short amount time remaining on her sentence and the potential implications of proceeding with the vulvoplasty now, while in custody, as opposed to that procedure or even what appears to be her preferred option, the vaginoplasty, after she returns to the community, the absence of such a discussion is notable.

16. Even aside from these considerations such as post-operative care, the Plaintiff's records include numerous comments about her experiences with being rejected, mistreated, and misgendered by other individuals in the prison setting. It also appears that her transfer to a female facility evidently worsened some of these issues, and she appeared to be experiencing increased distress while at the female facility, to the degree that she discussed transferring back to a male facility. Correctional facilities are one of the most sex-segregated settings in the United States, and this segregation can evoke more intense feelings of gender dysphoria even when the person is placed in a facility that matches their gender. Mixed gender community settings, particularly those where the Plaintiff has more opportunity to seek support, information, and guidance from other transgender and gender diverse people who have undergone similar procedures, potentially offers significant psychosocial advantages for amelioration of the Plaintiff's gender dysphoria as well as

access to more supportive social engagement (compared with a correctional setting). Surgery cannot reasonably be expected to have any impact on these sorts of factors.

17. Again, it is not evident in Dr. Ettner's report that these factors were considered or reviewed as part of an informed consent assessment.

18. Lastly, I would note that Dr. Ettner offered opinions regarding the adequacy of interventions offered to the Plaintiff by the North Carolina Department of Public Safety. Records do indicate that these interventions include hormone replacement therapy, mental health therapy, medications, a transfer to a female facility, and access to various other non-medical affirming items. While the records indicate that there may have been interruptions to certain aspects of the Plaintiff non-surgical affirming care, and that some requests were denied, it is my understanding that the quality of the past treatment is not presently at issue in the Plaintiff request for a preliminary injunction.

19. Thus, it is noteworthy that Dr. Ettner does not explain how the Plaintiff's past non-surgical affirming care, including any interruptions or denials factors into the Plaintiff's need for this particular surgical intervention, at this particular time, in this particular setting.

20. It is my opinion that a comprehensive evaluation in this context should include a thorough exploration of informed consent (with an emphasis on the patient's expectations of the potential impact of a given intervention), collateral interviews, an assessment of possible contributory causes or at least exacerbating factors of psychology distress, and considerations of factors which are unique to the setting in which the intervention is to be provided. As discussed above, Dr. Ettner's declaration does not indicate that such evaluative tasks were performed. The absence of these tasks and relevant information indicates that Dr. Ettner has an insufficient basis to offer the assertion that undergoing a vulvoplasty would cure the Plaintiff's gender dysphoria.

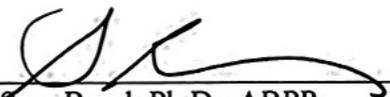
21. Accordingly, based on my review of the materials referenced above, my education, training, and professional experience, it is my opinion that Dr. Ettner's declaration fails to describe and evaluate several major factors which I believe to be critical to assessing the adequacy of a given intervention for the Plaintiff, at this time, in her current setting.

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SIGNATURE PAGE TO FOLLOW

Pursuant to 28 U.S.C. § 1746, I declare that the foregoing is true and correct.

This the 15th day of July, 2022.


Sara Boyd, Ph.D., ABPP



Sara Boyd, Ph.D. Licensed Clinical Psychologist

ph: 571.317.0979 | fax: 844.598.6534

*Institute of Law, Psychiatry, & Public Policy at the University of Virginia, &
Boyd Forensic Psychology Services, LLC*

EDUCATION

Graduate:

Doctor of Philosophy, Clinical Psychology, University of Kentucky, August 2013.

Master of Science, Clinical Psychology, University of Kentucky, 2010.

Master of Science, Counseling Psychology, University of Kentucky, 2005.

Certificate in Developmental Disabilities, University of Kentucky, 2005.

Undergraduate:

Bachelor of Science, Psychology, University of Illinois, May 2003.

PROFESSIONAL LICENSES & CREDENTIALS

Diplomate, American Board of Professional Psychology (ABPP), Forensic Specialty, November 2019 to present. Diploma no. 9023

Licensed Clinical Psychologist, Virginia Department of Health Professionals, July 3, 2014 to present. License number: 0810005036

Licensed Clinical Psychologist, District of Columbia Department of Health Professional Licensing, February 10, 2015 to present. License number: PSY1001030

Licensed Clinical Psychologist, West Virginia Board of Examiners of Psychologists, August 24, 2016 to present. License no. 1149

Licensed Psychologist, Kentucky Board of Examiners of Psychologists, October 20, 2020 to present. License no. 251807

National Register Health Psychologist #54431

CLINICAL EXPERIENCE & EMPLOYMENT

Institute of Law, Psychiatry, and Public Policy, University of Virginia Health System, Licensed Clinical Psychologist/Forensic Evaluator. Charlottesville, Virginia. June 2016 to Present.

Providing forensic evaluation and consultation in adult and juvenile criminal and civil matters. Supervising postdoctoral fellows and graduate students, and developing/presenting professional trainings for forensic evaluators and attorneys.

Woodbridge Psychological Associates, P.C., Licensed Clinical Psychologist, Woodbridge, Virginia, September 2014 to June 2016.

Providing forensic evaluation and consultation in adult and juvenile criminal and civil matters.

Institute of Law, Psychiatry, and Public Policy, University of Virginia Health System, Forensic Psychology Postdoctoral Fellow, Charlottesville and Staunton, Virginia, August 2013 to August 2014.

Postdoctoral fellowship consisted of two primary assignments: Western State Hospital, and the Institute of Law, Psychiatry, and Public Policy forensic clinic at the University of Virginia.

Western State Hospital—Virginia Department of Behavioral Health and Developmental Services

- Conducted mental state at the time of offense and competency to stand trial evaluations in an inpatient forensic setting.
- Provide training and consultation on intellectual disability, forensic, domestic/sexual violence, and LGBTQ-related topics for mental health providers.

Institute of Law, Psychiatry, and Public Policy

- Conducted gender dysphoria evaluations for Virginia Department of Corrections, general psychological evaluations, sex offender risk assessment, violence risk assessment, mental state at the time of offense, and competency to stand trial evaluations in an outpatient forensic clinic.
- Developed and provided training and consultation services to private and public mental health professionals.

Westchester Jewish Community Services, APA-Accredited Internship, Psychology Fellow, Yonkers and Hartsdale, New York, July 2012 to July 2013.

Pre-doctoral Internship at community mental health agency composed of rotations in a treatment and evaluation program for juvenile sex offenders, court assessment program, treatment center for survivors of trauma and abuse, a program for individuals with developmental disabilities (DD), an autism evaluation clinic, and a learning center. Provided consultation to multidisciplinary teams on such matters as psychological assessment, research, and empirically-supported treatment.

Treatment Center for Trauma and Abuse

- Utilized Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Prolonged

Exposure, behavioral activation, and other empirically-based methods to treat child, adolescent, and adult survivors of trauma, sexual and physical abuse, and domestic violence.

- Conducted focal and comprehensive psychological assessments to assist in treatment planning. Provided feedback to clients, families, and clinicians.

Autism Evaluation Program

- Assessed and determined diagnoses of adults and children referred due to suspected Autism Spectrum Disorders (ASDs). Utilized ADOS-2, adaptive functioning, intellectual ability, achievement and neuropsychological measures, in addition to in-depth clinical interview, collateral interviews, and record review.

Developmental Disabilities Program

- Utilized cognitive-behavioral therapy (CBT) and parent management training interventions with children and adults with intellectual and developmental disabilities (ID/DD) and their families.
- Provided diagnostic clarification, crisis management services, and psychotherapy to individuals recently discharged from inpatient settings.
- Co-led a social skills group for 5- and 6-year-old children with ASDs.

Juveniles Starting Over Program

- Conducted risk and safety assessments, including ERASOR, for adjudicated juvenile sex offenders and children and adolescents with sexual behavior problems.
- Provided individual and family therapy to adjudicated juvenile sex offenders and non-adjudicated youth with sexual behavior problems.

Court Assessment Program

- Co-evaluated custody/visitation, termination of parental rights, delinquency, abuse/neglect, and probation cases.
- Co-performed specialized evaluations of juvenile sex offenders.
- Consulted to psychiatrists, judges, court staff, and guardians.
- Conducted brief psychoeducational screenings.

Learning Center

- Conducted comprehensive and focal cognitive, educational, and personality assessments of children, adolescents, and adults.
- Evaluated individuals with potential learning disabilities, executive function deficits,

Attention-Deficit Hyperactivity Disorder (ADHD), and other psychiatric diagnoses.

- Developed comprehensive educational, social, and vocational recommendations as part of an integrative written report, and provided feedback to clients, families, and clinicians.

Bluegrass Mental Health/Mental Retardation Board, Eastern State Hospital, Forensic/Inpatient Psychology Trainee, Lexington, Kentucky, June 2010 to July 2011.

Provided forensic assessments to individuals with serious mental disorders in an inpatient setting. Assisted in evaluations of competency to stand trial and criminal responsibility for misdemeanors and felonies. Consulted to psychologists on forensic cases involving individuals with ID/DD. Administered adjunct malingering and neuropsychological testing for the supervising forensic psychologist. Other rotations included assessment and individual and group therapy on a high-risk unit, geriatric/medically fragile unit, and a day treatment program. Developed special expertise in intervention and testing of dually diagnosed consumers with ID/DD and severe mental illness.

University of Kentucky, Harris Psychological Services Center, Graduate Student Therapist, Lexington, Kentucky, July 2007 to July 2011.

Assessed risk as part of employment screening for weapons-handling personnel at an international security company. Conducted integrative assessments for ADHD and learning disabilities. Provided individual psychotherapy for clients with ASDs, major depression, adjustment disorder, conversion disorder, generalized anxiety disorder, post-traumatic stress disorder, and borderline personality disorder.

University of Kentucky, Harris Psychological Services Center, Social Skills Group Co-Leader, Lexington, Kentucky, September 2008 to December 2008.

Conducted intakes for potential group members, and co-led a manualized skills-based intervention group for children with social impairments. Met with parents to exchange feedback, and conducted pre- and post-intervention behavioral assessments. Group members had ASD and/or anxiety disorders.

University of Kentucky, Harris Psychological Services Center, Assessment Coordinator, Lexington, Kentucky, July 2007 to August 2008.

Responsible for all aspects of outpatient clinic testing. Supervised assessments; performed intakes; participated in administrative meetings to determine the appropriateness and disposition of potential clients; reviewed clinic policies and procedures; researched, identified, and ordered new instruments; engaged in community outreach; and maintained clinic assessment records.

Bluegrass Rape Crisis Center, Crisis Counselor, Lexington, Kentucky, September 2005 to September 2006.

Provided crisis counseling services at a community agency for survivors of sexual assault. Accompanied survivors (including survivors with disabilities) to the local emergency room, provided advocacy and support throughout the medical examination and detectives' questioning, and answered crisis line calls.

Center for Women, Children, and Families, Counseling Psychology Trainee, Lexington, Kentucky, January 2006 to May 2006.

Led psychoeducational groups for adult survivors of domestic violence who had lost custody of their children and were seeking reunification. Conducted intakes and provided individual CBT to children and adults. Diagnoses included Fragile X and other developmental disabilities, post-traumatic stress, adjustment, acute stress, and major depressive disorders.

PROFESSIONAL & COMMUNITY SERVICE ACTIVITIES

Virginia Department of Behavioral Health and Developmental Services, Structured Measures of Intellectual Functioning Review Panel. Commonwealth of Virginia, 2020 to 2021 (death penalty was abolished in Virginia in 2021).

Invited to join the five-member professional panel, selected by the DBHDS Forensic Evaluation Oversight Manager, to provide guidance with regard to updating the list of psychological measure of intellectual functioning for use in death penalty cases in Virginia, as required by § 19.2-264.3:1.1 and 19.2-264.3:1.2.

University of Kentucky, Department of Psychology, Diversity Committee Founding Member, Lexington, Kentucky, February 2012 to August 2012.

Identified need, and assisted in assembling members and faculty support for, a graduate student-led committee to revise departmental policies relating to sexual and gender minority students and Psychology Department clinic clients. Advised faculty and community supervisors regarding training requirements, materials, and procedures. Developed multimedia training materials ultimately implemented in graduate curriculum.

Project SAFE (Safety and Accessibility for Everyone), Coordinator, Frankfort, Kentucky, September 2005 to September 2006.

Created project to increase physical and attitudinal accessibility of domestic violence shelters and rape crisis centers in Kentucky. Identified and invited representatives from state agencies addressing domestic and sexual violence, disability rights, and crime victim advocacy to provide project leadership. Scheduled and led meetings. Project SAFE became an ongoing organization and was awarded a three-year Department of Justice Violence Against Women Act grant for \$750,000 in 2008.

Consumer Advisory Council of Kentucky, Board Member, Frankfort, Kentucky, November 2006 to November 2008.

Assisted in senior level decision-making regarding priorities and policies of the Human Development Institute, with special emphasis on creating an inclusive environment for people with disabilities. Reviewed and provided feedback on Institute research, funding, and grant applications. Monitored organization's compliance with the strategic plan.

RESEARCH EXPERIENCE

Westchester Jewish Community Services, Co-Principal Investigator, "Sexual Knowledge and Attitudes of Adolescents and Young Adults with Developmental Disabilities, Before and After a Psycho-Educational Intervention." White Plains and Hartsdale, New York, July 2012 to July 2013.

Co-originated study concept, developed methodology, identified appropriate assessment instruments, and generated hypotheses for a study examining outcomes for adolescents and young adults with ASDs who participated in a psycho-educational healthy sexuality group.

Variables include sexual knowledge and attitudes, Axis I psychopathology, and intellectual functioning.

University of Kentucky, Principal Investigator, "General Personality, Personality Disorder, Psychopathology, and Adaptive Functioning in Adults with Intellectual Disabilities." Lexington, Kentucky, October 2011 to August 2013.

Wrote literature review, developed study methodology and hypotheses, obtained IRB approval, recruited participants from vulnerable populations, and collected, analyzed, and interpreted data. Dissertation.

University of Kentucky, Co-Investigator, "Gender Identity, Sexual Orientation, and Personality." Lexington, Kentucky, September 2012 to 2013.

This project is comprised of three studies examining the relations among non-normative gender identity, personality, and sexuality. Generated research idea, developed study methodology, obtained IRB approval, and collected, analyzed, and interpreted data for study one. Co-principal investigator: Tory Eisenlohr-Moul, Ph.D.

University of Kentucky, Widiger Personality Laboratory, Graduate Researcher, Lexington, Kentucky, September 2005 to July 2012.

Administered the Personality Disorder Interview-IV and Structured Interview for the Five Factor Model to participants in studies of personality disorders; generated ideas for laboratory research; co-developed methodology for studies of Five Factor Model personality; coded semi-structured interviews for reliability; read and critiqued papers submitted for publication; and identified test items for use in Five Factor Model research. Principal Investigator: Thomas Widiger, Ph.D.

University of Kentucky, Department of Behavioral Sciences, Graduate Research Assistant, Lexington, Kentucky, June 2008 to May 2010.

Collected, analyzed, and interpreted data, co-authored manuscripts, and wrote annual reports for funding sources.

University of Kentucky, Preservice Health Training Project, Research Assistant, Lexington, Kentucky, August 2005 to June 2008.

Assisted in a project evaluating outcomes of online training modules for health professionals serving people with disabilities. Co-authored six manuscripts published in peer-reviewed journals; collected, analyzed, and

interpreted data; co-developed study methodology; and coordinated and edited contributions by co-authors. Principal Investigator: Harold Kleinert, Ed.D.

University of Illinois, Korol Sex Steroids and Behavior Rodent Laboratory, Research Assistant, Lexington, Kentucky, May 2002 to August 2002.

Assisted in a study of rodent spatial navigation strategies, resulting in a *Neuroscience* publication. Performed rodent surgeries, including ovariectomy and cannulae implantation in the striatum and hippocampus, tested rodent behavior, and performed histology on frozen brain tissue. Principal Investigator: Donna Korol, Ph.D.

PUBLICATIONS

Boyd, S. E. (2012). Five Factor Model personality functioning in adults with intellectual disabilities. In T.A. Widiger & P.T. Costa (Eds.), *Personality Disorders and the Five Factor Model of Personality* (3rd ed.) (pp. 209 - 217). Washington, D.C.: American Psychological Association.

Adams, Z., and **Boyd, S.E.** [shared first-authorship] (2010). Ethical challenges in the treatment of individuals with intellectual disabilities. *Ethics and Behavior*, 20, 407-418.

Boyd, S., Sanders, C., Kleinert, H., Huff, M., Lock, S., Johnson, S., et al. (2008). Virtual patient training to improve reproductive healthcare for women with intellectual disabilities. *Journal of Midwifery and Women's Health*, 53, 453-460.

Kleinert, H. K., Fisher, S., Sanders, C., & **Boyd, S.** (2007). Improving physician assistant competencies in developmental disabilities using virtual patient modules. *Journal of Physician Assistant Education*, 18, 33-40.

Kleinert, H. K., Sanders, C. B., Mink, J., Nash, D., Johnson, J., **Boyd, S.**, et al. (2007). Improving student dentist competencies and comfort in delivering care to children with developmental disabilities using a virtual patient module. *Journal of Dental Education*, 71, 279-286.

Knudsen, H. K., Studts, J. L., **Boyd, S. E.**, & Roman, P. M. (2010). Structural and cultural barriers to the adoption of smoking cessation services in addiction treatment organizations. *Journal of Addictive Diseases*, 29, 294-305.

Knudsen, H. K., **Boyd, S. E.**, Studts, J. L. (2010). Substance abuse treatment counselors and tobacco use: a comparison of comprehensive and indoor-only smoking bans. *Nicotine and Tobacco Research*, 12, 1151-1155.

Sanders, C. L., Kleinert, H. K., Free, T. F., Slusher, I., Clevenger, K., Johnson, S., **Boyd, S. E.** (2007). Caring for children with intellectual and developmental disabilities: Virtual patient instruction improves students' knowledge and comfort level. *Journal of Pediatric Nursing*, 22, 457-466.

Sanders, C. L., Kleinert, H. K., Free, T. F., Slusher, I., Clevenger, K., **Boyd, S.**, et al. (2007). Caring for children with intellectual and developmental disabilities: Virtual patient instruction improves students' knowledge and comfort level. *Journal of Pediatric Nursing*, 22, 457-466.

Sanders, C. L., Kleinert, H. K., **Boyd, S. E.** Herren, C., Theiss, L., & Mink, J. (2008). Virtual patient instruction for dental students: can it improve dental care access for persons with special needs? *Special Care Dentistry*, 28, 205-213.

Sanders, C. L., Kleinert, H. K., Free, T. F., Slusher, I., Clevenger, K., **Boyd, S.**, et al. (2008). Developmental disabilities: improving competence in care using virtual patients. *Journal of Nursing Education*, 47, 66-73.

Widiger, T. A., & **Boyd, S.** (2009). Personality disorder assessment instruments. In J. N. Butcher (Ed.), *Oxford handbook of personality assessment (3rd ed.)*(pp. 336-363). New York: Oxford University Press.

Zurkovsky, L., Brown, S. L., **Boyd, S.**, & Korol, D. L. (2007). Estrogen modulates learning in female rats by acting directly at distinct memory systems. *Neuroscience*, 144, 26-37.

TEACHING & TRAINING EXPERIENCE

Conducting Forensic Mental Health Evaluations with Individuals Who Are Transgender or Gender Non-Conforming. Part 1: December 10, 2020, Part 2: April 9, 2021.

One of four presenters describing basic information about individuals who are transgender and gender non-conforming in the criminal justice context, ethical considerations, example language and queries for taking a gender development history, relevant case law, and referral considerations. Attendees were mental health professionals.

