UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

ASHLEY DIAMOND,
Plaintiff,
v.
TIMOTHY WARD, et al.,
Defendants.

CASE NO. 5:20-CV-00453-MTT

SUPPLEMENTAL EXPERT REPORT OF DR. RANDI ETTNER

I. INTRODUCTION

1. My name is Dr. Randi Ettner. I have been retained by counsel for Plaintiff Ashley Diamond to provide my expert opinion regarding the adequacy of the Gender Dysphoria treatment Ms. Diamond received while incarcerated in the Georgia Department of Corrections (GDC), and the impact of prison sexual abuse within GDC on Ms. Diamond's mental health.

2. This report ("Report") serves as a supplement to the expert opinions I prepared on April 9, 2021, May 10, 2021, and January 13, 2022 (collectively "Initial Reports"), and, like my Initial Reports, it sets forth the opinions I may express at trial and the bases for my opinions. The opinions expressed in this Report are based on the information that I have reviewed to date. In order to provide the most accurate and comprehensive opinions helpful to the Court, should additional relevant medical and mental health records concerning Ms. Diamond, or additional deposition testimony from GDC personnel involved in Ms. Diamond's Gender Dysphoria care, become available, I wish to be provided the opportunity to revise and supplement my opinions prior to trial.

3. My qualifications and expertise, including my curriculum vitae, list of publications, previous expert testimony, and rates, appear in my Initial Reports and addendums, so rather than repeat them I incorporate them herein. But, since the release of the Initial Reports, I have also testified as an expert in the following matter: *Cecilia Gilbert v. Dell Technologies*, No. 1:19-cv-01938 (JGK), JAMS No. 1425032318 (S.D.N.Y. 2022).

II. MATERIALS CONSIDERED

4. In addition to the materials and clinical assessments I identified in my Initial Reports, the supplemental opinions contained herein are based on my interview with Ashley Diamond on August 5, 2022 regarding the treatment of her Gender Dysphoria and Post-Traumatic Stress Disorder within GDC and resulting symptoms, the records and literature identified in the attached Appendix, and my considerable professional experience regarding the condition of Gender Dysphoria and its symptoms.

III. SUMMARY OF SUPPLEMENTAL OPINIONS

A. Summary of August 5, 2022 Assessment

5. On August 5, 2022, I spoke with Ms. Diamond following her discharge from Coastal State Prison. My interview took place via telephone and lasted approximately one hour. Ms. Diamond was oriented in all spheres, sensorium were intact, and thought processes were logical, goal-oriented and without distortion. Affect was very sad, but appropriate to content in the expression of feelings of emotional pain, disadvantage, loss, despair, grief, helplessness, and disappointment. Ms. Diamond wept copiously when describing the harassment and mistreatment she experienced during her incarceration and continuing up to and including discharge.

6. Ms. Diamond relayed that she is unable to sleep, continuously hypervigilant in the anticipation that somebody may be "coming up behind her." The anxious arousal, emotional dysregulation, hypervigilance, and other symptoms of complex trauma are not unexpected, and,

as previously noted, require intense, trauma-informed care. It is my opinion that Ms. Diamond now has exacerbated symptomatology as a result of the mistreatment she endured while incarcerated.

7. Ms. Diamond also confirmed that her challenges accessing necessary forms of Gender Dysphoria treatment persisted up until her release, and, equally worrisome, that she was released from GDC without the mandatory 30-day supply of medications that she requires. It can be life-threatening to stop a patient's medication (including hormone treatment) abruptly, or without medical rationale and supervision. Abrupt cessation of cross-sex hormone medication can negatively impact every organ system in the body, as sex steroids play a role in the regulation of every system. Therefore, without uninterrupted access to essential medication, she is at extreme risk of devolving mental illness or possible death.

B. Observations Concerning Ms. Diamond's Acute and Persistent Gender Dysphoria Symptoms

8. When Gender Dysphoria is inadequately or inappropriately treated in carceral settings, the results are predictable and dire, and take one of three paths: profound psychological decompensation, surgical self-treatment (auto-castration or auto-penectomy), or suicide. During her multi-year incarceration within GDC, Ms. Diamond exhibited all of the aforementioned sequelae, which is not uncommon in institutional settings where access to medically-indicated care is inadequate or denied. (See Brown, 2010; Brown & McDuffie, 2009).

Risks of Providing Inadequate Care

9. Without adequate treatment, gender dysphoric adults experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues. Ultimately, coping strategies are exhausted, resiliency erodes, and, as in Ms. Diamond's case, one can experience emotional decompensation—the severe deterioration of

mental health, profound symptomatology and an inability to function. The result of emotional decompensation can be complete—and may cause an individual to be incapable of accomplishing simple everyday tasks or result in institutional isolation (segregation or suicide watch) which may serve to further exacerbate their symptoms. Many gender dysphoric women without access to appropriate care are often so desperate for relief that they resort to life-threatening attempts at auto-castration (the attempt to remove one's testicles) or auto-penectomy (the attempt to remove the penis), in the hopes of eliminating the offending genitals that kindle the Gender Dysphoria.

10. Ms. Diamond confirms, and her medical records reflect, that at various points during her incarceration in GDC she attempted surgical self-treatment (i.e. auto-castration or auto-penectomy). Although Gender Dysphoria is a serious medical condition, many providers who lack knowledge of this specialized area of medicine often mistake an individual's attempt to remove the genitalia as "mutilation." In fact, surgical self-treatment is a rational and strategic attempt, albeit dangerous, for those who lack agency and can't access the care for Gender Dysphoria available in the community. Attempted removal of the genitals is not a symptom of any other mental health diagnosis Ms. Diamond has currently or historically received.

