IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,	)	
Plaintiffs,	)	
- vs-	)	No. 18-156-NJR
ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN,	)	
Defendants.	)	

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

The Defendants, ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN (sued in their official capacities only as IDOC Officials), by and through their attorney, Kwame Raoul, Attorney General for the State of Illinois, move for summary judgment in their favor pursuant to Federal Rule 56 and Local Rule 7.1(c).

Introduction

Plaintiffs allege that Defendants subject them and a class of prisoners with gender dysphoria to a substantial risk of serious harm that violates the Eighth Amendment. Their claim is based on policies and practices of IDOC pertaining to the evaluation and treatment of gender dysphoria. [Doc. 1, at 36, ¶ 120.]

Plaintiffs seek a permanent injunction enjoining the alleged violations and requiring:

> Defendants . . . to develop and implement, as soon as practical, a plan to eliminate the substantial risk of serious harm that Plaintiffs and members of the Plaintiff Class suffer due to Defendants' inadequate evaluation and treatment of gender dysphoria. At a minimum, this plan should include: (i) Prisoner access to clinicians to treat gender dysphoria who meet[ ] the competency requirements stated in the Standards of Care; (ii) Prompt evaluation for gender dysphoria upon request or clinical indication of the condition; (iii) Timely fulfillment of medically prescribed treatment for gender dysphoria, including, but not limited to, hormone therapy and gender affirming surgery; (iv) Accommodation of medically necessary social transition, including individualized placement determinations, avoidance of cross-gender strip searches, and access to gender affirming clothing and grooming items; and (v) Ceasing the practice whereby medical decisions regarding gender dysphoria are second-guessed and treatment is governed by the GID Committee.

[Doc. 1, at 36-37.]

In addition, Plaintiffs request the Court "[r]etain jurisdiction . . . until Defendants have fully complied with the orders of this Court, and there is a reasonable assurance that Defendants will continue to comply in the future absent continuing jurisdiction." [Doc. 1, at 38, ¶ f.]

This Court certified a plaintiff class, defined as "all prisoners in the custody of IDOC who have requested evaluation or treatment for gender dysphoria." [Doc. 213, at 11.] Plaintiffs are not entitled to the relief they seek whether as a class or only on behalf of the five representative individuals. Plaintiffs are unable to meet their burden, as they cannot show that IDOC is violating or will continue to violate their Eighth Amendment rights. Further, Plaintiffs are unable to meet the other elements necessary for a permanent injunction. Moreover, Plaintiffs' requests are out of

bounds set by the Eleventh Amendment and the Prison Litigation Reform Act. For these reasons, as argued more fully below, Defendants are entitled to summary judgment in their favor.

Preliminary Injunction

On December 19, 2019, after considering evidence presented over the course of a two-day hearing and the arguments of the parties, the Court granted Plaintiffs' request for preliminary injunctive relief. [*See* Doc. 123 (Pl.'s Mot.); Doc. 145 (Defs.' Resp.).] Defendants were ordered to cease certain policies and practices and mandated to take further action. [Docs. 186-87.] Defendants sought reconsideration of the Court's order. [Doc. 203.]

On March 4, 2020, the Court clarified its order [Doc. 211] and entered an amended preliminary injunction. [Doc. 212.] The Court ordered Defendants to immediately:

> 1. cease the policy and practice of allowing the Transgender Committee to make the medical decisions regarding gender dysphoria and develop a policy to ensure that decisions about treatment for gender dysphoria are made by medical professionals who are qualified to treat gender dysphoria;
>
> 2. ensure that timely hormone therapy is provided when medically necessary, including the administration of hormone dosage adjustments, and to perform routine monitoring of hormone levels; and
>
> 3. cease the policy and practice of depriving gender dysphoric prisoners of medically necessary social transition, including by mechanically assigning housing based on genitalia and/or physical size or appearance.

[Doc. 212, at 1-2.] The Court also ordered Defendants to:

> 1. develop policies and procedures which allow transgender inmates access to clinicians who meet the competency requirements stated in the WPATH Standards of Care to treat gender dysphoria;
>
> 2. allow inmates to obtain evaluations for gender dysphoria upon request or clinical indications of the condition;
>
> 3. develop a policy to allow transgender inmates medically necessary social transition, including individualized placement determinations, avoidance of cross-gender strip searches, and access to gender-affirming clothing and grooming items; and

> 4. advise the Court what steps, if any, IDOC has taken to train all correctional staff on transgender issues, including the harms caused by misgendering and harassment—by both IDOC staff and other inmates.

[*Id.* at 2.]

Statement of Facts

Relevant IDOC Policies and Training

At the time of the Court's preliminary injunction order, IDOC followed an Administrative Directive titled "Evaluations of Transgender Offenders." (Ex. 1, A.D. 04.03.104, eff. July 1, 2019.) The Directive provided for a Transgender Care Review Committee (TCRC) that would review placements, security concerns, health-related treatments, and gender-related accommodations for prisoners diagnosed with gender dysphoria. (Ex. 1, at 3, ¶ G.) Prisoners were to be screened during the reception and classification process for prisoners who self-identified as transgender or "for whom there are questions regarding gender identity or Gender Dysphoria." (Ex. 1, at 3, ¶ H.1.) The reception and classification facility medical director was to take steps to ensure the prisoner would be housed and provided with necessary gender specific clothing, in accordance with the prisoner's gender-related needs. (Ex. 1, at 4, ¶ H.4.) After arrival to a parent facility or after a new disclosure of gender identity, a mental health professional (with the assistance of a health care representative) was required to complete a form and to present the prisoner to the TCRC, which would then make a final recommendation for housing and "any additional matters that may be of issue including, but not limited to, hormone therapy, gender specific clothing, showers and searches." (Ex. 1, at 4-5, ¶ H.5.) The TCRC was to conduct follow-up reviews on an as-needed basis. (Ex. 1, at 5, ¶ H.6.) Hormone therapy would only be provided after consultation with and approval by the Agency Medical Director or Chief of Psychiatry (or designees). (Ex. 1, at 3, ¶ H.1.b.)

After the initial preliminary injunction order, the TCRC ceased making decisions regarding direct medical treatment for gender dysphoria. [Doc. 202, at 2, ¶ 4.] IDOC and Wexford have made continuing efforts to ensure that prisoners diagnosed with gender dysphoria continue to receive timely and appropriate hormone therapy. *See*, *e.g.*, Doc. 226 at 13; Doc. 226-6, pp. 180-81; Doc. 226-9, pp. 45-46, 59; Ex. 5, Email BATES 320535-320536. The TCRC structure is being changed to delineate between a medical committee and one overseeing security-related accommodations. *See, e.g.*, Doc. 226, pp. 12-14; Ex. 2, p. 9.

IDOC also contracted with Dr. Erica Anderson and The Moss Group for consultation services and assistance in drafting a new Directive to replace A.D. 04.03.104. [Doc. 202, at 5-6, ¶¶ 11, 13; Doc. 226, at. 8-12]. IDOC desires to maintain WPATH Standards of Care (Standards) and to meet other prison standards. *E.g.,* Doc. 226; Doc. 226-6, p. 10; Ex. 2, Reister Tr. at 90. In recent weeks, IDOC has updated its commissary items for transgender prisoners. (Ex. 3, eff. Nov. 5, 2020.) While the initial plan had been noted as one to offer universal items throughout all facilities, the policy eventually adopted and effective November 5, 2020, is applicable to transgender female prisoners. (*Id.*) This change allows transgender female prisoners to purchase items such as bras, panties, makeup, facial hair remover, and scrunchies regardless of the facility in which they are housed. (*Id*.)

Many prisoners come to IDOC with a gender dysphoria diagnosis. (Ex. 2, at 268.) In those instances, they may very quickly have such diagnoses confirmed. (*Id.* at 269.) If someone needs a diagnosis clarified, they are brought to the attention of mental health staff through screening that specifically asks about being transgender. (*Id.* at 269.) If gender dysphoric symptoms are disclosed while working with a mental health provider, that provider is authorized to make a diagnosis. (*Id.* at 270.)

IDOC had already been in the process of providing training on transgender concerns to all staff members. (*Id.*, at 123-24.) In January 2020, Defendants noted that training was underway to provide an introduction to IDOC staff. [Doc. 202, at 6, ¶12.] IDOC used a two-hour training developed by Dr. Shane Reister to provide training to all staff members. (Ex. 2, at 46, 123, 130.) Dr. Reister provides a separate two-part training for mental health providers. (*Id.* at 128-29.) Dr. Reister also incorporated into both trainings information as to the psychological impact and microaggressive form of transphobia related to individuals misgendering prisoners. (*Id.* at 93.) This means that every staff member in IDOC, regardless of position, received training to not misgender prisoners. (*Id.* at 94.) IDOC has a "very clear policy on not misgendering offenders." (*Id.* at 93.) IDOC also worked with WPATH for a targeted training to be done via Zoom for medical and mental health providers. (*Id.* at 46-47.) In September 2020, they completed part one of the WPATH training.

IDOC employees operate under a code of conduct that requires them to conduct themselves in a manner that will not reflect unfavorably on the Department and that will not impair the operations of the Department. 20 Ill. Admin. Code § 120.30. After receiving complaints about employees' use of social media that put down certain groups of prisoners, IDOC set forth an Administrative Directive reiterating that IDOC employees are required to "conduct themselves in a professional manner when engaging in personal use of social media platforms and, whether on duty or off duty, not engage in conduct that is unbecoming of a State employee or that may reflect unfavorably on or impair operations of the Department." (Ex. 4, A.D. 03.02.113, eff. Nov. 1, 2019.) The policy prohibits employees from posting, displaying, or otherwise transmitting content that disparages a person or group based on race, religion, sexual orientation or any other protected class. (*Id.* at 3, ¶ II.G.4.g.)

Representative Plaintiffs

There are five representative Plaintiffs prosecuting this action: Janiah Monroe, Marilyn Melendez, Lydia Helena Vision, Sora Kuykendall, and Sasha Reed.[1]

1. Janiah Monroe

Plaintiff Monroe is housed, since April 1, 2019, at Logan Correctional Center, an institution that houses female prisoners. (Ex. 6, Monroe Tr. 6.) In June 2019, Monroe was nearly moved to another facility (*Id.* at 6), but that transfer was stopped. Ms. Monroe filed a separate action in the Central District of Illinois seeking equitable relief pertaining to her housing and care at Logan: *Monroe vs. Jeffreys*, CDIL no. 19-1060. That case remains pending.

At Logan, Monroe has access to makeup, female cosmetics, perfume, female hair care products, and female clothing and shoes. (*Id.* at 42-43.) Monroe finds the female clothing to be reassuring. (*Id.* at 43.) Monroe is unable to say at this time that there is any other property that she would need for social transition that she does not already have access to. (*Id.* at 44-45.) Strip searches of Monroe, if penologically required, are done only by female security officers. She still "sometimes" experiences misgendering, but it is less common than it was for her at a men's prison. (*Id.* at 47-48.)

Ms. Monroe testified in August 2020 that she had been participating in group treatment for gender dysphoria, which was paused while on quarantine. (*Id.* at 36-37.) Monroe's treatment is led by Dr. Pfost, who Monroe feels tries but does not "have a lot of knowledge to offer." (*Id.* at 37.) Monroe believes that she should be receiving additional treatment to prepare her for surgery, which

[1] These are the Plaintiffs' preferred names, but not their legal names. Generally, IDOC records use prisoner legal names rather than preferred names. Defendants will use Plaintiffs' preferred names throughout this filing; however, as a practical matter, legal names are used in underlying IDOC records.

she has discussed with her treating physician, Dr. Sang. Besides that preparation there, is nothing else on the mental health side that she believes is lacking. (*Id.* at 38.)

Ms. Monroe continues receiving hormone therapy at Logan Correctional Center, prescribed by Dr. Sang. (*Id.* at 39.) Monroe has her blood drawn and hormone levels monitored. (*Id.* at 39.) Yet, as recently as July 2020, there have been concerns that Monroe has not been taking her hormone therapy as prescribed. A progress note dated July 24, 2020, and signed by Dr. Daphne Maurer, M.D. notes that Monroe's Tegretol had recently been crushed to avoid "cheeking" medication. Her Tegregtol levels were noted to be low, but Monroe quit taking it after it was crushed. (Ex. 7, BATES 357976-357980.) Dr. Maurer noted staff would give "her the benefit of the doubt" and cease crushing her Tegretol at that time. (*Id*. at 357978.)

2. Marilyn Melendez

Ms. Melendez is incarcerated at Pontiac Correctional Center. She has not had a cellmate per her request since the end of 2018. (Ex. 8, Melendez Tr. 11-12.) Ms. Melendez testified that she has attempted suicide close to five times, most recently in early August 2020. (*Id.* at 25.) Ms. Melendez testified that her recent suicide attempt came because of her gender dysphoria and feelings related to her "life of constantly being ridiculed, disrespected, looked at as a freak, as an abomination . . . . the fact that [she has] to take medications . . . [and] attempt to get surgeries so [she] can feel aligned with herself." (*Id.* at 27.) Ms. Melendez began taking feminizing hormones in 2015, the same year she was diagnosed with gender dysphoria. (*Id.*, at 43.) Melendez has some concerns as to the hormone levels she is receiving, and as of her deposition in August, had received a lab test within a few months and requested to see her treating physician, Dr. Tilden. (*Id.*, at 43-46.) At the time of her deposition, she had not heard back from Dr. Tilden but had been told either that he was not present at the facility or was taking care of patients with serious needs, so she

would not be able to see Dr. Tilden unless it was an emergency. (*Id.*, at 48.) Ms. Melendez has asked her physician for surgery, including breast augmentation, liposuction, lipofilling, contouring of the abdomen, a trachea shave, and gender-affirming surgery. (*Id.*, at 59.) Dr. Tilden has denied these requests, but told Melendez he would look into the orchiectomy she requested. (*Id.*, at 58-60.) Sometime in 2019, Ms. Melendez began regularly attending a monthly transgender group. (*Id.*, at 61-63.) Melendez has not requested a transfer to a female institution since about 2017, because she has been at Pontiac for about five years and is accustomed to where she is. (*Id.*, at 68-69.) Ms. Melendez is still misgendered by the majority of staff at Pontiac and, although some staff will speak to her respectfully when she brings it to their attention, the majority of staff is disrespectful to her. (*Id.*, at 69, 72-73.) But, Ms. Melendez is not aware of any of the staff members acting unprofessional being reported for discipline. (*Id.*, at 74.) Ms. Melendez has made only one PREA complaint for staff harassment. (*Id.*, at 88-89.) Ms. Melendez has a number of item requests: a stronger brush, comb, scented shampoo, lotions, soaps, "better hair ties," women's undergarments and shoes. (*Id.*, at 77-82.) Typically, Melendez has no issue with searches and may choose a female officer to pat-search her, though there have been a few instances where the Tactical Team came in and refused to accommodate her request for a female to conduct the strip search. (*Id.*, at 85-86.)

3. Sora Kuykendall

Ms. Kuykendall is incarcerated at Menard Correctional Center. She receives feminizing hormonal therapy and laboratory follow-ups to monitor her hormones. Though she recently refused labs in May 2020, she was scheduled for a transgender clinic and after a provider spoke to her in June, Ms. Kuykendall agreed to have labs taken. (Ex. 9, BATES 361313.) She has since raised

concerns with her hormone therapy and had labs re-taken in October 2020. (*Id.*, BATES 361352-361356.)

Ms. Kuykendall still desires placement in a female institution plus gender affirming surgery, including "general reassignment surgery, voice feminization surgery, [and a] tracheal shave." (Ex. 10, Kuykendall Tr. 94). She also wants the same items that any other woman in IDOC gets. (*Id.*, at 95).

4. Sasha Reed

Ms. Reed is also incarcerated at Menard Correctional Center, and receives feminizing hormones. (Ex. 11, Reed Tr. 43). In June 2020, she asked for hormonal injections rather than pills, and she also requested female panties and bras. (Ex. 12, BATES 361357.) She was provided with a medical permit for sports bras and women's underwear in June 2020. (*Id.*) She also had lab work done in June 2020 and August 2020. Her hormones were adjusted in September 2020 after it was noted that her prolactin level was elevated. (*Id.*, BATES 361427.) Ms. Reed desires to have gender-affirming "bottom" surgery and breast implants. (Ex. 11, at 45, 80).

5. Lydia Helena Vision

Plaintiff Lydia Helena Vision was diagnosed with gender dysphoria in 2016, while in IDOC custody. (Ex. 13, Vision Tr.. 8.) Ms. Vision began receiving hormone therapy in late 2018. (*Id.* at 16.) As of her deposition at the end of August 2020, Ms. Vision had no complaints about the hormones that she was taking. (*Id.* at 16.) When she was initially prescribed hormone therapy, Ms. Vision complained that the nurses and medical staff were giving her a smaller percent of the hormones than she had been prescribed, but it only took about a month or two to correct. (*Id.* at 16-17.) Ms. Vision has not had any complaints about her hormones since then. (*Id.* at 18.) Labs are drawn to review the amounts of hormones in her system and she meets with a medical doctor

to discuss the results of her lab work. (*Id.* at 18.) Ms. Vision is at a facility that houses males, but she is single-celled and showers alone. (*Id.* at 9, 18.) Ms. Vision does not feel she is given sufficient privacy in the shower on her wing—it is a single shower with a curtain containing mesh over the top half and is located in a place where people pass; when she raised the issue, she was given the option to go to another building to shower. (*Id.* at 18-20.) Ms. Vision declined the offer because it would require her to make a 30-minute round trip and the other shower was in a location similar to one from a different facility where she filed a PREA complaint. (*Id.* at 20-21.) Ms. Vision has been approved for a transfer to a female facility, but has not been moved due to restrictions associated with COVID-19. [Doc. 226, at 14-15; Doc. 226-10, at 2, #3.] Ms. Vision believes that a transfer to a female facility will alleviate some of her concerns about threats. (Ex. 13 at 21-23.) Ms. Vision testified that she is strip-searched by male security staff and that she asked for a female security member to search her but did not get a pleasant response. (*Id.* at 27-28.) She believes that she wrote a grievance on the issue but does not know if she kept a copy of it[2] and does not remember obtaining a response. (*Id.* at 28-29.) Ms. Vision would like to obtain surgery and voice coaching.

Plaintiffs have identified no unnamed class members to provide evidence.

Plaintiffs' Experts[3]

Dr. Tangpricha is an endocrinologist who has authored many publications related to transgender care. His primary employment is as a professor and endocrinologist at Emory University. (Ex. 14, Tangpricha Tr. 30-31.) According to Dr. Tangpricha, there are a large number of transgender patients in the Atlanta area and not all of them are seen at Emory. (*Id.* at 38.) In his

[2] Ms. Vision has produced no documents.

[3] Two of Plaintiffs' three experts, Dr. Tangpricha and Dr. Ettner, testified in the preliminary injunction hearing. James Aiken's opinions are challenged by separate motion.

experience, not all transgender patients are treated by an endocrinologist. And, as he stated: "hormones are not restricted to endocrinologists. Any physician is able to prescribe hormone therapy, provided they do it safely and know what regimes to use, and those are all public knowledge." (*Id.* at 38.) Dr. Tangpricha testified that physicians are able to receive training that will make them comfortable and competent in prescribing hormone therapy. (*Id.* at 49-50.) But, Dr. Tangpricha also believes that nearly all transgender patients who want hormone therapy receive it, though this is contradicted by news in Illinois and nationally. (*See* Ex. 15; Ex. 16; Ex. 17 (*Insurance Coverage and Use of Hormones Among Transgender Respondents to a National Survey*, 18 Annals Fam. Med. 528 (2020).)

Dr. Ettner is a psychologist who has worked for WPATH and received numerous awards and accolades. Dr. Ettner is not a medical doctor, and did not go to medical school nor does she have the ability to prescribe medications. (Ex. 18, Ettner Tr. 7.) Dr. Ettner does not distinguish whether a particular treatment is medical in nature, but rather considers all treatments and accommodations related to gender dysphoria, including social transition, as medically necessary. (*Id.* at 9-11, 49.) Dr. Ettner believes that female accommodation requests are a necessary part of medical treatment for gender dysphoria and that individuals should have a right to that treatment.

WPATH formed a Global Education Initiative in 2014 to provide an introduction to the field by people trained to do so. (*Id.* at 19, 28.) WPATH's trainers provide the training offered through its Initiative. (*Id.* at 53.) As of October 2020, Dr. Ettner was aware that IDOC had provided the first part of the WPATH training online. (*Id.*) Dr. Ettner considers the training a "first step" but thinks the two-day training is a "good introduction and overview to the field." (*Id.* at 53.) Per its website, the Global Education Initiative courses are offered to "increase access to knowledgeable healthcare providers for the transgender community by training those providers

globally in the context and principles of the WPATH Standards of Care, and their implementation into clinical practice." (Ex. 20.) The courses "serve as the Core Curriculum for WPATH Members pursuing WPATH GEI SOC7 Certification." (*Id*.) According to Dr. Ettner, the Initiative had not been brought into other state prison systems like in Illinois. (Ex. 18 at 54.)

WPATH currently has a nine-step certification process. (*Id.* at 21-22.) The first step is to complete the foundations training, which is typically eight hours. (*Id.* at 21-22.) There are also the following prerequisites: "eight hours of an advanced coursework, four hours of additional workshops, ten hours of outside approved WPATH workshops, five years of some community experience or work, evidence of knowledge or expertise in the field, such as publication in a peer review journal, 20 approved WPATH . . . continuing education courses every two years, and ten hours of mentorship at the time that an individual sits to take the certification exam." (*Id.* at 22 (see errata correction).)

Dr. Ettner is a co-chair of WPATH'S Committee for Incarcerated Persons. (Ex. 18 at 29-31.) All of the people on this Committee have had interaction with incarcerated persons, but Dr. Ettner is not aware of whether any individuals on the Committee have actually worked day-to-day in a correctional facility. (*Id.* at 31.) The WPATH Standards of Care pertaining to all institutionalized persons provide that the treatment should mirror that which is available in the community. (*Id.* at 33; Ex. 19, § XIV at 67-68.) The WPATH Standards for incarcerated persons contemplate changes to the delivery of care, but not changes or denials based on security concerns. Dr. Ettner was not able to answer whether a denial of social accommodation based on security concerns would be inconsistent with the Standards, but she opined simply that "denial of social role transition is placing a gender dysphoric prisoner at risk." (Ex. 18 at 33-38.) Dr. Ettner has been hired to conduct forensic work for prisoners in other lawsuits. Dr. Ettner reviewed IDOC

records for this case and interviewed the representative Plaintiffs. Dr. Ettner has interviewed only one other IDOC prisoner, who has been released from IDOC custody, and was not interviewed as part of this case. (*Id.* at 64.) Dr. Ettner has opined that all five of the representative Plaintiffs in this action are at a serious risk of self-harm. (*Id.* at 45-46.) Out of the 40 or more prisoners she has evaluated, she can think of only about two that she found were not at risk of self-harm at the time she evaluated them. (*Id.* at 14, 44-45.) Dr. Ettner testified that she saw instances in her review of the class members' records where she observed that prisoners were receiving hormones correctly and appeared to be stable. (*Id.* at 65.)

Argument

I. Plaintiffs are not entitled to a permanent injunction.

First and foremost, a plaintiff must be able to succeed on the merits of their case before permanent injunctive relief may be entered. *E.g., Plummer v. Am. Inst. of Certified Pub. Accountants*, 97 F.3d 220, 229 (7th Cir. 1996). Then, "[a]ccording to well-established principles of equity, a plaintiff seeking a permanent injunction must satisfy a four-factor test before a court may grant such relief." *eBay Inc. v. MercExchange, LLC*, 547 U.S. 388, 391 (2006). It is the Plaintiffs' burden here to establish that: (1) the class has suffered irreparable injury; (2) the remedies available at law are inadequate to compensate the class for that injury; (3) the benefits of granting the injunction outweigh the injury to the Defendants; and (4) the public interest would not be harmed by a permanent injunction. *Id.*; *see also ADT Sec. Servs. Inc. v. Lisle-Woodridge Fire Prot. Dist.*, 672 F.3d 492, 498, (7th Cir. 2012) (citing *Collins v. Hamilton*, 349 F.3d 371, 374 (7th Cir. 2003)).

Plaintiffs will be unable to succeed on their Eighth Amendment claim and cannot meet the accompanying burden to warrant the imposition of injunctive relief.

A. Plaintiffs cannot succeed on their Eighth Amendment claim.

In order to proceed past summary judgment where a prisoner seeks injunctive relief based on an Eighth Amendment claim, the plaintiff "must come forward with evidence from which it can be inferred that the defendant-officials were at the time suit was filed, and are at the time of summary judgment, knowingly and unreasonably disregarding an objectively intolerable risk of harm, and that they will continue to do so." *Farmer v. Brennan*, 511 U.S.825, 846-47 (1994). To be eligible for injunctive relief, the plaintiff "must demonstrate the continuance of that disregard during the remainder of the litigation and into the future." *Id*. at 847. Plaintiffs cannot meet this burden. Although the Plaintiffs contend that they are facing an objectively serious risk of harm, it is not so clear. *See Jackson v. Pollion*, 733 F.3d 786, 790 (7th Cir. 2013) (distinguishing between a serious medical condition and the risk of harm for failure to treat condition). For purposes of this motion, however, Defendants will not focus on the objectively serious prong, but will instead focus on the state of mind required for an Eighth Amendment claim.

1. Precedent sets constitutional limits for Eighth Amendment cases claiming deliberate indifference and there is no strict liability; rather there must be some sort of punishment or subjective cruelty.

The Eighth Amendment prohibits the infliction of "cruel and unusual punishments." U.S. Const. amend. VIII. In assessing the Plaintiffs' claim here, it is necessary to look to Supreme Court precedent regarding Eighth Amendment medical indifference claims. In *Estelle v. Gamble*, the Supreme Court concluded that a claim of deliberate indifference to serious medical needs falls under the Eighth Amendment prohibition of cruel and unusual punishments. 429 U.S. 97, 104 (1976). In so holding, the Supreme Court considered prior Eighth Amendment case law with respect to torture and barbarous methods of punishment. *Id*. at 102. It also reiterated previous holdings that the Eighth Amendment must remain in line with "evolving standards of decency that

mark the progress of a maturing society." *Id.*, *quoting Trop v. Dulles*, 356 U.S. 86, 101 (1958) (Discussing prior recognition that the words of the Eighth Amendment "are not precise, and that their scope is not static.").

The Court drew a fine point to its holding by adding: "This conclusion does not mean, however, that every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment." *Estelle,* 429 U.S. at 105. An inadvertent failure to provide adequate care does not violate the Eighth Amendment. The Court continued:

> Similarly, in the medical context, an inadvertent failure to provide adequate medical care cannot be said to constitute "an unnecessary and wanton infliction of pain" or to be "repugnant to the conscience of mankind." Thus, a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.

Id. at 105-06.

Eighteen years after its holding in *Estelle*, the Court considered an Eighth Amendment claim raised in *Farmer* where the Court further discussed the meaning of the term "deliberate indifference." 511 U.S. 825. Although the Constitution does not mandate comfortable prisons, the Eighth Amendment imposes duties on prison officials to provide humane conditions of confinement, which includes "adequate food, clothing, shelter, and medical care" and that they must "take reasonable measures to guarantee the safety of the inmates." *Id*. at 832-33 (internal quotations omitted). But, there is no strict liability for failure to meet this constitutional floor. *Id*. at 834. Prison officials may only violate the Eighth Amendment when two requirements are met: "First, the deprivation alleged must be, objectively, sufficiently serious; a prison official's act or omission must result in the denial of the minimal civilized measure of life's necessities," *id*. (internal quotations and citations omitted); and, second, a prison official must have acted with a "sufficiently culpable state of mind," *id*. This test remains in effect for adjudicating Eighth

Amendment prison conditions cases. *See Giles v. Godinez*, 914 F.3d 1040, 1049-50 (7th Cir. 2019) (no deliberate indifference where non-medical officials reasonably rely on the judgment of medical professionals). The Court again was clear that there must be some form of *punishment* at issue. *Farmer*, 511 U.S. 837. The requirement that the prison official first know of and then disregard an excessive risk to inmate health or safety was found to comport with the Eighth Amendment because it "does not outlaw cruel and unusual 'conditions'; it outlaws cruel and unusual 'punishments.'" *Id*.

2. Plaintiffs are attempting to expand the Eighth Amendment beyond its limits because they cannot show that they are suffering punishment rather than individual medical complaints.

In light of the applicable case law, Plaintiffs will be unable to establish a likelihood of success on the merits. Plaintiffs cannot establish that Defendants, who have been sued in their capacities as IDOC officials rather than as individuals, nor any other high-ranking IDOC officials are indifferent to their needs. The Defendants are not subjecting Plaintiffs to *punishment* that violates the Eighth Amendment. Instead, Plaintiffs have couched medical malpractice claims as constitutional violations, which are not equivalent. Neither medical malpractice nor common law negligence are sufficient to meet the high hurdle of deliberate indifference. *E.g., Farmer*, 511 U.S. at 837; *Holloway v. Delaware County Sheriff*, 700 F.3d 1063, 1073 (7th Cir. 2012); *Rosario v. Brawn,* 670 F.3d 816, 821 (7th Cir. 2012); *Roe v. Elyea*, 631 F.3d 843, 857 (7th Cir. 2011). Courts have strained to set forth a balance between constitutional backstops and tort claims, but they have been clear that the Eighth Amendment is not a medical malpractice statute for prisoners. *See e.g., Forbes v. Edgar*, 112 F.3d 262, 266-67 (7th Cir. 1997) (The Eighth Amendment does not provide either specific treatment or foolproof protection from infection); *Snipes v. DeTella*, 95 F.3d 586, 590-92 (7th Cir. 1996) (discussed below); *Bryant v. Madigan*, 84 F.3d 246, 249 (7th Cir. 1996) (comparing ADA with Eighth Amendment and writing: "Moreover, the courts have labored

mightily to prevent the transformation of the Eighth Amendment's cruel and unusual punishments clause into a medical malpractice statute for prisoners.").

In *Snipes*, the Seventh Circuit rejected a prisoner's attempt to expand the Eighth Amendment to prevent "a risk of needless pain." 95 F.3d at 592. There, the court noted that:

> [T]he Constitution is not a medical code that mandates specific medical treatment. *Davis* [*v. Jones*, 936 F.2d 971, 972 (7th Cir. 1991)] did not find deliberate indifference to "needless pain," even though the authorities knew plaintiff was injured but did nothing. The issue there was delay in treatment, not the constitutional threshold of when pain is "needless."
>
> Whether and how pain associated with medical treatment should be mitigated is for doctors to decide free from judicial interference, except in the most extreme situations. *A prisoner's dissatisfaction with a doctor's prescribed course of treatment does not give rise to a constitutional claim unless the medical treatment is "so blatantly inappropriate as to evidence intentional mistreatment likely to seriously aggravate the prisoner's condition."*

Snipes, 95 F.3d at 592 (emphasis added) (some internal citations omitted)..

Here, Plaintiffs seek full accommodation for whatever they request regardless of how it may impact IDOC operations and security, or fellow prisoners. Their expert, Dr. Ettner, sees no difference between accommodations for prisoners and those outside of prison. And, the WPATH Standards of Care provide for very limited exceptions for care to those in institutional environments, which include both prisons and health care facilities. (Ex. 19 § XIV at 67-68.) The only exceptions contemplated by the WPATH Standards are those that "do not jeopardize the delivery of medically necessary care to people with gender dysphoria." (Ex. 19 at 68.) The only example given is using one method to deliver hormones, if not medically contraindicated, as opposed to another. (*Id.*) Aside from that one example, the Standards of Care do not elaborate. But, the standards for incarcerated persons have been criticized for setting forth aspirations rather than acknowledging reality. (Ex. 21, Arch Sex Behav., 45:1649-1663). In a journal article published in 2016, the authors identified the issue succinctly: "Its confident simplicity may not

adequately take account of the clinical and contextual complexities that inmates with GD present." (*Id*. at 1651.) The authors elaborated on some of these complexities:

> Many inmates who seek treatment for GD in prison never sought treatment in the community. Many have lived troubled, chaotic lives characterized by early family and economic instability, substance abuse and other psychiatric problems, failed school and employment experiences, and early involvement in crime. Inmates who seek treatment for GD typically display little resemblance to the patients who present for treatment in the community, and prison life bears little resemblance to life in the community. The SOC were not developed with the complexities, vulnerabilities, and life circumstances of incarcerated persons in mind.

(*Id*.) And, Dr. Anderson has questioned whether all items related to social transition are medically necessary support as opposed to "psychosocial support." [Doc. 226-3, p. 18, at 148]. Yet, even aside from complexities underlying the specific requests the Plaintiffs have made, it is unclear at what point accommodation falls outside of necessity and is just based on "a risk of needless pain."

3. Defendants are not constitutionally mandated to provide the relief sought by Plaintiffs.

Defendants are entitled to summary judgment in this action because they are not constitutionally mandated to comport with WPATH Standards of Care. Mental health and medical providers working in IDOC facilities have strived to follow the WPATH Standards; however, those standards are not the constitutional floor for adequate treatment. *Brown v. Plata*, 563 U.S. 493, 539-40 (2011) (citing *Rhodes v. Chapman*, 452 U.S. 337, 348 n.3 (1981)) ("Of course, courts must not confuse professional standards with constitutional requirements."). Prisoners are not entitled to "preferred therapy." *Forbes*, 112 F.3d at 267. Nor are prisoners entitled to demand specific care or the best care possible under the Eighth Amendment. *Id*. In a recent opinion involving a Fourth Amendment constitutional claim, the Seventh Circuit reiterated that best practices, while relevant, do not set the constitutional floor. *Turner v. City of Champaign*, 979 F.3d 563, (7th Cir. Nov. 3, 2020) (citing *United States v. Brown*, 871 F.3d 532, 536-37 (7th Cir. 2017) and *Mays v. Dart*, 974 F.3d 810, 823-24 (7th Cir. 2020)). It has been noted by others and bears

repeating here that while WPATH Standards are general and non-specific and subject to modification by professionals, they also lack evidentiary support for some of their standards. *See* Ex. 19 at 2; Ex. 2 at 56; Ex. 21 at 1650-51; *see also Edmo v. Corizon*, 949 F.3d 489, 499 (9th Cir. Feb. 10, 2020) (O'Scannlain. J., dissenting) ("The panel's disposition results from its failure to put the WPATH Standards in proper perspective.").

Nor are Defendants constitutionally required to provide the same care as that set forth by Plaintiffs' experts, Dr. Tangpricha and Dr. Ettner, who sit on the WPATH Board. Expert opinions may be relevant to the question of how to remedy constitutional violations or useful in determining what is obtainable and acceptable in the prison context. *Id*. at 540. But, here, the Plaintiffs' experts provide little that is useful in the context of prison reform. Rather, Plaintiffs' experts attempt to change a necessarily regimented system into one that matches the best potential and preferential care instead of acting within the context of incarceration and the Eighth Amendment's limitations.

Analysis of the Eighth Amendment must above all be based in objective factors. *Rhodes*, 452 U.S. at 346. This requires a review of contemporary standards such as those "derived from history, the action of state legislatures, and the sentencing by juries." *Id*. at 346-47. A review of history with respect to the care and treatment of gender dysphoria shows that there is no set treatment, let alone one that may easily be determined in the prison environment. This history is also reflected in the case law, which articulates no set Eighth Amendment standard for the care and treatment of gender dysphoria. The cases specific to the types of claims and relief at issue here have set no clear lines. Even since the hearing in this matter on Plaintiffs' motion for preliminary injunction, recent cases involving similar claims have pulled in different directions.

In *Campbell v. Kallas*, the Seventh Circuit rejected a gender dysphoric prisoner's attempt to proceed on an Eighth Amendment claim framed at a "'high level of generality." 936 F.3d 536,

545 (7th Cir. Aug. 19, 2019). There, the Court reviewed a denial of qualified immunity, which does not apply here, but the Court's findings and discussion are instructive for this case. The court reiterated its prior determination that "'inmate medical care decisions must be fact-based with respect to the particular inmate' rather than the product of categorical rules." *Id*. at 546 (quoting *Roe v. Elyea*, 631 F.3d 843, 859, 863 (7th Cir. 2011)). The Court wrote:

> But prisons aren't obligated to provide every requested treatment once medical care begins. In a deliberate-indifference case challenging the medical judgment of prison healthcare professionals who actually diagnose and treat an inmate's medical condition (as opposed to ignoring it), we necessarily evaluate those discrete treatment decisions. And we defer to those decisions 'unless no minimally competent professional would have' made them. *Sain*, 512 F.3d at 895 (quotation marks omitted). Deciding whether a particular treatment plan was a 'substantial departure from accepted professional judgment, practice, or standards'—a necessary predicate to establish an Eighth Amendment violation—requires a close examination of professional standards and the specific choices made by care providers. *Id*. (quotation marks omitted).

Campbell, 936 F.3d at 548. The Court of Appeals found that qualified immunity for the prison officials was appropriate because there was no clearly established right to the sex-reassignment surgery sought by the prisoner. At most, there was arguably a right to hormone therapy to treat gender dysphoria. *Id*. at 549. And, there was no prior indication that "denying arguably nonmedical cosmetic accommodations" such as electrolysis and makeup violated the Eighth Amendment. *Id*. Even though Defendants may not assert qualified immunity for this action, *Campbell* establishes that this class of Plaintiffs cannot show a clear right to the relief they seek.

And, if we expand our search beyond the Seventh Circuit to look at the national jurisprudence, there is less support for Plaintiffs' position. As discussed by Defendants in their response to Plaintiffs' motion for a preliminary injunction, the Fifth Circuit recently declined to find that providing some but not all of the treatments recommended by WPATH amounted to deliberate indifference. *Gibson v. Collier*, 920 F.3d 212, 220 (5th Cir. 2019), *cert. denied*, 140 S. Ct. 653 (Dec. 9, 2019). Just prior to that, the Tenth Circuit affirmed summary judgment in favor

of prison officials and against a prisoner who claimed that she was receiving inadequate care for her gender dysphoria. *Lamb v. Norwood*, 899 F.3d 1159, 1161 (10th Cir. 2018) ("We have consistently held that prison officials do not act with deliberate indifference when they provide medical treatment even if it is subpar or different from what the inmate wants."). And in *Edmo v. Corizon, Inc.*, the Ninth Circuit upheld an injunction requiring Idaho prison officials to provide gender confirmation surgery to avoid subsequent self-castration attempts. 935 F.3d 757, 803 (9th Cir. Aug. 23, 2019), *cert. denied*, __ S. Ct. __, 2020 WL 6037411 (Memo) (Oct. 13, 2020).

In *Keohane v. Florida Department of Corrections Secretary*, the Eleventh Circuit followed a similar vein to that in the Seventh Circuit, but *Keohane* more closely resembles this suit than *Campbell*. There, the Eleventh Circuit held that there was no Eighth Amendment violation that warranted injunctive relief based on prison officials' denial of social transitioning accommodation to a gender dysphoric prisoner. 952 F.3d 1257, 1262 (11th Cir. Mar. 11, 2020). The prisoner-plaintiff raised three main issues with her gender dysphoria treatment, but two of the issues were mooted during the pendency of the suit. *Id*. at 1263. The only live controversy that remained related to the prisoner's requests to grow her hair long, use makeup, and wear female undergarments. *Id*. at 1272. The parties did not agree that the plaintiff's social transitioning requests were medically necessary to treat her gender dysphoria. *Id*. at 1264. In a carefully considered opinion, contested by one dissenting Judge, the Eleventh Circuit reversed the district court's entry of a permanent injunction directing prison officials to allow the plaintiff to socially transition, noting the court could not say that failing to provide the total preferred treatment was sufficient to show deliberate indifference. *Id*. at 1277, 1279.

This case differs from *Keohane* and *Campbell* in a major way: those cases (along with the others cited above) were brought by one plaintiff rather than a class, which allowed for a court and

the parties to present adequate testimony as to individual needs rather than a group as a whole. But, even there, where the parties were able to look at specific needs and the specific care and treatment afforded for the prisoner-plaintiffs, the courts were unwilling to find that such demands for accommodation violated the Eighth Amendment. Yet, even analyzing the holdings in *Campbell* and *Keohane* more broadly in the context of this case, there can be no showing sufficient to establish that the care and treatment provided by IDOC violates the Eighth Amendment.

And, though it is an outlier in the group of recent cases on this topic, *Edmo* only supports the need for an individualized assessment. The Ninth Circuit opinion—in acknowledging that transgender health care has changed throughout the decades based on the medical community's understanding of medical necessity—explained that the original injunction and its affirmance were based on the unique facts and circumstances presented in that case and were not to be construed as a general finding. *Edmo*, 935 F.3d at 783. Despite the court's assurances as to the limitations to the injunction ordered in *Edmo*, nine Judges called the decision an "unjustified" and "unprecedented" expansion of the Eighth Amendment in a "highly controversial area of medical practice." *Edmo*, 949 F.3d at 490 (O'Scannlain, J., dissenting from denial of reh'g en banc).

This Court must also take into account the efforts made following its preliminary injunction order. *Farmer,* 511 U.S. 845-47; *Helling v. McKinney*, 509 U.S. 25, 36-37 (1993). Although Defendants did not agree with the injunction entered by this Court, and do not agree that they are violating the Eighth Amendment, this Court should consider the steps it has taken when deciding whether this case should proceed. These steps include: restructuring administrative oversight of the care provided to transgender prisoners by working to replace the TCRC with a two-committee structure; providing additional training to staff and working with the WPATH Global Education Initiative for provider training; engaging consultants with correctional expertise and gender-

informed mental health expertise to update IDOC's policies and practices for gender dysphoric prisoners; and changing commissary restrictions to allow transgender female prisoners the ability to purchase makeup, undergarments, and other gender-affirming items. In her deposition in June 2020, Dr. Anderson, one of the consultants hired by IDOC, noted that the IDOC system had been "moving in a very positive direction" in spite of challenges with "a number of moving parts." [Doc. 226-3, p. 17 at 143]. Ultimately, Plaintiffs fail to establish Defendants are knowingly and unreasonably disregarding an objectively intolerable risk of harm, and that they will continue to do so. For these reasons, Defendants are entitled to summary judgment on Plaintiffs' Eighth Amendment claim.

B. Plaintiffs will be unable to carry the burden required for the issuance of a permanent injunction.

As noted above, in addition to showing they can prevail on the merits of their claim, Plaintiffs are tasked with meeting a four-part test before a permanent injunction may issue. *See eBay Inc.*, 547 U.S. at 391; *ADT Sec. Servs. Inc*., 672 F.3d at 498. The determination as to a permanent injunction differs from that of a preliminary injunction, and a court's findings of facts and conclusions of law in granting a preliminary injunction are not binding on the merits of a final determination. *Univ. of Texas v. Camenisch*, 451 U.S. 1830, 1833-34 (1981); *e.g., Michigan v. U.S. Army Corps of Engineers*, 667 F.3d 765, 782 (7th Cir. 2011) (findings made at the preliminary injunction stage do not bind the court as the case progresses); *Ayres v. City of Chicago,* 125 F.3d 1010, 1013 (7th Cir. 1997) (purpose of a preliminary injunction is not a decision on the merits).

1. Plaintiffs cannot show irreparable injury here.

Throughout this suit, Plaintiffs have merely hinted at the *possibility* that IDOC's policies lead to a risk of harm. Dr. Ettner has opined that the five representative Plaintiffs are at a substantial risk of serious harm, but, as noted above, she finds the same in nearly all of the forensic analyses

she performs. Regardless, Plaintiffs cannot show that there is a "presently existing actual threat" as a result of IDOC policies. *Michigan v. U.S. Army Corps of Engineers*, 667 F.3d at 789 (quoting 11A Charles Alan Wright, et al., Federal Practice and Procedure, § 2948.1, at 154-55 (2d ed. 1995)). Although the Plaintiffs have each discussed complaints about the treatment and accommodations they receive, some of the more recent issues (like Ms. Vision's wait for a transfer [Doc. 226, at 14-15; Doc. 226-10, at 2, #3] and Ms. Melendez's request for an appointment with her physician (Ex. 8 at 48.)) are largely outside of IDOC's immediate control due to COVID-19 restrictions. These are not creations of Departmental policy, but result from the need to control the spread of COVID or different priorities for health care providers who work in the prison. As Dr. Conway testified and others echoed, much of the work for the transgender prisoners has been disrupted by COVID-19, including a "major agenda item" such as gender-affirming surgeries. [Doc. 226-6 at 7-8 pp. 25-26; *id*. at 28, p. 259]. Other complaints are outside the scope of IDOC policy or practice, such as Plaintiffs' allegations that individual staff are disregarding IDOC's policies and training, and are dependent on numerous factors specific to the facilities where the representative Plaintiffs are housed and the specific needs of the Plaintiffs themselves.

In a recent opinion, the Seventh Circuit reversed the entry of a preliminary injunction where equivocal evidence as to a risk of harm was insufficient to meet the necessary hurdle for irreparable harm. *Orr v. Shicker*, 953 F.3d 490, 502 (7th Cir. Mar. 23, 2020). The court concluded that the district court's analysis was flawed because it found only that a substantial risk *could* arise rather than irreparable harm was *likely*. *Id*. Similarly, here, the evidence is equivocal. Plaintiffs' evidence fails to rise to the level of likely irreparable harm. Accordingly, Plaintiffs are not entitled to a permanent injunction.

2. Plaintiffs cannot show traditional legal remedies are inadequate.

The Plaintiffs must also show that traditional legal remedies ("i.e., money damages") would be inadequate to compensate them for any harm. *Girl Scouts of Manitou Council, Inc. v. Girl Scouts of U.S. of Am., Inc.*, 549 F.3d 1079, 1096 (7th Cir. 2008). "In saying that the plaintiff must show that an award of damages at the end of trial will be inadequate, we do not mean wholly ineffectual; we mean seriously deficient as a remedy for the harm suffered." *Roland Mach. Co. v. Dresser Indus., Inc.*, 749 F.2d 380, 386 (7th Cir. 1984). The Seventh Circuit notes several reasons why damages could be inadequate, and thus warrant injunctive relief—a business could shutter while waiting for a damage award; a plaintiff could be unable to finance his lawsuit without revenues impacted by a suit; damages may be unobtainable from the defendant; lost profits may be difficult to calculate in the distant future. *Id*. But, here, if Plaintiffs do in fact suffer a compensable injury, they are able to seek damages for such an injury. Due to the vague and general nature of this suit, Plaintiffs are unable to establish that traditional legal remedies are inadequate.

Defendants acknowledge that a risk of suicide or self-harm related to an unconstitutional policy could be sufficient to establish that there are no adequate remedies at law. *See Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1046 (7th Cir. 2017). But, the *Whitaker* case involved a discrete issue and policy related to whether a student could use the restroom associated with the student's gender identity. At issue was a preliminary injunction entered in the individual student's favor. *Id*. at 1039. The student had been able to show that the policy exacerbated an underlying medical condition that made the student susceptible to fainting and seizures and, additionally, that the policy caused him "educational and emotional harm, including suicidal ideations." *Id*. The court found that the student adequately established that there was no adequate remedy of law available to him. *Id*. at 1046. By contrast, here, it is not clear that

injunctive relief will resolve any one individual prisoner's feelings of self-harm. The burden is on the Plaintiffs here, and they cannot show that traditional legal remedies would be inadequate to resolve their civil right claims.

3. Issuance of a permanent injunction will cause injury to Defendants that outweighs the harm to the Plaintiffs.

As Defendants have raised previously, the Department is entitled to substantial deference in handling its agency. Governmental actors in general, and prison officials in particular, are given deference in managing and fulfilling their public obligations. *See, e.g., Johnson v. California*, 543 U.S. 499, 529 (2005) ("[E]xperienced prison administrators, and not judges, are in the best position to supervise the daily operations of prisons across this country."). Although various aspects of Plaintiffs' suit have been mooted by changes in IDOC practices and informal policies, IDOC has not yet finalized the new directive pertaining to the care and treatment of transgender prisoners. This final piece may entirely moot Plaintiffs' complaints. IDOC's attempts to modify its policy should be given weight. *Compare Fed'n of Adver. Indus. Representatives, Inc. v. City of Chicago*, 326 F.3d 924, 929 (7th Cir. 2003) ("[W]hen the defendants are public officials . . . . we place greater stock in their acts of self-correction, so long as they appear genuine.") (internal quotations and citations omitted) *and Ragsdale v. Turnock*, 841 F.2d 1358, 1365 (7th Cir. 1988) ("cessation of the allegedly illegal conduct by government officials has been treated with more solicitude by the courts than similar action by private parties.") *with ADT Sec. Servs., Inc. v. Lisle-Woodridge Fire Prot. Dist.*, 724 F.3d 854, 864 (7th Cir. 2013) (change in policy did not moot dispute over modified permanent injunction because it did not resolve parties' dispute). IDOC should be allowed to fully implement its new policies before this Court intervenes.

Additionally, Plaintiffs have suggested that Defendants have failed to provide access to competent clinicians. While all IDOC providers are required to meet minimum competency

requirements, any order that imposes WPATH requirements on every provider would be too difficult to achieve. WPATH-certification is not feasible, as it requires completion of a nine-step process that will take even a dedicated specialist many years. The providers are, however, able to meet the basic competency requirements. With some exceptions, most facility providers within IDOC prisons are contractual employees, contracted with Wexford Health Sources, Inc. The IDOC-Wexford contract requires that all mental health providers be licensed and meet educational requirements including knowledgeability of co-occurring mental health concerns and the DSM-V. (Ex. 2 at 81.) Facility mental health providers are required to: (1) have a master's degree or its equivalent in a clinical behavioral science field; (2) meet competence in using the DSM and/or International Classification of Diseases; (3) demonstrate DSM competency for licensure; and (4) document supervised training and competence in psychotherapy or counseling as required by educational prerequisites (but the amount varies). (*Id.* at 264-66.) IDOC has taken steps to improve providers' knowledgeability about gender non-conforming identities and expressions and the assessment of gender dysphoria through trainings. (*Id.* at 266.) And, they are providing continuing education in assessment and treatment of gender dysphoria through training and transgender specific case conferences. (*Id.* at 266-67.) The final WPATH competency requirement—working with someone in the field—is part of the reason IDOC engaged with Dr. Anderson. (*Id.* at 267-68.) IDOC has expended effort and money to provide additional training to its providers. To hold the providers to a specialty standard and require that IDOC provide the specialty standard through its providers injures Defendants in a way that outweighs harm to the Plaintiffs.

Plaintiffs complain about lack of competent care, yet both of Plaintiffs' experts testified that there is no one way to become competent. Dr. Tangpricha testified about very simple training that may be undertaken for prescribing gender-affirming hormones. He also explained that "there

are many paths to get training in . . . dealing with people with transgender identity" though not all training is equal. (Ex. 14 at 55-56.) WPATH just recently offered a certification course which allows a provider to say they are WPATH-certified in transgender health. As of August 2020, it had just recently launched and only a few had been certified to Dr. Tangpricha's knowledge. (*Id.* at 53-54.) And, Dr. Ettner testified that she has noticed more available providers in metropolitan areas than in rural areas, but any determination of competency would have to be looked at on an individual basis. (Ex. 18 at 26.) Because of the steps IDOC has already taken with respect to competency, and the fact that there is no set course to obtain competency, this Court should deny a permanent injunction with respect to such request.

In addition, the other requests sought in Plaintiffs' prayer for relief will burden Defendants in a way that outweighs any potential harm to Plaintiffs in the absence of such relief. Plaintiffs' requests for "[p]rompt evaluation for gender dysphoria[,] . . . [t]imely fulfillment of medically prescribed treatment for gender dysphoria, including, but not limited to, hormone therapy and gender affirming surgery[, and] . . . [a]ccommodation of medically necessary social transition, including individualized placement determinations, avoidance of cross-gender strip searches, and access to gender affirming clothing and grooming items" are broad, vague, and over-inclusive. What would constitute "prompt" or "timely" action is not readily discernible, and Plaintiff proposes no metric to assess compliance. Plaintiff's list of treatments or accommodations is open ended ("including, but not limited to"), while those items that are specified would not be expected to apply across the board to every person in the plaintiff class. Further, the list is not sufficiently cabined by the "medically necessary" term, because whether an accommodation or treatment meets that standard will depend on the discretion of individual health providers. There are no

workable metrics to guide Defendants' compliance, or monitor the same, regarding such nebulous relief.

4. Public interest weighs against the permanent injunction sought here.

The public interest is not served by Plaintiffs' approach. Institutional reform injunctions, such as the one sought here, raise "sensitive federalism concerns" because they involve "areas of core state responsibility." *Horne v. Flores*, 557 U.S. 433, 448 (2009). Here, Plaintiffs ask this Court to usurp the role of the IDOC and, by extension, the State. But this is not the role given to federal courts. Rather,

> It is the role of courts to provide relief to claimants, in individual or class actions, who have suffered, or will imminently suffer, actual harm; it is not the role of courts, but that of the political branches, to shape the institutions of government in such fashion as to comply with the laws and the Constitution.

Lewis v. Casey, 518 U.S. 343, 349 (1996).

For these reasons, in addition to those raised by Defendants in prior filings, the relief sought by Plaintiffs and the manner in which they have tried to obtain it disserves the public interest.

II. Plaintiffs' requested relief is barred by the Eleventh Amendment.

Eleventh Amendment concerns are implicated by requests for prospective as well as for retrospective relief. *Green v. Mansour*, 474 U.S. 64, 68 (1985). The *Ex Parte Young* exception allows a federal court to grant equitable relief against a state official acting in violation of the constitution or federal law. *Ex Parte Young*, 209 U.S. 123 (1908). The exception is very narrow and is not intended for suits such as the one brought here. Instead, the exception requires an unconstitutional act carried out by a state official claimed to be proceeding under authority of their government capacity to enforce an unconstitutional and, therefore, void law. *Id*. at 159-60. Such an act strips the individual of "official or representative character" and subjects them "to the consequences of [their] individual conduct." *Id*. at 160. This very limited purpose treats the official

as outside of "the state" to render the Eleventh Amendment inapplicable. *Id*.; *Green*, 474 U.S. at 68. But, without this clear violation of the law, such a suit against a state officer "should be treated for what it is: a suit against the state." *Watkins v. Blinzinger*, 789 F.2d 474, 484 (7th Cir. 1986) ("*Young* is a narrow and somewhat anomalous sidestep . . . ."). And, suits brought against the state—whether for damages or injunctive relief—are barred. *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 102 (1984).

The *Ex Parte Young* exception is limited to the "precise situation" "when a federal court commands a state official to do nothing more than refrain from violating federal law"; however, it does not apply when the "judgment sought would expend itself on the public treasury or domain, or interfere with public administration." *Virginia Office for Prot. & Advocacy v. Stewart*, 563 U.S. 247, 255 (2011) (quoting *Pennhurst*, 465 U.S. at 101, n.11). The relief sought by Plaintiffs here is not limited to stop a federal violation, but is rather engineered to control and interfere with the public administration of IDOC duties. This is evident from the Plaintiffs' court filings, including most recently their motion for appointment of a monitor.

The *Ex Parte Young* exception to the Eleventh Amendment does not allow "reparation for the past." *Endelman v. Jordan*, 415 U.S. 651, 665 (1974) (quoting *Rothstein v. Wyman*, 467 F.2d 226 (2d Cir. 1972)). Nor does it allow for deterrence or notice injunctions based on past conduct. *Green*, 474 U.S. at 68-69. Many of Plaintiffs' individual complaints are moot, and the entire process at issue is undergoing change. As noted above, IDOC has taken substantial steps to improve the care offered to gender dysphoric inmates in its custody. There are still some aspects pending finalization. Yet, it is not left to Defendants to establish that the federal claims are moot in order for the Eleventh Amendment to apply; such a view is "backwards." *Watkins*, 789 F.2d at 474. The rule "is that federal courts may not entertain suits against the states." *Watkins*, 789 F.2d

at 474. And, Plaintiffs' attempts to control the State through this suit are barred by the sovereign immunity afforded to the States.

III. The injunctive relief sought by Plaintiffs is not narrowly tailored.

The injunctive relief sought by Plaintiffs is overly broad. There is nothing that is narrowly tailored about the relief they seek. But under the Prison Litigation Reform Act:

> Prospective relief in any civil action with respect to prison conditions shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right.

18 U.S.C. § 3626. Although judicial remedies may have collateral effects, they are required to be narrowly tailored in the context of prison remedies. *Brown v. Plata*, 563 U.S. 493, 531 (2011). This means that there must be a "fit between the remedy's ends and the means chosen to accomplish those ends." *Id*. Even in non-prisoner civil rights suits, the law has been clear that a mere finding of a constitutional violation is insufficient to justify *any and all* remedies, but rather the scope and nature of the violation must be of sufficient magnitude to justify the magnitude of the remedy imposed. *Dayton Bd. of Edu. v. Brinkman*, 433 U.S. 406, 414 (1977).

Therefore, to find that relief is narrowly drawn and extends no further than necessary to correct the violation of the federal right, the Court must first, necessarily, identify the violation with sufficient precision. Here, there is no clarity as to the precise violation, as this case is built on a patchwork of individualized complaints that attempt to piece together a broad claim to buttress broad relief. But, such an approach broadens the scope of the case much more than is necessary and sweeps in reforms that were not needed in 2019 and are not needed now.

A finding of a "cumulative violation"—like that sought by Plaintiffs here and discussed by the Court in its order granting preliminary relief to Plaintiffs—is not sufficient for a system-wide

remedy that exceeds the scope of the evidence. *See Dayton*, 433 U.S. at 416-17 (lower courts' findings of cumulative violations in school desegregation case and imposition of overly broad remedy went beyond legal confines). Such requests are not appropriate without specific evidence of necessity for class members. *See, e.g., Barrow v. Shearing*, 2017 WL 3866818, at *3 (S.D. Ill. Sep. 5, 2017) ("Directing prison employees to give [the plaintiff] 'community standard of care treatment' and requiring a broad range of medical procedures without specific evidence of their necessity is hardly the least intrusive means."). Similarly, this Court has previously considered a prisoner's request for "proper medical treatment" and found that such a request was overly broad in contravention of the PLRA requirement for narrowly drawn relief. *See Owens v. Duncan*, 2017 WL 119173, at *8 (S.D. Ill. Jan. 12, 2017).

And, Plaintiffs' request for ongoing judicial enforcement is a blanket request that must be denied under the PLRA. The PLRA sets forth specific timing for the termination of prospective relief in civil actions concerning prison conditions. 18 U.S.C. § 3626(b). Such relief is terminable two years after the date that prospective relief was granted or approved or one year after a prior termination denial made under the Act. § 3626(b)(2). When termination is sought, it shall not terminate only if the court makes written findings on the record that the relief remains necessary and otherwise complies with the PLRA. § 3626(b)(3). Plaintiffs' prayer for relief has never been narrowed. Yet, it is clear that Defendants have taken steps to improve the care and treatment of gender dysphoric prisoners in IDOC custody. In light of the actions already taken by IDOC to alleviate Plaintiff's complaints, Plaintiff's requests for relief are not narrowly tailored and exceed what is necessary to correct any violation Plaintiffs could demonstrate.

Conclusion

Judgment should enter in Defendants' favor. The Eleventh Circuit noted earlier this year that cases like this "stir[ ] emotions" and the questions at issue are sensitive. *Keohane*, 952 F.3d at 1278. Defendants and IDOC appreciate the sensitive issues here and have made attempts to provide care that is better than adequate to treat gender dysphoric prisoners. Plaintiffs cannot show that IDOC is presently violating or will in the future violate the Eighth Amendment with respect to this class claim. Plaintiffs also fail to meet the corresponding burden required for a permanent injunction. Moreover, the relief sought by Plaintiffs exceeds that which is allowed under the Eleventh Amendment and the PLRA. For these reasons, Defendants are entitled to summary judgment.

WHEREFORE, Defendants respectfully request that this Court grant their motion for summary judgment and enter judgment in their favor.

Respectfully submitted,

ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN,

Defendants,

KWAME RAOUL, Attorney General
State of Illinois

Attorney for Defendants,

By: s/Lisa A. Cook
Lisa A. Cook

Lisa A. Cook, #6298233
Assistant Attorney General
500 South Second Street
Springfield, Illinois 62701
(217) 782-9014 Phone
(217) 524-5091 Fax
Email: lcook@atg.state.il.us

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,	)	
Plaintiffs,	)	
- vs-	)	No. 18-156-NJR-MAB
JOHN BALDWIN, MELVIN HINTON, and STEVE MEEKS,	)	
Defendants.	)	

CERTIFICATE OF SERVICE

I hereby certify that on December 2, 2020, the foregoing document, *Defendants' Motion for Summary Judgment,* was electronically filed with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

John A. Knight	jknight@aclu.il.org
Catherine L. Fitzpatrick	cfitzpatrick@kirkland.com
Erica B. Zolner	ezolner@kirkland.com
Ghirlandi Guidetti	gguidetti@aclu.il.org
Megan M. New	mnew@kirkland.com
Sydney L. Schneider	Sydney.schneider@kirkland.com
Jordan M. Heinz	jheinz@kirkland.com
Sarah Jane Hunt	sarahjane@tkennedylaw.com
Thomas E. Kennedy, III	tkennedy@tkennedylaw.com
Brent P. Ray	bray@kslaw.com
Samantha G. Rose	sam.rose@kirkland.com
Austin B. Stephenson	austin.stephenson@kirkland.com
Carolyn M. Wald	cwald@aclu-il.org
Amelia Bailey	abailey@kirkland.com
Camille Bennett	cbennett@aclu-il.org

s/ Lisa A. Cook
Lisa A. Cook, #6298233
Assistant Attorney General
Office of the Attorney General
500 South Second Street
Springfield, Illinois 62701
(217) 782-9014 Phone
(217) 524-5091 Fax
Email: lcook@atg.state.il.us

 Exhibit 1

Illinois Department of Corrections

Administrative Directive

Number:	Title:	Effective:
04.03.104	**Evaluations of Transgender Offenders**	**7/1/2019**

Authorized by:	*[Original Authorized Copy on File]* **Rob Jeffreys**, Acting Director
Supersedes:	04.03.104 effective 5/1/2013

Authority:	**Referenced Policies:**	**Referenced Forms:**
730 ILCS 5/3-2-2, 5/3-7-2 and 5/3-8-2	04.01.301 05.07.101	DOC 0282 – Mental Health Progress Note DOC 0400 – Transgender Care Review Committee Recommendation DOC 0494 – Screening for Potential Sexual Victimization or Sexual Abuse

I. POLICY

The Department shall evaluate offenders at a Reception and Classification Center to ensure appropriate facility placement; and provide appropriate accommodations and treatment for all offenders who are self-identified or suspected of having gender identity incongruence issues, are transgendered or who are diagnosed by the Department as having Gender Dysphoria.

II. PROCEDURE

A. Purpose

The purpose of this directive is to establish a written procedure for conducting medical and mental health evaluations of offenders self-identified as transgendered or suspected of having Gender Dysphoria or other concerns related to gender identity, and to address adjustment to the prison environment related to gender identity throughout their incarceration.

B. Applicability

This directive is applicable to all facilities within the Department.

C. Facility Review

A facility review of this directive shall be conducted at least annually.

D. Designees

Individuals specified in this directive may delegate stated responsibilities to another person or persons unless otherwise directed.

E. Definitions

Gender Dysphoria – a specific mental health disorder meeting diagnostic criteria of the current version of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) that includes a marked incongruence between an individual's experienced or expressed gender and his or her assigned gender; a strong and persistent desire to be a member of the opposite or alternative gender; persistent discomfort with his or her assigned gender or a sense of inappropriateness with the gender role. Gender Dysphoria is typically associated with clinically significant distress or impairment in occupational, social or other important areas of functioning; and absence of evidence of intersex characteristics (hermaphroditism), or a congenital disorder in which the development of chromosomal or anatomical sex is atypical.

NOTE: The offender may have had cosmetic or other surgery to enhance appearance, undergone hormonal therapy and frequently lived as a person of the opposite gender in the free community in spite of genetically being a male or female. A transvestite (cross-dresser) or non-transgender homosexual shall not be considered a person with Gender Dysphoria for purpose of this directive.

Gender identity – a person's internal sense of being male, female or an alternative gender regardless of anatomical genitalia at birth or sexual orientation. Gender identity is a result of genetics and environmental influences and may be manifested by appearance, behavior or other aspects of the individual's lifestyle.

Medical Provider – for the purpose of this directive, shall mean a Physician, Physician's Assistant or a Nurse Practitioner.

Sexual orientation – a pattern of sexual attraction to a specific gender or genders or lack of sexual attraction to a specific gender or genders. Sexual orientation and gender identity are distinct and separate concepts.

Transgender – an individual whose gender identity is different from his or her assigned gender at birth.

Transvestite – an individual who chooses to dress as the opposite gender without drawing their primary gender into question.

F. General Provisions

1. In accordance with Administrative Directive 05.07.101, all offenders shall undergo a detailed medical history, physical examination and mental health screening during the reception and classification process. This shall be competed within 24 hours of arrival at a Reception and Classification Center (R&C) for any offender self-identified or for whom there are questions regarding gender identity or Gender Dysphoria.

2. All requests for surgery for the specific purpose of gender reassignment must be submitted in writing to the Transgender Care Review Committee. The Agency Medical Director, in consultation with an interdisciplinary team of medical and mental health professionals, shall make a recommendation to the Director regarding the offender's request for surgery. The Director, after a review of the recommendation, shall make the final determination as to whether the Department will perform or allow the performance of the surgery.

3. Hormone therapy shall require prior approval of the Agency Medical Director or Chief of Psychiatry.

G. Transgender Care Review Committee (TCRC)

The Agency Medical Director or, in the absence of or at the designation of the Agency Medical Director, the Chief of Psychiatry (no other designee) shall establish and head a committee for the purpose of reviewing placements, security concerns and overall health-related treatment plans of transgender offenders and offenders diagnosed with Gender Dysphoria; and overseeing the gender related accommodations for these offenders. At a minimum, the committee shall be comprised of the:

1. Agency Medical Director or Chief of Psychiatry (no designee);

2. Chief of Mental Health;

3. Transfer Coordinator; and

4. Chief of Operations.

H. Requirements

1. The Chief Administrative Officer shall ensure a written procedure is established and maintained that requires a detailed medical examination and mental health screening to be conducted during the reception and classification process for any offender who is self-identified as transgender or for whom there are questions regarding gender identity or Gender Dysphoria. The procedure shall provide for the following:

   a. Medical History

      (1) As part of the detailed medical history obtained from the offender by a medical provider, including information about past illnesses and family medical history, the medical provider shall also elicit information about:

         (a) Sexual activity, specifically homosexual, heterosexual or bisexual activity;

         (b) Previous operative procedures related to gender identity; and

         (c) Hormone therapy.

      (2) The medical provider shall also ask the offender questions that would:

         (a) Clarify the offender's sense of gender identity; and

         (b) Reveal any plans the offender may have with regard to future surgery and life style.

   b. Physical Examination

      (1) The physical examination report shall provide a concise description of the presence of genitalia including the presence or absence of natal primary sexual characteristics. If necessary, additional diagnostic testing may be performed.

      (2) If possible, the medical provider who was managing the offender's gender related treatment prior to incarceration shall be contacted for verification of the course of treatment and to obtain relevant medical records.

      (3) The Facility Medical Director shall inform the offender of the Department's policy regarding gender reassignment surgery, as necessary. Hormone therapy shall only be provided after consultation with, and approval by, the Agency Medical Director or Chief of Psychiatry.

   c. Mental Health Screening

      (1) As part of the mental health screening, a psychiatrist shall evaluate the offender using current DSM criteria to determine if he or she has Gender Dysphoria and:

         (a) The consistency of the offender's gender identity other than that assigned at birth;

         (b) The offender's capacity to give informed consent;

         (c) The offender's sexual activity, sexual preference and current gender identification;

         (d) The regularity and history of any hormone therapy; and

(e) The presence or absence of any gender related counseling activities and goals prior to incarceration.

(2) If applicable, the offender's mental health symptoms and psychiatric stability shall be evaluated for consideration of readiness for any requested hormone therapy.

(3) In accordance with Administrative Directive 04.01.301, a Screening for Potential of Sexual Victimization or Sexual Abuse, DOC 0494, shall be completed.

2. Upon conclusion of the medical history and physical examination:

a. The R&C Facility Medical Director shall contact the Agency Medical Director or Chief of Psychiatry to review the offender's medical history and physical examination including:

(1) Gender identification;

(2) Anatomical description;

(3) Preference for sexual partners; and

(4) History of any gender identity related medical or surgical treatment received, including hormone therapy or gender reassignment surgery.

b. The Agency Medical Director or Chief of Psychiatry, as applicable, shall make a preliminary determination of gender and recommendations, including, but not limited to, housing, showering restrictions and hormone therapy.

c. The R&C Facility Medical Director shall:

(1) Document the determination of gender and any recommendations of the Agency Medical Director or Chief of Psychiatry, as applicable, in the offender's medical record; and

(2) Notify the Health Care Unit Administrator and Mental Health Administrator of the gender determination and the preliminary recommendations in accordance with Paragraph II.H.2.b. above.

3. The Health Care Unit Administrator shall notify the Supervisor or Administrator of the R&C of the determination of the offender's gender identity.

4. The Supervisor or Administrator of the R&C shall ensure the offender is housed and provided with necessary gender specific clothing in accordance with the offender's gender-related needs.

5. Within 30 days of an offender identified under Paragraph II.H.1. arriving at the assigned parent facility or new disclosure of transgender or alternate gender identity at the parent facility, a mental health professional shall:

a. Complete a social history interview and review any relevant documentation regarding gender expression or life experience the offender may have had in the gender role other than the gender assigned at birth. The history shall be documented on the Mental Health Progress Note, DOC 0282, and shall include, but may not be limited to, the offender's:

(1) Mental health history;

(2) Current mental health status;

(3) General adaptive functioning;

(4) Gender identity and the development of gender identity or Gender Dysphoria, as applicable;

(5) Positive or stigma experiences in social situations;

(6) The availability of support in the community and in the correctional setting;

(7) Experiences during any previous incarcerations, if applicable; and

(8) Any efforts to legally change his or her name, efforts to obtain hormone therapy or gender reassignment, or gender affirming cosmetic surgery or procedures including preparation for surgery.

b. With the assistance of a representative from Health Care, complete Sections I through IX of the Transgender Care Review Committee Recommendation, DOC 0400. The completed DOC 0400 shall be submitted to the TCRC Chairperson who shall schedule a meeting of the Committee, during which the case shall be presented.

c. The TCRC shall review the case and make the final recommendation for housing and any additional matters that may be of issue including, but not limited to, hormone therapy, gender specific clothing, showers and searches. The review and recommendations shall be documented on the DOC 0400.

6. The TCRC shall conduct follow-up reviews on an as-needed basis. Follow-up reviews shall be documented on the DOC 0400.

Exhibit 2

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL and SASHA REED,	)	
Plaintiffs,	)	Civil No. 3:18-cv-00156-NJR
vs.	)	
ROB JEFFREYS, STEVE MEEKS and MELVIN HINTON,	)	
Defendants.	)	

The videotaped videoconference deposition of DR. SHANE REISTER called by the Plaintiffs for examination, pursuant to notice and pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before Diane J. Corona, CSR, License No. 084-00257, via Magna Legal Vision, on Monday, August 17, 2020, commencing at the hour of 8:59 clock a.m. CST.

Magna Legal Services
866.624.6221
www.MagnaLS.com, by:
Diane J. Corona, CSR

APPEARANCES: (All appearing via Zoom)

KING & SPALDING LLP
353 North Clark Street
Chicago, Illinois 60654
Telephone: (312) 995-6333
Bray@kslaw.com, by:
BRENT P. RAY, ESQ.
- and -
KING & SPAULDING LLP
1100 Louisiana Street, Suite 4000
Houston, Texas 77002
Telephone: (713) 751-3294
Aparsons@kslaw.com, by:
ABBY L. PARSONS, ESQ.,

appeared on behalf of the Plaintiffs;

OFFICE OF THE ILLINOIS ATTORNEY GENERAL - SPRINGFIELD
500 South Second Street
Springfield, Illinois 62701
Lcook@atg.state.il.us, by:
LISA COOK, ESQ.,

appeared on behalf of the Defendants and Dr. Reister.

Also present: Anthony Scardapane, videographer

* * * *

I N D E X

THE WITNESS: DR. SHANE REISTER

THE VIDEOGRAPHER: Good morning. We are now on the record. This begins videotape No. 1 of the deposition of Dr. Shane Reister in the matter of Monroe and others versus Rob Jeffreys, Melvin Hinton, and others in the U.S. District Court, Southern Illinois. Case Number 3:18-CV-00156-NJR.

Today is Monday, August 17, 2020. The time now on the record is 8:59 a.m. Central time. This deposition is being taken via virtual deposition at the request of King & Spalding of Houston, Texas.

The videographer today is Anthony Scardapane of Magna Legal Services, and our court reporter is Diane Corona also of Magna Legal Services.

Will counsel and all parties present please state your appearance and whom you represent.

MR. RAY: Brent Ray of King & Spalding for the plaintiffs. Along with me today virtually is my colleague, Abby Parsons, from Houston.

MS. COOK: And Lisa Cook present for

the defendants. And I'm also representing Dr. Reister for this deposition.

THE VIDEOGRAPHER: Okay. Will the court reporter now please swear in the witness.

THE REPORTER: Raise your right hand, please.

(Witness sworn.)

THE VIDEOGRAPHER: Thank you. Please proceed.

DR. SHANE REISTER,
called as a witness on behalf of the Defendants, having been first duly sworn, was examined and testified as follows:

E X A M I N A T I O N

BY MR. RAY:

Q Good morning, Dr. Reister.
A Morning.
Q Would you kindly please state your full name for the record.
A Shane Michael Reister.
Q Dr. Reister, I know that we're conducting today's deposition virtually. You may have had some experience with this over the last few months. If for any reason you're having

difficulty either hearing me or hearing anybody on the phone or viewing a document, please let us know, and we will try and improve the connection or whatever we need to do so that you can see and hear everything you need to for today. Is that okay?

A That works.

Q Okay.

A Thank you.

Q All right. So you understand today that you are appearing as a witness not only in your personal capacity, but also to testify regarding some topics in a Rule 30(b)(6) notice as a designee of the defendants in this matter; is that right?

A That's correct.

Q Okay. And what I'm going to do now is show you, as best I can -- Dr. Reister, are you able to see my screen?

A I can see it, but I'll be honest. It's a little small for me to be able to see. Can you hit the little square button at the upper right hand to expand it?

Perfect.

(Reister Exhibit No. 1 was marked for identification.)

BY MR. RAY:

Q So what I've gone ahead and premarked, as you can see up here in the upper right-hand corner as Reister Exhibit 1, this is a copy, as I scroll down, of a Rule 30(b)(6) notice that has specific deposition topics listed in it. Have -- and I'm going to make this small again and just flip through it slowly.

Can you tell me whether you've seen this document before?

A I have seen that document before. It's been a few months, but I am familiar with the document.

Q Okay. And you are here today testifying regarding specific topics in this document; is that right?