Capital Area Immigrants' Rights (CAIR) Coalition, Detained Children's Program webinar presenter: Detention Conditions, Health Impact of Detention on Children, & Legal Issues of Children's Detention.

Washington, DC, July 2019.

One of three presenters providing overviews of legal, health, and psychological realities and risks for immigrant children in detention. Webinar attendees were stakeholders and grant foundations.

University of Virginia Health Services, Panelist: How Experience Might Inform Ethical Practice. Transgender Youth and Systems-Level Reforms for Girls. Charlottesville, VA, April 2019.

One of three panelists reviewing potential ethical considerations, and responding to training participant questions, regarding forensic assessment of transgender and gender non-conforming individuals.

District of Columbia Department of Behavioral Health, Training Presenter. Washington, D.C., December 2018.

Developed training materials and presented on the topic of adjudicative competency restoration for adults with Intellectual Disabilities.

National Legal Aid & Defender Association Presenter. Philadelphia, PA, June 2018.

Developed training materials, and co-presented with Joette James, Ph.D., as well as presenting (solo) regarding accommodations-related assessments for defendants with cognitive and psychiatric disabilities, and about psychopathy and Antisocial Personality Disorder, respectively.

Georgetown Juvenile Justice Initiative and National Juvenile Defender Center Symposium: Race and Juvenile Justice 50 Years after Gault Presenter/Panelist. Washington, D.C., May 2017.

Co-panelist with Daniel Murrie, Ph.D., for discussion of race and risk assessment of juveniles.

Georgetown Juvenile Justice Center Presenter. November 2016.

Developed and presented a training for public defenders regarding common errors in risk assessment reports and strategies for critical reading of risk assessment evaluations.

Superior Court Judicial and Senior Manager Spring Conference Presenter. Washington, D.C., April 2015.

Developed and presented training materials for Superior Court Judges as part of a panel on risk assessment of juvenile and adult defendants.

Training for Attorneys Preparing to Represent Defendants on the Prince William Mental Health Court Docket. Manassas, Virginia, April 2015, April 2016, & April 2018.

Prepared and presented a training for attorneys and judges about psychiatric disorders and forensic psychology considerations relevant to defendants with suspected or confirmed psychiatric disorders.

Institute of Law, Psychiatry, and Public Policy, Presenter. Charlottesville, Virginia, 2014 to present.

Developed and presented training curriculum for forensic evaluators assessing risk-related online behaviors in juveniles.

Institute of Law, Psychiatry, and Public Policy, Presenter. Charlottesville, Virginia, October 2014 to present.

Developed and presented training curriculum for evaluating competency to stand trial and mental state at the time of offense in defendants with intellectual disabilities and borderline intellectual functioning.

Institute of Law, Psychiatry, and Public Policy, Training Faculty. Richmond, Virginia, and Charlottesville, Virginia, May 2015 and September 2014.

Developed and presented a one-day training curriculum on assessing online behavior of forensic evaluatees, with emphasis on issues relevant to problematic sexual behavior online, applicable statutes, and recommendations for supervision.

Washington, District of Columbia, Department of Behavioral Health, Presenter. August 2014.

Developed and presented a training curriculum on evaluating adjudicative competency of defendants with intellectual disabilities. Trainees were forensic psychologists and psychiatrists employed by the Department of Behavioral Health.

Department of Behavioral Health and Developmental Services, Presenter. August 2014.

Developed and presented a grand rounds for mental health service providers at Western State Hospital; topic was introduction to internet culture, and how and why to query online activities of individuals with severe mental illness.

Department of Behavioral Health and Developmental Services, Presenter. July 2014.

Developed and presented Psychology Department inservice training concerning adapting empirically-supported PTSD treatments for inpatient forensic populations.

Department of Behavioral Health and Developmental Services, Training Facilitator, Richmond, Roanoke, and Newport News, Virginia, April 2014 to May 2014.

Developed and presented a training curriculum on customizing outpatient restoration of competency to stand trial services for individuals with intellectual disabilities. Trainees were community mental health providers.

Institute of Law, Psychiatry, and Public Policy, Presenter. Charlottesville, Virginia, March 2014 to present.

Developed and presented training curriculum on assessing online behavior of forensic evaluatees, with emphasis on issues relevant to problematic sexual behavior online.

Western State Hospital, Department of Behavioral Health and Developmental Services, Presenter, Staunton, Virginia, November 2013.

Developed and presented a grand rounds for mental health providers, concerning personality disorders in adults with intellectual disabilities, also developed and presented a psychology department inservice training focused on adapting evidence-based trauma treatment interventions for inpatient forensic populations.

Westchester Jewish Community Services, Instructor, Yonkers and Hartsdale, New York, September 2012 to July 2013.

Developed training curriculum on assessing online activity of children, adolescents, and young adults. Presented training to an outpatient trauma treatment center, a violence intervention and prevention program, and a program for teen parents.

University of Kentucky, University Center for Excellence in Developmental Disabilities, Curriculum Development and Project Coordinator, Lexington, Kentucky, January 2012 to July 2012.

Originated concept, generated learning objectives and teaching strategies, and developed content for an inter-disciplinary, multi-media online training for mental health professionals to provide more competent and ethical care to adults with ID/DD. Wrote scripts, cast actors, and filmed and edited illustrative video vignettes. Applied for and obtained continuing education credits from the Kentucky Psychological Association.

University of Kentucky, Human Development Institute, Instructor, Lexington, Kentucky, 2008 to 2011.

Lectured on sexual abuse of adults with disabilities to students enrolled in the interdisciplinary Graduate Developmental Disabilities Certificate Program. Converted lecture to online format for the distance learning section of program.

Migrant Network Coalition, Workshop Co-Leader, Lexington, Kentucky, August 2010.

Researched and developed materials and co-led a training workshop on the intersection of disability and immigration status.

University of Kentucky, Department of Behavioral Sciences, Graduate Student Trainee, Lexington, Kentucky, August 2007 to May 2009.

Developed training materials and facilitated *in vivo* experiences to prepare medical students for treating patients with DD and their families. Developed student/family mentorship program, still in use by the medical school.

University of Kentucky, Human Development Institute, Project Supervisor, Lexington, Kentucky, November 2007 to July 2008.

Researched and developed instructional content of a multi-media online training package for direct service professionals who support adults with DD. Coordinated marketing and distribution of training program to Medicaid waiver providers. Funded by the Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities.

University of Kentucky, Preservice Health Training, Project Assistant, Lexington, Kentucky, August 2005 to June 2008.

Helped identify training needs of professionals (e.g., dentistry, nursing, women's health) treating individuals with ID/DD; researched and wrote content for training materials; and co-scripted video vignettes for an award-winning series of online, multi-media, interdisciplinary training modules.

Project SAFE (Safety and Accessibility for Everyone), Coordinator, Frankfort, Kentucky, September 2005 to September 2006.

Created and presented three trainings on the topic of sexual and domestic violence perpetrated against individuals with disabilities. Audience included team members from a coalition of state agencies dealing with sexual assault, domestic/interpersonal violence, disability rights, and crime victims' advocacy.

Commonwealth of Kentucky, Coalition of State Disability and Employment Agencies, Training Facilitator, Frankfort, Kentucky, April 2005 to June 2005.

Coordinated disability-awareness trainings, led by facilitators with disabilities, for state employees of Kentucky One-Stop Job Centers.

PRESENTATIONS

- Boyd, S.,** Brodsky, S. (chair), Murrie, D.M., & Stejskal, W.J. (2016, March). *Bias in Forensic Mental Health Evaluations*. Symposium at the American Psychology-Law Society Conference. Atlanta, Georgia.
- Boyd, S.,** Barretto, R., & Zelle, H. (2015, June). *Using Advance Directives for Self-Advocacy and Planning: An Overview and Example of the Process*. Presentation at the 14th Annual Philadelphia Trans Health Conference. Philadelphia, PA.
- Boyd, S.** (2010, November). *Personality, motives, and adaptive functioning in adults with intellectual disability*. Poster presented at the Association of University Centers on Disability conference, Crystal City, VA.
- Boyd, S.,** & Adams, Z. (2008, April; shared first authorship). *Ethical considerations in the treatment of individuals with Intellectual Disability*. Award Presentation session at the annual American Psychological Association conference, Boston, MA.
- Boyd, S.** (2008, month) *Traits, motives, and behavior: comparing the NEO PI-R and the Reiss Profile*. Poster Presented on September 26 at the 2008 Society for Research in Psychopathology conference, Pittsburgh, PA.
- Kleinert, H. K., Caldwell, S., **Boyd, S.** (2006, October). *Interactive virtual training for residential physicians and student dentists on caring for patients with developmental disabilities*. Concurrent session presented at the annual Association of University Centers on Disability conference, Washington, D.C.

SUPERVISION

- Institute of Law, Psychiatry, & Public Policy Graduate Student and Postdoctoral Fellow Supervisor,** Charlottesville, Virginia. August 2017 to present.
Supervised graduate students and postdoctoral fellows in reviewing and conducting forensic psychological evaluations. Presented at case conferences for student and practitioner attendees.
- Westchester Jewish Community Services, Clinical Psychology Extern Supervisor,** Hartsdale, New York, September 2012 to July 2013.
Supervised a graduate-level psychology extern in providing evidence-based treatments to a clinic population. Discussed differential diagnoses, case formulations, treatment goals, interventions, and collateral services. Provided ongoing feedback and conduct formal written evaluations.
- University of Kentucky, Student Supervisor,** Lexington, Kentucky, May 2008 to June 2012.
Supervised four undergraduate student assistants in laboratories investigating psychopathology, personality, and self-regulation. Oversaw data collection and analysis, manuscript preparation, and conference presentations. Provided guidance on professional development, including graduate school applications.

HONORS

2012 Research Endowment Award, from the Human Development Institute, University of Kentucky.

2011 Research Funding Award, from the Department of Psychology, University of Kentucky.

2008 Winner, American Psychological Association (APA) of Graduate Students ethics paper contest.
Awarded at the APA annual conference in Boston, MA, August 2008. Paper, co-authored with Z.W. Adams, titled: Ethical Considerations in Psychotherapy with Adults with Intellectual Disabilities.

2008 Research Funding Award, from the Department of Psychology, University of Kentucky.

2007 Burberry Award, from the Human Development Institute, University of Kentucky, a University Center for Excellence in Developmental Disabilities.
This award recognizes outstanding academic achievement and advocacy efforts in graduate student trainees.

2006 Travel Award, from the Department of Psychology, University of Kentucky.

2006 Anne Rudiger Award, from the Association of University Centers on Disability (AUCD).
This national award recognizes academic and advocacy-related achievement among graduate student trainees in the AUCD network.

1998-1999 James Scholar Honors Program, University of Illinois.

PROFESSIONAL MEMBERSHIPS

American Psychological Association (APA)

APA Division 25: *Behavior Analysis*

APA Division 33: *Intellectual and Developmental Disabilities/Autism Spectrum Disorders*

APA Division 35: *Society for the Psychology of Women*

APA Division 44: *Society for the Psychology of Sexual Orientation and Gender Diversity*

APA Division 46: *American Psychology-Law Society*

APA Division 56: *Trauma Psychology*

American Association on Intellectual and Developmental Disabilities (AAIDD)

Association for the Treatment of Sexual Abusers (ATSA)

Fellow, American Board of Forensic Psychology (ABFP)

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
No. 3:22-CV-0191-MOC-DCK

KANAUTICA ZAYRE-BROWN,)	
)	
Plaintiff,	)	AFFIDAVIT OF JOSEPH PENN, MD,
	)	IN SUPPORT OF DEFENDANTS’
v.	)	RESPONSE TO PLAINTIFF’S
	)	MOTION FOR PRELIMINARY
THE NORTH CAROLINA DEPARTMENT	)	INJUNCTION
OF PUBLIC SAFETY, et al.,)	
Defendants.)	

Professional Background

1. I am a psychiatrist based in Conroe, Texas. I am triple board-certified in forensic psychiatry, general psychiatry, and child and adolescent psychiatry. These board certifications are issued by the American Board of Psychiatry and Neurology, which is a member board of the American Board of Medical Specialties, the organization that grants board certification for psychiatrists and neurologists in the United States. I am fully licensed to practice medicine in Texas. I have been retained by Defendants in this matter to provide expert opinions.

2. I am currently the Director of Mental Health Services of the University of Texas Medical Branch (UTMB) Correctional Managed Care (CMC), which is a university-based correctional health care system. I have held this position since February 2008. In this capacity, I oversee the statewide provision of psychiatric, psychological, and mental health services to approximately 80% of adults (approximately 110,000 people) incarcerated in the Texas Department of Criminal Justice (TDCJ) which is the largest state prison system in the USA. This includes TDCJ’s jails and state prisons. I also manage the child and adolescent psychiatric services of approximately 800 youths housed in the custody of the Texas Department of Juvenile Justice

(TJJD) and housed in various facilities across the state.

3. Over the past 30 years, I have devoted most of my professional time to the practice and teaching of general adult, child and adolescent, forensic, and correctional psychiatry. Since 1999, I have focused my clinical, administrative, and forensic work in correctional settings including adult and juvenile detention facilities, jails, and prisons, and non-correctional civil detention facilities.

4. Prior to relocating to Texas, I provided direct patient care and forensic psychiatry consultation in Rhode Island for approximately 15 years and in Connecticut for 1 year.

5. As the Director of Mental Health Services for the UTMB CMC, I oversee approximately 320 mental health staff including psychiatrists, psychologists, mental health managers and clinicians, case managers, psychiatric nurse practitioners (NP), psychiatric physician assistants (PA), and other qualified mental health professionals, as well as medical and physician assistant student trainees. I also directly supervise some psychiatric NPs and PAs and review and co-sign a percentage of their medical records. Additionally, I conduct peer reviews of psychiatrists and midlevel (NP and PA) psychiatric providers. I directly oversee all of the gender dysphoria specialists in our UTMB CMC system who provide direct patient care to transgender inmates with or without gender dysphoria. I also provide clinical supervision, approve or defer certain medications, support, prescribe, order, reorder, or adjust feminizing and masculinizing hormone medications and other psychotropic medications. Additionally, I provide other consultation and behavioral treatment recommendations to psychiatric and mental health, nursing, and medical treatment staff and to the custody leadership of the TDCJ. I also assist with direct patient care as needed, including by providing “on-call” after hours psychiatric coverage for both incarcerated TDCJ adults and TJJD youths statewide.

6. In addition to the above responsibilities and roles, during different periods of time, I served as the acting clinical director (i.e., the lead psychiatrist) of two dedicated inpatient psychiatric units, that house more than 500 adults. These units house TDCJ patients that are determined to be at imminent risk of significant self-injury or suicide, and/or have acute or serious mental health needs that cannot be managed at their assigned outpatient unit. Presently, I supervise the two current clinical directors that oversee the psychiatric and mental health care at these units. I am routinely involved in the referral, acceptance, admission, transfer, and discharge of patients within the state's dedicated inpatient psychiatric units. When needed, I also consult and oversee the evaluation and management of these inpatients, including transgender persons with or without gender dysphoria admitted to these inpatient psychiatric units, and of other particularly complicated patients across the TDCJ system. Additionally, I obtained hospital privileges at a local community hospital where several patients from our system were transferred.

7. I have achieved and maintained a specialized certification as a Certified Correctional Health Professional-Mental Health (CCHP-MH) since 2004. This certification is provided by the National Commission on Correctional Health Care (NCCHC) and requires passing a written national examination, demonstrating proficiency in national correctional health standards, annual attestation of continuing medical education credits, full medical licensure without restrictions, and must be recertified annually. The NCCHC provides health care accreditation of jails and short-term detention facilities, prisons, juvenile facilities, and opioid treatment programs for correctional facilities across the country. I have undergone specialized training to serve as a physician surveyor for the NCCHC and have surveyed several major metropolitan county jails and short-term detention facilities. I am also the past chair of the NCCHC accreditation committee and continue to serve as a committee member. Additionally, I have served

on several task force groups charged with revising certain NCCHC standards.

8. I remain current in the evaluation, diagnosis, and treatment of individuals within both correctional, forensic, and community settings. In particular, I remain knowledgeable about issues related to clinical psychiatry and systems of care in community settings, at both the state and national level, through my leadership work with organizations such the American Academy of Psychiatry and the Law (AAPL), the American Psychiatric Association (APA), the Texas Society of Psychiatric Physicians (TSPP), the American College of Psychiatrists (ACOP), and other medical and psychiatric organizations.

9. As such, I am familiar with mental health and psychiatry best practices, including in the evaluation and treatment of gender dysphoria and suicide prevention policies and practices in correctional, forensic, and community settings nationally. And I have published and presented in the areas of correctional mental health care and suicide prevention, and I have presented regarding the evaluation and management of incarcerated transgender individuals with and without gender dysphoria, at state, national, and international meetings.

10. I have also published extensively in scientific journals and other peer reviewed publications in the areas of correctional patient care, mental health needs of geriatric inmates, and other correctional mental health, recidivism, and continuity of care of incarcerated individuals with mental health and substance abuse, and suicide prevention topics.

11. I have been appointed to councils, committees, work groups, task forces and made numerous national and international contributions, within many organizations including but not limited to the APA, the American Academy of Child and Adolescent Psychiatry, and the AAPL. I served as an appointed member of the APA Council on Psychiatry and Law, which reviews law and psychiatry issues, and as past chair of the APA Council on Children, Adolescents and Their

Families.

12. I have presented nationally and internationally on correctional and non-correctional mental health care delivery and standards of care. Some recent examples of agencies that I have either consulted with or presented to, include: the Office of the California Attorney General; the Office of the Nevada Attorney General; the Sacramento County Commissioners and County Board of Supervisors; the Rhode Island Department of Corrections; the Vermont Department of Corrections. I also served as a consultant to the National Institute of Mental Health (NIMH) regarding detainees of U.S. Immigration and Customs Enforcement. And I have a pending invitation to present to the U.S. Department of Justice on suicide prevention in correctional settings. Other examples are listed in my CV.

13. I maintain clinical knowledge of the unique mental health and health care needs of incarcerated transgender individuals, with or without gender dysphoria. I completed specialized clinical training regarding the evaluation and treatment of this patient population under the supervision of Dr. Walter Meyer. Dr. Meyer, who is now retired, was a UTMB faculty psychiatrist and endocrinologist. Dr. Meyer is a respected international leader in transgender health care. Dr. Meyer was one of the members and lead authors on the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) Volume 7 Revision Committee. World Professional Association for Transgender Health. (2012)¹.

14. I remain knowledgeable regarding the WPATH Standards of Care (SOC) and other relevant literature. I have presented nationally, and recently internationally, regarding the evaluation and diagnosis, clinical management, and treatment of transgender individuals with or without gender dysphoria within correctional settings.

¹ *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* [7th Version] accessible at: <https://www.wpath.org/publications/soc>.

15. I have evaluated, diagnosed, and treated incarcerated TDCJ patients with gender dysphoria and have performed second opinion evaluations/consultations throughout Texas and other states. I oversaw the development and implementation of a specialized gender dysphoria referral and clinical program, which is a joint operation of the UTMB CMC, the TDCJ, and Texas Tech University. This program is used throughout the TDCJ system. I continue to oversee the program and maintain direct clinical involvement in the same. I have also overseen the systemwide development, revisions, and implementation of a disease management guideline for the evaluation and treatment of incarcerated adults seeking evaluation and treatment for gender dysphoria. I have also provided input and assisted with revisions to the State of Texas's Correctional Managed Health Care Committee policy entitled Policy G-51.11 Correctional Managed Health Care Policy Manual, which concerns the treatment of incarcerated persons with intersex conditions and gender dysphoria. I have also served as a consultant to several state prison systems including Colorado, Kansas, New Jersey, and California regarding gender dysphoria diagnoses, evaluation and treatment programs, policies, and practices, and medical and surgical interventions for various state inmates.