11. Attempts to remove one's genitals are a clear indication that lack of access to medically-necessary treatment or inadequate treatment has led to overwhelming feelings of hopelessness and they remain the only means of attaining relief. (See Brown, 2010; Brown & McDuffie, 2009). Any attempt at surgical self-treatment is clinically concerning. Such attempts should alert providers to the severity of an individual's Gender Dysphoria and prompt immediate attention. Multiple attempts at surgical self-treatment are dire, and require immediate

consultation with a professional who can evaluate the patient and generate a treatment plan that adequately and timely attenuates the escalation and potential lethality of their Gender Dysphoria.

12. Ms. Diamond's struggles with surgical self-treatment or ideation are documented in her GDC medical and mental health records, which contain findings from multiple health care providers and go as far as to document physical injuries she sustained. Of her diagnoses, Gender Dysphoria is the only available cause for Ms. Diamond's attempts at surgical self-treatment since it is clear from the literature that auto-castration and auto-penectomy are not behavioral manifestations associated with Bipolar Disorder, Post-Traumatic Stress Disorder ("PTSD"), or Major Depressive Disorder. (DSM-5).

Suicidal Ideation

13. Ms. Diamond's medical records at GDC and my past clinical assessments are rife with indications that Ms. Diamond struggled with feelings of suicidality during her multi-year incarceration in GDC. Further, these sources indicate that Ms. Diamond's persistent suicidal ideation and attempts were the result of two comorbid conditions: her chronic, inadequately treated Gender Dysphoria and Complex PTSD/Trauma (ICD-11, 6B41) ("Complex PTSD"). At the behest of the Surgeon General, a plan for identifying populations at risk for suicide and advancement of scientific methods to assess risk has resulted in recent abundant scientific investigation. Several lines of research suggest that single suicide attempters differ significantly from multiple suicide attempters. Multiple attempters are far more likely to die by suicide than single attempters. Bauer et al. found that denying gender-affirming care was associated with suicidality, and found a 62% reduction in risk of suicide with the completion of medical transition. (Bauer et al., 2015).

Observations Concerning Ms. Diamond's PTSD and Complex PTSD

14. Ms. Diamond previously was diagnosed with PTSD as a result of the abuse she experienced in a prior incarceration at GDC, and now suffers from Complex PTSD. Complex PTSD results from repetitive exposure to inescapable danger, similar to what victims of torture experience. PTSD and Complex PTSD are both physical and psychological, and can be conceptualized as a dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis and the neurocircuitry of the brain.

15. Patients with PTSD and Complex PTSD can no longer mediate the fight-flight-freeze response, as the fear circuitry stops responding to signals from the prefrontal cortex. Symptoms of these conditions include intrusive thoughts, nightmares, flashbacks, negative alterations in cognition and mood, sleep problems, hypervigilance, increased startle response and self-destructive behavior, and arise spontaneously, beyond an individual's control. Additionally, Complex PTSD includes the presence of four additional symptom constellations, which I confirmed during psychodiagnostic testing and assessment of Ms. Diamond. The scientific literature makes the connection between sexual abuse and PTSD diagnoses plain: individuals who experience interpersonal violence like sexual abuse on more than one occasion experience many of the same symptoms that torture victims and prisoners of war experience. Unfortunately, this provides an apt description of Ms. Diamond and her mental state following her 2019-2022 incarceration within GDC.

16. Ms. Diamond now suffers from Complex PTSD. The U.S. Department of Veterans Affairs describes people with Complex PTSD as being at heightened risk for suicide, plagued by strong dissociative symptoms, prone to extreme isolation and distrust, and given to crises of faith. They are also highly susceptible to substance abuse and other forms of self-harm. They may be considered "treatment-resistant." Complex PTSD symptoms can be more intense

and last longer than typical PTSD symptoms. Given the ingravescent course and the failure of psychotropic medications, cannabis and ketamine have demonstrated therapeutic efficacy for some treatment-resistant patients. (Lirano et al., 2019; O'Neil et al., 2017).

C. Observations Concerning Ms. Diamond's Major Depressive Disorder and Related Mental Health Conditions

17. Ms. Diamond's medical records and my clinical assessments confirm that Ms. Diamond's periods of incarceration within GDC led to the development of the additional, serious psychiatric disorder, Major Depressive Disorder (DSM-5, 296.23).[1]

18. Based on my review of Ms. Diamond's medical records and relevant literature, Ms. Diamond's Major Depressive Disorder appears to be attributable to her two comorbid conditions: acutely symptomatic Gender Dysphoria and complex, worsening PTSD. Eighty percent of people diagnosed with PTSD go on to receive a Major Depressive Disorder diagnosis. (Yang et al., 2015).

D. The Demonstrable Lack of Expertise of GDC Providers and Clinicians

19. Since my Initial Reports, I also received the deposition testimony of GDC personnel and contractors involved in the care and treatment of Ms. Diamond. Together, they paint a distressing picture—indicating the extent to which Ms. Diamond went without minimally adequate treatment for her Gender Dysphoria, or healthcare providers with the minimal-necessary qualifications, during her incarceration in GDC.[2]

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[1] I previously discussed the diagnostic criteria for this condition in my Initial Reports.