A That's correct.

Q Do you know which topics you're here to testify about?

A I can't read them, but I actually got an excerpt the other day from Lisa Cook, so I am familiar with the topics.

Q Okay. Maybe let's go through them by number and we'll -- maybe that'll refresh your recollection as to which topics you are here to testify about.

So topic No. 2, are you here to testify about topic No. 2?

A That's correct.

Q Okay. Scrolling down, are you also here to testify on topic No. 7?

A You're moving the document. Okay. Thank you.

Yes. That, also.

Q Are you also here to testify about topic No. 8?

A Yes, that is also correct.

Q And scrolling down just a bit more, are you also here to testify on topic No. 10?

A Yes.

Q Okay. And you understand that your testimony regarding these four topics is on behalf of the defendants in this case, not merely in your own personal capacity?

A That's correct.

Q Okay. I'm going to go up.

Okay. So in the past -- and I'm talking pre-2020 -- was there something that was sort of known within IDOC as the transgender committee?

A Yes. The Transgender Care Review Committee is a committee that is -- before 2020 -- we're in the process of eliminating that committee and splitting it into two to cover various areas of expertise for each of the committees.

Q And what are the two anticipated new committees going to be?

A The Transgender Administrative Review Committee and the Transgender Health and Wellness Committee.

Q Prior to that change, does the Transgender Care Review Committee still exist today?

A It currently exists until the new AD gets through our review process. We have already written it, and so now it has to be reviewed; things like, you know, grammar, editing, what have you. And then it will be assigned by the director to activate it.

Q And by -- just to make sure the

record is clear, when you say "AD," you mean administrative directive; is that right?
A That's correct.
Q So as we sit here today, August 17, 2020, the Transgender Care Review Committee that existed in 2018-2019 still exists today in its present form?
A It still exists today.
Q Have you ever been a member of the Transgender Care Review Committee?
A Yes.
Q When did you become a member?
A 2012.
Q Have you been a member continuously between 2012 and today?
A I have been a regular member. I occasionally have to miss some of the committees due to vacations, time off, other commitments, but mostly I have been on the committee during the various meetings.
Q During the time you have been a member of the Transgender Care Review Committee, have you ever had a vote?
A Yes.

Q So you would classify yourself as a voting member of that committee?
A That's correct.
Q Have you been a voting member of that committee since 2012?
A Correct.
Q How many members are on the transgender review committee -- excuse me. Strike that.
How many present members are on the Transgender Care Review Committee today?
A I'm counting in my head, so if you give me a second.
Between seven and ten. Now, that is not including the sites. Also, from the sites there are an administrative representative, a mental health representative, and a medical representative, minimum.
Q Do the seven to ten members plus the site administrative, mental health, and medical members all have votes as well?
A No, not everybody has votes.
Q Which people on the committee presently have votes?

A The core members have votes.
Q Who are the core members?
A The core members are not the administrative -- I'm sorry -- not the administration, mental health, and medical from the site.
Q Okay. Understood. Who are the core members of the committee today, though?
A Myself, Dr. Hinton, Dr. Conway, Eilers or a designee. We usually will have somebody representing some kind of investigative division. Sometimes we might have an additional mental health person. It would be basically a regional administrator for mental health or above.
Q Is Dr. Puga a core member of the committee?
A Yes, and Dr. Puga. Dr. Puga is the current chair. Also, Dr. Conway can also be a chair as well. Dr. Conway is from medical. Chief Puga is from mental health.
Q Just to be clear, each one of these core members presently has a vote on the committee; is that right?
A Not -- not every committee member

currently would -- would vote in certain matters. For example, if there's a recommendation that is out of my scope of practice such as a recommendation for, you know, some kind of hormone care or something along those lines that I wouldn't have knowledge of, I would defer to medical.
So there are some topics that, you know, I wouldn't be able to speak about because it's outside of my scope of practice.
Q Okay. So presently, the way the committee works is amongst the core members, certain members can select or deselect themselves to vote on a particular issue based upon their expertise?
A Yeah. You're allowed to deselect yourself based on your expertise.
Q When a -- to your example, when an issue comes up in the committee regarding hormone treatment for a particular transgender inmate, who deselects themselves during that vote?
A Well, currently, due to an injunction -- and I don't -- I think it might be a different case than this one -- that decision doesn't happen

at the TCRC level. It now is a decision made between the offender who is requesting that hormone treatment and the site level medical care provider. So the TCRC has not -- and I can't remember the date of that -- but it does not make those decisions any longer.

Q So your testimony today is that the TCRC does not make any decisions whatsoever on hormone treatment?

A No, it no longer does. And what will happen is if somebody brings it to us by mistake, we will refer them back to the site level medical doctor to go over the requirements and the risks and benefits.

Q Does the TCRC currently make any decisions whatsoever regarding surgery for transgender inmates?

A Currently, we have not made a decision regarding the surgical procedure request.

Q When you say currently you have not made any decisions, have -- are you saying that you have never authorized surgery?

A No. What I'm saying is we have not reviewed those decisions as of those -- as of

today. We are in the process of gathering information on offenders' interest in that. Based on our plan for the new committee, the THAW Committee, I am responsible for gathering research data so that we know the offender population.

That data is not due back to me until the 31st of this month. It will take me a month or two to analyze the data. And from that data from all the sites, we'll have a list of offenders who are wanting various surgical procedures.

Q Okay.

A And we'll know whether or not they're wanting top or bottom surgery as well.

Q Is the new administrative directive going to contain a provision relating to surgery?

A Yes. But it is changing that decision -- the final decision away from the director, who the decision would be beyond their scope of practice, and shift it down to the chair of the THAW Committee who will be a medical person, such as currently Dr. Conway would make the final decision.

Now, currently, Dr. Puga and I

would do the readiness letter that the surgeons will need according to WPATH standards, and we'll write those in consultation with Erica Anderson who is the USPATH president. She is our expert consultant, and so she will help us with those surgical letters.

Q Okay. So just to make sure I understand the process, let's unpack that just a bit.

As you're -- you're currently gathering data from the prison population about who wishes to have -- who wishes to be considered for surgery; is that right?

A Yes.

Q Did you send out a survey or did you -- how did you -- how are you gathering that information?

A I created an Excel spreadsheet with between 40 and 50 questions. Some of them were related specifically to surgery. Some of them were related to mental health topics that I will be working on developing if we don't currently have that particular topic for their group. There are also demographic information regarding their

parole times or whether they have a life sentence so that we know basically what kind of time frames individuals have.

And I can further analyze that data as well as addiction recovery information; what are their top three substances of abuse or more serious addiction. And basically -- as well as their mental health symptoms; the major ones that they might have such as major depressive disorder; i.e., depressive disorder, bipolar disorder, psychotic disorder and so forth. Trauma is really big in the transgender research, so PTSD and trauma that hasn't risen to the level of PTSD is also taken a look at.

So it's a comprehensive survey. It will be the first one I do. I will also break down additional topics to see if there are other materials that would be useful for the population. But I believe that the amount that we have is a number to begin with, and then over time we can add in materials for the groups. But we have plenty of topics depending on whether or not those are selected by the offenders.

Our mental health providers

provide basic case management, and they will be the ones that are coordinating getting that information. And that information will be sent back to me by the 31st for collecting the data and then analyzing it.

Some of the information that I've talked about has already generated automatically into charts so that I can analyze them. But some of the information I will have to analyze, write some formulas and what have you to be able to get that data. I wasn't able to get all the programming done, but I have a good chunk of the programming.

Q Okay. And how did you go about creating this list of 40 to 50 questions?

A Well, I am a WPATH member and I go to WPATH conferences. A lot of the information and the interest in certain topics was related to research that was discussed at the conference and -- such as the high amount of trauma, the high level of underground ways of supporting one's self. These are topics that were discussed at the conference.

Also, just in general, the

requests that we have received from offenders such as wanting various types of medical interventions have already been discussed; and, therefore, I added those in. And then I utilized information regarding various gender identities and sexual orientation information for some of the factors that are going to be broken down for this population.

For example, I wanted to do some comparisons between trans men and trans women and gender non-binary or other senses of gender that are not falling into the dichotomous sense of gender, and that way we understand the population and are gathering information regarding a correctional population.

I'm hoping over time that we'll have enough data to see if there is a way to just recommend and to talk with therapists and to expand out the part one and part two transgender trainings that I developed so that people are aware of common problems for our population and common requests.

So a lot of this is gathering information to improve the training of the IDOC

staff in the mental health department.

Q Well, we'll definitely cover the training in a bit. I want to stay on this topic just for a little bit longer.

So then did anyone help you create these 40 or 50 questions, or did you do it yourself?

A This is something that I did myself. These are based on topics that were recommended at WPATH as areas for further research.

Q And when did you create these questions?

A These questions were created -- I believe I started at the beginning of March or along that time period. So it takes a little bit of time for me to scan through the research and to create the questions and then to write the formulas necessary to generate the charts. So it took several months. And I launched it at the end of last month. So it took about that period of time to take a look at the research and to write the formulas into the database.

Q Okay. Did somebody ask you to create these -- this -- these questions?

A This was part of the design that I worked on in terms of the new committees that were developed. I wanted a research section so that we can be sure that we're meeting population needs.

And again, all of these trainings and research are designed for gathering and updating information over time. So this is not a one-time survey. That's why I included it as a regular piece of the THAW Committee.

Q So but it was -- nobody -- so you're saying nobody asked you to do this? This was your idea to do it?

A We -- it was -- I was the originator of the idea, and then the THAW proposal was given to the medical and mental health committee members for review. We wrote out a more specific description of, you know -- well, we discussed this and I explained the importance of it. So there were several conversations that we've had with the committee members about why that would be important for ongoing development.

Q Thank you. I'm sorry to interrupt, Dr. Reister.

Did Dr. Anderson review the

questions before they went out to inmates?
A She did not have a chance to look at those questions, but they are pretty typical questions that all of us in WPATH are aware of. The committee and the discussion of survey is -- was reviewed by her.
Q I'm sorry. Do you mind repeating that? What did she review?
A The -- she did review and has been part of the decision about the various committees. We basically took a Moss group proposal and tailored it to IDOC, and she's been involved in terms of taking a look at that. She has also reviewed my training materials, which is the bulk of where these questions have come out of.
So she's approved the training topics, and these are extensions of the training topics.
Q And how will you -- what procedures will you have to analyze the results that you get back from these surveys?
A I am a licensed clinical psychologist. Part of my training involves research. I will be analyzing, basically, the

numbers and the mean -- or in other words, the averages -- of various frequencies of various interests as well as the medical procedures.
Those procedures will be communicated to medical of interest. And then I will incorporate the rates and the means of the various topics into the training slides and get updates to those.
Q Okay. Is a particular inmate's response to these questions going to be used in deciding whether or not a referral letter will be written by yourself or Dr. Puga for surgery?
A The offenders are going to be broken down specifically. Because the data collects includes specific offenders and ID numbers. However, when we're talking about the data and the averages and how those are incorporated into the trainings, all of the offender names and ID numbers are redacted. I'm looking at aggregate data for that. So --
Q Okay.
A -- their names will be removed.
Q Okay. So there is -- there is really then two things going on here. You have these

questions to try and assess what the sort of state of the world is regarding attitudes about surgical procedures, desire for surgical consideration from these questions. Separately, what you're saying, is there is going to be a process for you and Dr. Reister to write referral letters to Dr. Conway for whether or not somebody should be considered for surgery. Is that right?
A Yes. And those letters would also go to the UIC Gender Clinic surgeons. They were recommended by Erica Anderson as a good surgical provider team, and they have good endocrinologists.
So it would -- they would also go to that team because they're going to need copies of the letters as well for them to perform the surgery.
Q Okay. So this -- none of this has happened yet. This is what the process is going to be once the new administrative directive goes into effect; is that right?
A Yes.
Q That you are going --
A That --

Q -- to be writing referral letters, and Dr. Puga will do the same, in coordination with gender clinic surgeons at UIC?
A Yes.
Q Is there a particular person at UIC who you've been working with on this topic?
A The surgeons -- I don't remember their names. They were mentioned. Erica Anderson would know that information because they were her recommendations.
Q Okay. And but ultimately, the referral letters go to Dr. Conway who makes the decision as to whether or not somebody should be considered for surgery?
A Yes. As the chair of the THAWC, and the chair has to come from the medical central office, ultimately she would be the sign-off.
Q I want to step back to sort of what the committee is doing more generally. We talked a little bit about hormone therapy. We've talked about surgery.
What about sort of gender-affirming items? Is the Transgender Review Committee currently making decisions on that?

A We've already made that decision without the new ADs. The TCRC had the power to do that. So what we have decided already is that we're going to merge the male and female division commissary items, and then the security side will go through those items for specific institutions and remove the items that might be dangerous at various institutions.

So we've already made that decision. My understanding is that operations has already reached out to other correctional systems, taken a look at what they've done. And they reported back, and we're now in the process of going through and merging those commissary items. We need to merge both because -- through my discussion in both the male and female divisions, both trans men and trans women would like commissary items from the opposite division current list.

Q So -- but if an inmate currently requests to have a brush -- a hair brush or a bra, does that request still need to come through the Transgender Care Review Committee for decision and vote?

A Those go through the site medical personnel who go through their medical provider.

Q So then other than this more recent decision to consolidate and sort of, I guess -- yeah, I guess consolidate male and female commissary items into one sort of pool, does the Transgender Care Review Committee make any other decisions currently on whether or not an inmate may have access to a gender-affirming item?

A No. We refer that back currently to the site level.

Q Okay. And if you would, when there is a separation of these committees into -- I'm sorry. Before I move on to that. What decisions does the Transgender Care Review Committee currently make relating to transfer requests?

A The committee makes transfer requests, and that is a joint decision. There is a -- well, there is an operational concern such as our COVID-19 protocol. There's also an operational transfer office sorts of decisions that are -- I haven't been trained on. And then the mental health stability pieces are also taken a look at. Where they're at in medical treatment

is taken a look at as well. And then we confer to see if the various pieces are in place. We no longer use genitalia as the sole decision-making for doing that.

However, for example, genitalia was used for a trans man without going to the committee, and he wanted to go into the male division and that was granted. So there are times. He was bottom surgery postoperative, and so that just automatically went through without the committee decision and upon entrance, I believe.

And I'm doing this from memory and I wasn't involved necessarily with that case. But he initially came into my region at Centralia Correctional Center and then requested for programming to go up to East Moline Correctional Center. I believe he is out of the system now. But again, I don't remember exactly because he is out of our -- out of my region.

Q Okay.

A I cover only the southern region for those kind of day-to-day operational decisions.

Q Just to make sure I'm clear, the

Transgender Care Review Committee still today votes and decides upon transfer requests from transgender prisoners who wish to go to a different institution; is that right?

A That's correct. And that will be flipped over to the Transgender Administrative Review Committee upon launching of the new system.

Q When transfer requests come up for a vote in the current committee, do any of the core members deselect themselves for voting?

A I'll be honest. I cannot remember who all voted, but that would be found in Chief Puga's minutes. They are generated for the committees.

Q Okay. So you're not aware of anybody who routinely deselects themselves on transfer issues at the committee level?

A There's no written policy regarding that. And I'll be honest. I'm a little more focused on my piece. And since I don't write down who is in attendance 'cause, you know, my role is to basically provide information from a mental health perspective, I don't know one way or the other -- I don't recall.

Q Okay. And then you mentioned this already in kind of going back to the anticipated division of this committee. So there's an administrative review committee. What will be the roles and responsibilities of that committee when it is finalized?

A Well, one of the things that it may take a look at is operational concerns such as housing issues. And that's not just division changes. Sometimes there will be requests that will go up to that committee if, perhaps, the offender does not like current decisions at the site. Like, for example, maybe they want a single cell and maybe they are double-celled, or maybe the reverse, and they can't find a good cellie match at the institution. Those sorts of second opinions would go up to the TAR Committee. If there is an item that's not found in either the male or female division currently, they could put up requests to have that added to the commissary in the future. So it's not necessarily a final list.

And so it'll provide those operational concerns. If they have other concerns

that might impact operations, it's a source for a second opinion.

Q So the Transgender Administrative Committee will handle housing and operational issues. Will it handle any other types of issues?

A It won't be handling things like mental healthcare. It won't be handling medical care. It might deal with programs, issues. Perhaps somebody wants to transfer into a different facility. Maybe they want to have their security level reduced from maximum to medium or minimum so they can get into some special program somewhere. They can put that request, if it doesn't go through as they like at a site level. They can deal with those operational issues as well.

So things that fall under the operations side, departments and programs that fall under operations, they can go and put that forward if they are unsatisfied with what decisions are being made at the site level, or if the site level administration wants a consult as well. Sometimes an administrative team might want a second opinion themselves and want to get, um,

like I said earlier, an outside consult.

Q Is the -- are the core members of the Transgender Administrative Committee already decided who is going to be on that committee?

A There is not a final decision on who is going to be at that committee. Obviously, Chief Eilers is somebody who would be on that committee, or a designee. And so that committee might have various designees.

We also have staff turnover to consider so -- you know, I don't know what people's retirements dates are and things like that. So people are pretty high in their career when they get to those regional and statewide positions. But it will be somebody out with -- basically at Concordia, our central -- our central office designation.

Q Do you intend to be on the Transgender Administrative Committee?

A I would be a consultant for them to ask questions. Like, for example, if somebody is requesting a transfer over to the female division and they're unstable -- for example, maybe they were recently on a crisis watch -- we need to

determine if they're stabilized for transport before we could transport them. Let's say somebody is wanting a transfer from one -- I'll just throw an example -- one medium secured facility to another medium secured facility, but those are both outpatient, and this person is -- again, cannot be managed at an outpatient level and needs a residential treatment unit level, the mental health would discuss that as well. Because the transfer may require transfer to an RTU.

Q Okay. So to, I think, sum that up, you don't expect to be a core member of the Transgender Administrative Committee, but if needed, you can consult on specific issues?

A Correct. They may have questions also about WPATH standards and what would be gender confirming. I can speak to that as well. You know, or Erica Anderson is always a consultant for the department, so she could be consulted.

So the idea is to bring in specialists as needed to talk about various topics that might be relevant to the question at hand. And since the mental health providers at the site level are the case managers to determine the

referrals, they have the ability to consult on the questions, and then we can discuss who is appropriate for the committee. We have good interdepartmental communication. We still have that ability to talk about those issues about various specialists that could be brought in to make decisions more individualized and tailored.

Q Okay. Moving on then to the Transgender Health and Wellness Committee, what will that committee be responsible for?

A That committee can also be a second opinion for sites that -- like, for example, a medical doctor has a patient. Perhaps they want a second opinion on hormones or endocrinology results. They are always welcome to consult with the committee. The committee, as we've discussed earlier, will be involved in the -- deploying Dr. Puga and I to do letters of recommendation for the surgical procedures. It will also be responsible for the research, which I talked about earlier as well, that I'm doing so that we can identify needs, whether it's medical or the mental health needs, so that we can get the proper referrals started. And it can deal basically with

various requests that would involve medical or mental health.

Q What about requests for gender-affirming items?

A That, if we received that, would be referred over to the Transgender Administrative Review Committee. If there's something specific that they need information about how that would help with the psychology of the individuals, we can provide that information if they would like us to act as a consultant.

Q So for the Transgender Health and Wellness Committee, you are going to be a core member of that committee?

A Yes.

Q Will you be the chair or will Dr. Puga be the chair?

A Actually, neither us will be the chair. Dr. Conway will be the chair due to the nature of the surgical requests.

Q Other than Dr. Puga, yourself, and Dr. Conway, who else will be the core members on the Transgender Health and Wellness Committee?

A Dr. Hinton would also be a member of

the committee. Dr. Conway can, of course, bring in other medical people if she would like to the committee in terms of voting individuals. So it will be medical and mental health.

Q Okay.

A And then we can also bring in Dr. Erica Anderson as well because that will provide a perspective as well.

Q But Dr. Anderson is not going to be a core member of this committee?

A That hasn't been determined, but I can see her being identified as a core member. She is employed with us, and that can also be done.

Some of the decisions like deploying Dr. Puga and I are pretty straightforward and may not necessarily require her consultation. We're basically doing that by offender request.

Q Okay. In the past the Transgender Care Review Committee has met via phone once per month for, I believe, two to three hours in length. Is that still the review frequency and duration today for that committee?

A It depends on the number of offenders that have requests. We sometimes, if there is a complex case, we will set up a second meeting as well in the month. If we think it will take up too much time in the regular committee, then we can also do that -- that as a second day. Sometimes we might do that if we run out of time.

Q Okay. But the default is once per month, about two to three hours via phone?

A Yes.

Q And does -- will that be the anticipated meeting frequency and format for the Transgender Administrative Committee and the Transgender Health and Wellness Committee?

A I would suspect -- and again, we don't know how many requests are going to be administrative. Generally, the requests that we have are along the lines of medical and mental health. Therefore, I -- albeit I have no data to know that, I would suspect it would be less often for the administrative review committee just because of the smaller number of issues that are being requested. Perhaps initially there might be a larger number of individuals asking for transfer

to the female division. However, I don't know how long that would take to get through that list of individuals.

Q Okay. So you suspect the Transgender Administrative Committee may meet maybe once every few months instead of once a month?

A Well, it would depend on just the amount. But I would expect, you know, maybe every other month to every month depending on the newness of the committee. I suspect initially it will be higher and then taper off to less frequent based on a sender request.

But again, this is completely based on the current population. Most of their requests are much fewer in terms of transfer between divisions versus other mental health/ medical requests.

Q How many, if you know, transgender prisoners are currently under the care of IDOC?

A The last time I did research to try to determine this population, we had two -- 120, roughly, offenders. One of the reasons why I wanted to do the survey is to get the actual population number again. So individuals have come

into our system. Other individuals have gone on parole and, I imagine, have discharged as well. So I need current data.

Q Now, those are the hundred -- those are 120 prisoners who are known to be transgender. Do you suspect the number in fact that are actually suffering from gender dysphoria is more?

A I have been told by the other offenders that they know other offenders at their facility from the community who identified as transgender. We ask every offender when they are on intake to each facility and into our system whether or not they're transgender, but it is their right to remain in the closet and not disclose their true gender identity.

Q When you --

A So that is antidotal evidence.

Q I'm sorry again to interrupt, Dr. Reister. I apologize.

When you have a referral or information from a -- for example, a current transgender inmate that there may be another inmate out there who is transgender, is there any effort made to approach that person specifically

and reach out about it?

A They do not disclose to us -- at least so far they have not disclosed to us the identity of the individual. So we would just remind them to remind that person that we are available and that an offender request form or letting a staff member know that a referral is needed is all that it takes to reach us.

But so far nobody has actually disclosed those individuals to us. And they will be asked again on transfer, so they periodically will get opportunities. And so that information is available to them if they choose to take advantage of our services.

Q In the 40 to 50 questions that you prepared to try and gather additional data about the transgender population, did those go out to each one of these 120 or so individuals?

A They went out to point of contact people at each facility, and those individuals were responsible for utilizing their list. Because it would be very difficult due to transfers for me to know whether or not somebody transferred, for example, the week that that

survey was sent out. So I wanted it to be real time according to the knowledge of the staff. And that information is readily available to the mental health team at the sites.

Q Okay. I mean, just kind of going back to this topic -- I know I asked you a similar question -- but I mean in your experience -- and you've been with the prison system for a while and, you know, you've obviously -- you've been a WPATH member for a while. I mean, do you truly believe that there's actually only 120 transgender individuals within IDOC's care amongst the thousands of prisoners that are in the state?

A Well, I assume that we're getting accurate information on -- that there are additional offenders who are in the closet. We also -- I was aware of somebody who did tell me that she wanted to remain in the closet and did not want hormone therapy during her very short stay in IDOC. She had a very -- it was under two years. It might have been even under a year. And she just wanted to keep a low profile. She thought that that would be a way that she could do it. We talked about the availability of services,

and she continued to want to remain in the closet, which we respect that right of individuals.

Q Okay.

MR. RAY: We've been going for just about an hour. Why don't we take a short five-minute break, and then we can come back online at a little bit after 10:00 a.m. Is that all right?

THE WITNESS: That works well.

THE VIDEOGRAPHER: The time now is 9:56 a.m. We are off the video record.

(After a brief recess, the deposition continued as follows:)

THE VIDEOGRAPHER: The time now is 10:02 a.m. We are back on the video record.

BY MR. RAY:

Q Dr. Reister, you've made mention of it a few times today, so I'm going to assume you're aware of this, but I'll ask anyways. You're aware of an organization called WPATH?

A That's correct.

Q And you are aware that it has promulgated a set of standards of care?

A That's correct.

Q And you are a WPATH member?

A That's correct.

Q When did you become a WPATH member, sir?

A I believe, if I recall correctly, it was around 2013. I'm doing that from memory.

Q Okay. And --

A So I'm pretty sure that's what it is.

Q Do you recall the first time that you -- well, let me back up for a moment. Have you reviewed the WPATH Standards of Care before?

A Yes, many times.

Q Okay. When is the first time you recall reviewing it?

A In, I believe, 2012 was the first time that I reviewed it when I went on to the committee.

Q And how often would you say that you consult the standards of care in your day-to-day work?

A Well, frequently. Because I utilize the standards of care in the training revisions that I do, as well as during consultations I will

review various parts of it. The most common part that is referenced is readiness issues because sometimes I will receive questions about that. Sometimes people want the definitions from the back.

Q When you say readiness issues, what do you mean?

A For example, the consistency of identity over time, capacity to make an informed decision. You know, for example, for surgery, have they been on hormones for 12 months. Are they well stabilized for surgery. Those sorts of standards I may get questions about. Individuals -- like mental health are involved in stabilization.

So we want to have somebody well stabilized. They may ask me questions about that or ask for suggestions for stabilization would be common. They may ask questions regarding the stability of gender over time. It's not unusual for somebody who comes out of the closet at a very young age to go through a period in adolescence of some confusion as they become more sexually aware, and then to reconsolidate the

difference between sexual identity and gender.

So they'll consult with me about that, and I'll explain some of the those dynamics and that that's a normal part of the process for many transgender people. Those are the types of questions that I might talk about and explain.

Q In all of IDOC, is there anyone who is as or more qualified than you to speak about transgender issues for -- as it relates to mental health?

A Well, obviously, Dr. Erica Anderson, who we've employed and who I consult with on a regular basis. She is going to be coming to my monthly case conferences whenever she is available and doesn't have a conflict. Obviously she is USPATH's president. She, you know, clearly has more expertise than me. And if she doesn't know something -- for example, I had a question about autism in the transgender population. She was able to link me up so I could talk with Finn Gratton, and I consulted with them. And we're working on a training with Finn and --

So she has contacts that she

doesn't [sic] know to help me identify training and trainers. So she -- she clearly has more knowledge. She knows the people involved in various subspecialties.

Q Other than Dr. Anderson -- and I'm going to circle back to her in just a moment -- is there anybody else within IDOC that has, you know, more experience with this than you?

A Probably not more experience. But we have some very gifted clinicians who have done lots and lots of work with the transgender population, continual ongoing learning. We've had individuals attend WPATH conferences.

So there are individuals that really have a very strong interest in this population and have gone above and beyond the basic requirements. We are actually upping our training to include -- WPATH is working on specific training for us, and they're going to do it via Zoom so that we can get various experts to get further training. The idea being that my training part one and part two are the introduction to mental healthcare and corrections, and they will provide some advanced training after

that.

Q Okay. Let's -- we'll circle back to that in just a bit as well. I want to make sure I understand.

Is Dr. Anderson now -- do you consider her to be an IDOC employee?

A Yes.

Q Okay. Is she a full-time employee?

A No. She is a consulting employee, so she comes in not as full time.

Q How many hours per week does she spend working with IDOC on these issues?

A I don't know. Because I am aware she consults with other people when I'm not aware. So various people consult with her. So I really don't know how often she consults.

Q How many times per week do you speak with Dr. Anderson about transgender health issues for your prison population?

A I speak with her as needed. For example, the questions about autism, I have had a couple of discussions with Finn Gratton. So it depends on the question whether I consult with her. And I don't always have -- because I don't

carry a caseload as an administrator, I will consult with her on things like when we were designing the changes, we were consulting with her every week, if not more than once a week. Because sometimes I -- since I was one that was chiefly writing up and explaining the changes, I might have talked to her, you know, more than once a week.

But during that phase we were talking once a week. Now it will be about once a month. And then in between if I get questions or I have a question when I'm doing additional reading, I can consult with her. So that would be on an as-needed basis and when I have questions.

Q Is the anticipation --

A Or my clinicians have questions.

Q Okay. Do IDOC mental health providers other than yourself have direct access to Dr. Anderson?

A Yes. The mental health providers who attend the Transgender Care Review Committee, we encourage them to attend at least 50 percent, but hopefully 100 percent. People have vacations. And in, I believe --

Sorry. I hope that didn't hurt your ears too much when it fell off the table. The mic fell off the table.

And there's a committee that usually gets cancelled because it's the fourth Thursday of the month, noon to 1:00 p.m. And so there is one, I believe, that gets cancelled automatically. And then people will sometimes get sick or have vacations or be quarentined due to COVID-19 testing and that sort of thing so...

But they try to go to each one with Dr. Anderson beginning to attend those. That will give direct access to the treatment providers.

Q Okay. So there is a -- is this a monthly meeting that Dr. Anderson is available for on the fourth --

A Yes.

Q -- Thursday of every month for one hour, and the mental health providers can attend and ask her questions at that time?

A Correct.

Q And what is the -- is this a particular committee that meets, or is this a --

does this kind of regular meeting have a name?
A This is called a case conference. Case conferences are used in mental health for mental health providers to share information and to do case conceptualization on cases. People will bring in a clinical issue that they have a question about. They'll pose that to the other clinicians who are present, and people will share information.
For example, if a client comes in and they are -- their treatment plans are -- let me reword that. That was confusing.
If a clinician comes in with a case they want to present -- for example, they are having a hard time stabilizing an offender on a crisis watch -- they can consult and get other ideas about what other clinicians have done to do stabilization. If a clinician is having a hard time with identity development, then they can ask the people who are in attendance what has worked with your client for identity confusion.
Those are the type of things that might be brought in. For example, somebody might suggest, well, clients sometimes don't have

a dichotomous sense of gender. They could be gender nonconforming. Have you talked about various spectrum of gender? And then the clinician can say, yeah, I -- you know, could do that, and then they could talk about, you know, using graphs that they use to explain, maybe it's the verbal modality isn't good for the client. So people could say, you know, not everybody learns through the auditory. Maybe they need a visual diagram to help them understand and think about and process gender.
So that's one example -- or actually two examples of different things people might bring into the committee to get ideas, feedback, treatment plan, and homework assignments. It's not unique to transgender care. We also do it with other issues as well in the department.
Q Okay. So this monthly fourth Thursday of every month one-hour meeting is not limited to transgender issues. It's just more of a case conference call across the board where, you know, any issues that are coming up that merit a group discussion can be raised?

A I don't think I'm explaining it correctly. What I'm saying is there is another case conference that is used separately from this that you can present a case, but this case conference is specifically to the transgender population.
Q Okay.
A And so, for example, maybe there's a transgender offender who is having a specific time -- a specific kind of crisis stabilization that might be related to being transgender and -- for example, maybe they're having stress coping with peers that are disrespectful to them, for example, and that is straining the coping skills, and so they end up on a crisis watch. But that's separate from the other committees we use for consultation.
Does that make better sense? So it would be related to transgender care for this committee.
Q So how long has Dr. Anderson been attending then this once-a-month care conference specific to transgender issues?
A Well, we're in the process of getting

her scheduled, and so hopefully this month there won't be any conflicts and we can have her start joining this month. This is all part of our redesign of the care and -- you know, we're piecing in the various pieces over the next few months.
Q Okay. So Dr. Anderson has not yet attended any of these conferences. But the anticipation is that if she doesn't have a conflict, that she will be able to attend future ones?
A Yes. And I'm hoping she'll be able to attend all the future ones.
Q Okay. Is the plan for her to attend these conferences indefinitely, or is there a sort of phase-in process where she's available for the first six months or a year and then see how it goes?
A No. It was discussed as indefinitely. I mean, obviously if she's not available, we could look for another expert if she, you know, doesn't continue the contract. So there's nothing that specifies it can only be her. And it's possible we might bring in another expert

for a specific issue. Oftentimes clinicians will let me know in advance that they want to present a case. And so if there's somebody that might be good to add in as an expert, we can do that. So it's not exclusively limited to her.

Q Okay. And you mentioned Dr. Anderson has a contract. Does that contract have a duration?

A I don't know. I'm not involved in the human resources side of that contract.

Q And then talking about, you know, if not Dr. Anderson, perhaps another expert, I mean would you agree with me that it's -- it's helpful to have sort of an outside expert be able to assess and review and oversee what's going on within IDOC about the treatment of transgender individuals?

A Yes. That's why I'm really excited about our new approach.

Q Okay. And I think you'd agree with me as well that it's important for that expert to be sort of an impartial person who can provide feedback to you and to others within IDOC to say, you know, this is working, this isn't working, and

this is what we can do better. I think you'd agree with me that not only you, but also IDOC would benefit from such an expert?

A Yes. That's one of the reasons why we brought in the Moss Group.

Q So you've mentioned training that WPATH is putting together for IDOC. When did that -- what was the genesis of that project?

A Our new redesign. We wanted it to be comprehensive, including training, so that is borne out of what we're doing. We're implementing as much as possible already, like the training component and the gathering information about the population that I'm doing. So we're implementing as soon as possible those items.

Q Okay. Who is coordinating with WPATH over this training at IDOC? Is that you?

A No. That's Dr. Anderson.

Q Whose idea was it to have WPATH do specific training for IDOC in addition to the training that you had put together?

A I believe it was Dr. Anderson.

Q Is there a time frame for when that training will be completed?

A We're still in the process of getting that. That would be a question, since she's coordinating it, that she would be able to have that information. Obviously things may be slowed down. I don't know in terms of their schedules. It would depend on the experts themselves and their scheduling. So I don't know for sure. She would have a better estimate.

Q Okay. Going back to the WPATH Standards of Care, would you agree with me that the -- that those standards of care, that sort of nucleus of information, is the best resource to understand how to care for transgender individuals from a mental health standpoint?

A From a mental health standpoint, yes. They're very general, though, and so the specifics you really need additional training.

Q Okay. Well, maybe if I can share my screen again, perhaps we can put these up.

A I apologize. I hit the mic again.

Q Okay.

A Yes, I can see that.

Q Can you see the WPATH Standards of Care then on your screen?

A Yes.

Q All right. And you'll see that this is marked as Reister Exhibit 2. So I'd like to introduce that into the record for this deposition.

(Reister Exhibit No. 2 was marked for identification.)

BY MR. RAY:

Q So you've reviewed this document before, you said, many times?

A I have.

Q All right. So I'm going to turn to some pages here, and hopefully that will come up on your screen okay. And I apologize for the dizzying scrolling forward, but I want to try to get to a particular section.

Okay. So right now I'm on Page 21 of Exhibit 2, which is a WPATH Standards of Care Version 7, which is the current version of the standards of care. And I'm referring to Chapter 7 which is called Mental Health.

Do you see that on your screen, sir?

A I do see that.

Page 58

Q Okay. And then I'm flipping now to Page 22, and this is a list of -- on this page of the recommended minimal -- "minimum credentials for mental health professionals who work with adults presenting with gender dysphoria." And I'd like to go through each one of these with you.
A Can you make it larger, please?
Q Of course.
Is that better, sir?
A That's much better. Thank you. I'm wondering if there's a way to get rid of the -- perfect. Okay. I had to turn off my picture --
Q Okay.
A -- to be able to read it.
Q Great. So then turning to this list, which is the "recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria," Item 1 is "A master's degree or its equivalent in a clinical behavioral science field."
Do you have this, Dr. Reister?
A I do. I'm a licensed clinical psychologist.
Q Okay. Turning then to the second

Page 59

item, "Competence using the Diagnostic Statistical Manual of Mental Disorders," which I believe is also known as the DSM-V, "and/or the International Classification of Diseases for diagnostic purposes." Do you have this, sir?
A Yes.
Q Okay. Is your competence using the DSM-V or the International Classification of Diseases or both?
A DSM-V.
Q Dr. Reister, then do you have the "Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria?"
A Yes.
Q Dr. Reister, do you have "Documented supervised training and competence in psychotherapy or counseling?"
A Yes.
Q Okay. Have you ever been supervised by a WPATH member in your work in this regard?
A I have not, other than Dr. Anderson.
Q Okay. And when did your supervision by Dr. Anderson begin?

Page 60

A In 2020.
Q And specifically do you have a month?
A Oh, no. We've been doing it for a few months.
Q About how many --
A Before that my supervision was not by WPATH members, by LGBT training.
Q Okay. About how many hours would you say that you have had supervised training under Dr. Anderson?
A Oh, goodness. Well, you figure the weekly was -- I believe that was four -- I'm guessing, without calculating it, probably around 20.
I've also had some consultations with -- and again, I don't know whether they're WPATH members or not -- but with an individual from Howard Brown, which is a major LGBT organization in Chicago. They provide comprehensive care. And they actually came in and did a training at one of our quarterly mental health meetings, and I've also had a few conversations with her.
I've also had conversations

Page 61

with somebody from Planned Parenthood who is a trans person who helped me with the original transgender part one and part two trainings that I had developed.
I wanted both of them to take a look at those trainings so I could get outside ideas and opinions on that training. And then Dr. Anderson took a look at that more recently.
So those are the other people that I consulted with, you know. I mean, obviously when I went to the conferences, we would talk about -- I would talk with other people offline about what we were doing and idea gathering as well. But that wasn't formal, those were more informal consultations.
Q Okay. And what is the name of the individual who helped you as well with this training with Dr. Anderson?
A Len Meyers [sic] from Planned Parenthood in Illinois who does a lot of the transgender care and training. She's on the -- I'm sorry. They're on the governor's LGBT committee. Taken a look at, you know, issues affecting the community.

And Caitlin Williams from Howard Brown -- Howard Brown Health Centers in Chicago.

Q Okay.

A In addition, you know, I have consulted for the all-staff training. We had to train about 12,000 staff members. And I did consult with a trans officer, but he prefers to remain -- basically doesn't want to disclose, you know, to courts. But I wanted to get an officer's perspective. And as well, Len Meyers also worked I believe as an officer in the North Carolina system. So they also have correctional experience.

Because, again, when I'm going over the -- that third training that I did for all staff, I also wanted a correctional officer perspective. I'm going to be revising that material.

Q Okay. And this officer who is transgender, this is a current IDOC employee?

A Correct.

Q Okay. And you're not able to give me that person's name?

A Yeah. I -- I cannot. I had a specific request not to out this individual. Is that okay?

Q Well, we are under a protective order, but, you know, I also understand that, you know, there is right to privacy relating to the transgender status that at this point in time I -- I don't feel like it's, you know, worth -- if this person wishes to remain that way, then I -- I'm fine with that. We may take it up later if it's important, but -- okay.

And I know you've been a WPATH member now, you say, perhaps for about seven years or so. How many conferences have you been to?

A Two.

Q And what years were those in?

A Oh, goodness. One -- well, the latest one is easy. That was last September in 2019 in Washington, DC. I also went to another conference that launched just before the global education initiative. They were just talking about launching it. So that would have been probably -- and again, I can't remember exactly. Probably around 2014 maybe. It's been a while for

that one.

Q Okay.

A Maybe '15.

Q Dr. Reister, then are you "Knowledgeable about gender-nonconforming identities and expressions in the assessment and treatment of gender dysphoria?"

A Yes. And I would base that on the positive feedback that I received from all of the individuals reviewing my trainings.

Q You mean the individuals -- the training materials that you were preparing and you have prepared for IDOC personnel?

A Yes. From the mental health providers I got very positive feedback on those materials. They included both describing basic definitions of gender nonconforming identities and expression assessment section. There was also a treatment planning section to talk about how one would formulate treatment plans and what that might look like. And I received very positive feedback.

Q Okay. And then relating to Item 6, continuing education and the assessment and

treatment of gender dysphoria, have you -- have you accomplished this?

A Yes. And I do plan on continuing to do this since they're great conferences through WPATH and USPATH. So they're really good in clinical skills in general as well as transgender specific, so -- they're great conferences.

Q All right. So then on that basis then, Dr. Reister, do you consider yourself to be somebody who meets the minimum credential for mental health providers who are working with adults who presenting with gender dysphoria?

A Yes. And in addition to that, which isn't mentioned, is the reading of various books and research on transgender issues. Like, for example, I get the WPATH journal that comes out and various books. There's a really nice edited volume from, you know -- has a lot of the top experts and various other readings. So it's not just about conferences. You also have to do your homework in terms of reading as well.

Q Okay. You'd agree with me, though, that you can't become an expert in the field by self-study, though, right?

Page 66

A Oh, no. That's why you need to go to the conferences. You need to do the consults. That's why the department has implemented that more intensive outside supervision. It just makes it easier for clinicians. And it also, you know, makes it cost effective as well to provide that free for our clinicians, so...

Q Would you consider yourself an expert in the field of the treatment of gender dysphoria?

A I would.

Q When did you become an expert in that field?

A I think it happened over time. I think that the conferences have really improved that competency because that afforded me the opportunity to talk about specific issues in the department with various experts. You know, it's not just about the trainings themselves. It's about going to the dinner, sitting at the table, and specifically consulting with people. As well as consulting with Howard Brown. Howard Brown does our aftercare. The majority of our clients need those sliding C scales and things like that.

So having consultations.

Page 67

Also, just the real-life experience of talking with trans people, both offenders and as well as community people, keeping up on what's going on. There's a very large trans community in the community I live in.

And so you need all of that. You know, you can't just hear from an expert. You need to talk with actual trans people as well.

So again, it's the combination of all of that that I think has informed my expertise, that it goes well above the average clinician and what you would be taught in school or at a standard practicum --

Q Okay.

A -- or internship.

Q I appreciate the answer. I was seeking just a little more discrete. When did you become an expert in this field?

A Oh, I think that I achieved -- well, I always had a lot more information than the average clinician, but I do think that the information that I had gained was basically starting after the WPATH conferences that I went to. That's when it really afforded me the

Page 68

opportunity to have those discussions and talk more specifically with other professionals that were working in this field.

Q So then on that basis --

A And then in combining that -- yeah. I'm sorry.

Q That's okay. I apologize for interrupting. I didn't know you weren't finished with your response.

Then on that basis then, did you become an expert in this field then sometime after September 2019?

A I think I began with the expertise -- because in terms of being an expert, you need to have more than the average knowledge that somebody would have. So I've had that extra knowledge for quite some time. But the thing about becoming an expert is it's not an on/off switch. I do think that it is a continuum more like a dimmer switch with less and more. And that has been building over time. And I think it just skyrocketed talking -- once we added that expert, Dr. Anderson. And also, the last conference was amazing as well.

Page 69

So it skyrocketed within the last year in terms of the expertise. And I think it really helped me when we were redesigning our programming.

Q When did you first start working with Dr. Anderson?

A That was a few months ago. I can't remember the exact date of when that was. I think it was before we were locked down -- well, it was before we were locked down for COVID. I'm pretty sure that's when it was. But I'll be honest, I didn't mark the calendar.

Q Do you think you became an expert in this field after you started working with Dr. Anderson?

A I think I had expertise far above the average clinician before I worked with Dr. Anderson. But in particular, it afforded me the chance to really cement down and also confirm my knowledge.

One of the things that Dr. Anderson really did was highlight the expertise that I had because of the training materials I developed. The content was good.

There weren't content revisions in that training.

So that expertise, although I don't know exactly when that tipped over into expertise, but the fact that it was acknowledged as comprehensive did indicate that it predated my work with her.

When that exact date is is hard to say, but -- because I had a lot of different experiences. But clearly since that training was done long before -- well before she reviewed it and it didn't have content revision, I think that the expertise was in advance of 2020, at least for many years. Because I had been teaching that content for a long, long time. Many, many years. The content that I had hasn't changed. I think that my ability to communicate that in the actual visuals, that has improved. But that has more to do with teaching, learning how to teach, you know.

Q Okay. So setting aside Dr. Anderson, who I would assume you believe is also an expert in this field --

A Yes.

Q -- is there anyone else within IDOC

who you would consider to be an expert in the field of treatment of gender dysphoria?

A Dr. Puga has experience in the community as well, so he also provides some information. Particularly on the medical side since he is a medical doctor by training, he has some perspectives that are helpful. You know, medical is outside of my scope of practice, it's not in my training background.

So he and Dr. Conway and other medical providers have really helped educate me. Because what the offenders talk about in their experience includes their medical interventions as well.

I have, you know, talked with and had trainings with some top endocrinologists, of course, at WPATH, you know. So that's been very good for my education. But I don't use that in my actual clinical. It just helps provide a context for what my staff/clients are, you know, going through and their experiences.

Q So do you consider Dr. Puga to be an expert in the field of treatment of transgender individuals?

A I believe so. I believe him to be. Do keep in mind, his specialty is outside of my scope of practice, so I wouldn't be the appropriate person to determine that, but -- so I would refer you back to him or somebody that would be able to evaluate what a medical doctor would do. But he definitely has provided me information that was very helpful in terms of understanding hormones in particular and the impact on the human body.

Q Do you consider Dr. Conway to be an expert in the field of the treatment of transgender individuals?

A I'm assuming so. But do keep in mind, I haven't had conversations, so you would -- I would have to refer you to speak with a medical person. Same reason. It's outside of my scope of practice. What she's bringing to the table is just beyond what I could assess.

Q Why do you assume that she would be an expert in this field?

A Because she works closely with Dr. Puga. But again, this is beyond my ability, and -- and nor is it in -- you know, what I would

deal with in my job. It wouldn't be my job to assess her qualifications. I wouldn't -- it wouldn't be within my job to ever see her résumé or anything like that or to question that. That is not my role, nor would it be appropriate for me to ask to see those things. There are -- there's a whole division for medical that would be more appropriate to consult with if you're, you know, interested in finding out.

Q Well, I'm just asking you, so...

A Oh. For me, I can't assess her medical skills. She seems to be knowledgeable. I haven't heard any other medical professionals, or in Dr. Anderson's discussions I've never seen concerns raised. But again, I'm just basing it on the feedback not being provided by other medical professionals. I haven't heard complaints about what she's saying.

Q Okay. So just to make sure the record's clear. You do -- it is your opinion that Dr. Puga is an expert in the field of treatment of transgender individuals; is that right?

A As far as a mental health -- keep in mind, I cannot assess that. So my best guess is

he is. Because again, that's not -- I don't have the ability to assess his medical skills.

Q Other than Drs. Puga and Conway, is there anyone else within IDOC -- again, setting aside Dr. Anderson -- who you believe is an expert in the field of treatment of transgender individuals?

A I will be honest. All medical care in terms of transgender care is by the medical division. I don't even know the names of very many of those medical doctors providing that care, so I can't make that determination because I don't know who those people are because it's out of my supervisory area.

Q Okay. But what about on the mental health side?

MS. COOK: Well, and just so I can interject. I would ask for clarification because you keep using the word "expert," but do you mean they fall under the WPATH standards?

MR. RAY: Counsel, if there's a point of clarification -- the witness did not have any difficulty understanding what I was saying. So you may redirect on this point, if you wish, but I

don't think it's a proper objection at this point in time. So do you have an objection?

MS. COOK: I'm just asking for clarification as to what you mean when you keep saying "expert."

MR. RAY: Well, I will turn the question over to the witness.

BY MR. RAY:

Q Dr. Reister, when I say "expert" in the field of treatment of transgender individuals, do you understand what I mean?

A I would say --

MS. COOK: I would --

MR. RAY: Counsel, don't interrupt.

MS. COOK: If I could, please. I'm just asking to make --

MR. RAY: Do you have an objection?

MS. COOK: Are we staying on the topics, is what I'm trying to determine.

MR. RAY: I need to know whether you have an objection or not.

MS. COOK: I'm asking what you intend. Because I need to know if you're staying within the scope of the topics that we are

discussing.

MR. RAY: I don't see how that has anything to do with anything.

I'll ask my question of the witness again.

BY MR. RAY:

Q Dr. Reister --

MS. COOK: So I want -- we need to --

MR. RAY: Look, counsel, you can't interrupt me when I'm asking the witness a question. You may have a chance to object after I'm done. Okay? And you may have a chance, of course, to redirect the witness if you wish. But this is -- what you're doing right now is a blatant speaking objection.

MS. COOK: I'm not doing a speaking objection.

MR. RAY: I'm not even -- let me finish, please. You're not even actually stating an objection. You're asking, "What do you mean by this?" And frankly, you're not testifying today. The witness is. So the witness can also -- and you may object if you wish. Okay? And if you want to instruct the witness not to answer, you

can take your risk doing that as well. But otherwise, I don't think it's proper for you to just interject and say well, I'm not sure what you meant by that after the questioning is done. So I'm giving -- I'm turning it over to the witness again to ask him if he understood what I meant, and we'll see where it goes. But otherwise, I don't think what you're doing is proper.

MS. COOK: I will object to it then as outside of the scope of the 30(b)(6) topics he has been produced for.

MR. RAY: You may object to that if you wish. He's still here in his personal capacity as well.

MS. COOK: Well, we are doing two separate depositions. You can ask him his personal capacity questions, but first we're doing the representative questions, and so I want to make sure we stay on topic.

MR. RAY: Your objection is outside the scope. You can make that objection. I'm still going to proceed.

MS. COOK: So wait. So are you going to continue to ask him also topics -- is this a

30(b)(6) deposition or a personal deposition?
MR. RAY: This is both, and right now we are on topic No. 2 of the 30(b)(6) deposition which applies the transgender committee to the WPATH Standards of Care, and we referred to document Exhibit 2 which talks about minimum qualifications for individuals, and that's what I'm asking about.
MS. COOK: So you're asking whether they fall under the standards of care, not whether or they are a, quote/unquote, "expert"?
MR. RAY: Okay. This is what we're not doing today. Because that's not an objection. You've made your objection outside the scope. If you want to clarify something on the record when you have a chance to redirect, then fine. Otherwise, you don't have an ability to make speaking objections right now. You made your objection, so I'm going to proceed.
BY MR. RAY:
Q Dr. Reister, do you understand what I meant when I asked if somebody was an expert in the field of the treatment of transgender individuals?

A My understanding was since we were going over the standards of care was their following of the standards of care. And what I was talking about is the other -- in terms of medical decisions is beyond my ability to assess because that is outside my scope of practice. I cannot -- and the other thing is, I can really only talk about their -- the other thing I mentioned is I don't know the résumés. So I can't really determine whether or not they are operating within the scope. And then the other thing I was talking about is that determining that is, again, outside of my, A, scope of practice, as well as outside of my job duties. I haven't assessed for any of that.
So I can't speak in terms of my understanding of what's going on, as well as I haven't met all the people that you're talking about. The vast majority of medical providers I wouldn't know because they're not even in the mental health department, so I wouldn't even have an opportunity to meet with them.
So I have a very limited -- when you're talking about medical doctors, whether

they're the -- whether it's Dr. Puga as a chief -- he's above my rank because he's a chief and I'm a regional. I won't see his résumé, for example. Does that make sense?
So, you know, I'm hearing individuals providing care, and what I'm speaking to is I haven't heard of any egregious medical -- I'm not aware of any medical malpractice or anything like that. But I really don't have the ability to tell you whether or not these individuals are operating with good medical care because, again, it's out of my scope of practice and it's also out of my scope of duties. And that's both for speaking for the State as well as myself. You know, I can't assess somebody who isn't even in my field.
Q Okay. I understand your response on Dr. Puga and Dr. Conway then. Okay. And what I was getting to is then is within the mental health side of things, is there anyone else other than -- as you proclaim yourself to be an expert, are there any other experts within IDOC in the care and treatment of individuals on the mental health side?

A Well, everybody who's working with this population has access to consult with me. I'm sure that Wexford Health Sources, who is our contract company providing those therapists, also has opportunities. But again, their HR -- in other words, their human resources -- is not an area that's under my -- under my jurisdiction, I guess would be the best way. But we do, as State people, provide them trainings and consultations in terms of all of that.
I do know by our contract that they all have licenses and educations that would -- that would allow them to meet the criteria in terms of knowledgeability on co-occurring mental health concerns. Use of the DSM-V is also one of the minimal requirements. They all have to have supervised training and competence in psychotherapy due to their training and IDOC's requirements for hiring.
So gender identity and expression is a ready part of our training. It also, you know, should be part of their education as well, but we do reinforce that. And gender dysphoria is a part of the DSM-V, so it does

include gender dysphoria for those individuals.
So they have the ability to increase their knowledge through us and also seek supervision as well to improve their competency.
Q Okay. Can you name an individual on the mental health side other than yourself who you consider to be an expert in the care of transgender?
A I think Kelly Gaye (phonetic) is very -- is a very good clinician and has very good responses in stability from her clients. She also is very, very knowledgeable in all the training materials, understands its use. So I think that she's very good in terms of transgender care. And she seeks supervision on a regular basis, attends all the case conferences and what have you. So she is a really good clinician with this population and has received a lot of positive feedback.
Q Okay.
A The offenders will generally let me know. Because I try to go in and interview lots of offenders who are transgender and -- you know, to also get an idea about what training, you know,

I might want to beef up, that sort of thing.
So, you know, that's part of why I meet with offenders. Not for psychotherapy, but from an administrative training perspective, I do meet with offenders on a regular basis. In the last month alone I met with everyone but one transgender offender, a trans man every -- you know, of the trans men over at Logan Correctional Center. I just met with the Pinckneyville, half of the transgender offenders. The other half I am meeting with this week. So I've gone up to Dixon, Danville.
So that's part of the process of me making sure that we're on the right track with the treatment. And if there are concerns, then trying to address those concerns specifically with staff.
Q Okay. How many clinicians do you have under your supervision?
A There are 30 sites, and there are multiple clinicians at certain sites. So for example, there are two clinicians, Jamie --
THE REPORTER: I'm sorry. You cut out. I'm sorry. You had cut out there a little

bit.
THE WITNESS: So there are two --
THE REPORTER: I'm sorry. I didn't get the name of the clinician.
THE WITNESS: Jamie Chasin, who is the state mental health director of that programing, and Jamie Wiggin, those -- both of those individuals, I've gone into their groups. I've, you know, helped show, you know, the group dynamics and, you know, addressing various issues. And they also attend the case conferences -- the transgender case conferences on a regular basis.
So that would be an example of, you know, a site that has more than one person. I've had to train --
BY MR. RAY:
Q I'm sorry. I'm sorry. Let me -- I just want to know how many. Give me an approximate number.
A I would guess probably between 30 and 40. It's hard to keep track because we have a lot of staff turnover. So, you know, that number of people has changed over time, and there are newer employees as well who are just at the beginning

process of training.
Q Okay. So best guess right now is currently clinicians -- mental health clinicians under your supervision, approximately 35 to 40; is that right?
A Yes, something along those lines are under my supervision. And, you know, very soon starting, Erica Anderson will be also helping out with those supervision contacts, and already has in terms of, you know, indirectly through me.
Q Okay. So are there additional mental health providers within IDOC who are not under your supervision who are under a different regional director's oversight?
A I should be clearer. I cover all three regions for transgender care. For mental healthcare in general, a cis and trans offenders, I only cover the south. For trans care I cover the north and central as well.
Q Okay. So when you're talking about the 35 to 40, is that statewide or is that only within your region?
A That's statewide. And I'm estimating it based on the number of facilities and trying to

kind of keep in mind that some of the larger facilities may have two individuals that are under training and developing their skills. They're going to be at all different levels of where they're at in that training process and that expertise. So there will be variants between the clinicians based on how long they've been under supervision.

You know, we have hired individuals that have gone through Howard Brown's training, for example. I don't always know whether they were those clinicians. I had one in the south for a while. And I don't know up north how many, but I would imagine they were -- they would be more likely, since Howard Brown is in the Chicago area, to be somewhere around the northern region if those students were recruited by Wexford.

But again, their HR, I -- I don't have control of, and nor am I to monitor their credentialing and their résumés because that falls under the jurisdiction of Wexford. And it would be considered dual employment for me to cross into that HR or human resources grounds.

Q Okay.

A So my role is to provide training, ongoing consultation.

Q So based upon your limited knowledge then of qualifications and HR information on these individuals who are -- who ultimately work for you, you don't know one way or the other whether at every site there is a clinician who meets the minimum competency standards under the WPATH Standards of Care?

A I cannot know for certain because I don't have access to their human resources file due to dual employment, you know, preventions and union requirements.

MR. RAY: Okay. We've been going for about an hour. Now is a good time for another short five-minute break. Is that all right?

THE WITNESS: That works for me. Thank you.

THE VIDEOGRAPHER: The time now is 11:05. We are off the video.

(After a brief recess, the deposition continued as follows:)

THE VIDEOGRAPHER: The time now is 11:13. We are back on the video record.

BY MR. RAY:

Q Dr. Reister, is it the defendants' position in this matter that as we sit here today on August 17, 2020, that the Transgender Care Review Committee follows and applies all relevant WPATH Standards of Care in its decisions?

A We do. We have recently consulted with Dr. Anderson to make sure that we are in line, as well as court decisions that have clarified what we need to do as well. And so we are currently implementing as many of the updates as we can so that we can be in compliance with -- with WPATH standards. So that is something that is definitely guiding our approach.

Q Okay. I'm not sure I understand your response then. So is what you're saying is that as we sit here today, you are compliant or that you are trying to become compliant?

A We are compliant.

Q Okay. And does that compliance also extend to the mental health providers who are making decisions on hormone treatment, surgery,

gender-affirming items, and transfer?

A They wouldn't be making decisions on those. What they would be making decisions is on the readiness of individuals for those.

Now, do keep in mind that in terms of surgeries, that wouldn't be done on site level. That would be done externally through myself and Dr. Puga.

Q Okay. Maybe I'll -- let me rephrase my question then because I know that some of the decisions we're talking about here -- going to hormone treatment, surgery, gender-affirming items and transfer -- involves people other than just the core members of the Transgender Care Review Committee. So I'll rephrase my question this way.

For all those involved in making decisions relating to issues on transgender health, are those decisions made in compliance with the WPATH Standards of Care as of today?

A We are supposed to make those decisions, and I will definitely point out if there is something that modification would be advantageous for.

Q When you say you're supposed to be

making decisions, what do you mean?
A Um, decisions are made according to WPATH. We've talked about very clearly that we want to maintain and that we will maintain WPATH standards. That's one of the reasons why Dr. Anderson was employed. That way we can ensure that we are in compliance.
Q When Dr. -- did she do an assessment of IDOC's policies, procedures, and actions to see whether or not they were in compliance with WPATH Standards of Care?
A Yes. And that's one of the reasons why we are adapting our suggestions -- or not suggestions, I'm sorry -- our administrative directives. And Moss Group has also weighed in and also provided some outside perspective. And so that is the purpose -- or one of the purposes in addition to training consultation.
Q But the new administrative directive is not yet final, correct?
A It's not yet final.
Q Okay. So is it -- are you saying that you are WPATH compliant across the board even though the administrative directive is not yet in

place?
A We are currently implementing as much as possible. We don't have a procedure that is in writing that we would do for the surgical interventions. You know, for example, we changed out the director making a final decision. That's still in the current AD, but we're not at that part of the process because we are still gathering information on those who need that intervention.
But -- but the current policy as it's written is not according to WPATH standards in terms of that person's competency. That's why it was changed so that it moves it from the director to medical personnel.
Does that make sense?
Q What you're saying is that the administrative directive that is currently in place today is not WPATH compliant, but that when the new AD issues, you believe that it will be because it'll take surgery decisions away from the director level and into the hands of Dr. Conway?
A Correct.
Q Okay. Other than the surgery provision we just talked about, is the current AD

that's in effect today non-WPATH compliant in any other ways?
A In terms of the social transition component of gender-affirming care, we need to get that commissary merged. And although it's in the process of being merged, it still isn't available. And I still have to, you know, discuss with offenders. I get lots of questions about the merger.
So yes, that is not in compliance when we're trying to work as mental health people with that transition. So that isn't in compliance, but, again, it's in the process of being in compliance.
Q Anything else from the currently active administrative directive that's not in compliance?
A The current administrative directive does not address the transfer not based on genitalia into the opposite from the gender-assigned-at-birth division. By practice, we have already changed that due to court orders, but that's also, you know, another thing that would not be specified in the current AD, but it

is in practice done.
Q Okay. Anything else?
A One of the things that we're working on through the training, and it has been a complaint of offenders, is misgendering pronouns. We have a very clear policy on not misgendering offenders. We are looking at a voluntary appropriate pronoun on IDs to help staff with that process. That, again, is not in the current AD. It has not been finalized.
And in addition, I have incorporated into the all-staff training as well as the mental health provider training the psychological impact and the microaggression form of transphobia of individuals misgendering offenders.
Q Okay. Anything else in the current policy that renders it not compliant with WPATH Standards of Care?
A I cannot recall one way or the other without looking at it whether or not it covers gender nonbinary. It probably does, but I cannot assure you without looking at the document, so it's possible it may not include that.

So again, I'm doing this from memory as well. But again, that's in the training. And that's in the all-staff training as well. So every staff member, regardless of your position, has received that training despite the AD and how it may be currently written.

Q When Dr. Anderson reviewed -- well, first off, anything else in the current AD policy that you believe is not compliant with WPATH Standards of Care?

A I cannot recall anything in addition in that AD.

Q Okay. When -- you said that you have made changes to the draft AD based upon comments from Dr. Anderson and the Moss Group. Did you receive comments back in a document?

A We had meetings with Dr. Anderson that were teleconferences where we discussed policy and where to change policies.

Q Was there any documents or meeting notes or summaries included as part --

A The meeting notes would've come out of Chief Puga's office.

Q So Puga's office created meeting

notes relating to those meetings with Dr. Anderson regarding the compliance or lack thereof of IDOC as it relates to WPATH Standards of Care?

A I don't know one way or the other. But since he currently chairs the committee, it would go to his office staff, not my office staff.

Q Okay.

A And most likelihood if she were available. Somebody else could be assigned, but I don't know for sure. I don't coordinate the recording of minutes. That would go under the chair.

Q Okay. So -- and then same question for the Moss Group. Any feedback that was received from them regarding the compliance or lack thereof of IDOC with WPATH Standards of Care? Do you recall any documents or feedback along those lines in written format from the Moss Group?

A Yeah. The Moss Group submitted to us a suggestion for specialized unit programming that might help us be in compliance with the PREA standards. Both myself as well as the department's position is that the PREA standards, which is the Prison Rape Elimination Act, has a

section that prevents us from creating a specialized LGBT-only unit.

And so they proposed an idea for a specialized unit. It was similar in idea to one I had proposed earlier about a unit that was not specific to transgender people, but would have a very strong transgender support with other populations that were more vulnerable also in it.

I took that Moss Group and I talked with the department about, A, that that population would be too huge to even fit in one facility if that were implemented. And so I really talked about narrowing it down to other -- another bullied population. Because at the end of the day, the transgender community repeatedly has communicated with me that their peers and -- their peers can have a bullying affect on them, and that that increases their minority stress. Again, all those microaggressions, sometimes actual aggressions. We've had reports of gangs preventing access to telephones. You know, those kinds of things we can do a specialized unit that addresses bullying.

And so by combining those

populations, it's not specific to LGBT. It's really addressing the bullying and emotional abuse of peers. It also would allow us to have better knowledgeable correctional staff they have the majority of the time with the offenders because they are actually on the unit. And then we also discussed -- one thing I added was some unit meetings to deal with issues that arise on the unit and having mental health providers that are well trained and knowledgeable, also having security well trained and knowledgeable.

Q Okay. So just to make sure I understand the -- where does that -- so the Moss Group recommended or suggested that perhaps it made sense to separate out at least high-risk individuals for bullying, which would include transgender prisoners, into either their own prison or at least their own section of a prison; is that correct?

A No. The bullying was my modification of the Moss Group plan. They had things like elderly people and groups with disabilities and what have you. And that population would be far too large to really provide the security, cameras

in a vary enhanced way, and the amount of additional, you know, training and supports and what have you.

Also, I want a location that is close to a major metropolitan community in case there is a complication with the medical side such as a surgery. I want somebody near a hospital. That's why I had recommended Centralia Correctional Center. It meets basically all the criteria that I'm really looking for. They are very supportive of the trans population. They're knowledgeable and have very aware staff on trans issues, not just criminals, people with criminogenic histories, but also just in general. And it's in very close proximity to St. Louis which provides large hospitals. If there is a complication, we can get them there very quickly. So that was my recommendation.

They didn't specifically say the institution, nor did they say those other factors for considering. I added those additional factors and limited down and broke down the population into a smaller group of people who are bullied a lot.

So that was the final submission. I felt that there were missing pieces that the Moss Group overlooked that needed to be in there. I don't know if overlooked is the right word, but they didn't have it included in their plan specifically, and I wanted those factors in because I want it to be successful in -- you know, if we're going to implement it, and I want to address all the issues.

And that would be a voluntary program, not required. Because not all offenders want to go into the facility, either the bullied offenders or the trans offenders. So it would be voluntary.

Q Dr. Reister, I know that there is an administrative directive that we talked about today that is in the works. When will that be finalized and enacted?

A I don't know. It is out of the developers, which is myself, Dr. Puga, Dr. Conway the operations individuals, and my understanding -- and again, it's not within the scope of my job task. But my understanding is that is going to policy and directives. They review all the

policies and make sure there isn't any inconsistencies or conflicts or mistakes in basic grammar, writing, that sort of thing.

So it is far along in the process. However, I don't know how long it will take them, to be honest. It could be a matter of weeks or a matter of months. I can't foresee the future, but it's -- it's very short.

Q Okay. We can --

A We update mental health policies and they come out a few months later.

Q Okay. And would you agree with me that until the new administrative directive is -- scratch that.

You would agree with me that the current administrative directive that is in place today renders IDOC not in compliance with WPATH Standards of Care?

A As written, it does. But in practice, we have already implemented changes that are beyond that such as -- you know, we've already enacted the survey, for example. We've already enacted that hormone decisions are made on the site level. So we have been eliminating things

that are noncompliant.

We've already implemented reaching out to WPATH to created additional trainings to enhance the mental health providers' expertise. We're already implementing Dr. Anderson's trainings in terms of consultations, case conferences. So we are implementing many of the pieces in advance of that AD coming out.

Q Okay. So you're working on it?

A We're working on it, yes. We're working very steadily, and we're very serious about working on it. I have a lot of support for the changes.

Q Now, I want to go back to something we talked about before the break as well regarding the mental health providers that work under your supervision. Are those individuals IDOC employees or are they Wexford employees?

A They're Wexford employees. There are a few exceptions, but in general they are IDOC employees. You know, myself, I might sit in on a group and I might provide feedback or interject something into the group process. But in general,

Page 102

they are Wexford employees.
Q Just to make sure the record is clear, that with some rare exception, the -- well, you are an IDOC employee. The mental health providers that you oversee are Wexford employees?
A Yes, that I provide consultation for. I have no -- I have no human resources jurisdiction over them.
Q Okay. And you also don't have access to their personnel files and résumés?
A That's correct.
Q Okay. So when -- if you are under the -- you have no way to know one way or the other then what the qualifications are of a particular mental health provider because you don't have access to that file?
A I know the basics that we talked about earlier in terms of in order for them to qualify. Because they do have contractual obligations in terms of getting us individuals who can do that differential diagnosis, people who are DSM-V competent. So those basic clinical requirements that are listed in the competency, you know, having supervised practicums, those are

Page 103

requirements of the contract. But some of the other transgender specific, I wouldn't have access to that because that would be part of the résumé, not the basic contract that we have.
Q Okay. So you -- so is it your -- is it your testimony then that it is not a basic requirement to be hired by Wexford to be a mental health provider within IDOC to have met all minimum requirements under the WPATH Standard of Care competency requirements?
A No. That's not what I'm saying. What I'm saying is I am not privy to the additional requirements that they might have in terms of their recruitment and hiring of employees. I can't speak to those additional requirements that are outside of our contract. The reason I can speak to the contract is -- items is it's written specifically in our contract. So I can't speak to the additional employment pieces that are beyond the contract.
Q Okay. So maybe let me ask it a different way. You assume that the -- well, let me ask it this way.
Based upon your knowledge of

Page 104

the contract that Wexford has with IDOC to supply mental health providers to IDOC, does someone who has -- meets those basic requirements guarantee that they will be competent under the WPATH Standards of Care?
A I cannot speak directly to that. But I can say that employees, that they do have an initial trial and training period. And if they don't meet those standards, um, of competency, that they do have it so that they can actually terminate employment of individuals that aren't meeting competency standards. It's up to them to determine competency standards for individuals and trainability.
Q So are you saying then that Wexford will not hire anybody who doesn't meet the WPATH Standards of Care and minimum competency requirements?
A I can't say whether that's part of their hiring process. I have no way of knowing if that's one of their required areas that are beyond the State's contract with them.
Q Okay.
A So I have no way of knowing.

Page 105

Q Is IDOC compliant with the WPATH Standards of Care when it comes to assessing gender dysphoria in transgender prisoners?
A Yes. We are all -- I provide screening on the assessment domain so that the clinicians can do proper assessments. I utilize a combination. They first start off with our mental health evaluation form, and that is due 14 days after arrival at a parent institution. Or if it's been done 60 days prior to a transfer, then they would review that -- that mental health evaluation.
That's a starting point. It provides basic demographics, basic background, histories on family. It provides an ability for people to determine addiction recovery issues and mental health problems. And then -- because proper assessments of co-occurring disorders, which would be, you know, intellectual disabilities and substance abuse and mental health addiction issues is part of the basic care that's provided, it's also part of the WPATH Standards of Care as well. And then they will do additional interviewing to gather WPATH transgender specific

things like, you know, what is their gender identity over time, you know, what is their -- the extent and how gender dysphoria has presented itself. I ask them to address in their assessment their minority stress management in general.

Because remember, transgender people aren't just transgender. They are the intersectionality of all of their identities. So they may be impacted by racism, Islamaphobia, or any number of other prejudice and all of those combined. And they may have different ways of managing different elements, different aspects of their identity, or there may be a consistent form.

So I want to know the different ways that they're coping and whether they're healthy or unhealthy. We have individuals, for example, that relieve emotional distress through, you know, cutting behavior. They're enacting the emotional pain with physical. There's a lot of psycho dynamics as to why that is. There's a lot of individuals that also have addiction recovery issues because they're managing those feelings through chemicals. Some individuals may engage in fighting behavior and

other forms of acting out. Some people may be social support seekers. Those are just a few examples of the types of stress management they may use. There are other coping skills. We use that to determine whether we need to help them develop additional healthy coping.

The other element that I wanted --

Q Okay.

A Oh, do you want me to go over everything, or do you want just kind of a skimming over?

Q Well, I mean, I don't mean to interrupt, but I did just want to pipe in on something here just to clarify a point then.

I mean, it is the -- it is the site mental health providers who are responsible for assessing whether or not a -- whether or not an inmate has gender dysphoria, correct?

A That is correct.

Q Okay. And it's the same site mental health providers that are going to be educating, for example, those inmates on what options might be available for them for treatment?

A Yes. But they would be referring out ultimately the medical interventions.

Q Right.

A They might mention medical, but they're going to refer out to medical those.

Q Understood.

Is there a written sort of guide so that these mental health providers know how to do this? Are they provided something?

A There are three sources to gather information. Obviously -- well, not obviously. But the administrative directives do provide some basic guidance on major areas, but it's very brief and vague. So it's expanded upon in the standard operating procedure manuals. But do keep in mind that manual is based on the old ideas and it's going to need to be updated. But these assessment criteria won't change. It will be more some of the other specifics that we talked about that we're changing earlier.

And in addition, part one and part two mental health and corrections training that I've talked about earlier, is on our mental health SharePoint. So if they want to re-review

the materials, they can. And I do periodically update those. You know, I've, you know, basically rearranged the slides so I thought it was more user friendly so that they can have ready access. Some individuals may choose to print off certain pages like on assessment or certain pages on the DSM assessment or, you know, that sort of thing.

So it's available through those three sources. And I also talk with them that they should be printing off the WPATH Standards of Care, or at least using the electronic version because that's free and available off of WPATH.com. And so the clinicians will take a look at that as well. But probably the most user friendly is the slides from my training.

Q And what quality assurance do you have that these 35 to 40 mental health providers are going about this in the right way?

MS. COOK: And I'll object to that. Outside the scope. Dr. Conway will talk about quality assurance.

MR. RAY: I think that as part of WPATH -- I mean, your objection is noted. But as

part of being compliant with WPATH is also making sure that the things are getting done right.
BY MR. RAY:
Q So I'm asking the 35 to 40 mental health professionals under your supervision, what quality assurance do you have that they're doing this and going about assessing gender dysphoria and educating inmates in the proper manner?
A We have a division of mental health -- and do keep in mind, I'm not speaking to medical. We do have a separate division within mental health that provides our QI for the mental health services. A lot of those criteria that showed competency are directly applied. You know, for example, the -- you know, dealing with co-occurring disorders and mental health assessment.
In terms of the oversight, you know, of gender dysphoria, everybody is required to do proper diagnosing, and so we do look at those mental health evaluations. That should have gender dysphoria listed. It should meet -- and individuals are supposed to be identifying why they came up with the diagnoses. So that should

be in there and in that.
So our quality assurance piece is within those departments.
Q So you personally don't --
A And that's conducted -- I'm sorry. And that's conducted by the State.
Q Okay. So you personally are not reviewing their records to make sure that they're doing it correctly. That's a separate department that is -- that is doing quality checking?
A The quality assurance piece that you were asking about in terms of how you phrased it and how I understood it is done by a separate department. However, I do, when I go into facilities, look at charts and take samples as I'm working with those.
For example, when offender Monroe -- when we were making the decision to transfer to the female division, Dr. Puga and I both looked at the chart, and gender dysphoria was clearly identified. So we didn't just go by our interview when we went to interview the offender at Pontiac. We also looked at the chart to, you know, see that this individual meets gender

dysphoria.
In general, I haven't found a lot of problems with gender dysphoria diagnosing with the mental health team. The criteria are pretty straightforward. It's just really a matter of following our assessment, interview guides. And they're pretty straightforward, too.
Q Okay. So just to make sure I have this straight. When an inmate is being assessed for gender dysphoria, is being educated about the things that they have, the options available to them when they're being looked at, for example, for potential referrals for hormone treatment and the like, it is obviously the site level mental health provider who is doing that work, correct?
A Correct.
Q Okay. And the quality assurance of that work is being done by a separate department by the State, although you may from time to time also see those records for certain inmates, correct?
A Correct.
Q Okay. The people who are doing the quality assurance checking at the State, are any

of those people -- do they meet the minimum competency requirements under WPATH Standards of Care?
A I wouldn't know that because that doesn't fall under my job tasks. They -- if they have attended my training, they would have at least those base information. But I can't say specifically their job qualifications in terms of WPATH standards.
Q And are the quality assurance people you are talking about, those are employees of IDOC and not Wexford?
A They're IDOC employees. And all of them are -- are experts in terms of DSM-V which is where you get the gender dysphoria diagnosis. So they all are competent in gender dysphoria diagnosing.
Q Okay. Is IDOC, when it comes to the topic of hormone therapy, currently compliant with all applicable WPATH Standards of Care?
A That's outside of my scope of practice, so I can't tell you. And I don't assess the medical department because it's outside my scope.