16. I have served as an expert witness in both civil and criminal matters. In civil matters, I have been retained by and served as an expert for both plaintiffs and defendants. Likewise, in criminal matters, I have been by retained and served as an expert for both the prosecution and defendants. Additionally, I have served as a court-appointed expert in civil and criminal matters. As such, I have been qualified as an expert witness in various state and federal courts, in the fields of forensic, child and adolescent, and correctional psychiatry. I have provided expert opinions in several areas, including the standards of care in different types of correctional facilities and other settings, the use of psychotropic medications, psychic harm, PTSD, suicide,

suicide prevention, suicide risk assessment, seclusion and restraint, and other topics.

17. For a period of time between 2013 and 2014, I served as a correctional psychiatric consultant to the Special Master in the case captioned *Coleman v. Brown, Governor of California, et al.*, Case No. CIV. S-90-520 LKK/DAD (PC) in the United States District Court for the Eastern District of California.

18. From 2017 to 2019, I served as a consultant to the State of California's Office of the Attorney General concerning several topics such as mental health staffing, telepsychiatry, and the improvement of health care delivery efficiency in the California Department of Corrections and Rehabilitation prison system. And effective this month, July 2022, I am again serving as a consultant regarding the use of telepsychiatry within correctional settings.

19. Additionally, since 1998, I have conducted numerous evaluations and site tours of various state prisons in Rhode Island, Vermont, Texas, California, and Arizona. I have also conducted evaluations and site tours of several county jails and juvenile detention facilities in Florida, and ICE facilities across various jurisdictions.

20. I am also familiar with different custody and housing levels, inmate movements for various activities, and other operational issues concerning the incarcerated population. Thus, I have a fundamental appreciation of the impact, interplay, and communication between correctional custody, nursing and medical staff and other staff, and mental health care delivery in the carceral setting. This is of particular relevance to providing care to transgendered inmates with or without gender dysphoria.

21. For a more detailed statement of my education and experience, see my *Curriculum Vitae* (CV) attached hereto as Exhibit A.

22. Due to my professional experience, as described above and in my CV, I am well

positioned to render opinions regarding the provision of psychiatric, mental health, and medical services in a correctional setting to transgender patients with or without gender dysphoria. And I am also well positioned to render opinions concerning the medical, psychiatric, mental health and other clinical indications for various courses of treatment aimed at addressing gender dysphoria, including surgical interventions; and the safety, effectiveness, associated risks, costs, and benefits of, and the alternatives to, such treatment options.

23. All conclusions and opinions stated herein are based upon my years of education, training, and professional experience, as well as my review of Plaintiff's medical and mental health records, her motion for preliminary injunctive relief, and supporting materials, which included a declaration signed by Randi C. Ettner, Ph.D. Additionally, all conclusions and opinions stated herein are stated to a reasonable degree of medical, psychiatric, and mental health certainty.

Policies Concerning Evaluation and Management of Transgender Patients in Correctional Settings

24. It is critical to note that there are currently no published national correctional standards or correctional health standards concerning the policies and/or protocols for the evaluation, treatment, or clinical management of transgender individuals with or without gender dysphoria in the carceral setting. Thus, organizations such as the American Correctional Association, the NCCHC, the American Psychiatric Association, and the American Psychological Association, and other medical and professional organizations, do not have specific clinical guidance for correctional systems regarding what constitutes minimum or best practices or standards of care for the evaluation and management of this population of incarcerated individuals.

25. That the only correctional health accrediting body in the US, the NCCHC, does not have any correctional health standards concerning this population, is significant. The NCCHC's origins date to the early 1970s, when an American Medical Association (AMA) study found

inadequate, disorganized health services, and a lack of national correctional health standards. In collaboration with other medical, legal, and other professional organizations, the AMA established a program to address the issue. In 1983 this program became an independent, 501(c)(3) nonprofit organization—the NCCHC. The NCCHC is supported by major national organizations in the health, mental health, legal, and corrections fields, including the American Bar Association (ABA), the AMA, the American Nurses Association, the American Public Health Association, the National Association of Social Workers, and others. The NCCHC publishes national correctional health care standards, position statements, and provides educational conferences to guide correctional health professionals, administrators, and systems. Given the NCCHC’s history, its work, its educational and clinical training mission, the multi-disciplinary input, and the support it receives, the fact that the NCCHC does not currently have any published guidance or correctional health care standards on this specific topic is significant because it indicates the tremendous lack of consensus in the correctional health care and administrative and custody staff community on this complicated topic.

26. The NCCHC does have a 2020 position statement entitled: “Transgender and Gender Diverse Health Care in Correctional Settings.”² That position statement, which I assisted in revising and approving, addresses, at a high-level, the challenges in evaluating and managing the incarcerated transgender population. It is important to note that this new NCCHC position statement, like others, is a statement of an aspirational goal or ideal in the correctional field and thus does not in any way assert itself or represent itself to be a standard of care, definitive clinical expectations or mandates to the field. Nor is the position statement intended to stand on its own as a disease management guideline or clinical protocol, or as a consensus statement. Instead, it

² <https://www.ncchc.org/transgender-and-gender-diverse-health-care-in-correctional-settings-2020>

provides some general and non-specific “real world” practical guidance to correctional health and administrative and custody staff on issues to consider with this special population. Accordingly, these types of position statements are of limited assistance in crafting definitive policy and procedures concerning the evaluation and management of transgender individuals with or without gender dysphoria in various correctional settings. This is especially true given the tremendous variability in size of facilities, clinical staffing and resources, and the varying and other numerous patient variables and population characteristics. Moreover, the NCCHC is explicitly clear that its existing standards and position statements do not define any medical or mental health or other health care “standard of care.”

27. As such, correctional leaders with specialized knowledge and experience in correctional medicine, psychiatry and health care, and custody and operational leaders must work together and develop highly individualized practices, policies, and procedures without the benefit of any current national correctional standards. Also, in doing so, systems must avoid an overreliance on standards promulgated by national organizations who lack correctional experience or knowledge. The lack of any current national standards contributes to the numerous unique challenges faced by correctional systems when developing and implementing comprehensive care protocols for transgender persons with or without gender dysphoria.

28. When creating such health care protocols, disease management guidelines, and related policies, procedures, and practices, correctional agencies must develop their policies and procedures based on a variety of sources of information. These sources of information can include the existing WPATH recommendations, local medical and community practices, if available, recent legal cases (some of which have highly disparate rulings), and the one limited and highly generalized position statement of the NCCHC. Gathering, reviewing, and synthesizing this

information so that useful standards and protocols can be developed and implemented, which includes training various multidisciplinary health care and custody staff on these challenging topics across large and complex systems is no small feat.

29. The North Carolina Department of Public Safety (“the Department”) has developed a policy and set of procedures concerning the evaluation and management of the transgender population. I have reviewed the Department’s policy. It, like many other correctional systems, relies on a multidisciplinary review process. It is my understanding that the multidisciplinary team that reviews various requests by incarcerated transgender patients for certain medical, mental health, and surgical interventions, includes individuals with decades of experience in custody/corrections, medical care, psychiatry, behavioral health care, and other disciplines.

30. An attribute of the Department’s approach in its policy that is of particular importance, is that the policy is fluid and evolving. This results in an approach that can more easily be refined and updated as needed.

31. Given the complexity of addressing certain needs of some of the transgender incarcerated population, the Department’s policy rightly provides for a case-by-case review and evaluation of various requests for interventions. This approach allows for the Department to assess various aspects implicated by certain requests and to do so in a way that accounts for the reality of providing health care in the correctional setting. In doing so, the Department’s individualized approach acknowledges and appreciates that every incarcerated individual is different and thus requires an individualized evaluation and treatment plan approach for each person and that correctional health care requires numerous additional unique considerations. This is critical because gender dysphoria falls along a spectrum—so does the array of various and possibly effective treatment options. Thus, there can be no blanket solutions or approaches. Additionally,

the need for case-by-case considerations and fluidity in responding to changes in circumstances is particularly important in the correctional setting because of the unique factors attendant therein which are not present in the community.

32. Based on my review of the Department's policy, my approximately 30 years of correctional health care experience, and my knowledge and training concerning transgender health care in the carceral setting, it is my opinion that the Department's policy comports with or exceeds what I would consider to be an acceptable standard for a comprehensive set of health care protocols for transgender patients, with or without gender dysphoria, in a correctional system. Indeed, the Department's policy and procedures are equivalent to those of other state prison systems, including some of the larger systems in the country.

33. Further, it is my opinion that the Department's policy is necessary, integral, and instrumental to ensuring the timely provision of quality psychiatric, mental health, and other medical care to transgender patients, with or without gender dysphoria. Additionally, it is my opinion that the Department's practices, policies, procedures, referral, diagnostic/evaluation, and gender dysphoria treatment approaches and practices comport with evidence-based practices.

34. Therefore, it is my opinion that the Department's policy provides for the requisite access to care and continuity of care to transgendered individuals housed in North Carolina state prisons.

Unique Considerations in the Correctional Setting

35. That the correctional setting is different than the community is obvious. However, there are a host of considerations regarding the delivery of health care, in general, and in particular the management of transgender health care, in the correctional setting which are not so obvious.

36. Additionally, in the correctional setting, unique issues must be considered that are

simply not present in the community. Or issues that must be considered in community, must be considered in the unique context of the correctional setting.

37. For example, in the community, a person's legal or criminal history is not factored into an analysis of whether to proceed with a particular intervention, or even whether certain decisions are even considered interventions. This is not the same in the correctional context. In the correctional setting, a person typically has no control over where they are housed or with whom or the number and location of cellmates. But a person may request a certain type of housing assignment. A transgender person may request a particular housing assignment as an intervention aimed at ameliorating one's gender dysphoria. In such a scenario, a person's past legal or criminal history, mental health and medical status and clinical stability, disciplinary history, which may include a history of physical assaults on peers or staff or both, or history of sexual offending in the community or while incarcerated, security threat group/gang affiliations, and other variables must be taken into account for safety and security reasons. To illustrate, a transgender female inmate with a history of sexual violence against females who now requests transfer from a male facility to a female facility by an individual with a history of sexual violence or abuse will warrant further consideration than the same request by someone without such a history. These considerations are not just theoretical. These considerations have serious implications for other inmates and staff, as they may pose a risk of disruption to the unit safety, rehabilitation efforts, treatment efforts and programming, the overall unit milieu, and sense of safety and risks of physical and sexual assaults and intimidation and coercion to other potentially vulnerable inmates in particular. There are news reports of at least one recent instance³ of a transgendered female, that still had male genitalia,

³ <https://www.nj.com/news/2022/04/two-women-at-nj-prison-are-pregnant-after-consensual-sex-between-inmates-doc-says.html>; <https://news.yahoo.com/nj-transgender-woman-transferred-women-134955783.html?guccounter=1>.

impregnating female inmates in a female prison unit in New Jersey.

38. Similarly, there is extensive literature⁴ indicating that incarcerated females have extensive trauma and victimization histories, including adverse childhood experiences and past domestic violence, emotional, physical, and sexual abuse, exploitation, and other traumas. Thus, placing a transgendered female who has masculine secondary characteristics (e.g., body shape and stature, broad shoulders, masculine voice, etc.) in a female prison unit might result in triggering/re-experiencing of fear, avoidance, other trauma recollection, PTSD experiences, flashbacks, and other indications of clinical deterioration, all of which can result in various forms of self-harm, and other morbidity and mortality of the females already housed in that unit.

39. While the above examples concern housing considerations, which I understand are not at issue in this phase of the litigation, custody, housing and classification determinations and other custody related considerations, that are unique to the correctional setting, must also be seriously considered with regard to any other interventions, including medical (hormonal treatments) and/or surgical interventions. Surgical considerations include, but are not limited to, the psychiatric/mental health stability of the patient, the availability of qualified in-state surgeons with particular knowledge and expertise in performing various surgeries for transgendered individuals and who are comfortable and are willing to provide surgery to incarcerated individuals, rates of patient acceptance and satisfaction with the particular proposed surgeon or surgical

⁴ Stanton AE, Rose SJ. The Mental Health of Mothers Currently and Formerly Incarcerated in Jails and Prisons: An Integrative Review on Mental Health, Mental Health Treatment, and Traumatic Experiences. *J Forensic Nurs.* 2020 Oct/Dec;16(4):224-231. Doi: 10.1097/JFN.0000000000000302. PMID: 32947439.

Nowotny KM, Belknap J, Lynch S, DeHart D. Risk profile and treatment needs of women in jail with co-occurring serious mental illness and substance use disorders. *Women Health.* 2014;54(8):781-95. Doi: 10.1080/03630242.2014.932892. PMID: 25204664; PMCID: PMC4224671.

Lewis C. Treating incarcerated women: gender matters. *Psychiatr Clin North Am.* 2006 Sep;29(3):773-89. Doi: 10.1016/j.psc.2006.04.013. PMID: 16904511.

practice, effectiveness of alternative non-surgical interventions, short and long term clinical outcomes, risks of anesthesia and surgery and post-surgical complications, potential benefits versus the patient's perception of harm from postponing the procedure (until it can be performed in the community), pre-operative procedures, post-operative care, costs of the procedures, attainment of fully informed consent (e.g., the patient's ability to weigh the various risks, benefits and alternatives and provide truly voluntary informed consent), and more. All of these factors warrant consideration regardless of the proposed surgical intervention at issue. And this is especially true with regard to the provision of gender-affirming surgery, including the vulvoplasty requested by the Plaintiff, due to the irreversible and permanent nature of the surgical removal of the patient's penis, and the associated risks and potential post-surgical complications involved

40. It is my understanding that a vulvoplasty is a highly specialized urologic surgical procedure that is not performed by a great number of surgeons. Thus, I would anticipate a longer wait time for this procedure than with other less specialized and more routine non-genital surgeries. In the correctional setting, the availability of qualified and willing surgical professionals to perform such a given procedure, and in particular to an incarcerated individual who will be returning to a state prison setting post-operatively opposed to the community is critical because the pre-operative testing, actual surgical procedure, and post operative follow-up appointments must be scheduled to account for a variety of correctional and custody related issues. These include planning and coordination of transportation to and from the prison to the surgeon's office or community or academic center hospital or clinics for pre-operative evaluations, blood work and EKG and other pre-operative tests, bowel preparation and fasting must be coordinated, custody staff escorts and supervision at all times (e.g., due to the risks of escape or taking staff hostage or other safety issues) and whether the surgeon, clinic, practice or hospital has trepidation regarding

these issues and custody staff present in the waiting room, patient room, and the like. Similarly, planning for the procedure must allow sufficient time for post-operative follow-up with the surgeon to monitor wound healing. Importantly, considerations for planning and coordinating surgery must also consider whether the surgical recovery and other post-operative timetables falls within an incarcerated person's projected release date. An additional major public health variable facing correctional patient populations is the issue of communicable diseases such as COVID-19, tuberculosis, MRSA (methicillin resistant staph aureus) skin infections, candida (fungal infections) and transmission and other infectious disease risks, transmission, infections, status and the ability to safely transport the inmate patient to/from a hospital setting for appointments, the planned surgery, and post-surgical interventions (should there be complications) during the current COVID pandemic and in particular due to recent variants and correctional and community infections and re-infections. Dr. Ettner's declaration does not appear to meaningfully address these numerous important issues or considerations.

41. Consideration of the rate of patient satisfaction with a particular surgeon and/or of a given surgical intervention is also extremely important. This is especially true when considering an irreversible and complicated procedure, such as the type requested by Plaintiff. This consideration is even more critical in light of the Plaintiff's expressed desire to undergo additional surgery in the same area. Some of the Plaintiff's records indicate that she initially wanted a vaginoplasty but opted to request a vulvoplasty due to a sense of expediency and post-operative concerns. However, her records also indicate that even after verbally expressing a preference on the day of the scheduled clinic appointment to the surgical staffer for a vulvoplasty, that the Plaintiff expressed a desire to pursue the vaginoplasty at a later date after first undergoing the vulvoplasty. Thus, in this case, not only must patient satisfaction concerning a vulvoplasty be

considered, so too must satisfaction and anticipated compliance and follow through in pursuing a vulvoplasty as the first phase to be followed by a vaginoplasty as a second phase. Moreover, any patient satisfaction's regarding any reconstructive surgical procedure is highly variable, especially when serial (back-to-back similar) surgeries are required. Additionally, any repeat surgery poses additional risks of adhesions, scarring, decreased range of motion/movement, and further surgical complications. Dr. Ettner's declaration does not appear to meaningfully address these considerations.

42. A correctional system must also consider its ability to address pre and post-operative issues described above, and potential short and long-term continuity of care and placement issues which may arise following any type of surgery. This would include an assessment of the ability to ensure an appropriate level and type of care immediately following surgery. Issues such as location of recovery, staffing levels (medical and custody supervision), and transportation will factor into this near-term analysis. A correctional system will also need to consider any potential short and long-term implications of any proposed surgical intervention. This consideration may turn on issues such as whether a more permanent housing arrangement is warranted and that determination involves factors such as post-surgical observation in a medical infirmary during immediate post-surgical recovery period, whether there will be an indwelling catheter, IV or oral antibiotics, pain medication administration, wound care, or other interventions, whether and which types of follow-up surgeries (or other procedures) are likely, and whether and how an incarcerated post-surgical patient's activities of daily living (e.g. walking from assigned housing cell to day room, walking to the cafeteria, work assignments, day room and recreational activities, shower and bathroom) may be impacted, as this may have implications for other services (medical or otherwise) provided by the prison. Also, a system must assess the potential

complications and risks associated with the given surgical intervention, as this assessment may be critical in the broader continuity of care and placement considerations. I understand that this patient has requested a specific gender affirming surgery, a vulvoplasty, which is a particularly delicate and highly complex surgery. The same is true with other gender affirming surgeries like vaginoplasty, penectomy, orchiectomy, and others. Indeed, Current Urology Reports recently noted that in the largest single-site study performed by an experienced surgeon an estimated incidence of 28.7% complication rate attributed to male to female gender affirming surgery was reported.⁵ Thus, there appears to be a moderately high rate of complications, regardless whether the patient pursues vaginoplasty or a vulvoplasty followed by a vaginoplasty. These complications may include things like: rectovaginal fistulas, bleeding from the well-vascularized spongiosum tissue of the urethra, urethral meatus stricture, vaginal stenosis, hair in the vagina, pain with dilation, formation of granulation tissue, vaginal tear, and issues with cosmesis. Additionally, many patients seek re-operation to include a revision labiaplasty, with greater than half of the cases performed for cosmetic reasons. When fistulas do occur, small ones can be managed conservatively with bowel rest. However, more complicated cases may require surgical excision and possible intestinal diversion. Also necrosis and loss of the neovaginal pouch will require a substitution with virgin tissue from another well vascularized flap, most commonly the ileum or the sigmoid. Vaginal stenosis occurs with a frequency of about 14% but surgical correction is required in only about 41% of those cases. Dr. Ettner's declaration does not appear to meaningfully address these considerations.

43. Assessing the effectiveness of alternative interventions is also critical, particularly complex surgical intervention. In this case, it is my understanding that the Plaintiff has been

⁵ Shu Pan & Stanton C. Honig. "Gender-Affirming Surgery: Current Concepts," Current Urology Reports (2018) 19:62 <https://doi.org/10.1007/s11934-018-0809-9>

transferred to a female facility, has been on feminizing estrogen therapy, has been receiving individual psychotherapy (e.g., talk therapy), and has been on multiple medications in an effort to address her gender dysphoria. Yet, Dr. Ettner's declaration does not contain a robust examination of the effectiveness of those non-surgical and well accepted interventions for an individual with DSM-5-TR gender dysphoria. Before approving a request for a vulvoplasty, or any other irreversible gender-affirming surgery, a correctional system would need to fully evaluate whether all other viable risks, benefits, and other alternatives have been considered, and to what extent they have been effective, and if not some inquiry into why. This consideration would also involve evaluating an individual's active participation and compliance with offered medical and mental health treatment modalities that are available and offered.