[2] The *WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7th Ed. 2011) ("SOC")—the accepted clinical standards on the treatment of Gender Dysphoria, which I helped to author—contain important discussion on the responsibilities of and necessary qualifications for healthcare providers involved in the care of gender dysphoric patients. (See SOC at 22-28, 41). In a section entitled "Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals," the SOC also note that "[b]ecause this field of medicine is evolving, clinicians should become familiar and keep current with the medical

20. As healthcare providers, Drs. Lewis, Jackson, and Awe are members of a highly regulated profession subject to ethical rules and community standards. Key among them is a prohibition on making patient care decisions without the necessary and appropriate expertise. Having appropriate qualifications is not simply a question of whether a provider is licensed or has obtained a doctorate or medical degree. Instead, it turns on whether the provider has adequate knowledge, training, experience, or certification regarding a given healthcare condition. By analogy, a psychiatrist is not equipped to draw up treatment plans for patients with leukemia. Nor is an oncologist qualified to medically manage the treatment of a patient with schizophrenia.[3] Yet this basic precept was ignored within GDC with respect to key providers involved in Ashley Diamond's care.

21. For instance, Dr. Lewis, GDC's Statewide Medical Director, whose background is in Pediatrics, admitted that neither she nor then-Statewide Medical Director Dr. Javel Jackson had training or expertise concerning the treatment of Gender Dysphoria in adults or otherwise.[4] Dr. Olatunji Awe, the Medical Director at Coastal State Prison, where Ashley Diamond was housed beginning in 2020 until August 2022, also made his lack of Gender Dysphoria knowledge plain over the course of his deposition. Dr. Awe admitted that he had not received any training related to Gender Dysphoria as a provider at GDC, and had never reviewed the SOC, which constitute the accepted guidelines for treating the condition. He also demonstrated

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literature and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations." (*Id.* at 41).

[3] In addition, the SOC contain detailed provisions on the minimum qualifications necessary for mental health providers involved in patient care. These provisions, which are outlined in my Initial Reports, make clear that formal training and licensure do not confer competency without specialized knowledge and training and/or continued education.

[4] At the time of this Supplemental Report, the deposition of Dr. Jackson and several other witnesses had not yet occurred due to postponements, so I reserve the right to supplement this Report and the opinions I offer at trial in response to this additional testimony.

near-total ignorance about the condition when asked to provide basic information about the diagnosis or its treatment pathways.

22. Pursuant to these baseline care standards, neither Dr. Lewis, Dr. Jackson, nor Dr. Awe have the minimum knowledge, training, or qualifications necessary to: (1) make treatment decisions concerning patients with Gender Dysphoria; (2) review, approve, or deny Gender Dysphoria treatment plans; (3) supervise any of the practitioners involved in administering Gender Dysphoria care; (4) determine if, or when, symptoms of a patient like Ms. Diamond are severe enough to require a specialist referral; or (5) make any determinations as to the medical necessity of specific forms of Gender Dysphoria treatment in patients.[5] Instead, the appropriate course is to provide patients immediate (and, if necessary, expedited) referral to a practitioner with the necessary expertise. However, this was decidedly not done within GDC.

23. Dr. Awe also displayed a combination of hostility and ignorance towards the condition of Gender Dysphoria and the needs of affected patients, going as far as to declare that Gender Dysphoria was "not [his] favorite subject." Dr. Awe also made his lack of knowledge concerning Gender Dysphoria plain when he briefly suggested, contrary to the scientific literature, that Ms. Diamond's self-surgery attempts could be understood as a symptom of Bipolar Disorder.[6]

24. It is axiomatic that the healthcare providers who have any involvement in the treatment of patients with Gender Dysphoria must be minimally-competent. (See SOC at 28, 41).

[5] These statements apply with even greater force to Jennifer Ammons, an attorney who participated in Ms. Diamond's care decisions as well despite her lack of a healthcare background or training.

[6] Dr. Awe eventually acknowledged that self-surgery attempts are indeed a symptom of Gender Dysphoria and withdrew his unsupported statement that Bipolar Disorder might instead be a cause.

Because the Statewide Medical Director and Statewide Mental Health Director were given a final say on the Gender Dysphoria treatment patients within GDC receive under GDC's Standard Operating Procedures, Dr. Lewis and Dr. Jackson were required to be knowledgeable about and/or have specialized training on Gender Dysphoria and its treatment pathways, along with the SOC. (SOC at 22-28, 41). The minimum competency requirement also applies to Dr. Awe given his status as gatekeeper for specialist appointments at Coastal State Prison, even if he ultimately delegated treatment decisions.

25. However, from the materials I reviewed, it is clear these minimum competency requirements were not met. Not only did Ms. Diamond's providers (including Dr. Lewis and Dr. Awe) lack specialized training or expertise on the condition of Gender Dysphoria, they were unable to differentiate transgender women from transgender men and referred to Ms. Diamond as a man or a "transgender male" in medical records. There can be no clearer evidence that these individuals were utterly devoid of the most basic understanding of this serious medical condition while Ms. Diamond was in GDC relegated to their care. Indeed, because of Dr. Awe's ignorance about or disregard for the significance of self-surgery attempts in dysphoric patients, he never arranged for Ms. Diamond to be evaluated by a provider knowledgeable about Gender Dysphoria other than concerning hormone administration.

E. The Response to Ms. Diamond's Acute Medical and Mental Health Conditions by GDC Personnel and Clinicians

Inattention to Ms. Diamond's Gender Dysphoria Treatment Needs

26. The SOC establish the therapeutic importance of changes in gender expression by means of social signifiers that align with gender identity. Gender Dysphoria, like many medical conditions, often requires more than a single intervention for effective treatment. For example, clothing and grooming that affirm one's gender identity, such as make-up for transgender

females, and the use of congruent pronouns are critically important components of treatment protocols. (See Greenberg & Laurence, 1981; Ettner, 1999; Devor, 2004).