Q Okay. You are here to testify about whether the committee follows and applies the WPATH Standards of Care or any other medical standards to its treatment decisions, correct?

A I can't tell you about the medical side of whether that care meets medical compliance. That would be something that Dr. Puga could speak to. I can basically speak to the fact that they are all required to follow that. But in terms of quality assurance for their care, I can't determine their quality assurance for medical. Mental health doesn't oversee that quality assurance piece. But they are all required to -- they're supposed to be following WPATH standards.

MR. RAY: Okay. All right. Maybe, Ms. Cook, you and I can take that up offline if perhaps Mr. Puga is able to address other parts of these topics at his deposition on Monday.

BY MR. RAY:

Q But let me try and stay on hormone therapy for a bit. When a mental health provider does a referral letter and -- as it relates to hormone treatment, is that process done fully in compliance with WPATH Standards of Care as of

today?

A They do it via a multidisciplinary team staffing of the individuals, and that would be documented again in terms of the criteria that's used for it in medical. So they are supposed to work with medical in a multidisciplinary in person or via the telemedicine. So that is actually done in person and documented on IDOC forms rather than a traditional, like, letter like I would do for surgery. That letter I wouldn't do on an IDOC form because it's going to outside individuals.

Q Okay.

A So that will be a form specific to, you know, how you would see it in the community.

Q Okay. So when IDOC mental health providers issue a referral for hormone therapy, it's done in relation to filling out a specific form; is that right?

A Whenever they come into the facility, offenders get a 0400 form, and the mental health providers are filling that out. They are -- they use a multidisciplinary approach with medical. So there are medical components to that and there are

mental health components to it. And in fact, there is actually administrative components as well. Like, shower separately and privately, for example.

So it's a multidisciplinary process. I -- that's documented on an IDOC 0400 form. And that is also through verbal. I know that in my region the -- like, for example, at Menard, I know there's a lot of conversations between mental health and the medical providers in terms of those decisions.

Q Okay. So then does the 0400 form that a mental health provider at least partially completes with the help of others, is that essentially the referral letter for when hormone treatment should be considered by a medical professional?

A Yes. I would consider that similar to a referral letter, although it's much more -- it's basically like a form format. It will ask sections like right out of DSM and that sort of thing. So it's got content. And a lot of our offenders actually come into the system having already been on hormones as well. So, you know,

those individuals, we wouldn't stop their hormone use obviously when they came into the facility.

Q And then for surgery, when a transgender inmate is being attended to by a mental health professional, is there another form for when a -- there is a referral letter relating to surgery?

A You cut out a little bit, but -- if I don't answer the completely. But my understanding of what you're asking was that does mental health provide that letter, and the mental health providers on-site would not be the ones to write that letter. I would consult with them. I would consult with the record. And I would interview the offender as well for that beforehand.

I've also trained staff about the importance of preparing offenders who want the surgery to make sure they are, you know, gathering information, talking with their medical providers. So we also provide that pre-procedure just to talk with offenders about the importance of preparing themselves, having some basic idea to communicate with medical providers, that sort of thing. If they have difficulty, you know, communicating with

Page 118

medical providers, then we can talk about those issues about, you know, maybe it might be helpful to write it down what you want to talk about before, you know, in case you get nervous. So we also provide that as assistance for medical so medical can -- can provide, you know, optimal services.

Q Okay. And this is going back to the process that I think you were talking about earlier today where all surgery referal letters would come from either you or Dr. Puga and then ultimately go to Dr. Conway for approval; is that right?

A Yes.

Q Okay. Is there a particular format that those letters -- well, let me back up. Have you written, or Dr. Puga, has he written, any such referral letters for surgery yet?

A I have not written that letter, which is why Erica Anderson is going to help me write the letter. Of course, it was discussed at WPATH. However, I want somebody to actually review it to make sure that it has everything that the surgical team would need.

Page 119

Q All right. And just following up on hormone treatment then, you are not able to testify today as to whether or not IDOC is compliant with all relevant WPATH Standards of Care on hormone treatment, correct?

A We are supposed to be. However, I don't audit that, so I can't speak for certain other than they need to have basic competency for providing all their medical services.

Q Okay. And so -- and you are not also able to testify today whether any or all of the physicians within IDOC who are prescribing hormones are competent to do so?

A It's outside of my scope of practice.

Q All right. And I'm going to assume then you are also unable to testify today regarding whether or not IDOC is in compliance with all WPATH Standards of Care relating to surgery?

A We haven't actually done a referral for surgery yet. So therefore, there's -- there is not a way to assess that. I know that it's part of the new policy.

Q That is hopefully going to be

Page 120

finalized soon?

A Yes.

Q Okay. Do you know whether or not IDOC is in compliance with all WPATH Standards of Care relating to postoperative care and follow-up after surgery?

A We haven't provided that, and it's out of my scope of practice. Mental health will be providing aftercare and helping individuals with that process in terms of mental health care.

Q Dr. Reister, are you aware that there is a specific section within the WPATH Standards of Care relating to the applicability of these standards to people living in institutionalized environments?

A Yes.

Q Is IDOC, as we sit here today, fully compliant with all provisions of that chapter?

A I reviewed it. It's been a minute since -- or a little bit of time since I reviewed it. At the time it was not completely in compliance. It's -- my understanding is it's actually going to be expanded in revision eight, and so I -- having an expert from USPATH is going

Page 121

to help us so that we are compliant with standards. So that's one of the other advantages of having somebody from USPATH helping us with policies.

Q And when you had done this review and had determined yourself that IDOC was not in compliance, when did this review occur?

A Oh, goodness. It was a couple of years ago. And one of the things that I was concerned about is the ability for individuals to live in their gender and their gender congruent manner just because of the things we talked about earlier that make it a challenge. And we have made movement in terms of those things, but it's been a little time and I can't remember all the points from it. I just, you know, recall that there were some things that might be helpful to modify.

Q Okay. And are those -- strike that.

MR. RAY: It's a little bit after noon. We've been going for about an hour. How about we take a lunch break now?

Dr. Reister, I see you brought some food with you today. But how long would you

like to take for lunch?
THE WITNESS: I only need ten minutes, so you probably will take longer than I will.
MR. RAY: Well, why don't we take a half hour? Is that all right with everybody? And we'll try to do a half hour so we can keep moving today? Lisa, is that all right with you?
MS. COOK: Yes.
MR. RAY: Okay. Diane, is that all right with you, too?
THE REPORTER: That's fine.
MR. RAY: Okay. Let's try and come back around 12:40 or so and resume then.
THE VIDEOGRAPHER: The time now is 12:07. We are off the video record.
(After a lunch recess, the deposition continued as follows:)
THE VIDEOGRAPHER: The time now is 12:41 p.m. Central time. We are back on the video record.
BY MR. RAY:
Q Dr. Reister, welcome back. I hope

you had a good lunch.
I now would like to talk a bit about training for IDOC staff. And so what I'd first like to talk about is prior to 2020, so setting this year aside.
What was the required training for IDOC staff on issues relating to transgender individuals?
A Well, all staff have an initial training that we go through. Mental health calls it PSOT. And it goes over IDOC policies and general function. That training is very, very general in terms of diversity awareness and PREA. And then additionally, every staff member will get what we call cycle training and -- again, sexual harassment, abuse. Professional standards is covered again. But again, that's not intensive trans specific. It would be sort of like a subgroup discussion of the larger topics.
And so what we developed -- there was a court action that required me to develop an all-staff training to deal specifically with transgender concerns. And so that training was a two-hour training. It was implemented in

the previous fiscal year. It was completed. And that training involved topics -- would you like me to go over the topics? I'm not sure if you want me to go over them.
Q Yeah. But just to make sure we have a timeline here. So this is training that you put together and was completed in 2019.
A Yes.
Q Okay. Was it --
A And 2020. Because the fiscal year goes from July 1st through the end of June the following year. So it was in 2019 through 2020.
Q Okay. Do you recall what month you began working on that -- on that training?
A November of 2018.
Q Okay. So this is training that you started working on November 2018 that wound up getting deployed within the last fiscal year, correct?
A Yes.
Q Okay. And does this training bear any correlation to the part one or the part two that you had talked about earlier?
A That's correct. A lot of the

sections of it actually came from the part one and part two. I only had a few months to write it, according to the courts. So I wanted to -- I had that as a starting point. And then I put it again through the review process. I talked about with those outside consults. And so I basically crunched down the topics that were specific to trauma, emotional distress related to transphobia, as well as other forms of discrimination. We went into legal issues, existing court cases of discrimination. I spent a lot of time on misgendering, how to use proper pronouns, and mental health issues in general.
So the -- basically I pulled out the mental health provider specific topics and gave the basic definitions of the various terms and -- so that they were using those terms correctly. Discussed, in addition what I talked about a minute ago, you know, what kind of terminology would be not appropriate for use with this population.
Q Okay. For the part one and part two trainings that you're talking about, those are trainings that were created for mental health

professionals, correct?
A Yes.
Q All right. And then --
A And then I took excerpts out of that for the all-staff training.
Q For the all-staff training. Okay.
And when were part one and part two trainings created?
A Those were in development over multiple years, and I kept adding to them. I know I started working when I was in this position before I worked as a contract person for the department. I would say that they were started in 2013, but a majority of it was really basic information, and it wasn't as developed as what it is today.
So there was a revision that got completed in 2018 right after I came back from the WPATH conference, and I added some information about voice work, what kinds of topics might somebody use. I went and -- in terms of if you were a voice therapist with trans women in particular. And I added a little bit more in terms of helping people understand risks and

benefits and basically realistic expectations about the time frames that it would take. I pulled those -- that information right out of the WPATH Standards of Care, but I wanted to make sure that the MHPs were aware of the medical interventions.
Q Since --
A So that was the latest topics that I added.
Q Okay. So since 2018, the part one and part two trainings for the MHPs has remained the same?
A In content. I changed the -- what do you call it -- the background, the designs, and I rearranged a couple of the slides so -- because I felt like, you know, if I moved them to another section, it would read better. But yeah, the content has stayed the same.
Q Okay. And so other than the all-staff training that was completed in the last fiscal year and the part one and part two training for the MHPs, is there any other training for IDOC personnel at any level on transgender issues?
A We brought in Caitlin Williams that I

spoke about earlier from Howard Brown, and she came to one of our quarterly mental health meetings and she did a presentation as well. It was also one of the topics covered when we had one of our psychiatrists was dealing with diversity issues, and she incorporated it into her larger discussion. So there have been additional.
I also did another quarterly mental health meeting where I had talked about transgender issues and transgender training and helping people understand the additional needs of this population several years ago. So they've had a few other trainings primarily through quarterly mental health meetings.
Q All right. Do you know if there is any specific training for medical professionals relating to transgender health issues?
A I don't know. I heard rumors that there were. But I'll be honest, I don't know. I don't track that as much.
Oh, can I go back and say, we also had a -- Federal Bureau of Prisons did a training a few years ago. Probably like five or six years ago they did a training as well that was

attended by many of us.
Q Okay. So just to make sure the record is clear, though, you know, as the designee for the State on this issue, you're not aware of any specific training for medical professionals regarding the treatment of gender dysphoria or regarding transgender individuals?
A I'm told that Wexford Healthcare has something, but I'm not aware -- it's not something that I have tracked. But Wexford Health Sources, it's my understanding, has been -- has either completed it or they're working on it. I don't know where in the process it is. But that's a side issue that probably would be better directed to Dr. Puga because he would have that information about where they're at in that process, or Dr. Conway.
Q Okay.
MR. RAY: And, Lisa, I think we'll follow up on that after the deposition today. It seems like maybe there's a couple of things that Dr. Puga can address on Monday.
BY MR. RAY:
Q Okay. Are you aware of any training

relating to the treatment of gender dysphoria or regarding transgender individuals that is provided specifically to correction officers?

A I only -- the training -- the two-hour training was for correctional staff. It was every single staff member no matter what your position was. So that is the training that they received.

Q Okay. So that training was not specific for correction officers. That training was for everybody?

A Including correctional officers. I, in particular, want -- a lot of the issues were related to security issues and concerns, so that training, when I was developing it, was having that in mind. Because the issues that were brought up in the other court case was regarding security staff, behaviors of misgendering in particular. And so it was actually designed -- and that's one of the reasons why I had Len Meyers take a look at it as well because I wanted to make sure it met the needs of correctional officers staff.

And do keep in mind, I am

planning this to be a multiyear process because social psychology research says that you make small, incremental changes. So I'm going to be continuing to develop trainings and information for people and the correctional officers as well. But I can only work on so many projects at once. So that's going to be, you know, once I finish some of the ones that we are talking about right now.

Q So just to make sure the record is clear, although correction officers were among the population of IDOC employees that received the all-staff training, that training was not specifically directed towards correction officers, correct?

A It was directed specifically towards correction officers, but a lot of the material was also appropriate for other non-security professionals and they received it as well. But it was designed specifically for correctional officers in particular to the other staff.

Q Okay. Did you receive any feedback from the Moss Group relating to your all-staff training materials?

A I don't recall any feedback having received. I am always appreciative of any feedback, particularly since I'm going to be revising.

Q Okay. So you don't recall even in the last couple of months receiving any feedback from Wendy Leach or anybody at the Moss Group regarding your training materials?

A I have information and feedback from Erica Anderson. Most of the feedback that I received was regarding perhaps using examples and different things that might be -- how should I put it -- not at a master's level, there were some things that they were suggesting to maybe include some other things that might capture the attention of non-mental health staff. Because it was pulled out of the mental health staff due to the time constraints. But it had all the information, and then I did get that feedback from other correctional people.

So all the feedback -- I'm going to look, and I will -- when I go to actually revise those materials, I'm actually going to solicit from, you know, all of our sources. The

Moss Group wasn't working with us at the time that those slides were due.

Q When do you anticipate having a revised version of that training available?

A I'm going to work on that in probably 2020. I'm also working on some other projects as well.

Q Okay. And does that all-staff training session that's two hours, are they just -- do they receive that once?

A It's received once. And then that's why I'm working on some follow-up trainings because it will take more than one exposure to the information. Clearly, the training lieutenants have been exposed, and there are opportunities to talk about diversity and intersection of identity. So it will be covered, but I want some more specific training as well as -- particularly in racism as well. Because I want to address that intersectionality.

We have a very large black trans population, particularly in the female division, and so I want to make sure we're dealing with the intersectionality. Particularly when you

take a look at the research and some of the stats. The murder rate for that population is very, very high. And so, you know, I want to talk a little bit more about that kind of information. So things like that that may capture people's attention.

I'm also going to probably beef up a little bit regarding and do something to make it stand out in people's mind that even biology is not dichotomous. And, you know, I did cover that, but also I want to do something, and I'm still in the creation to really make that stand out. Because I do think it's easier to understand gender not fitting into cultural -- typical cultural ideas. If you can take a look at -- even biology doesn't -- isn't that simple.

And I know that that caught a lot of people's attention, and so I want to take the things that I keep getting feedback from people that catch their attention and help explain working with this population and take some of that feedback and maybe -- and maybe, you know -- you know, increase it a notch or two so that, you know, it really captures people's attention.

Q So when there is a -- when the all-staff does the training session, is there a -- do they all sit in a room and do it together? Do they do it on their computer? How is it delivered?

A I actually recorded the dialogue -- the script basically. So I did the -- it's on a PowerPoint platform. I did -- basically I wrote a script and I recorded it. I got a professional mic and I recorded it for everybody. And again, there were time constraints. There were only so many, you know, takes I could do. So I will probably also work on the delivery and getting maybe more of a professional sound studio, that sort of thing, to make it a little bit easier to be more animated, for example, in the delivery. I think that would help so it doesn't come across as so dry.

Due to the nature of the recording studio I created to do it, it's -- I think it will be more engaging, you know, to record it again and really up it a notch to capture people's attention.

Q Did you receive any feedback from

anybody who received -- who had the training that it wasn't -- it needed to be more engaging or it wasn't -- they didn't understand it?

A They didn't like the inflections in my voice. I was too monotone. And it had to do with how I recorded it and the fact that I, you know, could only do so many takes to get it done on time. Because it was two hours worth of recording. And so that's something I'm going to work on.

I do a lot of public speaking, and one of the comments people said I'm so animated normally, and it wasn't kind of my normal animated style of presenting. And so they were suggesting to, you know, basically get the right conditions and take the time necessary to get that inflection more animated to, you know, capture people's attention. So that was the feedback that I received in terms of engagement.

Q Okay. I'm going to share a document with you that I wanted to follow up on a point regarding the Moss Group, so bear with me as I attempt to share my screen once again.

(Reister Exhibit No. 6 was marked for identification.)

BY MR. RAY:

Q Can you see a document that's marked at the top Reister Exhibit 6?

A If you could enlarge it, it -- because it's too small for me to read.

There you go. Yes, I can read that.

Q Okay. This is a document -- I know that the logo is really difficult to see in the upper right-hand corner, but it says the Moss Group up here. Do you see that?

A I do.

Q Okay. And this is entitled "Review of IDOC staff training on transgender offenders," and gives the title of the presentation dated May 18, 2020. My question is have you seen this document before?

A If I have, I have not had a chance to incorporate it. Because in May of this time of year I was on medical leave around that time period. So I can double-check the huge amount of e-mails that I received during that time period

because I was off for a few weeks. So it's possible I missed it or I went through so many that I can't remember it.

Because I've been planning to revise the materials, so I may have just tabled it and stuck it in my training ideas folder.

Q As you sit here today, you don't know whether you reviewed this document or not?

A I can't remember whether I reviewed it. I definitely at that date wouldn't have been able to review it in the time that I would have received it. It's probably to be reviewed. I'm basically -- I've got so many different projects I'm doing. I can only do so many at once.

And that time period was designing, you know, things like the specialized unit and what have you. So I basically put things in folders, and when I'm ready to work on those projects, I'll go through. So I would have basically skimmed over it if I read it and then stuck it in a folder for when I revised training.

Q Okay. I mean, do you have any help to put together these training materials within IDOC? I mean, obviously Dr. Anderson is available

for you now at least in a part-time consultancy role. But otherwise, does it really just fall on your shoulders to put these things together?

A No. The -- for example, the information on microaggressions is coming from our training academy. They do deal with racism and, you know, other issues of diversity. And they would go and we would share, you know, appropriate documents. Implicit bias was one of the trainings I utilized. Also, Dr. Christian Gillespie and I developed a different training called the Intersectionality of Identity, and that heavily influenced -- and she gave me permission to utilize our training that we made for a conference to utilize it in these materials.

So, you know, I had those other individuals that are also consultants on diversity issues, and in particular implicit bias, minority stress, and those particular topics. So those were not specifically just mine, or some of them were actually not mine. They were borrowed from the training department's implicit bias training.

Q When the staff received the training

earlier this year and maybe even late in 2019, the two-hour training, how did they receive that? Is it -- I think I asked this already, but maybe we got off on a different topic. Do they all sit in the room and watch the video together with your voice-over, or is it on them to find it, you know, click on a link in their e-mail and watch the video themselves?

A I believe that the training department, which implemented it -- I provided the slides and they implemented, were going to have this presented in a class. However, it was designed to do either -- either method. So either one would work given the didactic nature of it. I designed it specifically depending on the needs.

Particularly with COVID, you know, at the -- you know, recently since March, we wouldn't have been able to do those trainings. So it would have had to have been done -- if somebody hadn't completed it, it would have had to have been done via the online version just because we can't get those people into the rooms to do that training. Only recently have we opened up, and they're very small groups so -- but I don't track

specifically. I was told it was finished by the end of the year.

Q Okay. As part of that two-hour training for all staff, as well is there like a quiz or something either spaced throughout the presentation or at the end to confirm that some of the content was understood and received?

A There was not a quiz to pass. There was basically a myth section at the end. If you had been paying attention, you would be able to answer the question. But there was no recording of, like, for example, a quiz. You know, if people think I should incorporate that, I definitely could incorporate it into the revisions.

Q You said a myth section; is that right?

A Yeah, different topics that people, you know -- basically turning the discussion points into misconceptions that people may have. They were basically different topics if you've been paying attention that you would be able to identify if that was true or not true.

And I can't remember the

specifics, but it would be basically something where whether it was a definition, whether it was, you know, a particular topic. But basically I would turn it into, you know, a question that would be more or less designed if somebody thought X, Y, Z, is that true or is that false, and then the answer would float into the slide of what that answer was. So it would give you a second to think what your answer would be and then to -- then to generate your answer.

Q Okay. But it's not like they had to answer that question correctly to demonstrate that they had actually taken the training?

A No. No. But I know how to do that, and I can incorporate that if somebody would like me to incorporate that in.

Q Well, see, maybe today was productive after all then, you know, so -- you know, have open minds about depositions, right? And I know you sat through a few of them already so...

A Uh-huh.

Q Okay. So did Dr. Anderson review any of these training materials and provide feedback?

A Yes.

Q Okay.

A Yes. She reviewed the training materials. She liked the training materials. She found a couple of redundant slides in them. When I'm presenting, if I find a slide that's redundant, I either skip it or I bring up a new topic. I do sometimes repeat topics or little mini questions to make sure people are, you know, paying attention, that sort of thing. I kind of just take a look at the audience and how they're doing, or -- you know, as kind of a warm-up when you come back from a break -- a little bathroom break or something, then, you know, quiz them to see what's going on in terms of their learning process.

But again, not written. It's really more of a group format.

Q Okay.

A Like for example, I might ask the group what's wrong with this treatment plan, you know. And like last week when I did the training, basically they were written in psychobabble, and I wanted people to basically come up with how would you say that treatment plan item in everyday terms

that would be more understandable by the average offender.

So those are the types of quizzes I would be doing to kind of see if they're getting the concepts.

Q Other than some redundancy in the presentations, did Dr. Anderson have any other constructive criticism for you?

A She didn't have content changes to be made.

Q Anything else?

A She said it was comprehensive. It was basic. It was their more advanced training. And it was designed to be a basic understanding. I mean, one of the things that I go over is the importance of further education and consultation and, you know -- so that's part of the training. And so that is -- part is to acknowledge that this is preliminary. This isn't all you do.

And so that was really the springboard for her to work with WPATH experts in the field, to provide the advanced training that would follow up. So the plan is people have part one and part two. That provides a basic

foundation. And then the advanced training will happen in Zoom trainings that various experts are working on for us.

In addition, I also am working -- I think I mentioned this earlier, but in case I didn't -- but I'm also working with somebody on transgender issues and autism. There's an increased rate of transgender identity with this population. I also want to make sure that people can in general work well with this population. So -- and Dr. Anderson gave me that referral and this individual, and I have been corresponding planning that for 20 -- for 2021.

Q Okay. So basically the WPATH training that Dr. Anderson is working on with WPATH grew out of a -- her comments that the part one and part two training that you had for mental health professionals was basic, but perhaps something more advanced would be good for them?

A Yes.

Q And forgive me if I asked this before. Is there an ETA on when the WPATH training will be ready for mental health professionals?

A I know that they were wanting to get it launched this fall.
Q Have you seen any drafts of this presentation or training?
A I have not seen drafts. I don't know if Erica has drafts. But I imagine this is coming out of the global education initiative that these experts do, so I'm assuming it's going to be similar presentations and slides to what I saw last fall, maybe updated for any new research that came out.
Again, these are assumptions on my part. But given the fact that people kind of create their conference materials in certain ways and -- and, you know, when I'm doing conferences, I will, you know, utilize slides and things that might be relevant. Like when I'm doing my intersection of identity, I don't always redo every slide if I repeat that training.
Q Okay. Did Wexford have any input into any of your training materials?
A No.
Q Did you seek their input at all?
A They did not provide somebody with

the expertise. Wexford staff obviously have gone to the trainings. I've had administrative level Wexford in terms of mental health go to the training and give feedback. The feedback has been positive.
Q So when you say they didn't provide input because they didn't have somebody with expertise, what do you mean?
A They didn't offer anyone -- anyone from their training department. They have an entire training department, and I didn't have any resources from them, which is why I went and I got outside people to take a look at it.
Q Okay.
A The other thing, too, is a lot of those trainings are -- that they have are -- they're intellectual property, so I -- it would require a -- how should I put it? We would have to write a separate contract, I imagine, to be able to merge those trainings and for me to implement Wexford material. Due to dual employment and union issues, that could be a challenge. It would be much easier to do like we did and have, you know, Erica Anderson or an

outside group provide the feedback and training and what have you, or feedback on the training.
Q So does -- do the mental health professionals who are Wexford employees that work under you, do they get separate training on this issue from Wexford?
A I'm not aware of the mental health providers getting separate training. However, Wexford does provide some -- I've been told that Wexford provides some continuing education credits through some -- through some trainings. And I don't know whether those training materials include this topic or not. I imagine there are some online topics in particular that would be available right now. But, you know, most -- all the in-person conferences are basically are closed down right now.
But again, that -- that goes into their HR, and I don't tread into Wexford HR issues, but they do have additional continuing education credits.
Q Okay. So you are aware that there is some continuing education efforts by Wexford generally, but you don't know the effects of what

they get trained with or what they get told?
A Yes.
Q Okay. So --
A And can I make a further comment? And that's why the State does our trainings. That way we can, you know, further their education in terms of this training. So that was one of the reasons why I started working on these trainings and why we're continuing to invest in getting outside experts to help us out. You know, that way we don't have to impinge on HR issues, and yet we can provide that training to the Wexford employees.
Q Okay. Going back to the WPATH training that Dr. Anderson is putting together, have you seen any outlines of what's going to be covered or do you have any --
A Yes. I did see an outline on what was covered. It's been a while since I saw that outline. It all looked really good. It covered a lot of the issues that, you know, was in the conferences. So basically what it looked like to me is they took, you know, the global education initiative topics and then the WPATH global

education initiative topics, and then just tailored it to our adult correctional population.

Q Okay. Were you involved in the selection and retention of Dr. Anderson by IDOC?

A I was told that they were looking at experts, and then -- and they named off some experts, and I was very pleased to see Dr. Anderson on that list and I did express that. So yes, I was involved with that.

At the end of the day -- again, HR issues, I might make comments on, but at the end of the day, you know, the powers that be have to decide on those positions. But I'm very, very pleased with their selection. It was really a dream consult for somebody like me to be able to have somebody like Dr. Anderson.

Q Have you ever requested that IDOC bring on somebody like Dr. Anderson as a consultant before and play a more beneficial role other than having you just having to go it on your own and talk to people?

A Well, I'll be honest. I wish that was my idea, but I -- but it wasn't. I didn't even realize that, you know, there was a way to

bring a consultant in like this. So somebody was aware of that and utilized that approach.

I would say that they were very supportive of me going to WPATH, you know, utilizing that as part of my training and what have you. So they are very supportive of giving additional training. But to get the extra staff member is just -- it was a huge positive step.

Q What other names do you recall were on the list?

A Oh, goodness. I can't remember the other names. You know, when they had that name -- there was somebody that was in child adolescence, and I just didn't think that was appropriate for an adult population. So I can't remember. And I don't know who they eliminated before they came up with those names. So that is something that -- that once -- once I saw Dr. Anderson, that was pretty much it. That seemed like a perfect person.

Q Whose decision ultimately was it on who to hire?

A That's a really good question. We do have somebody in a position. The chief of staff

ultimately would have to approve it. I'll be honest. I'm not really sure. The director may have been involved, but I -- I don't know who all was involved. Obviously the chief of staff would have to sign off. Legal would want to make sure that person met our needs in terms of, you know, supporting a, you know, positive legal support for feedback we've received in court, so...

But the exact people, I don't know.

Q Okay. And you're not aware of the terms of Dr. Anderson's engagement with IDOC in terms of payment or duration of -- of the engagement?

A I don't know how long the current contract goes for. I have been given the impression that this is an indefinite, but I'm sure as with other people who are non-union, you know, they have contracts that periodically are reviewed and renewed, but I don't have any of those terms.

Q Okay. What is the nature of IDOC's engagement with the Moss Group?

A They are providing us suggestions on

various ways to enhance our correctional transgender care. And so, again, like the exhibit that you provided, they are providing us, you know, obviously with training suggestions that we'll incorporate into future training revisions.

The one I was reviewing from them and modifying currently was their recommendation for a specialized -- a specialized unit that both transgender and other populations -- because, again, we talked about the PREA laws prohibit having a specific unit without a court order or a settlement agreement, and we don't have either of those.

So I took a look at their -- their suggestions. And they had a write-up, and then I took those and I modified them to address populations like I talked about -- those who were susceptible to bullying, for example, lower functioning offenders -- and taking a look at how would we implement that, what would it look like at a facility, what kinds of facilities would work really well. And so I had to take a look at some facilities and take a look at their structure, like their physical design, to see if it made

sense for the size population that might be interested in volunteering for such a unit.

So that was the current Moss Group write-ups that I've been working with.

Again, I take a project at a time, and then I save up the other information. And when I start that one, I move on to the next one.

Q When was the Moss Group engaged?

A Well, I started getting those write-ups in spring of this year. I don't know when they actually engaged them. And I'll be honest. I don't even know if they are volunteering this information or whether they are contracted. I'm not sure exactly our relationship with them. But they have provided some, you know, good information, so -- and again, any time we can get a consult, it's helpful.

Q So I'm asking you right now some of this information in relation to topic No. 8, which is, "Whether the Transgender Committee or IDOC has engaged outside medical or mental health professionals with expertise in the treatment of gender dysphoria. And if so, the name of any such

outside professional, the reasons for engagement, and the terms of the engagement."

So did you do anything to prepare to testify on that topic today?

A Yes. And I have relayed, you know, Erica Anderson, Moss Group, Caitlin Williams, Len Meyers, [sic] and all of these individuals that we've been talking about throughout the day are individuals that we were consulting with.

Now, the financial arrangement is something that I'm not -- it is not within my ranking within the department.

Q Right. But I mean, when you identified those people and certainly were interested in the terms of the engagement, did you try and educate yourself as to what the terms of the engagement of each one of these individuals was?

A My understanding is that Dr. Anderson is an ongoing arrangement, and, you know, our non-union staff have contracts that last a period of time and then are renewed.

Q Does Mr. --

A It's the same as with our Wexford

contract. It's done for a period of time. It's agreed upon mutually and then it gets re-reviewed.

For example, they've been employed by the department through many, many contracts over the 12 years I've worked for the department. So just because the contract is designed to be reviewed at a certain point, you know, clearly -- with Wexford, for example -- it is ongoing, you know, into the future.

Q Does Caitlin Williams have a contract with IDOC?

A No. She was kind enough to just volunteer her time.

Len Meyers, part of her -- part of her funding or contract is to educate community professionals. For example, I actually -- I'm sorry. I met them at a training for, like, sheriffs and police departments and corrections. And so working with IDOC is part of the Planned Parenthood funding and that part of their job, you know, whereas Caitlin was volunteering some of her time to go over the materials and talk about those with me and coming in -- I don't know whether or not she got paid to come in and do the quarterly

mental health meeting. I assume that she got paid for that because it was during the week and during the workweek.

So those are the only arrangements that I am, you know, aware of.

Q Does Dr. Anderson have any ability to make any decisions, or is she just providing recommendations?

A She has the ability to be on the committees if we need some assistance with decision-making. And she also can be utilized to help, you know, people with the main issues that would be involved in making such issues. So -- and she has made comments in the past about reasons why -- you know, for example, the IDs. I was explaining the importance of helping the staff to be aware of pronouns for those offenders that want to voluntarily come out, and that that would, you know, probably most sufficiently be done on a modified ID. And then she also supported that and educated people about why I might recommend that as an option.

So that's the sort of thing that she would weigh in on, and it affects policy.

Q But ultimately, the decisions are for somebody else to actually decide whether to take action, right? She's making recommendations, but it's still not the personnel that are having to make the decisions, right?

A At the end of the day, what the director says goes. So everything is ultimately his decision, responsibility. He has been very supportive of our work and -- and, you know, really using, you know, consultation.

I can't speak beyond that, you know, because I don't want to speak for the director as the regional. But all of this is dependent upon the director's approval. And I don't foresee any problems because we are basing it on so much consultation.

Q Did Dr. Anderson have any recommendations or suggestions that were not adopted?

A Not that I'm aware of. If I am -- you know, I'm not always in the operations meetings, but I haven't heard of any operations decision that appear to be out of sync. And even some of the ones that were discussed in front of

me were in sync with the direction she was suggesting.

So the department is really trying to be doing its homework, basically, to try to ensure that we are utilizing the WPATH standards. Now, obviously we don't have WPATH Standards of Care aid, and so it may require some changes, but I don't think so since we are using an expert that is so closely involved in these -- in this process.

Q Would you agree with me that since Dr. Anderson was engaged, that the welfare of transgender prisoners under IDOC's care has improved?

A Oh, yes.

Q Okay. Why did it take Dr. Anderson to be hired for that to occur?

A I believe that what happened was when we went to court, it really highlighted areas that we could improve upon. And then they employed Dr. Anderson to be able to help us effectively remedy care standards and trying to make policies that make sense. So that was really the beginning. And it's not to say that I didn't, you

know, have -- like, for example, the Minahal (phonetic) provider trainings, that was initiated by me, not Dr. Anderson. So over the years I've tried to move the department along helping people understand the importance of misgendering. But bringing Dr. Anderson aboard basically skyrocketed the speed of these changes.

Q Why didn't these changes get adopted before?

A I don't know why the changes weren't adopted before. I for sure think that the courts had an influence on people realizing the importance of these changes.

Q Were you -- did you find yourself in prior years frustrated by the lack of progress by IDOC in relation to the care of transgender individuals?

MS. COOK: I'll object to this question. It's beyond the scope.

BY MR. RAY:

Q You can answer.

A Am I representing the State or myself?

Q No. I can -- I'll take this one out

of scope right now and ask you personally. Did you find yourself at any time in the past frustrated by IDOC's lack of progress or the status of their treatment -- level of treatment of transgender individuals?

MS. COOK: I'll just object again and ask that we just -- why don't you save that question for the next deposition.

MR. RAY: We're doing both depositions today, right?

MS. COOK: Yeah.

MR. RAY: Okay. So I'm telling you, it's outside the scope, fine. He's sitting here right now. It's in this line of questioning, and I want to ask it now.

MS. COOK: Well, I think it's very confusing for the witness.

MR. RAY: It's not confusing at all. He just asked am I asking him on behalf of the State or as a private individual. I'm saying this as an individual. If we go back on topic 8, I'll let you know that we're going to go back into topic 8. I'm asking him right now...

BY MR. RAY:
Q In the past, have you ever found yourself frustrated by the level of care of transgender individuals by IDOC?
MS. COOK: You can answer.
THE WITNESS: Did you say I can answer?
MR. RAY: You may answer.
MS. COOK: Yes, you may answer.
THE WITNESS: Okay. I was frustrated by the commissary items in particular. It was really hard for my clinicians to work on some of the interventions if they were out in the community, it would be much easier. For example, an assignment that somebody who wasn't ready to come out of the closest might do is to wear female undergarments under their clothing so that they psychologically knew that they were in feminine attire, or that trans men were in masculine attire, yet they didn't have to publicly come out with it.
So having those separations, you know, not having makeup in the male division, those sorts of things limited the amount of the

assignments that we could do as mental health for the social transition.
Also, the policy -- I am very pleased to move the medical decisions to, you know, a medical scope of practice. So yeah, on a personal level, getting these changes has been a big relief so that the policy is in line with the kinds of standards of care that I would do and the kinds of assignments I would do with a client in the community if I were to start a private practice.
BY MR. RAY:
Q Other than commissary items not being available as needed for gender-affirming and the policy of having medical decisions being made potentially outside of the medical scope of practice, any other frustrations you had over the years regarding the level of treatment of transgender individuals in IDOC's care?
A Well, I think it's been a great improvement that we're no longer using genitalia as the sole criteria for transfer between the gender divisions. I think that that was an enhancement in our care. You know, and the fact

that we're doing it on an individual-by-individual basis is allowing us to do it in a way that is appropriate to, you know, various needs so we can really look at it in detail in a multidisciplinary manner.
So those are the big issues. You know, getting that training component in definitely reduced frustration. Because I received many complaints about misgendering. And so being able to address that has been a relief. Because it was something that was -- something that mental health were having to deal with. And it's, you know, more efficient to deal with helping people understand the importance of that and the legal requirements to not misgender. So those are the kinds of things that I would find frustrating.
And, you know, change takes time in a large institution. And what I found is you focus, you know, on one thing and then you get that, and then you, you know, evaluate that effect, and that's when you work on the next thing. So we have been improving over the years, and, you know, it's just really, again,

skyrocketed with the support that we have today.
Is that what you're asking?
Q Yeah. I mean, you've got the -- sort of the history here to see sort of in your own mind how things have changed over time. But, you know, I asked because it sounds like -- though I'm not trying to put words in your mouth, but it sounds like that there's been some changes made, you know, after some court decisions, and then Dr. Anderson has come along and helped.
But I -- you know, you have said yourself that you've been involved in this field for a while. And I'm just trying to get a sense of when things weren't as good, what your frustrations were with the care of the individuals within IDOC. That was the reason for me asking.
A Yeah.
Q Following up then as well about the policy of having medical decisions within the medical scope of practice, do you mean that you were frustrated that it was a committee making medical decisions that wasn't necessarily qualified to do so?
A Yes.

Q So let's move on to --
MR. RAY: Actually, we've been going -- time flies when you're having fun -- just about an hour again. Why don't we take a short break and come back in five minutes.
THE VIDEOGRAPHER: The time now is 1:47. We are off the record.
(After a brief recess, the deposition continued as follows:)
THE VIDEOGRAPHER: Time now is 1:53 p.m. We are back on video record.
BY MR. RAY:
Q Dr. Reister, I would now like to spend a little time talking about transfer issues, and specifically topic 10 of our 30(b)(6) notice.
So in your experience, why -- and I know every case is different, but you've been around long enough. You've been in IDOC long enough. Why do transgender prisoners seek to transfer to different facilities consistent with their gender identity?
A What I'm told from those offenders is two major reasons. One is that -- well, one could

split the one into two -- so three reasons. One is due to complaints about transphobia and comments that are made at the division that the individuals are in. Most of the requests are in the -- they are starting they're trans women in the male division wanting to transfer to the female division.
The other issue that some, but not all, have brought up is how expressing your true inner self can be less -- you're less nervous doing that in a facility that matches that gender expression largely. Now, of course, there are trans men in the female division. You know, and people do vary in terms of stereotypical expressions of masculinity, femininity. And of course, people vary. And we look at those on different continuums in terms of masculinity, femininity, and other conceptions. You can be high or low in two of them.
But they feel that it would be easier in terms of being their genuine self in a setting that is supportive of living in your true gender. Whereas, peers may make comments on, you know, gender expression. People who, you know,

don't understand, for example, and aren't educated in trans issues, like a lot of their peers are not, may not even understand, you know, that their expression is about gender, not about sexual orientation. Just really basic information.
The other -- the other thought that individuals have is that, you know -- a lot of individuals are aware of, you know, sexual, you know, propositions and things like that. And they are hoping -- whether this is accurate or not -- but they perceive that that might be easier to manage in the female division.
I know there is also a trans man who wants to transfer to the female division, and he is in particular interested in -- very similar reasons, but also wants some specific programming as well in addiction recovery. So we talked a little bit about -- about what kinds of institutions would have that and that sort of thing.
So those are the major reasons why individuals may request that transfer. I would say that it's a small -- or smaller group of individuals making that particular request.

Q You mean to say that -- that it's only a subset of the transgender prisoner population that actually requests a transfer?
A Correct. And in fact, some of the trans men specifically were concerned about being forced into the male division, and so I had to have a discussion with them that this would require their request before we would make that change.
Q So in the current policy right now upon intake, how are prisoners assigned a facility regarding -- you know, if they identify as transgender at that time?
A Well, for individuals -- like, for example, we had a trans man who had bottom surgery and requested to be in the male division. We accommodated that request. And, um, for individuals that haven't been determined to that degree, what we would do is have those individuals taken a look at by the external committee for a request to transfer between divisions. So that occurred in a couple of cases.
There was also a trans woman who, I believe, was put immediately into the

female division as well. There have been -- (audio disruption). That was before my time, but I did hear about that.

MR. RAY: Let me stop you there. I'm sorry, Dr. Reister. I think you cut out there just for a moment. And I think, Diane, you were --

THE WITNESS: What I was saying is there was also a trans woman, I believe, before I started working in this capacity at IDOC as well. So it's happened for both a trans man and trans woman according to my best knowledge.

BY MR. RAY:

Q Would that --

A I actually knew the trans man from working with him.

Q Okay. And the trans man who came in on intake and was assigned to his desired gender facility, he had already had -- he was post-op? He'd already had surgery, correct?

A Yes, he was post-op.

Q Had the trans woman also had surgery?

A Yes.

Q Okay. Are you aware of any prisoner

coming in on intake who identified as transgender and was assigned to anything other than their -- a facility consistent with their -- sort of lack of a better term -- assigned gender at birth other than these two individuals?

A We have transferred individuals without bottom surgery on two occasions. And we have -- and I can't remember. I think it's like two or three individuals that are pending transfer, but have been approved.

So there have been, but not immediately upon entry, which I believe was the question.

Q Yes.

A So the ones who have, that was subsequent via request, and the TCRC reviewed those individuals for transfer.

Q Now, let's go back to the reasons that you delineated for why, in your experience, transgender prisoners do request transfer. And one of them is a complaint about transphobia. Do you believe that that's a legitimate concern that transgender prisoners have in IDOC?

A Yes.

Q And do you think that transphobia, if it got to a certain degree, could be harmful to their health?

A Yes.

Q How can it be harmful to their health?

A Well, it can be traumatizing depending on the person's coping capacities and the nature of it. You know, it can be associated with sexual violence, physical violence, emotional abuse. And there -- you know, basically any of those can create a trauma reaction, stress reaction, and potentially PTSD symptoms as well.

So that creates a risk, and that's what I talk a lot about in my all-staff training and in my mental health trainings is we need to follow the legal rules about this because it traumatizes individuals.

Q When you say "legal rules about this," you mean -- what do you mean?

A There were previous court cases. The Department of Justice actually a few years ago came out with basically a comprehensive overview of LGBT legal cases. And there were some -- and

again, I'm not a lawyer, so I don't remember them. But I do remember the content about you don't want to out somebody, you don't want to misgender them, you want to -- you know, maintain safe housing and what have you. Basic human rights to prevent harm.

Q And those type of risks can be more prevalent for transgender inmates if they are in a facility that might be congruent to their assigned gender at birth, but not their gender as they are currently incarcerated?

A Correct. Like, there is a research that shows a 13 percent higher rate of a PREA event. Again, you can reference that with the Department of Justice report.

Q Okay. You also mentioned a reason for transfer about inmates wanting to be in an environment where they felt more free to express their true genuine internal self in a facility that matches that gender. Is that, do you think, a viable reason also to transfer?

A Yes. That's one of the criteria that I would consider and that I have considered.

Q Okay. And if inmates are not in an

environment where they feel like they are able to be themselves, especially when it relates to their gender, can that be harmful to their health?

A That can be harmful to their mental health.

Q How so?

A Again, if they are trying to have that tension between who they are -- some individuals may be in the closet -- it creates a lot of internal stress and unhealthy acting-out behaviors as well. You know, for example, individuals who are in the closet in the community engage in, you know, substance use disorders to manage that. Well, in a correctional setting, you know, those people utilizing hootch, for example, which is homemade liquor, are they trying to do that. You know, are -- you know, are they doing other unhealthy behaviors like self-injurious behavior to relieve emotional distress. So it leaves people at risk of depression, is one of the consequences. Increased gender dysphoria can be one of the consequences.

Just the -- just being in the institution that is the same as they were assigned

at birth in terms of the gender of the institution, some individuals talk about that alone being a misgendering. Some of them view it as an institutional form of transphobia and dismissing their sense of gender. And so that can have an impact of any internalized transphobia they have, would be an example.

Q Okay. You had also talked about an increased risk of -- it sounds like sexual propositioning as being something that some prisoners mention when talking about desires to transfer. Is that a viable reason in your mind as well?

A Yes. That's a viable reason that some might want to transfer. And remember, all of these things are individualized and all of these impacts, you know, have a lot of intersection with coping skills and prior experience if you've been abused in the past before, for example.

Q As part of that sexual propositioning or the increased risk of it, is there also an increase risk of sexual assault of transgender prisoners in facilities that don't match their gender?

A 13 percent higher likelihood.

Q Okay. And so then -- so then what is the actual criteria then for when a transgender prisoner says, hey, here are my concerns, here is what I'm going through, I would like to be considered for transfer. What is the process as it exists today to handle that request?

A The mental health provider team will be the case manager, in effect, in terms of getting that request information to either the TCRC currently or to the Transgender Administrative Review Committee once that launches. Mental health provides that referal, and then it would be reviewed by the committee. And what would happen is if it is founded -- and so far they've all been appropriate -- then Dr. Puga and I will interview the offender, take a look at the chart, and talk about issues like the trauma. That came up really strong in one of the cases that we decided to transfer.

So -- you know, so we would look at that. We would also look at coping skills. We would also make sure that they have an informed consent to their request when we talk

about different people will have varying experiences. We can't guarantee that there wouldn't be sexual propositioning or aggression or misgendering; that they need to be aware that those behaviors, you know, are choices that individuals make, and that there are going to be people, you know, in the female division that vary in terms of antisocial attitudes and behaviors. So they just need to be aware that, you know, we can't guarantee that some negativity wouldn't happen.

We would also, you know, talk about the process, helping them understand that, you know, what would be the next step in terms of making those decisions.

So those decisions -- and we haven't had individuals change their minds during these things because we try to be balanced and there are a lot of benefits. And we'll talk about basically risks and benefits and expectations. And then so far we've had people say yes to continue with the process.

And then we would bring this information back to the committee and also speak

to the stability to transfer, whether or not what the level of care would need to be and what have you. So far we've had people who are very stable, didn't need to be transferred to the RTU section of Logan or anything like that. But we have to consider all of those possibilities as well as are they safe for physically transferring.

Then once -- the committee will also bring in people from the security, internal affairs side, and they would discuss concerns and issues. People representing the female division would talk about, you know, things like housing, readiness issues to bring somebody over, that sort of thing.

But, you know, our role in mental health would be basically to talk about the things that we've been talking about today in terms of risks and benefits.

Q So it's -- so it sounds like then, from your experience, that every time that somebody has -- any time that mental health provides a referral and you've interviewed that person, you've substantiated the mental health professional's referral to say this is a viable

request; is that right?

A Yes. We have approved multiple individuals. Some of them have been delayed due to COVID-19. And there was a case that we had a disagreement on. Mental health voted one way. Operations voted a different way than mental health. We voted for transfer. And so that decision, I believe, was -- I'm doing it from memory. I think we tabled that for re-review. And so, you know, I'm very familiar with that case. My opinion hasn't changed.

Q Okay. So --

A And that's my personal, not my IDOC, just to be clear.

Q Well, I mean, let's talk about that case. So I mean, did you feel like the concerns that were provided by the operations side of the committee were valid?

A I cannot remember their arguments. I didn't -- as a mental health provider, I didn't see them as something that would make me change my opinion. But I can't remember their exact arguments, but I didn't see them as something that I agreed with.

Q I mean, in your mind -- again, looking out for the best interests of the inmate to put them in the best position of care -- should IDOC be considering things like whether they've gotten any tickets recently?

A The nature of those tickets may be relevant to a placement, so that might be something to consider. For example, violent sexual assault might be something that operations may have comments upon, something like that. But we -- we don't take any one piece of information as a disqualifier. It's basically you pull the pieces together including the site's ability to manage, you know, safely.

The other thing is whenever a decision is rendered, it's not the final decision. Offenders are permitted to resubmit those same questions to be reviewed again.

Q By the same committee?

A By the same committee. And, like, for example, that person will eventually be reconsidered. I know this person. They're in my region, and I've talked with that individual.

Q In your history at IDOC, has the

committee ever changed its mind upon resubmission for transfer?

A We haven't gotten to that point yet. I would anticipate that we probably will in this case. But I cannot tell you what the votes of other people might be, but I would assume so.

Q Not for this particular case. But in your experience as a whole with this process, are you aware of the committee ever changing its mind for an inmate who has submitted an original transfer request and it was denied and submitted another request? Has the committee ever changed its mind, in your experience?

A These -- these transfers are a new option in IDOC. They actually grew out of another case that made clear that genitalia can't be the sole exclusionary criteria for transfer from the male -- I'm sorry -- from the female to the male division, so it had to be taken a look at in context.

Because it's so new, we haven't had a chance to take another look at this particular case. I'm just looking at the, you know -- I would suspect that that -- that this

probably would be changed at some point.
Q Okay.
A And this individual is going to -- has requested surgery as well, so I'm sure that also will have an impact. My guess is we'll probably transfer before then. But I don't know. I'm not sure which process would occur. With them splitting the committees up, I'm not sure. But anyway, it could be reviewed. I have no doubt that we have change decisions at times. Most likely the decisions will be tabled rather than a final decision, and probably people will come back with additional information. It's probably the most common.
But again, I'm doing some -- looking into the future based on the past, there have been individuals that we have already basically tabled rather than make a final decision because we want to gather more information.
Q Okay. But the individual where mental health thought the transfer should occur but operations did not, do you feel there is a risk of that person's well-being in their current incarceration situation rather than be

transferred?
A I've had discussions about this issue with this particular individual. They have a strong -- she's got a lot more hope than what she had in the past. Particularly surgeries, you know, the idea of that is something that has provided a lot of hope for this individual. Albeit, gender dysphoria is very high, she's also very well engaged with mental health for support. But she will request to go again in addition to she's already submitted for surgery. That request officially went out a few weeks ago, so...
Q Is that a request to be considered for surgery, or is she past --
A Yes. She requested surgery -- bottom surgery, and she has been on hormones and stable for quite a while. And so Dr. Puga and I would have to go out and interview her. I know her very well because she is in my region, and I just -- I know her from going into the groups before and meeting with her -- with her therapist.
And so we would go out there because we have to write the letter of recommendation that we talked about earlier.

Q As we sit here today, August 17, 2020, has the committee ever approved anyone for surgery before?
A No. But I'm pretty confident we are going to fairly soon.
Q Okay. Is it frustrating to you, as somebody who has some history with this subject matter and knowing that surgery can be, for some transgender individuals, medically necessary, that there still has been no approval of surgery here in 2020?
MS. COOK: And again, you're asking his personal opinion?
MR. RAY: Right.
MS. COOK: You may answer.
THE WITNESS: From a personal opinion, it can be frustrating, particularly for individuals who are having a lot of suffering from gender dysphoria. However, as a department, we've made so much progress that I have a lot of hope. And this is -- this is already -- in my opinion, this ship has sailed and we're just in the process of figuring out how to do it, so -- and we figured out a process, so now it's basically about coming

up and getting the final paperwork done trying to figure out the logistics and that sort of thing.
But, you know, the fact that we already have identified a top-notch surgical team that I would send any friend to get, you know, surgery -- gender confirmation surgery, I think really speaks to the movement. And so my frustration has been relieved. I'm not frustrated anymore. Historically I was.
I think that we basically have a plan in place that are going to allow us to address these issues that were unaddressed. I'll be honest. I'm very proud of where -- how far we've come in such a short amount of time in terms of, you know, IDOC. I mean, one of my facilities was built in the 1870s, and just in this short amount of time we've just made so much progress. And I'm full of so much hope that I -- I think that you're finding that a lot of offenders, what they were lacking was hope, and that's really what they needed.
So I think that our process, and I think once the AD comes out, I think you're going to be seeing a whole lot of hope. The fact

that we're asking the questions and developing a list and we haven't excluded any type of bottom surgery that they might be requesting, the fact we're showing care enough and indicating that their medical needs are important, that has a lot of symbolic meaning for the offenders. And they've directly told me that. And they've told me that the hope is much higher.

And I receive feedback that the misgendering is even a little bit better. It's not that we don't have ways to go in terms of that, but it's getting better. They're seeing steps in the right direction. And because a lot of them were in need of medical interventions, this is -- the fact that we are gathering this information is very meaningful and...

So yeah, I -- I am very pleased with where we are at. And the frustration that I'm sure they also felt, you know --- but remember. I have more information. Right? So their frustration in terms of they don't have information. Because we don't promise offenders things that we can't deliver on. And so when this -- when this change gets published, it's

really going to even skyrocket more. I think that there's indications that it's really going to be exciting for a lot of the offenders.

BY MR. RAY:

Q Now that in the future surgery might be allowed or at least not categorically excluded, is there going to be any specific training for mental health providers or medical providers at IDOC on how to recognize and refer transgender prisoners for surgery?

A I have already begun in my trainings, like the one I just did to talk about the importance of understanding and to take a look at the ongoing gender dysphoria as well as the sense of -- particularly like dysphoria in terms of individuals might look in the mirror and that might be very difficult. Some individuals may not even want to, you know, have contact with their genitalia. Of course, when you shower, you know, that can be triggering. So talking with and training individuals on listening to what their client is saying is really important, and making note of that information.

However, I've also talked with

them about that I don't want them gatekeeping those requests. So that's why I got the list on what the offenders and where the offenders are at in that process. Because I don't want gatekeeping happening.

So, you know, we can assess people if they aren't ready. You know -- you know, that's fine. I've talked with offenders, you know, about some of the criteria like 12 months on hormone, for example. I've talked with them about, you know, they have to be medically stable enough, so they have to talk to their doctor, is surgery a bad idea given maybe other health conditions that they have that are unrelated to gender dysphoria, and, you know, making sure that they have those conversations with their medical providers.

Stability factors, I encourage offenders not to wait until their mental health issues are a crisis. Early intervention can prevent a destabilization and prevent them from not meeting the criteria of well stabilized. Obviously, we'd be concerned if somebody was recently on a crisis watch, for example. So that

would be scrutinized and taken a look at. And those can be avoided by early communication with their mental health providers.

And it seemed like -- it seems like individuals are really understanding. The requests are coming in from offenders that have -- a lot of the ones that I've talked to -- and granted, I'm still gathering that list -- have educated themselves on the various procedures. And I just talk with them about, well, what are your thought processes, have you, you know -- why do you consider like a vaginoplasty over an orchiectomy and vice versa, and trying to have discussions with them about making decisions based on what they need. And to be able to communicate that clearly to providers so that they understand where they're coming from in their perspective.

Not every offender comes in with the best communication skills. And so sometimes we have to work with offenders about, well, how do you talk with individuals, how do you manage anxieties. Because there is a power differential between an offender and somebody who's going to go home at the end of the evening.

Page 190

You know, staff by just the very nature that they get to leave, that creates a dynamic. And we talk with them about how to do that and how do be able to communicate clearly.

Q Okay. Why does the possibility of surgery -- you mentioned this hope that you've seen in transgender prisoners. Why does the possibility of surgery suddenly give them hope?

A Well, not every offender is going home at any time soon. We have some individuals that are lifers or have such a long sentence -- you know, that's one of the challenges with the one case I was referring to earlier. She has such a long period that she's, like, trying to live in this body -- I mean, you know, paraphrasing her -- and since I have such a long sentence, you know, I'm going to be, you know, old. And I'm not -- I'm going to be spending my whole youth basically in a body that I'm not comfortable with, that I'm uncomfortable with looking at, touching, and what have you. So the prospect of that continuing on, you know, for, you know, more than a decade is very concerning for individuals, just the length of time of having to tolerate the gender

Page 191

dysphoria. You know, people who are going home relatively soon, they can envision being able to seek out those medical interventions. Like the gentleman I spoke to the other day who basically went home the next day after my interview, you know, this individual was, you know, seeing the opportunities available for medical interventions in the community. And so that instilled plenty of hope versus individuals -- you know, if you were to talk years ago, they would have thought it was impossible. By other institutions around the nation having performed a couple of surgeries, it's still -- they thought it was out of the realm of possibilities.

And so seeing this current interest in understanding and hearing -- being heard, basically -- being heard about what their needs are has been very helpful.

Q Okay. Going back to the transfer procedure, I know there's a number of criteria that the committee looks at in discerning whether or not a prisoner should be transferred. But I just wanted to kind of rattle off a few. And again, as a witness for the State on this topic, I

Page 192

wanted to get your testimony as to whether or not you think these are valid considerations and, again, whether the State thinks it's valid considerations.

Is a prisoner's criminal history relevant to whether or not they should be transferred?

A I will give an example -- the answer is yes. Can I give an example to explain that? Because it sounds strange until you hear the example. And again, we're talking not just one factor.

We have an individual, a trans woman in the department, who had a very, very violent rape, sexual -- well, it was a rape, and then murdered the woman involved. You know, as somebody who used to do sex offender-specific therapy, you know, I may have some questions; you know, has this individual been sexually fantasizing on rapes and murders for the past, you know -- you know, time period. I think it's been like one or two decades, you know. Individuals that I've worked with who spend a lot of time with those kind of sexual fantasies could be at a

Page 193

higher risk. Well, you know, I -- I don't know that. You know, you would need specific sex offender assessments to be done to know for sure.

Now, is that the only criteria? No. But I just want to point out I was working with individuals at the treatment detention facility. All of those individuals had served an entire sentence in IDOC that were still struggling with, you know, sexually deviant fantasies. Not all of them were obviously like this case. But that's an example of how a criminal history interacts with a mental health or behavioral concern. That, you know, needs to at least be considered, you know. Maybe not the whole criteria. But something we want to think about. You know, if somebody has that kind of history, how would you manage that? How triggered would they be around so many women? How isolating would it be to single-cell this person? You know, are there risks? Trying to consider would this person be appropriate maybe for a cellie with a trans man. You know, there are lots of questions, and we have to -- to take it, you know, individualized. But yes, that's just one example

where, you know, we have to consider their criminal history.

Q But you are building that into your list of considerations when you are working with the mental health provider to determine, hey, is this a request that should go to the committee or not. You and -- you and -- if I understand your testimony correctly, you --

A I would still have them present the case. And in fact, we did, and we tabled the decision.

You know, I wanted the case to be presented because I think it's important not just to pull out the criminal history out of the context of the whole person. So we would still present the case, but that would be one of the factors that we would take into consideration.

Now it's very different. What if this individual is not listed in a predatory status, but has that criminal history? Because we do have a classification of predator/vulnerable, and this is specific to sexual assaultive behavior or both. And so we can't just pull out the criminal history. We also have to look at their

classification in terms of predatory/vulnerability or both behavior. So you see how we would still need to present, and operations would present some of that information to the committee.

Q Okay. I'm just trying to get a sense of, you know, what is a valid consideration and what is not.

What about an inmate's age? Is that relevant?

A In terms of age, there's a number of things that would make that a consideration. For example, it's possible for a younger person to have fewer stigma management skills. Or perhaps a younger person might have very fresh -- a history of sexual abuse as a child, you know, and maybe they are still working through that very heavily. And the risk of sexual assault for that person may be very anxiety provoking, or maybe some of the abusive behaviors might be triggering of that event.

So, you know, age is something that I would want other information in combination, but it's something that I'm going to want in my interview to be mindful of and see if

there's some other factors that we needed to look into in terms of risk.

So yes, I would want to take a look at age and any interactions of age and their need for that environment.

Q Let me ask you this way. In your experience dealing with transfer discussions with the committee, has anyone ever brought up something that you said to yourself, hey, I know we're looking at all angles here, but we shouldn't be using this as a consideration or criteria for determining whether or not we're going to transfer this person?

A I don't recall any of those sorts of questions. If I had that concern, I would voice it. I'm a very vocal person. And if I had a concern, I would definitely raise it in real time. You know, I would basically suggest, well, this is the implication, and have you considered with that factor that this could be, you know, whatever the alternative would be -- would be at play.

So the fact that I'm very vocal with alternate -- alternate perspectives. And I'm also one that talks about you can have

more than one factor simultaneously occurring, and let's consider not just this factor, but another factor.

So to answer your question, I can't recall. But if something were -- like that were to occur, I would voice my objection and I would vote accordingly.

Q Have you had anybody in your conversations with people at IDOC and in your career try and suggest to you that people who identified as transgender were sort of making it up, that it wasn't real?

MS. COOK: This is --

THE WITNESS: I've had to address that --

MR. RAY: It's personal.

THE WITNESS: Oh, I'm sorry. What -- do you need to finish?

MR. RAY: No. You can answer.

THE WITNESS: I've had those training discussions. I like to go and get my -- some of my cycle training done at one of my facilities in my area, which is Menard. It's a maximum security facility. And -- and people will ask me because

they know that I may, you know, be the all-staff training. And they, you know, will pose questions like that, you know, off line like while we're waiting, and they'll, you know, sometimes ask question and that sort of thing. And I will usually -- and my go-to is usually the -- the nonbinary nature of physiological sex; how you have to look at the chromosomes and body parts to -- when they're doing gender assignments at birth, and how some people are now choosing not to identify a gender for those children and letting them choose for themselves. And I talk about why that might be and have them think about it, and it makes them take pause. When you see that biology isn't that simple, then they will consider that perhaps something as complex as one's identity isn't that simple either.

So that's how I would address that. And that's how mental health providers -- I'll be honest. I think some of those side conversations -- if you can make a safe environment for staff to actually talk about that, I think that some of those little side conversations that I and my mental health

providers have can sometimes really do a lot for moving that bar of understanding.

BY MR. RAY:

Q Have you had anybody other than a correctional officer have these conversations with you? Anybody who is a warden or assistant warden or somebody at your level or above?

MS. COOK: And I just object for the same reason. Are we truly going to have two depositions today, or is -- are you going to ask all of the questions now?

MR. RAY: I don't understand. I'm telling him he can answer in his personal capacity. And then when we go back into topic 10, I'll let him know. We've done this before without any issues today.

MS. COOK: Well, that's because when we discussed it earlier, I was under the impression, as we had agreed, that we would do the 30(b)(6), stop, and then have a personal deposition that --

MR. RAY: We've been through this already today. I'm telling him he can answer in his personal capacity. He's had no difficulty

doing this earlier today. Stop trying to get in the way of the testimony right now because I'll tell you when we are going back into topic 10. For right now I want to ask him this. There's nothing in the rule that says I can't do this.

MS. COOK: I want to know when one of the depositions ends and when one begins. And it's after this many instances where I have not made any objection or we've just let it proceed, I'm now believing that that's not going to happen --

MR. RAY: No.

MS. COOK: -- as we agreed before.

MR. RAY: You're wrong. And you can make your objections, outside the scope, and I don't contest that. I'm asking in his personal capacity.

MS. COOK: No. I'm going to stop this.

MR. RAY: Let's finish. I'm going to ask my question again. If you would like to object, then fine. Otherwise, we're going to proceed.

BY MR. RAY:

Q So again, the question is to you, Dr. Reister, has any of these conversations that you've had or people coming to you asking, hey, is this real, you know, expressing doubts about whether transgender was a real thing, were any of the people that came to you more than just a correctional officer-level individual, such as a warden, assistant warden, or anybody else, you know, at your level, above your level that has had these conversations with you?

MS. COOK: And again, I will object. I will ask that this be reserved for his personal deposition today, and that you continue on the topics.

BY MR. RAY:

Q Okay. You can answer.

MS. COOK: No. He cannot answer.

MR. RAY: I just want to make sure we're clear on this, Lisa. You're instructing him not to answer?

MS. COOK: I'm going to conclude this deposition, and we can take a break and call the Court or work it out as we can.

MR. RAY: I'm sorry. So just to make sure, you're instructing him not to answer and you're going to seek a protective order? I want to make sure I'm clear on what you're doing.

MS. COOK: I want to conclude this deposition and we can discuss this further. We can get the Court on the phone and see how they want to proceed. But this is -- this is too intermingled. The depositions are too intermingled.

MR. RAY: No. They're not. And I'm going to ask my question one more time and I want you to think about what you're doing.

MS. COOK: No. Because --

MR. RAY: What you're doing is not only against the rules, if you -- as you know, Lisa, if you instruct him not to answer a question and you don't have the basis to do so, it's sanctionable.

So I'm going to ask my question one more time. And if you want to instruct him not to answer, okay, then you're going to have to go seek a protective order. And we will suspend this deposition, and then we will

come back and it will be worse than when we left it for you.

So let me ask my question one more time.

MS. COOK: No, Mr. Ray --

BY MR. RAY:

Q Dr. Reister, okay, you just talked about having conversations with people who expressed doubts or at least had questions for you, hey, is this real, do people really transgender, is this something that actually happens. All I am asking you is do you recall having any of these conversations with somebody who wasn't just at a correctional officer level?

MS. COOK: And, Mr. Ray, again, I object. And you know that while I can't instruct him not to answer unless it's a privilege, we can absolutely conclude the deposition, and that's appropriate under the case law.

So I would prefer to work this out with you. However, if we cannot work it out, I will conclude the deposition right now.

MR. RAY: You are concluding the deposition unilaterally?

MS. COOK: Yes.

MR. RAY: I just want to make sure I'm clear on what you're doing. Because I'm telling him right now he can answer this to his personal capacity. This is one follow-up question I have. And then I'm going to finish up with topic 10. And then we're going to hit the rest of his personal deposition. There's no question whatsoever in what capacity I am asking him this question. And in no way, shape, or form will I make it reflect upon the State or any other defendant in this matter. I'm asking him, Dr. Reister.

MS. COOK: I don't understand why you can't wait until his personal deposition, though.

MR. RAY: I just -- you didn't object to the first -- I mean, you objected to the first question and let me ask it, which you should have. And now you're essentially -- are you instructing him not to answer or not?

MS. COOK: I've told you I don't believe that this will end. I gave you leeway because I'm not trying to be difficult. But eventually I have come to the conclusion that I

don't know how many more times this is going to occur. And since we're already doing the personal deposition as soon as this one is over, I don't understand why you can't wait until then and ask all these questions then. Because I don't know how many more questions you're going to do this to. It's very confusing for the transcript.

We asked repeatedly, and you and I discussed today that we need to have them separated. And there -- there are times I've let a lot go through because I'm not trying to conclude the deposition or end things. I'm trying to resolve it.

MR. RAY: Okay. So your position right now, after I have asked my question now, I think, three times -- are you going to let the witness answer the question?

MS. COOK: When -- during his personal deposition, of course.

MR. RAY: Are you instructing him not to answer the question now?

MS. COOK: I would like you to proceed on the topics, and then we'll proceed with his individual deposition. So I'm instructing him

to defer this question until his individual deposition.
BY MR. RAY:
Q Dr. Reister, you may answer the question.
MS. COOK: I'm -- Mr. Ray, I'm going to stop this deposition, yes. We can try to get the Court on the phone, but we need to conclude it now.
MR. RAY: Okay. This is highly not only objectionable, but, also, I don't think I have ever seen this in my entire career. You have no ability to do this, Lisa, particularly since the record is absolutely crystal clear I'm asking him this question which is a direct follow-up from the last one, okay, in his personal capacity.
MS. COOK: Then wait --
MR. RAY: Now you are unilaterally -- let me finish. You are unilaterally terminating a deposition with no ability or responsibility to do so.
MS. COOK: I have the ability to do.
MR. RAY: I have never seen this in my career.

BY MR. RAY:
Q You can answer the question, Dr. Reister.
MS. COOK: No. If you will proceed on to the topics, he can answer your questions. If you want to proceed with his individual deposition, then we should conclude and begin his individual deposition.
MR. RAY: We're going to take a break.
THE VIDEOGRAPHER: It's 2:53 p.m. We are off the video record.
(After a brief recess, the deposition continued as follows:)
THE VIDEOGRAPHER: The time now is 3:01 p.m. We are back on the record.
MR. RAY: All right. So to -- let me state for the record, I think that any insinuation to end the deposition early over this would be improper on multiple levels. However, I took the break so that I could check my outline to see what I had remaining on topic 10, and it's not very much. So I'm going to go back to that, and then I

will switch into personal deposition land, unless there is something that comes up the street relating to the topic that -- any of the topics that Dr. Reister brings up again.
But otherwise, in an effort to move past this, I will go ahead and finish my questioning on topic 10. So let me do that now, and then we will address the remainder of the questions. But I do not appreciate the insinuation, nor the -- what I frankly think is a -- beyond a speaking object at this point in time. But let's move past it.
BY MR. RAY:
Q I wanted to raise a couple of other considerations for you, Dr. Reister, relating to transfer. Is an inmate's sexual orientation a valid consideration for transfer?
A I don't see the relevance of sexual orientation beyond the risk of potential trauma because the -- the gay, lesbian, bisexual, and particularly gay men and trans people are targeted for, you know, PREA events, assault, that sort of thing. They may come in and it's something that Dr. Puga and I will have to assess to see if

there's any -- due to minority stress issues as well -- that the emotional impact of heterosexism -- we do need to consider if those are part of some of the negativity or violence.
For example, somebody who is an offender may think that the individual identifies as gay or bisexual when they're actually transgender because the offenders may not know the difference, and may be saying very heterosexist comments about same-sex behavior, for example. And, you know, that could be very extensive, and it could be something that is worth us being aware of the traumatic impact, that that could be something that might make us -- well, that would be one of the reasons why it would potentially be a consideration for transfer to a different setting. So it's -- I would call it as breadcrumbs as a clue; in other words, leading to potential concerns that we need to consider.
Q Okay. But as you know, there are LGBT prisoners in every facility, right?
A Different individuals may pull for more bullying and abuse, as well as some individuals may have better coping skills to deal

Page 210

with that and more support. So it really is a case-by-case basis whether or not an individual may need a transfer because they're just not able to adapt to that kind of bullying. And one of the possibilities might be a transfer to Logan.

So again, any piece of information to a psychologist or psychiatrist is an avenue that we explore the meaning. Because they are clues of potential traumas is one of the most common things that I'm going to be concerned about.

So maybe there isn't any problem with that, but it's something that as a psychologist I just -- I have to look into it.

Q What about a particular inmate's physical appearance or stature? Is that a consideration when looking to transfer?

A Some individuals may feel unsafe due to their size. They may feel that -- given the abuse level or their experiences they're having, they may feel particularly vulnerable and be more comfortable in the female division because the average height of women is shorter than the average height of men. So those individuals may

Page 211

feel safer, and that might be one of the other potential reasons somebody may request a transfer.

Q Okay. Do you think somebody's appearance or stature is a reason to deny transfer?

A Not in and of itself. I could see it being a consideration for operations in terms of placement. At Logan if there is somebody who has a history of violence and they are still in therapy and they have a maximum security status and they're still in need of some therapy, I could see them having to think about, well, how do we do this placement so that everybody is safe and this person doesn't set themselves up for a disciplinary if -- if acting out is a problem for them violence-wise.

So I could see operation using that in their planning. Because a TCRC is also a place where we discuss, you know, what kind of things in terms of planning for change do we need to do.

Q Okay. All right. So I think at this point in time -- sorry. Just a couple quick follow-ups.

Page 212

So would you agree with me, though, that if a transfer proceeding is coming before the committee for consideration that -- I know that you and -- have just one vote on that committee, but -- and, you know, others may have a vote -- but if it's at least past your gatekeeping function to say this is a, on its face, valid request, let's see what other people think.

A Can you word that differently? 'Cause I'm not quite sure what your question is getting at.

Q Sure.

A I may have -- I'm missing something.

Q Sure. When you -- let me back up for a moment. The MHPs who work underneath you field transfer requests from the prisoners that they see, correct?

A Yes.

Q And then those MHPs meet with you to say, hey, I have an inmate who is interested in transferring, let's talk about it. Right?

A Yes. And usually it's about how we could prepare this individual since they're going to make the request, what kinds of skills might

Page 213

make the transition more successful. Because I want them -- an offender has the right to request it. So the MHP's job is not to gatekeep. You know, the committee will meet and make the decision. So the job of the MHP is to consult and figure out how can you best prepare somebody or this particular client for success given their history.

Q Okay. But then after that meeting takes place where you talk about the concerns with the inmate and you prepare -- help them prepare their request to go to the committee, at least from a mental health standpoint looking out for the welfare of that inmate, you at least personally are of the mindset at that point in time, this is at least worth the consideration of the committee, correct?

A Yes. And I think the whole committee believes it's worth reviewing the request. I think everybody gets gender dysphoria and those kind of factors at this point. Even wardens get it.

Q Okay. So wardens didn't get it before?

Page 214

A I haven't talked with the majority of the wardens, so I can't speak to everybody. But I don't think that was a standard part of their training beforehand. You know, I've got a lot of positive feedback from the training that was helpful for their learning.

Q Okay. Is it fair to say that for any transfer request that you bring to the committee from a mental health standpoint that checks enough boxes for you, that you think that the inmate would benefit from transfer?

A Let me -- let me -- because I'm still not sure I got it, but let me answer and see if this is what you're saying.

I have the ability to vote what I feel is the correct transfer decision, and I also have the ability to ask for more time to further consider -- I have the ability to further -- to abstain from answering if that's something that is necessary. So I have those abilities.

Is that your question?

Q Not really. My question is --

A Okay. I'm not getting it. Say it

Page 215

again.

Q Okay. So as I understand the process, the transfer request comes to the TCRC Committee, as is currently composed, from you, correct?

A No. It comes through the mental health providers at the site. They submit a DOC 0400 form, and they submit that over to Chief Puga's exec secretary. And then she gets them on the roster for the next -- for the next committee.

So it comes actually not necessarily through me -- because I've educated, you know, the team go ahead and do a DOC 400 and so that we can begin the process. I don't want them to wait for me because -- you know, what if I'm out on vacation or what if I'm out sick or something like that?

I had a medical thing going on late last year and earlier in the year, and I didn't want them to wait for me to get back. So I told them, you know -- and I don't want that kind of extra layer, you know, of delay. So I have them go ahead and submit it, and then we'll take a look at it. But sometimes they just have

Page 216

questions along the way, and they may consult just for their own personal knowledge.

Q Okay. We're going to move on. Time to go back to the question that I had pending before we went on the break.

And recalling back to your conversations with individuals who had doubts about whether people were really transgender, I wanted to know if there were any individuals who you had spoken with about that topic who were either director-level individuals or wardens or assistant wardens or anybody in a managerial role?

A No, no individual. And I interact with a lot of different administrators, and nobody's questioned that.

Q Has anyone questioned whether gender dysphoria is real?

A No, nobody's questioned that. I think for one thing, by the time you get to be an administrator, you've been around for a while, and we've always had out transgender people. So I'm guessing that's probably why I don't hear those because you got more experienced staff in those positions.

Page 217

Q If people had been, though, you know, around for a while and seen transgender individuals throughout their career, why was there a categorical exclusion for surgery?

MS. COOK: I'm going to object --

THE WITNESS: Well --

MS. COOK: I mean, I thought you were following up on his questions about the training and conversations about the training. What topic does your next question have to do with?

MR. RAY: We're on to the personal dep now.

MS. COOK: Well, I'd like to clean up some things from the 30(b)(6) deposition.

MR. RAY: You want to do -- you want to stop and do redirect, and then I begin his personal deposition?

MS. COOK: Yes.

MR. RAY: Okay. Let me finish this line of questioning and you may do so.

BY MR. RAY:

Q Go ahead.

A Can you repeat the question?

Q Sure.