44. Additionally, correctional systems must assess the costs of approving various medical and other health care interventions for any disease state. These will include common chronic diseases, such as hypertension, diabetes, asthma, lower back pain, arthritis, chronic pain, headaches, and elevated cholesterol, various infectious diseases, such as tuberculosis, HIV, Hepatitis B and C, serious mental illness, such as schizophrenia and other psychotic disorders, and bipolar disorder, impulse control disorders, personality disorders, and more common mental disorders such as depressive and anxiety disorders, and more costly disease states, such as hemodialysis for end stage kidney disease, bone marrow or solid organ transplants, chemotherapy, or immunologic treatment for cancer and malignancies or clotting agents for blood clotting dyscrasias. Because correctional agencies are publicly funded, these entities must consider the financial implications associated with approving certain treatment modalities from the perspective of the government leaders such as legislature, public policy leaders, and taxpayers. And because these agencies provide care for thousands of patients, many with multiple disease states, high

comorbidity, past high risk-taking behaviors, and certain other considerations, like patient compliance and access to specialty care, particularly when approving interventions for the first time, must be considered at the system-level and not just at the individual level. Thus, a correctional agency, like the Department, must utilize its dollars in a way that allows it to provide for the health care needs of all persons in its care and custody most efficiently and fairly.

45. For example, there are new agents of long-acting injectable antipsychotic medications which may benefit some patients with chronic and treatment resistant psychotic disorders who refuse to take oral antipsychotic medications. However, these new agents are extremely expensive when compared to tried and true older and much less expensive medications with a long track record of clinical efficacy and safety in clinical practice. Given the costs associated with procuring and administering these new agents a system would undoubtedly undertake a cost-benefit analysis, medication use evaluation, and clinical rationale/justification of the proposed use of the new agent. Thus, considering costs is reasonable, and indeed prudent, when determining whether to proceed with a particular course of treatment in a correctional system which provides health care to thousands, and does so with public funds. Dr. Ettner's declaration does not appear to meaningfully address these considerations.

46. An assessment of whether the patient has truly provided fully informed consent is also critical. Prisons are inherently coercive settings, thus, in the correctional setting extra care must be taken to determine, as best as possible, that the patient understands the risks, benefits, and alternatives to a given procedure. Many of the considerations referenced above factor into this calculation. Informed consent, especially in the context of a surgery undertaken to address a condition, should include an assessment of the patient's expectations about their understanding of the potential ameliorative effect of the procedure. If the purpose of undergoing the surgery is to

reduce a patient's dysphoria, an exploration of why and how the patient believes this will occur is crucial. In the Plaintiff's records, she indicates a variety of factors that appear to affect her dysphoria, including the attitudes of other prisoners and complications stemming from the strict sex-based housing assignments. Surgical interventions will have no bearing on these factors. Thus, a discussion with the Plaintiff about her expectation of how and why she believes the surgery will ameliorate her dysphoria is critical. It does not appear that Dr. Ettner addressed this in her declaration, which makes her assertion that the vulvoplasty would be curative particularly specious.

47. Given the plethora of considerations in assessing the appropriateness of any given surgical intervention in the correctional setting, the potential impact of postponing the procedure until it can be performed in the community must also be evaluated. I understand that the Plaintiff's projected release date is November 2, 2024.⁶ At that time, the Plaintiff will be able to pursue whichever surgical intervention she desires. Surgery in the community typically carries numerous interpersonal and social benefits over surgery in the correctional setting. In the community, a patient can recover from a surgery in the comfortability of their home and with the therapeutic aid, support, attention, and care from loved ones. Moreover, in the community a patient typically has some choice in the selection of a surgeon, which in the context of gender-affirming surgery, is something I understand may be fundamental to patient satisfaction with the outcome. Thus, such benefits must be balanced against the potential hardship of waiting to undergo the surgery in the community. Dr. Ettner does not appear to thoroughly address this consideration either.

The Department's Evaluation of Plaintiff's Request for a Vulvoplasty

48. Because of the lack of a sufficient body of "gold standard" controlled, high quality,

⁶ This information is publicly available at <https://www.ncdps.gov/dps-services/crime-data/offender-search>.

and empirical research at the intersection of transgender health care and corrections, and the absence of any national correctional health care standards posing specific “do’s and dont’s” or other specific clinical recommendations regarding evaluation and treatment approaches and practice guidelines for incarcerated transgender individuals with gender dysphoria from organizations like the NCCHC, some clinicians, expert witnesses, and others rely exclusively on the guidance promulgated in the WPATH’s SOC. Overly or solely relying on the WPATH standards for evaluating the appropriateness of an intervention in the correctional setting has three distinct faults.

49. First, the WPATH standards do not provide any meaningful correctional specific guidance. While the authors assert that the SOC standards should apply in the correctional setting just as in the community, they do so based on very limited data and without accounting for the realities of correctional medicine. I understand that the authors of the SOC were comprised of a multidisciplinary team that included endocrinologists, psychiatrists, psychologists, and other medical professionals. However, it is my understanding that none of these individuals had any correctional clinical or administrative experience. Perhaps not surprisingly then, WPATH does not appear to appreciate or recognize the various nuances, challenges, and differences inherent delivering health care in the correctional setting, some of which are outlined above. To date⁷, the WPATH has not provided any meaningful clinical or administrative guidance concerning application of their standards in the correctional setting. Thus, the WPATH SOCs have limited value in providing definitive clinical guidance and management and application to correctional medical and mental health staff who evaluate and manage the care of transgender persons with or

⁷ I have reviewed a draft version of the pending WPATH “SOC” Volume 8 (which is currently in revision for future publication and dissemination). This document similarly lacks any guidance or cautions regarding generalizability and applicability within correctional settings

without gender dysphoria in the correctional context. Indeed, it is my understanding that the WPATH guidance was primarily intended to guide the evaluation and treatment of individuals within community settings.

50. Second, the authors of the SOC, however well intentioned, appear to direct their efforts in furtherance of advancing transgender health care advocacy. This raises some concerns that WPATH, as a member organization as opposed to an accreditation entity or a purely educational organization, may have an advocacy orientation that detracts from the academic and research rigor of a more solely evidence-based/research organization. While advocacy for this special patient population is certainly admirable, consideration of how that advocacy may influence the organization's publications, especially when promulgated as standards of care, is reasonable. This focus on advocacy corresponds extremely well with the primary goal as stated on page 7 of the 7th version of the SOC: "the overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment." While undoubtedly a noble goal, striving for such an objective of self-fulfillment does not, in and of itself, provide for a medical or surgical or mental health/psychiatric standard of care that is useful in the correctional setting.

51. Third, applying the WPATH's SOC as true standards of care for the incarcerated patient population is highly problematic for multiple reasons.

52. As an initial matter, I am unaware of any other medical or psychiatric organization that has any organizational medical publication titled "Standards of Care (SOC)." I am familiar with the writing of position statements, practice guidelines, and practice parameters, which

requires the writer to identify for the reader the level of importance and or certainty possible for each specific recommendation. As an example, I was the lead author of a practice parameter⁸ for the assessment and treatment of youth in juvenile detention and correctional facilities. In this practice parameter, we provided specific categories indicating the degree of importance or certainty of each recommendation. These categories were “Minimal Standards” which referred to practice recommendations that were based on substantial empirical evidence (such as well-controlled, double-blind trials) or overwhelming clinical consensus. Minimal Standards practices are expected to apply more than 95% of the time. “Clinical Guidelines” referred to recommendations that were based on some empirical evidence and/or strong clinical guidelines. Clinical Guidelines are expected to apply approximately 75% of the time. “Options” referred to practices that were acceptable, but not required, likely because they lack sufficient empirical evidence to warrant recommendation at a higher level of certainty. Lastly, “Not Endorsed” referred to practices that are known to be ineffective or contraindicated. These categories allowed practitioners to refer to a particular recommendation with a clearly articulated evidence base for use and consideration. The WPATH’s SOC simply do not contain the requisite level of clarity regarding the evidence base to guide the field.

53. Also, an over or exclusive reliance on the WPATH’s SOC in the correctional setting runs headlong into the lack of any research in the correctional setting. I conducted a recent literature review to determine if there is any literature regarding surgical intervention as a treatment for gender dysphoria in the correctional setting—I found none. In conducting this review, I used the Pub Med Search service, and input the following search terms: “Gender-affirming surgery

⁸ Penn JV, Thomas CR. AACAP Work Group on Quality Issues. Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities. J Am Acad Child Adolesc Psychiatry 2005; 10:1085-1098

(GAS)” AND “Corrections” “Correctional Settings” “Incarcerated Patients” “Incarcerated Individuals”.

54. Finding no literature in the correctional context, I reviewed the available literature concerning the effectiveness of surgery as an intervention in the community. Before turning to the conclusions of those studies, a few points are worth making. First, none of the available literature involves empirical studies done in the United States. There are some survey studies and re-analyses of survey studies, but I was unable to locate original studies that included clinical interviews with pre-surgical baseline and post-surgical follow-up assessments or that employed any validated screening or follow-up measures or testing. Second, none of the studies are longitudinal, which would be helpful in determining the long-term effectiveness of surgical intervention. Third, none of these studies are performed under the ideal models, (i.e., a control group, case matched or case control study design). Thus, relying on such surveys and re-analyses of survey studies and extrapolating results to the carceral setting is not a sound methodology.

55. Turning to the conclusions of these studies, which attempt to analyze the effectiveness of gender affirming surgery, some studies suggest that surgical intervention may be effective. For example, Richard Bränström, Ph.D., John E. Pachankis, Ph.D, published a commonly cited Swedish study that reported a reduction in mental health treatment utilization: “Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study.” The conclusions therein included that, the longitudinal association between gender-affirming surgery and reduced likelihood of mental health treatment lends support to the decision to provide gender-affirming surgeries to transgender individuals who seek them.

56. However, after the article “Reduction in Mental Health Treatment Utilization

Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study” by Richard Bränström, Ph.D., and John E. Pachankis, Ph.D. (doi: 10.1176/appi.ajp.2019.19010080), was published online on October 4, 2019, some letters containing questions on the statistical methodology employed in the study led the *Journal* to seek statistical consultations. The results of these consultations were presented to the study authors, who concurred with many of the points raised. Upon request, the authors reanalyzed the data to compare outcomes between individuals diagnosed with gender incongruence who had received gender-affirming surgical treatments and those diagnosed with gender incongruence who had not. While this comparison was performed retrospectively and was not part of the original research question, given that several other factors may differ between the groups, the results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or hospitalizations following suicide attempts in that comparison.

57. Given that the original study used neither a prospective cohort design nor a randomized controlled trial design, the conclusion that “the longitudinal association between gender-affirming surgery and lower use of mental health treatment lends support to the decision to provide gender-affirming surgeries to transgender individuals who seek them” is too strong. Finally, although the percentage of individuals with a gender incongruence diagnosis who had received gender-affirming surgical treatments during the follow-up period is correctly reported in a table (37.9%), the text incorrectly refers to this percentage as 48%. (emphasis added). The article was reposted on August 1, 2020, correcting this percentage and including an addendum referencing the post-publication discussion captured in the Letters to the Editor section of the August 2020 issue of the *Journal*.⁹

⁹ Kalin NH: “Reassessing mental health treatment utilization reduction in transgender individuals after gender-affirming surgeries: a comment by the editor on the process (letter).” *Am J Psychiatry* 2020; 177:765.

58. Other controlled studies either suggest that surgery may not be particularly effective or at least call the opposite conclusion into question. In the published Swedish study, Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden, Cecilia Dhejne et al., noted in the Context section: “The treatment for transsexualism is sex reassignment, including hormonal treatment and surgery aimed at making the person’s body as congruent with the opposite sex as possible. There is a dearth of long term, follow-up studies after sex reassignment.” The following Results were noted: “The overall mortality for sex-reassigned persons was higher during follow-up than for controls of the same birth sex, particularly death from suicide. Sex-reassigned persons also had an increased risk for suicide attempts and psychiatric inpatient care. Comparisons with controls matched on reassigned sex yielded similar results. Female-to-males, but not male-to-females, had a higher risk for criminal convictions than their respective birth sex controls.” The authors wrote the following in their Conclusions: “Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group.”

59. Accordingly, my literature review indicates that there are studies¹⁰ that reach highly conflicting conclusions on the topic of the long-term effectiveness and efficacy of gender affirming surgery. Moreover, there are no published studies that clearly demonstrate a cause and effect definitive “cure” or total alleviation of gender dysphoria symptoms or distress subsequent to gender affirming surgery.

¹⁰ The studies noted herein are not intended to be exhaustive but only representative. There are multiple other studies on the topic that reach conflicting conclusions.

60. Given the lack of studies on this topic in the correctional setting, the conflicting conclusions of existing research, and the limitations of the same, it is my professional opinion that to date, there is no medical consensus that substantial evidence exists supporting the use, acceptance, satisfaction, validity, reliability, and clinical outcomes of gender affirming surgery within the community or in the correctional populations in the United States.

Plaintiff's Formulation of Medical Necessity is Flawed

61. The Plaintiff and her expert, Randi Ettner, Ph.D., take the position that the requested vulvoplasty is “medically necessary.” This position appears to turn on a formulation of the phrase “medical necessity” which labels an intervention necessary so long as it has the potential to provide some therapeutic benefit. Such a formulation is not particularly helpful, accurate, or practical in the correctional setting. This is especially true when determining the appropriateness of a surgical intervention to treat to gender dysphoria.

62. This formulation of “medical necessity” is particularly problematic because there are no objective indicators or metrics of the progress in treating gender dysphoria. This is unlike other types of medical conditions, such as high blood pressure, diabetes, or glaucoma, which can be assessed and monitored by examinations, other testing, or lab testing. There is no equivalent for measuring progress of a person’s gender dysphoria. Rather, progress is solely based on self-reports and subjective life experience, and as such can be highly variable and unpredictable. For instance, some experience rapid effects from feminizing or masculinizing hormone therapy and may report feeling lower levels of dysphoria, while others may feel dissatisfied and continue to report higher levels of dysphoria.

63. Under the formulation of the phrase “medically necessary” as used by the Plaintiff and her expert, an intervention which may provide some benefit vis-à-vis a patient’s gender

dysphoria becomes medically necessary. However, that same logic would make a host of other interventions “medically necessary” to treat other conditions. For example, a patient with a perception of a large nose, skin wrinkles or sagging, or other distress or discomfort due to perceived facial or body features may derive a benefit from procedures targeting that body feature, such as a rhinoplasty, botox, or facelifts. Thus, under Plaintiff’s logic these procedures would be “medically necessary” because they may well benefit the patient by alleviating, to some degree, their perceived distress from their physical appearance or characteristics.

64. As a further example, many incarcerated persons experience depressed mood, dysphoria due to being incarcerated and away from family/loved ones, and/or anxiety, insomnia, and other DSM-5-TR recognized disorders. Research indicates that therapeutic massage may provide a benefit to patients with such conditions by improving their mood or alleviating distress. Under the formulation of “medically necessity” advanced by the Plaintiff and her expert, massages for incarcerated persons that have anxiety, insomnia, or other conditions, would be medically necessary.

65. There are interventions that are clearly and unquestionably “medically necessary.” For example, if a patient presents with acute and severe (or recurrent) abdominal pain, this could implicate a number of underlying causes such as acute appendicitis, diverticulitis, abdominal obstruction, strangulated or diseased bowel, bowel perforation, acute peritonitis, ulcerative colitis, and more, all of which could have a variety of causes (e.g., bacterial infection, gunshot wound, stabbing, etc.). Given this presentation, further emergency evaluation would be medically necessary to determine if observation, and perhaps hospitalization or surgery is required. This intervention is an obvious example of medically necessity because to not intervene would impose a known high risk of morbidity/mortality, scarring, and death.

66. Other examples might include a scenario where some skin mass or growth, of unclear etiology, is identified. In that instance, diagnostic imaging and biopsy is medically necessary so as to determine whether the growth is benign or malignant, and to guide additional interventions.

67. Similarly, as we have experienced during the COVID-19 pandemic, should an individual present with acute respiratory distress, shortness of breath, and other symptoms suggestive of a COVID infection, an emergency department evaluation would be medically necessary to determine whether admission to an intensive care unit because the patient may require intubation and mechanical ventilation, and IV medications and other treatments and failure to proceed in this manner could lead to respiratory distress, hypoxia (lack of oxygen), and death. These are just some examples of procedures and interventions that can be more appropriately considered “medically necessary.”

68. Thus, it is my opinion that Plaintiff and Dr. Ettner’s formulation of “medically necessity” is not accurate nor practical because it is not based on an understanding of the phrase that comports with my work, education, and direct clinical and administrative experience in correctional medicine and correctional psychiatry/mental health in particular, and creates an unworkable standard in the correctional context.

Conclusions

69. For the reasons stated above, and based on my years of education, professional experience, reading and additional ongoing study and continuing medical education, it is my professional opinion that based on the available literature, reasonable medical and mental health professionals can disagree as to the medical necessity of gender-affirming surgery to treat gender dysphoria, especially in the correctional setting.

70. Accordingly, it is my opinion that the Department's decision to not approve the Plaintiff's request for a vulvoplasty in April 2022 was a reasonable decision. This opinion is based on my conclusion that there is no research on this issue in the correctional setting and the relevant research that does exist indicates problematic and conflicting findings. Thus, I conclude that there is no current or established consensus on the effectiveness of such an invasive and irreversible intervention, especially in the correctional context. Additionally, it is my opinion that an accurate and comprehensive assessment of medical necessity must allow for the consideration of factors far beyond the potential for therapeutic benefit, as opined by Dr. Ettner. Therefore, it is my opinion that the Department's determination that the vulvoplasty was not medically necessary as of April 2022, was a reasonable determination.

71. In sum, it is my opinion, that the Plaintiff has received extensive and adequate treatment of her gender dysphoria and that the Department's conclusion—that although the Plaintiff has clearly communicated a desire for gender-affirming surgery, there is insufficient medical evidence to indicate that such a complex and irreversible surgical intervention is medically necessary at the present time—was reasonable and supported by the current body of existing empirical medical research.

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SIGNATURE PAGE TO FOLLOW

Pursuant to 28 U.S.C. § 1746, I declare that the foregoing is true and correct.

This the 19th day of July, 2022.