27. The SOC also specifically provide that permanent hair removal, the elimination of a visible secondary sex characteristic, is significant in alleviating Gender Dysphoria for transgender women. Other gender-appropriate grooming items for transgender women, such as feminine deodorant, moisturizer, and hair care items, may also be necessary for treatment. These accoutrements are critical to the social transition and mental well-being of gender dysphoric people, and are considered medically necessary, in that they ameliorate the condition.

28. The most commonly pursued gender-confirming medical intervention in transgender women is hair removal, as facial hair is an obvious source of distress. Electrolysis and/or laser hair removal are typically required to live safely and comfortably in the affirmed female gender. The removal of hair is an ongoing process for most transgender women, particularly those with dark and coarse hair, and requires numerous treatments. A very recent study explored satisfaction with hair removal in relation to Gender Dysphoria and psychological symptoms in a group of 281 transgender women. (Bradford, Rider & Spencer, 2019). Results found satisfaction with hair removal correlated with less body dysphoria, less depression and anxiety, and an overall enhanced sense of well-being. The authors conclude that "[t]hese findings cast significant doubt on the assertion that hair removal services for transfeminine people are 'cosmetic.'" (*Id.*) Indeed, no treatment can be considered cosmetic if there is an underlying medical diagnosis (e.g. Gender Dysphoria, or Polycystic Ovarian Syndrome).[7]

[7] As my previous Reports noted, Greenberg and Laurence, in a series of early studies, compared the psychiatric status of gender dysphoric individuals living as women—their identified gender—to those who were living as men, compared to psychiatric patients. Those who were living as women showed "a notable absence of psychopathology" while those who were living as men appeared more similar to the psychiatric patients, "underlin[ing] the importance of living as female."

29. Notably, three of Ms. Diamond's current and former healthcare providers within GDC—Dr. Will Ausborn, Dr. Daniel Fass, and Dr. Stephen Sloan—concur in my conclusion that outward female gender expression through grooming is a necessary component of Ms. Diamond's Gender Dysphoria treatment according to GDC records. These providers also confirmed Ms. Diamond's need for gender-affirming female grooming items in her medical and mental health records, and recommended that additional care be provided. However, despite the effective consensus within GDC that congruent gender expression was a medically-necessary treatment modality for Ms. Diamond, Ms. Diamond's outward gender expression needs were never accommodated by GDC between her October 29, 2019 entry into GDC custody and her August 1, 2022 release.

30. From the materials I reviewed, it appears that Ms. Diamond was never provided access to female commissary items, a female clothing package, a GDC makeup allowance comparable to the allowance provided to cisgender women prisoners, or authorization to grow out her hair and wear it in a feminine style, even though each of these items is part and parcel of the recognized guidelines for treating Gender Dysphoria in institutional settings and they have been safely provided to patients incarcerated in other jurisdictions. (SOC at 67-68).[8]

31. Denying a patient who is receiving hormone therapy the ability to outwardly express their gender is a gross departure from accepted clinical standards that undermines the efficacy of treatment and can lead to sequalae such as worsening anxiety, depression, suicidal

(Greenberg & Laurence, 1981). More recently, Sevelius concluded that access to gender-affirming social recognition equated with better mental health, fewer suicide attempts, and lower levels of depression and lower PTSD scores. (Sevelius, 2013).

[8] The Illinois Department of Corrections serves as one such example.

ideation and surgical self-treatment attempts. Yet, GDC providers and administrators, including Dr. Lewis and Mr. Sauls, admitted that no such treatment was available within GDC.[9]

32. Further, even though hair removal treatment has been shown to effectively attenuate Gender Dysphoria symptoms, Ms. Diamond was never furnished access to depilatories to ease the distress she experienced as a result of both facial hair growth and the male ritual of shaving, which each carry the stigma of masculinity.[10] In addition, GDC personnel and contractors, including Dr. Olatunji Awe, one of Ms. Diamond's own medical providers, insisted on using male pronouns to refer to her even though a core precept of Gender Dysphoria treatment is affirming patients in their gender, and refusing to do so can actively cause emotional distress and harm. (Swannell, 2000).

33. As such, throughout her incarceration in GDC, Ms. Diamond remained without the medically-indicated treatment for her Gender Dysphoria. It is also clear that her inability to express her female gender and to adequately remove her facial hair exacerbated Ms. Diamond's Gender Dysphoria and led to a deterioration of her mental health.

34. After observing Ms. Diamond's Gender Dysphoria symptoms and undertaking some self-study since formal training on Gender Dysphoria is not available within GDC, Ms. Diamond's current and former treating clinicians within GDC—Drs. Ausborn, Fass, and Sloan—

[9] While female undergarments can provide a number of tangible benefits, as noted in my Initial Reports, they do not constitute an outward gender expression or provide the social recognition achieved by female makeup, uniform, or hairstyle allowances, by virtue of being private and concealed—in Ms. Diamond's case, under a male prison uniform.

[10] Despite their medical training, Dr. Awe and Dr. Lewis appeared to be unaware that hair removal treatment such as laser hair removal and eflornithine (Vaniqa) are also considered to be a medically-indicated form of treatment for Polycystic Ovary Syndrome (PCOS), a condition which produces unwanted facial hair growth in cisgender women. (See, e.g., Lapidoth, 2010). The same body of research confirms the damaging psychosocial effects of male-pattern facial hair in people who identify as female.

each independently concluded, as did I, that Ms. Diamond required female items to express her affirmed gender, in addition to hormone therapy for her Gender Dysphoria.[11] These providers even went as far as to formally memorialize their recommendations in Ms. Diamond's medical and mental health records. Yet, it does not appear that any action was taken to revise or reevaluate Ms. Diamond's treatment regimen to comport with these suggestions other than to supply Ms. Diamond with female undergarments following numerous requests.