A It was a little bit of a delay. No problem. So if, like, you know, nobody was really questioning gender dysphoria and nobody was, as you say, questioning whether transgender individuals were real, and people had administrative abilities who were setting these policies were, you know, aware of a transgender population, why the categorical exclusion for surgery? I don't know. It's one of the things that, you know, I've been talking with people about over the years, that sometimes hormones are not sufficient for every person in general, you know. And so I'm not certain. I think the education process is a process, and I think there is a continuum of understanding and learning that people do. And I also think that a lot of people look too much towards those external finds about being read correctly. So they might think something along the lines of this person is on hormones, you know, everybody can see they are transgender, they're growing secondary female characteristics, and yet not understand that it's not about just external. You have to think about the person's internal sense of their body. Even

though people may not see their genitalia does not mean that that -- that they don't have a gender dysphoria -- dysphoric reaction to their genitalia. And they may not stop to think about, you know, the impact that has on healthy sexual expression, on, you know, just their general sense of themselves when they see their body. That -- it may be so out of somebody's frame of reference that they don't even think about that. And you know, part of my job as a psychologist is to help people kind of step outside of their own -- their own cultural viewpoint, their own privilege, to not even have to think about that and to help them to ask good questions about how somebody else in a different gender identity might view something that they take for granted like looking at their body, you know, and the reaction that might have.

And so I think some of that is just the process of education and something that, you know, people need to consider. It's more than what an external person sees. It's what the person feels like inside -- what the transgender person feels inside about their body and how that is a -- oftentimes a lot of the clients will talk

about a mistake of nature and things like that. Everybody has their own kind of terminology. But it's that mismatch between their body and how they feel inside. And that's something that you have to actually have a conversation. And when we're an operations person, have a sound, confidential location to ask those kind of questions, and it wouldn't be an appropriate conversation for them to educate themselves on.

And so since a lot of prisons are in rural areas, they may not have as much access as somebody like me who lives, you know, in a metropolitan community, has friends. You know, I can literally ask the questions. My friends and I are very open and -- you know, whereas somebody that -- I don't know. Name a prison. Like Robinson may not -- keep in mind, I don't know all the staff there. There could be a transgender staff there. But they may not have access the way some of us have access to ask those questions, you know, of individuals, or they may not think to check You Tube.

There's a lot of people that give personal accounts of being transgender, but,

of course, you don't know, you know, if this is real or not. Although, I think that when you hear from those individuals, you can tell that they're -- they're really talking from a genuine space and can give you things to think about in terms of the privilege that might make you not consider that kind of internal sense of one's self.

So I think it's really about just how the human mind works.

MR. RAY: One quick follow-up, Lisa, and then I'll let you ask your redirect.

BY MR. RAY:

Q When was the first time that you can remember raising a concern about the categorical exclusion on surgery?

A I'm trying to remember whether it came up with my client at Dixon. Because at one point in my career I was an administrator. I did direct care. Or whether it was after I was on the committee.

I can't remember exactly. It was pretty early on. It was either -- it was either in the late 2000s or early after I was on

the committee.

And I'll be honest. I don't remember when. My questions were really along the lines of a medical director making that decision doesn't make a lot of sense to me, and so I raised that concern pretty early on. But I don't remember when I read that -- that section of the AD specifically and raised that concern, but -- I don't remember exactly when it was.

MR. RAY: Okay. I have no further questions on the 30(b)(6) portion of this. I will note there were some aspects of the topics, namely the terms of the engagement relating to certain of the third parties that have engaged, where we didn't get right answers. We also had some issues relating to certain topics were relating to medical providing that Dr. Reister couldn't answer. So we're going to --

Lisa, I'll have a conversation with you after the deposition about seeing if Dr. Puga can cover some of those topics. Otherwise, we're going to leave the deposition open on those segments of the topics that were inadequately covered today.

But with that, I will pass the witness for the 30(b)(6) topics for today, and we will continue after with the 30(b)(1) portion of the deposition.

E X A M I N A T I O N

BY MS. COOK:

Q Okay. So Dr. Reister, I want to follow up on some of the questions you were asked. And just so it's clear, the TCRC that was in place and the administrative directive that were in place, they have been -- or been in the process of changing since the Court's order in this case, correct?

MR. RAY: Objection. Lacks foundation.

THE WITNESS: Correct. I'm sorry. I didn't --

MS. COOK: I think the court reporter got it down.

THE WITNESS: Okay.

BY MS. COOK:

Q So the transgender committee has still been working in some form until the new administrative directive is in place, correct?

A Correct.

Q And one of the things you were asked about was about the transgender committee overseeing hormone treatment. Does the Transgender Care Review Committee still oversee any hormone treatment?

A No. That's on the site level.

Q And so as far as WPATH standards concerning hormone treatment, that's not applicable to the Transgender Care Committee at this --

A That's correct.

MR. RAY: Object -- I'm sorry. Objection. Leading.

BY MS. COOK:

Q And then as far as any committee reviews of surgery, you anticipate that the THAW Committee that you discussed will be following WPATH standards?

MR. RAY: Objection.

THE WITNESS: Yes.

BY MS. COOK:

Q As far as you know, will the committee oversee aftercare of any prisoners who

do receive gender-affirming surgery?

A The site level would take care of aftercare needs, as well as the surgical team may have specific recommendations. But that -- that medical care would be taken care of at the site level, to the best of my knowledge.

Q And you mentioned that the department is in the process of engaging with University of Illinois Chicago Transgender Health Clinic?

A Yes.

Q Do you know exactly what that clinic is called?

A I don't know the exact name, to be honest.

Q Has the department finalized that relationship?

A No, it has not. Again, this is all in the works. We're moving as quickly as we can.

Q And you also explained that many of the commissary items will be available at facility regardless of the gender of the population, correct?

MR. RAY: Objection. Leading.

THE WITNESS: Correct.

Page 226

BY MS. COOK:
Q And so what kind of commissary items will be -- will the department be offering, say, to transgender females who are at a male facility?
A The common request of the female division, lotions and cosmetic products that have a certain scent that our culture perceives as feminine scents. And things like the makeup, we've talked about the importance of not concealing one's identity with how one uses those cosmetic products. So that also would be something that individuals would have to take some responsibility for how they utilize it, so that implies that those are going to be on there as well.
I believe the female division has different bras that are available, you know, and other female products that might be on there. The male division, the offenders are wanting more masculine clothing, and the masculine-scented cosmetic products is what they're asking for and they would get by the merger.
Q So many of the changes that are taking place are not reflected in the current

Page 227

administrative directive that's in place?
MR. RAY: Objection. Leading.
THE WITNESS: No.
BY MS. COOK:
Q And so I wanted to ask a little bit more about training just so that it's clear.
So WPATH, through its global education initiative, is going to offer training to IDOC staff; is that right?
MR. RAY: Objection. Leading.
THE WITNESS: Yes.
BY MS. COOK:
Q And that training, is that going to be for only mental health or medical and mental health?
MR. RAY: Objection. Leading.
THE WITNESS: Mental health.
BY MS. COOK:
Q If Dr. Bowman and Dr. Anderson testified that it was for medical staff and mental health staff, would you dispute that, or are they different trainings?
MR. RAY: Objection. Assumes facts not in evidence, and also leading again. Lacks

Page 228

foundation. Also outside the scope of my testimony.
BY MS. COOK:
Q You may answer.
A I only track the mental health training, so I -- I wouldn't be in on any meetings with Dr. Anderson about the medical. So anything they have going, I wouldn't be in on those meetings.
Q When the department does trainings like the transgender health training that you have been putting on, are those solely for State employees, or are contractual employees also doing those trainings?
A Both State and contractual employees. Also the chief of chaplain services attended one of them. So we get requests, and I will consider those requests. But yes, both Wexford Health Sources and State mental health are invited, and it's designed specifically for them.
Q And so the only trainings that maybe people who work under you or who work with gender dysphoria patients in IDOC, the only trainings you don't know about are Wexford's proprietary

Page 229

trainings?
MR. RAY: Objection.
THE WITNESS: Correct.
MR. RAY: I don't know how he can know what he doesn't know. Also, objection, leading.
BY MS. COOK:
Q Do you know as far as other WPATH trainings, are staff members trying to take -- have they been trying to take WPATH conference trainings?
A One individual was able to do it. And I'm so sorry. I'm blanking on her name. I'm sorry. Webb. I'm sorry. Debbie Webb took a WPATH training. I know that a number of people signed up for the May Kansas City training. Unfortunately, that was cancelled due to COVID-19, including myself. I was also going to go to that. So like, for example, Dr. Fairless signed up for that training.
So yes, staff are -- are -- you know, as an interest is -- they are going to get additional education.
Q And will the State pay for that, or

do people have to pay on their own?
A If you want it paid for the State, you have to be a State worker, and you have to submit a request and a rationale why. And -- for example, they agreed to pay for mine. Now, I didn't submit for that, but I could have submitted for it. So I know that at least in one case, my own, they were willing to pay for it.
Q And the department also has a training department, correct?
A They do.
Q And so that is who often gives the training that you created?
A Yes. That is -- and they coordinate tracking the all-staff training. They also track my trainings as well. I had to submit my trainings to them, and they keep it on file and what have you. We have an entire training system so that we can keep track of that. As well as my -- as well as my executive secretary, she keeps a list of individuals as well so that we can create and generate from the waiting list who would like training or retraining.
Q And you mentioned that your -- you

know, you consider your training to be a work in progress. Do you intend to incorporate all the notes you've been collecting into the training as you revise it?
A Well, what I -- what I do is as I go and I give a training and I get a new piece of information, I just quickly try to put it in. But the notes -- the feedback I get goes into a pile, and then there are some times I'll keep a little pile in my office of journals and different books. I've had to expand the length of the training as I expand the materials. So I can't guarantee you -- we're up to ten hours now, so it may go even higher over time as different things come out. So it really depends on the feedback and the, you know, research I do or the trainings I go to. Because I do this on an ongoing basis.
Intersectionality of identity is a specialty area I'd like to gather further information on. Not just transgender, but race and all the other forms of identity.
Q You were asked also about housing decisions. You know, you mentioned some of the decisions could be tabled. Do you know, is it up

to those offenders to re-raise the -- their request to be moved to a different facility, or is that something that staff can do?
A Staff can definitely do that. When we've tabled things, we'll usually give a specified time frame. You know, it would be a case-by-case basis. But my survey includes that question, so we're very soon going to have a list of people who have that request. Of course, we'll have to cross reference in case there's somebody who is already approved, but it's been delayed due to COVID-19. But that's pretty easy to do that.
So I'll have a list of everybody outstanding who has not moved divisions who are wanting to be moved.
Q Are any inmates being moved to different facilities right now during COVID-19?
A We have emergency transfers to, like, our inpatient units and our residential treatment units, and then we have a quarentine process. But no, and we're having an upswing in our cases that's pretty significant, particularly in Southern Illinois, but also at places like East Moline and some of the other sites.

So COVID-19 is a concern right now because of the upswing of cases, offenders and staff.
Q And in addition, has Logan Correctional Center asked that transfers be staggered?
A I believe they have asked for it to be staggered so that they can -- they can prepare and also acclimate offenders who are received there. And that allows us to address any individual concerns those individuals have. So they have requested that, but with COVID-19 we're basically backlogged on transfers. Even transfers to the RTUs are being held or only doing the emergency ones at this point in time.
MS. COOK: Those are all the follow-up questions I had.
MR. RAY: I didn't have any follow-ups on the 30(b)(6) portion. I think we can move on to the personal deposition.
THE REPORTER: Can we go off the record for just a minute. I'm having some technical difficulties.
MR. RAY: Why don't we take a two- or

three-minute break.
THE REPORTER: That would be great. Thank you.
THE VIDEOGRAPHER: The time is 3:40. We are off the video.
(After a brief recess, the deposition continued as follows:)
THE VIDEOGRAPHER: The time now is 3:43 p.m. We are back on the video record.
MR. RAY: All right. We're now going to begin the personal deposition portion of today. Dr. Reister, thank you for your time and patience already today, and we will see if we can move quickly through the rest of the content today.
DR. SHANE REISTER,
having been first duly sworn, was examined and testified as follows:
EXAMINATION
BY MR. RAY:
Q So I just wanted to confirm, in terms of your conferences and training, you have attended two WPATH conferences in your life; is

that right?
A Yes.
Q Have you done any other sort of WPATH-sanctioned training sessions or workshops in addition to those two conferences?
A No workshops. I do get the journals and Listserv information where people are talking about cases, but nothing like other workshops.
Q And you do not consider yourself an expert in hormone therapy, correct?
A No, I'm not.
Q Within IDOC, who do you turn to with questions about hormone therapy?
A Dr. Puga would be somebody that I might talk to, or Dr. Conway. I haven't had to do so, but those would be the people I might go to. I do reference -- Dr. Puga had a handy outline of risk/benefits for offenders. And so that's a reference source that we utilize because it goes over some of the basics, which is about the level of knowledge that a mental health provider would need to familiarize themselves with.
Q You're also not an expert in surgery for transgender individuals, correct?

A Correct.
Q And who do you defer to or turn to with questions about surgery?
A I would refer that over to medical, and then they would have to refer it over to an outside surgeon. We don't have any actual surgeons on staff. That would require a contract being written up for that service.
Q What did you do -- and this -- actually this question is relevant actually to both sides of the deposition, but it's just one sort of the nucleus of questions. What did you do to prepare for today's deposition?
A I looked over some of our new directives. I looked at the basic structure and design. I reviewed my training materials on the part one and the part two, so -- I looked over the -- the um -- Lisa Cook sent out a listing of the major topics. So those are the kind of things that I did to prepare for today.
Q What kind of list was this?
A It was the list that was what you were putting up there on the screen when you were talking about the 1 through 10.

Q Yes. Okay. Since it didn't draw a privilege objection, I figured that's probably what it was.
Did you discuss the deposition with Ms. Cook prior to today?
A Yes.
Q When did you do that discussion?
A Oh, goodness. It was within the last, I think, week or so. She may know off the top of her head better than I do. But it was recently.
Q And did this occur via phone or in person?
A Phone.
Q And how long did you meet with Ms. Cook?
A Again, I didn't really time it, to be honest. I don't know. It could have been like 30 minutes or an hour. But I'll be honest, I really don't know. I didn't even see what time the clock was during the call.
Q During that session with Ms. Cook, did you review any documents?
A No. But we, you know, talked about

the questions in there. So, you know, obviously, you know, standards of care would be discussed.

Q Okay. Have you had any conversations with Dr. Puga, for example, about this case?

A Not specifically about this case. I mean, we consult all the time on issues. But I don't recall this offender being discussed any time soon. But this offender has been discussed so much, I mean it's hard to say whether this case has come up in terms of recent discussions. But this is one of the cases that come up on a regular basis.

We periodically review how she's doing over at Logan. So one of those reviews, I can't remember when we last had one. But we do -- we consult on a regular basis about the offender and how she's doing over in Logan currently. I don't believe there's any problems. And I was just over at Logan and they didn't identify any problems.

Q Okay. Earlier during the deposition Ms. Cook had mentioned an order, and I know you've talked about some orders from the courts. I know there's a couple of different lawsuits that have

been filed over the years. But are you familiar with the preliminary injunction that the Court in this case handed down in December of 2019?

A Um, I'm going to be honest. I sometimes mix up the different court cases. You know, there's basically three cases that have been involved with various decisions like that, and I can't remember the details of what came out of which case, to be honest. Some things I'll remember, but some things just kind of go into the back of my mind as you got to do X, Y, Z.

Q Okay. Let me show you the preliminary injunction in this case. Take a look at that to refresh your recollection. I will make this bigger now.

(Reister Exhibit No. 3 was marked for identification.)

BY MR. RAY:

Q Okay. Dr. Reister, does this particular document that I'm scrolling through slowly look familiar to you?

A Yes.

Q Okay. And what -- please describe sort of the first time you had seen this document

and what happened after that?

A It was -- I received copies once it posted. Probably it would have come from the legal department, and then it would have been discussed by the transgender committee.

And is this the one that has the medical providers that has to be done on site? I think it may be, but I could be wrong. Again, I haven't read this in a while.

Yeah. It has the gatekeeping thing, about the committee would kind of delay getting those.

Q So I'm happy to flip through the remainder of this. There's some additional points here down on the second page of the document.

But it sounds like you're familiar with this as an order handed down by the Court in this case, correct?

A Yes.

Q Okay. And this was things that the Court was ordering the defendants or IDOC to do in response to a preliminary injunction motion. Is that your understanding?

A That is my understanding.

Q Okay. And have you been asked to look at what IDOC has done or is doing to comply with this order ever to compare and contrast what is the -- the Court has ordered IDOC to do versus what it is doing?

A The Transgender Care Review Committee is -- has been particularly recently really taken a look at all of the requirements as well as, you know, trying to foresee if there might be anything else that hasn't been ordered. And so we've been trying to anticipate, you know, and talk about in discussions about issues and taking a look at the orders as well.

I don't believe that any of the orders required us to merge the commissary items, but we thought that that would be a good way to go about addressing the gender-affirming clothing and grooming items. So that's an example where we tried to anticipate what might be helpful beyond what was ordered.

Q Okay. And I know you're not a lawyer, but is it your personal view that IDOC is fully in compliance with every part of this order?

A Well, we're not yet, but I do think

that we are going to be within compliance. I do think that the parts about misgendering is not an instant fix. I think that this is going to take time, and it's going to require repetition as well. And I've talked about that earlier when I talked about training and attitudinal research showing that attitude change happens in small increments toward a more positive view. And so I really view that part to be -- to be a process over time that I'm going to be investing in.

So, you know, not everything is an instant fix. There's -- definitely attitudes can be read by people. I mean, people can read facial expressions. It's not just about words that come out of people's mouths. And so I'm hoping over time we'll get more and more culturally competent if we continue to do the training. And the training department's implicit bias training is really important for the work I'm trying to do as well.

So again, it's not just my trainings. My trainings interact with other trainings. And some other things that I want to work on, such as racism, those -- and a lot on

privilege -- you know, those kind of things interact. And the mental health department also has a share point with lots of information. And our quarterly mental health meetings incorporate a lot of different topics, all of which will interact with various staff growing in terms of cultural competence.

Q So Dr. Reister, I appreciate the answer, but you agree with me that on -- in this order it says the Court orders defendants to immediately do these things, correct?

A Yes. And that's why I was saying that it's really an in-progress part in terms of being able to do that. Getting those changes implemented is not something that can always immediately happen.

I give the example of I can't even get quarters where I live because of logistics problems distributing to the stores and the banks. So in the middle of COVID trying to get, like, for example, commissary items logistics planned out I imagine would probably be more challenging than other points in IDOC history.

So again, some of them you

wouldn't be able to do immediately, and some of them would require, I suspect, having different contracts to even do that piece.

So immediately we have -- you know, in terms of where we're going is we've made these decisions, and now we're just in the process of finalizing, is the impression I get. Keeping in mind that I don't know what all the details and intricacies involved in things like logistics or all the details in the operations side. But they're all in the works currently.

Q So the -- I just want to make sure I'm clear, too, in the timeline here. The all-staff training that you put together that addresses misgendering, that was --

A Uh-huh.

Q -- was that training complete as of the date of this order in December of 2019, or was it finished later?

A No. I had to actually write up that material. It took me several months to write up material that would be appropriate for all of the staff. And plus, recording it took time. There was no way I could get it done immediately. But I

did immediately start with the writing of it and the -- because remember, I have to remove psychobabble that -- tech terms that, you know, might confuse people. I have to figure out how am I going to communicate some of these concepts that perhaps may be closer to my master's level clinician's, you know, training level that somebody with a high school diploma may not have that kind of background, like in biology and things like that.

So I had different considerations, and it took time for me to do that. Plus, having somebody take a look at the materials also takes time as well. So I -- I have to, um -- I couldn't immediately do it, but I could immediately start the process of it.

Now, not being a lawyer, I don't know whether or not being in process counts as immediate, but I do know that immediately, you know, I started working on it as soon as I was asked to work on -- on it.

And, you know -- so that's as fast as I can do it. I can't -- you know, I can't just pull out of a hat material that's appropriate

for all staff.
Q But it was ultimately you who was working on all this material, right? You were tasked with it?
A Yes. Yes. And I had a considerable amount of my time that I set aside to do this because it was so labor intensive.
Q But I would also like to refer to another section of this order to -- and it's No. 1 on the screen right now -- to develop policies and procedures which allows transgender inmates access to clinicians who meet the competency requirements stated in the WPATH Standards of Care to treat gender dysphoria.
You have already said that you believe that you meet the competency requirements stated in the standards of care, correct?
A Uh-huh.
Q Okay. But you do not treat -- you are not a primary treating clinician for any transgender inmate, correct?
A That's correct.
Q And Dr. Anderson is -- you believe also meets the competency requirements in the

WPATH Standards of Care, correct?
A Yes.
Q But she is a part-time consultant at IDOC, and she does not have primary responsibility for any transgender inmate, correct?
A Correct.
Q Okay. So my question is this. What other clinicians exist within IDOC who meet the competency requirements stated in the WPATH Standards of Care who have primary responsibility for transgender inmates?
A I'm not a lawyer, but every clinician at some point starts working with new populations for the first time, whether it's of an internship or on a job. And so meeting competency requires lots of consultation for individuals.
If I start working with a new population, I have to go and do the research, not having the client teach me about that particular issue or concern. So, you know, there are always areas where individuals need to grow in competency, reach out, do consultations or work with other clinicians on growing.
So having access to clinicians

who meet the competency requirements, if somebody were to need me to come out and deal with a particular issue -- and I have done that before, not with this particular, you know, person -- but with other people I have gone out and worked with the clinician and doing basically a supervised therapy session with them to help work through concerns that they had. And the offenders can always write the central office or they can ask their clinician for, you know, additional support.
We have a grievance process in the IDOC that allows them to have a look at concerns. And the mental health caseload clients regularly use that process to draw attention to issues. So that is something that we definitely can address so that they have access --
Q My question is --
A -- if necessary.
Q Okay. I appreciate the answer. My question was different, through, and is --
A Okay. Let me try again.
Q That's okay. It's been a long day. But it's an important question.
A Yes.

Q Well, so can you name one clinician who has primary responsibility for treatment of inmates who meets the competency requirements stated in the WPATH Standards of Care?
A I can't -- I can't attest to the fact that they meet all the standards of care. I do believe that they're providing competent care and that they are in the process of training and growing as a clinician.
So that is something that is a standard practice in terms of people working with new populations. That's part of all of our ethics standards is to do those kind of consultations and supervisions and working with other people more knowledgeable and going to trainings. So that is part of any standard of care, whether it's WPATH or any other organization.
Q Are you aware of Wexford hiring any individuals for the specific purpose of having a clinician who could primarily treat inmates who met the competency requirements of WPATH Standards of Care?
A They have not informed me of doing that.

Q I'd like to do now sort of a couple of basic hypotheticals. And in the first one, presume an inmate shows up at intake and they are currently on hormones. And I'm asking if -- let's say the prisoner had obtained those hormones on the street, not from a doctor. Would it be appropriate for IDOC to stop that hormone treatment?

MS. COOK: I'll object to foundation.

But you may answer.

THE WITNESS: Our offenders come into our system through county jails primarily. We try to get them linked up. Those who are parole violators should already be linked up with aftercare, so they would be coming in -- to my knowledge, they're coming in on non-street hormones. Because we talk with them about the importance of knowing where their hormones are coming from. They don't know what's happening in terms of is -- what they're receiving is actually correct.

So most of them are going to be coming from the Chicago area, so they would get it from Howard Brown because they do have the

ability to work with people who don't have jobs and access to funding.

BY MR. RAY:

Q My question was slightly different. My question was, if you have a prisoner coming in on intake, so new to the system, and you find out that that prisoner is taking hormones that they got off the streets. Okay? Is it appropriate for IDOC to stop hormone treatment after learning that fact?

MS. COOK: And I just want to repeat my foundation objection.

But you may answer.

THE WITNESS: Well, when they come into the facility on hormones and we do the intake, the medical doctor is supposed to contact the medical director -- and I believe Dr. Conway would qualify, and I think Dr. Puga can act as a backup because he's also a medical doctor, but you'd have to check with him -- to make a decision about, you know, and to confirm what that decision is.

So if they had an objection to those hormones being discontinued, they could

provide that feedback to the primary care physician or the medical professional that would be deciding whether to continue or discontinue.

I'll be honest. I'm not aware of this scenario ever happening. But again, they wouldn't be consulting with me on such an occurrence. So it would be basically conjecture because I'm not aware. But there would be an opportunity for that to be -- to get a consult.

BY MR. RAY:

Q So obviously part of the WPATH Standards of Care relates to things like hormone therapy and surgery. And obviously there is a significant medical part of that which is outside of your expertise, correct?

A Yes --

Q Okay. So --

A -- outside.

Q So who is it within IDOC then, who from the medical standpoint, has the expertise on hormone treatment and surgery? Is it Drs. Puga and Conway?

A My understanding is that Wexford has competent physicians at the R and Cs so that when

somebody like this would come in, that they could make the decision to continue the hormones assuming that the level was safe and that there weren't contraindications. If somebody has, for example, a blood clot, it might be dangerous and the offender may not know that, and so there could be reasons why that wouldn't happen.

But again, the specifics, I'm not aware of a scenario to point to for how we would respond. But that, I believe, is the process according to our administrative directives that already exist to ensure, you know, continuity of care. So that's already indicated in the ADs.

Q Okay.

A Because they're supposed to be doing a consult, and that would -- any gatekeeping or concerns about that would be caught during that consult. But again, the actual specifics is outside of my scope of practice for how they implement that.

Q Okay. And it's really Wexford's bailiwick to make sure that its physicians are properly trained on that, right?

A Correct.

Q Dr. Reister, do you believe that IDOC has consistently sufficient initial screening to serve the needs of transgender prisoners?

A The initial screenings when I first started were not sufficient. We even had to change the wording of gender on the forms that were utilized. So the assessment process has improved greatly from when I started working for the department.

Q Does IDOC have a consistently sufficient referral system by correction officers and other non-mental health professionals to serve the needs of transgender prisoners?

A Yes. Yeah. We already have existing for multidisciplinary communication between the various departments. Mental health receives calls. We receive paper notices. We receive e-mails getting ahold of mental health who coordinate the case management side and can make sure that the various components are addressed. We have communications very easily and regularly with the other departments.

Q Do you believe that IDOC has a consistently effective quality assurance process

in place to serve the needs of transgender prisoners?

A Well, we could --

MS. COOK: Object to form.

THE WITNESS: I'm sorry.

MS. COOK: That's okay. You can go.

THE WITNESS: I think that, you know, we could beef that side up when we get the -- particularly when we get the changes in place we're doing. I think that taking a look at how we might be able to utilize a very similar process for quality can be very helpful to the system. So that would be definitely something that we could look into improving.

We're constantly improving our quality assurance process and mental health, and our audit tools change all the time, and we are always working towards that process of improvement. So that would be helpful to take a look at how we might do that.

MR. RAY: Okay. Let's do this. Let me -- let's go ahead and take a five-minute break and try and see what I have left.

THE VIDEOGRAPHER: Time now is 4:16.

We are off the record.

(After a brief recess, the deposition continued as follows:)

THE VIDEOGRAPHER: The time now is now 4:24 p.m. We are back on the video record.

BY MR. RAY:

Q Dr. Reister, just one quick follow-up with you. It actually relates to the transfer procedures that we talked about earlier.

Is there a written document that sets forth, that you're aware of at least, the criteria for determining whether or not to transfer a transgender individual?

A I would frame it as a document -- I believe Dr. Puga was the author of it -- that gives some considerations to have. It's not intended to be a -- you know, there's not a scoring system, for example, for it. You have to basically just think about those considerations at minimum.

Also, you know, obviously, I would use my clinical skills for some of the aspects of transfer. And we've talked about a lot

of the considerations for that. And, um, so I believe it was Dr. Puga who authored that document.

Now, do keep in mind that that's not in the AD, and it's not in our standard operating procedure manual for mental health. This was just something to help people, um, you know, give some thought to what they might want to consider.

Q Do you recall what that document is called, if it's got a title?

A Oh, I don't remember the title of the document. I don't remember the title or -- I'm not even sure it had a title or not because it wasn't an official form. But, you know -- so no, I don't recall the title of it.

Q If you were asked to go look for it, could you find it easily, though?

A No. That was produced a little while ago. I kind of felt like they were pretty straightforward things that a psychologist would look at and consider. I think it is probably the most helpful for non-mental health people. I think that they're pretty straightforward for us,

so -- and I can't remember if I was involved in creating that list or not. It was quite a while ago. But they were pretty straightforward things to think about.

Q So that list you're thinking about, though, from Dr. Puga and you believe he created it, that document is still used today to guide transfer discussions?

A It's things to consider to help guide people's transfer decisions.

Q Okay. Thank you for that clarification at the end.

With that, I have no further questions for today.

I pass the witness.

MS. COOK: Okay. I do have some questions and just some cleaning up, but it shouldn't be too long.

EXAMINATION

BY MS. COOK:

Q I did want to clarify, just so the record is clear, you and I spoke more than once this month --

A Yes.

Q -- about the deposition.

A Yes. I'm sorry. I've been really busy this month.

Q I will not take offense to you not remembering.

And then I want to ask about -- so the preliminary injunction order, you were asked some questions about it, and it was Exhibit 3. And so the Court ordered the defendant, the Department of Corrections, to stop -- immediately cease the policy and practice of allowing the transgender committee to make medical decisions regarding gender dysphoria. Did the transgender committee follow that order?

A Yes.

MR. RAY: Objection. Lacks foundation.

BY MS. COOK:

Q And the Court ordered defendants to cease the policy and practice of denying and delaying hormone therapy for reasons that are not recognized as contraindications to treatment.

I understand you're not a medical doctor, but as far as you know, has the

department been working to fulfill that?

A Yes. And I believe it was just that same thing that I received was distributed to the medical side as well. So I wasn't the only -- mental health wasn't the only one to receive that to work on each of our pieces of that order.

Q But from what you know in your perspective, the transgender Care Committee immediately ceased having --

A Yes.

MR. RAY: Objection. Leading.

THE WITNESS: Yeah. The Transgender Care Review Committee immediately stopped doing that. And the information that I had received from sites is that they also would do that. And we would just simply refer it back to the mental health -- I'm sorry -- to the medical provider if a site were to mistakenly do that.

Of course, if they need a consult, you know, they can contact Dr. Conway or Dr. Puga. They're both readily available by phone, you know, State cell, 24/7.

BY MS. COOK:

Q And the Court also ordered

immediately that the defendants cease the policy and practice of depriving gender dysphoric prisoners of medically necessary social transition, including biomechanically assigning housing based on genitalia and/or physical size or appearance. It was kind of two different things.

But you did mention in your other deposition that the department has quit assigning prisoners mechanically based on their genitalia, correct?

A That's correct.

Q And as far as social transition, has the department been depriving prisoners of social transition?

MR. RAY: Objection. Lacks foundation. You can answer.

BY MS. COOK:

Q You may answer.

A Okay. In terms of social transition, the offenders are already socially transitioning. However, they are requesting additional things like we discussed earlier for that transition. A large, large number of individuals have -- are out of the closet, you know. They -- if staff are

unaware of their gender identity, they will correct them on pronouns, that sort of thing.

Q And I know you -- we talked already about the commissary items. But do you -- in your opinion and based on your experience, has that been held up a little bit by COVID-19?

A Definitely.

Q And so then the other items we talked about -- so Page 2 is stuff the Court ordered the defendants to start doing, and I just want to get it clear on the training.

So you had already begun developing training before December of 2019; is that right?

A That's correct. And a lot of that material became the core, so I didn't have to do from scratch the all-staff training.

Q And as far as allowing inmates access to clinicians to fall under the WPATH Standards of Care, do -- in your opinion, do prisoners have access to you?

A Yes. And in fact, I -- to ensure that they do, I do visit even prisons outside of my region, and I go into their transgender care

support groups on a regular basis. So obviously COVID-19 has curtailed that significantly. There were -- basically from March until -- oh, goodness. What was that -- the end of or middle of June, I was one of the State workers that had to work out of my house and not enter facilities to prevent the spread of COVID-19, and so that curtailed that. That's why recently I have resumed going -- for example, Pinckneyville has a very large population of trans women. Logan obviously has a large population of trans men and some -- a trans woman as well who we're familiar with from this case.

So yes, it has been curtailed, but they do have access. And if they were to request, I can actually go to any of the sites. I'm out of Concordia as a southern regional, and so I can travel outside of my region to do those kind of consults.

Q And is it the goal that through the UIC clinic that prisoners will have direct access to providers?

A Yes. For the medical side, that will provide to specialized surgical teams, medical

people.

Q And as far as the standard of care on the mental health side -- you know, so the first bullet point in the WPATH standards, and it's Page 21 which we already discussed -- is a master's degree or its equivalent in a clinical behavioral science field.

A Uh-huh.

Q Do the mental health providers in facilities have that accreditation?

A Yes. That's a requirement.

Q And then so just going down to No. 2, competence in using the DSM and/or International Classification of Diseases, do mental health providers in the facilities have to meet that?

A Yes.

Q And so ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria, are you -- is training geared to help providers do that?

MR. RAY: Objection. Vague.

THE WITNESS: Well, it is to provide it. But also to get licensed, you have to

demonstrate DSM competency. So that's part of everybody's training.

BY MS. COOK:

Q So in -- just so I understand, so the people who are already accredited to work as mental health providers, through the DSM they have to be able to distinguish those?

A Yeah. You have to -- to pass licensure, you're responsible for the whole DSM, so not just portions of it. And what we're doing is really highlighting those differences and making sure that they understand the differences. That's not usually where the challenge is in terms of training. Most clinicians are very adept, and it's very well written and easy to follow. Usually they're wanting more information on, you know, gender nonbinary, treatment planning, that sort of thing.

Q And so going to 4, it's the documented supervised training and competence in psychotherapy or counseling. Do the providers need to have that?

A Yes. And that's a requirement for the schools that we graduate from, so everybody

has to have that. Now, the schools vary on how much. Obviously I have a doctorate, so I have many more years of supervised training as well as my post doc. But everybody has to do that. And also, to, you know, qualify to even, you know, take the licensure exam, there are basic requirements like that.

Q And then being knowledgeable about gender nonconforming identities and expressions and the assessment and treatment of gender dysphoria, what about that?

A That is --

MR. RAY: Wait. Objection.

THE WITNESS: Oh. Can I answer?

BY MS. COOK:

Q Yes, you may answer.

A That is something that I include in my trainings so that I'm certain they received it regardless of the school that they might have graduated from or their practicum site that they might have gone to.

Q And No. 6 is continuing education in assessment and treatment of gender dysphoria. Do you know if people in DOC facilities meet that?

A Yes. That's why we're doing the transgender specific case conferences. That way we can distribute information and also train them on clinical care using actual case examples that they bring into that training. So that is part of that training.

So -- and they're also welcome to retake the part one and part two. They're also -- the WPATH is working on that other training for more advanced. So there are lots of opportunities for them to improve their skills and continue their education. And, you know, those don't require them, you know, having, you know, money from their own personal budgets going to, like, global education initiative conferences if they can't afford that. We are trying to provide those kind of trainings for free.

Q And then as far as, you know, working with somebody in the field, is that something that you're able to do with your providers right now?

MR. RAY: Objection. Form.

BY MS. COOK:

Q You may answer.

A You know, that's part of the reason

why I go around. That's part of the reason why I want Dr. Anderson to be at our case conferences. I want people to be growing as clinicians continuously. Even if they've been doing this work, you know, for years and years, I still want people to grow as a clinician. It keeps people's skills fresh and it keeps people aware of new research that comes out. And by, you know, collaborating and sharing new resources, sometimes a mental health provider will have a good resource. They can talk about what they've read and provide people ideas.

So that sharing of information is a big core part of working with any population in mental health.

Q Okay. And then as far as the mental health side, what steps does an inmate have to take before they may be diagnosed with gender dysphoria, like with the mental health staff?

A Many of the offenders actually come into our system with a gender dysphoria diagnosis through the county jail system, in particular Cook County. You know, and if they also have been through our system before, like many of them have,

they may have already received that diagnosis in the past. So if they have those diagnoses confirmed, that's how they would receive a gender dysphoria diagnosis the fastest.

If somebody does need to get that diagnosis clarified, then we already know who the out transgender offenders are via a couple of routes. The first one is we have a PREA screen to look at PREA risk factors for classification; like we talked about earlier, the predator/vulnerable or both classifications. And one of the questions is explicit about their -- about being transgender.

So that could trigger communication with mental health. That will provide case management. And if the offender would like, they can also receive mental health support. Or if they have another mental health condition, they can also receive that mental health care as well. Because a very large percentage of our population has other serious mental illnesses or mental illnesses that require monitoring and treatment.

The other way is through

disclosures to other staff. Staff will fill out forms, send e-mails to communicate with mental health, and so that might be a mode for a mental health provider to do an assessment.

Frequently what will happen is individuals will disclose their gender identity while working with a mental health provider. Many will seek that support. And during the process of the interview process -- I believe I talked a little bit about the 14-day mental health evaluation and then the additional questions that they can readily find in my trainings and the SOP and the AD -- to be available to fill out their case conceptualization, and that is another mode for getting that gender dysphoria diagnosis.

Psychiatrists and medical doctors very often will make those diagnoses as well. And because we use a multidisciplinary approach, you know, everybody will communicate that. If somebody happens to give a diagnosis before a different person, they can consult on the reason for that diagnosis with the other providers.

Q And so if -- you know, have you seen

where a mental health provider at one facility might reach out to somebody at a new facility and say you're getting so and so, you know, we should talk about his or her care?

A Correct.

MS. COOK: Those are all the questions I had.

MR. RAY: I had just one quick follow-up.

FURTHER EXAMINATION

BY MR. RAY:

Q Talking about your level of access -- or the level of access that transgender prisoners had to you, They also had access to you before December 2019, correct?

A Yes, they also had that. And in fact, the one consult I talked about as an example with the therapist and the client was actually before that time period. Since then, both the client and the clinician have left IDOC. But yes, it happened before as well.

I think I'm better known today due to the number of lawsuits we're dealing with, and so I think offenders are better educated on my

availability and my openness to address concerns that they have. So I think that, you know, it may be easier for them.

But, you know, usually what is really happening is when I'm coming into sites, I always like to ask about how it's going. And I like to ask about how we can improve our system as a whole so we can get feedback and make changes. They sometimes have really great ideas. And, you know, if it works, we can definitely consider those ideas.

So that's one of the reasons why I ask those kind of questions to make sure that we get feedback from the consumer of our services.

Q But you did those site visits and asked those questions before December of 2019 as well, right?

A Yes.

MR. RAY: No further questions.

MS. COOK: Okay. I don't have anything else. I guess we can go off the record.

THE VIDEOGRAPHER: Okay. The time now is 4:48 p.m. You're off the record. And that

is the end of the deposition.

(Off the video record.)

MS. COOK: Did you want to review it and sign it?

THE WITNESS: I think I'm comfortable with it. Do you think I need to? I think I was pretty clear. But if you think I should do that, I am more than comfortable doing it. What's your recommendation?

(Discussion off the record.)

MS. COOK: As long as she thinks she got it, I would waive.

THE WITNESS: I will go ahead and waive that.

THE REPORTER: Brent, do you need a rough ASCII right away?

MR. RAY: Whatever our order is.

THE REPORTER: And Lisa, do you need a copy of the deposition?

MS. COOK: I will take a copy, but I can't pay for exhibits or anything extra.

FURTHER DEPONENT SAITH NOT. . .

STATE OF ILLINOIS)
) SS.
COUNTY OF C O O K)

I, Diane J. Corona, a certified shorthand reporter in the State of Illinois, do hereby certify that DR. SHANE REISTER was by me first duly sworn to testify to the truth, and that the above matter was recorded stenographically by me and reduced to writing by me.

I FURTHER CERTIFY that the foregoing transcript of the said matter is a true, correct and complete transcript of the testimony given by the said witness at the time and place specified herein before.

I FURTHER CERTIFY that I am not a relative or employee of any of the parties, nor a relative or employee of the attorneys of record, or financially interested directly or indirectly in the action.

IN WITNESS WHEREOF, I have hereunto set my hand at Chicago, Illinois this 23rd day of August, 2020.

Certified Shorthand Reporter
Illinois CSR License No. 084-00257

Exhibit 3

From: Locke, Angela
To: DOC.DL-Warden"s Adult Group; DOC.DL-DOC Business Administrators
Cc: Puga, William; Conway, Lamenta
Subject: Transgender Female Commissary List
Date: Thursday, November 5, 2020 2:31:08 PM
Attachments: Transgender Female Commissary 11-05-2020.docx

Please find attached the approved Statewide Transgender Female Commissary list. These items should be offered as soon as you have inventory on hand and they shall only be sold to the offenders who identify as Transgender Female. The Administrative Directive governing all transgender related items is forthcoming. This list will be posted on the intranet along with the other commissary list.

Angela M. Locke
Warden
Vandalia Correctional Center
(618) 283-4170 ext. 2142
(217) 450-7498 cell
Angela.locke@illinois.gov

State of Illinois - CONFIDENTIALITY NOTICE: The information contained in this communication is confidential, may be attorney-client privileged or attorney work product, may constitute inside information or internal deliberative staff communication, and is intended only for the use of the addressee. Unauthorized use, disclosure or copying of this communication or any part thereof is strictly prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately by return e-mail and destroy this communication and all copies thereof, including all attachments. Receipt by an unintended recipient does not waive attorney-client privilege, attorney work product privilege, or any other exemption from disclosure.

Transgender Female Commissary List

Bras – white only (4)

ICI Panties – white only (8)

Hair Net – Brown (1)

Scrunchies – Black (1)

Blush – (1)

Eye Shadow (Neutral Color) – (1)

Eyebrow Pencil – (1)

Eyeliner Pencil – (1)

Foundation – (1)

Lip Gloss (Clear) – (1)

Lipstick (Neutral Color) – (1)

Mascara – (1)

Cosmetic Bag (clear plastic) – (1)

Body Scrubber – (1)

Facial Hair Remover/Magic shave – (1)

 Exhibit 4

Illinois Department of Corrections

Administrative Directive

Number:	Title:	Effective:
03.02.113	**Personal Use of Social Media**	**11/1/2019**

Authorized by:	*[Original Authorized Copy on File]*	**Rob Jeffreys** Acting Director

Authority:	**Referenced Policies:**	**Referenced Forms:**
730 ILCS 5/3-2-2 820 ILCS 55/10	01.02.400	

I. POLICY

The Department shall require employees to conduct themselves in a professional manner when engaging in personal use of social media platforms and, whether on duty or off duty, not engage in conduct that is unbecoming of a State employee or that may reflect unfavorably on or impair operations of the Department.

II. PROCEDURE

A. Purpose

The purpose of this directive is to establish written standards for personal use of social media by all employees of the Department.

B. Applicability

This directive is applicable to all employees of the Department.

C. Facility Reviews

A facility review of this directive shall be conducted at least annually.

D. Designees

Individuals specified in this directive may delegate stated responsibilities to another person or persons unless otherwise directed.

E. Definitions

Employee – for purposes of this directive, refers to any full-time, part-time, conditional or temporary, State or contractual staff member of the Department.

Personal use of social media – engagement or participation in any social media platform not related to a person's employment.

Post (noun) – an item inserted in a blog, or an entry to any type of social media platform.

Post (verb) – the act of creating, uploading, editing or adding information to any social media platform. This shall include, but not be limited to, text, photographs, audio, video or any other multimedia file.

Social Media Platform – any electronic communication (such as personal websites and outlets for social networking and microblogging) through which participants utilize online communities to share information, ideas, personal messages and other content through any electronic format including, but not limited to, text, video, photographs, digital documents, audio and other multimedia files. Examples of social media outlets include, but are not limited to, Facebook, Instagram, LinkedIn, Reddit, Tumblr, Twitter, WhatsApp and YouTube.

F. General Provisions

This directive shall address the full breadth and scope of social media rather than any one particular format. The Department recognizes that as technology advances, new methods for social media participation will emerge.

1. All employees shall be informed of the provisions of this directive and the directive shall be accessible to employees.

2. Training on the Department's policy on personal use of social media shall be included in pre-service training for new employees and shall be a component of annual training programs.

3. Nothing in this directive shall prohibit employees from engaging in their constitutional right to express their views under the First Amendment but shall prohibit personal use of social media to disseminate certain content not protected by the First Amendment.

4. Employees shall not use Department property, including, but not limited to, desktop computers, laptop computers, cell phones, handheld digital or electronic devices and digital media storage, to engage in personal use of social media.

5. Employees shall have no reasonable expectation of privacy when engaging in personal use of social media.

    a. Any information employees create, transmit, download, exchange or discuss that is available online in a public forum or that is accessible by the public may be accessed by the Department without prior notice.

    b. The content of social networking websites may be obtained for use in criminal trials, civil proceedings and Department investigations.

6. Employees shall respect the confidentiality of information and are prohibited from accessing or disclosing information such as, but not limited to, investigations, offender records and personnel issues, except to the extent needed in the performance of their job duties.

G. Requirements

1. Employees shall obey all Department Rules, Administrative Directives and applicable federal, State and local laws.

2. Use of any social media platform(s) by an authorized employee in the performance of his or her job duties shall be in accordance with Administrative Directive 01.02.400.

3. Unless otherwise authorized by the Director, employees shall not suggest or imply that they are:

    a. Speaking or acting on behalf of the Department; or

    b. Representing or presenting the interests of the Department.

4. Employees shall not post, display or transmit:

    a. Any communications that discredit or reflect poorly on the Department, its mission or goals, or in any way jeopardize or impair the operations of the Department, including the ability of others to perform their duties.

    b. Any information, including but not limited to rank, title or position, that in any way suggests they are representing themselves as an official spokesperson of the

Department and the State of Illinois without written permission from the Director.

c. Any intellectual property of the Department or the State of Illinois without the specific authorization of the Director. Intellectual property shall include, but not be limited to, any depiction or illustration of the State or Department seal, or the Department name, logo, uniform, ID Card or badge, patch, official photographs, audio or video files or any text documents (paper or electronic).

d. Any depiction or illustration of Department issued firearms, restraints or tactical equipment.

e. Any references to any other employee's employment by the Department without that person's consent.

f. Information, records, documents, video or audio recordings, or photographs belonging to the Department or relating to offenders in the Department's custody to which they have access as a result of their employment without the written permission of the Director, including but not limited to information regarding:

(1) Current, past or pending Department investigation, where such post would impede or interfere with said investigation; jeopardize the safety and security of the Department, its employees or offender population; or release confidential information regarding staff or offenders.

(2) Current, past or pending criminal or civil proceedings pertaining to or arising from any matter involving the Department, including allegations of misconduct, where such post would impede or interfere in said proceedings.

g. Any content that could be viewed as: vulgar; obscene; threatening; intimidating; harassing; as a violation of the Department's polices on discrimination or harassment; or that is otherwise disparaging to a person or group based on race, religion, sexual orientation or any other protected class under federal or State law. Such content shall include, but not be limited to:

(1) Use of ethnic slurs, profanity, personal insults, any material that is harassing, defamatory, fraudulent or discriminatory, or other content or communications that would not be acceptable under Department Rules, Administrative Directive, or State or federal law.

(2) Use or display of sexually explicit images, cartoons, jokes, messages or other material that would be considered in violation of Department Rules, Administrative Directives and State laws regarding sexual harassment.

Exhibit 5

From: Conway, Lamenta
To: Roderick L. Matticks; Glen Babich
Cc: Bowman, Steven; Johnson, Lisa M.; Puga, William; Fanning, Robert L.; "Shannis Stock-Jones"; Crain, Angela; Hackney, Katie; Klein, Mary L.
Subject: Transgender Health and Hormone Therapy
Date: Friday, May 1, 2020 10:18:44 PM

Greetings

As we all know, a law suit was filed in the U.S. District Courts regarding the care of our transgender patients. One of the major expectations of the law suit, was to decentralize the decisions to provide hormone therapy from the TRCC and to localize that care to the individual prison facilities. The purpose of that mandate and a major complaint in the lawsuit was that there were unacceptable delays in initiating hormone therapy.

It has come to our attention that a number of providers are yet uncomfortable initiating and prescribing hormone therapy for those who are appropriate for treatment and have been diagnosed with gender dysphoria by Mental Health. Others may be refusing to provide appropriate hormone therapy

Despite the extreme challenges of COVID-19 and the demands on all of our time, IDOC remains subject to the demands of the lawsuit**. I would like to schedule a meeting Monday, May 4th, 2020 at 1pm** if available, to discuss how we might support and empower the medical directors to provide appropriate care expediently. Wexford developed an early draft that was meant to be a national policy for Transgender Health. It was a very good draft with excellent information on how to initiate and titrate hormone therapy. There are other handouts available as well that can simplify the challenging process.

If we can connect for 30 minutes, let's discuss how we can get our Medical Directors on board with prescribing hormone therapy as indicated. If there are barriers to care, lets identify those as well.

LaMenta S. Conway, MD, MPH
Deputy Chief of Health Services
Illinois Department of Corrections
JRTC 4th Floor
100 West Randolph
Chicago, IL 60601-3210
(312) 814-5776 (office)
(312) 261-0702 (mobile)

State of Illinois - CONFIDENTIALITY NOTICE: The information contained in this communication is confidential, may be attorney-client privileged or attorney work product, may constitute inside information

or internal deliberative staff communication, and is intended only for the use of the addressee. Unauthorized use, disclosure or copying of this communication or any part thereof is strictly prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately by return e-mail and destroy this communication and all copies thereof, including all attachments. Receipt by an unintended recipient does not waive attorney-client privilege, attorney work product privilege, or any other exemption from disclosure.

Exhibit 6

ANDRE PATTERSON a.k.a JANIAH MONROE 8/24/2020

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.

ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN,

Defendants.

) Case No. 18-156-NJR

The deposition via videoconference of ANDRE PATTERSON a.k.a JANIAH MONROE, taken before Alyssa N. Kuipers, Certified Shorthand Reporter and Registered Professional Reporter, commencing at 9:26 a.m. on the 24th day of August, 2020.

INDEX

EXHIBITS

(NO EXHIBITS MARKED.)

APPEARANCES:

ACLU OF ILLINOIS
MS. CAROLYN WALD (via videoconference)
150 North Michigan Avenue
Suite 600
Chicago, Illinois 60601
Phone: (312) 201-9740
E-mail: cwald@aclu-il.org
On behalf of the Plaintiffs;

ASSISTANT ATTORNEY GENERAL
MR. CHRISTOPHER HIGGERSON (via videoconference)
500 South Second Street
Springfield, Illinois 62701
Phone: (217) 782-4445
E-mail: chiggerson@atg.state.il.us
On behalf of the Defendants.

* * * * * *

(Witness sworn.)

WHEREUPON:

ANDRE PATTERSON a.k.a JANIAH MONROE, called as a witness herein, having been first duly sworn, was examined and testified via videoconference as follows:

DIRECT EXAMINATION

BY MR. HIGGERSON:

Q. Could you please state your name for the record.

A. Janiah Monroe.

Q. And that is your chosen name, correct?

A. Yes.

Q. Can you tell us your inmate number just so that we have you properly identified?

A. Y35508.

Q. Okay. Thank you. How long have you been in the Illinois Department of Corrections?

A. Since 2008.

Q. And what was the crime you were convicted of?

A. My original charge?

Q. Yes, the one that led you to come to

Page 5

DOC.
A. Originally, my original charge was attempted murder.
Q. Was there a later charge added to that?
A. I was convicted of ten other crimes.
Q. Is that within either Cook County or the Illinois Department of Corrections?
A. I caught eight other cases in Cook County and two in Livingston County.
Q. Is one of the additional ones in Cook County involving a cellmate at the Cook County Jail?
A. Yes.
Q. Was that a murder charge also?
A. Second-degree murder, voluntary manslaughter.
Q. You are now housed at Logan Correctional Center, correct?
A. Yes.
Q. When did you move there?
A. 2019. April 1st, 2019.
Q. Have you been housed there continuously since?

Page 6

A. Yes.
Q. There was an attempt to move you at one point, correct?
A. Yes.
Q. When was that?
A. In June of 2019.
Q. You never actually arrived at another prison, though, correct?
A. No. They put me in a van and was taking me outside the gate, and the transfer was stopped because they said that the governor stopped the transfer.
Q. To your knowledge, have there been any further attempts to move you from Logan Correctional Center?
A. To my knowledge, there has been talk of transferring me out of the institution, but there haven't been the actual physical attempt to move me out of the institution. There's been talk.
Q. Have you ever heard talk or have people told you that there's been talk?
A. I've been told by the administration that they're trying to transfer me.

Page 7

Q. Who told you that?
A. Teri Kennedy.
Q. When was that?
A. She told me she didn't want me down here when she first came down here as warden.
Q. Do you know when that was?
A. I don't know exactly when she came down here. I was in seg.
Q. What was -- Why were you talking to the warden at that time?
A. Why was I talking to the warden?
Q. Yes.
A. I think I was talking to her because she hadn't seen me. Because we knew each other from Pontiac, and I was trying to get her to let me out of seg and to restore my grade, because I was in C grade, and to help me. I thought she might help me, but she wasn't trying to help me at all. She was actually taking a harder stand against me.
Q. Did she say there was anybody but her who wanted to move you out of Logan Correctional Center?
A. She told me that since she came

Page 8

here, that she thought that I shouldn't be here and that it was other people that thought the same thing.
Q. Did she say --
A. She didn't name any names specifically, but I know ever since she's been here, I have been housed on the D wing and they have refused to move me from the D wing, which is punitive housing, during her whole time as warden.
Q. Is Teri Kennedy still the warden?
A. I have no idea, but I believe so, but I heard she was supposed to be leaving, so I'm not sure if she's still the warden or not at this moment. I heard she was supposed to be leaving.
Q. When you first arrived at Logan Correctional Center, where were you housed?
A. Everybody at that time was going from Receiving to D wing. The system was B wing, A wing, D wing, and then to grounds. So I went from B wing to D wing, and then I was on D wing for longer than other people. And then I finally made it to grounds, and then I

Page 9

went to seg.
Q. Okay. What type of unit is B wing, the one you said you started in?
A. That's receiving.
Q. Were you single-celled in there, or how were you celled?
A. Whenever I'm on House 15, they single-cell me.
Q. Is that in B wing you were single-celled?
A. Yes.
Q. Okay. And how long were you in B wing?
A. Like two days.
Q. Did you say most people move from B to A wing?
A. Yes.
Q. Did you go to A wing?
A. I went straight to D wing.
Q. What type of wing is D wing?
A. D wing now is a punitive housing wing. D wing at that time was a transitional wing. Now, it's a punitive housing wing.
Q. What did it mean that it was a

Page 10

transitional wing?
A. Like it was the next stop. You had to go from B to A to D in order to go to grounds. It was a routine, like it was protocol. That's what they were doing.
Q. And how is the housing in D wing as far as is it single-cell or double-cell or anything else?
A. It's double cells, but I'm the only one that they don't give a celly to.
Q. When you were in D wing the first time after coming off of B wing, you were single-celled in D wing?
A. Yes. Every time I'm on D wing, they never give me a celly. They always isolate me.
Q. How long did you stay on D wing the first time?
A. From April to June.
Q. And when did you leave D wing?
A. In June.
Q. Was that before or after the started attempt to move you to Pontiac?
A. Before.
Q. Okay. So did you leave B wing when

Page 11

they brought you back into the prison?
A. No. I left D wing. I said I left D wing before they tried to move me.
Q. Okay. And where did you go from D wing?
A. I just said I left D wing before they tried to move me. I went to House 10, and then I went into the cell with a girl named Danielle Carter.
Q. What type of classification is 10?
A. It's general population.
Q. How long were you housed with Danielle Carter?
A. Like a day.
Q. Do you know why you were only with her for one day?
A. Yes, I do.
Q. Why was that?
A. Because a girl that I was in a relationship with accused me of sexually assaulting her.
Q. When had you started the relationship with this girl who accused you of sexual assault?

Page 12

A. While we was on the D wing.
Q. Had she also moved from D wing to 10?
A. Yes.
Q. So you were out of D wing one day and she made this allegation?
A. Yes.
Q. Is this the same assault allegation that has been brought in Federal Court now?
A. To my knowledge, yes.
Q. So where did you go after she made that allegation against you?
A. To segregation.
Q. Were you single-celled there?
A. Yes.
Q. And how long were you in segregation?
A. I was in segregation -- I don't remember exactly how long I was in segregation. I don't remember exactly how long.
Q. Did you receive a ticket as a result of that sexual assault allegation?
A. Yes.
Q. What was the finding on that ticket?

A. They found that we had consensual sex, and they found me guilty of sexual misconduct.

Q. Do you know if she received a ticket for that?

A. Yes.

Q. Yes, you know, or, yes, she did?

A. Yes, she received a ticket as well.

Q. Do you know if she was found guilty?

A. I know that she was found guilty because I know that that's one of the things she's suing about.

Q. Did you receive any other discipline while you were in segregation?

A. I believe they put me on day room restriction or C grade.

Q. Were there any other tickets while you were in segregation?

A. Yes.

Q. And what were those for?

A. Well, after they found me guilty, they immediately tried to transfer me. After they couldn't transfer me, they wrote me approximately 15 tickets for

intimidation/threats back to back, like approximately. I don't know the exact number, but I believe it was around 15 tickets for intimidation/threats and being -- yeah.

Q. Was that intimidation and threats against staff?

A. Intimidation and threats against staff, I believe, yes.

Q. Had you actually made any comments to staff that would amount to intimidation or threats?

A. I didn't threaten the staff at that time.

Q. Did you curse at them?

A. I have cursed at staff.

Q. Did that lead to tickets for the intimidation and threats?

A. This is what happens: I be -- I was getting provoked by staff. They were mad I was in this institution, and they got disrespecting. And I wasn't just going to let people disrespect me. And sometimes I will lose my cool and I will disrespect them back, but that does not justify the fact that they

lied on the tickets and said I threatened them.

Q. Were you found guilty on any of those tickets?

A. I was found guilty on all the tickets. To this day, I'm almost never found not guilty. I'm always almost found guilty of everything.

Q. Who were the staff members who you had these interactions with where they would disrespect you and then you would say things back to them?

A. I don't even -- Sergeant Jackson, Officer Lara. I don't even remember, like, everybody's name. It was a lot of people.

Q. Did you file grievances about the way they treated you?

A. I have filed grievances, yes. I filed grievances. I filed PREAs for some of the stuff that was said against me.

Q. Have any of the grievances been resolved in your favor? Did any of them say that you were correct?

A. No. They mostly don't really respond. Like, they will give me an answer

that's not really an answer; it's a very vague answer.

And, like, I filed a grievance against Officer Angilee (phonetic) because he was making sexual comments about my privates online on Facebook. And they sent my grievance to Internal Affairs, and I never got my grievance back.

Q. How did you know that officer was making comments on Facebook?

A. Because I have family.

Q. Is that officer still at Logan Correctional Center?

A. Yes, to my knowledge.

Q. Is it a he?

A. It's a man.

Q. Okay. When was the last time you saw him?

A. Probably a couple months ago.

Q. Were any of your PREA complaints against staff substantiated?

A. No, but I filed legitimate PREA complaints. I filed a PREA complaint against an officer named Lara, which was legit, and he

Page 17

just got fired from down here for sexually assaulting a female and it was legit. And I filed a PREA against him when I first got here, and they told me that was unsubstantiated. IA is corrupt down here. Whatever I file, they never fully investigate my stuff the way that they're supposed to.

Q. What did Lara do to you that led to the -- Are you saying Laura that sounds like the woman's first name?

A. Lara, L A R A.

Q. What did he do to you that led to your PREA complaint?

A. He told me to suck his dick.

Q. As an insult or as an instruction on what to do?

A. Like, I don't know what it was. I just know I felt that it was inappropriate, and I filed a PREA about it. And IA said it was unsubstantiated even though I had witnesses. And they just said like it never happened. They found me guilty of a ticket he wrote on me. He turned around and wrote me a ticket because I filed a PREA on him, and they found

Page 18

me guilty of his ticket.

Q. What was the charge in his ticket to you?

A. He said -- I think he said I called him a wet back.

Q. Did you do that?

A. No. I'm not racist against Mexicans.

Q. Are you racist against somebody else?

A. No.

Q. I'm just wondering why you qualified that.

Okay. Have you filed PREA complaints against other inmates while you were at Logan Correctional Center?

A. Yes, I have.

Q. Have any of those been substantiated?

A. I've had one that was substantiated.

Q. Was that substantiated by investigation by IA?

A. Yes.

Q. And, to your knowledge, have there

Page 19

been PREA complaints against you by other inmates at Logan?

A. Yes.

Q. And have any of those been substantiated?

A. Yes.

Q. Do you know how many have been substantiated?

A. I don't know. I just know that the ones that have been substantiated against me were the ones where somebody said I said something, and they will have like one of their friends as a witness to say I said this or I said that.

Because what a lot of girls do down here is they will use me to get moved, because this is the thing: I'm on D wing; it's a punitive wing. Nobody wants to be on D wing. And since everybody knows that the wardens are not moving me off of D wing, they say they're going to file a PREA on me and they're going to use me to get moved. Because if they file a PREA on me, they have to get moved; it's guaranteed. So that's what everybody do, they

Page 20

file PREAs on me to get moved.

That's why when I go to grounds -- The only person to ever file a PREA on me on grounds was Amanda Scott. That's it. She was the only person. But all of my PREAs have been filed on me on D wing because all these girls use me to get moved off of D wing because they know that the administration refuses to move me off of D wing. To this day, I've been on D wing right now going on nine months.

Q. Let's finish the timeline. We had talked up until June of 2019, is when you were placed in segregation, correct?

A. Yeah.

Q. And where is segregation located?

A. It's in House 15.

Q. Were you released from that segregation -- that time in segregation at some point?

A. Yes.

Q. When was that?

A. Like a month later.

Q. And where did you go from segregation?

A. To D wing.
Q. Which is -- at that time, was still a transition wing?
A. Yes.
Q. And how long were you on D wing that time?
A. I was on D wing that time until October.
Q. Where did you go when you left D wing in October of 2019?
A. Well, first, I went to seg, and I believe it was August or September. August, I believe, I went to seg. I believe I went to seg in August. And when I got out of seg, they placed me in health care on what they created for me, which they called administrative detention. They don't even have administrative detention in this prison, but they created it for me as another form to isolate me from everybody else where they would not let me have any interactions with any inmates at all. I had to stay in my cell, and when I did come out, I had to be escorted by a tac member and a sergeant or a tac member and a lieutenant

everywhere I went. And I had no interactions with any other inmates at all, and I was in my cell.
Q. Why did you go to segregation in August of 2019?
A. For sexual misconduct.
Q. And what was --
A. I believe it was around August.
Q. Okay. And what was the sexual misconduct allegation at that time?
A. It was a PREA.
Q. What were you accused of doing?
A. I'm not quite sure because IA never asked me anything, did I force myself on them, anything. Like, they just investigated it and found for theirself that it was false.
Q. Okay. Were you put in segregation during the investigation?
A. Yes.
Q. And then when they found it was false, you were let out of segregation?
A. No. When they found it was false, they put me in health care. I was in seg for 45 days on a ticket that they sentenced me to

30 days seg for. They gave me 30 days seg on this ticket, but they held me in seg for 45 days. Then they put me in health care and isolated me from everybody.
Q. I thought you said you were found not guilty on the ticket?
A. No. I said I was found not guilty of a PREA. That's what I said.
Q. Okay. So you were found guilty of sexual misconduct, but not of assaulting anybody?
A. Yes.
Q. Okay. And that's when you went to the health care unit?
A. Yes.
Q. And you were single-celled there?
A. Yes. I was isolated there from everybody. I had no interaction with any other inmates at all.
Q. Could you talk to people if they passed through, in and out of the health care unit?
A. No. They told people if they talked to me, they was going to go to seg. I was

completely isolated to the point that I tried to kill myself, and I went to an outside hospital in Springfield.
Q. What type of cell were you housed in in the health care unit?
A. In an isolation cell.
Q. Is that the same as a crisis cell?
A. Yes.
Q. How long were you there before you tried to hurt yourself?
A. I don't know.
Q. And when did you eventually get out of the health care unit?
A. When some psych doctors came down there and told them that -- and told the administration down here that I needed human interaction and that if they continued to isolate me, that I was going to kill myself. Then they let me out and sent me to House 10.
Q. Do you know who that doctor was who said that?
A. I don't remember. I believe he came down here with Dr. Puga. I believe it was Dr. Puga and somebody else.

Q. And then you said you went back to general population at that time?
A. Yes.
Q. When you were in general population, where did you shower?
A. I showered in the shower.
Q. Were you given any directions to shower anywhere else?
A. They told me that they would prefer that I shower in the health care.
Q. But you preferred to shower on the actual -- on 10?
A. Yes.
Q. Did you shower by yourself or with other inmates?
A. This is how the shower is set up: I believe it's four, like, shower heads and there's curtains to separate the showers, so what I would do is when I get in, I would have my friend get in one in her -- one in front of me, so nobody can say I was doing anything inappropriate, so her curtain blocked mines. You see what I'm saying?
Q. Yes. Were you ever accused of doing

anything inappropriate in the shower?
A. Was I ever accused of doing anything inappropriate in the shower?
Q. Yes.
A. I think so, yes, but not with her.
Q. When you say "not with her," you mean not with your friend?
A. Yeah.
Q. Who were you accused of doing something inappropriate with in the shower?
A. A girl named Catrina Cotton.
Q. How were you accused of that if your friend was in there between you and anybody else?
A. People say what they want to say.
Q. What did she accuse you of doing?
A. Catrina didn't accuse me of nothing. It was other people that said this.
Q. Who said it?
A. I don't know. This is what IA told me.
Q. Was that claim substantiated?
A. I don't know. I just know that -- this is what I think. Me and Catrina Cotton

was in a relationship while I was on 10, and one of the things that people said we did was behaved inappropriate in the shower. Now, I don't know if they believed that we did something in the shower or not; that's on them. I never did anything inappropriate in the shower. I didn't. But we were found guilty of sexual misconduct.
Q. When you say you didn't do anything inappropriate, do you think that having sex with her when she is doing it voluntarily would have been inappropriate?
A. Look, I understand breaking the rules is inappropriate; I understand that, but you need to understand this: Number 1, everybody down here almost is in a relationship. That is the norm. If you was to come visit this prison, almost every female here is in some form of relationship. That is the norm of prison life.
Even you are to go to the men's prison, there are jailhouse relationships. It's something that we do. We form connections because we are so isolated and alone. No one

wants to do this time alone.
I've been locked up for 15 years. I've been locked up since I was 16. I've lost everything. I refuse to be alone by myself. One thing I will not do is force myself on another person. I am a rape victim. I have been raped by over six different people. I will never force myself on nobody else. But I'm not going to be by myself, and it's not right to ask me to be. I'm a respectful person. I'm an honest person.
Q. So were you -- you were actually guilty of what they accused you of doing in the ticket, though, correct?
A. Except behave inappropriate in the shower.
Q. But you were having sexual contact in the shower; you just don't think that's inappropriate, correct?
A. I did not say that we had any sexual contact in the shower.
Q. Okay.
A. I did not say that.
Q. Did you have sexual contact in the

Page 29

shower?
A. No. I just told you no.
Q. What happened -- Did you stay in general population even after that ticket?
A. I didn't get a ticket at that time. I was moved to House 9 because I was placed under investigation. They didn't have enough evidence at the time. We was placed on investigation. I was moved to House 9.
Q. What kind of housing is House 9?
A. It's general population.
Q. In 9, were you single-celled or were you with somebody else?
A. I was with four other people.
Q. What happened -- How long were you on 9?
A. Until December.
Q. What happened in December?
A. I was placed on D wing.
Q. Why?
A. I was placed under investigation.
Q. For what?
A. Because they thought that I had assaulted somebody physically.

Page 30

Q. Okay. Who thought that you had assaulted somebody physically?
A. IA.
Q. Did somebody report that to them? Is that why they thought that?
A. Yes.
Q. Who told them that you -- Was it the person who said that they were physically assaulted who told them that?
A. No. It was somebody else. I don't know who, a confidential source, but that claim was found not true.
Q. You said you went to D wing; that was December of 2019. Was it still a transitional unit at that time?
A. At that time?
Q. Yes.
A. I don't remember.
Q. Okay. You said, at some point, it became a punitive unit?
A. Yes.
Q. When did that change?
A. I'm not sure the exact month that it changed, but they stopped sending people from A wing and B wing to D wing and they started sending them to grounds, and they started sending people from segregation to D wing. And it started to be that you had to go 30 days without a ticket and you can get moved from D wing to grounds.

Page 31

Q. So it sounds like it was still a transitional unit, but just not for new arrivals?
A. If that's how you want to look at it, but it was a punitive thing, disciplinary.
Q. Were you the only person who went directly to D wing? You said it was for people who were leaving seg.
A. I was the only person that was continuously housed on D wing, and I'm still housed on D wing from December to August. I'm still on D wing. Everybody else is gone and I'm still there, and I still don't have a celly.
Q. Okay. Have you received any other discipline since you've been on D wing starting in December of 2019.
A. Any other discipline like what?

Page 32

Q. Did you get any tickets while you've been on D wing?
A. I've got like two minor tickets, I believe.
Q. For what?
A. No. Like, I got -- No. I got a couple tickets, yeah.
Q. For what?
A. I have one major ticket and two minor tickets.
Q. What were the charges?
A. I don't remember. Hold on. Let me see. Okay. No. I had a ticket for an old sexual from when I was on House 9 that I was under investigation for. And then they wrote me a ticket for assault on a girl -- a trans man, but they, like, cut my time in half because they saw on camera that I just pushed 'em back because they spit in my face and I wasn't trying to fight. They cut my time in half. Normally, it would be 30 days. They gave me 15 days because I wasn't trying to fight them. The person said I punched 'em, but I just pushed 'em back. And after that, I got

Page 33

some minor tickets for insolence.
Q. During the time since December, when you've been on D wing, have you ever gone to segregation or have you been on D wing the entire time?
A. Yeah. I went to seg for the sexual and for the assault, that I remember. Yeah.
Q. When was the time you were in segregation?
A. I was in seg from January, I believe, to like February. I don't know. I got out of seg -- I just know I just got out of seg in April. I got out of seg in April. I've been out of seg since April. I haven't went back to seg since April.
Q. Okay. So you've only been in D wing continuously since -- from April to August because you were in segregation before that?
A. I've been in and out.
Q. You have been diagnosed with gender dysphoria, correct?
A. Yes.
Q. Do you see a mental health professional to be treated for that?

Page 34

A. Yes, I do.
Q. Who do you see right now that's treating you for gender dysphoria?
A. Dr. Post.
Q. What was the last time you saw Dr. Post?
A. Last week.
Q. What was -- Why did you see her last week?
A. To talk about anger management groups.
Q. Are you part of an anger management group right now?
A. I've been part of the anger management group. It's supposed to be starting back up.
Q. Is that what you were talking to her about, about it starting back up?
A. Yes.
Q. Was there anything else you talked to her about?
A. Not last week, no. She just said that she was happy that I was doing better, that I've been doing good. She's proud that

Page 35

I've been staying out of trouble and I'm in school and stuff like that.
Q. When was the last time you saw her to talk about the gender dysphoria?
A. Like, last month, I think.
Q. Is that a regularly scheduled appointment? Do you see her every so often?
A. Yeah.
Q. How often do you see her?
A. Like every month when she come in to check on me. Like, every month.
Q. Do you have any other type of treatment for gender dysphoria from the mental health people?
A. I mean, it's not really, like, a form of treatment for this gender dysphoria. She just asks me like how am I doing. It's just to check in, a wellness check-in. You know what I'm saying? It's not like she's treating my gender dysphoria. She is just checking on me to see how I'm doing because, like, I struggle with suicidal ideations. I've attempted suicide multiple times since I have been down here. She's concerned about me, so

Page 36

she comes in to check on me because -- and she knows that I'm trying to get my surgery.
And the last time I talked to her last month, I spoke to her about being displeased that Dr. Reister is putting my surgery on hold, because Dr. Sang had said I could have my surgery, but Dr. Reister is saying that he has to speak to me, and I don't understand. So my surgery is not happening, so they just keep giving me the runaround, so, like, they just keep --
Q. Who is Dr. Sang?
A. She's the medical director.
Q. Okay. Do you participate in any group therapy for your gender dysphoria?
A. Before we went on quarantine, there was a group for gender dysphoria.
Q. And how often did you participate in that?
A. It was every week.
Q. And who led that group?
A. Dr. Post.
Q. Is there any other mental health treatment that you are receiving for your

Page 37

gender dysphoria?
A. No.
Q. And I understand -- we'll talk about surgery and the medical side of it in a minute. Is there any mental health treatment that you believe you should be receiving that you're not?
A. I believe that, for one, they really don't know how to treat gender dysphoria down here. I believe that -- Like, I did some groups for gender dysphoria. I believe they don't -- they're not informed. I believe Dr. Post tries. You know, she's willing to listen and hear what we have to say and listen to how we feel, but I feel like she don't really have a lot of knowledge to offer me. I feel like I know more about what I need than her. Like, if I have questions, I can't go to her like for help.
And I need -- Sometimes I need people I can talk to about my problems, and I can't talk to her.
Q. That goes to the quality of the treatment or whether she is qualified. Do you

Page 38

think there's any form of treatment on the mental health side for gender dysphoria that you should be receiving that you're not?
A. Yeah.
Q. And what is that?
A. For one, I believe that they're supposed to be giving me the counseling and preparing me with therapy to make sure that I'm ready and everything for the surgeries and everything that I'm ready to go through. And that's supposed to take place now in the time leading up before surgery and everything, not at the last moment. That's supposed to be happening now, but they're not doing that.
Q. Is there anything else on the mental health side that you think is not being provided to you?
A. That is mental health.
Q. I understand. I'm just asking: Is there anything else, besides the preparation for surgery, on the mental health side that you think you're not being provided?
A. No.
Q. On the physical side of it, the

Page 39

medical side of it, you receive hormone therapy, correct?
A. Yes.
Q. Who has prescribed those hormones to you?
A. Dr. Sang.
Q. Have you been having your blood drawn and monitored to check on your hormone levels?
A. Yes.
Q. When was the last time that was done?
A. I don't know. Like a month or two ago probably.
Q. Do you know what the results were of your blood test?
A. No.
Q. Was there a change in the hormones you're being given as a result of that blood test?
A. Was there a change, no. They haven't changed my hormones. My hormones have been consistent. I've been trying to get my hormones changed because I feel that they're

Page 40

inadequate.
Q. But you haven't seen the actual test results on what your levels are, correct?
A. I seen some when I first got here. I seen some of my levels, but I haven't requested any recently. I seen some when I first got here.
Q. When you say "here," are you talking about Logan or Department of Corrections?
A. Here, Logan.
Q. Okay. Now, have you talked to somebody about -- Who have you talked to about wanting surgery?
A. Everybody. I was talking to Dr. Sang. I've spoken to Dr. Reister. I've spoken to Dr. Puga. I've spoken to Dr. Ashley. I've spoken to Dr. Post. I've spoken to everybody that's willing to listen. I've spoken to Dr. Hinton. I've spoken to everybody.
Q. Okay. To your knowledge, have any of those conversations been an actual evaluation for surgery?
A. No.