Joseph V. Penn, MD, CCHP FAPA

July 15, 2022

**CURRICULUM VITAE
JOSEPH V. PENN, MD CCHP LFAPA**

Business Address: University of Texas Medical Branch (UTMB)
Correctional Managed Care (CMC)
Mental Health Services
200 River Pointe Drive, Suite 200
Conroe, Texas 77304

Business Telephone: (936) 494-4183
Business Fax: (936) 494-4194
E-mail: jopenn@utmb.edu

EDUCATION

Undergraduate 1987 B.S. in Biology
University of the Incarnate Word (formerly Incarnate Word College), San Antonio, Texas
Honors: Alpha Chi, Academic All-American, Who's Who in American Universities & Colleges, Graduated Summa Cum Laude

Medical School 1992 M.D.
University of Texas Medical Branch, Galveston, Texas
Honors: Who's Who in American Colleges/Universities, Junior Marshal

POSTGRADUATE EDUCATION

2014 Management Certificate
Physician Leadership Academy
University of Houston Clear Lake &
University of Texas Medical Branch, Galveston, Texas

POSTGRADUATE TRAINING

Residency 1992-1996 General Psychiatry
1995-1996 Chief Resident
Department of Psychiatry and Human Behavior,
Brown University, Providence, Rhode Island

Residency 1996-1998 Child and Adolescent Psychiatry
Department of Psychiatry and Human Behavior,
Brown University, Providence, Rhode Island

Fellowship 1998-1999 Forensic Psychiatry
Department of Psychiatry
Yale University, New Haven, Connecticut

POSTGRADUATE HONORS AND AWARDS

- 1994 ACNP Program for Minority Research Training in Psychiatry
- 1994 Center for Mental Health Services Scholarship
- 1995 Mead Johnson Fellow, Association for Academic Psychiatry
- 1995 Laughlin Fellow, American College of Psychiatrists
- 1996 Outstanding Young Men of America
- 1996 Chester M. Pierce, M.D., Sc.D. Resident Research Award
- 1997 Lebensohn Award, American Association of General Hospital Psychiatrists
- 1997 Rappeport Fellow, American Academy of Psychiatry & the Law
- 1999 Presidential Scholar, American Academy of Child & Adolescent Psychiatry
- 2000 Pilot Research Award, American Academy of Child & Adolescent Psychiatry
- 2001 America's Registry of Outstanding Professionals
- 2002 Who's Who in Medicine and Healthcare
- 2003 Who's Who in America
- 2003 Who's Who in Science and Engineering
- 2003 Junior Faculty Development Award, Association for Academic Psychiatry
- 2004 Brown Medical School Teaching Recognition Award
- 2004 Distinguished Alumnus, University of the Incarnate Word
- 2004 Strathmore's Professional Honor Society
- 2005- Best Doctors in America
- 2006 Madison Who's Who
- 2006 Fellow, American Psychiatric Association (Life Fellow Status in 2022)
- 2007 Who's Who Among Executives and Professionals
- 2007 Fellow, The Lloyd Society
- 2008 Member, American College of Psychiatrists
- 2011 Cambridge Who's Who Registry among Executives and Professionals in the Field of Research, Medicine, and Healthcare

MILITARY SERVICE None

PROFESSIONAL LICENSES AND BOARD CERTIFICATION

- 1993 Rhode Island Medical License # 8849
- 1997 Diplomate, American Board of Psychiatry & Neurology # 43847
- 1998 Additional Certification, Child and Adolescent Psychiatry # 4583
- 1998 Connecticut Medical License # 36678
- 1999 Texas Medical License # K7081
- 1999 Massachusetts Medical License # 161086
- 2003 Additional Certification, Forensic Psychiatry # 1438
- 2004 Certified Correctional Health Care Professional (CCHP), National Commission on Correctional Health Care
- 2007 Re-Certification, American Board of Psychiatry & Neurology # 43847
- 2013 Re-Certification, Forensic Psychiatry, American Board of Psychiatry & Neurology #1438
- 2017 Re-Certification, General Psychiatry, American Board of Psychiatry & Neurology #43847
- 2017 Re-Certification, Child and Adolescent Psychiatry, American Board of Psychiatry & Neurology #4583

ACADEMIC APPOINTMENTS

- 1995-1996 Assistant Instructor in Psychiatry
1998-2007 Clinical Assistant Professor of Psychiatry, Department of Psychiatry and Human Behavior, Brown University School of Medicine, Providence, Rhode Island
2007-2012 Clinical Associate Professor of Psychiatry, Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Providence, Rhode Island
2009-2013 Clinical Associate Professor of Psychiatry, Department of Psychiatry and Behavioral Sciences, UTMB Medical School, Galveston, Texas
2014- Clinical Professor of Psychiatry, Department of Psychiatry and Behavioral Sciences, UTMB Medical School, Galveston, Texas
2017- Clinical Professor, Physician Assistant Studies, UTMB Medical School, Galveston, Texas

HOSPITAL APPOINTMENTS

- 1994-1997 Psychiatric House Officer, Landmark Medical Center, Woonsocket, RI
1994-1998 Psychiatric House Officer, St. Joseph Center for Psychiatric Services, Providence, RI
1999-2008 Medical Staff, Rhode Island Hospital, Providence, RI
1999-2008 Medical Staff, Emma Pendleton Bradley Hospital, East Providence, RI
1999-2008 Director, Child and Adolescent Forensic Psychiatry, Rhode Island Hospital, Providence, RI
2008- Director, Mental Health Services, University of Texas Medical Branch (UTMB), Correctional Managed Care (CMC), Conroe, Texas
2013-2014 Acting Clinical Director, Texas Department of Criminal Justice (TDCJ), TDCJ Skyview/Hodge Units, Rusk, Texas
2017- Staff Psychiatrist, University Medicine Associates, Bexar County Hospital District d/b/a University Health, in conjunction with Detention Health Care Services (“University Health”), Bexar County Jail, San Antonio, Texas
2018-2020 Consulting Psychiatrist, River Oaks Hospital and Clinics, Houston, Texas
2019-2020 Acting Clinical Director, TDCJ, Jester IV Unit, Richmond, Texas

OTHER APPOINTMENTS

- 1995- Reviewer, Hospital Physician
1996 Reviewer, Academic Psychiatry
1996 Reviewer, Journal of Nervous and Mental Disease
1997 Reviewer, Journal of Clinical Psychiatry
1997 Staff Psychiatrist, Kent County Mental Health Center, Warwick, RI

Joseph V. Penn, MD CCHP FAPA Curriculum Vitae

1998-2001 Consultant, New Haven State's Attorney Office, New Haven, CT
1998-2000 Consultant, Capital Defense and Trial Services Unit, Office of the Chief Public Defender, Hartford, CT
1998-2001 Consultant, Office of the Public Defender, Bridgeport, CT
1998-1999 Psychiatrist, New Haven Court Clinic, New Haven, CT
1998-1999 Consultant, Disabilities Clinic, Yale Law School, New Haven, CT
1998-1999 Psychiatric Expert Witness, Trial Practice Course, Yale Law School, New Haven, CT
1998-1999 Consultant, Special Populations Unit, CT Department of Mental Health and Addictions Services, Hartford, CT
1998-1999 Genesis Group Co-leader and Individual Therapist, Whiting Forensic Institute, Middletown, CT
1998-1999 Child Custody and Placement Clinic, Yale Child Study Center, New Haven, CT
1998-2001 Consultant, Superior Court, Juvenile Matters, Stamford, CT
1999 Consultant, Psychiatric Security Review Board, Middletown, CT
1999 Consultant, United States Department of State, Washington, DC
1999-2001 Staff Child Psychiatrist, The Family Health Center at SSTAR Program, Fall River, MA
1999-2008 Director of Psychiatric Services, Rhode Island Training School, Cranston, RI
1999-2008 Consultant, Rhode Island Family Court
1999-2008 Consultant, Rhode Island Department of Children, Youth, and Families
1999-2008 Consultant, RI Department of Disability Determination Services, Providence, RI
1999-2000 Consultant, Providence Police Department, Kid's INC. Program, Providence, RI
1999-2001 Consultant, Office of the Attorney General, Providence, RI
2000-2001 Consultant, Superior Court, Juvenile Matters, Hartford, CT
2000-2001 Consultant, United States Attorney, District of Rhode Island, Providence, RI
2001 Consultant, Butler Hospital, Providence, RI
2001 Consultant, Northwest Special Education Region, Scituate, RI
2001 Consultant, Qualidigm, Middletown, CT
2001-2003 Consultant, Town of Narragansett, Narragansett, RI
2001-2002 Consultant, Office of the Public Defender, Enfield, CT
2001-2002 Consultant, Medical Consultants Network, Seattle, WA
2001-2002 Advisory Board, HELP Mental Health and Wellness Initiative, Providence, RI
2002 Consultant, Yarmouth Police Department, Yarmouth, MA
2002-2003 Consultant, Office of the Mental Health Advocate, Cranston, RI
2002 Consultant, Commonwealth of Massachusetts, Committee for Public Council, Boston, MA
2002- Editorial Board, Hospital Physician
2002- Reviewer, Journal of Correctional Health Care
2003- Consultant, Bradley Hospital, East Providence, RI
2003- Representative, American Academy of Child & Adolescent Psychiatry to the National Commission on Correctional Health Care, Chicago, Illinois
2003- Board of Directors, National Commission on Correctional Health Care, Chicago, Illinois
2003 Advisory Panel, ADHD in Correctional Institutions, National Commission on Correctional Health Care, Chicago, Illinois
2004 Consultant, Town of West Warwick, RI, Pension Board
2004 Consultant, Rhode Island Department of Corrections

Joseph V. Penn, MD CCHP FAPA Curriculum Vitae

2004 Reviewer, Journal of the American Medical Women's Association
2004- Editorial Board, Psychiatry
2005 Consultant, Florida Department of Juvenile Justice
2005-2008 Consultant, Office of the Public Defender, Providence, RI
2005 Consultant, Bradley School, Portsmouth, RI
2005-2006 Consultant, Office of the Attorney General, Hartford, CT
2006-2007 Consultant, Phoenix House, New York, NY
2006- Editorial Board, Correctional Health Report
2006-2008 Consultant, Physicians and Lawyers for National Drug Policy
2006-2008 Board of Directors, Academy of Correctional Health Care Professionals
2007-2009 Consultant, Town of East Providence, RI, Police Department
2007-2009 Technical Assistance Project Consultant, National Commission on Correctional Health Care, Various Correctional Facilities, Valhalla, New York
2007-2010 Chair (Chair-Elect, Chair, Immediate Past), Board of Directors, National Commission on Correctional Health Care, Chicago, Illinois
2008 Consultant, National Institute of Mental Health (NIMH), Bethesda, MD
2009 Consultant, Kansas Department of Juvenile Corrections
2009 Consultant, Philadelphia Department of Behavioral Health and Mental Retardation Services
2009 Reviewer, Ambulatory Pediatrics
2009- Board of Directors, Society of Correctional Physicians (SCP)
2011- Editorial Board, Journal of Correctional Health Care
2011 Technical Assistance Project Consultant, U.S. Department of Justice, National Institute of Corrections (NIC)
2011 Consultant, Rhode Island Department of Corrections
2011- Consultant, Agency for Health Research and Quality's (AHRQ) Effective Health Care (EHC) Program
2011 Consultant, Office of the Attorney General, Providence, Rhode Island
2011 Consultant, Vermont Department of Corrections
2012 Technical Assistance Project Consultant, National Commission on Correctional Health Care, Idaho Department of Corrections
2012 Consultant, National Commission on Correctional Health Care, US Immigration and Customs Enforcement (ICE) San Diego Contract Detention Facility, San Diego, California
2012 Surveyor, National Commission on Correctional Health Care, Orleans Parish Criminal Sheriff's Office, New Orleans, Louisiana
2012 Surveyor, National Commission on Correctional Health Care, Hudson County Correctional Center, Kearny, New Jersey
2012 Reviewer, Academic Pediatrics
2012-2013 Consultant, Office of the Attorney General, Providence, Rhode Island
2013- Consultant, Polk County Juvenile Detention Center/Polk County Jail, Bartow, Florida
2013-2016 Member, Council on Psychiatry and Law, American Psychiatric Association, Arlington, Virginia
2013 Surveyor, National Commission on Correctional Health Care, Harris County Jail, Houston, Texas
2013 Surveyor, National Commission on Correctional Health Care, Rio Grande Detention Center, Laredo, Texas

- 2013-2014 Consultant, Juvenile Justice Commission (JJC) State of New Jersey, and the University of Medicine and Dentistry of New Jersey (UMDNJ)-University Behavioral HealthCare/University Correctional HealthCare, Trenton, New Jersey
- 2013- Consultant, J Allen and Associates of Texas, Friendswood, Texas
- 2013- Reviewer, Suicide and Life-Threatening Behavior
- 2013- Consultant, Division of Health Services, Arizona Department of Corrections, Phoenix, Arizona
- 2013 Surveyor, National Commission on Correctional Health Care, El Paso Service Processing Center, El Paso, Texas
- 2013-2014 Consultant to Special Master, *Coleman v. Brown, Governor of California, et al.*, United States Court of Appeals, Ninth Circuit, Pasadena, California.
- 2015-2017 Chair, Council on Children, Adolescents and Their Families, American Psychiatric Association, Arlington, Virginia

ADDITIONAL INFORMATION

- 2007-2011 Contributor and Consultant to the American Academy of Child and Adolescent Psychiatry (AACAP) Work Group on Quality Issues. Practice Parameter for Child and Adolescent Forensic Evaluations. J Am Acad Child Adolesc Psychiatry 2011; 50:1299-1312

HOSPITAL COMMITTEES

- 1994-96 Pharmacy and Therapeutics Committee, Butler Hospital, Providence, RI
- 1995-96 Outpatient Specialty Program Directors Group, Butler Hospital, Providence, RI

UNIVERSITY COMMITTEES

Brown University Department of Psychiatry and Human Behavior

- 1992-96 Policy Committee, Residency Training Program
- 1992-96 Selection Committee, Residency Training Program
- 1994 Residency Recruitment Coordination Committee
- 1994-96 SDDS/Primary Care Psychiatry Research Committee
- 1994 Search Committee, Director of General Psychiatry Residency Training Program
- 1998 Selection Committee, Child and Adolescent Psychiatry Residency Program

Brown University School of Medicine

- 2000-2002 Search Committee, Department of Pediatrics
- 2003-2007 Search Committee, Post-Doctoral Training Program in Juvenile Forensic Psychology

University of Texas Medical Branch Correctional Managed Care

- 2008- Continuing Medical Education (CME) Committee
- 2008-2010 County Jail Pharmacy and Therapeutics Committee
- 2008- Mental Health Services Policy Committee
- 2008- Quality Council
- 2008- Mental Health Inpatient Leadership Group (Chair)
- 2009-2011 Medical Executive Committee (Chair)
- 2009- Executive Council

NATIONAL COMMITTEES

Academy of Correctional Health Care Professionals

- 2003-2004 Education Committee
- 2005-2008 Membership Committee
- 2006-2008 Board of Directors
- 2007-2008 Education Committee

American Academy of Child and Adolescent Psychiatry

- 1997-2000 Television and the Media Committee
- 1999- Rights and Legal Matters Committee
- 1999-2002 Task Force on Juvenile Justice Reform
- 2002-2006 Committee on Juvenile Justice Reform
- 2016- Children and the Law Committee

American Board of Psychiatry and Neurology

- 1998- 2001 Psychiatry Re-Certification Committee
- 2001-2004 Re-appointed, Psychiatry Re-Certification Committee
- 2006 Examiner, Part II General Psychiatry Examination Committee
- 2001-2006 Examiner, Child and Adolescent Psychiatry Examination Committee
- 2007-2014 Forensic Psychiatry Examination Committee

American Academy of Psychiatry and the Law

- 1998- Rapoport Fellowship Committee
- 2006- Suicidology Committee
- 2010-12 Institutional and Correctional Psychiatry
- 2011- (Chair) Suicidology Committee

American College of Psychiatrists

- 2014-2017 Committee on the Education Award

American Correctional Association

- 2013-2021 Health Care Committee
- 2013-2021 Mental Health Committee

American Psychiatric Association

- 2012-2014 Workgroup on Persons with Mental Illness in the Criminal Justice System
- 2014- Workgroup on Mental Illness and Criminal Justice

Association for Academic Psychiatry

- 2003-2004 Program Committee

Coalition for Juvenile Justice

- 2001-2002 Membership Committee

National Commission on Correctional Health Care

- 2003- Juvenile Health Committee
- 2003-2004 Standards Revision Task Force, Standards for Health Services in Juvenile Detention and Confinement Facilities
- 2005 Program Committee
- 2005 (Chair) Clinical Guidelines Monitoring Subcommittee
- 2006-2007 (Vice-Chair) Clinical Guidelines Monitoring Subcommittee
- 2006-2010 Executive Committee, Member At-Large
- 2007-2008 (Chair) Juvenile Health Committee

2007-2008 Clinical Guidelines Monitoring Subcommittee
2008-2010 Finance Committee
2011-2014 (Chair) Juvenile Health Committee
2011- Executive Committee
2011- Accreditation Committee
2012-2014 (Vice Chair) Accreditation Committee
2013 Standards Revision Task Force, Standards for Health Services in Jails and Prisons
2014- (Chair) Accreditation Committee
2014- Certified Correctional Health Professional-Mental Health (CCHP-MH) Committee
2014- Mental Health Standards Revision Task Force, Standards for Mental Health Services in Correctional Facilities
2016 Standards Revision Task Force, Standards for Health Services in Jails and Prisons

STATE AND LOCAL COMMITTEES

Rhode Island Psychiatric Society

1995-1996 Executive Committee
2006-2008 (Chair) Public Affairs Committee

Rhode Island Training School

2000-2001 Health, Mental Health, and Suicide Prevention Work Group
2002 Resocialization Steering Committee
2003-2008 Pharmacy and Therapeutics Committee
2004-2008 Risk Management Committee
2004-2008 Suicide Prevention Work Group

Rhode Island Department of Children, Youth, and Families

2003 Article 23 Committee and Subcommittee
2004 Psychotropic Medications and Chemical Restraints

Rhode Island Department of Health

2006-2008 Suicide Prevention Subcommittee

Texas Department of Criminal Justice

2008- Correctional Managed Care Pharmacy and Therapeutics Committee
2008- Psychiatry Subcommittee
2008-2009 Drug Withdrawal/Benzodiazepine Discontinuation Subcommittee
2008- Joint Suicide Prevention Operational Workgroup
2008- Joint Mental Health Committee
2008- Suicide Prevention Working Group
2008- System Leadership Council
2009-2011 Joint Mental Health Work Group (Chair)
2012-2017 Joint Gender Identity Disorder Committee
2012- Integrated Mental Health Procedure Committee
2014-2016 Joint Mental Health Work Group (Chair)
2017- Joint Gender Identity Disorder Committee (Co-Chair)
2017- Correctional Managed Care Pharmacy and Therapeutics Committee (Chair)

Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)

2009-2014 Advisory Committee

Texas Juvenile Justice Department (formerly known as the Texas Youth Commission)

2008- Youth Health Services Leadership Council

2008- Youth Services Pharmacy and Therapeutics Committee

2008- Mental Health Subcommittee

2008- Psychiatry Subcommittee

2016-2018 (Chair) Youth Services Pharmacy and Therapeutics Committee

Texas Society of Psychiatric Physicians

2009- Government Affairs Committee

2009-2012 Public Mental Health Services Committee

2009-2010 Strategic Planning and Coordinating Committee

2012-2013 (Vice-Chair) Forensic Psychiatry Committee

2013-2015 Continuing Medical Education Committee

2013- (Chair) Forensic Psychiatry Committee

2013- Executive Council

2018-2019 President

MEMBERSHIP IN SOCIETIES

1987-99 American Medical Association

2002-2003 American Medical Association

1992- Theta Kappa Psi Medical Fraternity Alumni

1992- American Psychiatric Association

1993-2008 Rhode Island Psychiatric Society

1995- American Academy of Child and Adolescent Psychiatry

1996-2004 Association for Academic Psychiatry

1996-98 Rhode Island Medical Society

1997-98 American Association of General Hospital Psychiatrists

1997-98 Brown University Housestaff Association

1999-2008 Rhode Island Council of Child and Adolescent Psychiatry

1997- American Academy of Psychiatry and the Law

1998-99 Connecticut Psychiatric Society

2002- Academy of Correctional Health Professionals

2008- Texas Society of Psychiatric Physicians

2008- Texas Society of Child and Adolescent Psychiatry

2009- American College of Psychiatrists

2011- American College of Physician Executives

PUBLICATIONS

1. Jenkins M, Malloy P, Cohen R, Salloway S, Neepner R, **Penn JV**, Chang K. Attentional and Learning Dysfunction Among Adults with History of Childhood ADHD Journal of the International Neuropsychological Society 1996;2:209.
2. **Penn JV**, Boland RJ, McCartney JR, Kohn R, Mulvey T. Recognition and Treatment of Depressive Disorders by Internal Medicine Residents and Attendings General Hospital Psychiatry 1997;19:179-184.