35. As the SOC explain in a Section entitled "Applicability of the Standards of Care to People Living in Institutional Environments," "All elements of assessment and treatment as described in the SOC can be provided to people living in institutions. . . . Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements." (SOC at 67). The SOC also explain that "[i]f the in-house expertise of health professionals in the direct or indirect employment of the institution does not exist to assess and/or treat people with Gender Dysphoria, it is appropriate to obtain outside consultations from professionals who are knowledgeable about this specialized area of health care." (*Id.* at 67-68).

36. Yet, when Ms. Diamond voiced a need for additional Gender Dysphoria treatment in the form of a medicated facial hair removal product, close in time to her July 2020 surgical self-treatment attempt, Dr. Awe failed to consult anyone about the request besides Dr. Lewis, a provider who openly admitted her lack of Gender Dysphoria-related expertise. Then, in a further departure from community practice standards, Dr. Lewis declined to enlist the assistance of an

[11] While Drs. Ausborn and Fass cared for Ms. Diamond during her 2019-2022 period of incarceration, Dr. Sloan made similar notes and treatment recommendations in 2015.

Self-study also appears to have been required because, as Mr. Sauls, Dr. Lewis, and GDC Representative Mark London all made clear, GDC does not require its practitioners to have Gender Dysphoria expertise, or otherwise make Gender Dysphoria training available to the practitioners responsible for patient care in GDC.

experienced clinician when confronted with Ms. Diamond's care request. Instead, Dr. Lewis referred the ultimate decision on whether to provide Ms. Diamond additional Gender Dysphoria treatment to Jennifer Ammons, an attorney for GDC with no medical background whatsoever, and instructed Dr. Awe to deny Ms. Diamond's treatment request based on the attorney instructions. [12] Dr. Lewis's decision to delegate care decisions concerning a patient to an attorney without any medical or clinical training represents a shocking departure from ethical and professional standards.

37. Dr. Lewis and Dr. Jackson also adopted Ms. Ammons's directive denying hair removal treatment as cosmetic and transformed it into a formal policy applicable to all gender dysphoric patients. Pursuant to that policy—crafted by an attorney, instead of a medical provider—GDC now deems hair removal treatment to be cosmetic in all cases and therefore unavailable within GDC, regardless of a patient's diagnoses or medical need. Given WPATH's unequivocal guidance that hair removal treatment can be a medically-necessary treatment modality for dysphoric patients, it is clear that GDC's policy is neither clinically sound nor evidenced-based. Furthermore, it is a policy that has endangered and will continue to endanger gender dysphoric patients imprisoned within GDC, as Ms. Diamond's worsening Gender Dysphoria and ongoing surgical self-treatment attempts following the denial of her facial hair removal requests indicate.

38. Finally, while counseling is not a substitute for medically-indicated treatment, as my Initial Reports explained, the counseling available within GDC does not rise to the level of Gender Dysphoria treatment *at all* because GDC did not take any steps to hire, train, or recruit

[12] Although her deposition is still forthcoming, it appears that like Dr. Lewis, Dr. Jackson concurred in the decision to deny hair removal treatment without exercising any independent clinical judgment, relying on the advice of Ms. Ammons, an attorney with no healthcare background, instead.

mental health providers qualified in the treatment of Gender Dysphoria per the SOC, let alone providers with any issue expertise. As a case in point, instead of receiving psychotherapy that treated Gender Dysphoria as its focus, much of the "counseling" Ms. Diamond received concerned run-of-the-mill stress relief techniques like deep breathing or coloring.

Lack of Individualized Treatment or Care

39. Core to the practice of healthcare is the notion that treatment decisions will be based on an individual assessment of a patient's healthcare needs. Pursuant to this standard, providers are required to individually evaluate patients and familiarize themselves with the patient's medical history and records, to the extent they are available, before making critical decisions regarding their care.[13] This precept is so foundational in the healthcare professions that it applies equally in institutionalized environments as in the free world.

40. Yet, from the materials I reviewed, this baseline standard of care was flagrantly ignored. For instance, when Dr. Lewis was asked to review Ms. Diamond's request for hair removal treatment as a Gender Dysphoria treatment, Dr. Lewis denied the request without ever speaking to, examining, or evaluating Ms. Diamond. Dr. Lewis also failed to so much as review the medical records available to her before declining to provide treatment—a course of conduct that is so far afield from community standards that it cannot be justified by the simple fact that Dr. Lewis is a practitioner in a prison environment, with a purported high patient volume.[14]

41. Further, from the materials I reviewed (and as discussed further in section F below), GDC adopted policies that put certain forms of Gender Dysphoria treatment

[13] While this standard does not foreclose expert consultations or tele-visits, particularly during Covid-19, it does not permit healthcare decisions in an information vacuum, without the benefit of any clinical evaluation or records review.

[14] Indeed, conduct of this type in a patient care setting could warrant investigation by licensing boards and jeopardize a practitioner's license.

categorically out of reach for GDC patients regardless of medical need, even though treatment bans are contrary to the core tenets of clinical practice as Dr. Lewis admitted.