Q. Okay. Do you know if anybody has reached a conclusion that you are appropriate for surgery?

A. Dr. Sang said that she was approving me for surgery and that she wanted to schedule me to go out to be evaluated for surgery, but then Dr. Reister stopped her.

Q. Have you talked to Dr. Reister about that?

A. Dr. Reister came to this prison and spoke to all the trans men, but would not talk to me.

Q. Okay. Was it Dr. Sang who told you that Dr. Reister stopped her?

A. Yes. She told me that she was prepared to have me sent out and evaluated for surgery and scheduled, but that Dr. Reister said he wanted her to wait until he could speak to me.

Q. Do you know when that was?

A. She told me this in June.

Q. And you have not spoken to Dr. Reister since then?

A. No.

Q. What property have you had access to -- have you been able -- What have you been able to buy on the commissary that you were not able to buy before you came to Logan Correctional Center?

A. Makeup, female cosmetics, and perfume.

Q. That's all sold through the commissary at Logan?

A. Yes.

Q. Is there anything else you've been able to buy that you were not able to buy at Pontiac?

A. Perms, a lot of hair care products and stuff like that.

Q. Has what's been available on commissary changed since you've been at Logan or is it the same as when you first arrived?

A. I mean, different items become available at different times, yes, but, basically, the female products are still the same. The female products haven't changed.

Q. Has the clothing that you're able to wear changed since you've been at Logan?

A. The clothing that I'm able to wear?

Q. Yes.

A. Versus the clothing I was able to wear in the men's prison?

Q. Yes?

A. Yeah. Like, these are -- jogging pants and stuff, these are female jogging pants and female shoes, you know, stuff like that.

Q. What makes them female jogging pants as opposed to male or unisex jogging pants?

A. Because they fit different. Men's pants fit different; they're cut different. Female pants, they hug, they show your figure, your shape. Men don't want pants that's going to show off their body, they butt, and everything like that. Like, if you put on some female jogging pants, I don't think you're going to like how they fit you.

Q. What's the difference between male and female shoes?

A. It's not really a big difference between male and female shoes. It's just -- for me, I just -- like, it's a psychological thing. You know, it's a psychological thing.

Like, it's just a psychological thing, knowing that I have female clothes on versus having men's stuff on. It's reassuring to me. But some of the female shoes do look different than the men's shoes.

Q. Different in what way?

A. In, like, the styles. Some female shoes are made to look cuter versus, like, men's shoes are made -- some men's shoes are made to look more like functional or sporty, and some female shoes are made to look more cute and, you know, stuff like that.

Q. Is there any other property that you need for social transitioning that you do not have access to at Logan?

A. That I need?

Q. Yes.

A. I can't say that there's any other thing that I need. There may be some things that I would like. Like, because -- like, I feel, like, inadequate without it because it's a problem. Like, the main thing that I would want because -- like, okay. I feel like there's going to be issues with -- Like, you

Page 45

got people who are in different situations than I am. Like, I don't grow a lot of facial hair. I don't grow a lot of body hair. You see what I'm saying? But you got other people that are way more masculine than I am and they have a lot more different needs than I have. See what I'm saying?

You got some trans women who -- like, hormones does not stop -- does not replace male pattern baldness. It will stop hair that you already lost. Like, you won't grow back the hair that you lost, but you won't lose any more hair. You see what I'm saying?

But at the same time, hair can be a big factor in making you feel feminine. It can be a big part of how you feel. And when you walk around a female prison and you see all these girls that got this long hair and then you sit up here with a bald-head and you're like: I'm bald-headed and look like a man and my hair fell out.

That's going to be a problem for other people when you got them transitioning to female and they're probably bald-headed and

Page 46

they transitioning from female. I think they might want wigs or something like that.

It's not a problem for me because my hair grows. My hair grows as long as I want it to grow. I'm just saying that would be an issue. I know because I had a friend who was in a men's prison and she started taking hormones and she was trying to transition, but no matter what she did, she felt inadequate because she had went bald and she didn't feel like a woman and she killed herself.

And I know that's a major insecurity that some people cannot overcome. Your hair plays a major part in how you feel as a woman. I feel like, you know, I don't want to be bald-headed, you know. So that's a big thing. Your hair has a lot to do with how you feel as a woman.

Q. Are hair removal products available at Logan?

A. Hair removal products are available, yes.

Q. Is that just razors or is it other things?

Page 47

A. Razors. Yeah, razors and (inaudible) shave are available.

Q. How are strip-searches done at Logan?

A. Are you asking like what the routine is like, or are you asking by who?

Q. Who does a strip-search of you?

A. Females.

Q. Do men ever do strip-searches of you?

A. No. If I was sent to a men's prison, a man would strip-search me.

Q. That's the way it was the last time you were at a men's prison, right?

A. Yes.

Q. Do you experience misgendering at Logan Correctional Center?

A. Sometimes.

Q. How common is it?

A. It's not as common as it was in the men's prison, but it still happens from time to time.

Q. Has the frequency changed since you arrived at Logan until today?

Page 48

A. I mean, like, you have some officers that are just assholes, like, that are just jerks who refuse to see me as a woman, who, every time they see me, they call me Mr. Patterson or Andre or things like that. And they know that I identify as female. And I just try not to let it get under my skin, you know, but it's not something that the majority does. I still experience misgendering on a daily basis, depending on which officer I encounter.

Q. Do the officers who do the misgendering, do they do it in front of their superior officers or the administrators or do they only do it when it's just them talking to you?

A. Sometimes, it will be some of the superior officers that do it.

Q. Sergeants do it?

A. There has been a sergeant that does it.

Q. Are there lieutenants who do it?

A. No.

Q. Majors? Any majors that do it?

A. No.
Q. And are there any wardens or assistant wardens who do it?
A. No.
Q. Does anybody on the medical or mental health staff do it?
A. There's a dentist that does it.
Q. You said dentist, right?
A. Yeah.
Q. Is that just a man or a woman?
A. A woman. Well, I think she's a woman. I'm not sure.
Q. Does she misgender you in front of other people or just when she's talking just to you?
A. In front of other people.
Q. Who has she done it in front of?
A. I don't know. I don't keep track of stuff like that. I'm so used to being misgendered that I don't keep track of dates and locations. It's a part of my every-day. I've been locked up 15 years. I've been transgender my whole life. I'm going to get misgendered. I'm going to get disrespected.

They're going to look at me as -- I'm used to these things. I don't expect to be not misgendered. When they do it, it's an irritant.
Maybe one of these days, I will be treated like a human person, you know, but I expect it. So I don't remember: Oh. On this day and this time, I was misgendered. I don't even file grievances on that stuff because I would be filing grievances every day, you know? It's pointless.
Q. When you write grievances, do you write them yourself?
A. Yes.
Q. Do you keep copies of the grievances you file?
A. Usually.
Q. Do you keep any other kind of notes about what's going on and how you're treated in prison?
A. I have a couple things, like some witness signatures, things that they've witnessed.
Q. Are those things you have given to

the Department of Corrections or things you have the only copy of?
A. Things that I have shown to the Department of Corrections.
Q. But you haven't made those part of a grievance or anything?
A. No.
Q. Do you keep any kind of a journal or diary or anything?
A. No.
Q. Do you keep a calendar where you keep track of the days where things happen?
A. No, I don't calendar. I have been locked up 15 years. One thing I learned about a calendar and when you have time like I have, it makes you feel every day; your time goes by too slow, so I don't use calendars.
Q. Do you have anybody that you write letters to who are on the outside?
A. Yes.
Q. Do you ever talk about your experiences as a transgender woman in the Department of Corrections in those letters?
A. Sometimes.

Q. Do you keep copies of those letters?
A. No.
Q. You mentioned specifically a transgender woman who you thought needed a wig and eventually killed herself. Are there other transgender women with whom you discuss your experiences and their experiences in the Department of Corrections?
A. Yes.
Q. Right now, you're the only transgender woman at Logan; is that correct?
A. Yes, that is.
Q. So what other transgender women have you discussed your experiences with?
A. In Logan?
Q. Well, before Logan because there isn't anybody else at Logan.
A. Before I came to Logan, I used to help all the girls with their transition, all of them. In every prison I was at, they all looked up to me because I was the first one to get hormones, so I used to teach them how to get hormones and everything. I used to help them with their transition. I used to help

Page 53

them work on their voices and how to make makeup and everything. I used to help them, so they all looked up to me, so ...

Q. When you say you helped them know how to get hormones, what was it that you told them?

A. The appropriate procedures to go through, how to file the grievances and get everything rolling.

Q. Have you spoken to Marilyn Melendez about your experiences as a transgender woman?

A. Yes.

Q. What discussions did you have with her?

A. I don't recall specifically.

Q. Have you talked to her about this case in particular?

A. Have I talked to her about this case in particular?

Q. Yes.

A. I don't know. I think we probably spoke about it a little bit. I'm not sure.

Q. Do you remember anything that you talked to her about?

Page 54

A. Mostly, about surgeries and my hope for the future.

Q. Have you talked to Lydia Helena Vision about this case?

A. No.

Q. Do you know her at all?

A. No.

Q. Have you talked to Sora Kuykendall about this case?

A. No.

Q. Do you know her at all?

A. No.

Q. And have you talked to Sasha Reed about this case?

A. No.

Q. Do you know her at all?

A. I don't believe so.

Q. Have you ever met Director Jeffreys?

A. No.

Q. Have you ever had any type of communication with Director Jeffreys?

A. No.

Q. What about former Director Baldwin? Did you ever talk to him?

Page 55

A. I don't believe so.

Q. Have you met Dr. Bowman?

A. Dr. who?

Q. Dr. Bowman.

A. I don't think so.

Q. Did you ever meet Dr. Meeks when Dr. Meeks worked for the Department?

A. Yes, I believe so.

Q. Do you know when you met Dr. Meeks?

A. No. I believe that was a long time ago.

Q. Did you discuss your transgender status with Dr. Meeks?

A. I believe so.

Q. Do you remember anything that you talked specifically to Dr. Meeks about?

A. No.

Q. And you said you spoke to Dr. Hinton. How often have you spoken to Dr. Hinton?

A. I've known Dr. Hinton since Dr. Hinton worked at Dixon, so I've spoken to Dr. Hinton on numerous occasions. So I've spoken to him several times.

Page 56

Q. When was the most recent time you spoke to Dr. Hinton?

A. The last time I spoke to Dr. Hinton was, I believe, last year when Warden Austin was here. He came down here to visit me.

Q. And did you discuss your treatment for gender dysphoria with Dr. Hinton?

A. No, no. We discussed behavior. That's what we discussed.

Q. So the way you were behaving; is that what you were discussing?

A. Yes.

Q. And what was the result of that discussion? Did it affect how you behaved after that?

A. This is the thing: When I came down here, I will admit I had a lot of anger in me because I was just raped by a male officer, and I was very what they call hypervigilant, as it says in my record.

So when the officers were disrespecting me and verbally abusive to me, I was not able to respond and hold my tongue the way that I should have been able to do, you

Page 57

know, because I was just assaulted by an officer and then I was assaulted by his coworkers. So I wasn't able to told my tongue because I felt like if I took it, it was going to lead to me being assaulted or something even worse again. I wasn't going to open the door for me to be victimized even more, you know.

But, since then, I have not been giving into the bait. I've had officers try to fight me. Recently, I've had officers try to fight me. I've had a supervisor try to fight me. I've had people come up in my face and call me (inaudible) bitches and get up in my face, and I walked the other way.

You know, Officer Ledbetter came up in my face to try to fight me, and I literally ran to the door and got Lieutenant Armstrong and Sergeant Schrock to come onto the deck so they could break it up and get him because he was trying to fight me. You know what I'm saying? So I've been doing the right thing. This has been for the last five months. I've been doing better. I'm in school. I'm working on myself, you know, so ...

Page 58

Q. So it seems like your time at Logan Correctional Center is a better experience right now than it was when you started; is that right?

A. It's a better experience than it was when I started? I wouldn't say that because it's -- the only thing that's better is that the officers -- the majority of the officers have gotten to know me as an individual. You still got a couple officers that are assholes, but the majority of the officers have gotten to know me and we have got an understanding and a respect for each other. You see what I'm saying?

But the administration is my main problem right now with the wardens and the doctors; they're singling me out, and they've made me a target for the other girls. They've made me a target because they refuse to house me normally. So now everybody sees me as a target for these PREAs because they refuse to house me outside of the D wing. So people use me to get moved off D wing. And it's still going on. People file false PREA after false

Page 59

PREA after false PREA. And it irritates my soul because I'm a rape victim. I've been raped multiple times since I was four. To have people lying on me and saying I'm a rapist or I'm assaulting them or I'm saying things to them, that irritates my soul because the last thing I would ever do is victimize someone else because I know what that feels like.

But the administration has made me this target because the girls see PREA as a tool that they can use to get moved to their girlfriend. That's what they use PREA for down here. That's why this prison probably has one of the highest PREA rates than anything because they use PREA to get moved.

When you're in a house, you get into it with somebody, they use PREA to get that person moved or to get theirself moved to they girlfriend. You're some place you don't want to be, PREA to get moved. That's what they do. They use PREA on officers. They use PREA on inmates. That's what they do. It's a PREA game. It's all a game to them. Me, I'm just a big target because everybody knows I'm on the D

Page 60

wing; I'm not going anywhere.

Q. Have you been given a plan of what you need to accomplish or what you need to do in order to get off of D wing?

A. They had told me that if I did anger management and a PTSD group, that I would get moved off of the D wing, but then this COVID stuff happened and they stopped all the groups, so then I'm like: Okay. We only had two weeks left in the groups. I should have got moved.

But they refused to move me. And I thought that's unfair. Y'all just holding me. So now they're starting the groups back up. But my thing is this: I talked to Dr. Post and she says that even when they finish these groups, she don't know if they're going to move me or not. So, now, they're going back on what they initially said because they told the judge in Federal Court that I was in a step-down program, like every other inmate on the D wing. Every other inmate has to go 30 days without a ticket and then they get moved. They said I was in a step-down program. But then I'm like: Okay. I was doing the groups.

Then a reasonable person would say: The groups is cancelled. Patterson has been doing good.

I'm staying out of trouble, I'm in school. Everybody knows my behavior has been different. "Put Patterson on grounds."

They're not doing that, though. They're holding me because they want to irritate me. They want to provoke me. They want a reaction because they don't want my transition to work. They don't want to see me successful.

Q. After the groups were cancelled because of quarantine, was anybody moving off of D wing or was everybody staying at their current assignment during the quarantine?

A. We're still on quarantine.

Q. Right. Were people being moved off of D wing during that time?

A. Yes. People are still being moved. People are still being moved. I'm the only one that's not being moved.

Q. You said you haven't been to seg since April. Have you received a ticket since

then?

A. Yeah, I received a minor ticket.

Q. When was the last time you received a ticket?

A. I don't know the exact date, but if you was to talk to Lieutenant Armstrong, if you was to talk to Sergeant Schrock, they can tell you that same ticket should have been thrown out. I told you I don't really get tickets. That was a false ticket.

Officer Ledbetter tried to fight me. I literally ran to the door and got the sergeant to come on the deck because he was trying to fight me. And he wrote me a false ticket, and they found me guilty of the ticket. The lieutenant and the sergeant can vouch for me because they wrote reports in my favor, but the committee is so biased against me that they find me guilty of virtually everything almost.

Q. What were the charges on that ticket?

A. He wrote me a ticket for intimidation and threats. They found me guilty of insolence. They reduced it to insolence.

They always got to find me guilty of something.

Q. Has there been a time when you went 30 days without a ticket since --

A. There's been times when I went months without a ticket.

Q. Since April of this year, have you had a 30-day stretch with no tickets?

A. Yes.

Q. You mentioned that you spoke to Dr. Puga. When was the last time you spoke to Dr. Puga?

A. I don't know. That time, I was in the health care.

Q. You haven't spoken to him since about surgery?

A. No.

Q. Have you met Dr. Conway since she started with the Department of Corrections?

A. No.

MR. HIGGERSON: That is all the questions that I have.

MS. WALD: And I don't have any redirect. We'll reserve signature.

(Witness excused, 10:45.)

UNITED STATES OF AMERICA)
SOUTHERN DISTRICT OF ILLINOIS)
EAST ST. LOUIS DIVISION) SS.

STATE OF ILLINOIS)
COUNTY OF COOK)

I, Alyssa N. Kuipers, Certified Shorthand Reporter, Registered Professional Reporter, do hereby certify that ANDRE PATTERSON a.k.a JANIAH MONROE was first duly sworn by me to testify to the whole truth and that the above deposition was reported stenographically by me and reduced to typewriting under my personal direction.

I further certify that the said deposition was taken at the time and place specified and that the taking of said deposition commenced on the 24th day of August, 2020, at 9:26 a.m.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties, nor a relative or employee of such attorney or counsel, nor financially interested directly or indirectly in this action.

I witness my official signature on this 10th day of September, 2020.

____

ALYSSA N. KUIPERS, CSR, RPR

CSR No. 084-004857

ALARIS LITIGATION SERVICES

September 10, 2020

ACLU OF ILLINOIS
MS. CAROLYN WALD
150 NORTH MICHIGAN AVENUE
SUITE 600
CHICAGO, ILLINOIS 60601

IN RE: JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED v. ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN

Dear MS. CAROLYN WALD:

Please find enclosed your copies of the deposition of ANDRE PATTERSON a.k.a JANIAH MONROE taken on August 24, 2020 in the above-referenced case. Also enclosed is the original signature page and errata sheets.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheets and notarized signature page within 30 days to our office at 1608 Locust Street, Kansas City, MO 64108 for filing.

Sincerely,

ALYSSA N. KUIPERS

Enclosures

ERRATA SHEET

Witness Name: ANDRE PATTERSON a.k.a JANIAH MONROE

Case Name: JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED v. ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN

Date Taken: AUGUST 24, 2020

Page #_____ Line #_____
Should read: ______________________________
Reason for change: ______________________________

Page #_____ Line #_____
Should read: ______________________________
Reason for change: ______________________________

Page #_____ Line #_____
Should read: ______________________________
Reason for change: ______________________________

Page #_____ Line #_____
Should read: ______________________________
Reason for change: ______________________________

Page #_____ Line #_____
Should read: ______________________________
Reason for change: ______________________________

Witness Signature: ______________________________

STATE OF ______________)

COUNTY OF ______________)

I, ANDRE PATTERSON a.k.a JANIAH MONROE, do hereby certify:

That I have read the foregoing deposition;

That I have made such changes in form and/or substance to the within deposition as might be necessary to render the same true and correct;

That having made such changes thereon, I hereby subscribe my name to the deposition.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this _____ day of ______________, 20___, at ________________________.

____

ANDRE PATTERSON a.k.a JANIAH MONROE

____

NOTARY PUBLIC

My Commission Expires:

Exhibit 7

ILLINOIS DEPARTMENT OF CORRECTIONS
Mental Health Progress Note
LOGAN CORRECTIONAL CTR Center

07/24/2020 08:22

Offender Information			
PATTERSON	ANDRE		ID#: y35508
Last Name	First Name	MI	
Race: B	Gender: male	Date of Birth: 07/23/1989	

0502 PROGRESS NOTE:

Date: 7/24/20 Start Time: 0845
Diagnosis:

Mental Health:
Unspecified Anxiety Disorder First Observed 4/25/2019 09:56PM
Unspecified Depressive Disorder First Observed 4/25/2019 09:56PM
Borderline Personality Disorder First Observed 4/25/2019 09:57PM
Bipolar I Disorder, Most Recent Episode (or Current) Depressed, Moderate First Observed 5/1/2019 02:01PM

Not Specified:
Unspecified Gender Dysphoria First Observed 4/1/2019 02:59PM
Nausea And Vomiting First Observed 5/17/2019 06:28PM
Constipation First Observed 5/23/2019 02:39PM
Anemia First Observed 6/3/2019 08:56PM
Personal History Of Self-harm First Observed 7/6/2019 04:26PM
Fever First Observed 2/11/2020 01:16PM

Medications: SPIRONOLACTONE 100 MG TABS, 1 TABS ORAL(po) TWICE DAILY
ESTRADIOL CYPIONATE 5MG/ML ML, 5 MG INTRA-MUSC EVERY 2 WEEKS
GEODON 60 MG CAPSULE, 1 CAPS ORAL(po) BEDTIME
MIRTAZAPINE 15 MG TAB, 1 TABS ORAL(po) BEDTIME
CARBAMAZEPINE 200 MG TAB, 1 TABS ORAL(po) TWICE DAILY
GEODON 20 MG CAPSULE, 1 CAPS ORAL(po) DAILY
TOPAMAX 50 MG TAB, 1 TABS ORAL(po) TWICE DAILY
FLUOXETINE HCL 20 MG CAPSULE, 1 CAPS ORAL(po) DAILY

Allergies or medication sensitivities? No ☐ Yes ☒ If yes, then describe:
Allergies: Fish Containing Products
Scheduled Visit Type: Routine Follow Up ☒ Complex Follow Up Evaluation ☐
Level of Care: Outpatient ☒ Residential Treatment Unit ☐ Inpatient ☐ Crisis ☐
Type of Visit: Telepsychiatry ☐ Onsite Evaluation ☒ Other ☐ (identify):
Has offender been on Crisis Watch since last psychiatric visit? No ☒ Yes ☐
If yes, explain:

Source of Information: (check all that apply)
☒ Offender ☐ Mental Health Staff ☐ Medical Staff ☐ Mental Health Progress Notes
☐ Medical Progress Notes ☐ Mental Health Evaluation dated:
☐ Crisis Records ☐ Other (identify):
☒ Previous Psychiatric Progress Note

Subjective/Objective

ILLINOIS DEPARTMENT OF CORRECTIONS
Mental Health Progress Note
LOGAN CORRECTIONAL CTR Center

07/24/2020 08:22

Offender Information			
PATTERSON	ANDRE		ID#: y35508
Last Name	First Name	MI	
Race: B	Gender: male	Date of Birth: 07/23/1989	

Patient here for follow up. She says that she is upset about her tegretol being crushed. She denies that she is cheeking or selling her tegretol although level is less than two. She says that she is not in a good mood because she is still on D wing. She is taking her other medictations but not the crushed tegretol. She is really down about the D wing issue. She is starting to get triggered and is having night terrors again. No SI. No HI. No A/V hallucinations. She feels like her medications are okay if she can get the tegretol uncrushed. Appetite has not been the greatest and she says that the chow hall food makes her sick. Patient becomes upset during end of visit and gets up and leaves because she needs to get her hair done and be in day room.

LIST CURRENT PSYCHOTROPIC MEDICATIONS:

Geodon 20 mg q 2 pm, 60 qhs
Remeron 15 qhs
Tegretol 200 bid-has not been taking since crushed
Topamax 50 bid
Prozac 20 qday

☐ **Check if none**

Pertinent medical medications:

Compliance: ☐ Good ☐ Poor (list details) see above
Side effects: ☒ None ☐ Yes (list details)
MAR reviewed: Yes ☒ No ☐
Is offender currently prescribed Involuntary Psychotropic Medication(s)? Yes ☐ No ☒
Lab Results: Comment on abnormal results and include drug levels: Non ordered ☐
tegretol level 7/23/19=<2.0; will check when last flp and a1c as results do not come up in computer

Medical/Mental Health – Female Specific: ☒ Not applicable

Is the offender currently pregnant? No ☒ Yes ☐ - expected due date:

Mental Status Examination

Posture/Gait: ☒ Appropriate ☐ Inappropriate ☐ Slumped ☐ Tense ☐ Atypical ☐ Rigid ☐

Behavior: ☒ Unremarkable ☐ Poor physical boundaries ☐ Posturing aggressively ☐ Tensed muscles ☐ Closed body posture ☐ Guarded/protective posturing ☐ Psychomotor retardation ☐ Psychomotor agitation ☒ irritated

Eye Contact: ☒ Appropriate ☐ Avoids eye contact ☐ Looks down in his/her lap ☐ Timid ☐ Unfocused ☐

Level of appearance: ☒ Appropriately groomed ☐ Disheveled ☐ Poor hygiene ☐ Malodorous ☐

Level of consciousness: ☒ Alert ☐ Clouded consciousness ☐ Lethargic ☐ Delirious ☐ Somnolent ☐

Level of cooperation: ☒ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative ☐

DOC 0502 (Rev. 1/2019)

ILLINOIS DEPARTMENT OF CORRECTIONS
Mental Health Progress Note
LOGAN CORRECTIONAL CTR Center

07/24/2020 08:22

Offender Information			
PATTERSON	ANDRE		ID#: y35508
Last Name	**First Name**	**MI**	
Race: B	Gender: male	Date of Birth: 07/23/1989	

Orientation:	☒ Ox4 (Time, place, person, reality) ☐ OX (list:) ☐ Disoriented
Attention:	☒ Appropriately focused ☐ Selective attention/inattention ☐ Distractible ☐ Unaware ☐
Speech:	☒ Unremarkable ☐ Slowed ☐ Rapid ☐ Inarticulate ☐ Pressured ☐
In tone:	☒ Unremarkable ☐ Impatience ☐ Irritability ☐ Terse ☐ Flatted tone ☐
Thought processes:	☐ Circumstantial ☐ Disorganized ☐ ☒ Clear/coherent ☐ Tangential ☐ Loose association ☐ Word Salad/Incoherent
Thought content:	☒ Unremarkable ☐ Paranoid ☐ Delusional ☐ Excessive religiosity ☐ Referential ☐
Explain:	
Perceptions	☐ Hallucination ☐ Auditory ☐ Visual ☐ Olfactory ☐ Somatic ☐ Illusions
Explain:	
Affect:	☐ Unremarkable (Euthymic) ☐ Constricted ☐ Expansive ☐ Blunt/Inexpressive ☐ Flat ☐ Hyperthymic ☐ Euphoric ☐ Dysthymic ☐ Manic ☐ Appropriate ☐ Inappropriate ☒ slightly irritated
Mood:	☒ Euthymic ☐ Dysthymic ☐ Anxious ☐ Fearful ☒ some mild feeling down due to placement
Suicidal ideation:	☒ None ☐ Yes, details:
Homicidal ideation:	☒ None ☐ Yes, details:
Memory:	Short–term ☒ Intact ☐ Long-term ☒ Intact ☐
Estimated Intelligence:	☐ Above average ☒ Average ☐ Below average
Insight:	☐ Adequate ☐ Poor ☒ fair
Judgment:	☐ Adequate ☐ Poor ☒ fair
Motivation:	☐ Good ☒ Adequate ☐ Poor ☐
Historian:	☒ Reliable ☐ Poor ☐ Inconsistent ☐ Unable to assess at this time

Diagnoses

Psychiatric Diagnosis: BPAD, gender dysphoria, anxiety unspecified

Medical Diagnosis: see above

Based upon today's evaluation: Since last visit, offender's psychiatric symptoms have:	Improved ☐ Remained same ☐ Worsened ☐

Modified Global Assessment 50 **to** 55

Based upon diagnosis, Modified GAF and need for supportive services, Offender is designated SMI? Yes ☒ No ☐

Narrative Summary

Patient continues with feelings of frustration that she is being discriminated against and kept on D wing. Since having tegretol crushed has wanted to just stop all psychiatric medications. Denies cheeking or selling the medication and says that levels of hormones have not been where they need to be either with the tegretol. Although level less than two, will keep her on the tegretol and uncrush it giving her the benefit of the doubt at this time. Overall, mood is relatively stable and she is coping with things. Will continue medications and will continue to monitor closely. Blood pressure

DOC 0502 (Rev. 1/2019)

ILLINOIS DEPARTMENT OF CORRECTIONS
Mental Health Progress Note
LOGAN CORRECTIONAL CTR Center

07/24/2020 08:22

Offender Information

PATTERSON	. ANDRE		ID#: y35508
Last Name	First Name	MI	

Race: B Gender: male Date of Birth: 07/23/1989

has been running high and will refer to medical.

13. Psychiatric Plan

Psychotropic Medication: ☐ Started ☐ Discontinued ☐ Changed

☒ Continue Current Medication

☐ Medication specifics and rationale:

Stopped Meds:

CARBAMAZEPINE 200 MG TAB 43353095353 06/08/2020 09:23
1 TABLETS ORAL(po) TWICE DAILY x 60 Days
Special Instructions:Give With 100mg To =300mg Bid
STOP DATE: 07/24/2020 08:57 REFILLS:

FLUOXETINE HCL 20 MG CAPSULE 65862019399 06/18/2020 14:51
1 CAPSULES ORAL(po) DAILY x 60 Days
STOP DATE: 07/24/2020 08:57 REFILLS: 0

GEODON 20 MG CAPSULE 00049396060 06/18/2020 14:50
1 CAPSULES ORAL(po) DAILY x 60 Days
Special Instructions:Give At 2pm Daily
STOP DATE: 07/24/2020 08:57 REFILLS: 0

GEODON 60 MG CAPSULE 00049398060 06/08/2020 09:21
1 CAPSULES ORAL(po) BEDTIME x 60 Days
STOP DATE: 07/24/2020 08:57 REFILLS: 0

MIRTAZAPINE 15 MG TAB 00378351593 06/08/2020 09:21
1 TABLETS ORAL(po) BEDTIME x 60 Days
STOP DATE: 07/24/2020 08:57 REFILLS:

TOPAMAX 50 MG TAB 54868534301 06/18/2020 14:51
1 TABLETS ORAL(po) TWICE DAILY x 60 Days
STOP DATE: 07/24/2020 08:57 REFILLS:

Reordered Meds:

CARBAMAZEPINE 200 MG TABS 43353095353 07/24/2020 08:56
1 TABLETS ORAL(po) TWICE DAILY x 60 Days
Special Instructions:Okay To Give Not Crushed
STOP DATE: 09/22/2020 08:56 REFILLS:

FLUOXETINE HCL 20 MG CAPSULE 65862019399 07/24/2020 08:57
1 CAPSULES ORAL(po) DAILY x 60 Days
STOP DATE: 09/22/2020 08:57 REFILLS: 0

GEODON 20 MG CAPSULE 00049396060 07/24/2020 08:57
1 CAPSULES ORAL(po) DAILY x 60 Days
Special Instructions:Give At 2pm Daily
STOP DATE: 09/22/2020 08:57 REFILLS: 0

GEODON 60 MG CAPSULE 00049398060 07/24/2020 08:55
1 CAPSULES ORAL(po) BEDTIME x 60 Days
STOP DATE: 09/22/2020 08:55 REFILLS: 0

MIRTAZAPINE 15 MG TAB 00378351593 07/24/2020 08:55
1 TABLETS ORAL(po) BEDTIME x 60 Days
STOP DATE: 09/22/2020 08:55 REFILLS:

TOPAMAX 50 MG TAB 54868534301 07/24/2020 08:57

DOC 0502 (Rev. 1/2019)

ILLINOIS DEPARTMENT OF CORRECTIONS
Mental Health Progress Note
LOGAN CORRECTIONAL CTR Center

07/24/2020 08:22

Offender Information			
PATTERSON	ANDRE		ID#: y35508
Last Name	First Name	MI	
Race: B	Gender: male	Date of Birth: 07/23/1989	

1 TABLETS ORAL(po) TWICE DAILY x 60 Days
STOP DATE: 09/22/2020 08:57 REFILLS:

☐ AIMS completed today ☐ AIMS to be done by RN (if available)

☐ Labs ☐ CMP ☐ BMP ☐ CBC+Plts ☐ Thyroid Profile ☐ Lithium ☐ Carbamazepine
☐ VPA ☐ Lipid Profile ☐ A1C ☐ EKG ☐ Other: Other:

☐ Abdominal circumference: ☐ BMI ☐ BP/P

☐ Fill in values and measurements on Metabolic Monitoring form:
☐ Needs medical referral for:
☐ Needs MHP referral (Complete DOC 0387) for:

☐ Sleep hygiene ☐ Anger management ☐ Trauma history ☐ Psychometric testing
☐ Other:
☐ Crush/float all Psychotropics due to ☐ Hx of non-compliance ☐ Hx of hoarding medications
☐ Abuse Potential ☐ Other:

☒ Offender has been given a copy of the Psychotropic Medication Information brochure.

☒ I have verbally reviewed any medication changes, side-effects, risks and benefits of treatment or refusing treatment with the offender

☐ Offender's psychiatric condition has been stable on the same psychotropic medication(s) at the same dose for the past 60 days – may be seen max OP – 3 months, RTU – 2 months, Enforced – 1 month.

☐ The offender has signed his/her Medication Consent Form

☐ Treatment plan update needed based on change of diagnosis, direction of treatment, etc. (DOC 0546)

Designation: ☒ SMI ☐ Enforced Psychotropic to be continued (based on clinical need)
☐ Other: (identify):

Disposition (Level of Care)

☒ Outpatient Level of Care ☐ Residential Treatment Unit ☐ Inpatient ☐ Crisis

Next Appointment Date: 3-4 weeks

Evaluation completed by:

Daphne Maurer		**Psychiatry**
Print Name	**Signature**	**Title**
7/24/20	**0900**	
Date	**End Time**	

Electronically Signed by MAURER, DAPHNE M.D. on 07/24/2020.
##And No Others##

DOC 0502 (Rev. 1/2019)

Exhibit 8

MARILYN MELENDEZ 8/20/2020

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.) No. 18-156-NJR

ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN,)

Defendants.

The videoconference deposition of MARILYN MELENDEZ, called by the Defendants for examination, taken pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before Verla A. Todd, Certified Shorthand Reporter in and for the State of Illinois, CSR License No. 084-003498, taken via Webex on the 20th day of August, 2020, commencing at approximately 9:10 a.m.

APPEARANCES

KIRKLAND & ELLIS, LLP, by
SAMANTHA G. ROSE, Esq.
300 North LaSalle Street
Chicago, Illinois 60654
(312) 862-4026
sam.rose@kirkland.com
Appeared on behalf of the Plaintiffs

KWAME RAOUL, ATTORNEY GENERAL, STATE OF ILLINOIS, by
LISA A. COOK, Esq., AAG
500 South Second Street
Springfield, Illinois 62701
(217) 782-4445
lcook@atg.state.il.us
Appeared on behalf of the Defendants

INDEX TO TRANSCRIPT

INDEX TO EXHIBITS

ID

NONE MARKED

(Witness sworn)

MARILYN MELENDEZ,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. COOK:

Q. Ms. Melendez, you know you are here for a deposition in a lawsuit that you are a party to in the Southern District of Illinois, correct?

A. Yes, ma'am.

Q. And can you go ahead -- just so the record is clear, can you state and spell your legal name?

A. My legal name is XXX Rico Melendez, X-X-X-X-X, R-I-C-O, M-E-L-E-N-D-E-Z

Q. And, Ms. Melendez, what name do you go by?

A. Marilyn.

Q. And can you spell that, too?

A. M-A-R-I-L-Y-N.

Q. And I did see in some of your records your name was noted as Maryland, like the state. You're looking confused. Would that -- to your knowledge would that have been a mistake?

A. Probably.

Q. Have you ever had your deposition taken before?

A. No, ma'am.
Q. I'm sure that you've spoken with your attorney about this, but the deposition is just my chance to ask you some questions about your lawsuit. The court reporter is taking down everything that we say on the record. If you don't understand a question that I ask you, please let me know, and I will rephrase it. Do you understand that?
A. Yes, ma'am.
Q. And if you need a break or we need to stop for some reason, please let me know that as well, okay?
A. Okay.
Q. And you're doing a great job, but the important thing is to speak clearly and hopefully we can wait for each other to finish speaking so that the court reporter can take down everything that we're saying accurately, okay?
A. Um-hmm.
Q. And when you answer a question, I will ask that you say yes or no because um-hmm or uhn-uhn, they look funny when you read them. They look the same. So if I follow up and say was that a yes, it's just to make sure that the record is clear, okay?
A. Okay.
Q. Thank you.

And I note that -- so you gave testimony for this lawsuit in court in July of last year, so this is similar to that. I ask you questions and you give me whatever answers you're able to. But just like being in court, you are now under oath. Do you understand that?
A. Yes, I do.
Q. Again, I'm going to try to avoid overlapping with the questions that I already asked you. There may be a bit of repetition there, but I'm going to avoid going through all of that again, okay?
A. Yes.
Q. So to prepare for your deposition today, were you able to speak with your attorneys?
A. Yes, I was.
Q. And did you review any documents to prepare for today?
A. No.
Q. I want to start by asking you just some general questions about your backgrounds. I'm not going to spend too much time on this, but I just want to get a sense of some of your history.
So starting with your education background, have you received your GED?
A. No.
Q. Have you started classes towards obtaining

that?
A. When I was in Menard prison, I tried, but they said that I had too much time to qualify for classes like that since I was in the max cell house, and then Stateville didn't offer it and Pontiac doesn't have any school unless you go to the MSU.
Q. And are you eligible to go to the MSU?
A. I put in before. They've denied me.
Q. Do you -- you were incarcerated very young, correct, Ms. Melendez?
A. Yes.
Q. Aside from trying to finish your GED, have you been able to take any other classes or educational programs while you've been incarcerated?
A. I have attempted to getting them, but I'm always shot down. Either it's time or the case that I have or the prison that I'm in or housed. So it's something that stopped me from getting education.
Q. Other than this lawsuit that we're discussing today, have you filed any other civil lawsuits?
A. No.
Q. And the crimes you are incarcerated for, are those the only felonies that you have?
A. Yes.
Q. And what are those felonies?

A. Attempted murder and then I have -- sorry, forgive me. It's murder on the first one. Then the other case was attempted murder, and it was lowered down to aggravated battery with a firearm, aggravated battery discharge and aggravated bodily harm to a person.
Q. Do you have any misdemeanors for things like fraud or, you know, something to do with dishonesty?
A. No.
Q. In your history with the Illinois Department of Corrections, when were you first placed in the Illinois Department of Corrections?
A. Adult or including youth?
Q. Well, you can start with the youth and then when you transferred to the adult prison.
A. In 2010 I believe I was sent to St. Charles in around November, and then from there I was transferred to IYC Joliet. I did almost a year and a half there. And then 2011 I was sent to Stateville. I did two weeks there, and from there I was sent to Menard.
Q. And what prisons -- have you only been incarcerated in three prisons in the adult system?
A. Yes.
Q. And what are those?
A. The three max prisons, Menard, Stateville and Pontiac.

Q. How long have you been at Pontiac Correctional Center?
A. Since 2015, June.
Q. Is that the only prison you've been at since June of 2015?
A. Yes.
Q. Have you been placed in protective custody at Pontiac Correctional Center?
A. Yes.
Q. Are you in protective custody now?
A. No.
Q. Where are you housed now?
A. I'm currently housed in west cell house segregation.
Q. Is that for a disciplinary infraction?
A. Yes.
Q. How long have you gone been in segregation for that infraction?
A. Since the 5th of this month.
Q. So since August 5. Do you know how long your term of segregation is?
A. As of right now, no. I heard the ticket this Tuesday, and I asked them, you know, what's -- you know, what's going on. I'm pleading not guilty to one charge and guilty to the other. They said that they will get

back at me and I'll find out once they send me their summary judgment.
Q. So you had a hearing, but you haven't received the results of that hearing?
A. Exactly.
Q. Until August 5 have you been in protective custody up until that point?
A. Before this incident, yeah, I was in PC, yes.
Q. Do you know approximately how long you had been in protective custody before the disciplinary infraction?
A. Well, to be honest, it's on and off because anytime you go to seg, that PC status is revoked and if the ticket isn't expunged then you have to wait until you get out of seg and write to go to the PC approval all over again. Right before this I was over there for three months, and before that I had went to seg for another infraction.
Q. So when you've gone to segregation for disciplinary issues, have you been able to get back into protective custody after your segregation term is over?
A. Yes.
MS. ROSE: Objection.
BY MS. COOK:
Q. And where you're housed right now currently,

do you have a cellmate?
A. No.
Q. When you were in protective custody, did you have a cellmate?
A. Before yes; most recently, no.
Q. Do you remember the last time that you had a cellmate?
A. Let me see. I believe the last time was two years ago, 2018.
Q. Have you requested to have no cellmate?
A. Before, no, I was fine having a cellmate as long as I told staff like, look, if you have me down to have a cellmate and it's necessary space or whatever and I'm gonna have one, all I ask is that you take into consideration, you know, I'm transgender and you have individuals here who can be homophobic or transphobic or whatever reason that they don't want to be in the cell with me, and I told them like just don't put me in a situation where they come in here and either they want me to walk myself and go to seg or they try to be aggressive and then we end up fighting or you try to put somebody who is a predator or a sexual deviant in here and they're trying to do something to me and then I defend myself and I'm going to seg for it. And, you know, some lieutenants are understanding and work with

me. Some, you know, obviously are transphobic and they just believe that I'm just in here trying to have sex. So I wrote Emily Ruskin, the warden, and said look your staff is on some, you know, issues with me, I don't know what they're on with me, I'm asking if you'll put me in a cell by myself, that way I don't have to go through these issues. Emily Ruskin, you know, helped me out and put me single cell status.
Q. And when did you write to Ms. Ruskin?
A. 2018 toward the end, I believe, December.
Q. Was Ms. Ruskin an assistant warden at that time?
A. She was the acting warden of operations, number two warden.
Q. And right now she's the top warden?
A. No. Actually the number one warden at the time Teri Kennedy, Ruskin, they -- I'm not entirely sure if they retired or they left the prison, but they don't work here anymore. We have a new warden.
Q. But Ruskin is no longer at Pontiac Correctional Center?
A. No, she is not.
Q. Do you have a copy of that letter you sent to Ms. Ruskin?
A. To be honest, I'm not entirely sure right now

Page 13

because while I'm in seg, a lot of my legal envelopes, some papers were taken. They said they were torn or altered or got thrown away. A bunch of my materials are jumbled up along with my mail. I'm still trying to sort it out.

Q. And so has anybody tried to put a cellmate in with you since 2018?

MS. ROSE: Objection, form, vague.

BY MS. COOK:

Q. Has security staff attempted to put a cellmate in your cell with you since 2018?

A. There has been a few times where they'll come by asking me if I could help them out and get a cellie since some cells obviously -- it's an old facility, either the cell leaks or something is wrong with the cell. And I will tell them like if it's somebody you'll let me recommend that I get along with, I don't have a problem, but if you're trying to throw a random individual in there, no, because, you know, that's like you're just asking me like hey can you have a cellie and I say yeah and then you put somebody in here and we end up fighting or whatever disagreement and I end up going to seg over something that they did.

Q. So what happens in that scenario?

A. Well, for one scenario, for example, they put

Page 14

me in a cell with a guy named Davonte [phonetic]. At first he seemed okay. Then eventually he started asking me disturbing sexual questions. I said look man, just leave me alone, I have to be in a cell with you, you have to be the cell, you don't have to talk to me, you can do your prison bit, I'll do mine, leave me alone. Then eventually he started saying that if I do not, forgive me, suck his dick that he will take it. So I said what are you trying to say, that you're going to rape me? And he got aggressive and tried to hit me and we fought and went to seg over that. I told staff about it because I didn't want to be in a cell with him from the beginning, but at that time it's like okay if I don't want to be in here with him, he doesn't want me, I'm not going to be the one to walk myself from [inaudible] housing and do some time in seg over this stuff that staff can easily fix. They could have easily put me in a cell with somebody else, and they chose not to. His exact words, which was Lieutenant Bennett [phonetic] at the time, he says you can either, excuse my language, fuck or fight.

Q. And when did that happen?

A. That was in 2016.

Q. And what you described earlier where staff will say hey will you help us out and take a cellmate

Page 15

right now, if you say only if I can select the inmate as my cellmate, then what does staff do then?

MS. ROSE: Objection, calls for speculation, foundation.

BY MS. COOK:

Q. You can answer if you understand.

A. I'm fine.

Q. Do you understand the question?

A. Can you rephrase the question?

Q. Sure. So let's say an officer comes up to you and asks you can you help us out and take a cellmate, we're trying to move people around right now, and you say I will only accept a cellmate if -- something like I will only accept a cellmate if I can select him and I have some input, then what does security staff do or say to you after that?

MS. ROSE: Same objections. Go ahead and answer if you understand the question.

THE WITNESS: They will either say that if I say yes that I don't get to pick and choose because either it's the fact that I don't dictate their pace, they make the rules, they set their scenarios and boundaries, or it's the other ones who say we knew you would say that sissy, you're just trying to have somebody so you can have sex.

Page 16

BY MS. COOK:

Q. Do they put -- do they end up putting somebody in with you in that scenario?

A. They have tried, but I know you can always -- in my position I've learned that I can ask for a crisis team. That way something is either documented, or mental health will explain to them, you know, I'm transgender, the issues and situation. I can ask to have a PREA filed, and then once I start doing that, they're like oh we were just playing with you. Or it's that they tried to and as the person got to my cell, I'll tell them look man, I don't know you, I don't want you in here. If you come in here, I'm letting you know. I'm not playing with the staff. I told them if anyone who's in here I'm not comfortable with, I'm not letting you in the door, get in a fight. So the person will tell the lieutenant look I'm not trying to go to seg if they're going to fight me, and they will put them somewhere else, magically find an open cell or space or cellmate or something.

Q. And has staff asked you to accept a cellmate in your cell with you since 2018?

A. They have even though they know that I am single cell status, and having that status I'm not even supposed to have a cellmate. So they shouldn't even be

Page 17

asking me that if on my paper single cell status, but that's what they do to either make room or accommodate somebody.

Q. How many times have they asked you since you've been on single cell status?

A. Four times.

Q. In those four times since 2018, have you just said no?

A. I mean, yeah. If they're not going to allow me to pick somebody that I feel comfortable with or I have known for a while, then I'm fine, don't give me a cellie. But if you're asking me to help you out, if I'm helping you out, why would you put me in a messed up situation or why would you put me in a situation that's going to be harmful to me if I'm the one helping you out?

Q. And have you been disciplined because you said no?

A. I mean, there's the occasional my cell will get shook down after it's been shaken down and stuff like that. I will go in there some stuff will be missing, you know. It's tricky. They do things in ways to punish an individual and make it seem like it's according to their 504 rules, just like this ticket that I'm in seg for.

Page 18

Q. And when you were put on single cell status, was this something that was verbally communicated to you, or did you receive a letter informing you of that?

A. No. When I wrote Emily Ruskin, they eventually have what call cadet training or tours where they have people walk galleys or floors with the staff, and she was walking by and she told me, she said hey, don't worry, you're getting your single cell status. With Emily Ruskin anything that tells you it's usually the best of her knowledge what she's doing or something that's gonna be done. So when she said it, I took her for her word and eventually -- at five gallery they have a cage where they have a board -- a dry erase board with a list of people who either have permanent cells or whatever they have, and they'll put single cell if you're not allowed to have cellies in your single cell and eventually that was put on there.

Q. And you're talking about like a dry erase board for staff?

A. Yes, so they know -- like if somebody moves from 17 cell to 20 cell, they put their name, erase it and put it here or whoever their cellie is. If they have permits, if they're handicap and stuff like that, they use that to know.

Q. I want to switch now a little bit to your past medical and mental health history. I will talk about gender dysphoria separately, but I just want to know based on your records you do have some -- a psych history; is that correct?

MS. ROSE: Objection, form, vague. You can answer if you understand nine question.

BY MS. COOK:

Q. You can answer.

A. My psych history, are you saying that I have mental illnesses or disorders or that I take psychotropic medication? I don't completely understand.

Q. Well, all of that. So you have -- have you been diagnosed with mental health or psychiatric disorders?

A. Yes.

Q. And what are those?

A. Bipolar, depression, anxiety.

Q. And when were you first diagnosed with those?

A. Bipolar and anxiety at a very early age. Depression was never actually done because, you know, as a juvenile getting in trouble at school, sometimes they will recommend that oh your child needs anger management or they need to go to therapy or counseling for their issues. And from there my mom would have me see people. That's where I was being bipolar, that I had anxiety.

Page 20

And before anything else was done, shortly afterwards I had got incarcerated.

Q. So have you received prescription medications for the diagnoses?

A. Yes. Outside of the world, yes, and then coming to prison, St. Charles and IYC Joliet said -- their exact words were since I'm a ward of the state, certain medications aren't listed on their approved psychotropics to give to inmates. So the medication I was on in the world they -- if it's not approved in here, they will not give it to me. So they gave me other medication that they deemed was necessary for me to help me with my disorder.

Q. And then what happened when you came into the adult system?

A. Basically the same thing. They said that I have a history here and they have reviewed it and said that we're going to keep the same medications that you had back then, it seems to be working fine.

Q. The same medication that you had in the juvenile system or the same medication you had in the world?

A. In the juvenile system.

Q. And what has your access to mental health staff been like for your bipolar disorder, depression

and anxiety?

A. It has been very poor, you know. You go see mental health and they deem that our session, or whatever it is, is enough to help with that when all they do is ask you how are you feeling today, what's today's date, what's your name, are you taking your meds? And you say you know the day or whatever, taking our meds. Okay, so are you feeling suicidal, do you want to kill yourself? And if you be honest and say I'm having thoughts yes, they're going to put you on watch, which shouldn't even be necessary if you don't tell staff that I'm having an issue, I'm going to kill myself or I'm not attempting to kill myself.

Q. At least, you know, in the past two years how often do you see mental health staff?

A. It's supposed to be every 30 days, you know. They'll say that they're short staffed or there's too many people on each caseload, they can't come see every person all the time. I've gone sometimes two or three months from seeing them and it's supposed to be every 30 days.

Q. In the past two years have they made any changes to your medication?

A. Upon my request, yes.

Q. Has that begun to alleviate some of your

symptoms from bipolar, depression and anxiety?

A. To an extent because the medication they had me on at first, Depakote, they draw blood for it and the dosage they put me on was so high that it was causing me to vomit, causing me to have sweats, causing my hands to tremble. The hair was thinning out and [inaudible] was difficult. I was having diarrhea, and I kept asking to have it switched. They keep refusing.

Then eventually I saw another doctor and I told him can you please issue -- because it's not working and it's causing more harm than good and he suggested lithium. They switched me to lithium, which again, another medication that I said I'll try for one month and if it doesn't work for me, take me off. They kept me on it for several months, and I gained excessive weight. I had complications with my thyroid. They make me vomit. I wouldn't feel comfortable eating. I would be -- I couldn't eat. It was just causing bodily issues as well. They did blood tests and said well it is kind of high but, you know, we think it's working, even though I'm telling them what's going on.

I saw a different doctor, Dr. Sharif [phonetic], who was more understanding, and he's like you know what, I saw the blood test, I don't why they kept you on it, I'm going to switch you over to a

different medication. Do it for 30 days and I will come see you again, and if it doesn't work, let me know and we're going to find something else. They gave me the medication. It gave me a rash. He switched to Trileptal [phonetic], which was the medication I was currently on. It was working fine, and so they discontinued it. And now they're telling me that there's only two other options. One of them was the one that gave me the rash and the other one can cause damage to your blood cells. I've tried recommending other medication. They're saying that that's not my job, that's their job.

Q. So right now you feel like you're on medication that's helping you?

A. No.

Q. Have you been designated within IDOC as seriously mentally ill?

MS. ROSE: Objection, foundation.

THE WITNESS: Yes.

BY MS. COOK:

Q. Is that something that is communicated to you?

A. At first I didn't know. This was in 2013 before that case before they actually started doing actual mental evaluations where you do seg time regardless of your diagnosis and you have to do the

whole time. I received a one year cut. I never knew why, and one time I got a ticket and they put SMI at the top corner. And I what is that, and they said oh well, that's a label that's put for people who are mentally ill. So I said MI is mentally ill? He was like yes. What's the S for? He said that's severely. Then he said they have ESMI which is extremely severely mentally ill. And I said well how am I severely ill if I'm able to understand people and communicate and my disorder, if I take my medication correctly, doesn't affect -- you know, doesn't affect me to where I don't understand or am aware of my surroundings? He said well, that's for them to know. I've asked why, and they're just saying that's protocol of what they do, even though I know other inmates who are bipolar and aren't deemed SMI.

Q. So nobody has really -- they've explained to you that you've been designated SMI, but not really -- they can't really explain to you why that is?

A. Yes, that is correct.

Q. And have you spoken with mental health staff about that?

A. Yes.

Q. Have you engaged in self harm while in the Illinois Department of Corrections?

A. What do you mean by self harm exactly?

Q. Well, I guess I can split it up in two ways. Have you attempted suicide?
A. Yes.
Q. And when have you done that?
A. How many times or do you want like the year?
Q. Both. So how many times have you attempted suicide?
A. A few times. At least five about now.
Q. When was the last time you attempted suicide?
A. Let's see. So the day I went on watch was the 5th of this month.
Q. So August 5?
A. Yes.
Q. Was it before -- did you attempt suicide before or after the basis for your discipline?
MS. ROSE: Objection, vague, form and foundation.
BY MS. COOK:
Q. You can answer.
A. Do I have to answer that question?
Q. I'm not trying to ask you anything that is not relevant to this case, but part of the case has to do with self harm and suicide of transgender prisoners. And so I just want to get a sense of the timing. I'm not trying to ask you anything to upset you, but I would

like to know what precipitated the suicide attempt.
MS. ROSE: Marilyn, would it be helpful for Ms. Cook to repeat the question?
THE WITNESS: Can you --
BY MS. COOK:
Q. How about I ask it this way. Approximately what time of the day on August 5 did you attempt suicide?
A. It was before med lines in the morning, so med lines come anywhere from four to six. So before that I had woken up and tried. I didn't look at the clock really.
Q. So probably before 4:00 a.m. you think?
A. I'm going to be hones with you. It's tricky because med lines aren't always done at 4:00. That's why they have 4:00 to 6:00 range. They might start from a different cell house and make their way to other sell houses. That's why all I know is that I had woken up, you know what I'm saying? I tried something I wasn't in -- and me trying to kill myself I'm not worried about time or looking at what time it is. If that's what you're asking, I don't know.
Q. No. So it was the early morning hours. Was it still dark outside?
A. Yes.

Q. And what were you feeling that caused you to try to commit suicide?
A. My gender dysphoria.
Q. What about gender dysphoria?
A. I mean, I don't want to sound rude but what about it? It's happy, something that you want to live.
Q. Was there anything in particular or was it just, you know, a general feeling?
A. I will try to sum it for you. Reflecting on my life of constantly being ridiculed, disrespected, looked at as a freak, as an abomination, as some COs say something that my mother should have swallowed instead of birthed. Maybe the fact that I have to take medications. I have to attempt to get surgeries so I can feel aligned with myself. The disturbing fact that I have testicles, that I have a penis, that I have an Adam's apple, that I've gone through male puberty, things like that.
Q. When you tried to commit suicide on August 5, was that all you were thinking of when you tried, or were there other things on your mind as well?
A. I mean, I thought maybe it's easier to get the suffering over with. Yeah, I thought about that.
Q. Are there people who you can talk to when you feel like that?

A. You mean staff in prison, or do you mean family members and friends?
Q. Anybody.
A. Well, in my current situation I can't have video visits. I can't message my family. I'm only given the phone once a week and their system is messed up so we can't even use the phone. As of right now all I can do is write, and sometimes having to wait that long to communicate with somebody through snail mail, no, not right now.
Q. You mean while you're in segregation you're limited in how you can communicate with others outside?
A. Yes.
Q. Before being in segregation -- I know COVID has kind of messed up like in-person visitations, but even while COVID was underway and when you were in just protective custody status, could you have phone calls with your family?
MS. ROSE: Objection, form.
THE WITNESS: Yes.
BY MS. COOK:
Q. How often?
A. I'm sorry, how does this have to do with the suicide, conversation with my family?
Q. I just want to know how often you're able to

Page 29

talk with others outside of the prison.

A. Well, they have a rule that we can only use the phone one time and I have to pass it to other cells. And there's 52 cells on a gallery in south house, so it's not that easy unless somebody doesn't use it and they want to sell their time, which is basically I'll give them something that I buy from commissary so I can get their phone time. Or if we go to the yard and there's phones open, I'll try to use it. We don't have yard every day per COVID. We have yard once a week for one hour.

Q. So the phone, when you say one time, is that one time per week?

A. Per day.

Q. And you mentioned -- so before August 5 when was the last time that you had tried to commit suicide?

A. Like maybe two years ago at least.

Q. So maybe in 2018?

A. Yes.

Q. And you mentioned that -- well, I'll split the question up. When I asked about self harm, I also meant do you engage in other forms of self harm such as self mutilation or, you know, cutting yourself?

A. I don't do self mutilation as some type of pleasure if that's what you're asking. I don't like

Page 30

doing stuff like that.

Q. Do you do it to hurt yourself?

A. When I attempt suicide, I don't do it to hurt myself. I try to kill myself. I don't understand what you're trying to point out or say exactly.

Q. I'm trying to understand your history. So I guess when you tried to commit suicide in August, how did you do it?

A. I bought some medication from another inmate and I took them.

Q. And the same thing in 2018, how did you try to commit suicide?

A. At first I thought about using a cord to try to hang myself, and knowing that it didn't work out before when I tried, I tried taking some more medication.

Q. You mentioned that sometimes you're able to ask for a crisis. In what instances would you ask for a crisis team?

A. Usually it's when staff is, you know, either trying to harass me, mess with me or, you know, they're trying to do something they're not supposed to do to me, and asking for a crisis team, you know, mental health is supposed to be notified. They're supposed to come talk to me and pull me out. With that I'm able to use mental

Page 31

health to basically try to get them to leave me alone, get off my back or try to get them to understand or something, you know, to let them know just leave the person alone. They're already in prison going through a difficult time and obviously I have problems, you know. They're not making it any easier by trying to harass me or being disrespectful or doing something harmful.

Q. So when you have felt suicidal, is it something that you try to raise with mental health staff beforehand?

A. No, because if I'm going to kill myself, why would you I tell you that so you can come stop me?

Q. Your 2018 attempt -- your suicide attempt, was that also related to your gender dysphoria?

A. Yes.

Q. In what way?

A. The same ways I told you earlier.

Q. And what about the other attempts? I'm not going to go through each of them individually, but you mentioned there might be around five. So the three others, were they for similar reasons?

A. Some of them yes, some of them no.

Q. Is there ever anything that happens right before your suicide attempt that contributes to your suicidal feelings?

Page 32

A. I mean besides my gender dysphoria, you know, I had multiple family members that were already, you know, great grandparents and grandparents, and they were already old, but being real close to them and they're oh, great grandpa is gone, great grandpa is gone, great uncle is gone, grandpa is gone. And it's like I'm in prison. These people won't even let me go to their funeral and have a goodbye. I can't see them anymore. I can't talk to them anymore. I'm in prison. Do you understand what that's like?

Q. I guess -- and I want to know, too, you know, it sounds like there are a lot of general things behind your suicide attempts. Do you want to take a break?

A. Yes, if I can. Thank you.

MS. COOK: Okay. Let's take like ten minutes and then we will resume.

(Recess taken)

MS. COOK: We will go back on the record.

BY MS. COOK:

Q. So, Ms. Melendez, before the break I was asking you some questions. I just want to get a sense of whether, you know -- at least your most recent suicide attempts, if they're related to just general feelings or if it's feeling compounded by a specific action.

Page 33

MS. ROSE: Objection, form.
BY MS. COOK:
Q. You can answer, Ms. Melendez.
A. Like I said earlier, my last suicide was my gender dysphoria.
Q. Is it just your gender dysphoria generally or that staff says something to you or another inmate says something to you that leads you to become suicidal?
A. I mean, there's certain things that, you know, end up being said or done that you can say play a part in it, but, you know, if somebody calls me a fag today, I'm not going to kill myself, if that's what you're asking. My recent two suicide attempts are particularly related to my gender dysphoria which I described to you before I went out. Specifically that.
Q. I'm just trying to see if there is anything else or if you've told me everything. So if there's nothing specific that contributes to it besides what you've told me, then that's fine. I will move on.
Just so I'm clear, we did talk about suicide attempts, but aside from your suicide attempts have you tried to harm your body through cutting or mutilation and or anything like that?
MS. ROSE: Objection.
THE WITNESS: There was a time that I did slit

Page 34

my wrist, but it's not that oh I'm depressed, I'm going to be a self mutilator to get rid of the pain. It's just that I tried to kill myself. There's a difference between someone who is a self mutilator that they could find pleasure in the pain that they cause. I'm not a self mutilator. Do you understand that?
BY MS. COOK:
Q. Yes. Thank you for explaining.
So moving on to your gender dysphoria, like I said, we already talked about some of this. You testified about it last year in the preliminary injunction hearing, so I will only briefly go over anything related to that and most of it is leading up to additional questions I had related to your prior testimony.
Just so the record is clear, you were born a male and you identify as female, right?
MS. ROSE: Objection, form and phrasing of the question.
BY MS. COOK:
Q. Okay. What sex did you have when you were born, Ms. Melendez?
A. Obviously I was born biologically male.
Q. But how do you identify?
A. As female.

Page 35

Q. And you testified that you knew that from an early age and that your mother was able to obtain for you hormones [inaudible]. Is that accurate?
A. It's tricky because as a kid keeping up with actual oh I was eight or, you know, you could say I'm seven and three-fourths, stuff like that, but it's around that age, yes. She was supportive of it, you know, and she helped.
Q. And where did those hormones come from?
MS. ROSE: Objection, foundation. You can answer.
THE WITNESS: As a kid, I'm not -- I don't really know how back then how meds were made or how they were obtained or prescribed. All I know is that my mother said that I'm her baby, she's going to do whatever I can to help him and she got me the medication.
BY MS. COOK:
Q. Did you see a provider for gender dysphoria at that time?
A. We went to see the doctor that as a child I guess I was assigned to, you know. They would ask certain questions, ask if I was doing okay, how am I progressing, stuff like that.
Q. Was it just your normal doctor who you went to

Page 36

see at that time?
A. I had a normal doctor and then I had another doctor because we had moved from Waukegan, Illinois to Crystal Lake when my mother got a different job. So I had seen another doctor at that time which was in Crystal Lake.
Q. Did you see a gender dysphoria specialist?
A. I'm going to be honest with you. I was a kid. I don't know the difference -- didn't know the difference between what a gender dysphoria specialist or a doctor who does -- or even a dentist, to be honest with you. As a kid you really don't know. All we know is everyone is a dentist. You go in and you see what you presume as a kid is a dentist, or we're going to see this doctor. So I can't honestly tell you yeah, it was a gender dysphoria person.
Q. So then you stopped taking hormones when you were a teenager; is that right?
A. Yes. My mother could no longer afford it.
Q. So when you were -- was that about the time that you were into juvenile custody?
A. It was before that. I went almost a year and a half before I got sent to the detention center for the crimes.
Q. And at the detention center did they treat you

Page 37

for gender dysphoria?

A. At the detention center it was different from anything regarding the actual state because in detention center I wasn't a ward of anything. My mother still had to pay to bring me my bipolar medication, my anxiety medication. She had tried to bring me -- eventually she told me she was able to get some hormones for me. They would not allow her to bring that in to be given to me because they said that they didn't know where to house me, if they put me in the dorm with the boys or they put me in the dorm with the girls. They said they didn't know what to do. So my mother said well if you're making me pay for dental and everything else, why don't you allow my child to have her medication. They said because obviously it would cause an issue, so they wouldn't let her do it.

Q. And then how soon after you were in the detention center were you committed to the Department of Juvenile Justice?

A. I was there for at least a little over a year and a half. I turned 15 and then turned 16 because when I got obviously incarcerated, I was a few months off from being 15.

Q. And at the juvenile justice center, they did not prescribe you hormones, correct?

Page 38

A. No. I requested them. They said that they don't do that. I said well, you know, I need to speak to my mom about it. They're saying that, you know, you're a ward of the state now, your mom doesn't have a say-so of what you can or can't be given, the state is in charge of that and that's something they don't do.

Q. Do you know if your mom tried to contact the juvenile justice people about it?

A. Well, I know she called who was the warden at the time that. Her name was Carter. I know her last name. I didn't know her first name. But my mom basically tried to, I guess, persuade her or talk to her like if you won't let me give them, can you give them to her, and she basically said look, I can't let you bring medication in here to give to your child that we're not allowed to give the ward of the state and I can't make medical staff here prescribe her something that we're not allowed to do.

Q. Did you raise your gender dysphoria with the medical and mental health providers in the Department of Juvenile Justice?

A. In IYC St. Charles their intake screening was simply okay you're a juvenile, you got this much time, this is where you're going. They didn't ask questions like that, even after I had a question about the

Page 39

hormones. So once I saw that they won't even let me get the hormones here when my mom tried and she couldn't and it didn't work, there is only so much I can do after that. They wouldn't do evaluations for that. They didn't even know I was bipolar until the paperwork followed me from the detention center. So that's what they went off of. They never actually did their own evaluation.

Q. But did you have to speak with mental health staff to get renewed prescriptions or were those just automatically renewed?

A. There was no mental health down there. They had what they call counselors. Counselors were -- would do basically everything from grievances to you ask them about time, seg out days and stuff like that. The only staff that were there were medical staff who would give like medication such as anything that's prescribed. There actually was no mental health. That's why IYC Joliet was shut down because they were doing so many things that were wrong and violations.

Q. How old were you when you came into the Illinois Department of Corrections?

A. Adults?

Q. Yes.

A. 17.

Page 40

Q. So before that I know you discussed how you felt. You felt female. You were taking hormones. But do you know if you had a gender dysphoria diagnosis?

MS. ROSE: Objection to the extent that characterizes -- mischaracterizes prior testimony.

BY MS. COOK:

Q. You may answer.

A. I don't mean to sound rude, but we went through some of these questions before, correct? I don't understand, you know, something that is well documented, something that I have written multiple grievances about, have expressed it even in the last hearing I was at to you and it's continually repeated and documented that I have gender dysphoria, you know. If you want to go off just prison, because obviously that's -- these people in prison do or you go off paperwork that they have in prison, I repeatedly asked staff that I was gender -- transgender, that I had gender dysphoria, that I wanted hormones. They at Stateville said that I need further counseling. They said how do I know that I'm transgender, that I have gender dysphoria if they have no paperwork that I've been diagnosed. I may not be a doctor. I may not be a mental health specialist, but obviously I know who I am. And then eventually when they evaluated me,

whoop-de-doo, I have gender dysphoria.

Q. Ms. Melendez, I'm sorry to interrupt you. I don't -- I'm not arguing whether you have gender dysphoria or not. I just want to understand if you have received a diagnosis that was documented because, as you pointed out, often the prison goes by the records they've already received. So I just want to know at what point it was recorded that you have gender dysphoria. And I don't have your juvenile records and I don't have your childhood records.

So I just want to know if, to your knowledge, before you came into the adult system you had been diagnosed with gender dysphoria?

A. Like I had said, IYC Joliet and St. Charles were not doing mental health evaluations. They weren't doing evaluations for anything. So that's why there wouldn't be any records because is there is no mental health staff there, how can they write anything down if there is no people to document it?

Q. So you don't have a reason to suspect that your records would say anything about gender dysphoria? Is that what I'm getting?

A. They wouldn't say anything about it because when I asked about hormones or about being housed separately, it's this is what it is. You are here,

you're doing your time, we don't do that. These counselors never wrote that stuff down, and I can almost guarantee if you find these records, they won't have anything to say about mental health evaluations, transgender. Mostly you will find paperwork that will say they came from detention center, these medications were prescribed, continue medication.

Q. And again -- and I think I asked you this last year, but I just want to confirm that nothing has changed. You haven't seen your IDOC medical or mental health records; is that correct?

A. No, not really.

Q. What do you mean by not really?

A. I haven't physically seen them. I've been told by staff when I see them that this what the levels are, this, this and this. Sometimes they'll say that I'm doing fine off what they've written. I will ask what does that mean, and they won't really tell me that. I had one scenario where I just got switched over to a medication. They did blood tests, and I asked how is it going and they said that it looks okay. And I asked, well, what are the dosages, what's the levels, do I need to go up, down or readjustments? Well, you look fine. Everything has to be working fine apparently. And I asked well is my liver or kidney at risk? Am I losing

bone density, osteoporosis, something regarding blood loss or my health. Oh, well, you know, that's really Tilden's job, I'm just here to tell you you're doing fine. Scenarios like that happen.

Q. Just so it's clear, you had been raising gender dysphoria issues with prison staff when you got into the adult system; is that right?

A. Correct.

Q. But you weren't actually diagnosed with gender dysphoria until 2015?

A. That is correct.

Q. And that same year is when you began receiving hormones?

A. Yes, that is correct.

Q. So the hormones that you're taking, do you have any current complaints about your hormones?

A. The current ones as of now?

Q. Yes.

A. Yes.

Q. What are they?

A. I have been on hormone medications for five years and I'm still getting frequent erections, which being on proper dosages from what I -- I'm not a doctor, but from what I've read is that that shouldn't be happening. Still growing excessive hairs in places.

Even though it doesn't stop growing, it should thin out. Isn't happening. I was switched over from Menest to estradiol, and then I believe one or two months, not even beknownst to me, I was switched to Premarin, which I don't know even know why. I put in a medical request to see Tilden about it, and then before I ever get seen, out of nowhere it got switched back to estradiol.

They did one blood test, and I didn't even see it. I don't even know what my testosterone levels are, what my estrogen levels are. For all I know, I don't know if there's anything wrong with me. Am I at risk for blood clots right now? I don't even know. Am I at risk for osteoporosis? Is there any risks, side effects, complications that I could be facing that could be permanent? I don't even know because they won't even show me the paper when I went.

A nurse brought it to me and said this is it, didn't show it to me, said that that's Tilden's job. But Tilden hasn't seen me. I've requested to see Tilden for several months now, medical request to see medical director. Every time my medication prescription hormones run out, he's the one I see to renew them. Recently he hasn't been coming in. I just put in a medical request slip three days ago about the same issue again. He still has not seen me or even told me what my

levels are or what my risks are, if my kidneys are all right, is my liver all right, is the blood pressure and cholesterol all right from the testosterone blocker, none of that.

I even suggested that -- you know, he's telling me that 200 milligrams already is too much, and I explained to him there's other testosterone blockers that if they don't work, there is other options you can give me. It's either oh, they're implants or patches and we don't do that or it's too expensive. I don't understand where expense comes into a problem with that. If there is someone right now who needs cancer surgery, eventually they're going to get that surgery. It costs money to do it, but they don't tell him it's too expensive. So why should I be told that my medication or any surgery that I'm having is expensive if I'm a ward of the state? If somebody had cancer right now, they would do a CAT scan, MRI, chemo, radiation, whatever they need to do to help the person here. I don't understand that -- I think that's more expensive than the simple medication I'm asking for. They won't even do it because it's expensive.

I even said okay, you can't give me gender reassignment surgery, you said you're not approved, okay give me an orchiectomy. If you remove my

testes, my gonads, my testosterone is basically little to none. I don't need testosterone blockers. They save money with that. The estrogen has to be lower now. They save money off that. Still, oh well, that's an expensive surgery.

Q. So you mentioned you had one blood test. When was that?

A. It was before COVID hit. It might have been -- I think it was around March.

Q. But you don't know the results of that lab check?

A. No.

Q. And is Dr. Tilden the only medical doctor who is coming in to Pontiac right now?

MS. ROSE: Objection, foundation. Go ahead if you know.

THE WITNESS: As of right now I haven't even gone to medical, so I can't tell you who's coming in or out or if they have another medical director coming in because after five years I've been here, that's who I've always see, Dr. Tilden. That's all I know. That's all I see.

As of right now -- because I asked other inmates or staff or nurses when they do their rounds who is the medical director today, and it always ends up

being Tilden, which it's usually done -- examinations or hormones or like the stuff regarding me were done on first shift, before 3:00, anywhere from 8:00 to 3:00. So that's all I know.

BY MS. COOK:

Q. And when you want a request to see a physician, do you put in a specific request, like an M.D. request?

A. Well, they have -- they call it medical request slip and basically put your name, number, date and cell. Then they have a list. It could be stomach or bowel issue, allergies, back pain, knee pain, eye issues, you know. They don't say. Then they'll say legal medications. Nothing that has to -- they don't put anything transgender, so what I do I put an X by the box that says other and I will attach a piece of paper explaining what's going on.

So what I did recently, since I only have one month for my hormones, I put renew medication, the number, the dosage of the medication, how many times I take it a day. Then at the bottom I'll put need to see Tilden regarding blood test, need to know what's going on with test results to know about health, know of adjustment of hormones. That's basically what I have to submit.

When that's put in, routinely anywhere from five to seven days a nurse or a nurse practitioner is supposed to have us pulled out, but with COVID you don't go to health care. So it's somewhere in the cell house in a little room where they read it, asks us what's going on. You explains what's going on, and most of the time with me, with transgender, they will put refer to Tilden. That's usually what happens. The only time it doesn't happen with me is if it's to renew cream or shampoo or antibiotic or something that doesn't have to do with transgender, date and sign off.

Q. So you just haven't heard anything back about when you will see Dr. Tilden?

A. No. They always tell me that either he's not here or he's here, he's extremely busy, that he can't come over to the cell house, that he's in the health care taking care of severe patients and that with COVID I won't be going to health care unless it's an emergency or something that's extremely threatening.

Q. So it sounds like in the past -- so you had your blood test possibly in March of this year, but when was the last time you actually spoke with a medical provider about your hormones?

A. The hormones in regards as in what? Like adjustment or exactly what?

Q. Adjustment or complaints about how you're reacting with the hormones.

A. I mean, when the nurses walk by in the morning or at med line, they will tell you like look, whatever you're trying to tell me, you have to put in a sick call. So that has to be done to see that nurse. I put in three sick calls since I've been in seg from this month on the 5th. Still have not been pulled out to see a nurse. I'm being told to be patient, they will come see me.

Q. And before that -- you were talking about this month, but before this month when was the last time you spoke with a medical provider about adjusting or complaints with your hormones?

A. The last time I saw Tilden was -- when I tell sick call staff, hey, all we know is you got to see Tilden, he's not here yet or he will get to you when he gets to you or he's busy or whatever.

Q. And you do you recall about when that was, the last time you spoke with Dr. Tilden?

A. That was probably maybe March -- no, no. It had to have been toward the end of January, beginning of February, because I had seen him about the medication. He had renewed it for six months and then he said that since you've been on it for a while, I'm going to order

a blood test. That was during the time where I had went to seg and staff or medical had lost my hormones for over a month.

Q. So there was a month where you were not given hormones?

A. Yes, that is correct.

Q. And when was that?

A. The last time I went to seg before this infraction. The incident occurred in the jail where me and another inmate were fighting. They cuffed me up, took me to seg. It's routine that staff packs a seg pack, which they grab a laundry bag, put -- what they're supposed to do is two sheets, two pillow cases, two shirts, two bottoms, two bras, my fan and at least one soap, a towel and a washcloth and if they have -- the inmate has blister packs, that as well. So if I have an inhaler, that comes with it. If I have medication for whether it's hormones, cholesterol, diabetes or anything like that that's in a pack, they put that in there as well.