3. Jenkins M, Cohen R, Malloy P, Salloway S, Gillard E, **Penn JV**, Marcotte A. Neuropsychological Measures which Discriminate Among Adults with Residual Attention Deficit Disorder and Other Attentional Complaints Clin Neuropsychologist 1998;12:74-83.
4. **Penn JV**, Esposito CL, Schaeffer LE, Fritz GK, Spirito A. Suicide Attempts and Self-Mutilative Behavior in a Juvenile Correctional Facility J Am Acad Child Adolesc Psychiatry 2003; 7:762-769.
5. Zonfrillo MR, **Penn JV**, Leonard HL. Pediatric Psychotropic Polypharmacy. Psychiatry 2005 2005; 8:14-19.
6. Stein, LAR, Lebeau-Craven, R, Martin R, Colby SM, Barnett, NP, Golembeske, C, **Penn, JV**. Use of the Adolescent SASSI in a Juvenile Correctional Setting. Assessment 2005, 12:384-394.
7. **Penn JV**, Thomas CR. AACAP Work Group on Quality Issues. Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities. J Am Acad Child Adolesc Psychiatry 2005; 10:1085-1098.
8. **Penn JV**, Esposito CL, Stein LAR, Lacher-Katz M, Spirito A. Juvenile Correctional Workers' Perceptions of Suicide Risk Factors and Mental Health Issues of Incarcerated Juveniles. J Correctional Health Care 2006; Volume 11, Issue 4: 333-346.
9. Cascade EF, Kalali AH, **Penn JV**, Feifel D. Recent Changes in Prescriptions for Antipsychotics in Children and Adolescents. Psychiatry (Edgmont). 2006 Volume 3, Issue 9:18-20.
10. Esposito-Smythers CL, **Penn JV**, Stein LAR, Lacher-Katz M, Spirito A. A Test of Problem Behavior and Self-Medication Theories in Incarcerated Adolescent Males. J Child Adol Substance Abuse 2008; Volume 17, Issue 4: 41-56.
11. Baillargeon J, Binswanger IA, **Penn JV**, Williams BA, Murray OJ. Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door. The American Journal of Psychiatry 2009; Volume 166, Issue 1:103-109.
12. Baillargeon J, **Penn JV**, Thomas CR, Temple JR, Baillargeon G, Murray OJ. Suicide in America's Largest Prison System. Journal of the American Academy of Psychiatry and the Law 2009; Volume 37, Number 2: 188-193.
13. Garvey KA, **Penn JV**, Campbell AL, Esposito-Smythers CL, Spirito A. Contracting For Safety with Patients: Clinical Practice and Forensic Implications. Journal of the American Academy of Psychiatry and the Law 2009; Volume 37, Number 3: 363-370.
14. Ochoa KC, Pleasants GL, **Penn JV**, Stone DC. Disparities in Justice and Care: Persons With Severe Mental Illnesses in the U.S. Immigration Detention System. Journal of the American Academy of Psychiatry and the Law 2010; Volume 38, Number 3: 392-399.
15. Baillargeon J, Hoge SK, **Penn JV**. Addressing the Challenge of Community Reentry among Released Inmates with Serious Mental Illness. American Journal of Community Psychology 2010; Volume 46, Number 3-4: 361-375.
16. Baillargeon J, **Penn JV**, Knight K, Harzke AJ, Baillargeon G, Becker EA. Risk of Reincarceration among Prisoners with Co-occurring Severe Mental Illness and Substance Use Disorders. Adm Policy Ment Health 2010; Volume 37, Number 4:367-74.

17. Harzke, AJ, Baillargeon J, Baillargeon G, Henry J, Olvera R, Torrealday O., **Penn, JV**, Parikh, R. Prevalence of Psychiatric Disorders in the Texas Juvenile Correctional System. Journal of Correctional Health Care 2012; Volume 18, Number 2: 143-157.
18. Harzke AJ, Baillargeon J, Baillargeon G, Olvera R, Torrealday O, **Penn JV**, Parikh R. Co-occurrence of Substance Use Disorders with Other Psychiatric Disorders in the Texas Juvenile Correctional system. International Journal of Prisoner Health 2011; 7, 4-16.
19. Hilliard WT, Barloon L, Farley P, **Penn JV**, Koranek A. Bupropion Diversion and Misuse in the Correctional Facility. Journal of Correctional Health Care 2013; Volume 19, Number 3: 211-217.
20. McKee J, **Penn JV**, Koranek A. Psychoactive Medication Use and Misadventuring Issues in Correctional Healthcare – What all Clinicians Should Know. Journal of Correctional Health Care 2014; 20(3):249-260.
21. Trestman, RL (Chair), **Penn JV**, et al. Psychiatric Services in Correctional Facilities: Third Edition A Work Group Report of the American Psychiatric Association. American Psychiatric Publishing 2015.
22. Tamburello A, Metzner J, Ferguson E, Champion M, Ford E, Glancy G, Appelbaum K, **Penn J**, Burns K, Ourada J. The American Academy of Psychiatry and the Law Practice Resource for Prescribing in Corrections. Journal of the American Academy of Psychiatry and Law 46:242-43, 2018. DOI:10.29158/JAAPL.003762-18
23. Tamburello A, **Penn J**, Ford E, Champion M, Glancy G, Metzner J, Ferguson E, Tomita T, Ourada J. The American Academy of Psychiatry and the Law Practice Resource for Prescribing in Corrections. Journal of the American Academy of Psychiatry and Law (in press)
24. Tamburello A, **Penn JV**, Negron-Muñoz R, Kaliebe K. Prescribing Psychotropic Medications for Justice-Involved Juveniles. Journal of Correctional Health Care (under editorial review)

OTHER PEER-REVIEWED PUBLICATIONS

1. Chang K, Neeper R, Jenkins M, **Penn JV**, Bollivar L, Israeli L, Malloy P, Salloway SP. Clinical Profile of Patients Referred for Evaluation of Adult Attention-Deficit Hyperactivity Disorder (Abstract) Journal of Neuropsychiatry and Clinical Neurosciences 1995;7:400-1.
2. **Penn JV**, Salloway SP. Development of Multiple Sclerosis in a Patient with Attention-Deficit Hyperactivity Disorder (Abstract) Journal of Neuropsychiatry and Clinical Neurosciences 1995;7:406-7.
3. **Penn JV**, Child and Adolescent Forensic Psychiatry, Medicine and Health Rhode Island 2005;9:310-317.

OTHER NON-PEER REVIEWED PUBLICATIONS

1. **Penn JV**, Martini J, Radka D. Weight Gain Associated with Risperidone (Letter to Editor) Journal of Clinical Psychopharmacology 1996;16:259-260.

2. **Penn JV**, Leonard HL, March J: OCD in Children and Adolescents. In M.T. Pato, G Steketee (eds.), OCD Across the Life Cycle, Annual Review of Psychiatry, Volume 16. Washington, DC: American Psychiatric Press, 1997, pp 7-53.
3. **Penn JV**, Hagino O: Child and Adolescent Psychiatry. In R.J. Goldberg, Practical Guide to the Care of the Psychiatric Patient, 2nd Edition. St. Louis: Mosby, 1998, pp 340-374.
4. **Penn, JV**, Casoli-Reardon M. Antisocial and Violent Youth (Book Review) Shamsie Lugus et al., Journal of the American Academy of Child and Adolescent Psychiatry 2001;12:1483-1484.
5. **Penn, JV**, Casoli-Reardon M. Antisocial and Violent Youth (Book Review) Shamsie Lugus et al., Journal of Developmental and Behavioral Pediatrics 2001; 22: 258-259.
6. **Penn JV**. Attention-Deficit/Hyperactivity Disorder: Review Questions. Hospital Physician 2001; 6:27-28.
7. **Penn JV**. Quick to Cry? Parenting 2001; 4:185.
8. **Penn JV**, Leonard HL: Diagnosis and Treatment of Obsessive-Compulsive Disorder in Children and Adolescents. In M.T. Pato, J. Zohar (eds.), Current Treatments of Obsessive-Compulsive Disorder, 2nd Edition. Washington, DC: American Psychiatric Press, 2001, pp. 109-132.
9. **Penn JV**. Justice for Youth? A History of the Juvenile and Family Court. The Brown University Child and Adolescent Behavior Letter 2001; 9:1-4.
10. **Penn JV**. Child and Adolescent Depression: Review Questions. Hospital Physician 2002; 1:39-40.
11. Thomas CR, **Penn JV**: Juvenile Justice Mental Health Services, In Child and Adolescent Psychiatric Clinics of North America. Edited by Haller L. Philadelphia: WB Saunders, 2002, pp 731-748.
12. **Penn JV**: Use of Psychotropic Medications with Incarcerated Youth. Standards for Health Services in Juvenile Detention and Confinement Facilities National Commission on Correctional Health Care, 2004, 263-265.
13. Carlsen AB, **Penn JV** Kids Who Commit Adult Crimes: Serious Criminality by Juvenile Offenders (Book Review) Flowers RB, Journal of Developmental & Behavioral Pediatrics 2005; 26:390-391.
14. Kraus LJ, **Penn JV**: Standards for Juvenile Detention and Confinement Facilities. In Recommendations for Juvenile Justice Reform. (Monograph) 2nd Edition. American Academy of Child and Adolescent Psychiatry Committee on Juvenile Justice Reform, 2005, p.40-47.
15. Masters KJ, **Penn JV**: Seclusion and Restraint: Juvenile Justice Plus Restrictive Interventions Equals Fragmentation. AACAP News, 2005, p. 164, 172.
16. **Penn JV**: Safe Use of Psychotropic Medications with Confined Youth. Correct Care, 2005, Volume 19, Issue 2, p. 12.
17. Murakami S, Rappaport N, **Penn JV**: An Overview of Juveniles and School Violence. In Psychiatric Clinics of North America. Edited by Scott C. Philadelphia: Elsevier, 2006, pp. 725-741.

18. **Penn JV**: Expert Commentary: Antipsychotic Use Among Children and Adolescents. Psychiatry 2006. 2006; 9:19.
19. **Penn JV**: Child and Adolescent Psychiatry. In R.J. Goldberg, Practical Guide to the Care of the Psychiatric Patient, 3rd Edition. Elsevier: Philadelphia, PA, 2007, pp 389-441.
20. Romero L, **Penn JV**. Ethical Issues of Youthful Offenders: Confidentiality, Right to and Right to Refuse Treatment, Seclusion and Restraint. In C. Kessler and L. Kraus, The Mental Health Needs of Young Offenders, Cambridge University Press, Cambridge, UK, 2007, pp. 401-422.
21. **Penn JV**, Thomas CR. Mental Health Care in Juvenile Detention Facilities: A Review (Letter to Editor) Journal of the American Academy of Psychiatry and the Law. 2006; 34:570-571.
22. Faille L, Clair M, **Penn JV**. Special Risk Management Issues in Child and Adolescent Psychiatry. Psychiatric Times. 2007; 7:64-67.
23. **Penn JV**. Invited Editorial: "Psychotropic Medications in Incarcerated Juveniles: Over versus Under-Prescribed?" Arch Pediatr Adolesc Med. 2008 Mar;162(3):281-3.
24. Baillargeon J, Paar DP, **Penn JV** Psychiatric Disorders and HIV/Hepatitis Coinfection CorrDocs. Volume 11, Issue 3:12.
25. Baillargeon J, **Penn JV**, (Letter to Editor) The American Journal of Psychiatry 2009; 166:490.
26. **Penn JV**. Suicide Prevention Strategies for Juveniles in Correctional Settings. In Condotta Suicidaria: Un'analisi Nel Sistema Degli Istituti Penali Minorili (Suicide Behavior: An Analysis of the Juvenile Justice/Correctional System). Numeri Pensati: Gangemi Editore, Rome, Italy, 2010, pp 66-76.
27. Clair M, Faille L, **Penn JV**. Prevention and Treatment of Violent Offending/Offenders. In Ferguson CJ, Violent Crime: Clinical and Social Implications, Sage Publications, Thousand Oaks, CA, 2010, 351-372.
28. **Penn JV**. Standards and Accreditation for Jails, Prisons, and Juvenile Facilities, In Oxford Textbook of Correctional Psychiatry. Edited by Trestman R, Appelbaum K, and Metzner J. Oxford University Press, New York, NY, 2015, pp 359-365.
29. McGlasson T, Champion MK, **Penn JV**. Geriatric Offenders: Evaluation and Treatment within Correctional Settings, In Oxford Textbook of Geriatric Forensic Psychiatry. Edited by Holzer J, Kohn R, Recupero P, and Ellison, J. Oxford University Press, New York, NY (in press).
30. **Penn JV**, Weinstein HC. Correctional Psychiatry, In Kaplan & Sadock's Comprehensive Textbook of Psychiatry 10th edition. Edited by Sadock BJ, Sadock VA and Ruiz P, Lippincott Williams & Wilkins, Philadelphia, PA (in press).

ABSTRACTS

1. Penn JV, Phillips KA. (1995). Body Dysmorphic Disorder and Social Phobia, Young Investigator's Poster Session, American Psychiatric Association Annual Meeting, Miami, Florida.

2. Penn JV, Boland RJ, McCartney JR. (1995). Recognition and Treatment of Depressive Disorders Among Internists, Young Investigator's Poster Session, American Psychiatric Association Annual Meeting. Miami, Florida.
3. Penn JV, Salloway SP. (1995). Development of Multiple Sclerosis in a Patient with Attention-Deficit Hyperactivity Disorder, Poster Session, American Neuropsychiatric Association Annual Meeting. Pittsburgh, Pennsylvania.
4. Chang K, Neeper R, Jenkins M, Penn JV, Bollivar L, Israeli L, Malloy P, Salloway SP. (1995). Clinical Profile of Patients Referred for Evaluation of Adult Attention-Deficit Hyperactivity Disorder, Poster Session, American Neuropsychiatric Association Annual Meeting. Pittsburgh, Pennsylvania.
5. Penn JV, Zimmerman M, Mattia J. (1996). Screening for Psychiatric Disorders in Medical Outpatients: A Patient Acceptance Study, Young Investigator's Poster Session, American Psychiatric Association Annual Meeting. New York, New York.
6. Jenkins M, Malloy P, Cohen R, Salloway SP, Neeper R, Penn JV, Chang K. (1996). Attentional and Learning Dysfunction among Adults with History of Childhood ADHD, Poster Session, International Neuropsychological Society Annual Mid-Year Meeting. Veldhoven, The Netherlands.
7. Penn JV, Boland RJ, McCartney JR. (1996). Recognition and Treatment of Depressive Disorders by Internal Medicine Attendings and Housestaff, Annual Chester M. Pierce, M.D., Sc.D., Resident and Medical Student Research Symposium, National Medical Association 101st Scientific Assembly, Chicago, Illinois.
8. Penn JV, Boland RJ, McCartney JR. (1996). Recognition and Treatment of Depressive Disorders by Internal Medicine Attendings and Housestaff, Poster Session, Annual Lifespan Hospitals Research Celebration, Providence, Rhode Island.
9. Penn JV, Holden P, Hendren RL. (1997). Can You Teach Child and Adolescent Psychopharmacology from Somebody Else's Lecture Notes? Workshop Presentation and Poster Session, Annual Meeting Association for Academic Psychiatry, Albuquerque, New Mexico.
10. Leonard HL, Penn JV, March J. (1997). OCD in Children and Adolescents, Review of Psychiatry, Obsessive-Compulsive Disorder Across the Life Cycle, American Psychiatric Association Annual Meeting. San Diego, California.
11. Penn JV, Esposito C, Spirito A. (2001). Incidence of Suicide Attempts and Self-Injurious Behavior in a Juvenile Correctional Facility, Poster Session, American Academy of Child and Adolescent Psychiatry Annual Meeting. Honolulu, Hawaii.
12. Penn JV, Esposito CL, Stein LAR, Lacher-Katz M, Spirito A. (2003) Juvenile Correctional Workers' Perceptions of Suicide Risk Factors and Mental Health Issues of Incarcerated Juveniles, Poster Session, American Academy of Psychiatry and the Law Annual Meeting, San Antonio, Texas.
13. Penn JV. (2005) AACAP Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities, Symposium, Emerging Frontier of Psychiatry: Juvenile Justice, American Psychiatric Association Annual Meeting, Atlanta, Georgia.

14. Penn JV. (2005) Surviving the Challenges of Juvenile Corrections: Suicide Prevention Strategies, Symposium, Juvenile Justice and Mental Health, International Academy of Law and Mental Health, International Congress on Law and Mental Health, Paris, France.
15. Merideth P, Janofsky J, Penn JV, Phillips RTM, Recupero P. (2005) Difficult Case? Consult Your Colleagues, Workshop, American Academy of Psychiatry and the Law Annual Meeting, Montreal, Canada.
16. Chen JT, Hunt J, Penn JV, Spirito A. (2006) Psychiatric Differences Among Adolescents in a Psychiatric Hospital Versus a Juvenile Correctional Facility, Poster Session, American Psychiatric Association, Institute on Psychiatric Services, New York, New York.
17. Penn JV. (2006) Suicide Attempts and Self-Mutilative Behavior in a Juvenile Correctional Facility, Symposium, Recent Developments in the Research of Juvenile Offenders, American Academy of Child and Adolescent Psychiatry Annual Meeting. San Diego, California.
18. Penn JV. (2007) Acting Out: How to Manage Difficult Adolescents in Correctional Settings, Symposium (Chair), Novel Approaches to the Evaluation and Treatment of Juvenile Offenders, International Academy of Law and Mental Health, International Congress on Law and Mental Health, Padua, Italy.
19. Garvey KA, Penn JV. (2007) Contracting for Safety with Adolescents: Is This an Empirically-Based Practice? Poster Session, American Academy of Psychiatry and the Law Annual Meeting, Miami, Florida.
20. Ryan E, Penn JV. (2007) Juvenile Sexual Offenders: Update on Clinical and Forensic Evaluation Strategies, Workshop Presentation, American Academy of Child and Adolescent Psychiatry Annual Meeting. Boston, Massachusetts.
21. Baillargeon J, Penn JV. (2008) The Prevalence and Treatment of Psychiatric Disorders in a State Prison System, Academic and Health Policy Conference on Correctional Health, Quincy, Massachusetts.
22. Garvey KA, Penn JV, Campbell AL, Esposito-Smythers CL, Spirito A. (2008) Contracting for Safety: Clinical Practice and Forensic Implications, Paper Session, American Academy of Psychiatry and the Law Annual Meeting, Seattle, Washington.
23. Baillargeon J, Penn JV, (2009) Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door, Symposium, International Academy of Law and Mental Health, International Congress on Law and Mental Health, New York, New York.
24. Baillargeon J, Penn JV, (2009) Psychiatric Disorder and Parole Revocation Among Texas Prison Inmates, Academic and Health Policy Conference on Correctional Health, Fort Lauderdale, Florida.
25. Dingle AD, Zito JM, Sharma S, Zima BT, Varley CK, Carlson GA, Penn JV. (2010) Psychotropic Medication Use in Vulnerable Child and Adolescent Populations, Symposium, American Academy of Child and Adolescent Psychiatry Annual Meeting, New York, New York.
26. Penn JV, (2011) Framework of Correctional Managed Care Models: Formulary Development and Implementation, Symposium, International Academy of Law and Mental Health, International Congress on Law and Mental Health, Berlin, Germany.