Inattention to Ms. Diamond's Self-Surgery Attempts

42. Across the board, the GDC healthcare providers and administrators involved in Ashley Diamond's treatment and care ignored her repeated and escalated surgical self-treatment (auto-castration or auto-penectomy) attempts. For instance, though Dr. Lewis affirmed in her deposition that surgical self-treatment attempts are a symptom of Gender Dysphoria requiring treatment and that the goal of Gender Dysphoria treatment is to abate symptoms, she admittedly took no steps to refer Ms. Diamond for additional evaluation or care related to Gender Dysphoria after being notified of Ms. Diamond's surgical self-treatment attempts.

43. Likewise, Jack Randy Sauls, the Assistant Administrator for the Health Services Division of GDC, admitted to receiving notices that described Ms. Diamond's worsening Gender Dysphoria symptoms, including her suicidal ideation and surgical self-treatment attempts. However, Mr. Sauls did not take any steps or launch any inquiries to explore whether Ms. Diamond was receiving adequate Gender Dysphoria care or required additional treatment, even though he had the ability to do so.

44. Dr. Lewis and Mr. Sauls's failure to act on Ms. Diamond's behalf or order a further review of Ms. Diamond's Gender Dysphoria treatment needs despite her acute symptoms and presentation is clinically inexplicable. Equally troubling was Dr. Lewis's decision to deny Gender Dysphoria treatment requests that Ms. Diamond made to GDC medical providers in proximity to her surgical self-treatment attempts without so much as reviewing her medical records, evaluating her, or, most importantly, sending her to a Gender Dysphoria specialist for evaluation.

45. Dr. Awe's response to Ms. Diamond's surgical self-treatment attempts was also equal parts shocking and dangerous. For instance, when Ms. Diamond presented with injuries from a July 2020 attempt that resulted in a urinary blockage and bladder distention, Dr. Awe dismissed her surgical self-treatment attempts as "attention-seeking" behavior, when in reality it is a classic presentation of Gender Dysphoria that even a minimally-competent provider would perceive as such given Ms. Diamond's medical diagnoses. As such, Ms. Diamond's surgical self-treatment attempts are not "attention-seeking" but rather an unmistakable "last resort" for Ms. Diamond to attain relief from Gender Dysphoria. Unfortunately, the desperation of these attempts was ignored by all of the decisionmakers at GDC involved in her care.[15]

46. Dr. Awe failed to take any steps to refer her for further evaluation or treatment by a knowledgeable Gender Dysphoria practitioner. Dr. Awe also refused to provide Ms. Diamond an expedited follow-up appointment with an endocrinologist in the wake of her repeated surgical self-treatment attempts, instead leaving her to wait 3-6 months at a time for further appointments.[16]

47. Even though Ms. Diamond's self-surgery attempts also persisted throughout her incarceration in GDC as Ms. Diamond and the medical records presently at my disposal attest, Dr. Awe remained dismissive even when GDC medical records documented penile injuries and infections she suffered as a result of the attempts. Dr. Awe even went as far as to criticize Ms.

[15] Dr. Awe's testimony is also puzzling, because mutilating one's penis or testicles is not socially-rewarded behavior in society or in male prison environments. Further, even in the hypothetical universe where auto-castration and auto-penectomy attempts were not established Gender Dysphoria symptoms, they would be evidence of a severe mental disorder that also necessitated treatment.

[16] To the extent that Dr. Awe identified endocrinologists as the only providers relevant to Gender Dysphoria care, he is also mistaken. In reality, Gender Dysphoria treatment requires a multidisciplinary approach. Mental health providers, primary care physicians, endocrinologists, surgeons, and other providers collaborate in the provision of care.

Diamond for not injuring herself more severely as a result of her auto-penectomy attempts. To state the very obvious, much like suicidal ideation, the severity of a patient's condition and their need for treatment are not determined by whether their attempt actually succeeded in bringing about their death or a catastrophic injury.

48. Given that Dr. Awe's responsibilities at Coastal State Prison included determining if and when to provide gender dysphoric patients like Ms. Diamond specialist referrals, Dr. Awe's inability (or refusal) to recognize that Ashley Diamond's surgical self-treatment attempts were a Gender Dysphoria symptom also evinces how GDC's approach to correctional healthcare endangers incarcerated patients. Specifically, by refusing to require that its healthcare providers receive training on Gender Dysphoria (or indeed, any of the other conditions present within the inmate population) as a prerequisite to patient care, GDC all but guarantees that patients like Ms. Diamond will remain without medically-necessary care even while displaying acute symptoms that pose a risk to their lives.

Inattention to Ms. Diamond's Suicidal Ideation and Related Conditions

49. Triaging suicidality, depression, anxiety, and Major Depressive Disorder requires addressing their underlying source, which in this case is Ms. Diamond's severe Gender Dysphoria and Complex PTSD. However, this was never done. Ms. Diamond was repeatedly denied a transfer away from Coastal State Prison, the male facility that even her mental health providers recognized was contributing to her mental decompensation and where she stood an outsized risk of sexual abuse (and, indeed, where she reported more than a dozen such incidents). Dr. Lewis, Dr. Jackson, and Mr. Sauls also failed to revisit or revise the limits that were placed on Ms. Diamond's ability to access Gender Dysphoria care, including their determination that

only hormone therapy was available as medical treatment to gender dysphoric patients within GDC.[17]

50. These same individuals, along with Dr. Awe, also refused to refer Ms. Diamond to an appropriate specialist for evaluation and treatment when they received notice of Ms. Diamond's worsening Gender Dysphoria symptoms, or otherwise respond. As such, they each failed to address Ms. Diamond's suicidal ideation or other mental health conditions related to her Gender Dysphoria in a manner that was clinically appropriate. The same can be said of Mr. Sauls in his role as Assistant Commissioner of the Health Services Division because he failed to initiate a review or inquiry of Ms. Diamond's Gender Dysphoria care needs even after receiving notice of her deteriorating mental and physical health. Placing Ms. Diamond in isolation units or on suicide precautions is no substitute for addressing the underlying source of her condition: specifically, the profound insecurity she experienced as a woman cut off from adequate Gender Dysphoria care, confined to a men's facility that even her providers deemed unsafe for her.