With me for some reason whenever I come to seg, my hormones are never ever in my seg bag. They're never brought to me. I ask staff. Oh, well, they should have put it in there, but it's not. I ask them can they check. Oh, ask the nurse, that's medication. I will ask the nurse when they do med runs,

oh we don't know where it's at. I ask property. Property says oh, we sent it to health care. So I tell health care well here is the paper from property saying it's at health care. Oh, it must be first shift that has it, we don't have it, we're second shift. I ask first shift where's my hormones? Oh, second shift must have it, we don't know where they put it at.

Miraculously nobody knows where my hormones are, but I guarantee you, and I have seen it time and time again, if there is an inmate who is diabetic, whether he takes a pill or insulin, that day when they run med lines, depending on what time they come because they give insulin shots from 3:00 to 4:00 and they do that mornings from I want to say after breakfast, so anywhere from 5:00 to 7:00 they do insulin shots. He just got here that day, hasn't even been 24 hours, it's documented he has diabetes, he needs his pill or his insulin.

Me, I'm documented with gender dysphoria. I've been on hormones for over five years, but yet every time I go to seg they somehow disappear. Oh, they're lost. Oh, we have to reorder them. The minute a hunger strike is done, the minute I need a crisis team or the minute I file a grievance, oh wait, we're going to find them. I thought they were lost. Oh

yeah, we found them. Property said they sent them to health care and they were misplaced.

If it's a medication I'm supposed to have, it should be in my seg pack. And if you think that it's not mine, they will say my name on there. The staff, wanting to be prejudiced towards me, ripped apart the stuff with my name and ID on it. Medical staff said we finally got it, but he name was ripped off so we don't know if they're really yours. I said well you guys know every month you bring me blister packs that have my hormones and the dosages. Why don't you just look on my chart and see if I get these exact medications? Yeah, but even if you do, how do we know that these are yours? What?

Q. Well, so do you -- you take estrogen and then you have the testosterone blocker. Are both of those given to you in a blister pack?

A. Yes.

Q. So the nursing staff, when they run medications, they don't bring either of those to you, correct?

A. No. They bring a month's worth supply. So let's just say they start my meds over and I have five days left. So anywhere from three to five days, they will bring the new ones. They do it enough to where you

Page 53

have enough for 30 days, and at least they add four more days in there in case it gets late coming from the medical company here. That's how they do it. They do it like that because, you know, before I seen other transgender inmates go through the problem of nurses will bring meds in the packages that they do at health care and put them in a cup and give it to you. Sometimes nurses -- I don't know why -- forget to put hormones in there. I see them go through it multiple times.

With me, instead of me going through that, I said look, you have no documents of me ever abusing medication or anything like that, just give me my hormones in a pack. That way, one, you don't have to worry about you misplacing them because I'll always have them in my cell. If nurses don't come or some excuse happens, I always have them.

Q. And when this most recent time when you went to segregation this month, did you have that same problem?

A. Yes.

Q. Have you received your hormones?

A. Eventually, yes.

Q. Do you know about how long it took that you were without them?

Page 54

A. A week.

Q. But when they brought them to you this time in August, did they bring you a whole new blister pack, or did they find your old one again?

A. They found it after they said it was lost or thrown away.

Q. Can you tell a difference in how you feel when you don't have the hormones?

A. Yes.

Q. Can you explain what the difference is?

A. Well, you know, it's kind of difficult to fully explain, but it's like, you know, knowing that I'm not getting the medication causes obviously distress, you know what I'm saying, causes my anxiety to go up because I already know in my mind they're using some excuse for not giving them to me for whatever reason, they're trying -- you know, there's that factor, and there's the one where I went for a month without having them. You know, even though that they're not what you call an addictive medication or like pain killers or anything like that, just like with all medications, if you go a certain amount of time without taking them, there are side effects of not taking them.

It's just like if you have high blood pressure and you don't want to take them no more, you

Page 55

can't just stop. You have to gradually go down to smaller dosages, just like with psychotropic medications. If they switch you over to a new medication, they give you some of your old one with the new one until you adjust. They just don't stop it completely, and I started feeling that. I started getting like -- I just get hot flashes. I just start sweating out of nowhere. I feel anxious, like I just can't sit still. My hands shake. I don't feel right. My stomach goes -- discomfort, you know. It's like when you feel like throwing up but when you do it's I guess like a dry vomit. Nothing comes out.

Q. So you have distress just by knowing you're not getting medication, and then you have these other symptoms.

Aside from -- you mentioned specifically hot flashes, hand shaking, nausea, anxiety. Are there any other physical symptoms that you have?

A. At that time, not -- no, nothing more really happened further.

Q. About how long from when you took your last hormone pills until you start experiencing these side effects?

A. You mean when did I notice that they started happening from not taking them?

Page 56

Q. Correct.

A. Within at least two weeks. That's when I started, you know, like -- you just know when you don't feel right, like I feel a headache coming, I'm getting a headache, but you can just tell when something isn't right with you.

Q. So you mentioned some conversations with staff members about the expense of the hormone or testosterone blocker. Do you remember when those conversations occurred?

A. The most recent one was when I had just seen Tilden January -- around towards the end of January, beginning of February, and, you know -- because he said that with the estradiol, even though it's the same dosage that was the Menest, obviously they're different medications and that he would do a blood test to see if my estrogen was going up or down, side effects, testosterone. He told me that if the testosterone and frequent erections continue to be a problem that he doesn't really know what he can do because, you know, the other testosterone blockers, whether it's an implant or the patch or the other one that is too expensive, saying that, you know, we can't have those.

So then I said okay, why don't you include micronized progesterone. They're known to, from

what I read, bind to what they call free testosterone, and they do another thing where it tricks the body into not releasing them to get to the gonads. So that will help reduce testosterone and increase estrogen. He says micronized progesterone is too dangerous. And I asked him why is that. He said that it's tricky to know if it's really going to help. I said well why don't you put me on it for one to two months and see what happens. He didn't want to.

And then he said that another problem is that they give us so much of a high dosage of estrogen that five milligrams is already too much. That's when I suggested well remove my testicles and we won't have to worry about any or a lot of what we're going through. Again, he doesn't know if he's supposed to do that and it's expensive.

Q. Has anybody given you like written information -- anybody from DOC given you written information about hormones, your options and the risks?

A. No. The only time I was told verbally was by Ms. Bell and Ms. Cheserick [phonetic] who in 2015 were part of mental health regarding gender dysphoria at Stateville. They explained some of it to me basically, you know, when you take this, you develop breasts, body fat distribution, blood clots, the chances of

osteoporosis, cardiovascular disease, increase in diabetes and breast cancer and stuff like that. That I already knew about.

Q. When they give you your blister packs of medication, does that come with like a medication insert with the risks and side effects and things written down?

A. No. All it says is my name, my cell number, the type of prescription. So testosterone says 100 milligrams twice a day. Estradiol says 2.5 milligrams twice a day, and then they'll have a little red sticker which they put on all medications saying be careful, this is a hazardous medication or hazardous risk.

Q. And I'm assuming that you have not heard anything from Dr. Tilden or any DOC medical staff about Wexford direction regarding hormones that came out this year?

A. No. I didn't even know they had something out like that.

Q. And the last time you had a discussion about surgery requests was that the one you had with Dr. Tilden earlier this year?

A. Yes. That was this year, and I did it obviously the year before, and surgery is not approved. He says the orchiectomy is not approved but he will look into that. And I'm still waiting to see what he says.

Q. And last year when you asked about it, was that also to Dr. Tilden?

A. Yes. He's the -- I tried before with other medical nurse practitioners and medical staff. They're saying that issues like those should only be addressed to the medical director since I guess they have the overall say-so.

Q. And what specifically -- I know you mentioned one surgery request, but have you made other surgery requests recently?

A. Yes.

Q. What are those?

A. He said that these were mostly deemed cosmetic or plastic surgery, which is breast augmentation, liposuction, lipofilling, contouring of the abdominal area to have more kind of a shape, a trachea shave which is the shaving of the Adam's apple, and obviously the SRS surgery.

Q. What do you mean when you say SRS?

A. It could be labeled as gender affirming surgery, sexual reassignment surgery, gender affirming surgery.

Q. And then the other requests, did Dr. Tilden characterize them as cosmetic?

A. Cosmetic, plastic surgery that isn't deemed

medically necessary even though specialists say otherwise, but I guess.

Q. When did you talk to Dr. Tilden about those requests?

A. Usually every time I see him. When he sees me, either for the six month followup or giving me the physical for my birthday, I always bring it up and ask about it. I mean, I know I'm going to get the same answer, but it's always good to stay hopeful.

Q. Have you ever tried to go above Dr. Tilden to like the Office of Health Services?

A. I have tried in the past when -- you know, once I bring it up at certain decisions, even though he's the medical doctor or if it's entirely at his discretion or up to him, and I ask him well if it's not you, then who? Gender committee. I said well can you tell who they are so I can write them? Well, you know, the committee they're not always here or we have to do a certain amount of time until they meet. I said okay, well can you at least tell me who they are and who do I write so it gets to them? Clinical services? Is it health care or is it like I send it to the warden? They hardly want to tell me names, hardly want to tell me who it is or who to write to.

I ask them if these people are in charge

Page 61

of what hormones I get, what dosage I get, what surgeries or approved or not approved, why don't you at least give me information to write them or speak with them? I've written the counselor about it. They said that I have to ask Tilden, which when I ask him, I get spinned back to a counselor or I get spinned to ask the warden and then the warden say that that's not their thing, the warden is simply here to uphold the law and order in the prison. That is what they tell me, and I get sent back to medical.

I ask mental health. Mental health says well we really don't know who is or who isn't except for Hoover. Hoover used to come here, but then he stopped. So I could never actually write an individual who is on the committee and ask.

Q. So have you been able to go to any transgender groups?

A. They didn't have those before. I have gone, yes.

Q. When did those start?

A. I didn't actually go to one until, I want to say, I think last year. Ms. Hardy started doing them.

Q. And what role does Ms. Hardy have at the prison?

A. What I'm told she is a mental health

Page 62

professional who was put here from Springfield to deal with transgender mental health and run groups.

Q. Is there only one transgender group at Pontiac?

A. Well, at first she was understaffed, so it was only her running them. So wherever there are -- they're in the cell houses, so I'm in seg, I can't attend group with those in PC or unapproved or different status. So once a month for an hour she'll come see us and hold group. She says she has to do it once a month because she has to run it in other cell houses, plus she has to deal with -- she also has a regular mental health staff assigned to the house to deal with various other people on caseloads.

Q. Have you continued groups while COVID has been going on?

A. At first they were not running them saying they don't have enough staff or that there isn't enough space or they don't have adequate room to have the six feet required distancing, and, you know, that was an excuse because you'll run us to yard and people can walk side by side. That's not six feet, but you still run it. Then one time they told us she couldn't run it because Lieutenant Zimmerman says I'm not going to have a staff member sit outside this door for an hour and

Page 63

have to monitor fags.

Q. Did you hear somebody say that?

A. Yes, Lieutenant Zimmerman.

Q. What's the group called? Does it have a name?

A. Well, she did it to where, you know, if staff pass it out, they don't really know. It's called GIFT group. It was supposed to be like gender identify focus team therapy, something along that line. That way if staff sees it -- because at first they'll say, you know, oh here is your pass to go to the sissy group or hey sissy, are you going to chicks with dicks class. So that's why she switched it so staff would stop saying very humiliating and disrespectful stuff like that.

Q. And do you feel so far that it's a productive group?

A. It's tricky because in that one hour that once a month, it's not really a lot of time to focus in on so many things in that one hour because you have obviously people who are transgender in there who are on hormones, haven't been on hormones yet. They're at different stages. So it's hard for her to bring one topic up that would only address those who aren't on hormones and then she has to switch the topic to those who are, and then you have some who might not want surgery. So it's tricky for her to make it as productive as it has to be

Page 64

in that one hour because, you know, if she has a topic of the day what is your ideal day and what she was aiming for was for everybody to say what is the most thing that can be taken away that --

(Connection lost)

BY MS. COOK:

Q. Were you in a group when you were in protective custody?

A. Yes.

MS. COOK: Did we lose you, Ms. Todd?

THE REPORTER: Yes, you did.

(Previous answer read)

MS. COOK: I think that was about the end of her answer anyway, so I will just start back with my question that I asked after that.

BY MS. COOK:

Q. So, Ms. Melendez, about how many people are in the group?

A. The last time I was there, there were four.

Q. And that was while you were still in protective custody?

A. Yes.

Q. So while you've been in segregation in the month of August, have you had any GIFT grouping?

A. No. I've requested it and they're saying that

Ms. Yuhas [phonetic], she was just assigned to -- I guess assigned or approved or however they go about it to run the GIFT group on her own in seg, and when I saw her, she told me you will be seeing me in group and she said before I could attend group that there is a questionnaire that I have to fill out where she was asking me questions that was from the -- it's supposed to be an overall evaluation scope from some doctor named Risker [phonetic], and they started asking me questions where was I born male? Yes. Am I transgender? Yes. Do I identify as female? Yes or no questions. And then do I want hormones or surgery, and then it started going into very irrelevant and disrespectful questions as to was I prostituted before, have I done sex trafficking, was I selling drugs, do I want to go to a women's facility and if yes, do I want a cellie just to have sex, you know. They were just asking very irrelevant and disrespectful questions that I don't really think has anything to do with me going to a transgender group.

Q. I see. So somebody -- it was presented to you like you needed to answer the questions before group could begin?

A. Basically that I needed -- basically she will ask me those questions. I'm supposed to say yes or no, have it filled out, and then from there I would be

placed in her group, which I found odd because with Ms. Hardy's group I was never asked this questionnaire. I was never asked these questions. I just found it odd, but if it's something new they're doing, you know, I answered questions that I felt were all right. Like all that prostituting and drug trafficking and sex trafficking and having sex with people, I stopped there because I told them if I have to answer this to go to your group, I would rather not because if that's how you're starting this out for me to go to your group, I will just stay in my cell because that's disrespectful.

BY MS. COOK:

Q. So were you able to decline answering some of those questions that you did not want to answer?

A. I mean, right after -- as soon as it got to the prostitute and sex trafficking and going to women's prison and wanting to have sex, I said look, stop right there, don't put yes or no for anything else. What I answered so far, you can use that. She was like I have to fill it out. I said well, you can put that I refuse to comply. If you want to write a ticket or incident report or whatever you have to do, go ahead because I'm not going to sit there and be asked questions like that. They're irrelevant for me to even attend the group if I was already attending a group. It's very disrespectful.

I know you would take offense if you out of nowhere seeing a mental health professional, oh by the way, have you prostituted yourself in the past, were you in sex trafficking. That's just wrong.

Q. Nobody told you where the questions came from except for a doctor who you don't know; is that correct?

A. Some guy name Rister or Risker, that he was doing a questionnaire to get overall scope and understanding of transgender individuals.

Q. And you do want to go just live in a female institution; is that correct?

A. You mean do I want to get transferred to a female prison?

Q. Yes.

A. I mean, I've requested it before. I want to. It's just, you know, tricky right now because from what I've heard about one of my friends, Janiah Monroe, is that they put her in a house where she's segregated. She's even said that she's gone through seg, gone through issues there, and it's like the whole point of going there is not to be discriminated against, to be recognized for the person that I am. And it's like from what I've seen from her, she's going there and it's like she's still being discriminated against, still being humiliated, still being treated wrong. And it's like

wow, what's the difference? Regardless of where I go, I'm going to be continued to be given this type of treatment.

Now, if you tell me that I go there and it's going to be fine and I'm not going to have those issues, of course I want to go. That way I don't have to worry about people saying oh, well, you're still a man because you're in a male prison. So once I go there, what are they going to say next? That I have a male name. It's always something. Now, if it's the ideal world and I don't have to worry about it, then of course.

Q. So the last time in the preliminary injunction hearing, you testified that you had stopped asking for a transfer to a female institution in about 2017. Has that changed?

A. I have thought about re-asking again, but it's -- you know, it's -- how do I say this? Being in prison is already like walking on edge. It's already a difficult and hard position to be in and, you know, having to sit down and actually think do I want to do it and then once I get there, it's worse than where I'm at. I've been here five years, so there are staff and people who know me who aren't always like everybody else, aren't always homophobic, transphobic or whatever reason

Page 69

they have to not like me and at least still respect me. Some staff don't feel comfortable saying she. So what they'll do is to have a respect thing, you don't want to call me she? Okay, you can just say Melendez is my last name, or if you feel comfortable, they, them. That way you don't have to misgender me. Some do that. Some still are -- obviously it's not a perfect world. You're going to have idiotic people who don't understand or don't want to understand other people.

Q. And so at least this year, in 2020, has the misgendering improved at all for you?

A. It's the same. I'm still getting misgendered. It's tricky. Like I said, you have some staff who obviously either in the world or in here do not have a problem with saying Ms., she or proper pronunciations to me. They don't have a problem with it. And you have some who do. Then you have other ones who I don't know what their issue is. It's like I guess they hate me. They literally -- you can see it in their face and their eyes, the way they speak to me. Some go out their way, okay sir, go to your cell. I say you don't have to call me sir, you can say Melendez. I don't want you to misgender me. All right, man, go to your cell. Say man, you don't have to disrespect me, you can just call me by last name. Okay, go to your cell sissy, how about

Page 70

that, that's not man or girl. You have those.

The minute I start misgendering them, okay miss have a nice day, now I'm getting written up a ticket. Now I'm the bad person. Now I'm wrong, just how I'm in seg for this bogus ticket right now.

Q. And when you push back or if you misgender somebody, have you actually been disciplined for that?

A. Yeah. I'm either told you're going to call me by my name and I'm a man, you're going to call me that, give me my respect. And I will tell them, okay, well respect is a two-way street. Staff are trained in their protocols to not be confrontational or aggressive or intimidate inmates, yet they do. How can you get mad at me for treating you the same way you treat me? If you call me a fag and I ask don't call me that and you call me a sissy, and I say okay you're the fag. Now you want to cuff me up for insolence and then add on to the -- oh, inmate was being threatening and intimidating toward me, they called me a sissy, fag or they'll say other things and add on, talking about that I would beat them up or that I would assault them, stuff like that. They will add things like that because certain tickets do not carry seg time. So they will add stuff that are deemed worthy. Plus a lot of the time it's the officer's word over the inmate. That's usually how it goes. So they

Page 71

know that it's my word against him, I'm going to win or it's my word against hers, I'm going to win.

Q. What kind of penalties have you faced because of something like that, an interaction like that?

A. As a ticket right now, I was going to the yard any other day. Staff shook me down, found a comb. They let me go to the yard. Lieutenant Torres said come here, go in your cell. Why? Because I said so. If I didn't commit any 504 DR rule infraction, what is the justification of me going to my cell? He said I had a comb. I'm like okay, every other time I go to the yard and I pass by you I take a comb either to braid my hair or braid somebody else's hair and it's never been an issue.

Torres is one of those people who, for whatever reason, does not like me and hates me being transgender. I hardly even speak to this man, and when I do, I'm always respectful even though he's not to me. He's saying -- you know, swearing at me go to your F'ing cell because F'ing said so. I said why? Then he starts saying the whole fag and sissy stuff. I'm like you know what, if you want to be petty and take my yard over this, you know -- I don't really want to swear, but basically I said this is some bogus ass sugar honey ice tea and F you. And he said oh, you're intimidating,

Page 72

cuff up, intimidation threats.

I never once approached him. I never once touched my fist. I never raised my voice, looked or talked to him in an aggressive or threatening or intimidating manner, but he wrote it up. These people believed it and yet here I am sitting in seg because of a lie he did.

Q. At least the staff you deal with at Pontiac, you know, what proportion of them are the ones that aren't respectful to you versus the ones who will listen to you and be respectful?

A. I mean, the ones that are respectful and are understanding or at least do their jobs to their extent and not be prejudiced is -- they're outweighed by the ones that are. And then there has been times where staff will call me Ms. Melendez or she in front of other staff and they get either cursed out or chewed out or make fun of saying oh, you got a crush on the sissy, you're calling it a girl, and they get made fun of. That's why some of them don't even say it no more. They're like man, I'm trying to be polite and here are these guys ridiculing me for being nice to somebody. That's why so many people, you know, they try not do it in front of others that will make fun of them.

Q. So in your experience the vast majority of the

staff is at least disrespectful to you?

A. Yes.

Q. And what proportion of those are just the ones who you think are malicious, who you think hate you?

A. That number is smaller because, you know, some of them aren't as older brass as others. Some might show that hate but not go to the full extent of expressing it or portraying it and doing it. You know what I mean? So like you might have one who will walk by and look at give me a look and just I hate you. They choose not to speak to me.

Like there's been times this one guy -- I forgot his name, but I'm asking him about my legal call. I said hey officer. He looked at me, gave me a nasty look and kept walking. On the way back I said hey, I'm supposed to have a legal call. He says look here, do not talk to me, do your time and I'm going to do my job, leave me alone, leave it at that. I said hey, man, I'm just asking about my legal call. You say you want to do your job, okay, find out about my legal call so I'm not late. He says hey, I told you stop talking to me. I said you said you're going to do your job, I'm just asking you to do your job. He's like okay, you're talking to me again, I'm asking you to stop talking to me. What I mean about this is you don't ever

talk to me, you don't look at me. When it's your time for the shower, I will bring you over, you go in, then I let you out or you go to the yard and come back. Other than that, do not talk to me. I'm not going to do nothing for you except for what I'm required to do. And I left it at that because I'm not going to sit here and waste my time arguing with an idiotic person like that.

Q. So in your experience none of that type of conduct has improved over this past year?

A. Over the past year, no. The stage I'm at now, I've got to go through five years of this for at least to have some people be like you know what, they just are who they are, man, just be respectful.

Q. And are you aware of any of the people who have been -- some of the examples you've given where they're just highly unprofessional, are you aware of them being reported at all for discipline?

A. I mean, obviously inmates and staff rumors pass around, gossiping and stuff like that, but as far as actually hearing and knowing about it, I can't tell you because that's usually an internal affairs thing where there's staff assigned to that specific thing and I don't know about it.

MS. COOK: Well, I think now might be a good time for a break. Is everybody good with that?

MS. ROSE: Yes, sure. Is this like lunch? Do you anticipate having a longer afternoon? Should we make this a lunch break?

MS. COOK: I don't have that much longer, so if everybody is okay pushing through, we could just do that. I don't know what Ms. Melendez's lunch situation is like there. I don't know if they have a bag waiting for her or what.

MS. ROSE: Okay. Are you okay to continue with just a short break and then just continuing? It doesn't seem like we're going to be that much longer.

THE WITNESS: That will be fine.

MS. ROSE: So let's meet back in like 10 minutes.

(Recess taken)

MS. COOK: Back on the record.

BY MS. COOK:

Q. I know that in the preliminary injunction hearing you noted that you had been requesting women's clothing. Has anything about that changed in the past year?

A. No. The only thing they still provide is a sports bra.

Q. Have you heard anything about changes in commissary that may be occurring in the Department of

Corrections?

A. No. I have written two commissary supervisors, Ms. Stooks and Ms. Wolf. I have written them letters asking about it, and either I don't get heard back and I can't personally speak to them anymore. Because of COVID our commissary is brought to our cell now. We don't go over there.

Before, before Emily Ruskin left, she was trying to have it to where -- you know, she would grab items, put them through the TAC team, because it's a max prison, so certain things we won't be able to get. For example, like an emery board they say we can't get because it's like a sandpaper and if anybody purchases it, they can use it to sharpen objects. So certain stuff like that she said we wouldn't get. She was trying to get it like -- you know, try to get us everything we could to have, and that's when she had left. The new warden, Leonta Jackson, isn't doing anything about it. When I was in seg, he did a walk-through. I asked him about it. He says don't get my hopes up anytime soon.

Q. Is that about clothing and hygiene items, or did you just ask him -- what did you ask Mr. Jackson?

A. When I saw him, I asked him if I could speak with him. I asked like man, before the previous warden

Page 77

had left, she was in process of trying to get items as far as cosmetic, hygiene, clothing, you know, stuff like that we're allowed, and I was trying to go into depth and explain better shampoo and stuff like that. He says don't get my hopes up anytime soon.

Q. You had mentioned that you could get some hygiene items, like soap or shampoo or lotion maybe, by asking medical staff. Are you able to get any medical prescriptions for the hygiene items you want?

A. As of right now the only thing I'm getting is supposed to be -- they call is T/Gel Shampoo, anti-dandruff charcoal, and it's basically like if you have sensitive scalp, irritation, rash, dandruff. I think psoriasis is one of them. They prescribe it for that, and they give me Minerin Creme, which is for like diabetics or people with severely dry sensitive skin. So they gave it to me because the testosterone blocker dries the skin out, so they gave it to me for that. Plus the soaps they sell here, it's -- even though they're for men, the main issue is that they dry me out. The skin cracks or it makes me just itch all over. So that's why they prescribed it.

Q. So do you still get the Minerin Creme, too?

A. Yes.

Q. But has anything changed with -- I think you

Page 78

discussed that you were seeking different soap. Are they offering different soaps to you at the commissary?

A. They do have a variety of soaps, yes, but as far as them actually being usable for me, no. Like for now I have to settle with a mild soap that, even though it's unscented, still dries me out but does me make -- like right now it doesn't make me oh, I've got to scratch all over, it's bearable, versus -- because they had another soap, Palmer's cocoa butter soap, that worked fine, but they stopped selling it and put a different soap on there. Then the Lever, which is the other soap I could use, they stopped selling that and put another soap on there. So now I'm stuck with having to pick a soap that I guess I could tolerate until -- that isn't that the bad I guess. I have to make it work. I don't have a choice.

Q. You also mentioned issues with the brush that you were offered at Pontiac Correctional Center. Have they offered any other brushes that work better for you?

A. No. All they have is little small palm brushes, like little plastic bristles, and the problem with that is I have thick hair. It's not -- I can't untangle my hair with that. Like right now they've taken my combs that I had. They've taken them. All they give me is a palm brush. I have to use my fingers

Page 79

to try to untangle and comb my hair.

Q. When you were in protective custody, did you have a comb that you could use?

A. Yeah. I've had these three combs for four years when they were selling them. I tried to take care of them because they don't sell them anymore. It's hard to get them. And I went to seg over a comb, lost that one. The other two I had in my property they're trying to say they are unauthorized. For whatever reason I don't know. But, you know, I basically explain the property like how is it that it's unauthorized if it was once sold on commissary? They have a rule that anything that was once sold they cannot take from us unless it is deemed extremely dangerous. So if they were selling something that had like a real hard piece of plastic that you could use to stab somebody, they would look at anybody who buy it, shake the cell down or do a whole prison shakedown and take them. Every time TAC team shakes my cell down or has shaken my cell down, the combs aren't taken. Certain people, like whoever is in property, are just doing it because they know oh screw it, let's take their comb.

Q. Are they plastic combs?

A. Yes, they are. It's a black plastic comb about three or four inches.

Page 80

Q. Is it like a wide tooth comb?

A. No, it's like a little pocket comb. It's about that wide and about this long [indicating]. That's it, small teeth, but it's -- the label says unbreakable, so it's extremely hard.

Q. Just so the record is clear, when you said how big it is, can you just say what those approximate dimensions are?

A. It's about three or four inches in length and maybe at the most one, one and a half inch wide, not that much really. Fits in your pocket.

Q. And you mentioned that you wrote to the commissary supervisors. What were you writing to them about?

A. Asking if there was any followup of approval items from the previous warden, Emily Ruskin, regarding the products. I had written a list down. I said I don't know exactly what she could have or didn't submit, but here is a list of certain things. And it's frustrating because I don't know if they're doing it out of spite or if they're being lazy or maybe they just feel whatever they have or selling now is adequate I guess. If you're selling deodorant and I'm asking for the same solid deodorant or clear deodorant that's sold but the only difference is it might be Lady Speed Stick,

not even not even used different, and they're not trying to approve it. Certain things like I don't even understand why you wouldn't just approve it. If it's something that -- like maybe you could say nail polish remover. Somebody might try to drink it or kill themselves or throw it at staff or metal tweezers.

You know, certain things that would actually pose a security issue, I could understand. I'm in a max prison. It's not a minimum. So that's understandable. It's just the things that we do get in here, the only difference would be they would be for women. It's like they're not even trying to do it.

Q. Do you remember what specific things you had asked about?

A. I had asked for shampoo, and they said that they have a new rule that the shampoo bottles have to be four ounces. Why I don't understand because they sell us 20 ounce pop bottle. But I said okay. So I have the catalog that the prison orders from. I specifically wrote the company and they sent me a catalog. I've listed three shampoos that are four ounces or less. I've listed various four ounce lotions. I've listed picks, combs and brushes, vented brushes, better hair ties, lotions, deodorants, better soaps, better -- even body wash that's four ounces, as far as clothes,

undergarments, shoes, average stuff like that.

Q. So did you go through the catalog and write down exactly what you wanted from that vendor?

A. Well, the vendor that I wrote the stuff down from, the IDOC at Pontiac at times orders from them, so like the bras that they order for us to purchase is from this company. Like some of the commissary food or shoes they order from this company. So I found out about the company through Ms. Brooks. She's like look this is where we order from. So I wrote the address down and wrote them. I had to pay $10 for the catalog. Every year they have a new catalog come out, and on the catalog they say all of these items have been tested and approved at the prison, don't have chemical or alcohol compound, because you know if it has alcohol people will drink it or set it on fire or stuff like that, that they're safe.

So I pointed out and wrote stuff down saying you guys are already ordering this deodorant, this and this from here, why can't you order this? And it's like we have to wait to get approved. I'm like well who approves it? Oh, TAC team, because tactical team review it or the people that work in task force are the ones who search the facility, cells, compound and look through commissary items for stuff that we receive

here and they deem if it's something that can be altered, broken or used as a weapon to cause harm to any of their staff. You know, if it's actually them that does that commissary approval, I don't know. This is what I'm being told.

Q. So you wrote a letter to the commissary staff, right? Do you have a copy of that letter?

A. I did. I have to go look. I have to see what I have. I know I wrote one to the commissary. I wrote one to the warden. I even wrote some grievance where I basically listed them on there.

Q. Did you put the brand name and everything?

A. Yes. What I did -- because if they send an order from that company, what I did I put the item, its size. So let's just say it's deodorant four ounces. I deodorant, the name of it, four ounces, and then I put slash, the ordering or shipping weight or whatever it is they -- you know, how they order it in bulk or individual from the company. That way when they look through the pages, they know where to go and which ones specifically I'm talking about so they can't get it confused.

Q. The response that you got back, was your response in writing or did somebody come speak with you?

A. Most of the time they usually come speak to

me. That way it's verbal and their response isn't on paper.

Q. When was the last time somebody came to speak with you about these commissary things?

A. The only time that was recently was with the warden when he was doing a walk by.

Q. Do you still shower alone?

A. Yes. Well, in the max prison cell they have showers that are individual. You go in one at a time.

Q. Last time you mentioned that it was open bars. Has that changed at all, on the shower door?

A. They still have -- the showers are always behind the bars, but they had did in south house -- as far as I know it's the only cell house that does it. They have shower doors where you can open and close it, and that covers you basically from chest to calf. In seg they have no shower doors, and east house they have no shower doors. I don't know why.

Q. Before you went into segregation, what house were you living in?

A. South house, protective custody.

Q. You also testified about searches by staff members. Has the way that you're strip search changed at all?

A. No.

Q. Has anybody ever asked you your preference on the gender of the person searching you?

A. They never ask it. In general I usually have to be the one to say something. Like this month already twice we've been stripped down by TAC team where basically they suit up, tell us to cuff up, and before they do they strip us, and I ask hey, is there a female officer here? They're saying yeah. I say well can you bring her here so I can get strip searched? He said that they don't do cross gender searches. I said what do you mean? He's like basically it has to be male-male searches. I said okay, man, I'm transgender. I said they have a PREA guideline thing that came out that specifically says you aren't supposed to search me and to at least give me the option of having another staff search me. He says that's not going to happen, are you gonna to strip or not? If not, let me know. If not, we'll just Mace you, open your door and restrain you. Let me know what you're going to do.

So to avoid all that, I'm like you know what, come on, let's just get this over, because I'm not going to waste my time arguing with him and he's constantly not trying to hear it. The next thing he's saying is either I do it or I don't and he's talking about macing me. That's happened twice.

Q. And both times was it with the TAC team?

A. Yes, and not in seg. When we go to yard, basically we walk down the galleries. We can go out. They can do one to two what they call pat-down or searches where they'll feel your side your, pocket or want to see your shoes, whatever you have. And on that it's -- there'll be a few staff. Sometimes it will be men and women, so usually I'll gravitate toward the women. It's never a problem, but it's never an option, though. If they're not there and I for it, it's not going to be an option. If they're there and I go to them, it's not a problem, but if I request it on a shakedown or strip search, then it's a problem.

Q. So when you request it, has your request always been denied?

A. Yeah, always. Their excuse is they can't do cross gender searches even though time and time again I've basically explained to them part of the PREA guideline thing that came out was to prevent this and there's supposed to be at least one female staff who can do this. The issue with that is they don't it. Then you got some guys that they're disrespectful. They're supposed to do a pat in a search, not supposed to do a grope. You're not supposed to do a squeeze and then say fag or sissy or like bitch, stuff like that, whore and

other words they're not supposed to be saying.

Q. Leaving out the tactical team searches, how often are you strip searched a month?

A. Well, strip search, those are only done on like particular circumstances. So an example is if staff believe that I have dangerous contraband, which could be anything from, I guess, drugs, alcohol, prison made hooch or weapons, they will cuff me up, take me to the shower. They will have officers go in my cell, shake it down, and while I'm in the shower they will ask me like hey, you've got to strip search. They'll cuff me, give me clothes, behind the ears, open my mouth, turn around, spread, cough, stuff like that. That doesn't always happen. Sometimes it happens, you know. There's people here who -- you know, they're A holes. That's just what they feel like doing to get a reaction out of a person to have an excuse to send somebody to seg by doing that, you know.

There was one time they had a five day officer. Every five days he's there, and they just -- I don't know what it is. I hardly spoke to him, and at least once every two weeks he insists upon searching my cell for contraband and putting me in the shower and strip searching me. Now, I can't really complain about it because if it's something that, oh well, they deem

that it's necessary and they're giving me a shakedown slip, what can I say? I can't refuse a shakedown. That's a violation. I can go to seg for that, plus I know I don't have anything in there. But at the same time, you know, sometimes there's things that are borderline harassment that you -- I can't really tell that they are, if they're following rules or if it's just to mess with me.

Q. Have you made any PREA complaints about staff harassment?

A. I have made one and it took six months investigation and basically it was thrown out saying that there wasn't enough sufficient data to basically prove my claims or allegations against the officer.

Q. And when was that?

A. This was last year, and this was regarding -- what is his name? Sergeant Ellinger, he was one of them, and he -- it was in seg. He asked me to move to a cell and I didn't want to. So this time he didn't write a ticket but he took me to the shower and grabbed one of my bras, walked up and down the gallery saying that there is bra wearer fag in this cell. He's walking around with my bra spinning it on his finger saying that if you guys throw shit on him, I won't write a ticket. He put me back in the cell, threw my bra back in there,

Page 89

didn't write me a ticket.

And then later on again, two weeks later, he came by and asked me to move. I said just leave me alone, I'm not moving. Then he wrote me up another bogus ticket saying that I disobeyed a direct order and caused a dangerous and [inaudible] safety to security, which basically means that whatever situation occurred that I refused, TAC team had to come, either Mace me, restrain me and physically take me up out the cell and put me somewhere else or take me and strip, or whatever it is TAC team had to be used. TAC team was never used and he wrote it up and I still had to do time in seg because of it. He said that's what I get for being a fag and not wanting to move.

Q. You have contact with other transgender prisoners at Pontiac Correctional Center, correct?

A. As of right now, no.

Q. When you went to group, was that the only contact you had with other transgender prisoners there?

A. Well, group is basically because, you know, some of you us might not be on the same said. So in south house they have PC, five, seven, six and eight gallery, and there's 52 cells on each gallery. So on my gallery there's another transgender but she's like all the way in 48 cell and I'm in 19 cell. So us to

Page 90

communicate in our cell in quarantine is impossible because we have to be able to yell over everybody else. If the COs want to be mean or find a reason to write a ticket, they just say excessive noise, which is a ticket, basically banging or yelling. On the gallery it's deemable as a ticket. So the only time we can do it is go to yard for that one hour or group during -- not quarantine though. When we go to yard together, we're able to talk and communicate.

Q. Have you heard other -- similar complaints about staff conduct from other transgender prisoners at Pontiac?

A. Yes.

Q. And aside from Dr. Tilden, do you have an assigned mental health provider right now?

A. Tilden is the medical director, but the person I'm assigned to mental health right now is Ms. Yuhas.

Q. Have you spoken with Ms. Yuhas about gender dysphoria?

A. Yes. My first time speaking to her was with the questionnaire in group. That was the first time I've spoken to her on a one-on-one. That's what they call it where you're on their case so they pull you out, put you in like a little bullpen, cuffed, with a screen, and they talk to you.

Page 91

Q. So how many times have you seen her then total?

A. One time.

Q. Before Ms. Yuhas, who was your mental health provider?

A. At south house it was Ms. Hardy. She was assigned for transgenders and she has the mental health caseloads at that house. So I would see her for issues in group regarding gender dysphoria, then bipolar, anxiety and stuff like that on a separate note because she has the cell house for that caseload.

Q. Have you been satisfied with the care that Ms. Hardy provided?

A. I mean to an extent because she's only able to do what they allow her to do. Anything that she's allow to do and can do, one thing about Ms. Hardy she will do or she will try to do. And if she can't, she will tell you exactly why not.

Q. And I know that you spoke with Dr. Ettner at one point before the preliminary injunction hearing. Have you had any follow-up discussions with Dr. Ettner since then?

A. No.

Q. Have you spoken with anybody outside of the Department of Corrections about your care or treatment?

Page 92

A. As far as them being unprofessional or asking them or just anybody?

Q. I mean, sometimes I know there are TeleMed referrals or you might speak with somebody who doesn't work for the department from the prison.

A. I mean, I have friends and family and I have an organization that is basically active for people of LGBTQ that do the best they can to keep people informed and knowledgeable of either new meds or new rulings or stuff like that. I will speak to them sometimes.

Q. And what's that group?

A. It's an organization in Chicago called Black and Pink.

Q. And how can you talk to them?

A. One of them that works there is a friend I grew up with that moved to Chicago, and I already had their number and they work there. So either they write me or we talk on the phone.

Q. So do you talk -- is this somebody who you seek clinical advice from, like a mental health professional or doctor, or are you just seeking updates on transgender issues?

A. Well, they're not a professional of anything. They just work there like as far as passing out new magazines or if you want them to look something up. So

if I say that is there any other medication besides Spirolactone testosterone blocker that is helpful, they will look it up. They're not specialists of anything, though.

Q. Got you.

Do you have contact with any of the other named plaintiffs in this case? So you mentioned Ms. Monroe. Do you have contact with her?

A. No. She's in a different prison.

Q. And you don't write or call each other?

A. They don't allow inmates to call each other or write each other. I think the only way that could happen I believe is they have to be either a spouse or relatives.

Q. You mentioned you heard about Ms. Monroe, complaints that she had from Logan Correctional Center, which is the women's prison. Was that all information that you got from her before the preliminary injunction hearing last year?

A. When I saw her there and we were next to each other, she had told me about some of the issues and difficulties that she was going through, yes, and then I also found out through Black and Pink, because they try to stay obviously relevant on what's happening. So they're like just, you know, this person called here and

they're transgender saying they have problems. They'll ask some of the things they're going through and ask me if that's something they're going through so they can try to help.

Q. So some of the -- at least from Ms. Monroe some of the complaints that you heard were just from when you were at the courthouse together?

A. Yes.

Q. Do you have any contact with Sasha Reed?

A. No.

Q. Do you have any contact with -- well, I guess Sasha Reed also known as XXXX Reed. Is it the same answer?

A. I haven't had any contact with her.

BY MS. ROSE: Can we go off the record for a second.

MS. COOK: Sure.

(Discussion off the record)

MS. COOK: Back on the record.

Just so it's clear, I'm not going to refer to the plaintiffs by their legal names, and I have agreed to -- if the transcript is filed, to redact Ms. Reed's legal name.

BY MS. COOK:

Q. And so just to ask you about the others, do

you have any contact with Lydia Helena Vision?

A. No.

Q. What about Sora Kuykendall?

A. No.

Q. And I know Ebony Stamps is no longer in IDOC. Do you have any ongoing communication with Ms. Stamps?

A. No.

Q. So we've talked about your present complaints with the care that you're receiving, which it sounds like it could be broken down into staff harassment and treatment, hormone information and changes to your hormones, the commissary items that we spoke about and surgical changes that you're seeking.

Is there any other accommodation or treatment for gender dysphoria that you are seeking?

MS. ROSE: Objection, form and object to the extent it mischaracterizes prior testimony. You can answer.

THE WITNESS: You know, all I really seek, not just for myself but anybody who is transgender and going through what I'm going through, all I'm asking is that the IDOC follows WPATH standards, which is just adequate. I'm not saying you have to give me the best accommodation or the best mental health or medical. I'm just asking that you at least give me -- let me receive

the bare minimum that's required, you know, put somebody who knows what they're doing to deal with my health.

You wouldn't want to go to the dentist to have your teeth cleaned add guy is talking about oh I'm really a garbage man, this is my side job, or you go in to have a hernia fixed and he's talking about that he's a dermatologist. I just want a person that's supposed to take care of me to be at least licensed or pass some type of test they have to to have the position they're qualified to have.

BY MS. COOK:

Q. Do you know if the providers meet the standard for the licenses they have?

A. Tilden doesn't. Dr. Tilden has told me out of his own mouth when he first met me that transgender is something new to him, he doesn't really have any hands-on experience, that he has read some things. I had to walk him through and explain to him what conjugated estrogens do. I've had to provide him with WPATH standards because he says they don't have them. In case he was lying, here you go. Now you can't say you're lying, you don't know.

That's why when he will say things like either it's too expensive, WPATH says that regardless of the cost, expense should never be an issue if I'm a ward

of the state. I should be afforded or given the option of the same treatment I was given for in the world.

Q. Aside from what we've already discuss, is there anything that you have requested that you have not received related to your gender dysphoria?

A. I don't understand what you mean.

Q. I just want to make sure that I know -- the things that we've talked about that you have sought for treatment for your gender dysphoria, is there anything that we have not yet talked about?

MS. ROSE: Objection, form, vague.

THE WITNESS: Are you asking me if there's something that I haven't brought up already that I would want or am asking for?

BY MS. COOK:

Q. Yes. Is there anything else that we haven't talked about that you're seeking from the Department of Corrections?

MS. ROSE: Same objection.

THE WITNESS: I mean, as far as I know, I think I've listed everything I want or should I say need.

MS. COOK: Okay. I don't have additional questions. I don't know if your counsel has some follow-up questions.

MS. ROSE: No, no further questions.

MS. COOK: Okay. We can go off the record then.

MS. ROSE: We would like to see the transcript to make sure the redactions are done.

FURTHER DEPONENT SAYETH NOT...

STATE OF ILLINOIS }
} SS:
COUNTY OF C O O K }

I, Verla A. Todd, do hereby certify that MARILYN MELENDEZ was by me first duly sworn to testify the whole truth, and that the foregoing deposition was recorded stenographically by me and was reduced to computerized transcript under my direction, and that the said deposition constitutes a true record of the testimony given by said witness.

I further certify that the reading and signing of said deposition was not waived by the witness and counsel.

I further certify that I am not a relative or employee of any of the parties, or a relative or employee of such attorney or counsel, or financially interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto set my hand at Chicago, Illinois, this _____ day of _____, A.D. _____.

_____
Certified Shorthand Reporter
Illinois CSR License No. 084-003498

ALARIS LITIGATION SERVICES

September 4, 2020

SAMANTHA G. ROSE, Esq.
KIRKLAND & ELLIS, LLP
300 North LaSalle Street
Chicago, Illinois 60654

IN RE: JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED v. ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN

Dear Ms. Rose:

Please find enclosed your copies of the deposition of MARILYN MELENDEZ taken on August 20, 2020 in the above-referenced case. Also enclosed is the original signature page and errata sheets.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheets and notarized signature page within 30 days to our office at 711 N 11th Street, St. Louis, MO 63101 for filing.

Sincerely,

Verla A. Todd

Enclosures

ERRATA SHEET

Witness Name: MARILYN MELENDEZ

Case Name: JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED v. ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN

Date Taken: AUGUST 20, 2020

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Witness Signature: _____

STATE OF _____)

COUNTY OF _____)

I, MARILYN MELENDEZ, do hereby certify:

That I have read the foregoing deposition;

That I have made such changes in form and/or substance to the within deposition as might be necessary to render the same true and correct;

That having made such changes thereon, I hereby subscribe my name to the deposition.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this _____ day of _____, 20___, at _____.

_____
MARILYN MELENDEZ

_____
NOTARY PUBLIC

My Commission Expires:

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard CC CENTER

Offender Information

KUYKENDALL	JORDAN	ID#: B89676
Last Name	First Name	

Date / Time	Subjective, Objective, Assessment	Plans
5/22/2020	RN/LPN/Phlebotomist Note (Circle One)	
	Lab Note :	
	Scheduled for GM 5-20	
	ESTRADIOL LEVEL/TESTOSTERONE LEVEL	
	Done : Yes (No) Signed Refusal (Yes) No	
	Recall :	
	Unable / Ate / Work /Move / No Show / Security / Other ______	
6/26/2020	NPCL:	P: Admin
950A	S: I/m schedule for T.G. clinic	T.G. labs
	Refusal of labs in chart. Spoke	then reschedule
	c I/m. Will take labs.	
	O: A&Ox4. Skin soft/w/D.	
	A: Reschedule T.G. clinic	M. [illegible] APN

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)

(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Kuykendall (Last Name) Jordan (First Name) B89676 (ID#:) (MI)

Date/Time	Subjective, Objective, Assessment	Plans
11/6/20 8A	Cont note S:o: offender requesting permit for Bras + panties - A) transgender concerns	P) Refer to NP Zimmer [illegible]

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: June 11, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 12:24pm

Allergies or Medication Sensitivities? ☒ No ☐ Yes If yes, then describe:

Scheduled Visit Type: Routine Follow Up ☒ Complex Follow Up Evaluation ☐

Level of Care: Outpatient ☒ Residential Treatment Unit ☐ Inpatient ☐ Crisis ☐

Type of Visit: Telepsychiatry ☐ Onsite Evaluation ☒ Other ☐ (identify):

Has offender been on Crisis Watch since last psychiatric visit? Yes ☐ No ☒

If yes, explain:

Source of Information: (Check all that apply)
GBMI inmate

☒ Offender ☐ Mental Health Staff ☐ Medical Staff ☒ Mental Health Progress Notes
☐ Medical Progress Notes ☐ Mental Health Evaluation dated:
☐ Crisis Records ☐ Other (identify):
☒ Previous Psychiatric Progress Note

Subjective/Objective

S: NF for Wellbutrin expired, offender has noted significant worsening of mood, fatigue
Also has T'd stress related to COVID-19 situation, concern re: nationwide protests. Has met E MHP but not comfortable enough other yet to discuss full extent of stressors.

LIST CURRENT PSYCHOTROPIC MEDICATIONS:

Wellbutrin 100 mg bid
↳ has not received since NF expired 5/21/2020

☐ Check if None

Pertinent medical medications:

Premarin
spironolactone

Compliance: ☒ Good ☐ Poor (list details)

Side effects: ☒ None ☐ Yes (list details)

MAR reviewed: Yes ☒ No ☐

when taking - c/o fatigue and sig worsening of depressed mood since med has not been available

Is offender currently prescribed Involuntary Psychotropic Medication(s)? Yes ☐ No ☒

Lab Results: Comment on abnormal results and include drug levels. None ordered ☐

Distribution: Offender Medical File

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: June 11, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 12:24pm

Medical/Mental Health – Female Specific: ☒ Not Applicable

Is the offender currently pregnant? No ☐ Yes ☐ Expected due date:

Mental Status Examination

Posture/Gait: ☐ Appropriate ☐ Inappropriate ☒ Slumped ☐ Tense ☐ Atypical ☐ Rigid ☐

Behavior: ☐ Unremarkable ☐ Poor physical boundaries ☐ Posturing aggressively
☐ Tensed muscles ☐ Closed body posture ☐ Guarded/protective posturing
☒ Psychomotor retardation ☐ Psychomotor agitation ☐

Eye contact: ☒ Appropriate ☐ Avoids eye contact ☐ Looks down in his/her lap
☐ Timid ☐ Unfocused ☐

Level of Appearance: ☐ Appropriately Groomed ☒ Disheveled ☐ Poor Hygiene ☐ Malodorous ☐
↳ unusually so for this offender

Level of Consciousness: ☒ Alert ☐ Clouded ☐ Lethargic ☐ Delirious ☐ Somnolent ☐

Level of Cooperation: ☒ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative ☐

Orientation: ☒ Ox4 (Time, place, person, reality) ☐ OX (list:) ☐ Disoriented

Attention: ☒ Appropriately focused ☐ Selective attention/inattention ☐ Distractible ☐ Unaware ☐

Speech: ☒ Unremarkable ☐ Slowed ☐ Rapid ☐ Inarticulate ☐ Pressured ☐

In tone: ☒ Unremarkable ☐ Impatience ☐ Irritability ☐ Terse ☐ Flatted tone ☐

Thought Processes: ☐ Circumstantial ☐ Disorganized ☐
☒ Clear/Coherent ☐ Tangential ☐ Loose Association ☐ Word Salad/Incoherent

Thought content: ☐ Unremarkable ☐ Paranoid ☐ Delusional ☐ Excessive religiosity ☐ Referential ☐

Explain: "It's been really rough" – d/o problems related to interactions w/ other offenders/staff, concerns and increased stress due to COVID-19 pandemic

Perceptions: ☐ Hallucination ☐ Auditory ☐ Visual ☐ Olfactory ☐ Somatic ☐ Illusions

Explain: No abnormal perceptions

Affect: ☐ Unremarkable (Euthymic) ☐ Constricted ☐ Expansive ☐ Blunt/Inexpressive ☐ Flat
☐ Hyperthymic ☐ Euphoric ☒ Dysthymic ☐ Manic ☐ Inappropriate ☐

Mood: ☐ Euthymic ☒ Dysthymic ☒ Anxious ☐ Fearful ☐
↳ at times very worried about COVID pandemic and potential impact it might have on her family friends

Suicidal ideation: ☒ None ☐ Yes, details:

Homicidal ideation: ☒ None ☐ Yes, details:

Memory: Short-term ☒ Intact ☐ Long-term ☒ Intact ☐

Estimated Intelligence: ☐ Above average ☒ Average ☐ Below average

"overreacts"

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: June 11, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 12:24pm

Insight: ☒ Adequate ☐ Poor ☐

Judgment: ☒ Adequate ☐ Poor ☐

Motivation: ☐ Good ☒ Adequate ☐ Poor ☐

Historian: ☒ Reliable (Generally) ☐ Poor ☐ Inconsistent ☐ Unable to assess at this time

Diagnoses

Psychiatric Diagnosis: ① MDD, recurrent ② Persistent Depressive D/O ; ③ Anxiety D/O (unspec) ④ Autism Spectrum D/O (Asperger's); Transgender

Medical Diagnosis:

Based upon today's evaluation:
Since last visit, offender's psychiatric symptoms have: Improved ☐ Remained same ☐ Worsened ☐

Modified Global Assessment to

Based upon diagnosis, Modified GAF and need for supportive services, Offender is designated SMI? Yes ☒ No ☐

Narrative Summary

27yo Caucasian transgender female incarcerated for murdering teenage girlfriend. Offender attempting suicide after the murder, agreed to plead "guilty but mentally ill" and has had ongoing depression since incarcerated in 2014. Had poor response to other antidepressants, but did show some improvement with addition of Wellbutrin

Psychiatric PLAN

Psychotropic Medication: ☒ Started (DOC 0541) ☐ Discontinued ☐ Changed

☐ Continue Current Medication Bupropion ① 100 mg po bid x 2 wks, then increase to ② 150 mg po qam and 100 mg po qam x 6 mo.

☐ Medication specifics and rationale: NF submitted crushed and FLAT

☐ AIMS completed today (if necessary) (DOC 0336) ☐ AIMS to be done by RN (if necessary)

☐ Labs ☐ CMP ☐ BMP ☐ CBC+Plts ☐ Thyroid Profile ☐ Lithium ☐ Carbamazepine ☐ VPA ☐ Lipid Profile ☐ A1C ☐ EKG ☐ Other: ☐ Other:

☐ Abdominal circumference: ☐ BMI ☐ BP/P

→ still had residual sx on 100 mg bid, so plan to increase as noted but caution re potential anxiety ine

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: June 11, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 12:29pm

☐ Fill in values and measurements on Metabolic Screening and Monitoring form (DOC 0532)

☐ Needs medical referral for: _____

☐ Needs MHP referral (Complete DOC 0387) for:

☐ Sleep hygiene ☐ Anger management ☐ Trauma history ☐ Psychometric testing

☐ Other: _____

☒ Crush/float all Psychotropics due to ☐ Hx of non-compliance ☐ Hx of hoarding medications ☒ Abuse Potential for wellbutrin

☐ Other _____

☒ Offender has been given a copy of the Psychotropic Medication Information brochure.

☒ I have verbally reviewed any medication changes, side-effects, risks and benefits of treatment or refusing treatment with the offender.

☐ Offender's psychiatric condition has been stable on the same psychotropic medication(s) at the same dose for the past 60 days - may be seen max OP - 3 months, RTU - 2 months, Enforced - 1 month.

☒ The offender has signed his/her Medication Consent Form.

☐ Treatment plan update needed based on change of diagnosis, direction of treatment, etc. (DOC 0546)

Designation: ☒ SMI ☐ Enforced Psychotropic to be continued (clinically necessary)

☐ Other (identify): _____

Disposition (Level of Care)

☒ Outpatient Level of Care ☐ Residential Treatment Unit ☐ Inpatient ☐ Crisis

Next Appointment: 30 days

Evaluation completed by:

DR. THENA POTEAT — Print Name

Thena Poteat MD — Signature

PSYCHIATRIST — Title

6/11/2020 — Date

12:55pm — End Time

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Center

Facility

Session Date: June 30, 2020 **Time:** 1:00 pm **Session Duration:** -20- min

Offender Name: (Last, First) Kuykendall, Jordan **ID Number:** B89676

Part I: Offender Information

Level of Care: ☒ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: 06-30-2053 **Discharge:** 06-30-2056

Check all that apply: ☒ Designated SMI ☒ Designated GBMI ☐ On Enforced Medication ☒ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation:	☒ Cooperative	☐ Guarded/Suspicious	☐ Hostile	☐ Uncooperative	
Orientation:	☒ Ox3 (Time, place, person)	☒ OX situation	(list:)	☐ Disoriented	
Affect:	☒ Unremarkable	☐ Constricted	☐ Blunt/Inexpressive	☐ Flat	☐ Labile
Appearance:	☒ Appropriately Groomed	☐ Disheveled	☐ Poor Hygiene		
Thought Process:	☒ Clear/Coherent	☐ Circumstantial	☐ Tangential	☐ Perseveration	
	☐ Loose Association	☐ Word Salad/Incoherent	☐ Thought Blocking		

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

S: QMHP and inmate met individual therapy in a confidential location in North 2 Cell House Infirmary. Inmate reports that he is doing well and states that there are "4 or 5 others who I can talk with on the gallery, but there is no one that I trust." Inmate reports that he has no cellie. QMHP Draper also attending session. Inmate and QMHPs establish rapport as this is the first session with this writer and MHP Draper. Inmate reports that there are no medical problems to discuss and no mental health problems to discuss. QMHP provides support therapy, primarily Rogerian as inmate reports doing well and advocating for self well.
O: Inmate is observed to have good eye contact and smiling during session. Inmate denies suicidal/homicidal ideations upon direct inquiry, no evidence of hallucinations/delusions. Clear in thought. Oriented to person, place, time and situation. Inmate was observed well groomed. Good eye contact. Inmate is observed to be polite.
A: Gender Dyshoria
P: Inmate will meet in 30 days for individual therapy. Continue helping inmate with awareness techniques.

Clinician Name (Print): Samantha Stellhorn QMHP Signature:

Facility: Menard Correctional Center Title: Mental Health Professional

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

ILLINOIS DEPARTMENT OF CORRECTIONS

Psychiatric Progress Note

Facility: Menard Correctional Center

Offender Name:
Last, First KUYKENDALL, JORDAN **ID Number:** B89676 **Date:** Jul 10, 2020

☐ Labs ☐ CMP ☐ BMP ☐ CBC+Plts ☐ Thyroid Profile ☐ Lithium ☐ Carbamazepine

☐ VPA ☐ Lipid Profile ☐ A1C ☐ EKG ☐ Other: _____ ☐ Other: _____

☐ Abdominal circumference: _____ ☐ BMI _____ ☐ BP/P _____

☐ Fill in values and measurements on Metabolic Screening and Monitoring form (DOC 0532)

☐ Needs medical referral for: _____

☐ Needs MHP referral (Complete DOC 0387) for:

☐ Sleep hygiene ☐ Anger management ☐ Trauma history ☐ Psychometric testing

☐ Other: _____

☒ Crush/float all Psychotropics due to ☐ Hx of non-compliance ☐ Hx of hoarding medications ☒ Abuse Potential

☐ Other **for Wellbutrin**

☐ Offender has been given a copy of the Psychotropic Medication Information brochure.

☒ I have verbally reviewed any medication changes, side-effects, risks and benefits of treatment or refusing treatment with the offender.

☐ Offender's psychiatric condition has been stable on the same psychotropic medication(s) at the same dose for the past 60 days - may be seen max OP - 3 months, RTU - 2 months, Enforced - 1 month.

☐ The offender has signed his/her Medication Consent Form.

☐ Treatment plan update needed based on change of diagnosis, direction of treatment, etc. (DOC 0546)

Designation: ☐ SMI ☐ Enforced Psychotropic to be continued (clinically necessary)

☐ Other (identify): _____

Disposition (Level of Care)

☒ Outpatient Level of Care ☐ Residential Treatment Unit ☐ Inpatient ☐ Crisis

Next Appointment: 4 weeks

Evaluation completed by:

Farzana Alam	farzana Alam Digitally signed by farzana Alam Date: 2020.07.10 22:42:21 -05'00'	MD
Print Name	Signature	Title
07/10/20	3:02:00 PM	
Date	End Time	

Noted S Burkin 7-13-2020 2pm

Distribution: Offender Medical File

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: August 12, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 10:10 AM

Allergies or Medication Sensitivities? [X] No [ ] Yes If yes, then describe:

Scheduled Visit Type: Routine Follow Up [X] Complex Follow Up Evaluation [ ]

Level of Care: Outpatient [X] Residential Treatment Unit [ ] Inpatient [ ] Crisis [ ]

Type of Visit: Telepsychiatry [ ] Onsite Evaluation [X] Other [ ] (identify):

Has offender been on Crisis Watch since last psychiatric visit? Yes [ ] No [X]

If yes, explain:

Source of Information: (Check all that apply)
[X] Offender [ ] Mental Health Staff [ ] Medical Staff [X] Mental Health Progress Notes
[ ] Medical Progress Notes [ ] Mental Health Evaluation dated:
[ ] Crisis Records [ ] Other (identify):
[X] Previous Psychiatric Progress Note

Subjective/Objective

Note: seen briefly at cell front due to COVID-19 restrictions

S: Doing better since Wellbutrin restarted ~~but~~ but C/o some ↑ in anxiety, but much less depressed
Requested decrease in dose

LIST CURRENT PSYCHOTROPIC MEDICATIONS:

Wellbutrin 150mg qam and 100mg pogHs

[ ] Check if None

Pertinent medical medications:

Premarin
spironolactone

Compliance: [X] Good [ ] Poor (list details)

Side effects: [ ] None [X] Yes (list details) ↑'d anxiety/agitation (mild)

MAR reviewed: Yes [X] No [ ]

Is offender currently prescribed Involuntary Psychotropic Medication(s)? Yes [ ] No [X]

Lab Results: Comment on abnormal results and include drug levels. None ordered [ ]

7/10/2020 Estradiol 33
Testosterone less than 3

Distribution: Offender Medical File

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: August 12, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 10:10AM

Medical/Mental Health – Female Specific: ☒ Not Applicable

Is the offender currently pregnant? No ☐ Yes ☐ Expected due date: _____

Mental Status Examination

Posture/Gait: ☒ Appropriate ☐ Inappropriate ☐ Slumped ☐ Tense ☐ Atypical ☐ Rigid ☐ _____

Behavior: ☒ Unremarkable ☐ Poor physical boundaries ☐ Posturing aggressively
☐ Tensed muscles ☐ Closed body posture ☐ Guarded/protective posturing
☐ Psychomotor retardation ☐ Psychomotor agitation ☐ _____

Eye contact: ☒ Appropriate ☐ Avoids eye contact ☐ Looks down in his/her lap
☐ Timid ☐ Unfocused ☐ _____

Level of Appearance: ☒ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene ☐ Malodorous ☐ _____

Level of Consciousness: ☒ Alert ☐ Clouded ☐ Lethargic ☐ Delirious ☐ Somnolent ☐ _____

Level of Cooperation: ☒ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative ☐ _____

Orientation: ☒ Ox4 (Time, place, person, reality) ☐ OX _____ (list:) _____ ☐ Disoriented

Attention: ☒ Appropriately focused ☐ Selective attention/inattention ☐ Distractible ☐ Unaware ☐ _____

Speech: ☒ Unremarkable ☐ Slowed ☐ Rapid ☐ Inarticulate ☐ Pressured ☐ _____

In tone: ☒ Unremarkable ☐ Impatience ☐ Irritability ☐ Terse ☐ Flatted tone ☐ _____

Thought Processes: ☐ Circumstantial ☐ Disorganized ☐ _____
☒ Clear/Coherent ☐ Tangential ☐ Loose Association ☐ Word Salad/Incoherent

Thought content: ☒ Unremarkable ☐ Paranoid ☐ Delusional ☐ Excessive religiosity ☐ Referential ☐ _____

Explain: Notably improved mood since wellbutrin resumed

Perceptions: ☐ Hallucination ☐ Auditory ☐ Visual ☐ Olfactory ☐ Somatic ☐ Illusions

Explain:

Affect: ☒ Unremarkable (Euthymic) smiling ☐ Constricted ☐ Expansive ☐ Blunt/Inexpressive ☐ Flat
☐ Hyperthymic ☐ Euphoric ☐ Dysthymic ☐ Manic ☐ Inappropriate ☐ _____

Mood: ☒ Euthymic ☐ Dysthymic ☒ Anxious mildly ☐ Fearful ☐ _____

Suicidal ideation: ☒ None ☐ Yes, details: _____

Homicidal ideation: ☒ None ☐ Yes, details: _____

Memory: Short-term ☒ Intact ☐ _____ Long-term ☒ Intact ☐ _____

Estimated Intelligence: ☐ Above average ☒ Average or above ☐ Below average

Printed on Recycled Paper

Distribution: Offender Medical File

DOC 0502 (Rev. 1/2019)

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: August 12, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 10:10 am

Insight: ☒ Adequate ☐ Poor ☐

Judgment: ☒ Adequate ☐ Poor ☐

Motivation: ☒ Good ☐ Adequate ☐ Poor ☐

Historian: ☒ Reliable ☐ Poor ☐ Inconsistent ☐ Unable to assess at this time

Diagnoses

Psychiatric Diagnosis: MDD (recurrent), Anxiety D/O (unspec), Autistic Spectrum D/O, Transgender

Medical Diagnosis: takes feminizing hormones

Based upon today's evaluation:
Since last visit, offender's psychiatric symptoms have: Improved ☒ Remained same ☐ Worsened ☐

Modified Global Assessment 68 **to** 73

Based upon diagnosis, Modified GAF and need for supportive services, Offender is designated SMI? Yes ☒ No ☐ Also GBMI

Narrative Summary

28 yo transgender female, currently taking feminizing hormones. Mucless depressed, but requested decrease in Wellbutrin dose 2° some worsening of anxiety.

Psychiatric PLAN

Psychotropic Medication: ☐ Started (DOC 0541) ☐ Discontinued ☒ Changed

☐ Continue Current Medication

☐ Medication specifics and rationale: Decrease Wellbutrin to 100 mg po bid x 6 mo. Crush and float

☐ AIMS completed today (if necessary) (DOC 0336) ☐ AIMS to be done by RN (if necessary)

☐ Labs ☐ CMP ☐ BMP ☐ CBC+Plts ☐ Thyroid Profile ☐ Lithium ☐ Carbamazepine
☐ VPA ☐ Lipid Profile ☐ A1C ☐ EKG ☐ Other: ☐ Other:

☐ Abdominal circumference: ☐ BMI ☐ BP/P

Distribution: Offender Medical File

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: August 12, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 10:10AM

☐ Fill in values and measurements on Metabolic Screening and Monitoring form (DOC 0532)

☐ Needs medical referral for: _____

☐ Needs MHP referral (Complete DOC 0387) for:

☐ Sleep hygiene ☐ Anger management ☐ Trauma history ☐ Psychometric testing

☐ Other: _____

☒ Crush/float all Psychotropics due to ☐ Hx of non-compliance ☐ Hx of hoarding medications ☒ Abuse Potential

☐ Other _____

per protocol requested by Regional psychiatry supervisor

☒ Offender has been given a copy of the Psychotropic Medication Information brochure.

☒ I have verbally reviewed any medication changes, side-effects, risks and benefits of treatment or refusing treatment with the offender.

☐ Offender's psychiatric condition has been stable on the same psychotropic medication(s) at the same dose for the past 60 days - may be seen max OP - 3 months, RTU - 2 months, Enforced - 1 month.

☒ The offender has signed his/her Medication Consent Form.

☐ Treatment plan update needed based on change of diagnosis, direction of treatment, etc. (DOC 0546)

Designation: ☒ SMI ☐ Enforced Psychotropic to be continued (clinically necessary)

☐ Other (identify): _____

Disposition (Level of Care)

☒ Outpatient Level of Care ☐ Residential Treatment Unit ☐ Inpatient ☐ Crisis

Next Appointment: 30 days

Evaluation completed by:

DR. THENA POTEAT	Thena Poteat MD	PSYCHIATRIST
Print Name	Signature	Title
8/12/2020	10:15AM	
Date	End Time	

8/12/2020

Menard Correctional Center
711 Kaskaskia Street
PO Box 711
Menard, IL 62259

UNIVERSITY OF ILLINOIS
Hospital and Health Sciences System
Reference Laboratory

840 South Wood Street,
Room 170 (M/C 750)
Chicago, Illinois 60612
Ph# (877)FOR-LABS
Fredrick Behm, M.D., Director

PATIENT NAME	PATIENT ID	DOB	SEX	STATUS	DESTINATION
KUYKENDALL, JORDAN B89676	A208-89676	07/15/1992	M	Final	D208

PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE	PRINTED ON	PAGE
	07/10/2020 08:03	07/10/2020 23:23	07/15/2020 7:04	1

REQUISITION NO.	PT. LAB NO.	LAB REF NO.
A208.5899		

COMMENTS:

Diagnostic Procedure	Result In Range	Result Out of Range	Units	Reference Range
ESTRADIOL	33		PG/ML	
(NOTE)				
REFERENCE INTERVAL				
MALES (ADULT)				15-31 PG/ML
FEMALES (ADULTS):				
POSTMENOPAUSAL:				15-25 PG/ML
FOLLICULAR PHASE:				25-115 PG/ML
MIDCYCLE:				32-517 PG/ML
LUTEAL PHASE:				36-246 PG/ML
New reference interval implemented 6/11/19. Assay is performed on the Beckman DXI platform.				
TESTOSTERONE		<3 L		
Reference range: 300 to 1080				
Unit: ng/dL				
(NOTE)				
Total testosterone values may not reflect optimal concentrations in all individuals. Free or bioavailable testosterone measurements may provide supportive information.				
REFERENCE INTERVAL: Testosterone, Adult Male				
Access complete set of age- and/or gender-specific reference intervals for this test in the ARUP Laboratory Test Directory (aruplab.com).				
Performed By: ARUP Laboratories 500 Chipeta Way Salt Lake City, UT 84108 Laboratory Director: Julio C. Delgado, MD, MS				

End of Report

KUYKENDALL, JORDAN B89676 07/15/2020 07:04 D208

Noted 7/21/20

M.D. REVIEW 7/21
DATE
DOCTOR
PULL CHART
SEE PATIENT
CC/PE/HIV

ILLINOIS DEPARTMENT OF CORRECTIONS

Consent for Medical Treatment

Menard Corr. Center

Date: 8/10/2020

Time: 9:35 ☒ a.m. ☐ p.m.

Patient Information:

Kuykendall Jordan ID#: B89674

Last Name First Name MI

☒ I authorize the performance upon Self of the following treatment:

Myself or Name of Patient

Breast exam

state the nature and extent of treatment

to be performed by Dr. Mary Zimmer, A.P.N. or whomever he or she may designate

Name of Physician

as his or her assistants.

☒ The nature and extent of the intended treatment has been explained to me in detail, including its risk, possible complications, and probable consequences by Dr. Mary Zimmer, A.P.N..

Name of Physician

I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

☒ I certify that I have read and fully understand the above Consent to Treatment, that the EXPLANATIONS therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in.

Jordan Kuykendall — Print Name of Patient

Signature of Patient

8/10/2020 — Date

When patient is a Minor or Incompetent to give consent:

Print Name of Person Authorized to Consent

Signature of Person Authorized to Consent

/ / — Date

M. Zimmer APN — Print Name of Witness

M. Zimmer APN — Signature of Witness

8/10/2020 — Date

Distribution: Patient's Medical Record

Printed on Recycled Paper

DOC 0094 (Eff. 9/2002)
(Replaces DC 7130-A)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Non-Specific Discomfort

Offender Information: Kluyendall (Last Name) Jordan (First Name) ____ (MI) B896076 ID#:

Date/Time	Subjective, Objective, Assessment	Plans
9/22/20 825 am	**RN NOTE** **LPN/CMT NOTE**	R) **MD Referral if:** Refu to Somer
	S) - Any Allergies? NKDA	- Patient presents more than twice at NSC for c/o same discomfort within one month
	- Location of pain / discomfort?	- Patient presents with signs of acute, severe discomfort
	- Describe pain Stabbing Throbbing Constant Intermittent Etc.	- Patient has abnormal vital signs
	- Have you had this pain before and how was it treated?	
	- Rate pain level scale of 1 – 10?	**No MD referral:**
	- Duration of pain?	- Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets)
	O) T 98.1 P 62 R 12 BP 108/76 WT 119	- Ibuprofen 200mg 1-2 tabs t.i.d. PRN for 3 days (18 tabs)
	- Signs of obvious discomfort	**Patient Teaching:**
	- Observations related to body part affected Currently on estradule 5mg PO daily. Offender is requesting dose to be increased	- Return to see provider if symptoms worsen or interfere with daily functioning
		Nurse Signature
	A) Non-Specific Discomfort	~~Payment voucher~~ ~~YES~~ ~~NO~~

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: August 12, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 10:10 AM

Allergies or Medication Sensitivities? [X] No [ ] Yes If yes, then describe:

Scheduled Visit Type: Routine Follow Up [X] Complex Follow Up Evaluation [ ]

Level of Care: Outpatient [X] Residential Treatment Unit [ ] Inpatient [ ] Crisis [ ]

Type of Visit: Telepsychiatry [ ] Onsite Evaluation [X] Other [ ] (identify):

Has offender been on Crisis Watch since last psychiatric visit? Yes [ ] No [X]

If yes, explain:

Source of Information: (Check all that apply)
[X] Offender [ ] Mental Health Staff [ ] Medical Staff [X] Mental Health Progress Notes
[ ] Medical Progress Notes [ ] Mental Health Evaluation dated:
[ ] Crisis Records [ ] Other (identify):
[X] Previous Psychiatric Progress Note

Subjective/Objective

Note: seen briefly at cell front due to COVID-19 restrictions
S: Doing better since Wellbutrin restarted ~~but~~ but c/o some ↑ in anxiety, but much less depressed
Requested decrease in dose

LIST CURRENT PSYCHOTROPIC MEDICATIONS:

Wellbutrin 150mg qam and 100mg pogths

[ ] Check if None

Pertinent medical medications:

Premarin
Spironolactone

Compliance: [X] Good [ ] Poor (list details)

Side effects: [ ] None [X] Yes (list details) ↑'d anxiety/agitation (mild)

MAR reviewed: Yes [X] No [ ]

Is offender currently prescribed Involuntary Psychotropic Medication(s)? Yes [ ] No [X]

Lab Results: Comment on abnormal results and include drug levels. None ordered [ ]

7/10/2020 Estradiol 33
Testosterone less than 3

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: August 12, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name: Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 10:10AM

Medical/Mental Health – Female Specific: ☒ Not Applicable

Is the offender currently pregnant? No ☐ Yes ☐ Expected due date:

Mental Status Examination

Posture/Gait: ☒ Appropriate ☐ Inappropriate ☐ Slumped ☐ Tense ☐ Atypical ☐ Rigid ☐

Behavior: ☒ Unremarkable ☐ Poor physical boundaries ☐ Posturing aggressively
☐ Tensed muscles ☐ Closed body posture ☐ Guarded/protective posturing
☐ Psychomotor retardation ☐ Psychomotor agitation ☐

Eye contact: ☒ Appropriate ☐ Avoids eye contact ☐ Looks down in his/her lap
☐ Timid ☐ Unfocused ☐

Level of Appearance: ☒ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene ☐ Malodorous ☐

Level of Consciousness: ☒ Alert ☐ Clouded ☐ Lethargic ☐ Delirious ☐ Somnolent ☐ smiling

Level of Cooperation: ☒ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative ☐

Orientation: ☒ Ox4 (Time, place, person, reality) ☐ OX (list:) ☐ Disoriented

Attention: ☒ Appropriately focused ☐ Selective attention/inattention ☐ Distractible ☐ Unaware ☐

Speech: ☒ Unremarkable ☐ Slowed ☐ Rapid ☐ Inarticulate ☐ Pressured ☐

In tone: ☒ Unremarkable ☐ Impatience ☐ Irritability ☐ Terse ☐ Flatted tone ☐

Thought Processes: ☐ Circumstantial ☐ Disorganized ☐
☒ Clear/Coherent ☐ Tangential ☐ Loose Association ☐ Word Salad/Incoherent

Thought content: ☒ Unremarkable ☐ Paranoid ☐ Delusional ☐ Excessive religiosity ☐ Referential ☐

Explain: Notably improved mood since we both in reserved

Perceptions: ☐ Hallucination ☐ Auditory ☐ Visual ☐ Olfactory ☐ Somatic ☐ Illusions

Explain:

Affect: ☒ Unremarkable (Euthymic) ☐ Constricted ☐ Expansive ☐ Blunt/Inexpressive ☐ Flat
☐ Hyperthymic ☐ Euphoric ☐ Dysthymic ☐ Manic ☐ Inappropriate ☐ smiling

Mood: ☒ Euthymic ☐ Dysthymic ☒ Anxious mildly ☐ Fearful ☐

Suicidal ideation: ☒ None ☐ Yes, details:

Homicidal ideation: ☒ None ☐ Yes, details:

Memory: Short-term ☒ Intact ☐ Long-term ☒ Intact ☐

Estimated Intelligence: ☐ Above average ☒ Average or above ☐ Below average

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: August 12, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 10:10 am

Insight: ☒ Adequate ☐ Poor ☐

Judgment: ☒ Adequate ☐ Poor ☐

Motivation: ☒ Good ☐ Adequate ☐ Poor ☐

Historian: ☒ Reliable ☐ Poor ☐ Inconsistent ☐ Unable to assess at this time

Diagnoses

Psychiatric Diagnosis: MDD (recurrent), Anxiety D/O (unspec), Autistic Spectrum D/O, Transgender

Medical Diagnosis: takes feminizing hormones

Based upon today's evaluation:
Since last visit, offender's psychiatric symptoms have: Improved ☒ Remained same ☐ Worsened ☐

Modified Global Assessment 68 to 73

Based upon diagnosis, Modified GAF and need for supportive services, Offender is designated SMI? Yes ☒ No ☐ Also GBMI

Narrative Summary

28 yo transgender female, currently taking feminizing hormones. Mochless depressed, but requested decrease in Wellbutrin dose 2° some worsening of anxiety.