27. Ochoa K, Penn JV, Venters H, Hustings E, Mehta S, Belous L. (2011) Seriously Mentally Ill Persons in U.S. Immigration Detention, Panel, American Academy of Psychiatry and the Law Annual Meeting, Boston, Massachusetts.
28. Penn JV, Harzke AJ, Baillargeon J, (2012) Risk of Reincarceration among Prisoners with Co-Occurring Serious Mental Illness and Substance Use Disorders, Academic and Health Policy Conference on Correctional Health, Atlanta, Georgia.
29. Penn JV, (2012) Practicing Behind Bars: Challenges and Opportunities Within Correctional Psychiatry, Symposium, Forensic Psychiatry: Informing Clinical Practice, American Psychiatric Association Annual Meeting, Philadelphia, Pennsylvania.
30. Torrealday O, Penn JV, (2013) Juveniles Behind Bars: Meeting Treatment Needs Through a Statewide Academic and Correctional Managed Care Partnership, Academic and Health Policy Conference on Correctional Health, Chicago, Illinois.
31. Penn JV, (2013) Psychiatric Services in Jails and Prisons: An Update on the APA Guidelines, American Psychiatric Association Annual Meeting, San Francisco, California.
32. Penn JV, (2013) Psychiatric Comorbidity in Secure Juvenile Settings: How Complex an Issue is It Really? International Academy of Law and Mental Health, International Congress on Law and Mental Health, Amsterdam, The Netherlands.
33. Torrealday O, Penn JV, Parikh R, (2014) Meeting Complex Mental Health Needs of Youthful Offenders, Academic and Health Policy Conference on Correctional Health, Houston, Texas.
34. Parikh R, Torrealday O, Penn JV, (2014) Save Money and Get Better Care? Cost Effective Health Care Delivery in Juvenile Corrections, Academic and Health Policy Conference on Correctional Health, Chicago, Illinois.
35. Torrealday O, Penn JV, (2015) Grievances: Strategies to Reduce Grief and Grievances While Improving Patient Care, Academic and Health Policy Conference on Correctional Health, Boston, Massachusetts.
36. Appelbaum K, Ford E, Metzner J, Penn JV, Trestman R, (2015) The New APA Guidelines on Correctional Psychiatry, Panel Presentation, American Academy of Psychiatry and the Law Annual Meeting, Fort Lauderdale, Florida.

INVITED PRESENTATIONS

1. "Cognitive Behavioral Treatment of Panic Disorder," Rhode Island Hospital, Department of Psychiatry, General Hospital Psychiatry Continuing Education Series, Providence, Rhode Island, 1993.
2. "Social Phobia: An Overview of Treatment Strategies," Rhode Island Hospital, Department of Psychiatry, General Hospital Psychiatry Continuing Education Series, Providence, Rhode Island, 1994.
3. "Paraphilias and Sexual Deviations," Butler Hospital, Outpatient Department Case Conference, Providence, Rhode Island, 1995.
4. "Cultural Competence in the Delivery of Mental Health Services," Rhode Island Psychological Association 1995 Annual Convention, Providence, Rhode Island, 1995.

5. "Can You Teach Child and Adolescent Psychopharmacology from Somebody Else's Lecture Notes?" Grand Rounds, Bradley Hospital, Brown University Department of Psychiatry, Division of Child and Adolescent Psychiatry, East Providence, Rhode Island, 1997.
6. "Consulting to the Community: A Challenge for the Child and Adolescent Psychiatrist," Grand Rounds, Bradley Hospital, Brown University Department of Psychiatry, Division of Child and Adolescent Psychiatry, East Providence, Rhode Island, 1997.
7. "A School-Based Approach to Selective Mutism," Elmhurst Elementary School, Portsmouth, Rhode Island, 1977.
8. "Moodiness and Depression in Children and Adolescents," WLNE ABC Channel 6, Providence, Rhode Island, 1997.
9. "Moodiness and Depression in Adolescents," Mount Hope High School, Bristol, Rhode Island, 1997.
10. "Moodiness and Depression in Children and Adolescents," Lifespan Health Connection, Speaking of Kids, Parenting Education Series, Bradley Hospital, East Providence, Rhode Island, 1997.
11. "Career Opportunities in Child and Family Psychiatry," Junior Explorers, Miriam Hospital, Providence, Rhode Island, 1998.
12. "The Crisis of School Violence: How Do We Help Our Children," Testimony before the Congressional Children's Caucus, Washington, District of Columbia, 1999.
13. "Assessment of Violent Behavior in Adolescents," Department of Pediatrics, Division of Adolescent Medicine, Hasbro/Rhode Island Hospital, Providence, Rhode Island, 1999.
14. "Overview of Child Psychiatric Consultation at the Rhode Island Training School to the Rhode Island Family Court," Annual Rhode Island Family Court Judges' Conference, Narragansett, Rhode Island, 1999.
15. "The New Law and Psychiatry Service at Brown," Grand Rounds, Bradley Hospital, Brown University Department of Psychiatry, Division of Child and Adolescent Psychiatry, East Providence, Rhode Island, 1999.
16. "Violent Threats Made by Adolescents: An Approach to Assessment and Treatment," The Family Health Center at SSTAR Program, Fall River, Massachusetts, 1999.
17. "Introduction to Child and Adolescent Psychopharmacology," Miriam Hospital, Rhode Island Nursing Association, Clinical Nurse Specialists Continuing Education Seminar, Providence, Rhode Island, 2000.
18. "What We Don't Want to Happen to Our Youth," Adolescent Mental Health and School Success Conference, Rhode Island Department of Health, Providence, Rhode Island, 2000.
19. "Psychiatric and Abuse Issues Affecting Incarcerated Youth," Justice for All Youth Conference, Rhode Island Office of the Child Advocate, Warwick, Rhode Island, 2000.
20. "Juvenile Violence," Grand Rounds, Newport Hospital, Newport, Rhode Island, 2000.

21. "Demystifying the Courts and the Legal Process for Juveniles," Grand Rounds, Bradley Hospital, Brown University Department of Psychiatry, Division of Child and Adolescent Psychiatry, East Providence, Rhode Island, 2000.
22. "Warning Signs in Adolescents: A Practical Guide for Families and Educators," Lifespan Health Connection, Parenting Matters, Parenting Education Series, Tollgate High School, Warwick, Rhode Island, 2000.
23. "Mood Dysregulation and Mood Disorders in Incarcerated Youth," Grand Rounds, Judge Baker Children's Center, Boston, Massachusetts, 2001.
24. "The Crisis of School Violence: How Do We Help Our Children," Grand Rounds, Department of Psychiatry, State University of New York, Buffalo, New York, 2001.
25. "Mental Health Evaluation and Treatment of Incarcerated Youth," Child Psychiatry Fellowship Seminar Series, New England Medical Center, Boston, Massachusetts, 2001.
26. "Mood, Substance Abuse, and Other Mental Disorders in Violent Youth," St. Anne's Hospital, Fall River, Massachusetts, 2001.
27. "Teen Violence: Risk Management and Malpractice Issues" Annual Conference, National Organization of Forensic Social Workers, Philadelphia, Pennsylvania, 2001.
28. "Mental Health Needs of Incarcerated Youth" Annual Conference, National Organization of Forensic Social Workers, Philadelphia, Pennsylvania, 2001.
29. "Children's Mental Health Issues in Rhode Island: Problems and Solutions" Testimony before Congressional Committee Hearing, Rhode Island State House, Providence, Rhode Island, 2001.
30. "Mental Health Evaluation and Treatment of Incarcerated Youth," Sixth New England Correctional Health Conference, Sturbridge, Massachusetts, 2001.
31. "When Psychotherapies Are Not Enough: Medical Management of Aggression," Pediatric Psychopharmacology: An Update for Primary Care Practitioners, Providence, Rhode Island, 2001.
32. "Mental Health Evaluation and Treatment of Incarcerated Juveniles," The Providence Center, Providence, Rhode Island, 2001.
33. "School Shootings and Youth Violence," Truman Taylor Show, WLNE ABC, Channel 6, Providence, Rhode Island, 2001.
34. "Juveniles Presenting with Violent or Threatening Behaviors" Greater Fall River Child Protection Council and St. Anne's Hospital Lecture Series, Fall River, Massachusetts, 2001.
35. "School Shootings and Youth Violence," Healthwatch, NBC, WJAR Channel 10, Providence, Rhode Island, 2001.
36. "Youth Violence," Bradley/Hasbro Hospitals: Parenting Matters 2001, Toll Gate High School, Warwick, Rhode Island, 2001.
37. "School Violence: Strategies for Schools and Families," N.A. Ferry Middle School, Johnston, Rhode Island, 2001.
38. "School Violence: Strategies for Schools and Families" CBS, WPRI, Channel 12, Providence, Rhode Island, 2001.

39. "Re-Defining the Use of Psychotropic Medications in Children and Adolescents," Annual Rhode Island Family Court Judges' Conference, Narragansett, Rhode Island, 2001.
40. "Bullying, Beatings & Beyond: Assessment and Treatment of Youth Violence," Rhode Island Psychological Society, Pawtucket, Rhode Island, 2001.
41. "Psychiatric Services for Incarcerated Juveniles," Annual Meeting, National Commission on Correctional Health Care (NCCHC), Albuquerque, New Mexico, 2001.
42. "Assessment and Treatment of Juvenile Sexual Offenders," (Discussant) Grand Rounds, Rhode Island Hospital, Brown University Department of Psychiatry, Division of Child and Adolescent Psychiatry, Providence, Rhode Island, 2001.
43. "Re-Defining the Use of Psychotropic Medications in Children and Adolescents," Rhode Island Training School, Clinical Staff In-Service, Cranston, Rhode Island, 2002.
44. "Youth Violence: Evaluation and Treatment Approaches," University of Texas Medical Branch, Department of Psychiatry, Psychiatry Resident's Journal Club, Galveston, Texas, 2002.
45. "Youth Violence: Practical Strategies for Clinicians," St. Luke's Hospital, Department of Psychiatry, Grand Rounds, New Bedford, Massachusetts, 2002.
46. "Redefining the Use of Psychotropic Medications in Juvenile Justice Populations," 7th Northeast Correctional Health Care Conference, Sturbridge, Massachusetts, 2002.
47. "Profile of a Columbine Type Perpetrator: What to Look for and What to do About it," Annual Juvenile Probation and Justice Management Conference (Juvenile Probation Track): National Council of Juvenile and Family Court Judges Conference, Tucson, Arizona, 2002.
48. "Conduct Disorder: Evaluation and Treatment Approaches," Plymouth, Massachusetts, 2002.
49. "Conduct Disorder: Evaluation and Treatment Approaches," Child and Adolescent Psychiatry Grand Rounds, Taunton State Hospital, Taunton, Massachusetts, 2002.
50. "Redefining the Use of Psychotropic Medications in Children and Adolescents," Kent County Mental Health Center, Warwick, Rhode Island, 2002.
51. "The Project Hope Experience: Evaluation and Treatment of Mental Health Issues in Incarcerated Juveniles," Children's Mental Health - A System of Care Approach, American Academy of Child and Adolescent Psychiatry, Boston, Massachusetts, 2002.
52. "Clinical Challenges in Child and Adolescent Psychiatry," Beaumont, Texas, 2002.
53. "Recognizing Other Psychiatric Disorders" American Academy of Pediatrics: DB:PREP An Intensive Review Course of Developmental and Behavioral Pediatrics, Providence, Rhode Island, 2002.
54. "Youth Violence: Practical Strategies for Clinicians," Family Service Association of Greater Fall River, Inc., Fall River, Massachusetts, 2002.
55. "Bullying, Beatings, and Beyond: Assessment and Treatment of Youth Violence," Grand Rounds, Department of Pediatrics, Hasbro/Rhode Island Hospital, Providence, Rhode Island, 2002.

56. "Psychotropic Medications: What They Do, What They Don't Do," Annual Rhode Island Family Court Judges' Conference, Narragansett, Rhode Island, 2002.
57. "Recognition and Management Strategies of Youth Violence for Mental Health Professionals," Child and Adolescent Psychiatry Grand Rounds, Taunton State Hospital, Taunton, Massachusetts, 2002.
58. "Suicide Prevention in Juvenile Correctional Facilities," Staff Training Program, Rhode Island Training School, Cranston, Rhode Island, 2002.
59. "The Elephant in the Room: How the Legal System Can Impact Therapy," (Discussant) Grand Rounds, Bradley Hospital, Brown University Department of Psychiatry, Division of Child and Adolescent Psychiatry, East Providence, Rhode Island, 2003.
60. "Youth Violence," Bradley/Hasbro Hospitals: Parenting Matters 2003, Toll Gate High School, Warwick, Rhode Island, 2003.
61. "Identification and Treatment of Mental Health Issues in Incarcerated Youth," 8th Northeast Correctional Health Care Conference, Sturbridge, Massachusetts, 2003.
62. "Missed Opportunities and Challenges: Identifying Mental Health and Substance Abuse Issues in Today's Youth," Physician Leadership on National Drug Policy Conference: Adolescent Substance Abuse and Mental Health: A Public Health Priority, Providence, Rhode Island, 2003.
63. "Evaluation and Treatment of Incarcerated Juveniles with Mental Health Issues: Challenges, Frustrations, and Solutions," Butler Hospital, Child and Adolescent Services Program Lecture Series, Providence, Rhode Island, 2003.
64. "Surviving the Challenges of Juvenile Corrections: Suicide Prevention Strategies," National Conference on Correctional Health Care, Austin, Texas, 2003.
65. "Redefining the Use of Psychotropic Medications in Children," Annual Meeting of the RI Chapter of the American Academy of Pediatrics, Providence, Rhode Island, 2003.
66. "How Young People Become Criminals: Their Developmental Trajectories Before and After," Brown University, Behavioral Misadventures Symposium, Providence, Rhode Island, 2003.
67. "Understanding and Defusing Explosive Kids," Annual Juvenile Probation and Justice Management Conference, National Council of Juvenile and Family Court Judges, Nashville, Tennessee, 2004.
68. "Mixing Legal and Street Drugs: A Cocktail for Disaster," Annual Juvenile Probation and Justice Management Conference, National Council of Juvenile and Family Court Judges, Nashville, Tennessee, 2004.
69. "Promising Programs: Suicide Prevention/Good Practices," 23 rd Annual Juvenile Probation and Justice Management Conference, National Council of Juvenile and Family Court Judges, Nashville, Tennessee, 2004.
70. "Challenging Youths, Families & Systems: Implementing Psychiatric Strategies and Risk Management Principles," Problems in Pediatrics Conference, Colby College, Waterville, Maine, 2004.
71. "Acting Out Youths: Practical Evaluation & Treatment Strategies," Problems in Pediatrics Conference, Colby College, Waterville, Maine, 2004.

72. Various Presentations in Developmental/Behavioral Pediatrics, American Academy of Pediatrics PREP Course: Costa Mesa, California, 2004.
73. "Risky Behavior: How to Keep Youth Safe in Inpatient and Community Settings," Grand Rounds, Department of Pediatrics, Hasbro/Rhode Island Hospital, Providence, Rhode Island, 2004.
74. "ADHD Co-Morbidity: Practical Evaluation and Treatment Approaches," 2004 Fall CME Conference, New York State Society of Physician Assistants, Albany, New York, 2004.
75. "Behavioral Health Issues for Juvenile Offenders," 3rd Annual Behavioral Health in Corrections Conference, University of Rhode Island, Kingston, Rhode Island, 2004.
76. "Redefining the Use of Psychotropic Medications for Incarcerated Juveniles," National Conference on Correctional Health Care, New Orleans, Louisiana, 2004.
77. "Surviving Juvenile Corrections: Timely Suicide Prevention Strategies," National Conference on Correctional Health Care, New Orleans, Louisiana, 2004.
78. "How Young People Become Criminals: Their Developmental Trajectories Before and After," Contemporary Social Work Practice, Bradley Hospital Educational Series, Bradley Hospital, East Providence, Rhode Island, 2004.
79. Various Presentations in Developmental/Behavioral Pediatrics, American Academy of Pediatrics: PREP Course: Miami, Florida, 2005.
80. "Forensic Mental Health Evaluations," Continuing Legal Education Program, Office of the Public Defender, Providence, Rhode Island, 2005.
81. "Juvenile Suicide Risk in Congregate Care Settings, "Suicide Prevention Promises and Practices – Focus on Youth Conference, Rocky Hill, Connecticut, 2005.
82. "Profile of a Columbine-Type Juvenile: What to Look for and What to Do About It," Juvenile Courts Association of Georgia 2005 Annual Seminar, Pineisle Resort at Lake Lanier, Georgia, 2005.
83. Various Presentations in Developmental/Behavioral Pediatrics, American Academy of Pediatrics: PREP Course: Portland, Oregon, 2005.
84. Various Presentations in Developmental/Behavioral Pediatrics, American Academy of Pediatrics: Practical Pediatrics Course: Beaver Creek, Colorado, 2005.
85. "Strategies for Resident Advocacy at the State Legislature," 2nd Northeast Pediatric Resident Advocacy Conference, Hasbro Children's Hospital, Brown Medical School, Providence, Rhode Island, 2005.
86. Various Presentations in Forensic Psychiatry, Forensic Science Course, Law School, Universidad Francisco Marroquin, Guatemala City, Guatemala, 2005.
87. "Suicide Prevention/Intervention Training," Staff Training Seminar Series, Rhode Island Training School, Cranston, Rhode Island, 2006.
88. "ADHD and Juvenile Delinquency," Annual Meeting, American Society for Adolescent Psychiatry, Miami, Florida, 2006.
89. "Forensic Mental Health Evaluations," Continuing Legal Education Program, Criminal Division, Office of the Attorney General, Providence, Rhode Island, 2006.

90. "Assessment and Treatment of Adolescent Substance Use Disorders in Correctional Settings," National Conference on Correctional Health Care, San Diego, California, 2006.
91. "Berber v. Mellott, MD: Lessons from a Medical Malpractice Mock Trial," Continuing Medical Education Program, Professional Risk Management Services, Inc., Providence, Rhode Island, 2006.
92. "How to Respond to Mentally Ill and Substance-Abusing Youth in the Juvenile Justice System," 25th Annual Juvenile Probation and Justice Management Conference, National Council of Juvenile and Family Court Judges, Providence, Rhode Island, 2006.
93. "Acting Out: How To Manage Difficult Adolescents," National Conference on Correctional Health Care, Atlanta, Georgia, 2006.
94. "You Be the Judge: A Mock Trial Involving an Inmate's Claim," National Conference on Correctional Health Care, Atlanta, Georgia, 2006.
95. "Assessment and Treatment of Court-Involved Youth in Juvenile Corrections and Other Settings: Challenges, Frustrations, and Solutions," Contemporary Social Work Practice, Bradley Hospital Educational Series, Bradley Hospital, East Providence, Rhode Island, 2006.
96. "Mental Health Services for Juvenile Offenders," Grand Rounds, Department of Psychiatry, Maine Medical Center, Portland, Maine, 2007.
97. "Strategies to Avoid the Courtroom – The Case for Thorough Medical Documentation," UNAP/Rhode Island Health Care Education Trust Seminar Series, Rhode Island Hospital, Providence, Rhode Island, 2007.
98. "Suicide Prevention Strategies for Juveniles in Correctional Settings," Congress: Prevention of Suicidal Conduct in Incarcerated Minors, Campidoglio, Sala Della Protomoteca, Rome, Italy, 2007.
99. "Assessment and Treatment of Adolescent Substance Use Disorders in Correctional Settings," National Conference on Correctional Health Care, Las Vegas, Nevada, 2007.
100. "Civil Commitment of Adolescents," Rhode Island/Hasbro Hospitals Department of Pediatric Emergency Medicine, Case Conference, Providence, Rhode Island, 2007.
101. "Emerging Issues in Forensic Psychiatry," St. Luke's Hospital, Department of Psychiatry, Grand Rounds, New Bedford, Massachusetts, 2007.
102. Various Presentations in Forensic Psychiatry, Forensic Science Course, Law School, Universidad Francisco Marroquin, Guatemala City, Guatemala, 2007.
103. "Redefining the Use of Psychotropic Medications for Incarcerated Juveniles," National Conference on Correctional Health Care, Nashville, Tennessee, 2007.
104. "Lessons Learned from Inside the Fence: Juvenile Offenders, the RI Training School and Family Court Systems," Rhode Island Psychiatric Society, Providence, Rhode Island, 2007.
105. "Use of Psychotropic Medications for Incarcerated Youth," Updates in Correctional Health Care, National Conference on Correctional Health Care, San Antonio, Texas, 2008.