51. Likewise, psychotropic medication is not a treatment for Gender Dysphoria or its resulting sequalae. By analogy, severe burn patients who suffer from disfigurement may self-isolate, but offering them anti-depressants instead of surgical treatment for their burn tissue would be clinically inexplicable.

52. Instead, the clinically appropriate approach to addressing Ms. Diamond's suicidal ideation, anxiety, and depression would have been for GDC to address the nexus of these conditions by: (1) initiating all of the medically-indicated forms of Gender Dysphoria treatment Ms. Diamond requires in consultation with a specialist, and (2) transferring her to a safer

[17] Although her deposition is still forthcoming, it appears the same is true of Dr. Jackson based on the records I've received to date.

institutional environment—ideally a women's facility— to spare her the ever-present threat of sexual abuse from cisgender men.

Inattention to the Remainder of Ms. Diamond's Housing Needs and PTSD Triggers

53. Because the housing placements of gender dysphoric patients in institutional settings can have profound impacts on their mental and physical well-being as well as the efficacy of Gender Dysphoria treatments, the SOC contain detailed guidance on the topic. The SOC explain that the placement of individuals in male or female facilities should be made on a case-by-case basis, rather than on the basis of sex assigned at birth or a person's surgical history. The Standards also emphasize that placements should be made with an eye towards safety. (SOC, Section XIV).

54. Importantly, GDC personnel involved in Ms. Diamond's initial intake into GDC advocated for Ms. Diamond to receive a female facility placement instead of a male prison placement based on her demonstrated need for accomodations related to her female gender expression. In addition, at least three of Ms. Diamond's treating clinicians—Dr. Ausborn, Dr. Fass, and Dr. Roth—identified Ms. Diamond's environment at Coastal State Prison to be hazardous to her mental and physical well-being and advocated for an amended placement. Yet, each time, these recommendations were ignored, and Ms. Diamond remained in an environment where she constantly feared predation and institutional restrictions concerning her gender expression.

55. The decision on the part of GDC personnel to confine Ms. Diamond at Coastal State Prison does not appear to be data-driven. The Federal Bureau of Prisons, along with a number of state Corrections Departments in the United States, have begun housing transgender women in female facilities where requested for health and safety purposes. Further, having reevaluated several other transgender women to determine their eligibility for placements at

female corrections facilities, I am not aware of any reason Ms. Diamond could not be safely placed in a female correctional facility. The evidence available to me suggests that Ms. Diamond poses no danger to female prisoners and would be capable of living harmoniously in a female population.[18]

F. GDC's Apparent Ban on Gender Dysphoria Treatment Other than Hormone Therapy

56. Finally, as noted above, the materials I have reviewed since my Initial Reports also confirm that GDC did not take an individualized approach to Gender Dysphoria treatment for its incarcerated patients. Instead, testimony and records show that GDC has adopted an institutional policy that limits the Gender Dysphoria treatment available within GDC largely to hormone therapy, irrespective of patient needs.

57. For instance, Dr. Lewis confirmed that GDC has never approved patients within GDC for healthcare beyond hormone therapy, even though she acknowledged that gender confirmation surgery, social role transition, and hair removal treatments are all forms of Gender Dysphoria treatment that gender dysphoric patients can require. In addition, Dr. Lewis, Dr. Awe, and Mr. Sauls each indicated that hair removal treatment and procedures are not available within GDC, even though the SOC and clinical research alike have recognized that hair removal can be a necessary form of treatment in patients with Gender Dysphoria or another medical diagnosis. (WPATH, 2016). Mr. Sauls also indicated that gender confirmation surgery is "not a covered benefit" within GDC, even though for some people—including patients like Ms. Diamond with

[18] Ms. Diamond's hormone levels are consistent with her female peers. In other words, she has been hormonally reassigned as female, which is tantamount to chemical castration. Therefore, Ms. Diamond is not capable of maintaining erections, engaging in penetrative sex, or impregnating others, as my Initial Reports note.

progressive, worsening Gender Dysphoria—it ultimately becomes the only effective means of treatment.[19]

58. As Chair of WPATH's Committee for Institutionalized Persons, and as a clinician who has treated over 3,000 individuals with Gender Dysphoria, I can confirm that policies like GDC's, which limit the treatment available to gender dysphoric patients irrespective of their symptomatology or individual care needs, are contrary to the SOC, clinically dangerous, and inconsistent with the community norms governing the healthcare profession.