Psychiatric PLAN

Psychotropic Medication: ☐ Started (DOC 0541) ☐ Discontinued ☒ Changed

☐ Continue Current Medication

☐ Medication specifics and rationale: Decrease Wellbatrin to 100 mg po bid x 6 mo. Crush and float

☐ AIMS completed today (if necessary) (DOC 0336) ☐ AIMS to be done by RN (if necessary)

☐ Labs ☐ CMP ☐ BMP ☐ CBC+Plts ☐ Thyroid Profile ☐ Lithium ☐ Carbamazepine
☐ VPA ☐ Lipid Profile ☐ A1C ☐ EKG ☐ Other: ☐ Other:

☐ Abdominal circumference: ☐ BMI ☐ BP/P

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: August 12, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Kuykendall, Jordan **ID Number:** B89676 **Start Time:** 10:10AM

☐ Fill in values and measurements on Metabolic Screening and Monitoring form (DOC 0532)

☐ Needs medical referral for: _____

☐ Needs MHP referral (Complete DOC 0387) for:

☐ Sleep hygiene ☐ Anger management ☐ Trauma history ☐ Psychometric testing

☐ Other: _____

☒ Crush/float all Psychotropics due to ☐ Hx of non-compliance ☐ Hx of hoarding medications ☒ Abuse Potential

☐ Other _____

per protocol requested by Regional psychiatry supervisor

☒ Offender has been given a copy of the Psychotropic Medication Information brochure.

☒ I have verbally reviewed any medication changes, side-effects, risks and benefits of treatment or refusing treatment with the offender.

☐ Offender's psychiatric condition has been stable on the same psychotropic medication(s) at the same dose for the past 60 days - may be seen max OP - 3 months, RTU - 2 months, Enforced - 1 month.

☒ The offender has signed his/her Medication Consent Form.

☐ Treatment plan update needed based on change of diagnosis, direction of treatment, etc. (DOC 0546)

Designation: ☒ SMI ☐ Enforced Psychotropic to be continued (clinically necessary)

☐ Other (identify): _____

Disposition (Level of Care)

☒ Outpatient Level of Care ☐ Residential Treatment Unit ☐ Inpatient ☐ Crisis

Next Appointment: 30 days

Evaluation completed by:

DR. THENA POTEAT — Print Name

Thena Poteat MD — Signature

PSYCHIATRIST — Title

8/12/2020 — Date

10:15AM — End Time

Thena Poteat MD 8/12/2020

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Center

Facility

Session Date: 8.16.20 **Time:** 9:25 Am. **Session Duration:** 8-10minutes

Offender Name: (Last, First) Kuykendall, Jordan "Sora" **ID Number:** B89676

Part I: Offender Information

Level of Care: ☒ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: _____ **Discharge:** _____

Check all that apply: ☐ Designated SMI ☐ Designated GBMI ☐ On Enforced Medication ☐ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation:	☒ Cooperative	☐ Guarded/Suspicious	☐ Hostile	☐ Uncooperative	
Orientation:	☒ Ox3 (Time, place, person)	☐ OX _____ (list:) _____	☐ Disoriented		
Affect:	☒ Unremarkable	☐ Constricted	☐ Blunt/Inexpressive	☐ Flat	☐ Labile
Appearance:	☒ Appropriately Groomed	☐ Disheveled	☐ Poor Hygiene		
Thought Process:	☒ Clear/Coherent	☐ Circumstantial	☐ Tangential	☐ Perseveration	
	☐ Loose Association	☐ Word Salad/Incoherent	☐ Thought Blocking		

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

S: "I'm good" The offender stated. Offender prefers to be referred to as her/she. Offender asked about her transfer. This QMHP will f/u.
O: = offender presented within normal limits of motor activities. no thoughts of homicide or suicide, no hallucinations/delusions. good eye contact, good

Clinician Name (Print): R. Draper Signature: R. Draper

Facility: Menard Correctional Center Title: QMHP

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2010)

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Center

Facility

Session Date: 8.14.20 **Time:** 9:30 Approx **Session Duration:** 8-10 min

Offender Name: (Last, First) KyKendall, Jordan **ID Number:** B89676

support, med compliant, and denies x's.

A: Transgender

P: Continue current course

Clinician Name (Print): R. Draper Signature: R. Draper LSW

Facility: Menard Correctional Center Title: QMHP

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: September 9, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First KUYKENDALL, JORDAN **ID Number:** B89676 **Start Time:**

Allergies or Medication Sensitivities? ☒ No ☐ Yes If yes, then describe:

Scheduled Visit Type: Routine Follow Up ☒ Complex Follow Up Evaluation ☐

Level of Care: Outpatient ☒ Residential Treatment Unit ☐ Inpatient ☐ Crisis ☐

Type of Visit: Telepsychiatry ☐ Onsite Evaluation ☒ Other ☐ (identify):

Has offender been on Crisis Watch since last psychiatric visit? Yes ☐ No ☒

If yes, explain:

Source of Information: (Check all that apply)
☒ Offender ☐ Mental Health Staff ☐ Medical Staff ☒ Mental Health Progress Notes
☐ Medical Progress Notes ☐ Mental Health Evaluation dated:
☐ Crisis Records ☐ Other (identify):
☒ Previous Psychiatric Progress Note

Subjective/Objective

S: "Really sad, all the time"
Does not want to change meds 2° higher dose of Wellbutrin 1'd anxiety

LIST CURRENT PSYCHOTROPIC MEDICATIONS:

Wellbutrin 100 mg po bid

☐ Check if None

Pertinent medical medications:

Premarin
spironolactone

Compliance: ☒ Good ☐ Poor (list details) Excellent - no missed doses

Side effects: ☐ None ☒ Yes (list details) some ↑ in anxiety

MAR reviewed: Yes ☒ No ☐

Is offender currently prescribed Involuntary Psychotropic Medication(s)? Yes ☐ No ☒

Lab Results: Comment on abnormal results and include drug levels. None ordered ☐

Distribution: Offender Medical File

ILLINOIS DEPARTMENT OF CORRECTIONS

Psychiatric Progress Note

Date: September 9, 2020

Facility MENARD CORRECTIONAL CENTER

Offender Name: Last, First KUYKENDALL, JORDAN **ID Number:** B89676 **Start Time:**

Medical/Mental Health – Female Specific: ☒ Not Applicable

Is the offender currently pregnant? No ☐ Yes ☐ Expected due date:

Mental Status Examination

Posture/Gait: ☒ Appropriate ☐ Inappropriate ☐ Slumped ☐ Tense ☐ Atypical ☐ Rigid ☐

Behavior: ☒ Unremarkable ☐ Poor physical boundaries ☐ Posturing aggressively
☐ Tensed muscles ☐ Closed body posture ☐ Guarded/protective posturing
☐ Psychomotor retardation ☐ Psychomotor agitation ☐

Eye contact: ☒ Appropriate ☐ Avoids eye contact ☐ Looks down in his/her lap
☐ Timid ☐ Unfocused ☐

Level of Appearance: ☒ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene ☐ Malodorous ☐
→ feminine appearance, as usual

Level of Consciousness: ☒ Alert ☐ Clouded ☐ Lethargic ☐ Delirious ☐ Somnolent ☐

Level of Cooperation: ☒ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative ☐

Orientation: ☒ Ox4 (Time, place, person, reality) ☐ OX ____ (list:) ____ ☐ Disoriented

Attention: ☒ Appropriately focused ☐ Selective attention/inattention ☐ Distractible ☐ Unaware ☐

Speech: ☒ Unremarkable ☐ Slowed ☐ Rapid ☐ Inarticulate ☐ Pressured ☐

In tone: ☒ Unremarkable ☐ Impatience ☐ Irritability ☐ Terse ☐ Flatted tone ☐

Thought Processes: ☐ Circumstantial ☐ Disorganized ☐
☒ Clear/Coherent ☐ Tangential ☐ Loose Association ☐ Word Salad/Incoherent

Thought content: ☒ Unremarkable ☐ Paranoid ☐ Delusional ☐ Excessive religiosity ☐ Referential ☐

Explain: Frustrated re: lack of access to female undergarments, hygiene products

Perceptions: ☐ Hallucination ☐ Auditory ☐ Visual ☐ Olfactory ☐ Somatic ☐ Illusions

Explain: No abnormal perceptions

Affect: ☐ Unremarkable (Euthymic) ☐ Constricted ☐ Expansive ☐ Blunt/Inexpressive ☐ Flat
☐ Hyperthymic ☐ Euphoric ☒ Dysthymic ☐ Manic ☐ Inappropriate ☒ full range
→ but responsive, intermittent smiles

Mood: ☐ Euthymic ☒ Dysthymic ☐ Anxious ☐ Fearful ☐

Suicidal ideation: ☐ None ☒ Yes, details: "All the time, but I don't act on them. I don't think changing medication will help."

Homicidal ideation: ☒ None ☐ Yes, details:

Memory: Short-term ☒ Intact ☐ Long-term ☒ Intact ☐

Estimated Intelligence: ☐ Above average ☒ Average or above ☐ Below average

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: September 9, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First KUYKENDALL, JORDAN **ID Number:** B89676 **Start Time:**

Insight: ☒ Adequate ☐ Poor ☐

Judgment: ☒ Adequate ☐ Poor ☐

Motivation: ☐ Good ☒ Adequate ☐ Poor ☐

Historian: ☒ Reliable ☐ Poor ☐ Inconsistent ☐ Unable to assess at this time

Diagnoses

Psychiatric Diagnosis: MDD recurrent; Anxiety D/O (unspec); Autistic Spectrum D/O

Medical Diagnosis: Transgender on feminizing hormones

Based upon today's evaluation:
Since last visit, offender's psychiatric symptoms have: Improved ☐ Remained same ☒ Worsened ☐

Modified Global Assessment 50 **to** 53

Based upon diagnosis, Modified GAF and need for supportive services, Offender is designated SMI? Yes ☒ No ☐

GBMI

Narrative Summary

28 yo transwoman w Recurrent MDD, stable on bupropion monotherapy but MH clearly adversely impacted by ~~lack of~~ environment as clearly female in a male prison.

Psychiatric PLAN

Psychotropic Medication: ☐ Started (DOC 0541) ☐ Discontinued ☐ Changed

☒ Continue Current Medication Wellbutrin 100mg po bid (exp 2/12/2021)

☐ Medication specifics and rationale:

☐ AIMS completed today (if necessary) (DOC 0336) ☐ AIMS to be done by RN (if necessary)

☐ Labs ☐ CMP ☐ BMP ☐ CBC+Plts ☐ Thyroid Profile ☐ Lithium ☐ Carbamazepine

☐ VPA ☐ Lipid Profile ☐ A1C ☐ EKG ☐ Other: ☐ Other:

☐ Abdominal circumference: ☐ BMI ☐ BP/P

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: September 9, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First KUYKENDALL, JORDAN **ID Number:** B89676 **Start Time:**

☐ Fill in values and measurements on Metabolic Screening and Monitoring form (DOC 0532)

☐ Needs medical referral for:

☐ Needs MHP referral (Complete DOC 0387) for:

☐ Sleep hygiene ☐ Anger management ☐ Trauma history ☐ Psychometric testing

☐ Other:

☒ Crush/float all Psychotropics due to ☐ Hx of non-compliance ☐ Hx of hoarding medications ☒ Abuse Potential

☐ Other

☒ Offender has been given a copy of the Psychotropic Medication Information brochure.

☒ I have verbally reviewed any medication changes, side-effects, risks and benefits of treatment or refusing treatment with the offender.

☐ Offender's psychiatric condition has been stable on the same psychotropic medication(s) at the same dose for the past 60 days - may be seen max OP - 3 months, RTU - 2 months, Enforced - 1 month.

☒ The offender has signed his/her Medication Consent Form.

☐ Treatment plan update needed based on change of diagnosis, direction of treatment, etc. (DOC 0546)

Designation: ☒ SMI ☐ Enforced Psychotropic to be continued (clinically necessary)

☐ Other (identify):

Disposition (Level of Care)

☒ Outpatient Level of Care ☐ Residential Treatment Unit ☐ Inpatient ☐ Crisis

Next Appointment: 30 days

Evaluation completed by:

DR. THENA POTEAT — Print Name

Signature

PSYCHIATRIST — Title

9/9/2020 — Date

End Time

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Kuykendall Jordan ID#: B89676

Last Name First Name MI

Date/Time	Subjective, Objective, Assessment	Plans
8/10/2020 932	**S: Gender Dysphoria Disorder** ✓ No change from previous unless noted	**Labs:** Estradiol: Level 33 Last done 7/10/20 (< 200) Testosterone: Level 53 Last done 7/10/20 (<100) CMP (if on spironolactone) K Level / Cr Not Last done ____
	GDD Related Treatment in the Past? Been on Hormone Tx since 2005	Other Lab: Level ____ Last done ____ Level ____ Last done ____ Level ____ Last done ____
	GDD Related Surgeries in the Past? Ø	
Wt 123	Other:	(consider: periodic lipids, CBC, prolactin level)
99.1	Family History: ✓ No change from previous unless noted	**Imaging:** Mammogram:
50	Reproductive Cancers Early Atherosclerosis HTN Dyslipidemia DM2	(Not needed) Needed Done ____
18	O: ✓ No change from previous unless noted ___ Exam not done (not necessary at every clinic)	(mammogram screening can be considered in any patient > 50 years of age who has had at least 5 years of hormone treatment)
117/98	Penis: (Present) Abnormal ____ (Normal)	
	Testis: (Present) Normal (Atrophied) Abnormal ____	**Counseling:** ____ Not done (only needed prior to starting treatment and periodically there after)
	Breasts: No Finding (Breast Bud) Developed Breasts	**Risk of treatment:** Increased risk of: thromboembolic disease, gallstones, elevated liver enzymes, weight gain, hypertriglyceridemia, cardiovascular disease (in the presence of risk factors)
	Note: breast growth usually stops after about 2-3 years of treatment and increased medication will not result in more growth.	Potential increased risk of: HTN, hyperprolactimenia or prolactinoma, DM2
	Adams Apple Alterations: YES (NO)	Reasons treatment may be stopped without patient consent include but are not limited to the following:
	Surgical alterations: (NO) YES ____	Non-compliance with medication Non-compliance with lab Monitoring Non-compliance with the GDD clinic
	Female Fat Distribution: (YES) NO	Development of a contention that is a contraindication of treatment
	Reduced Body / Facial Hair: (YES) NO	Decompensation of a condition that is a contraindication to treatment.
	Other:	**Patient teaching:** Verbalized or otherwise indicated understanding (YES) NO

Distribution: Offender's Medical Record

Monroe et al. v. Rauner, et al. (18-156) Document No.: 361338

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Kuykendall (Last Name) Jordan (First Name) ____ (MI) ID#: B89674

Date/Time	Subjective, Objective, Assessment	Plans
	Does the patient have: Hepatitis B Hepatitis C Cirrhosis HIV	**Orders:**
	Relative Contraindications to treatment: HTN/CAD Dyslipidemia Obesity	Cont Meds.
	Diabetes Psychiatric Disorders (these need to be well controlled before beginning treatment)	CBC, CMP, Lipids,
	Absolute Contraindications to treatment: ---- Active or recent DVT/PE	Test, Estradiol, Prolactin
	---- Hypercoagulable state __ Breast or other estrogen dependent cancer	prior to next C.C.
	__ End stage chronic liver disease __ Gallbladder disease requiring surgery	
	__ Metabolic syndrome __ Refractory or focal migraine	
	__ Seizure disorder __ Drug addiction	
	__ Active smoker __ Untreated prolactinoma	
	Medical Treatment: Wants medical treatment: YES NO	
	Medical treatment approved by GDD Team: YES NO	
	List GDD medications if already on medical treatment: Premarin 1.25mg 4 tablets/dy. Spironolactone 100mg BID	
		Next Clinic: March.
		Provider Signature:

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002 Replaces DC 7147)

ILLINOIS DEPARTMENT OF CORRECTIONS

Consent for Medical Treatment

Menard Corr. Center

Date: 8/10/2020

Time: 9:35 ☒ a.m. ☐ p.m.

Patient Information: Kuykendall Jordan ID#: B89674

Last Name First Name MI

☒ I authorize the performance upon Self of the following treatment:

Myself or Name of Patient

Breast exam

state the nature and extent of treatment

to be performed by Dr. Mary Zimmer, A.P.N. or whomever he or she may designate

Name of Physician

as his or her assistants.

☒ The nature and extent of the intended treatment has been explained to me in detail, including its risk, possible complications, and probable consequences by Dr. Mary Zimmer, A.P.N.

Name of Physician

I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

☒ I certify that I have read and fully understand the above Consent to Treatment, that the EXPLANATIONS therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in.

Jordan Kuykendall — Print Name of Patient

Signature of Patient

8/10/2020 — Date

When patient is a Minor or Incompetent to give consent:

Print Name of Person Authorized to Consent

Signature of Person Authorized to Consent

Date

M. Zimmer APN — Print Name of Witness

M. Zimmer APN — Signature of Witness

8/10/2020 — Date

Distribution: Patient's Medical Record

Printed on Recycled Paper

DOC 0094 (Eff. 9/2002)
(Replaces DC 7130-A)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Non-Specific Discomfort

Offender Information: Kuykendall (Last Name) Jordan (First Name) MI ID#: B89674

Date/Time	Subjective, Objective, Assessment	Plans
	RN NOTE **LPN/CMT NOTE** (circled)	**R) MD Referral if:** (circled)
9/22/20 825 am	**S)** - Any Allergies? NKDA	Refer to Zimmer
	- Location of pain / discomfort?	- Patient presents more than twice at NSC for c/o same discomfort within one month
	- Describe pain Stabbing Throbbing Constant Intermittent Etc.	- Patient presents with signs of acute, severe discomfort
	- Have you had this pain before and how was it treated?	- Patient has abnormal vital signs
	- Rate pain level scale of 1 – 10?	
	- Duration of pain?	**No MD referral:**
	O) T 98.1 P 62 R 12 BP 108/76 WT 119	- Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets)
	- Signs of obvious discomfort	- Ibuprofen 200mg 1-2 tabs t.i.d. PRN for 3 days (18 tabs)
		Patient Teaching:
	- Observations related to body part affected Currently on estradiol 8mg	- Return to see provider if symptoms worsen or interfere with daily functioning
	po day. Offender is requesting	
	dose to be increased	
		Nurse Signature [signature]
	A) Non-Specific Discomfort	~~Payment voucher YES NO~~

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information: Kuykendall Jordan MI ID#: B89676
Last Name First Name

Date/Time	Subjective, Objective, Assessment	Plans
	MONROE	
10/4/20 7:30 pm	JR: NF form.	
	Drug form	
	Filled for	
	Estradiol [illegible]	
		noted [illegible] 10/4/20 1150A

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard CC CENTER

Offender Information

KUYKENDALL	JORDAN	ID#: B89676
Last Name	First Name	

Date / Time	Subjective, Objective, Assessment	Plans
10/2/2020	**RN/LPN/Phlebotomist Note (Circle One)**	
	Lab Note :	
	Scheduled for NP-Zim	
	CMP/LPD/TESTOSTERONE/ESTRADIOL/PROLACTIN/CBC (PRIOR TO NEXT C	
	Done : Yes No Signed Refusal : Yes No	
	Recall :	
	Unable / Ate / Work /Move / No Show / Security / Other _____	

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC-147)

Printed on Recycled Paper

NL

Illinois Department of Corrections

Mental Health Progress Note

Menard CC
Facility

Session Date: 9.29.20 **Time:** 10:30 a.m. **Session Duration:** _____

Offender Name: (Last, First) Ky Kuykendall **ID Number:** B89676

Part I: Offender Information

Level of Care: ☑ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: 6/30/53 **Discharge:** 6/30/56

Check all that apply: ☑ Designated SMI ☑ Designated GBMI ☐ On Enforced Medication ☐ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation:	☑ Cooperative	☐ Guarded/Suspicious	☐ Hostile	☐ Uncooperative	
Orientation:	☑ Ox3 (Time, place, person)	☐ OX _____ (list:) _____	☐ Disoriented		
Affect:	☑ Unremarkable	☐ Constricted	☐ Blunt/Inexpressive	☐ Flat	☐ Labile
Appearance:	☑ Appropriately Groomed	☐ Disheveled	☐ Poor Hygiene		
Thought Process:	☑ Clear/Coherent	☐ Circumstantial	☐ Tangential	☐ Perseveration	
	☐ Loose Association	☐ Word Salad/Incoherent	☐ Thought Blocking		

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

S= Offender was seen in NL clinic room in a Confidential Setting. Offender denies any homicidal or Suicidal ideations. Most pressing issues is not having the surgery for transition yet.
O: Offender made good eye contact; attire was appropriate, good hygiene; no thought or perceptual disturbances; Clear coherent Speech; Offende

Clinician Name (Print): R. Draper Signature: R. Draper

Facility: _____ Title: QMHP

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

Illinois Department of Corrections

Mental Health Progress Note

Facility

Session Date: _____ **Time:** _____ **Session Duration:** _____

Offender Name: (Last, First) _____ **ID Number:** _____

was stable at the time of the assessment.
A: Gender Dysphoria
P: Continue current course. Identify
coping skills and triggers.
E: Identify triggers and coping.

Clinician Name (Print): R. Draper Signature: R. Draper, LCSW

Facility: Menard CC Title: Therapist

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

Illinois Department of Corrections

Mental Health Progress Note

Menard CC
Facility

Session Date: 10.12.20 **Time:** 1 **Session Duration:** Approx 5 min

Offender Name: (Last, First) Kleykendall, Jordan **ID Number:** B89676

Part I: Offender Information

Level of Care: ☑ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: 11/30/53 **Discharge:** 11/30/56

Check all that apply: ☑ Designated SMI ☑ Designated GBMI ☐ On Enforced Medication ☐ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation: ☑ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative

Orientation: ☑ Ox3 (Time, place, person) ☐ OX _____ (list:) _____ ☐ Disoriented

Affect: ☑ Unremarkable ☐ Constricted ☐ Blunt/Inexpressive ☐ Flat ☐ Labile

Appearance: ☑ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene

Thought Process: ☑ Clear/Coherent ☐ Circumstantial ☐ Tangential ☐ Perseveration
☐ Loose Association ☐ Word Salad/Incoherent ☐ Thought Blocking

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

Offender was seen in the NL dayroom in a confidential setting on the above date and approximate time. Offender was asked if she was homicidal or suicidal. - Offender stated "NO, not currently" "I've thought about it - I'm not at that place at the moment."

O: Offender presented within normal limits of

Clinician Name (Print): R Draper, LCSW Signature: R Draper, LCSW

Facility: Menard CC Title: QMHP

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

Illinois Department of Corrections

Mental Health Progress Note

Menard
Facility

Session Date: 10.12.20 **Time:** _____ **Session Duration:** Approx 15

Offender Name: (Last, First) Kuykendall, Jordan **ID Number:** B89670

motor activity; good eye contact. no thought or perceptual disturbances; oriented X4; affect was appropriate, hygiene was good. Support was good; Offender reported not having her meds (depression) wellbutrin. this QMHP will see offender in the next 28-30 days to follow-up.

A: Gender dysphoria

P: Continue current Coping - "Working on transfer/transition." Identify coping skills - See updated treatment plan 10.13.20

Clinician Name (Print): K. Draper LCSW Signature: K. Draper LCSW

Facility: Menard CC Title: QMHP

Distribution: Offender Medical File

DOC 0282 (Rev. 05/2016)

ILLINOIS DEPARTMENT OF CORRECTIONS

Mental Health Master Treatment Plan Update

Facility: Menard CC

Offender name: [redacted] IDOC #: B89676 DOB: July. 15, 1993

Treatment Plan Date: 10.13.20

Treatment Type: ☐ Crisis Watch Entry/7 days Seg Entry ☐ Routine Crisis Watch ☐ Crisis Watch upon discharge

Next Treatment Plan Due: ☑ Annually (OP) ☐ Every 6 months (SDP) ☐ Every 2 months (RTU) ☐ Monthly (SEG) ☐ Weekly (Input, Crisis)

Next Treatment Plan Due: 10.13.21

Diagnosis Change? ☑ No ☐ Yes

If yes, please add diagnosis and justification in the boxes below.

Diagnosis added or deleted:

NA

Justification for change:

NA

Medication(s):	Dose:	Frequency:	Indication:
Wellbutrin	150mg (Self-Report)	BID	Depression

Add Medication

Response to medication and other concurrent treatment: (Comment on enforced meds, compliance issues, lab follow-ups, etc.)

"It seems to Stabalize me some"

Currently awaiting Refill.

ILLINOIS DEPARTMENT OF CORRECTIONS

Mental Health Master Treatment Plan Update

Facility: Menard CC

Offender name: Kuykendall G | IDOC #: B89676 | DOB: July 15 1992

Client long-term goals: (use client direct quote)

"To transition and transfer"

Short-term Objectives: (Must be specific, measurable, attainable within review period, realistic and time-bound)

Objective number:	Objective (Linked to documented functional impairment, symptoms & diagnosis):	Clinical Interventions (Description, duration and staff responsible):	Client initials:	Involvement (Client agrees to participate by):
1	Offender will maintain stability by identifying coping skills and triggers.	MHP QMHP will continue to meet with Offender to help identify triggers and Coping Skills.	XSK	x Offender will continue to met with Clinician - Offender will be able to discuss triggers and coping skills that work effectively for her.

ILLINOIS DEPARTMENT OF CORRECTIONS

Mental Health Master Treatment Plan Update

Facility: Menard CC

Offender name: Kuykendall, J IDOC #: B 89676 DOB: July 15, 1992

Short-term Objectives (Must be specific, measurable, attainable within review period, realistic and time-bound)

Objective number:	Objective (Linked to documented functional impairment, symptoms & diagnosis):
2.	Offender will be able to name 2 benefits to taking her meds.
	Clinical Interventions (Description, duration and staff responsible):
	~~PN~~ Psychiatrist will continue to prescribe, monitor and educate offender on medications.
Client initials:	Involvement (Client agrees to participate by):
XSK	Offender will attend each apt. with Psych.

ILLINOIS DEPARTMENT OF CORRECTIONS

Mental Health Master Treatment Plan Update

Facility: Menard CC

Offender name: Krug Kendall, J. IDOC #: B89676 DOB: July 15, 1952

Short-term Objectives: (Must be specific, measurable, attainable within review period, realistic and time-bound)

Objective number:	Objective (Linked to documented functional impairment, symptoms & diagnosis):
3.	Offender will

Clinical Interventions (Description, duration and staff responsible):

Client initials: SK

Involvement (Client agrees to participate by):

No third objective

Primary QMHP (Print): R. Draper Signature: R. Draper Date: 10-13-20

Psychiatric Provider (Print): Thena Poteat MD Signature: [signature] Date: 10/15/2020

Title: Print & Sign: Date:

Title: Print & Sign: Date:

Title: Print & Sign: Date:

Title: Print & Sign: Date:

☒ I agree with this treatment plan ☐ I do not agree with this treatment plan

Client Signature: [signature] Date: 10/13/20

University of Illinois Hospital & Health Sciences System
Reference Laboratory
840 South Wood Street Room 170 (M/C 750)
Chicago, IL 60612
Ph: 312.355.5800

Laboratory Director: Frederick G. Behm, MD

UI Health | UIC

Menard Correctional Center
711 Kaskaskia St
PO Box 711
Menard Illinois 62259

PATIENT NAME	DOB	MRN	SEX	REQUISITION NO.
Kuykendall, Jordan B89676	7/15/1992	200172739	male	*RQ20569*

PHYSICIAN	OUTSIDE MRN	PRINTED DATE
SIDDIQUI, MOHAMMED	*A208-B89676*	10/7/2020 3:01 PM

Laboratory Pathology Report

Final Report

See Values: CMP (L), Prolactin (H), Testosterone (L), Blood Count (L)

Authorizing Provider

Mohammed Siddiqui, MD

CMP (Final result)

Component	Value	Ref. Range
BLOOD UREA NITROGEN	8	6 - 20 MG/DL
SODIUM	141	135 - 145 MMOL/L
POTASSIUM	3.6	3.5 - 5.2 MMOL/L
CHLORIDE	106	98 - 108 MMOL/L
CO2 CONTENT	25	24 - 32 MMOL/L
GLUCOSE	85	65 - 110 MG/DL
CALCIUM	8.8	8.6 - 10.6 MG/DL
CREATININE	0.85	0.50 - 1.50 MG/DL
TOTAL PROTEIN	6.6	6.0 - 8.0 GM/DL
ALBUMIN	4.1	3.4 - 5.0 GM/DL
ALK PHOS	46	40 - 125 U/L
ALT	10	7 - 50 U/L
AST	16	10 - 40 U/L
BILIRUBIN, TOTAL	0.3	<=1.2 MG/DL
ANION GAP	10	3 - 11 MMOL/L
BUN/CREAT RATIO	**9.4 (L)**	12.0 - 20.0

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-277CH0193. Ordered by Unspecified. Authorized by Mohammed Siddiqui, MD. Collected: 10/2/2020 0830 Received: 10/3/2020 0303.Verified: 10/3/2020 0357. Resulted by UI HEALTH PATHOLOGY LABORATORY.

Lipid Panel (Final result)

Component	Value	Ref. Range
CHOLESTEROL	166	<200 MG/DL

M.D. REVIEW
DATE 10/8/20
DOCTOR
CHART
SEE PATIENT X
FILE

University of Illinois Hospital & Health Sciences System
Reference Laboratory
840 South Wood Street Room 170 (M/C 750)
Chicago, IL 60612
Ph: 312.355.5800

Laboratory Director: Frederick G. Behm, MD

UI Health | UIC

Menard Correctional Center
711 Kaskaskia St
PO Box 711
Menard Illinois 62259

PATIENT NAME	DOB	MRN	SEX	REQUISITION NO.
Kuykendall, Jordan B89676	7/15/1992	200172739	male	*RQ20569*

PHYSICIAN	OUTSIDE MRN	PRINTED DATE
SIDDIQUI, MOHAMMED	*A208-B89676*	10/7/2020 3:01 PM

Laboratory Pathology Report

Component	Value	Ref. Range
Cholesterol(mg/dl): <200 DESIRABLE 200-239 BORDERLINE HIGH >239 HIGH		
HDL HDL <40 mg/dl is low and constitutes a coronary heart disease risk factor. HDL >59 mg/dl is a negative risk factor for coronary heart disease.	61	>40 MG/DL
TRIGLYCERIDE Triglycerides (mg/dl): <150 NORMAL 150-199 BORDERLINE HIGH 200-499 HIGH >499 VERY HIGH Triglyceride measurement must be performed on a specimen obtained from a fasting individual.	101	<150 MG/DL
LDL, CALCULATED LDL, Calculated(mg/dl): <100 OPTIMAL 100-129 NEAR OPTIMAL 130-159 BORDERLINE HIGH 160-189 HIGH >189 VERY HIGH --- LDL cannot be caluclated when triglycerides are >400 mg/dl The UIMCC Core Laboratory also offers direct measurement of LDL which may be ordered separately (LDL Cholesterol, Direct) --- RISK CATEGORY LDL GOAL(mg/dl) CHD or CHD risk equivalent(1) <100 Multiple (2+) risk factors(2) <130 Zero to one risk factor <160	85	0-<130 MG/DL

M.D. REVIEW
DATE 10/8/2020
DOCTOR
PULL CHART
PATIENT
FILE

UI Health | UIC

University of Illinois Hospital & Health Sciences System
Reference Laboratory
840 South Wood Street Room 170 (M/C 750)
Chicago, IL 60612
Ph: 312.355.5800

Laboratory Director: Frederick G. Behm, MD

Menard Correctional Center
711 Kaskaskia St
PO Box 711
Menard Illinois 62259

PATIENT NAME	DOB	MRN	SEX	REQUISITION NO.
Kuykendall, Jordan B89676	7/15/1992	200172739	male	*RQ20569*

PHYSICIAN	OUTSIDE MRN	PRINTED DATE
SIDDIQUI, MOHAMMED	*A208-B89676*	10/7/2020 3:01 PM

Laboratory Pathology Report

Component	Value	Ref. Range

(1)CHD risk equivalents include diabetes, other forms of atherosclerotic disease and/or multiple risk factors that confer a 10-year risk for CHD >20%.

(2)Major Risk Factors:
+1 Cigarette smoking
+1 Hypertension(BP > or =140/90 mmHg or on antihypertensive meds)
+1 Low HDL cholesterol (<40 mg/dL)
+1 Family history of premature CHD
+1 Age: men 45 years and older
women 55 years and older
-1 High HDL cholesterol (60 mg/dl or greater)

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-277CH0193. Ordered by Unspecified. Authorized by Mohammed Siddiqui, MD. Collected: 10/2/2020 0830 Received: 10/3/2020 0303.Verified: 10/3/2020 0357. Resulted by UI HEALTH PATHOLOGY LABORATORY.

Collection Questions

! Has the patient been fasting for 8 hours or more?	Yes

Estradiol (Final result)

Component	Value	Ref. Range
ESTRADIOL	35	15 - 31 PG/ML

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-277CH0193. Ordered by Unspecified. Authorized by Mohammed Siddiqui, MD. Collected: 10/2/2020 0830 Received: 10/3/2020 0303.Verified: 10/3/2020 0430. Resulted by UI HEALTH PATHOLOGY LABORATORY.

Prolactin (Final result)

Component	Value	Ref. Range
PROLACTIN	39.9 (H)	2.6 - 13.1 NG/ML

M.D. REVIEW

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-277CH0193. Ordered by Unspecified. Authorized by Mohammed Siddiqui, MD. Collected: 10/2/2020 0830 Received: 10/3/2020 0406. Resulted by UI HEALTH PATHOLOGY LABORATORY.

FULL CHART
SEE PATIENT

University of Illinois Hospital & Health Sciences System
Reference Laboratory
840 South Wood Street Room 170 (M/C 750)
Chicago, IL 60612
Ph: 312.355.5800

Laboratory Director: Frederick G. Behm, MD

Menard Correctional Center
711 Kaskaskia St
PO Box 711
Menard Illinois 62259

PATIENT NAME	DOB	MRN	SEX	REQUISITION NO.
Kuykendall, Jordan B89676	7/15/1992	200172739	male	*RQ20569*

PHYSICIAN	OUTSIDE MRN	PRINTED DATE
SIDDIQUI, MOHAMMED	*A208-B89676*	10/7/2020 3:01 PM

Laboratory Pathology Report

stosterone (Final result)

Component	Value	Ref. Range
Testosterone, Adult Male	**<3 (L)**	300-1080 ng/dL

Total testosterone values may not reflect optimal concentrations in all individuals. Free or bioavailable testosterone measurements may provide supportive information.
REFERENCE INTERVAL: Testosterone, Adult Male

Access complete set of age- and/or gender-specific reference intervals for this test in the ARUP Laboratory Test Directory (aruplab.com).
Performed By: ARUP Laboratories
500 Chipeta Way
Salt Lake City, UT 84108
Laboratory Director: Tracy I. George, MD

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20A-277RA0007. Ordered by Unspecified. Authorized by Mohammed Siddiqui, MD. Collected: 10/2/2020 0830 Received: 10/3/2020 0303.Verified: 10/7/2020 1304. Resulted by ARUP.

CBC and differential

Blood Count (Final result)

Component	Value	Ref. Range
WBC	5.8	3.9 - 12.0 K/UL
RBC	4.10	4.00 - 6.10 M/UL
HEMOGLOBIN	**12.9 (L)**	13.2 - 18.0 GM/DL
HEMATOCRIT	**37.5 (L)**	38.0 - 55.0 %
MCV	91.4	80.0 - 99.0 FL
MCH	31.3	26.0 - 35.0 PG
MCHC	34.3	32.0 - 37.0 GM/DL
RDW	12.7	11.6 - 15.0 %
PLATELET	251	150 - 450 K/UL
MPV	9.5	6.5 - 11.0 FL

M.D. REVIEW DATE 10/7/20 DOCTOR CHART PATIENT FILE

University of Illinois Hospital & Health Sciences System
Reference Laboratory
840 South Wood Street Room 170 (M/C 750)
Chicago, IL 60612
Ph: 312.355.5800

Laboratory Director: Frederick G. Behm, MD

UI Health | UIC

Menard Correctional Center
711 Kaskaskia St
PO Box 711
Menard Illinois 62259

PATIENT NAME	DOB	MRN	SEX	REQUISITION NO.
Kuykendall, Jordan B89676	7/15/1992	200172739	male	*RQ20569*

PHYSICIAN	OUTSIDE MRN	PRINTED DATE
SIDDIQUI, MOHAMMED	*A208-B89676*	10/7/2020 3:01 PM

Laboratory Pathology Report

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-277HM0085. Ordered by Unspecified. Authorized by Mohammed Siddiqui, MD. Collected: 10/2/2020 0830 Received: 10/3/2020 0303.Verified: 10/3/2020 0344. Resulted by UI HEALTH PATHOLOGY LABORATORY.

Differential (Final result)

Component	Value	Ref. Range
METHOD	Automated Differential	
% NEUTROPHIL	57.7	40.0 - 70.0 %
% LYMPHOCYTE	32.2	25.0 - 45.0 %
% MONOCYTE	7.6	2.0 - 12.0 %
% EOSINOPHIL	2.1	0.0 - 6.0 %
% BASOPHIL	0.4	0.0 - 2.0 %
ABSOLUTE NEUTROPHIL	3.3	1.3 - 7.5 K/UL
ABSOLUTE LYMPHOCYTE	1.9	1.3 - 4.2 K/UL
ABSOLUTE MONOCYTE	0.4	0.2 - 1.0 K/UL
ABSOLUTE EOSINOPHIL	0.1	0.0 - 0.5 K/UL
ABSOLUTE BASOPHIL	0.0	<=0.2 K/UL
NUCLEATED RBC'S	0.2	/100

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-277HM0085. Ordered by Unspecified. Authorized by Mohammed Siddiqui, MD. Collected: 10/2/2020 0830 Received: 10/3/2020 0303.Verified: 10/3/2020 0344. Resulted by UI HEALTH PATHOLOGY LABORATORY.

Resulting Labs

ARUP	ARUP LABORATORY, 500 Chipeta Way, Salt Lake City UT 84108 Director: Lab Director
CLIA: **14D0664392**	UI HEALTH PATHOLOGY LABORATORY, 840 South Wood Street Room 215 BLDG 920 (CSB), Chicago IL 60612 Director: Frederick Behm M.D.

Legend

L - Low **H** - High

M.D. REVIEW
DATE 10/7/20
DOCTOR
PULL CHART
SEE PATIENT
FILE

Monroe et al. v. Rauner, et al. (18-156) Document No.: 361356

Exhibit 10

SORA KUYKENDALL 8/31/2020

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.) NO. 18-156-NJR

ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS,

Defendants.

DEPOSITION OF SORA KUYKENDALL

MONDAY, AUGUST 31, 2020
9:00 A.M.

Via Webex

INDEX

(No exhibits marked.)

APPEARANCES:

FOR THE PLAINTIFF SORA KUYKENDALL:
MS. AMELIA BAILEY
Kirkland & Ellis, LLP
300 North LaSalle
Chicago, Illinois 60654
amelia.bailey@kirkland.com

FOR THE DEFENDANTS:
MS. CARLA TOLBERT
Assistant Attorney General
201 West Pointe Drive, Suite 7
Belleville, Illinois 62226

ALSO PRESENT:
Joyce D. Lawrence, CSR, CCR, RPR
CSR# 84-1716 CCR# 1329
Alaris Litigation Service
15 S. Old State Capitol Plaza
Springfield, Illinois 62701

IT IS HEREBY STIPULATED AND AGREED by and between Counsel for the Plaintiffs and Counsel for the Defendants that this deposition may be taken in shorthand by JOYCE D. LAWRENCE, an Illinois Certified Shorthand Reporter, and afterwards transcribed into typewriting, and the signature of the Witness is WAIVED.

****

(All counsel stipulate to the reporter swearing in the witness remotely.)

SORA KUYKENDALL,
called as a witness, being first duly sworn, was examined and testified as follows:

EXAMINATION
BY MS. TOLBERT

Q. Ms. Kuykendall, are you ready to get started?

A. I am.

Q. Okay. We met briefly earlier, but my name is Carla Tolbert. I am one of the Assistant Attorney Generals here in the Swansee/Belleville office and I represent the defendants in this case. Have you ever been deposed before?

Page 89

a prison rule. Not -- not IDOC, but among -- among prisoners.

Q. Okay. All right.

Who brings your meals? Is it a porter or staff or who delivers meals?

A. Right now, it's staff.

Q. Okay. All right. Do you interact with any other offenders?

A. I have also been groped.

Q. Okay. Now you mentioned that one time on the way to lunch, you said that's the reason you don't go out for meals anymore. Have you been groped other than that time?

A. I have.

Q. Okay. Do you recall when those other times were?

A. After that first time, but I don't have any dates.

Q. And was that by other inmates?

A. Yes.

Q. Have you ever been -- other than the groping, and not to minimize that, have you ever had any other kind of physical assault?

A. Like somebody hit me?

Q. Hit you or physical or sexual assaults in addition to the groping?

A. Like I said, I've had people, like, try to grab me through the bars.

Q. Okay.

A. And they pulled at my door, too.

Q. Okay. And how did that go down? Was that just other inmates walking by?

A. Well, that has happened before. But what I'm talking about is -- it was some -- this was actually multiple instances and it was somebody at my door who was trying to talk to me.

Q. Okay. Did you report that individual?

A. I did not.

Q. Okay. Why not?

A. Because I learned pretty early on that -- well, you can't -- you can't report people around here because the COs don't care. They're not going to do anything. And if -- if you -- if you go around snitching, that can get you beaten or, in more serious cases, killed. That's like a reality in here.

Q. How many transgender women are you aware of at Menard?

A. One.

Q. Okay. All right. Let me ask you about --

A. Counting myself?

Q. Counting yourself.

A. Okay. Two.

Q. Two, okay.

Let me ask you if you -- I'm going to give you some names and you tell me if you've known these people or heard of them, okay?

A. Okay.

Q. Marilyn Melendez?

A. I do.

Q. Do you know --

A. I just know she is part of the lawsuit.

Q. Okay. Do you know her personally or have you ever been housed with her?

A. I have never met her.

Q. Okay. Lydia Helena Vision?

A. That doesn't ring a bell at all.

Q. Okay. Sasha Reed?

A. Yes.

Q. And how do you know Sasha?

A. We are in the same housing unit.

Q. Okay. And she is also part of this lawsuit, correct?

A. Correct.

Q. Okay. How far away are you celled from Sasha?

A. She is on a different gallery on, like, the other end of -- the way the prison is set up, it's like a big hallway with a bunch of cells.

Q. Sure.

A. She is, like, all the way on the other end on a different gallery.

Q. Have you ever asked to be housed near or with Sasha?

A. I have. I've been can asked to have a -- I've requested to have a cellie before. I didn't specifically -- I don't think I specifically said her.

Q. What were you told about having a cellie?

A. That they don't give transgender people cellies.

Q. Did they give you a reason, other than that?

A. That they just don't do that here.

Q. Okay.

A. I was told that maybe I could try going to another place and maybe they would do it.

Q. Okay. You talked earlier about where you

Page 93

requested to go -- go ahead.
A. I do not believe what I was told.
Q. Okay. Other than requesting to go to a women's division, Logan, have you requested to go to any other IDOC facilities?
A. I didn't specifically say Logan.
Q. Okay. You just -- but you have requested to go other places?
A. To a women's prison, but that's it.
Q. Okay. All right. How about Janiah Monroe?
A. Is she on the lawsuit?
Q. Yes.
A. Okay. I have not met her in person, but I recognize the Monroe.
Q. Okay. How about Strawberry Hampton?
A. I've heard of her.
Q. Okay. Have you ever met Strawberry?
A. I have not.
Q. Okay. And Tay Tay Artalia Tate?
A. I don't know who that is.
Q. Okay. All right. I want to ask you about the defendants in this lawsuit. And again, it is not a memory test. Just to know what your interaction, if any, has been, okay.

Page 94

The first is Steve Meeks. Have you ever met Dr. Meeks?
A. No.
Q. Okay.
A. At least -- no.
Q. Okay. Do you know who Dr. Meeks is?
A. I do not.
Q. Okay. How about Rob Jeffreys?
A. I don't recall ever knowing anyone by that name.
Q. How about Melvin Hinton?
A. I don't recall meeting any of these people.
Q. Okay. Fair enough. Fair enough. Have you ever filed any lawsuits, other than this one?
A. No.
Q. No. Okay. And tell me, just in your words, what -- what are you wanting from this lawsuit?
A. Surgeries, proper placement.
Q. What surgeries do you want?
A. Reassignment surgery -- general reassignment surgery, voice feminization surgery, tracheal shave.

Page 95

Q. When you talk about sexual reassignment surgery, are you talking about top, bottom or both?
A. I wasn't -- wait, what do you mean.
Q. When you said you wanted reassignment surgery, correct?
A. The reassignment surgery is -- I mean, I want breast augmentation and a reassignment for genitalia.
Q. Okay. All right.
A. And then voice feminization surgery.
Q. Okay. Is there anything else?
A. Buttock augmentation.
Q. Say that again. I'm sorry.
A. Buttock augmentation.
Q. Okay. Okay. Is there anything else that you are looking for with this lawsuit?
A. As far as surgeries, or in general?
Q. In general, what are you trying to accomplish?
A. Laser hair removal.
Q. Okay. Anything else?
A. Proper clothing and hygiene items. I mean, we should have -- I'm trying to get everything else that any other woman in IDOC gets. I feel we

Page 96

should have access to that.
Q. Are you aware of what clothing the women in the women's division wear?
A. I know they have clothes that probably fit them, unlike here.
Q. Okay.
A. I know they have bras and underwear available.
Q. Okay. Ms. Kuykendall, how tall are you?
A. I'm 5'7 and a half.
Q. And do you know how much you weigh?
A. Last I was weighed, I was -- I actually don't remember. It was like -- I fluctuate between 120 and 125.
Q. Okay. Okay. Do they have small sizes at all in the commissary at Menard, like small shirts?
A. They don't have mediums or smalls.
Q. Okay.
A. That goes for shorts, too, and sweatpants. Everything is, like, large or bigger.
Q. How are you keeping them up?
A. Tie it.
Q. Okay. How about shoes; do they have

Page 97

shoes that fit you there?
A. They do.
Q. Okay. So they have smaller men's shoes?
A. Well, I just kind of got big feet.
Q. Fair enough. Got it. Okay.
MS. TOLBERT: All right. I think that's all I have for now. I'm sure your attorney has some questions.
WITNESS: All right.
MS. BAILEY: I do.
Sora, how are you doing? Do you want to take another break or do you want to push through? It's totally up to you.
WITNESS: I will push through. I want to go back, though. I wasn't done with the things I wanted.
MS. TOLBERT: Oh, okay. It's okay.
WITNESS: That people get hormone therapy and reviewed, that that is done properly.
BY MS. TOLBERT:
Q. Okay.
A. Blockers, as well. Hormone blockers.
Q. Okay. Is there anything else?
A. And someone to monitor IDOC for years now

Page 98

and going into the years from the outside to make sure these things get done, because I don't feel like they will. And from everything I have seen, all the history I have seen, I have seen no evidence that they will after all of this is over.
Q. Okay. Is there anything else that you personally are looking for out of this lawsuit?
A. No.
Q. How did you come to be involved in the lawsuit; do you recall?
A. I wrote the ACLU about an incident.
Q. And did the ACLU contact you?
A. Oh, on the last question, blood tests, as well. Like regular blood tests, proper medication.
Q. Okay. And then do you remember when you wrote the ACLU?
A. I do not. It was several -- several years ago now. I believe what I wrote them over was the Hasslemyer incident. I'm not sure about that, though. I'm not sure.
Q. And then the ACLU wrote you back?
A. I did hear back from them.
Q. Okay. And did the ACLU tell you that you would be part of a lawsuit?

Page 99

A. I don't remember if ACLU or Kirkland and Ellis --
Q. Okay. I don't -- I don't want to hear anything about Kirkland, okay.
MS. BAILEY: And I'll just say, the ACLU is representing Ms. Kuykendall, as well. So if anyone asks about, you know, dates of communications, that's fine, Carla.
MS. TOLBERT: That's fine.
BY MS. TOLBERT:
Q. Yeah. Do you remember anything else about your communication before you were represented, Ms. Kuykendall?
A. I mean, I remember writing them and at first -- like, dates or details, or --
Q. Just in general. I mean, I don't expect you to remember the exact date, but anything you can tell me about your communication before you were represented?
WITNESS: Amelia, can I say -- can I say what that was?
MS. BAILEY: Yeah, I think, Sora, I don't -- we don't -- I don't expect you to remember when we officially started representing you, but you can feel free to talk about your first letter to the

Page 100

ACLU. If you remember what the next communication was, you can talk about that, as well. But after that, I think that's going to be privileged.
MS. TOLBERT: Absolutely.
MS. BAILEY: So if there's anything else that you remember about when you first reached out to the ACLU or when or how you heard back from them, you should feel to mention that now.
WITNESS: Okay. I believe I was written back and that they said that they couldn't represent me or do anything at this time. I think that's what was said.
MS. TOLBERT: Okay.
Okay. All right. I think that's all I have. I'll turn it over to you, Amelia, now. I might have some redirect.
MS. BAILEY: Sure.
Sora, do you want to take a break now or are you okay to push through?
WITNESS: I'm okay to push through. Do you want to take a break?
MS. BAILEY: No, I'm okay. I'm okay.
EXAMINATION
BY MS. BAILEY
Q. So I just want to circle back to a few of

Page 101

the things that you spoke about with Carla.

So earlier today, you mentioned that you first realized that you were transgender or potentially suffering from gender dysphoria when you were about four or five years old; is that right?

A. That's when I asked to be called by a female name.

Q. Right. And at that point, you had asked -- go ahead. Sorry.

A. It wasn't until a little older that I -- that I could, like, articulate that and, like, really kind of fully understood all of that.

Q. Okay. So --

A. That was when I was --

Q. Say that one more time. I just couldn't hear you, Sora.

A. I knew I was a girl then. I just wanted to make that clear.

Q. And your knowledge that you were a girl continued on through the rest of your life, correct?

A. Right.

Q. So just because you did not continue to ask your family to call you by a female name doesn't mean that your feelings and knowledge of your true

Page 102

gender identity went away, correct?

A. Right.

Q. And then Carla asked you some questions about interactions you had with doctors prior to your incarceration. Do you remember that?

A. Yes.

Q. And she asked you if you had ever told the doctor about your knowledge that you were a woman or ever asked your doctor questions about that. Do you remember that?

A. She asked me a question?

Q. Correct. Does that ring a bell?

A. Yes.

Q. And the -- your hospitalization right before you were arrested was after your car accident, right?

A. Yes.

Q. And you had a number of pretty serious injuries after that car accident, right?

A. Right.

Q. And then just a little bit after you were hospitalized you were arrested, correct?

A. Right.

Q. So there wasn't a lot of time to discuss issues of gender identity with a doctor at that

Page 103

point, correct?

A. Right.

Q. It wasn't necessarily top of mind at that moment, right?

A. Right.

Q. And then thinking about the other times prior to your car accident and prior to your incarceration that you were hospitalized or saw a doctor, was your mom or another member of your family typically with you when you were speaking with the doctor?

A. Could you repeat the question? Sorry.

Q. Sure. It was a long question.

So thinking about your hospitalizations or interactions with doctors prior to your car accident, were you typically with a family member when you spoke to a doctor?

A. I mean, I was -- do you mean, like, a medical doctor or do you mean a -- like a psychiatrist or psychologist?

Q. Sure. Let's start with medical doctors. Were you typically with a family member when you spoke with them?

A. I think so, yeah.

Q. And your family had indicated to you that

Page 104

they were not accepting of transgenders, correct?

A. Yeah.

Q. So then I want to think about when you got to Menard. So remind me again when you first got into IDOC custody?

A. Sorry. Can you repeat that?

Q. No problem.

Can you remind me again the date that you first entered IDOC custody?

A. IDOC custody?

Q. Correct.

A. Or county?

Q. No, when you got to Menard.

A. I believe that was November 20, 2014.

Q. 2015, you said?

A. '14.

Q. 2014. Okay.

And you said today that you told someone during intake that you were not a boy, correct?

A. Right.

Q. And then when did you first start receiving hormones, if you remember?

A. Toward the end of January or the beginning of February.

Q. And what year?

Page 105

A. 2015.
Q. Okay. And since you have been receiving hormones, you've been taking Premarin as your form of estrogen, correct?
A. Right. I would be -- I would prefer to be taking estradiol.
Q. And why would you prefer estradiol?
A. It's the recommended one and it's safer. Premarin is made from horse urine.
Q. And have you asked anyone at IDOC to be switched to estradiol?
A. I have. I was told that my hormone numbers were fine so they weren't going to do that, and the numbers were not fine.
Q. And then you mentioned that a couple weeks ago, you got lab results back, right?
A. I did.
Q. And I think you said today one of your levels was at 32?
A. That's more or less. I think it was 32. I'm not 100 percent sure if that was the exact number.
Q. Okay. Was that your estrogen or testosterone level?
A. That was my estrogen level.

Page 106

Q. And then you spoke today a lot about certain hygiene and clothing items, gender-affirming items that you would like access to. So, for example, you mentioned women's underwear. Have you filed a grievance requesting access to women's underwear?
A. I have put in clothing.
Q. You said clothing, okay.
A. I don't count underwear as clothing.
Q. Fair enough. Have you filed a grievance requesting gender-affirming hygiene items?
A. I have.
Q. And what were the -- what was the response to those grievances?
A. They were ignored for a long time and then denied. So it's been a mixed bag of both. Ignored and denied.
Q. And we also spoke today about surgery, right?
A. Yes.
Q. Have you filed grievances requesting surgery?
A. I have.
Q. And what was the response you got to those grievances?

Page 107

A. Either ignored or forwarded it to the committee and then never hearing anything back.
Q. And have you filed grievances requesting transfer to a women's facility?
A. I'm actually not sure if I have or not.
Q. Okay. That's no problem.
But safe to say, you have filed a number of grievances related to your treatment as a transgender woman over the past couple of years, right?
A. Oh, yeah.
Q. And have any of -- have any of those grievances been granted? Have you ever gotten what you asked for in the grievance?
A. I mean, I grieved the bra issue. I don't know if I was given that because of the grievance, though. Because, I mean, I grieved that, I'm pretty sure, multiple times and it took them forever to get it to me.
Q. Other than your bras, have you ever gotten anything that you requested in a grievance that's related to your gender dysphoria?
A. When I was trying to get my spironolactone increased.
Q. Sora, just hold on one second.

Page 108

MS. BAILEY: Carla, I know you -- I don't want to be rude. Maybe you could mute yourself. There's a lot of papers and wrestling from you.
MS. TOLBERT: I don't think it's coming from me, but okay.
BY MS. BAILEY:
Q. Go ahead, Sora.
A. That was it.
Q. I will just repeat the question.
So other than when you received your bras, is there anything else that you requested in a grievance related to your gender dysphoria that you have since gotten?
A. I don't remember if I requested in a grievance or not, but -- so I just want to be clear on the record for that. As far as the spironolactone increase, because it was way too low at first. But again, that took months and months and months and months and months. And other than that, if that did happen, if I did grieve that, and the bra, that's it.
Q. So then you also spoke today about that you, for a period of time, were not going to the yard, right?
A. Right. For years.

Page 109

Q. Why did you not want to go to the yard?
A. Because -- partly because of the incident with -- where I was groped before. I didn't like -- I still don't like getting in lines. And then there is also harassment that -- the sexual harassment. Just all of the other -- all of the other stuff that goes on because I'm transgender.
Q. How do you -- when you used to go to the yard, how did that make you feel?
A. Could you go back? What do you mean?
Q. Sure. Well, I can say it this way: Did it make you feel anxious to be in the yard?
A. Oh, yeah. But I kind of -- we don't always have access to a phone, you know. So it's like something that I would blank out to put myself through that.
Q. Why did you feel like you had to put yourself through that?
A. So I could get on the phone. They come around every once in a while, they are passed around. But in the past, that has been kind of hit or miss. Sometimes it would be kind of often and sometimes not really at all. So, you know, if I have a phone call I need to make, I have to go out.

Page 110

Q. When you went to yard, did you feel unsafe?
A. There were times, yeah.
Q. But you would do it anyway because up wanted the chance to take a phone call and speak to someone on the phone; is that right?
A. For years and years, when I was staying in, that was always the case. And then later, I was coming out kind of regularly. So during that time, that was just loneliness.
Q. And then we also talked today about harassment you've experienced from the correctional officers. Did that include verbal harassment?
A. Yes.
Q. And did it include some physical harassment?
A. No.
Q. But did you experience physical harassment from other offenders?
A. It did. I have. On several occasions.
Q. And then we also spoke today about one disciplinary incident you had, right? Do you remember when that happened, Sora?
A. I think that was December of 2018. I'm not 100 percent sure. Or no, it was either the end

Page 111

of November or the beginning of December 2018, I think. I think it might have been December 3.
Q. And you haven't had any disciplinary incidences since then, correct?
A. No.
Q. And then we also spoke about, I think it's two incidents that happened with Officer Hoffman?
A. Uh-huh.
Q. And I know this -- I apologize. This is probably a little bit uncomfortable. But I just want to be clear that the first incident, did he say to you tits, tits, tits; is that right?
A. I don't know which one came first.
Q. Okay.
A. Especially during that time, there was just so much going on with -- with Hood and -- I mean, the COs were just being really ridiculous then around that time.
Q. But at one point, those are the words that he said to you, right?
A. Right.
Q. And then we spoke about another incident, and I just didn't catch this. What did he say to you in the second incident?

Page 112

A. Show me your boobs.
Q. And how did those incidents make you feel?
A. I mean, I was upset because the people who are supposed to be keeping me safe were behaving like that. It's dehumanizing.
Q. And then we also talked about a letter that your mom wrote that I think is included with a PREA report related to some harassment that you experienced. But it sounds like you didn't know that your mom wrote that letter; is that right?
A. I'm not sure on whether or not she wrote that. I mean, I remember talking to her about it and so I can tell you that that was definitely not word-for-word, if there was some discussion of a letter.
Q. And when you talked to your mom and told her about what was happening, did she seem concerned?
A. Yeah.
Q. Did she seem worried?
A. Yeah. I mean, she kind of tries not to -- to show those kind of emotions.
Q. Did she seem concerned for your safety?
A. Oh, yeah.

Page 113

Q. And did she seem concerned for your mental health?
A. Yes.
Q. And then we also spoke today or you told us about how every correctional officer misgenders you, correct?
A. Right.
Q. How does that -- go ahead?
A. Most of the medical staff does, too. I just want to be clear on that. Like, it's -- it's kind of everywhere and, you know, other prisoners and --
Q. So is it safe to say that the vast majority of people you interact with misgender you?
A. Right.
Q. And how does that make you feel?
A. Like -- like how I feel doesn't matter. Like, I feel trapped about it. That I can't do anything about it. That I can't get to a situation, change my circumstances to where, like, I blend in or that I can just avoid these people, because I can't. I can't escape this in here.
Q. And you mentioned one incident today where you were getting a breast exam and the curtain

Page 114

was left open and other people?
A. There was no curtain.
Q. There was no curtain. Sorry. No curtains. And I think you mentioned that others walked by when you were getting your breast exam and could see what was happening; is that right?
A. Someone walked by while I was getting the breast exam and the windows did not have curtains on them.
Q. Had there been other occasions where either if it -- whether it was a medical exam or maybe a strip search, where others came in and viewed things that made you uncomfortable?
A. Yes. One would be during the castration attempt. For whatever reason there had to be -- yeah, for whatever reason, there had to be three COs in there while the nurse checked to see, like, if there was any marks or whatever.
And then another instance during a strip search. During a strip search, somebody -- I was told that I -- I had to get a strip search, when, in the past, that hadn't been the case. I just received a pat down and that had been how it was many times previously. That's how I was told it was supposed to be done. And then I came out for a

Page 115

visit and I was told that I had to get a strip search and I had to go on my visit and, if I refused, I would be taken to seg and get strip searched anyways. And I asked if I could go back to my cell and just refuse my visit, but I was -- I was told, no, I have to go or I will be taken to seg. So I went on my visit and then, on the strip search from returning from the visit, because it was before and after, while I was -- while I was being strip searched, two people came in. And when I grieved this issue and when I reported it to PREA, I don't recall ever hearing back from PREA at all. And when I reported it, I was told by the counselor, you're not going to like my answer to this. And then when I got the response, they were saying that there's a curtain in the shakedown room. But the way it's set up is that curtain is between the cells and I was in the cell on this side and the door is here. So they came in and they could see everything while I was completely naked.
Q. When you say they, does that mean other correctional officers?
A. It was a correctional officer and a prisoner.
Q. And were they all males?

Page 116

A. Both were males.
Q. And the officer that strip searched you, was that a male officer, as well?
A. Yes, they always -- they always strip me by -- they always have me stripped by a male. And if I refuse, I was told -- once, when I asked, what if I refuse, I was told that I would be held down and they would forcibly strip me, so I needed to cooperate.
Q. And have you ever filed grievances requesting to not be strip searched by male correctional officers?
A. Yes.
Q. How does that make you feel when you are strip searched by a male correctional officer?
A. Terrible. I -- usually during it, I breakdown into tears and I'm shaking. And then when I get back to my cell, I do the same thing.
Q. And then you mentioned that you've requested to have a cellie, right?
A. Yeah. Could we take a break?
Q. Sure. Sure. Yeah.
MS. BAILEY: Is that okay, Carla?
MS. TOLBERT: Yeah, that is fine. Whatever you want.

Page 117

MS. BAILEY: Okay. Do you want, like, five or ten minutes, Sora? Is that okay?
WITNESS: Yes.
MS. BAILEY: And I'm almost done, so it won't be much longer, okay.
MS. TOLBERT: I have a very short amount of redirect, but I promise not much.
So, like ten minutes?
MS. BAILEY: Yes.
(Recess taken from 11:45 a.m. to 11:53 a.m.)
MS. BAILEY: Okay. We can go back on the record.
BY MS. BAILEY:
Q. Okay. Sora, I just have one more question for you. So you stated today that you, at one point, did request a cellie, right?
A. Yes.
Q. Okay. And why did you want to have a cellie?
A. Because it's lonely being in a cell all by yourself. Like, I don't have anyone to talk to at all.
MS. BAILEY: Okay. That's all from me.
FURTHER EXAMINATION
BY MS. TOLBERT

Page 118

A. Ms. Kuykendall, I have a few follow-ups and I hope not to take much more of your time. Thank you.
Earlier, you were asked some more questions about your hormone therapy and you said you were taking Premarin, but you wanted estradiol; is that correct?
A. That's right.
Q. Do you have any medical training or education?
A. No, but I got that information from someone who does.
Q. Well, that was my next question. Who did you get that information from?
A. Dr. Ettner.
Q. Dr. Ettner. Okay.
And how long has it been again? I know you told me earlier, but how long has it been again since you have talked to Dr. Ettner?
A. Just a few days.
Q. A few days ago. Does she call you or do you call her or how does that work?
A. She calls me.
Q. She calls you. Okay.
A. Well, I mean, my lawyers call me and

Page 119

she --
Q. Okay. Thank you.
Earlier, you told me you wanted laser hair removal; is that correct?
A. That's right.
Q. Okay. Have you had a decrease in your body hair since you've been on the estrogen?
A. I have not seen any decrease in my body hair.
Q. Okay. Okay. Are you allowed to shave?
A. I am given -- I mean, I can -- with like a guy's shaver, but that doesn't -- that doesn't remedy the situation because I still have, like, face stubble that comes in really quick. So I have to pluck it with a pair of -- I use nail clippers and I pluck them out.
Q. But you are given razors, correct?
A. We are given shavers, not razors.
Q. Shavers, okay.
And can you get those shavers any time you request them?
A. You can buy them out of the commissary.
Q. Okay. And do you have one that you have purchased?
A. I do.

Page 120

Q. Okay. And do you use that on your body hair and your face or --
A. I pluck may hairs out of my face --
Q. Okay.
A. -- with nail clippers, since tweezers aren't available.
Q. Sure. Okay.
A. But I use the shaver to shave my legs. It doesn't do a very good job, but, you know, do it long enough and --
Q. Okay. Is it -- I apologize. Is it a battery or an electric one? What kind do they sell?
A. It's an electric one.
Q. Electric one. All right.
You told me earlier you had a medical permit for your bra, correct?
A. That's right.
Q. Okay. And do you recall when you had that medical -- or when you received that medical permit?
A. It gets renewed. I don't recall when I was last issued it.
Q. Do you recall when it was first issued?
A. Oh. That would have been, I think, November or December of 2015. I'm not sure on

Page 121

that.
Q. Okay. And at that point, you had been on the hormones since you thought January or February of '15, correct?
A. That's right.
Q. So you got to Menard in November of '14?
A. Right.
Q. And by either January or February of '15, you were prescribed hormones, correct?
A. Because I castrated myself.
Q. Okay. And then you later on were given the bra. Got it.
Tell me about the results --
A. I developed breasts months before I actually got the bra, though, and I was -- I told them that and that I needed a bra and I was still ignored.
Q. Okay. Tell me about the effects of your self castration. Like, what's the -- what's the permanent effect?
A. There is no permanent effect.
Q. No permanent effect. Okay. You didn't lose any part of your genitals because of your attempt to do that, correct?
A. Right.

Page 122

Q. Okay. All right.
You've been -- well, since the time you have gotten to Menard, have you had any discussions with any of the wardens about your situation?
A. I've written kites.
Q. Okay. Right. Do the wardens make rounds through your housing unit?
A. They come to the housing units, I think, but they never come on the galleries, at least I've never seen -- I've seen a warden once, actually.
Q. Okay. But you haven't had any conversation with any of the wardens since you've been at Menard?
A. I've been written back before. I don't remember about what. And I don't remember when that was. I don't know if it was related to any of this or not.
Q. Okay.
A. But I've been written one time.
Q. Got it. Have you -- go ahead?
A. That I remember.
Q. Okay. Have you spoken with any other trans woman who is living in a women's division about how they feel about life there?
A. I mean, I don't think I can speak for

Page 123

anybody else or how they feel.
Q. No. My question was, have you spoken with any of them about how they feel?
A. Oh, yeah.
Q. Who have you talked to about who has lived at Logan?
A. Wait. At Logan?
Q. Or anywhere in the women's division.
My question was, have you spoken to any transgender woman who has lived in the women's division.
A. Okay. Now -- so I misheard that.
Q. Okay.
A. I have not heard or talked to any.
Q. Okay. All right. That's all I need to know there.
I did forget to ask you earlier: Tell me how showering works for you. Or do you shower alone or in medical; how does it work?
A. So you can get a shower permit, but the showers are on the gallery and there's a wall, but it only comes up to, like, waist level. So they can see everything above. There are no curtains. So I do not -- I do not shower. I shower in my cell with a rag and I wipe myself down and I wash my hair in

Page 124

my sink because I won't go to the showers with the men and the shower on the gallery doesn't -- doesn't give you privacy at all.
Q. Have you ever asked to shower in medical?
A. I can't -- I can't recall if I have.
Q. Okay. All right. And I wanted to go back. We both asked you about the incident where you were having a breast exam by Ms. Zimmer in medical and there was no curtain on the window, right?
A. There was no curtain.
Q. No curtain, right. And there were --
A. The room has windows on three sides and there are no curtains on any of them.
Q. Okay. Fair enough.
Were you alone in the room with Ms. Zimmer at the time?
A. No, there was a CO in the room, but he had his back -- he had to be in there during the procedure, but --
Q. All right.
A. But you know what I mean?
Q. Right.
A. But he was facing away.

Q. Okay. But he -- so he turned his back to you during the exam, right?
A. Right.
Q. Okay. So from your experience being in medical, are there both male and female personnel, whether they be health care personnel or guards in medical?
A. Could you rephrase that?
Q. Well, so of all of the people working in medical, whether it's doctors, nurses, technicians, officers, are they both men and women?
A. Yes.
Q. Okay. And --
A. But officers don't work as medical staff.
Q. No. No. No. But they are in medical either whether they are escorting a prisoner or there are some officers who are assigned to medical, correct?
A. Yes.
Q. Okay.
A. I don't know if there -- how the assigning and stuff works.
Q. I understand. But just in general, there are -- there are both genders present in medical,

right?
A. Right.
Q. Okay. Are you aware of whether male inmates are examined in that same room that you had your breast exam?
A. They are.
Q. Okay. And if so, they could be seen during their exam by any females who happened to be walking by, correct?
A. I don't know about any kind of, like, examination. I mean, that's the -- it's the room we go in when we see the doctor. That's the room. I don't know anything about anyone else's examinations or anything like that.
Q. Okay. Fair enough. Fair enough.
MS. TOLBERT: I think that's all I have.
MS. BAILEY: Nothing more from me. So I think we can go off the record.
MS. TOLBERT: Read or waive, though?
MS. BAILEY: Oh. Sora, are you comfortable waiving your signature for this deposition or, if not, we can get it sent to you and you can review it and sign it. We didn't -- I forgot to talk to you about this before your deposition. I'm comfortable waiving it, but --

WITNESS: I'll waive it then.
MS. BAILEY: Okay. We'll waive it.
MS. TOLBERT: Ms. Kuykendall, thank you very much. I know this was tough and I appreciate your patience.
Etrans.
MS. BAILEY: And I think the same for us. We would like a transcript and a mini, too, as well. No exhibits, so it makes it easy.
(Deposition concluded at 12:05 p.m.)

CERTIFICATE OF REPORTER

I, JOYCE D. LAWRENCE, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Joyce D. Lawrence
Certified Shorthand Reporter
Registered Professional Reporter
State of Illinois CSR License #84-1716

My commission expires:
August 4, 2022

Exhibit 11

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.) NO. 18-156-NJR

ROB JEFFREYS, MELVIN HINTON, and STEVE MEEKS,

Defendants.

DEPOSITION OF SASHA REED

MONDAY, AUGUST 31, 2020
1:00 P.M.

Via Webex

INDEX

(No exhibits marked.)

APPEARANCES:

FOR THE PLAINTIFF SASHA REED:
MS. SYDNEY SCHNEIDER
Kirkland & Ellis, LLP
300 North LaSalle
Chicago, Illinois 60654
Sydney.schneider@kirkland.com

FOR THE DEFENDANTS:
MS. CARLA TOLBERT
Assistant Attorney General
201 West Pointe Drive, Suite 7
Belleville, Illinois 62226

ALSO PRESENT:
Joyce D. Lawrence, CSR, CCR, RPR
CSR# 84-1716 CCR# 1329
Alaris Litigation Service
15 S. Old State Capitol Plaza
Springfield, Illinois 62701

IT IS HEREBY STIPULATED AND AGREED by and between Counsel for the Plaintiffs and Counsel for the Defendants that this deposition may be taken in shorthand by JOYCE D. LAWRENCE, an Illinois Certified Shorthand Reporter, and afterwards transcribed into typewriting, and the signature of the Witness is RESERVED.

****

(Deposition commenced at 12:54 p.m.)

COURT REPORTER: Do both counsel agree and stipulate that it is acceptable that I swear in the witness remotely?

MS. TOLBERT: We do for the Defendants.

MS. SCHNEIDER: We do for the Plaintiff.

SASHA REED,

called as a witness, being first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. TOLBERT

Q. Great. Hi, Ms. Reed. How are you?

A. I'm all right.

Q. All right. You'll pop up here. You pop up when you start talking.

Page 41

A. I saw mental health down there in Pontiac.
Q. Okay. How long after you got to Pontiac was it before you saw mental health?
A. For my transgender issues?
Q. Well, for anything. I mean, I'm sure the first time they saw you was maybe a general kind of appointment or did you -- were you initially seen for your transgender issues?
A. Well, when I went to Pontiac, I left -- I left NRC on crisis watch to Pontiac crisis watch.
Q. Okay.
A. So I saw mental health when I got down there and I didn't see them again until -- I don't remember the date.
Q. How long were you on crisis watch after you got to Pontiac; do you remember?
A. I don't remember.
Q. Okay. Have you been on crisis watch at other times after Pontiac?
A. I left Pontiac and came to Menard. Last time I was here, I wasn't on crisis watch and, yeah, at Lawrence.
Q. Okay. That was when you tried to hurt yourself again?

Page 42

A. Yeah.
Q. Okay. All right.
So how often are you seen by mental health now?
A. Every -- it's supposed to be once a month. Sometimes I can go a month or two without seeing them.
Q. Okay. Do they tell you why?
A. No.
Q. Okay.
A. Even if I drop a request.
Q. Yeah. And what kind of treatment or therapy are the mental health professionals doing with you?
A. Nothing that I feel that's helping me.
Q. Okay. But what kind of -- I'm sorry. Go ahead.
A. When I go in there, we just talk about -- she just asks me if I'm okay and I explain to her, like, as far as, like, my transgender issues and, like, how I'm feeling, like, stuff like that and they write down a little treatment plan or what we're going to work on, but we never work on anything, so -- we don't work on anything.
Q. So is all of your time with the mental health professional, is it one-on-one or are you ever in any kind of group classes or group therapies?
A. Just one-on-one.
Q. Okay. All right. Who is your current mental health provider -- professional?
A. Her name is Traper.
Q. Okay. And are you also seen by Dr. Siddique?
A. I haven't saw him for some months now.
Q. Okay. You're on hormones now, correct?
A. Correct.
Q. Okay. Do you know what medication -- what hormone medications that you are on?
A. Estradiol and spironolactone.
Q. And who is prescribing those, if you know?
A. Nurse Practitioner Ms. Zimmer.
Q. Okay. And do you recall when you first started taking the estradiol?
A. 2017.
Q. 2017. And the same date for the spironolactone?
A. There was a little -- like, a week apart.