106. "Mentally Ill Juveniles," American Correctional Association, New Orleans, Louisiana, 2008.
107. "Identification and Management of Juvenile Mental Disorders," National Conference on Correctional Health Care, Chicago, Illinois, 2008.
108. "Identification and Management of Juvenile and Adult Mental Disorders," Texas Corrections Association, Austin, Texas, 2008.
109. "Use of Psychotropic Medications Within Correctional Settings," Mental Health Managers Conference, UTMB CMC Mental Health Services, Huntsville, Texas, 2008.
110. Various Presentations in Forensic Psychiatry, Forensic Science Course, Law School, Universidad Francisco Marroquin, Guatemala City, Guatemala, 2008.
111. "Mental Health Services within the Texas Correctional System," National Institute of Mental Health (NIMH) and UTMB: Mental Illness, Incarceration and Community Re-Entry: Telepsychiatry and Continuity of Mental Health Care, Austin, Texas, 2008.
112. "Essentials of Correctional Juvenile Health Care," Updates in Correctional Health Care: Transforming Principles to Practice, Las Vegas, NV.
113. "Preventing Suicide in Corrections: Timely Collaboration Between Administration, Custody, and Clinical Staff," UTMB CMC Annual Conference, Galveston, Texas, 2009.
114. "Psychotropic Medication Education for Non-Psychiatrists," UTMB CMC Mental Health Services Conference, Huntsville, Texas, 2009.
115. "Malingering: Practical Evaluation and Management Approaches," UTMB CMC Mental Health Services Conference, Huntsville, Texas, 2009.
116. "Assessment and Treatment of Adolescent Substance Use Disorders in Correctional Settings," Academy of Correctional Health Professionals Regional Seminar, Austin, Texas, 2009.
117. "Rational Approach to Psychotropic Medications in Correctional Settings," Academy of Correctional Health Professionals Regional Seminar, Austin, Texas, 2009.
118. "Behind the Bars and Razor Wire: Mental Health Disorders Within Correctional Settings," Texas Department of Criminal Justice (TDCJ) Community Justice Assistance Division (CJAD) Skills Conference, Austin, Texas, 2009.
119. "Essentials of Correctional Juvenile Health Care," National Conference on Correctional Health Care, Orlando, Florida, 2009.
120. "Evaluation and Treatment of Personality Disorders," Mental Health Managers Conference, UTMB CMC Mental Health Services, Huntsville, Texas, 2009.
121. "Mental Health Issues of the Female Offender," Texas Corrections Association Annual Conference, Galveston, Texas, 2010.
122. "Identification and Management of Adult and Juvenile Mental Health Disorders in Correctional Settings, National Conference on Correctional Health Care, Boston, Massachusetts, 2010.
123. "An In-Depth Look at NCCHC's New Standards for Health Services in Juvenile Facilities," National Conference on Correctional Health Care, Las Vegas, Nevada, 2010.

124. "Essentials of Correctional Juvenile Health Care," National Conference on Correctional Health Care, Las Vegas, Nevada, 2010.
125. "Mental Health Formulary and Disease Management Guidelines Development and Utilization with the Texas Department of Criminal Justice," Mental Health Conference, United States Bureau of Prisons-Health Services Division, Oklahoma City, Oklahoma, 2010.
126. "Competency to Assist in Immigration/Deportation Hearings: Application of Existing Competency Evaluation Models to Immigration Context (Non-Citizens with Mental Disabilities)," United States Immigration and Customs Enforcement (ICE)/Office for Civil Rights and Civil Liberties (CRCL) Mental Health Roundtable, Washington, D.C., 2010.
127. "Mental Health Systems of Care, Formulary and Disease Management Guidelines Development and Utilization within the Texas Department of Criminal Justice," Forensic Best Practices Conference, Houston, Texas, 2010.
128. "Juvenile Waiver and Transfer to Criminal Court," Conference Update on Juvenile Forensic Evaluations, Capacity for Justice, Austin, Texas, 2010.
129. "Practicing Behind Bars: Challenges and Opportunities Within Correctional Psychiatry" Grand Rounds, UTMB Department of Psychiatry and Behavioral Sciences, Galveston, Texas, 2010.
130. "Behind the Bars and Razor Wire: Mental Health Disorders within Correctional Settings" University of Texas Arlington, Annual Psychiatric Nursing Symposium, Arlington, Texas, 2011.
131. "An In-Depth Look at NCCHC's New Standards for Health Services in Juvenile Facilities," National Conference on Correctional Health Care, Phoenix, Arizona, 2011.
132. "Medical Conditions That Can Present as 'Psychiatric' in Nature," National Conference on Correctional Health Care, Baltimore, Maryland, 2011.
133. "An In-Depth Look at NCCHC's New Standards for Health Services in Juvenile Facilities," National Conference on Correctional Health Care, Baltimore, Maryland, 2011.
134. "Containing Your Psychotropic Medication Expenses: Strategies for Formulary Development and Implementation," American Correctional Association, Phoenix, Arizona, 2012.
135. "Child and Adolescent Forensic Psychiatry," International Conference on Forensic Psychiatry, Santiago, Chile, 2012.
136. "An In-Depth Look at NCCHC's 2008 Standards for Health Services in Prisons and Jails, National Conference on Correctional Health Care, San Antonio, Texas, 2012.
137. "Acting Out" Offenders: Implementing Mental Health/Psychiatric Strategies and Risk Management Principles, National Conference on Correctional Health Care, San Antonio, Texas, 2012.
138. "Save Pharmacy Dollars: Contain Your Psychotropic Medication Use and Expenses" American Correctional Association, Denver, Colorado, 2012.

139. "Practicing Behind Bars: Challenges and Opportunities within Correctional Psychiatry" Grand Rounds, Keck School of Medicine of the University of Southern California, Department of Psychiatry, Los Angeles, California, 2012.
140. "Review of NCCHC's Standards for Health Services in Juvenile Facilities," National Conference on Correctional Health Care, Las Vegas, Nevada, 2012.
141. "Medical Conditions That Present as 'Psychiatric' in Nature," National Conference on Correctional Health Care, Las Vegas, Nevada, 2012.
142. "Mad Versus Bad Offenders: Implementing Mental Health Strategies and Risk Management Principles," National Conference on Correctional Health Care, Las Vegas, Nevada, 2012.
143. "Contain Your Psychotropic Medication Use and Expenses," American Correctional Association, Houston, Texas, 2013.
144. "Evaluation and Management of Juvenile Offenders," American Correctional Association, Houston, Texas, 2013.
145. "Integrating Mental Health and Medical Issues in the Complex Environment of Corrections," Society of Correctional Physicians, Denver, Colorado, 2013.
146. "Update on NCCHC Standards," National Institute on Corrections (NIC), U.S. Department of Justice, State Directors of Mental Health Network meeting, National Advocacy Center, Columbia, South Carolina, 2013.
147. "Identification and Prevention of Suicide and Self Injurious Behaviors in Correctional Settings," American Association of Suicidology, Austin, Texas 2013.
148. "'Acting Out' Adolescents: Pearls for Effective Evaluation and Management," American Correctional Association, National Harbor, Maryland, 2013.
149. "Preventing Suicide Behind Bars: Real World Approaches," American Correctional Association, National Harbor, Maryland, 2013.
150. "DSM-5: An Overview and Its Impact on Correctional Mental Health," UTMB CMC Annual Conference, Galveston, Texas, 2013.
151. "Overview of UTMB CMC Mental Health Services," Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) Advisory Committee, Austin, Texas, 2013.
152. "An In-Depth Look at NCCHC's 2014 Standards for Health Services in Prisons," National Conference on Correctional Health Care, Nashville, Tennessee, 2013.
153. "Institutional Self-Injury: Managing the Self-Destructive Juvenile," National Conference on Correctional Health Care, Nashville, Tennessee, 2013.
154. "Medical Conditions That Present as Psychiatric in Nature," National Conference on Correctional Health Care, Atlanta, Georgia, 2014.
155. "Guidelines for Treatment of Adolescents with ADHD," National Conference on Correctional Health Care, Atlanta, Georgia, 2014.
156. "Correctional Psychiatry: The Final Frontier of Psychiatry," Psychiatry Grand Rounds, John Peter Smith (JPS) Health Network, Fort Worth, Texas, 2014.

157. “DSM 5: What Pediatricians Need to Know,” “Psychopharmacology in Primary Care: Practical Strategies,” “Adolescent Substance Abuse,” and “Adolescent Suicide and Self-Injurious Behaviors,” American Academy of Pediatrics: Practical Pediatrics CME Course, Hilton Head, South Carolina, 2014.
158. “Mental Health Issues of Female Offenders,” and “Update on NCCHC Standards,” National Institute on Corrections (NIC), U.S. Department of Justice, State Directors of Mental Health Network meeting, National Corrections Academy, Aurora, Colorado, 2014.
159. “Correctional Psychiatry: The Final Frontier of Psychiatry?” Grand Rounds, UTMB Department of Psychiatry and Behavioral Sciences, Galveston, Texas, 2014.
160. “Mental Health Issues of the Female Offender,” American Correctional Association, Salt Lake City, 2014.
161. “Strategies to Improve Patient Safety and Professional Satisfaction,” National Conference On Correctional Health Care, Las Vegas, Nevada, 2014.
162. “Risk Management: How is Your Jail Liable?” National Conference on Correctional Health Care, Las Vegas, Nevada, 2014.
163. Various Topics in Child and Adolescent Psychiatry, 25th Annual Pediatric Symposium, Joe DiMaggio Children’s Hospital at Memorial, Fort Lauderdale, Florida, 2014.
164. “Breaking Bad: Timely Strategies for Offenders with Mental Illness,” Mid-Winter Workshop, Texas Corrections Association, Austin, Texas, 2014.
165. “Assessment & Prevention of Suicide and Self-Injurious Behaviors: Correctional Best Practices,” American Correctional Association, Long Beach, California, 2015.
166. “Diagnosing Mental Illness Using DSM-5,” American Correctional Association, Indianapolis, Indiana, 2015.
167. “An In-Depth Look at NCCHC’s 2015 Standards for Health Services in Juvenile Detention and Confinement Facilities,” National Conference on Correctional Health Care, Dallas, Texas, 2015.
168. “Medical Conditions That Present as Psychiatric in Nature.” National Conference on Correctional Health Care, Dallas, Texas, 2015.
169. “Demystifying Mental Illness: It’s Not All in Your Head.” Texas Department of Criminal Justice (TDCJ) Health Services Division Annual Conference, Huntsville, Texas, 2015.
170. “PTSD in Corrections, Diagnostic and Treatment Issues.” American Correctional Association, New Orleans, Louisiana, 2016.
171. “The Development of a University-Based Specialty Program for State Prisoners with Gender Dysphoria.” American Correctional Association, New Orleans, Louisiana, 2016.
172. “Acting Out Youths: Timely Forensic and Correctional Approaches.” Presidential Symposia, “Issues for Child and Adolescent Psychiatry in the 21st Century.” American Psychiatric Association, Atlanta, Georgia, 2016.
173. “Use of Telepsychiatry Within Correctional Settings.” American Correctional Association, Boston, Massachusetts, 2016.

174. "LGBT Offenders: Critical Issues in Gender Dysphoria." Coalition of Correctional Health Authorities, All Health Authority Training, National Institute of Corrections, Washington, D.C., 2016.
175. "Guidelines for Treating ADHD in Adolescents," NCCHC, Las Vegas, Nevada, October 2018.
176. "Epidemiology of Suicide." Texas Society of Psychiatric Physicians Conference, Austin, Texas. 2018.
177. "The Assessment and Management of Suicide Risk, Tex Med Conference, San Antonio, Texas May 2018.
178. "The Assessment and Management of Violence Risk, Tex Med Conference, San Antonio, Texas May 2018.
179. "Guidelines for Treating ADHD in Adolescents," NCCHC, Las Vegas, Nevada, October 2018.
180. "Practicing Correctional Psychiatry Behind the Bars and Razor Wire: Challenges and Opportunities," McMaster University: International Forensic Psychiatry Lecture Series. Virtual CME Program, December 2020.
181. "Mental Health: Finding a Way Past Trauma and Violence," UTMB Health Virtual Winter Series, Galveston, Texas, March 2021.
182. "Seclusion and Restraint in Correctional Settings," Texas Society of Child and Adolescent Psychiatry: Child Psychiatry at the Crossroads: Focus on At Risk Populations and Social Change. Virtual CME Program, July 2021
183. "Diagnosis and Treatment of Individuals with Gender Dysphoria (GD) Within Correctional Settings," Developments in Correctional Psychiatry Course, American Academy of Psychiatry and the Law (AAPL), Virtual CME Program, December 2021.

GRANTS

1. Penn (PI) 01/01/2002-01/01/2003
"Incidence of Suicide Attempts and Self-Injurious Behavior in a Juvenile Correctional Facility." Source: American Academy of Child and Adolescent Psychiatry, Eli Lilly and Company. \$ 9,000.
Role: Principal Investigator
2. Penn (PI) 01/01/2003-05/31/2004
"Correlates of Suicidal Behavior in Incarcerated Juveniles." Source: Lifespan Developmental Grant, Lifespan. \$ 29,451.
Role: Principal Investigator
3. Penn (PI) 06/30/2004-12/31/2005
"Liability Prevention for Hasbro Hospital Staff: Practical Strategies for Youths with Mental Health and Substance Abuse Issues." Source: Lifespan Risk Management, Lifespan. \$12,200.
Role: Principal Investigator
4. 5K23DA021532 (PI: Tolou-Shams, Ph.D.) 02/01/2008-01/13/2013

“HIV Prevention in the Family Drug Court.” Source: National Institute of Drug Abuse (NIDA)

Role: Consultant

UNIVERSITY TEACHING ROLES

Brown University, Residency in Psychiatry, 1995: “Effective Documentation and Medical Record Strategies for Psychiatrists,” New Residents’ Seminar Series (single seminar).

Brown University, Residency in Psychiatry, 1995: “Antipsychotics: An Introduction and Rational Clinical Approach,” New Residents’ Seminar Series (single seminar).

Brown University, Residency in Psychiatry, 1995: “Cultural Psychiatry,” PG-3 Seminar Series, Seminar Leader (weekly seminars).

Brown Medical School, 1997: “Biomed 278: Introduction to Clinical Psychiatry,” Small Group Leader, (weekly meetings).

Brown University, Residency in Psychiatry, 1997: “PG-2 Seminar: Mood Disorders in Children and Adolescents” (single seminar).

Brown University, Residency in Child and Adolescent Psychiatry, 1998: “Children’s Testimony in Court: Roles of the Expert Witness and Videotaped Interviews,” Child and Adolescent Forensic Psychiatry Seminar Series, (single seminar).

Yale University Law School, Disabilities Clinic, 1999: “Introduction to Child and Adolescent Psychopharmacology,” (single seminar).

Brown University, Residency in Child and Adolescent Psychiatry, 1999-2008: “Risk Assessment of Youth Violence,” Child Psychiatry Boot Camp Seminar Series, (single seminar).

Brown University, Residency in Child and Adolescent Psychiatry, 1999-2008: “Rhode Island Mental Health Law,” Child Psychiatry Boot Camp Seminar Series, (single seminar).

Brown University Residency in Psychiatry, 1999: “Introduction to Child and Adolescent Forensic Psychiatry,” PG-3 Resident Seminar, (single seminar).

Brown University, Residency in Child and Adolescent Psychiatry, 1999: Community Mental Health Center Rotation, Family Health Center at SSTAR, Fall River, Massachusetts, Clinical Supervisor, (weekly clinic and supervision).

Brown University, Residency in Child and Adolescent Psychiatry, 1999-2008: Clinical Supervisor, Brown University Child Psychiatry Forensic Psychiatry Elective, (weekly supervision).

Brown University Residency in Psychiatry, 2000-2001: “Disruptive Disorders, Antisocial Behaviors, and Legal Issues,” PG-2 Resident Seminar, (single seminar).

Brown University, Residency in Child and Adolescent Psychiatry, 2000-2008: “Child and Adolescent Forensic Psychiatry” Seminar Leader, (four seminars).

Brown University, Residency in Child and Adolescent Psychiatry, 2001-2002: Clinical Supervisor, Community Mental Health Center Rotation, Kent County Mental Health Center, Warwick, Rhode Island, (weekly clinic and supervision).

Brown University, Residency in Child and Adolescent Psychiatry, 2001-2008: Clinical Supervisor, Forensic/Juvenile Justice Rotation, Rhode Island Training School, Cranston, Rhode Island, (daily and weekly clinics and supervision).

Brown Medical School, 2002-2008: Clinical Supervisor for 3rd and 4th year medical students, Longitudinal elective, 4th year elective, and psychiatry rotation, Rhode Island Training School, Cranston, Rhode Island, (daily and weekly clinics and supervision).

Brown University Residency in Psychiatry, 2002-2003: Tutor-Advisor to Nada Milosavljevic, M.D., J.D., PG-2 Psychiatry Resident.

Brown University Residency in Psychiatry, 2003: "Bullying, Beatings, and Beyond: Assessment and Treatment of Youth Violence," Noon Seminar, (single seminar).

Brown University Post-Doctoral Juvenile Forensic Psychology Training Program, 2003-2008: Core Supervisor and Seminar Leader.

Brown University Psychology Intern and Post-Doctoral Fellowship Training Program, Child Track Seminar Series Presenter, 2004-2008: "The Law and Psychiatry/Psychology" (single seminar).

Brown University Residency in Psychiatry, 2004-2008: "Risk Assessment of Potentially Violent Juveniles," PG-3 Resident Seminar, (single seminar).

Brown University Residency in Psychiatry, 2004-2008: "Divorce, Custody and Visitation Issues: The Psychiatrist Facing Court Systems," PG-2 Resident Seminar, (single seminar).

Brown University Residency in Child and Adolescent Psychiatry, 2005-2008: "Evaluation and Treatment of Conduct Disorder," Child and Adolescent Psychiatry Developmental Psychopathology Seminar Series, (single seminar).

UTMB Department of Psychiatry and Behavioral Sciences, Residency in Psychiatry, 2008-present: "Opportunities and Challenges within Correctional and Forensic Psychiatry," (single seminar).

UT Health Science Center at Houston, Department of Psychiatry and Behavioral Sciences, Residency in Child Psychiatry, 2008-present: "Juvenile Correctional Mental Health Services in Texas," (single seminar).

UTMB Department of Psychiatry and Behavioral Sciences, Residency in Psychiatry, 2010-present: "Suicide Prevention and Litigation: Timely Risk Management Approaches," Forensic Psychiatry Seminar Series, (single seminar).

HOSPITAL TEACHING ROLES

Butler Hospital, 1993-1996: Seminar Leader, Various Psychiatry Topics, Brown University Medical Students' Psychiatry Clerkship, (multiple seminars).

Rhode Island Hospital, 1995: Psychiatry Preceptor and Consultant to Internal Medicine Housestaff Clinic, (twice weekly clinic).

E. P. Bradley Hospital, 1997: Adolescent Program Training, "The Use of Antipsychotics in Adolescents," (one seminar).