59. From the statements of Dr. Lewis, Mr. Sauls, and Dr. Awe, it is also clear that GDC's hormones-only approach to patient care also limited the evaluations, referrals, and treatment Ms. Diamond received within GDC when her Gender Dysphoria symptoms were most acute. Dr. Awe's statements are particularly illuminating: In his July 19, 2020 deposition, Dr. Awe indicated that since Ms. Diamond was already receiving the hormone treatment GDC approves for transgender women (estradiol and spironolactone), there was no further action or treatment referrals available or necessary for him to pursue following her surgical self-treatment attempts. These statements reveal how much GDC's treatment limitations conflict with the SOC and WPATH guidance, which make clear that social role transition, surgical intervention, and hair removal procedures are all treatment modalities that can be medically necessary for patients. Dr. Awe's statements also show how the treatment for Gender Dysphoria within GDC has become completely untethered from a core tenet of Gender Dysphoria care that even Dr. Lewis

[19] The fact that Ms. Diamond's Gender Dysphoria is worsening is evident from her medical records as well as the assessments I have conducted. Per the scientific literature, Gender Dysphoria also has a tendency to intensify with age, necessitating new and different clinical interventions. (Ettner & Wylie, 2013; Ettner, 2013). As such, Ms. Diamond may ultimately require surgery as treatment for her Gender Dysphoria.

acknowledged—reviewing and revising a patient's Gender Dysphoria treatment plan until their Gender Dysphoria symptoms abate.

IV. CONCLUSION

60. Based on my August 5, 2022 assessment of Ashley Diamond and the supplemental materials I reviewed, it is clear that the conditions of confinement which exacerbated Ms. Diamond's Gender Dysphoria and PTSD led to the manifestation of symptoms and a level of impairment that remained largely unchanged from October 2019 until her August 1, 2022 release. Specifically, Ms. Diamond was prohibited from expressing her female gender identity, where she was unable to receive access to female grooming standards, commissary items available to women in female facilities, or a safe and effective means of facial hair removal that would not in and of itself exacerbate her Gender Dysphoria (e.g. eflornithine or other prescription medications specifically for feminine facial hair removal, or laser hair removal), even though each of the aforementioned are accepted treatment modalities under the SOC and scientific literature, and medically-necessary treatments for Ms. Diamond's Gender Dysphoria that she received outside of prison.[20]

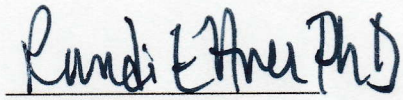
61. Further, it is clear that Ms. Diamond was never processed for a safety transfer away from Coastal State Prison despite the repeated recommendations of GDC medical and mental health providers, or placed at a female facility where she would have the greatest safety from sexual assault available within GDC alongside medically-necessary gender expression allowances (i.e. the ability to dress and groom as a woman and access female accoutrements and hygiene items).

[20] Specifically, Ms. Diamond lived in her affirmed female gender outside prison and received a prescription for eflornithine from her physician, according to records. Provider records also show that Ms. Diamond was prescribed a topical form of clindamycin while living in the community.

62. Finally, it is clear that as a result of the limited Gender Dysphoria treatment and facility placement denials that Ms. Diamond experienced while in GDC, as well as the inaction of Drs. Lewis, Jackson, and Awe and Mr. Sauls, Ms. Diamond's mental health and physical well-being continued to precipitously decline in the precise manner I predicted in my Initial Reports.

63. Consistent with my previous Reports, Ms. Diamond continued to display many of the symptoms of acute, untreated Gender Dysphoria, PTSD, and Complex PTSD, including suicidality, anxiety, depression, Major Depressive Disorder, and repeated attempts at surgical self-treatment. In my expert opinion, but for Ms. Diamond's August 1, 2022 release from GDC custody, Ms. Diamond would have decompensated even further due to her unmet Gender Dysphoria treatment needs and the PTSD triggers associated with her confinement at Coastal State Prison—putting her at an outrageous risk of death from suicide and at severe risk for injury related to her auto-penectomy and auto-castration attempts.

Respectfully submitted,



Randi Ettner PhD.

Dated: August 8, 2022

APPENDIX: ADDITIONAL MATERIALS CONSIDERED

I. DISCOVERY MATERIALS

Deposition Transcripts Reviewed:

- Deposition of Dr. Will Ausborn (June 30, 2022)
- Deposition of Dr. Olatunji Awe (July 19, 2022)
- Deposition of Brooks Benton (May 10, 2022)
- Deposition of Tamara Cantera (May 10, 2021)
- Deposition of Dr. Daniel Fass (May 11, 2021)
- Deposition of Tia Fletcher (May 10, 2021)
- Deposition of Dr. Sharon Lewis (April 26, 2022)
- Deposition of Mark London (July 22, 2022)
- Deposition of Gerilyn Pepin (February 24, 2022)
- Deposition of Dr. David Roth (May 11, 2021)
- Deposition of Jack Randy Sauls (May 17, 2022)

GDC Records Reviewed:

- DEF_141
- DEF_365
- DEF_407
- DEF_1149-DEF_1152
- DEF_1164
- DEF_1665-DEF_1666
- DEF_1669-DEF_1670
- DEF_1820-DEF_1821
- DEF_1824-DEF_1825
- DEF_1841
- DEF_05430
- DEF_05554
- DEF_031621
- DEF_038489-DEF_038572
- GDC Standard Operating Procedure 220.09
- GDC Standard Operating Procedure 507.04.68

Plaintiff Records Reviewed:

- PL001409-PL001435
- PL001436-PL001445
- PL001446-PL001493
- PL001494-PL001507
- PL001657
- PL001729-PL001731
- PL001833-PL001835

Other Materials Reviewed:

- Mental Health Diagnosis List dated July 8, 2020 (Roth Exhibit 3)
- Transfer Evaluation dated June 4, 2020 (Roth Exhibit 4)
- Compilation of Emails Concerning Ashley Diamond (Roth Exhibit 6)

II. SCIENTIFIC LITERATURE

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