Page 43

Page 44

Q. Okay. But about -- still in 2017, right?
A. Yes.
Q. Okay. Has Nurse Practitioner Zimmer always been the person to prescribe those medications?
A. Dr. Siddique was. He prescribed, when I got down here, basically, like, refill my order. Then I stopped seeing him and I started seeing Ms. Zimmer.
Q. Where were you housed when you first started taking estradiol and the spironolactone?
A. Menard.
Q. The first time at Menard or the second time?
A. The first time.
Q. The first, okay.
Looking at my dates here. Hang on.
While you were at Pontiac, prior to your first time at Menard, had you discussed hormones with any of the doctors or nurse practitioners at Pontiac? I'm sorry at --
A. No.
Q. No. Did you ask for them or did they just not want to discuss them?

A. I never discussed it with them until I got to Menard.

Q. All right. Had you ever heard of a transgender woman taking hormones before that?

A. Yes.

Q. Okay. All right. Have you -- have you talked to any medical provider at any facility about having surgery?

A. Yes.

Q. Okay. What kind of surgeries did you talk about?

A. I talked to Ms. Low about having bottom surgery. I filed grievances, which got denied.

Q. Okay. And where was that? Was that at Menard or was that before?

A. Menard and Lawrence.

Q. And was that Menard the first time or this time?

A. The first time.

Q. Have you talked to Dr. Siddique or anybody at Menard this time about having surgery?

A. Yes.

Q. Okay. Who did you talk to?

A. My last mental health doctor, Ms. Myers.

Q. Courtney Myer?

A. No. No, not her. It's another Myers.

Q. Okay.

A. She doesn't work here anymore, though.

Q. Got it.

And what did -- what did Ms. Myers say?

A. She told me that IDOC don't do those type of surgeries.

Q. Are you aware of the Transgender Care Review Committee? Have you ever heard that term?

A. Yes.

Q. Okay. Are you aware of whether any requests for surgery from you has been addressed by the committee?

A. No.

MS. SCHNEIDER: Objection. Foundation.

BY MS. TOLBERT:

Q. Are you aware, Ms. Reed?

A. No.

Q. Okay. Have you ever requested to go to Logan or Lincoln, to the women's division?

A. Yes.

Q. Okay. When did you first request that?

A. In some previous grievances that I filed and I requested and the request went through, but it

hasn't got approved yet this time around since I've been here.

Q. Got it. So you're -- you're waiting to go to -- is it Logan?

A. Well, they submitted me. They -- I don't know. They submitted -- they recommended or whatever. I don't know. I guess I got approved or whatever. So I don't want to say that I got approved or anything but --

Q. Got it. So you haven't been told if you're going to go soon?

A. No. They just said I was put in for it.

Q. Okay. All right. So -- all right. Who told you that?

A. Mental health and my attorney.

Q. Since you started taking hormones in 2017, what kind of physical changes have you had?

A. My breasts, my hands are a little softer and I don't grow, like, hair as much as I used to. And like, I -- my face is a little more feminine.

Q. Okay. Okay. Do you still have to shave?

A. Sometimes, yes.

Q. Okay. Do you have access to a shaver or

the razors to shave?

A. No.

Q. So how do you shave?

A. Okay. I get what you're saying. Sorry. I have my -- I have my own personal.

Q. You have an electric razor?

A. Yes. My personal, yes.

Q. Okay. And how good of a job does that do on your facial and body hair?

A. Not so good. It breaks my skin out. I always have, like, little bumps and stuff like that. So it doesn't do a good job.

Q. Okay. All right. How about, have you been given permission to wear a bra?

A. Yes.

Q. Okay. Did you have to get that -- get a slip from medical?

A. A permit, yes.

Q. And when did you get that?

A. When I first got down here.

Q. Okay. The first time or the second time?

A. Actually, I got a permit when I was here and at Lawrence.

Q. Okay. So you had had that permit for

Page 49

several years?
A. Yes.
Q. Okay. All right. How many bras are you allowed to have in your possession at any one time?
A. Four.
Q. Four. How about other women's undergarments, are you allowed to have those?
A. No.
Q. Okay. Now, tell me what you're wearing. It looks like a scrub top. But what kind of -- is that a top that you buy in the commissary?
A. No. This is the -- the state-issued uniform.
Q. Okay. And is that the same uniform top that the male prisoners would use or would wear?
A. Yes. Everybody wear the same uniform.
Q. Got it. Got it.
Ms. Reed, how tall are you?
A. Like, 5' 10.
Q. And do you know approximately how much you weigh?
A. 169.
Q. What size is your -- your blue top. Do you know offhand?

Page 50

A. A large.
Q. It's a large, okay.
And then how about pants, do they have pants that fit you?
A. Yeah.
Q. Okay. And -- go ahead.
A. I just got a pair of pants that I feel that fit me for my -- and that's a medium.
Q. So they did have smaller sizes?
A. Yes.
Q. Before that, were you wearing larger ones?
A. Yes.
Q. Okay. And did you have problems with the fit on those?
A. Yes.
Q. Okay. All right. And then do they have shoes that fit? Do you have smaller feet or bigger feet?
A. I wear a size 9.
Q. Okay. So they probably have shoes that fit you there, right?
A. Yeah. You can buy your own shoes.
Q. Yeah. Are you issued shoes at all or do you have to buy them?

Page 51

A. You buy your own shoes.
Q. Okay. All right.
So what's your current housing unit?
A. I stay in North 2 cell house.
Q. Uh-huh. What gallery?
A. North 2-7 gallery.
Q. 7? I'm sorry.
A. 7 gallery.
Q. 7 gallery. And do you have a cell mate?
A. No.
Q. No. Have you ever had a cell mate at Menard?
A. No.
Q. Okay. How about at Lawrence?
A. No.
Q. How about at Pontiac?
A. Yep.
Q. You did at Pontiac?
A. Yep.
Q. Did you have the same cellie the entire time you were there or did you have more than one?
A. I had a cellie for two months, until I got out of seg, and that was the same one.
Q. So the only time you had a cellie at

Page 52

Pontiac was when you were in segregation, right?
A. Yes.
Q. And how did you get along with the cellie?
A. It was okay.
Q. Okay. I mean, he didn't fight or hurt you or say bad things?
A. No.
Q. Okay. All right.
How, in general, are you treated by the other inmates at Menard?
A. Horrible.
Q. Okay.
A. Like, you know, Menard is an old prison, whatever. It's not like other facilities where they got, like, solid doors, whatever. And we have bars here. So anybody that walks past your cell, they can look in your cell. So, you know, I have guys that walk past my cell that harass me, sexual harass me, and make little statements to me. Pretty bad.
Q. Okay. So is -- and not to discount verbal harassment, but is the harassment from the other inmates verbal or have you had any physical kind of assault happen?
A. Since I have been here, it has been

Page 53

verbal.
Q. Okay. How about before you got to Menard this time?
A. When I was at Lawrence.
Q. What happened -- I'm sorry. Go ahead.
A. I had two fights.
Q. Two fights?
A. Yes.
Q. And why -- why were you fighting?
A. Because one inmate attacked me for no apparent reason.
Q. Okay.
A. And the other fight I had was because I was going through the --
Q. Could you repeat that?
A. I had one fight that was because someone attacked me and I had stitches and stuff like that. And another fight was because I was going through some little issues as far as my transgender issues and stuff and I was stressed out and whatever.
Q. Okay. All right. And were you attacked by other offenders or how did those two things happen?
A. Yeah. I was attacked.
Q. Okay. Now, at Menard, now days, because

Page 54

of the COVID, it's my understanding that you're not going to the chow hall; is that correct?
A. No. Just showers.
Q. Okay. So you're taking all of your meals in your cell, right?
A. Correct. Yes.
Q. Okay. Who is delivering meals? Is it a porter or is it staff?
A. Sometimes it's the COs, sometimes it's the workers.
Q. Okay. And then you mentioned showers. How are you showering at Menard?
A. I shower by myself, but there's no privacy because open bars. People who are out on the hall passes, they come back looking and making comments and stuff like that. So there's no privacy at all.
Q. Okay. All right. How is your relationship with the correctional staff?
A. Not good. I mean, I just stay out of their way because I deal with them harassing me and making sexual comments towards me. So I just try to stay out of their way.
Q. And is that every staff member that you encounter?

Page 55

A. Not every staff member I encounter, but a majority of the staff members I encounter, they always have something to say.
Q. Okay. Can you name any staff members who don't harass you?
A. I know one officer I'm cool with. His name is -- his name is Help or something. I don't know how to pronounce his name.
Q. That's okay.
A. There's a few I'm cool with and there's others that pick with me.
Q. Okay. How about the -- the senior officers -- sergeants, the lieutenants, the majors, do you have any encounters with them?
A. Not really, no.
Q. Okay. Have you ever had any conversation with any Menard -- well, any Menard warden since you have been there?
A. Yes.
Q. Okay. About issues you were having being a transgender woman?
A. Yes.
Q. Okay. Who did you talk to?
A. The head warden. I don't know his name. I think it's Franklin.

Page 56

Q. Frank Lawrence, maybe?
A. I don't know his name.
Q. Okay. And what did you tell him?
A. I asked him, I said, hey, do you know when the female cosmetics is supposed to be coming on commissary or whatever and he told me he don't know when, just keep putting it on my commissary slip. If I get it, I get it. That's about it.
Q. Okay. But did you tell him or talk to any warden about problems with staff?
A. No.
Q. Okay. So it's your understanding that the female commissary items are coming to Menard, right?
A. Right.
MS. SCHNEIDER: Objection.
BY MS. TOLBERT:
Q. You can answer.
A. You said, do I think they're coming?
Q. No. Do you know that they're coming?
A. They say they're coming, but there's --
Q. You haven't been told when, right?
A. (Shakes head).
Q. Okay. And do you know what kind of items are going to be available?

Page 57

A. No.
Q. Okay.
A. Cosmetics.
Q. All right. So what kind of things do you want to be able to purchase?
A. Soap, shampoo, lotion, things like makeup and, like, underwear and more bras and whatever -- whatever, like, a female item that I need on a day-to-day basis.
Q. Okay. Now, you get soap, though, correct?
A. Yes.
Q. Okay. So you just want a different kind of soap?
A. Female soap.
Q. Okay. And you have shampoo, though, right?
A. Yep.
Q. Okay. But you want another kind of shampoo, right?
A. Yeah. Female shampoo.
Q. Okay. All right.
I was going through some of your records and I saw there were -- there were quite a few PREAs that you have had over the last few years. Is

Page 58

that -- do you -- do you have any sense of how many PREA calls or PREA complaints you have made?
A. I don't remember all of them. I just remember, like, the most recent ones.
Q. Okay. And what was that?
A. The most recent ones was at Menard, I filed one on a CO because I was being sexually harassed and, supposedly, they said I admitted to saying that it didn't happen, which I never did, and they falsified it and said something I didn't say in it on top of that and wrote me a ticket.
Q. Okay. There was one I wanted to ask you about, and it is from Lawrence, and it is about an incident on September 16, 2019. An offender or an Erwin Mitchell or Mitchell Erwin, I guess, is the person that you said was the perpetrator. Do you recall anything about a Mitchell?
A. No.
Q. Okay. So the reason I wanted to ask you about this one is, Mitchell Erwin is a correctional officer. You claimed that he assaulted you or used excessive force. And they said that there was camera footage that refuted that. Do you remember that one?
A. I remember reading that in my ticket,

Page 59

yes.
Q. Okay. So you don't -- you said that's not true?
A. No, that's not true.
Q. Okay. So what happened?
A. That didn't happen. I told -- I made -- like I said, I made PREA complaints because I was being sexually harassed by officers and whatever they put on there is not what I said.
Q. Okay. Well, this one they talk about, they reviewed camera footage of the incident and that's not what happened. But do you not believe that?
A. No, I don't believe anything that they say in there.
Q. Okay. While you were at Lawrence, do you remember having any conversations with Assistant Warden Brookhart, Dr. Brookhart?
A. I spoke to her a lot.
Q. Okay. What did you -- what kind of things did you talk to Warden Brookhart about?
A. I talked to her about getting jobs, I talked to her about, like, selling, like, cosmetics in the commissary, and I don't remember everything I talked to her about, but I have spoke to her.

Page 60

Q. Okay. And what kind of things did Dr. Brookhart tell you?
A. I know, as far as, like, female cosmetics, and, like, selling us underwear, and stuff like that, and that wasn't happening. Like, when I spoke to her about getting a job, whatever, she did make that happen. I spoke to her on several occasions about having cell mates, whatever. She said that will never happen. I don't remember everything, but --
Q. So when she said -- when you asked her about cell mates, she said that will never happen, did she tell you why?
A. Security reasons.
Q. Okay.
A. For my safety, I guess.
Q. Okay. Do you think that's reasonable for your safety?
A. No.
Q. Okay. So you want a cell mate?
A. Yeah, I wouldn't mind having one.
Q. Okay. All right.
What kind of job did you have at Lawrence?
A. A porter job.

Page 61

Q. Porter. Laundry porter?
A. Uh-huh. Yes.
Q. Okay. Did Warden Brookhart tell you that she couldn't ensure your safety with a cell mate?
A. Not that -- yes, she did say that she don't want nothing to happen to me.
Q. Okay. Was she pretty good to you or did you have problems with her?
A. She was -- she was fair.
Q. Okay. Did you see more of the warden up at Lawrence than you did at Menard?
A. Yes.
Q. Okay. About half the population, though, isn't it?
A. Yes.
Q. Okay. We have been going about an hour. Do you feel like you need a break?
A. Yes.
Q. Get a drink?
A. Yes.
MS. TOLBERT: Is that okay with you Sydney?
MS. SCHNEIDER: Yes.
MS. TOLBERT: Okay. Let's take 10.
(Recess taken from 1:56 p.m. to 2:02 p.m.)

Page 62

BY MS. TOLBERT:
Q. So you were telling me about -- about how things went at Lawrence and involvement with Warden Brookhart when we went on break. You told me a lot about the -- the officers. Tell me how -- since you have been incarcerated, how the other offenders, the other inmates, treat you.
A. You have, like, some inmates that's cool and then you have some inmates that is, like, straight assholes and, like -- would, like -- especially with me being transgender, I have a lot of -- I bring a lot of attention to myself, not because I'm doing -- just because of being me and, you know, I have a lot of guys that talk down on me or, like, you know, disrespect me and stuff like that. Then I have some guys that's cool, that I can talk to and hang out with on the yard and stuff like that. So it depends.
Q. Okay. So -- I apologize. Can you say that last bit again?
A. It depends on the environment.
Q. Yeah. Now, are you going to yard now with the COVID shutdown?
A. No yard.
Q. No yard. And that has been since

Page 63

mid-March or so?
A. We haven't been to yard since June.
Q. Since June. Okay. All right.
Before the lockdown started, were you going to yard regularly?
A. Some days I go and some days I don't go.
Q. Okay. But was that by your choice or because, say, somebody threatened you?
A. Because -- yeah, because I had issues on the yard with other inmates making threats towards me.
Q. Okay. What kind of things would you do when you would go out to yard?
A. I would go out to yard, play cards with a person that I'm cool with, and walk around. That's about it. And try to use the telephone.
Q. Okay. There's a telephone out in the yard?
A. Yeah, they got phones out there.
Q. Oh, okay. All right.
How many phones do you have access to since you're not going to yard?
A. We get the phone every four days.
Q. Okay. Do you have, like, a set schedule

Page 64

or just every four days you go stand in line?
A. Every four days, whenever the phone comes up to the gallery that I'm on, I get it.
Q. Okay. All right. How long -- are your calls, like, limited in how long or how does that work?
A. 20-minute calls.
Q. Okay. All right.
So you said there is one person that you're cool with that you play cards with?
A. Yes.
Q. What is that guy's name?
A. His real name or his nickname?
Q. Well, do you know his real name?
A. His name is Anderson.
Q. Okay. All right. And you don't have any -- no issues with him. He doesn't pick on you or bully you or harass you?
A. No.
Q. Okay. All right. Are there other inmates that you feel like are cooler with you?
A. Like I said, there is some cool people on the wing that I'm on and then there is some that's not so cool.
Q. Yeah. Now, I know you don't have a cell

Page 65

mate, but are you in a cell with people on either side of you or are you on an end cell?
A. Yeah, two people on both sides.
Q. Okay. How are the people are the sides -- each side of you?
A. One guy, I don't talk to really and the other guy, he's real cool.
Q. Okay. So you can have some social interaction, at least. You can talk to him?
A. Yes.
Q. Okay. How long are you in your cell per day?
A. All day.
Q. All day. But that's -- that's the COVID, right? I mean, it's not seg, right?
A. Even if it -- even if it is not the COVID, you know, we are in our cell, like, 23 hours a day.
Q. Okay. So what do you do?
A. Watch TV. I'm writing a book.
Q. Really.
A. I work on that. I read.
Q. Okay.
A. Play music on the tablet.
Q. All right. Can you say that again? You

Page 66

what?
A. Tablet.
Q. Okay. How did you get the tablet?
A. They sell them.
Q. Really.
A. You can watch movies. You can stream music, play games and send emails out to your family and stuff like that.
Q. So there's Wi-Fi in your cellhouse?
A. There's Wi-Fi in every prison.
Q. Live and learn.
Okay. So what kind of tablet were you able to buy?
A. It's -- I don't know the brand, but it's -- they go through a company called GTL.
Okay.
A. And you buy it on commissary, buy a little link unit to stream music and movies and stuff.
Q. Okay. Are you getting money from the outside?
A. Yes.
Q. Okay. All right. And you can stream music and watch streamed movies and those kind of things?

Page 67

A. Play video games and send emails out.
Q. Okay. All right. I had no idea you could send emails.
A. Yep.
Q. Okay. So -- and you do have some interaction with one of the guys on the side of you, right?
A. Yes.
Q. Okay. And is he cool with you?
A. Yeah, he's cool.
Q. Okay. No harassment from him?
A. No.
Q. Is the other guy mean to you or he just -- he's just not really socialize?
A. No, he just doesn't really socialize.
Q. Okay. All right.
Have those two guys on either side of you been there for a fair amount of time?
A. Since I've been there.
Q. Okay. So -- so the three of you in that row have been there the whole time?
A. Yes.
Q. Okay. All right. What about other lines you might be in? Like, going to medical, have you been harassed in those lines?

Page 68

A. Usually when I go to health care, to the medical, whatever, the COs get me in and get me out and lock me back up. So I guess to prevent any issues or whatever with anybody. So I don't usually sit around and wait my turn and stuff.
Q. Okay. Now, how do you get your medicines? Do you keep those in your cell or do you have to go to med line or how does that work?
A. No more. They bring it to me.
Q. Okay. So are you on medicines once a day or twice a day?
A. Twice a day.
Q. And one of the nurses brings them?
A. Yes.
Q. Okay. And how do the nurses treat you?
A. They -- they -- they cool.
Q. Okay. All right.
Have you been -- okay. So tell me about your disciplinary record at Menard. Have you been disciplined?
MS. SCHNEIDER: Objection. Form. Are you talking about this time at Menard? Just so we're clear on the record, Carla.
MS. TOLBERT: Yes, most recent Menard.
WITNESS: Since I've been here, I don't

Page 69

have any -- I haven't caught any tickets.
BY MS. TOLBERT:
Q. Okay. How about at Lawrence?
A. I caught some tickets down there.
Q. I mean, can you tell me what those were for?
A. Two fighting tickets, two, 107s, sexual misconduct, and a few things, like, minor stuff, like unauthorized property OR misuse of property and stuff like that.
Q. Now, of the fights, one of them, you said, was the PREA that you disagreed with; is that correct?
A. Fights?
Q. Yeah. Didn't you -- weren't you telling me about one of the fights was for -- that there was subject of a PREA or did I misunderstand that?
A. No, I said --
Q. Okay.
A. One was because a guy attacked me.
Q. Okay.
A. Another fight I got into because I initiated it.
Q. Why did you initiate it?
A. Because all of the stuff that I was going

Page 70

through and I wanted to release some anger.
Q. Okay. What about the sexual misconduct tickets? What happened there?
A. Kissing in the day room, supposedly.
Q. Supposedly, meaning it didn't happen?
A. Supposedly they got me on camera kissing in the day room. I never kissed in the day room.
Q. That was on two occasions?
A. Another 107 was because the CO said that I made sexual comments to him.
Q. Did you?
A. No, I did not.
Q. Okay. You're grinning.
A. They initiated it.
Q. Okay. All right. All right.
What did you get with those disciplinary tickets? Did you get seg?
A. The last one that I caught, yeah.
Q. Did they give you 30 days each?
A. No. Six months.
Q. Six months seg each or six months total?
A. Six months total.
Q. Okay. Have you been in seg at all this time at Menard?

Page 71

A. I have, but that's because I left from Lawrence. I went from seg to seg.
Q. Okay. All right. And then you finished out that Lawrence seg from discipline and then you got out?
A. Yes.
Q. Okay. Did you have any disciplinary tickets at your first Menard?
A. The first time around?
Q. Uh-huh.
A. Nope.
Q. Nope. And then how about --
A. I'm sorry. I'm sorry. I couldn't remember.
Q. Go ahead.
A. I did have one disciplinary ticket the first time I came around. It was when I first got down here.
Q. Okay. And did you get seg with that?
A. Yes.
Q. Okay. And then how about at Pontiac?
A. I don't remember.
Q. Okay. How about at NRC?
A. Yes.
Q. Okay. And did you get seg with that?

Page 72

A. Yes.
Q. Okay. All right.
I'm going to ask you some names of some people. I want you to tell me if you know them, okay.
A. Okay.
Q. Marilyn Melendez?
A. They in IDOC?
Q. Yeah.
A. No.
Q. Why did you laugh?
A. Because I just laugh because I'm nervous.
Q. Okay. That's all. That's all right.
Lydia Helena Vision?
A. No.
Q. No. Janiah Monroe?
A. Oh, yeah. Yes, I know who that is.
Q. Do you know who she is or do you know her?
A. I know who she is, yes. I know her.
Q. That's because of this lawsuit, right?
A. No.
Q. How do you know her?
A. In Pontiac seg together.

Page 73

Q. You were in Pontiac seg with Ms. Monroe?
A. Yes.
Q. Okay. I'm going back to my list. You were in Pontiac -- don't tell me. So 2014, give or take?
A. Yes.
Q. Okay. And how well did you get to know Ms. Monroe?
A. We spoke. Not too well. We wasn't around each other for a long time.
Q. How long did you overlap in seg?
A. How long did I overlap in seg?
Q. With Ms. Monroe.
A. Probably, like, two months.
Q. Okay.
A. That I was around her.
Q. Were you cell mates?
A. No.
Q. Okay. And have you had any contact with Janiah Monroe since you left seg in Pontiac?
A. No.
Q. Okay. But you're aware she is part of this lawsuit?
A. Yes.

Page 74

Q. Okay.
A. The name that you just named is the people that's on the lawsuit?
Q. Yes.
A. Oh, okay. I'm sorry.
Q. They sound familiar, though, right?
A. Yeah.
Q. Okay. How about Sora Kuykendall?
A. Yes, I know her.
Q. That's because she's at Menard?
A. Yeah. And I knew her since the last time I was down here.
Q. Now, it's my understanding that you guys are on opposite wings of North 2, right? Opposite galleries?
A. Yes.
Q. Okay. Do you have any contact with Sora Kuykendall?
A. No.
Q. Okay. When you were with her or when you knew her on your first time through Menard, did you speak or have any kind of contact with her then?
A. Yeah, we was together on the same gallery.
Q. And were you friends?

Page 75

A. We was cordial. We spoke. She's not a really sociable person, so --
Q. But no bad blood or no fights or anything like that?
A. No.
Q. Okay. All right. How about Strawberry Hampton?
A. I have heard of her, but I don't know who she is.
Q. And in what -- you know, what did you know about her or how did you come to hear about her?
A. Just through other people and I heard that she was in Logan.
Q. Okay. How about Tay Tay Artalia Tate?
A. No.
Q. Don't know that name?
A. Uh-huh.
Q. Okay. Do you know any other transgender women at Menard, other than Ms. Kuykendall?
A. No.
Q. No. How about at your previous facilities? At Lawrence?
A. Yeah, I knew a few transgenders down there.

Page 76

Q. Okay. And did you get to be friends with them?
A. Yeah, some of them.
Q. Okay. Do you know if any of them have gone to Logan or to Lincoln?
A. Not that I know of.
Q. Do you know if any of them are still in IDOC?
A. I just know one is.
Q. Okay. Who is that?
A. Her name is Maria.
Q. Okay. All right. So do you know Dr. Melvin Hinton?
A. No. That's on the lawsuit, right?
Q. Yeah.
A. Okay. I don't know him. I just -- just from seeing his name on there.
Q. Okay. All right. Do you know Dr. Steve Meeks?
A. Just from seeing his name on the lawsuit paper.
Q. Okay. And do you know Rob Jeffreys?
A. Nope. Just from seeing his name on there.
Q. Do you know what Rob Jeffreys does?

Page 77

A. IDOC director.
Q. Okay. There you go.
How did you come to get involved in this lawsuit?
A. Sora told me about it.
Q. I'm sorry. Sora told you?
A. Yeah. The last time I was down here, she told me about it and I wrote to them.
Q. Okay. How did you come to discuss the lawsuit with Ms. Kuykendall?
A. Because I told her that I was -- I was transgender and I was trying to get on hormones and -- but they have been prolonging the process and she was like, hey, write this address -- and I forgot what she told me, but she gave me the address.
Q. Okay. Okay. So -- so you were at Menard the first time what years? So -- do you remember?
A. I came down here in '15, I think. 2015.
Q. Okay. And you were here for about a year and a half?
A. Yep, I think so.
Q. Okay. Okay. And when did you first get on hormones?
A. 2017.

Page 78

Q. Were you still at Menard when you first had them prescribed?
A. Yes.
Q. Okay. So you talked to Ms. Kuykendall sometime before you were prescribed hormones?
A. Yes.
Q. Okay. Have you filed any other lawsuits while you've been in IDOC custody?
A. Yes.
Q. Okay. And when were those?
A. I forgot. It was when I was in Lawrence. '18, 2018.
Q. Okay. And just one?
A. Yes.
Q. Okay. And who were you suing in that lawsuit?
A. IDOC.
Q. Okay. No individual people at Lawrence?
A. No.
Q. Okay. And why were you filing suit then?
A. Failure to protect.
Q. Was that about one of the fights that you described?

Page 79

A. It was the fight when I had got attacked.
Q. Which one -- I mean, you mentioned two fights. Which one was that that you say you got attacked?
A. I don't remember when it happened, but I only had two fight tickets on my disciplinary record and --
Q. Okay.
A. -- where that person was, that's the one.
Q. And what happened with that lawsuit?
A. It got dismissed because they said that I didn't exhaust my remedies or whatever, which I did. But --
Q. Okay. All right.
Do you know -- and it's okay if you don't. This is not a memory test. Do you know the number of that lawsuit?
A. No.
Q. Okay. That's okay. All right.
So Ms. Reed, what are you looking for in this lawsuit?
A. I'm looking for -- for a better, adequate medical treatment. Like, a transfer to Logan and

Page 80

for the officers to be more respectful to me and just -- really just get the right treatment that I need for my gender dysphoria.
Q. So you're on hormones, right?
A. Yes.
Q. And you have been for, I don't know, somewhere around three years, give or take?
A. Yes.
Q. Okay. So what other treatment do you want for your gender dysphoria?
A. I want my body surgery and I want, like, social transition and I want a transfer to Logan.
Q. Okay. Anything else?
A. Breast implants.
Q. Now, you said you had some breast development with the hormones and you are wearing a bra?
A. Yes.
Q. You still want implants?
A. Yes.
Q. Okay. And when you talk about social transition, you're talking about commissary things?
A. Yeah. That and also, like, groups, you know. Because at Lawrence, we used to have, like,

Page 81

groups every month, all of the transgenders, and we talked about, like, different little things and stuff. And, like, right now, there is none of that going on here.

Q. Okay. Do you personally know any of the transgender women that are housed at Lawrence?

A. I did a few of them.

Q. I'm sorry. Go ahead.

A. I knew a few of them that was there when I was there.

Q. Okay. Do you know any of the transgender women who are currently housed at Logan?

A. Janiah.

Q. You know Janiah. Have you had any contact with Janiah since she has been at Logan?

A. No.

Q. Okay. Has anyone told you how she's doing?

A. I heard that -- from what I read in, like, transcripts or whatever, she's -- her story that she told, all of that court hearing or whatever, that she -- she's okay and just that she has issues, or whatever.

Q. So when you say transcripts, you mean of the preliminary injunction hearing?

Page 82

A. Yeah.

Q. Okay.

A. I wasn't there to hear, so I read everything.

Q. Sure. Sure. Okay.

MS. TOLBERT: I think that's all I have right now. I might have some redirect, but --

MS. SCHNEIDER: Okay, Sasha, are you doing okay or do you want another break.

WITNESS: I'm cool.

EXAMINATION

BY MS. SCHNEIDER

Q. I'm just going to ask you some questions. It will probably be very brief but I just want to ask some clarifying questions and just about your experience primarily in the last few months when you have been at Menard.

Just for the record, we talked a lot about your different stays at places. Do you know approximately when you were transferred from Lawrence to Menard this time around?

A. I left Lawrence in, I would say, October of last year.

Q. So October 2019 or 2018?

A. 2019. I think it was November or

Page 83

October. I can't remember.

Q. And just generally speaking, Sasha, since you have been at Menard this time around, do you feel safe there?

A. No.

Q. Why not?

A. Because of the harassment, sexual harassment, and the threats that I get from inmates and stuff.

Q. Do inmates call you by female pronoun -- she, her -- or male pronoun -- he, him?

A. No. They -- majority of the inmates call me -- use male pronouns.

Q. How does that make you feel?

A. Don't feel -- makes me feel not a woman to say, yeah, him or he.

Q. What about the guards at Menard, Sasha, do they call you by female or male pronouns?

A. No.

Q. Do they call you by male pronouns, the guards?

A. Yeah, they use male pronouns.

Q. How does that make you feel?

A. Less of a woman. You may have, like, maybe, one or two officers that use female pronouns,

Page 84

but the majority of them use male pronouns.

Q. When an officer uses a male pronoun, in the past, have you corrected he or she?

A. Yes. I correct them. Like, you mean Mrs. Reed, and they'll tell me, no, Mr. Reed. You are in a male facility, you is not a woman.

Q. What about the medical staff, do -- have you encountered nurses or doctors at Menard who have called you by male pronouns?

A. Yes, I have.

Q. About how many?

A. The majority of the ones that I see use male pronouns, yeah.

Q. And have you tried to correct the nurses or doctors when they use male pronouns?

A. Yes.

Q. And what do they say in response or what have they said?

A. Majority of them will, like, ignore me when I say it and then some -- like, only one of them, like, oh, I'm sorry Miss -- Mrs. Reed.

Q. I believe you talked about this earlier, but I just want to clarify. Do you have access to any sort of transgender group therapy at Menard?

A. No. From what I was told is that they

Page 85

not doing it down here.
Q. Since Menard -- since you came to Menard, have you experienced depression or anxiety?
A. Yes.
Q. What do you attribute -- I'm sorry. What do you attribute that depression or anxiety to?
A. Sorry. Can you say that again?
Q. Why have you experienced depression or anxiety?
A. Because I'm not receiving adequate medical treatment.
Q. And when you say adequate medical treatment, treatment for what?
A. Like, for my, like, transfer hygiene items and stuff like that.
Q. Let's talk about hygiene items. What hygiene items have you requested at Menard?
A. I requested soap, shampoo, lotion deoderant, makeup.
Q. And have you received any of those items?
A. No.
Q. Have you been told when those items will be available to you at Menard?
A. No. They tell me that it's coming, but

Page 86

it never comes. Just -- I just get the runaround every time.
Q. So when was the first time -- since your time at Menard, taking a step back, since October 2019, when was the first time that you requested gender affirming grooming items?
A. In some of the grievances that I filed.
Q. Since January 2020, have you filed grievances or requested gender affirming items from IDOT staff?
A. Yes.
Q. And what was the response to your request?
A. That they're coming.
Q. And have they come, to your knowledge?
A. Nope.
Q. And how does it make you feel to not have access to these gender affirming grooming items?
A. Like, I be feeling like -- like, I need those items on a daily basis so that, you know, take care of my routine and as stuff like that. But not being able to have those things, you know, it caused me to, like, think about harming myself and just -- I don't know. Just don't feel right not being able to have those things.

Page 87

Q. Let's talk about -- you mentioned your showering and you say you shower by yourself; is that right, Sasha?
A. Yes.
Q. Is the shower private?
A. No.
Q. Why -- why isn't it private?
A. It's an open bar cell.
Q. Just --
A. It's like a cell, but it's a shower there. So if you walk past, anybody can look in there.
Q. Is there a shower curtain?
A. No. I requested a shower curtain in my grievances and stuff like that and they lied and said they were being utilized, which they're not.
Q. So you filed a grievance asking for a shower curtain and they said you had access to a shower curtain; is that right?
A. Yes.
Q. And to this day, do you have access to a shower curtain when you shower?
A. No.
Q. How does it make you feel to not have a private shower?

Page 88

A. Very uncomfortable because everybody that walks past always look in there.
Q. Sorry. I just have a few more questions. Sasha, when was the last time, to your knowledge, that you got your hormone levels tested?
A. Sometime this year.
Q. And this year, since that hormone testing, have you experienced any sort of, like, pain or discomfort in your breasts?
A. Yeah. I be having breast pain a lot. Yeah.
Q. And have you reported that pain to any staff at IDOT?
A. Yes, I reported it and they ordered a mammogram to be done and they -- but they denied it.
Q. When you say they denied it, what did you hear when you asked -- when you were told the mammogram was denied?
A. They sent me a form saying that Wexford -- I don't remember the doctor's name -- but it said that it was denied and I filed a grievance about it.
Q. And do you recall, like, on what day you got that form that the mammogram was denied?

Page 89

A. Like, two weeks ago.
Q. Do you get pat-down searches at Menard, Sasha?
A. Yes.
Q. And do male or female officers conduct the pat-down searches?
A. Male officers.
Q. How does that make you feel to have male officers conduct those searches?
A. Really uncomfortable. When I asked them to -- can I have a female officer pat me down or strip search me or whatever, or a nurse, they always tell me, no, I'm in a male facility, I don't need no female officer to pat me down.
Q. When was the last time you were patted down by a male officer?
A. When I was in seg.
Q. What about strip searches? Do you get stripped searched by male officers?
A. If they are necessary, yeah, they do it.
Q. And how does that make you feel?
A. Uncomfortable.
Q. All right. Have you requested hormone injections, Sasha?

Page 90

A. Yes.
Q. And do you recall approximately when you made that request?
A. I made it when I filed some grievances when I got down here and I also requested through mental health.
Q. And what were the responses to these requests that you received?
A. That IDOC don't do hormone injections.
MS. SCHNEIDER: Okay. That's all the questions I have. Thank you, Sasha.
MS. TOLBERT: I have just a -- just a very brief redirect.
Are you doing okay, Ms. Reed?
WITNESS: Yes.
FURTHER EXAMINATION
BY MS. TOLBERT
Q. Okay. So your attorney asked you about medical treatment, things that you were dissatisfied or what -- you mentioned you wanted transfer and hygiene items.
A. Yes.
Q. Do you consider transfer to be medical care?
MS. SCHNEIDER: Objection. Foundation.

Page 91

Form.
MS. TOLBERT: Well, he testified -- she testified to it.
BY MS. TOLBERT:
Q. Do you consider a transfer to be a medical treatment?
MS. SCHNEIDER: Same objection, but you can answer.
MS. TOLBERT: Okay.
WITNESS: No, that's not medical treatment.
BY MS. TOLBERT:
Q. And how about hygiene items?
A. No.
MS. SCHNEIDER: Objection to foundation. Form.
BY MS. TOLBERT:
Q. Okay. And you mentioned you had complained of breast pain. When was that?
A. I complained of breast pain sometime last month.
Q. Okay. I apologize. Who did you tell that to?
A. The nurse and the nurse practitioner, Ms. Zimmer.

Page 92

Q. Okay. And was -- did Ms. Zimmer put you in -- make a request for Wexford to send you for that or did Dr. Siddique or do you know?
A. Ms. Zimmer did.
Q. Okay. And Wexford denied you that, correct?
A. Yes.
Q. Okay. Are you aware of whether anyone in the IDOC denied you that?
A. No. Wexford.
Q. Got it. Have you spoken to Ms. Zimmer since that denial?
A. No.
Q. Okay. So -- well, I know the answer, but I need to ask it anyway. Are you aware of whether she had resubmitted that request to Wexford?
A. Well, I don't know. I was seen today by a -- before I came up here, I was seen by another nurse practitioner and they said that -- I forgot what he said, but there was some doctors going to look into the breast pain I'm having or whatever.
Q. Okay. All right. So you have discussed it with other medical providers since you have been denied, correct?
A. Yes.

Page 93

Q. Okay. Thanks.
Do you have any medical education or training?
A. No.
Q. Okay. You told your attorney that you had requested injectable hormones. Why is that?
A. Because the injections have a better effect than the pill does.
Q. Okay. Go ahead.
A. And you get the most use out of it than you would with the pills.
Q. And how do you know that?
A. Because what I read and other transgenders that takes it and they said the same things.
Q. Okay. Do you know physical details about those other transgender women's medical history or medical care?
A. No.
Q. Okay. Has any medical provider ever told you that injectable hormones were in any way more effective than oral hormones?
A. Just from what I read.
Q. Okay. Where did you read that?
A. In some -- I read it in some, like,

Page 94

medical books. And this -- I don't remember. I read it.
Q. Okay. Okay. But again, no medical provider has told you that, right?
A. No.
Q. Okay. So is there anything about your incarceration in IDOC dealing with your transgender issues that I haven't asked you about?
A. Yes. Anything other than my transgender issues?
Q. No. Dealing with your transgender issues. Dealing with the subject of this lawsuit. Is there anything I haven't asked you that you think I need to know?
A. That I'm not receiving my right hormones. I mean, I'm not receiving adequate treatment.
Q. Okay. All right. And the treatment -- the things that you think you're not getting correctly are the things you discussed with your attorney, right?
A. Yes.
Q. Okay. Anything --
A. The treatment that I -- that I am receiving, that was horrible.
Q. Okay. Anything else I need to know?

Page 95

A. No.
Q. Okay.
MS. TOLBERT: Read or waive, counsel?
MS. SCHNEIDER: I guess one thing we want -- sorry. No more questions.
MS. TOLBERT: No. Read or waive? Read the transcript or waive?
MS. SCHNEIDER: Sorry. I couldn't hear you. I'll read it, yes.
MS. TOLBERT: No, your client. Does your client want to reserve his right or her right to read the transcript before she signs or is she going to waive her right to signature?
MS. SCHNEIDER: What have the other plaintiffs been doing? I'll have her read it just because I want to make sure she -- just like I would do any other clients. Just if we wanted an expedited transcript, but at this point, I think -- I want Sasha to read it, make sure everything is accurate.
MS. TOLBERT: Okay. Then she'll get -- I guess, Joyce, you'll send her the transcript and the errata sheet?
MS. SCHNEIDER: Etran.
MS. TOLBERT: All right. That is all we

Page 96

have. Thank you very much for your time, Ms. Reed. Appreciate it.
MS. SCHNEIDER: Thank you.
(Deposition concluded at 2:42 p.m.)

CERTIFICATE OF REPORTER

I, JOYCE D. LAWRENCE, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Joyce D. Lawrence
Certified Shorthand Reporter
Registered Professional Reporter
State of Illinois CSR License #84-1716
My commission expires:
August 4, 2022

ALARIS LITIGATION SERVICES

September 14, 2020

MS. SYDNEY SCHNEIDER
Kirkland & Ellis, LLP
300 North LaSalle
Chicago, Illinois 60654

IN RE: JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL and SASHA REED v. ROB JEFFREYS, MELVIN HINTON and STEVE MEEKS

Dear Ms. Schneider:

Please find enclosed your copies of the deposition of SASHA REED taken on August 31, 2020 in the above-referenced case. Also enclosed is the original signature page and errata sheets.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheets and notarized signature page within 30 days to our office at 711 N 11th Street, St. Louis, MO 63101 for filing.

Sincerely,

JOYCE D. LAWRENCE

Enclosures

ERRATA SHEET

Witness Name: SASHA REED
Case Name: JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL and SASHA REED v. ROB JEFFREYS, MELVIN HINTON and STEVE MEEKS
Date Taken: AUGUST 31, 2020

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Witness Signature: _____

STATE OF _____)

COUNTY OF _____)

I, SASHA REED, do hereby certify:

That I have read the foregoing deposition;

That I have made such changes in form and/or substance to the within deposition as might be necessary to render the same true and correct;

That having made such changes thereon, I hereby subscribe my name to the deposition.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this _____ day of _____, 20___, at _____.

_____
SASHA REED

_____
NOTARY PUBLIC
My Commission Expires:

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard CC CENTER

Offender Information

REED	FADELL	ID#: M38260
Last Name	First Name	

Date / Time	Subjective, Objective, Assessment	Plans
6/12/2020	**RN/LPN/~~Phlebotomist~~ Note (Circle One)**	
818	**Lab Note :**	
	Scheduled for Combo 7-20	
	CMP/TESTOSTERONE LEVEL/ESTRADIOL LEVEL	
	Done : Yes No Signed Refusal : Yes No	
	Recall :	
	Unable / Ate / Work /Move / No Show / Security / Other _____	
6/11/2020 910	NPCL: S: F/u for questions RE transgender meds. I/m wanting injections. Requesting Prenatal Vitamins for hair + nail growth. Also, female panties + bras. Discussed with numbers 2 Jones in I/m commissary SR 4 sports bras et 8 pairs panties O: Alo x4. Skin W/D. Very feminine appearance. A: Transgender Questions.	P: Admin Prenatal Vitamin take po daily Permit for Bras + Panties Will inquire about injections

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

BACK PAIN

Offender Information: Reed (Last Name) Isabell (First Name) M (MI) M38260 (ID#)

Date/Time	Subjective, Objective, Assessment	Plans
7/1/20 805am	**RN NOTE** **LPN/CMT NOTE**	**P) Urgent Referral:** - Sudden back pain with hypotension and/or tachycardia or fever.
	S) - Cause of pain? laying on beds	- Inability to work or severe gait disturbance or change in continence. - Verify meds and allergies prior to treatment
	- Was the pain immediate or delayed?	**Refer to MD if:** 2nd RSC - Abnormal vital signs, temp greater than 100
	- For how long? Couple Weeks	- Loss of sensation or numbness
	- Location? Lower Back - Rate the pain (1-10) 4	- Foot drop
	- Pattern (radiation) what worsens / eliminates? Worsens laying in bed helps: Stretching / walking	- Difficulty ambulating
	- Color of urine? Yellow	- Dark or bloody urine
	- Frequency? 12x	- No improvement after 48 hour trial of Treatment Protocol
	- Any pain on urination? no	**When no MD referral:**
	- History of back problems and/or surgery? no	- Ibuprofen 200 mg, 1 – 2 t.i.d. PRN with meals X 3 days (18 tablets)
	- Fever chills night sweats dysuria none	- Or Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets)
	- Increase in pain with cough? no	- Avoid sporting activities until pain has been gone for at least two weeks
	- Are you taking any medications? IBU & APAP from NSC	- Begin gentle strengthening exercises as early as possible and observe proper lifting techniques. (provide exercise packet)
	- Any trauma? no	- Complete injury report DOC0313
	- Any bowel or bladder incontinence? no	- Urinalysis dip, if urinary symptoms present
	O) T 96.8 P 78 R 12 BP 138/84 WT 181	**OVER**

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

BACK PAIN (Cont.)

Offender Information: Reed (Last Name) Jadell (First Name) (MI) M38260 ID#:

Date/Time	Subjective, Objective, Assessment	Plans
	- Gait disturbance Steady	**Patient Teaching:**
	- Any change from sitting to standing NO	- **If injury could have been prevented, instruct on safety measures**
	- Swelling NO	- Proper body mechanics
	- Redness NO	- Avoid weight lifting, strenuous activity (Sports restriction)
	- Bruises NO	- Back exercises when indicated by MD
	- Tenderness to touch NO	- Recommend moist heat, e.g. warm shower when available.
	- Range of motion WNL	- Back exercises if indicated
	- Distress or pain with movement Sometimes	- Allow 48 hours of trial with simple analgesic
		- Return to sick call if symptoms persist or worsen
		- If obesity present – weight loss counseling
		Follow up:
		- If discomfort worsens or persists and prevents the patient from carrying out normal activities, return to sick call.
		Nurse Signature
	A) Impaired Comfort	~~Payment voucher~~ ~~YES~~ ~~NO~~

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

MENARD CORRECTIONAL Center

Breast Lump

Offender Information: Reed (Last Name) Fadell (First Name) M38260 (MI) ID#:

Date/Time	Subjective, Objective, Assessment	Plans
7/1/20 805a	S) "I noticed my breasts have been hurting and I have been on hormones for several years now"	Pt "Refer to Zimmer"
	- When did you first notice the lump?	- Moist heat (warm water) used during shower for discomfort
	- Any redness, pain or discharge (yes)	- Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets)
	- Has the lump changed since discovery Yes No n/a	or
	- Any history of fibrocystic breast disease or cancer NO	- Ibuprofen 200 mg, 1-2 tablets t.i.d. x 3 days (18 tabs)
	- Any breast surgeries Yes (No)	**Refer to MD**
	- Completes Self breast exam Yes (No)	- All self reported breast lumps
	- How often? Requesting Education n/a Breast Exams	
	- History of mammogram no	**Patient Teaching**
	- Last mammogram and results n/a	- Take medications as instructed
	- Family history of breast cancer no	- Instruction on Self breast exam
	- Last menstrual period? n/a	- Requesting a breast exam from NP to show her how to do them & also to see if there are abnormalities
	O) T 96.8 P 78 R 12 BP 138/94 WT 181	
	- General appearance of the breast n/t	
	- Breast change: Asymmetrical (Symmetrical)	OVER

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

MENARD CORRECTIONAL Center

Breast Lump (Cont.)

Offender Information: Reed (Last Name) Isabell (First Name) (MI) M38260 ID#:

Date/Time	Subjective, Objective, Assessment	Plans
	- Location of the lump along with description	
	- Size	
	- Consistency	
	- Movable	
	- Dimpling	
	- Tenderness	
	- Redness	
	- Discharge	
	- Scar	
	- Axillary Exam: Tenderness Swelling Mass	
		Nurse Signature
	A) Alteration of breast tissue	Payment voucher YES NO

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Headache

Offender Information: Reed (Last Name) Jadell (First Name) (MI) M38200 ID#:

Date/Time	Subjective, Objective, Assessment	Plans
7/7/20 8:25am	**RN NOTE** **LPN/CMT NOTE** **S)** - Duration of headache? Couple days - Is the headache progressively increasing in severity? no - What are your symptoms? pain - Pain location? temple - Is this a new type of headache? yes - Describe the pain? sharp - Describe level of pain 1 -10? 7-8 - Is this the worst headache of your life? no - Reports of any of the following? ☐ N/V ☐ dizziness ☐ blurry vision ☐ diplopia ☐ photophobia none - Reported Hx of similar episodes Yes No - If yes, what Tx is effective? Asp - effective - HIV infection or Cancer? no - Any recent trauma or injury? no - Allergic to medication? no **O)** T 97.8 P 70 R 16 BP 120/76 WT 179 **- Observe for altered level of consciousness, slurred speech and mental status** Alert - Speech Clear - Check pupils, hand grasps Appropriate PERRL + Equal & Strong **- Ability to touch chin to chest with mouth closed (test of stiff neck)** Yes **- Visual acuity** Glasses - WNL **A) Alteration in Comfort**	P) **Refer to MD if:** - Recent head injury - Stiff neck - Confused - VS's abnormal - Severe pain - Nausea / Vomiting - Dizziness - Photophobia - Double Vision - Headache continues despite Tx protocol - "Thunder Clap" onset or comment of "Worst headache I have ever had" - HIV(+) or history of cancer - Unequal pupils **No MD Referral:** - Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets) or Ibuprofen 200 mg 1-2 tabs t.i.d. for 3 days (18 tabs) - Cool compresses may be helpful - Encourage quiet, dark room **Patient Teaching:** - Relative cause of headache - Medication as instructed - Referral to physician clinic if symptoms persist, or if they intensify (i.e., development of stiff neck, nausea, vomiting) **Follow-Up:** Return to sick call if no improvement with treatment Nurse Signature ~~Payment voucher~~ ~~YES~~ ~~NO~~

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Printed on Recycled Paper

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Center

Facility

Session Date: June 4, 2020 **Time:** 12:15 PM **Session Duration:** 15 minutes

Offender Name: (Last, First) Reed, Fadell **ID Number:** M38260

Part I: Offender Information

Level of Care: ☒ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: 09/10/2021 **Discharge:** 3- LIFE

Check all that apply: ☐ Designated SMI ☐ Designated GBMI ☐ On Enforced Medication ☒ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation:	☒ Cooperative	☐ Guarded/Suspicious	☐ Hostile	☐ Uncooperative	
Orientation:	☒ Ox3 (Time, place, person)	☒ OX situation (list:)		☐ Disoriented	
Affect:	☒ Unremarkable	☐ Constricted	☐ Blunt/Inexpressive	☐ Flat	☐ Labile
Appearance:	☒ Appropriately Groomed	☐ Disheveled	☐ Poor Hygiene		
Thought Process:	☒ Clear/Coherent	☐ Circumstantial	☐ Tangential	☐ Perseveration	
	☐ Loose Association	☐ Word Salad/Incoherent	☐ Thought Blocking		

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

The offender met with this clinician in a secure and confidential setting in the North 2 Cell House. The offender had questions regarding the status of her request to be transferred to Logan or Dixon. She said that one of the nurses was able to get her approved for women's underwear. She stated that she has been requesting the hormone injection shots instead of the pill. She said that she wants this because she has read and seen first hand that it is more effective in terms of getting the appearance she desires. She said that she is also wanting to take prenatal vitamins. She reported that her overall mood was anxious due to waiting to hear the decision about her transfer.
The offender was alert and oriented times four. She was calm and cooperative. She had normal eye contact and posture. Her thoughts and speech were clear and goal directed. She denied suicidal and/or homicidal ideation. LOC in tact.
The offender has documented diagnoses of gender dysphoria and unspecified depressive disorder.
The offender will be seen again in 30 days. The offender stated that she knows how to contact mental health and crisis if needed.
This clinician referred the offender to the nurse practitioner in order to have her questions answered. This clinician explained the status of the offender's transfer request.

Clinician Name (Print): Scarlett M. Meyer, MA, LCPC Signature: Scarlett M. Meyer, LCPC

Facility: Menard Correctional Center Title: QMHP

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

ILLINOIS DEPARTMENT OF CORRECTIONS

Refusal of Mental Health Services

N2 708

Menard Correctional Center
Facility

Date: June 30 2020
Time: 12:00 ☐ a.m. ☒ p.m.

Offender Information:

Reed (Last Name) Fzdell (First Name) ___ (MI)
ID#: M38260

☒ **Refusal of Services**

I, the above named, hereby refuse the performance of service of any mental health treatment for the following condition for which it was offered:
~~Psychiatry appointment with Dr. Petcat~~ Individual Therapy

I further understand that this refusal shall only be effective for the stated condition which services or treatment were offered and shall not be considered a blanket refusal for all mental health treatment or services.

Samantha Stellhorn has explained the risks to me, possible complications and
Name of Qualified Mental Health Professional
probable consequences of refusing treatment

I hereby release the Attending Mental Health Professional, the Facility, and the Department of Corrections from all liability for damages or any injuries including to my health caused by or arising out of this refusal whether foreseen or unforeseen.

I certify that I have read and fully understand the above REFUSAL OF TREATMENT, that the explanations therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.

Fzdell, Reed
Print Name of Patient

could not sign, went to yard
Signature of Patient

June 30 2020
Date

Sam Stellhorn
Print Name Witness

Signature of Witness

June 30 2020
Date

Menard Correctional Center
711 Kaskaskia Street
PO Box 711
Menard, IL 62259

UNIVERSITY OF ILLINOIS
Hospital and Health Sciences System
Reference Laboratory

840 South Wood Street,
Room 170 (M/C 750)
Chicago, Illinois 60612
Ph# (877)FOR-LABS
Fredrick Behm, M.D., Director

UNIT:COMBO 7-20 FASTING: Y

PATIENT NAME	PATIENT ID	DOB	SEX	STATUS	DESTINATION
REED, FADELL M38260	A208-38260	01/22/1992	M	Final	D208

PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE	PRINTED ON	PAGE
SIDDIQUI, MOHAMMAD	06/12/2020 07:58	06/12/2020 23:30	06/17/2020 7:05	1

REQUISITION NO.	PT. LAB NO.	LAB REF NO.
A208.4922		

COMMENTS:

Diagnostic Procedure	Result In Range	Result Out of Range	Units	Reference Range
COMP METABOLIC PANEL				
BLOOD UREA NITROGEN	12		MG/DL	6-20
SODIUM	136		MMOL/L	135-145
POTASSIUM	4.1		MMOL/L	3.5-5.2
CHLORIDE	103		MMOL/L	98-108
GLUCOSE	75		MG/DL	65-110
CREATININE	1.08		MG/DL	0.50-1.50
CALCIUM	9.3		MG/DL	8.6-10.6
TOTAL PROTEIN	7.4		G/DL	6.0-8.0
ALBUMIN	4.1		GM/DL	3.4-5.0
BILIRUBIN,TOTAL	0.3		MG/DL	0-1.2
ALK PHOS	54		U/L	40-125
AST	18		U/L	10-40
CO2 CONTENT	24		MMOL/L	24-32
ANION GAP	9		MMOL/L	3-11
ALT	22		U/L	7-50
BUN/CREAT RATIO		11.1 L		12-20
ESTRADIOL	189		PG/ML	
(NOTE)				
REFERENCE INTERVAL				
MALES (ADULT)			15-31 PG/ML	
FEMALES (ADULTS):				
POSTMENOPAUSAL:			15-25 PG/ML	
FOLLICULAR PHASE:			25-115 PG/ML	
MIDCYCLE:			32-517 PG/ML	
LUTEAL PHASE:			36-246 PG/ML	
New reference interval implemented 6/11/19. Assay is performed on the Beckman DXI platform.				
TESTOSTERONE		162 L		
Reference range: 300 to 1080				
Unit: ng/dL				
(NOTE)				
Total testosterone values may not reflect optimal concentrations in all individuals. Free or bioavailable testosterone measurements may provide supportive information.				
REFERENCE INTERVAL: Testosterone, Adult Male				

Continued on the next page

M.D. REVIEW
DATE 6/17/20
DOCTOR
PULL CHART
SEE PATIENT
FILE

Menard Correctional Center
711 Kaskaskia Street
PO Box 711
Menard, IL 62259

UNIVERSITY OF ILLINOIS
Hospital and Health Sciences System
Reference Laboratory

840 South Wood Street,
Room 170 (M/C 750)
Chicago, Illinois 60612
Ph# (877)FOR-LABS
Fredrick Behm, M.D., Director

UNIT:COMBO 7-20 FASTING: Y

PATIENT NAME	PATIENT ID	DOB	SEX	STATUS	DESTINATION
REED, FADELL M38260	A208-38260	01/22/1992	M	Final	D208

PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE	PRINTED ON	PAGE
SIDDIQUI, MOHAMMAD	06/12/2020 07:58	06/12/2020 23:30	06/17/2020 7:05	2

REQUISITION NO.	PT. LAB NO.	LAB REF NO.
A208.4922		

COMMENTS:

Diagnostic Procedure	Result: In Range	Result: Out of Range	Units	Reference Range

Access complete set of age- and/or gender-specific reference
intervals for this test in the ARUP Laboratory Test Directory
(aruplab.com).
Performed by ARUP Laboratories,
500 Chipeta Way, SLC,UT 84108 800-522-2787
www.aruplab.com, Julio Delgado, MD, Lab. Director

End of Report

M.D. REVIEW
DATE AM 5/17
DOCTOR
PULL CHART
FE PATIENT CC/PL...V

ILLINOIS DEPARTMENT OF CORRECTIONS

MEDICAL PERMIT

MENARD CORRECTIONAL CENTER

OFFENDER NAME: Reed, Fadell ID NUMBER: M38260

HOUSING UNIT: N2 7-08

☒ New Order ☐ Change

☐ Renewal ☐ Cancel

☒ Lower Bunk	☒ Slow Walk	☒ Hearing Aid
☐ Low Gallery (A/B)	☒ Double Cuff	☐ Front Cuff
☐ Medical Lay-In	☒ Feed-In Cell	☐ No Yard
☐ Shower on Gallery	☒ C-Pap Machine	☐ Heel Cup Size:
☐ Knee Sleeve/Brace Size:	☐ Scrotal Support Size:	☐ TED Hose Size:
☐ Neck Collar Size:	☐ Mouth guard/Cup	☐ No Work

☒ Other: 1 size large Sports bras, + 1 size Med women's briefs

Start Date: 6/16/2020 Expiration Date: 6/16/2021

Authorized by:

MD [signature] Date: 6/16/2020

I understand that if this permit is altered; a disciplinary report will be written with termination of this permit. I also understand that it is my responsibility to maintain this permit in good condition and to produce to proper authority when requested.

Offender Signature: Reed

Distribution: White copy: Medical Records/OTS:
- ☐ Placement
- ☐ Cell House Sgt.
- ☐ D.O.N Secretary

Yellow Copy: Offender

MEN 0021 (EFF. 5/2015)

ILLINOIS DEPARTMENT OF CORRECTIONS

Psychiatric Progress Note

Facility: Menard Correctional Center

Offender Name:
Last, First THOMPSON, DION **ID Number:** M18222 **Date:** Jul 10, 2020

Start Time: 3:17:00 PM

Allergies or Medication Sensitivities? ☐ No ☒ Yes If yes, then describe: Chlorpromazine, Tubersol, fish

Scheduled Visit Type: Routine Follow Up ☒ Complex Follow Up Evaluation ☐

Level of Care: Outpatient ☒ Residential Treatment Unit ☐ Inpatient ☐ Crisis ☐

Type of Visit: Telepsychiatry ☒ Onsite Evaluation ☐ Other ☐ (identify): _____

Has offender been on Crisis Watch since last psychiatric visit? Yes ☐ No ☒

If yes, explain:

Source of Information: (Check all that apply)
☒ Offender ☒ Mental Health Staff ☐ Medical Staff ☒ Mental Health Progress Notes
☐ Medical Progress Notes ☐ Mental Health Evaluation dated: _____
☐ Crisis Records ☐ Other (identify): _____
☒ Previous Psychiatric Progress Note

Subjective/Objective

Pt seen for medication management and follow up. He was last seen on 05/13/2020 at which time Buspar dose was increased due to pt reported worsening of anxiety. Pt will be discharging in 2 weeks. Said Effexor was helpful in the past for anxiety and he wishes to take effexor. Pt said he likes to continue Buspar and Trazodone and in addition to that he was requesting to add Effexor. He denies feeling depressed or mood symptoms. No psychosis were reported or noted. Pt denies feeling hopeless, helpless or worthless. No issues with sleep or appetite. Pt talked about his family members and prior work history. He reports no current/recurrent thoughts of wishing/ wanting to be dead or to hurt/kill himself or others.

LIST CURRENT PSYCHOTROPIC MEDICATIONS:

- Buspar 30 mg po qHS (expires on 11/11/2020)
- Trazodone 150 mg po qHS (expires on 09/22/2020)

☐ Check if None

Pertinent medical medications:

Ibuprofen, Vit A and D

Compliance: ☒ Good ☐ Poor (list details)

Side effects: ☒ None ☐ Yes (list details)

MAR reviewed: Yes ☒ No ☐

Is offender currently prescribed Involuntary Psychotropic Medication(s)? Yes ☐ No ☒

Lab Results: Comment on abnormal results and include drug levels. None ordered ☒

ILLINOIS DEPARTMENT OF CORRECTIONS

Psychiatric Progress Note

Facility: Menard Correctional Center

Offender Name:
Last, First THOMPSON, DION **ID Number:** M18222 **Date:** Jul 10, 2020

Medical/Mental Health – Female Specific: ☒ Not Applicable

Is the offender currently pregnant? No ☐ Yes ☐ Expected due date: _____

Mental Status Examination

Posture/Gait: ☒ Appropriate ☐ Inappropriate ☐ Slumped ☐ Tense ☐ Atypical ☐ Rigid ☐ _____

Behavior: ☒ Unremarkable ☐ Poor physical boundaries ☐ Posturing aggressively
☐ Tensed muscles ☐ Closed body posture ☐ Guarded/protective posturing
☐ Psychomotor retardation ☐ Psychomotor agitation ☐ _____

Eye contact: ☒ Appropriate ☐ Avoids eye contact ☐ Looks down in his/her lap
☐ Timid ☐ Unfocused ☐ _____

Level of Appearance: ☒ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene ☐ Malodorous ☐ _____

Level of Consciousness: ☒ Alert ☐ Clouded ☐ Lethargic ☐ Delirious ☐ Somnolent ☐ _____

Level of Cooperation: ☒ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative ☐ _____

Orientation: ☒ Ox4 (Time, place, person, reality) ☐ OX _____ (list:) _____ ☐ Disoriented

Attention: ☒ Appropriately focused ☐ Selective attention/inattention ☐ Distractible ☐ Unaware ☐ _____

Speech: ☒ Unremarkable ☐ Slowed ☐ Rapid ☐ Inarticulate ☐ Pressured ☐ _____

In tone: ☒ Unremarkable ☐ Impatience ☐ Irritability ☐ Terse ☐ Flatted tone ☐ _____

Thought Processes: ☐ Circumstantial ☐ Disorganized ☐ _____
☒ Clear/Coherent ☐ Tangential ☐ Loose Association ☐ Word Salad/Incoherent

Thought content: ☒ Unremarkable ☐ Paranoid ☐ Delusional ☐ Excessive religiosity ☐ Referential ☐ _____

Explain:

Perceptions: ☐ Hallucination ☐ Auditory ☐ Visual ☐ Olfactory ☐ Somatic ☐ Illusions

Explain:
Denies AVH/no Delusions were noted or reported.

Affect: ☐ Unremarkable (Euthymic) ☐ Constricted ☐ Expansive ☐ Blunt/Inexpressive ☐ Flat
☐ Hyperthymic ☐ Euphoric ☐ Dysthymic ☐ Manic ☐ Inappropriate ☒ mood congruent

Mood: ☐ Euthymic ☐ Dysthymic ☒ Anxious ☐ Fearful ☐ _____

Suicidal ideation: ☒ None ☐ Yes, details: _____

Homicidal ideation: ☒ None ☐ Yes, details: _____

Memory: Short-term ☒ Intact ☐ _____ Long-term ☒ Intact ☐ _____

Estimated Intelligence: ☐ Above average ☒ Average ☐ Below average

ILLINOIS DEPARTMENT OF CORRECTIONS

Psychiatric Progress Note

Facility: Menard Correctional Center

Offender Name:
Last, First THOMPSON, DION **ID Number:** M18222 **Date:** Jul 10, 2020

Insight: ☒ Adequate ☐ Poor ☐

Judgment: ☒ Adequate ☐ Poor ☐

Motivation: ☐ Good ☒ Adequate ☐ Poor ☐

Historian: ☒ Reliable ☐ Poor ☐ Inconsistent ☐ Unable to assess at this time

Diagnoses

Psychiatric Diagnosis: Unspecified Depressive Disorder

Medical Diagnosis: None

Based upon today's evaluation:
Since last visit, offender's psychiatric symptoms have: Improved ☐ Remained same ☒ Worsened ☐

Modified Global Assessment 60 **to** 62

Based upon diagnosis, Modified GAF and need for supportive services, Offender is designated SMI? Yes ☐ No ☒

Narrative Summary

Pt presented for psychiatric follow up. He is leaving on 07/27/2020. His mood is stable since his last visit. He denies depression, mood symptoms or psychosis. Pt likes to continue Buspar and Trazodone. In addition to that he wishes to restart Effexor. Explained pt he does not need anti-depressants at this time since he does not have depression. Discussed SSRI for depression but he does not want any new meds other than Effexor. Pt was explained this provider will not order Effexor as he does not meet criteria to treat with Effexor at this time. . Discussed continuing the current medication which he is agreeable to. Pt verbalized understanding and agreed with the plan.

Suicide/Homicide/Aggressive risk assessment: Based on this assessment of both risk and protective factors, pt's risk is currently low. He denies SI/HI/aggressive ideation (AI) or no self-injuring behaviors (SIB) were reported or noted. Pt is goal and future oriented. He has the capacity to understand the risk and benefits of giving and/or withholding information regarding suicidal thoughts. Pt agrees to notify on-site staffs should he have a worsening of his mood or development of SI/HI/AI/SIB.

Psychiatric PLAN

Psychotropic Medication: ☐ Started (DOC 0541) ☐ Discontinued ☐ Changed

☒ Continue Current Medication

☒ Medication specifics and rationale:

- Buspar 30 mg po qHS (expires on 11/11/2020)
- Trazodone 150 mg po qHS (expires on 09/22/2020)

Reviewed medication compliance, risks/benefits and side effects.
Reviewed treatment plan risks/benefits/alternatives including no treatment.
Patient voices understanding/agreement with plan of care. Patient verbalizes understanding how to reach mental health for crisis if needed. Patient encouraged to work with MHP in individual/group therapies as recommended/indicated.

ILLINOIS DEPARTMENT OF CORRECTIONS

Psychiatric Progress Note

Facility: Menard Correctional Center

Offender Name:
Last, First THOMPSON, DION **ID Number:** M18222 **Date:** Jul 10, 2020

☐ AIMS completed today (if necessary) (DOC 0336) ☐ AIMS to be done by RN (if necessary)

☐ Labs ☐ CMP ☐ BMP ☐ CBC+Plts ☐ Thyroid Profile ☐ Lithium ☐ Carbamazepine
☐ VPA ☐ Lipid Profile ☐ A1C ☐ EKG ☐ Other: ☐ Other:

☐ Abdominal circumference: ☐ BMI ☐ BP/P

☐ Fill in values and measurements on Metabolic Screening and Monitoring form (DOC 0532)

☐ Needs medical referral for:

☐ Needs MHP referral (Complete DOC 0387) for:
☐ Sleep hygiene ☐ Anger management ☐ Trauma history ☐ Psychometric testing
☐ Other:

☐ Crush/float all Psychotropics due to ☐ Hx of non-compliance ☐ Hx of hoarding medications ☐ Abuse Potential
☒ Other **Per I-doc protocol**

☐ Offender has been given a copy of the Psychotropic Medication Information brochure.

☒ I have verbally reviewed any medication changes, side-effects, risks and benefits of treatment or refusing treatment with the offender.

☐ Offender's psychiatric condition has been stable on the same psychotropic medication(s) at the same dose for the past 60 days - may be seen max OP - 3 months, RTU - 2 months, Enforced - 1 month.

☐ The offender has signed his/her Medication Consent Form.

☐ Treatment plan update needed based on change of diagnosis, direction of treatment, etc. (DOC 0546)

Designation: ☐ SMI ☐ Enforced Psychotropic to be continued (clinically necessary)
☐ Other (identify):

Disposition (Level of Care)

☒ Outpatient Level of Care ☐ Residential Treatment Unit ☐ Inpatient ☐ Crisis

Next Appointment: 4 weeks

Evaluation completed by:

Farzana Alam	farzana Alam Digitally signed by farzana Alam Date: 2020.07.10 23:28:51 -05'00'	MD
Print Name	Signature	Title
07/10/20	3:39:00 PM	
Date	End Time	

Dated Signed 7-13-2020 7pm

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0502 (Rev. 1/2019)

Illinois Department of Corrections

MENTAL HEALTH SERVICES REFERRAL

N°2454

Menard Correctional Center

Facility

Offender's Name: Thompson, Dion ID #: M16000

Why is the offender being referred to the Office of Mental Health Management? (Include a summary of the observed behavior and any other information that may be useful in assessing the offender's status.)

I/M Refuses all meds @ HS.
① Buspar 30mg
② trazodone 150mg
please D/C.

E Knop cmt 07-14-20 [signature]

Print Referring Staff Name Date Referring Staff Signature

☐ **Check if Referring Individual is Security Staff.**

Distribution: Office of Mental Health Management
Offender Medical File

Printed on Recycled Paper

DOC 0387 (Rev. 10/2016)

Rec: 7/15/20
Sch w/BHT

Dont want med
spoke with Dr Poteat I/M states
they will try
something different
-See when scheduled.
7-30-20
DC.

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information: Reed (Last Name) fadell (First Name) (MI) M38260 ID#:

Date/Time	Subjective, Objective, Assessment	Plans
7/18/20 7:45am	Chart note Sto: Scheduled for nsc for Back pain - 1/m (R) - Refusal Signed A: Right to refuse	P: nsc prn
7/29/2020 930	NPC2: S: F/u for nsc. TG Im on GAHT ~ c/o breast pain & tenderness for about 6 mo. Has been on GAHT for 4 yrs. SR some clear stringy discharge 3 times O: Consent signed. Breast exam done. ⊘ drainage from nipples. Breast tissue soft A: Breast Pain on TG.	Collegial for Mammogram. Educated on Self Breast exams

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

COLD (UPPER RESPIRATORY INFECTION {URI}) Symptoms

Offender Information:

Reed (Last Name) Faden (First Name) ___ (MI) ID#: M80260

Date/Time	Subjective, Objective, Assessment	Plans
7/31/20 930A	**RN NOTE** **LPN/CMT NOTE**	**P) Refer to and call MD:**
	S) - How long have symptoms been present? SR "about 1 WK"	- If temp is 101 degrees F or above or
	- What symptoms do you have? Runny nose, Congestion	- If symptoms not resolved in 10 days
	- History of Asthma or COPD? -0	- Facial/ear pain
		- Productive cough with colored sputum
		- Red throat with exudate
	- Any allergies NKDA	**MD for Urgent Consultation:**
	O) T 97.4 P 80 R 20 BP 132/80 WT	- Asthma complicating a URI
	- Pulse Oximeter Reading - PO2 98% RA	• Wheezing or audible abnormal lung sounds
	- Lung sound CTA	- Shortness of breath
	- Sputum Sputum Color clear	- Uncertainty about patient condition
	- Nasal exam WNL	- If pulse ox < 92% or a drop of 5% or more from prior reading regardless if on O2 or not
	Throat exam	**Nursing Intervention: (verify medications and allergies prior to treatment)**
	- Red -0	- If significant congestion with runny nose:
	- Inflamed -0	CTM 4 mg, 1 tab t.i.d. PRN X 3 days (9 tabs)
	- Pustular -0	**OVER**

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

COLD (URI)

Cont.

Offender Information:

Reed (Last Name) Faded (First Name) ___ (MI) ID# M38260

Date/Time	Subjective, Objective, Assessment	Plans
7/31/20 930A	- Difficulty swallowing NO	- For fever or aches offer:
	- Drooling NO	Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets)
	- Dyspnea NO	✓ Ibuprofen 200mg 1-2 tablet t.i.d. x 3 days (18 tabs)
	- Check ear canals for redness ⊖ redness	✓ Guafenesin 200mg b.i.d for 7 days for cough (14 tabs)
	Neck	✓ Coldonyl 2 tabs q.i.d. prn for 3 days (24 tabs)
	- Enlarged lymph nodes ⊖	Patient Teaching:
	- Tender lymph nodes ⊖	✓ - Advise patient to get plenty of rest and increase fluid intake
	- Vital sign abnormalities (e.g. fever with tachycardia or increased respiratory rate) or abnormal pulse oximeter reading	✓ Instruct patient on proper hand washing technique & covering cough
	VS stable	✓ - Increase fluid intake
	C/O congestion & Runny nose	✓ - Medication Instruction
		Follow up:
		✓ Return to sick call if symptoms worsen or persist
		Nurse Signature [signature]
	A) R/O Upper Respiratory Infection (URI)	~~Payment voucher~~ ~~YES~~ ~~NO~~

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Fadell (First Name) (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
8/10/20 12:45pm	**Med Furlough Clerk Note:**	
	S:	P.) Give to x-ray to schedule onsite ultrasound.
	O.) Pt was presented to collegial on 8/6/20 for a onsite breast ultrasound. Dr. Ritz has reviewed the collegial and has approved the request. Authorization#752238884	E. Young Med Furlough Clerk
	A.) Collegial approval	

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Fadell (First Name) (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
8/10/20 10:27am	**Med Furlough Clerk Note:**	
	S:	
	O.) Pt was presented to collegial on 8/6//20 by Dr. Siddiqui for a mammogram. Wexford UM, Dr. Ritz, and Dr. Siddiqui have reviewed the collegial and has given the request an Alternative Treatment Plan made to obtain onsite Breast US instead. Check prolactin level onsite.	P.) Send an email to onsite scheduler to have offender be put on a MD/NP and discuss the alternative treatment plan.
	A.) Collegial Denial	E. Young Med Furlough Clerk

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Center

Offender Information:

Reed (Last Name) Fadell (First Name) ____ (MI) ID#: M58260

Date/Time	Subjective, Objective, Assessment	Plans
8/11/20	X-RAY NOTE	
8A	S/O: Approval letter for onsite breast Ultrasound received. Request will be forwarded to Precise Specialties for scheduling and completion.	P: Forward to Precise Specialties for scheduling and completion.
	A: Ultrasound	S Beckmon RN

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Center

Offender Information:

Reed (Last Name) Fadell (First Name) (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
8/11/20	X-RAY NOTE	
8A	S/O: Request sent to Precise Specialties for completion of ordered Ultrasound.	P: Request sent to Precise Specialties and will be scheduled when a date is given.
	A: Ultrasound	

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Center

Facility

Session Date: July 20, 2020 **Time:** 5:15 PM **Session Duration:** 0 min

Offender Name: (Last, First) Reed, Fadell **ID Number:** M38260

Part I: Offender Information

Level of Care: ☒ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: 09/10/2021 **Discharge:** 3-LIFE

Check all that apply: ☐ Designated SMI ☐ Designated GBMI ☐ On Enforced Medication ☒ None

☒ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation: ☐ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative

Orientation: ☐ Ox3 (Time, place, person) ☐ OX situation (list:) ☐ Disoriented

Affect: ☐ Unremarkable ☐ Constricted ☐ Blunt/Inexpressive ☐ Flat ☐ Labile

Appearance: ☐ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene

Thought Process: ☐ Clear/Coherent ☐ Circumstantial ☐ Tangential ☐ Perseveration
☐ Loose Association ☐ Word Salad/Incoherent ☐ Thought Blocking

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

The offender was not seen due to a quarantine in the North 2 Cell House.

Clinician Name (Print): Scarlett M. Meyer, MA, LCPC Signature: Scarlett M. Meyer, MA, LCPC

Facility: Menard Correctional Center Title: QMHP

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: July 30, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Reed, Fadell **ID Number:** M38260 **Start Time:** 10:09 am

Allergies or Medication Sensitivities? ☒ No ☐ Yes If yes, then describe:

Scheduled Visit Type: Routine Follow Up ☒ Complex Follow Up Evaluation ☐

Level of Care: Outpatient ☒ Residential Treatment Unit ☐ Inpatient ☐ Crisis ☐

Type of Visit: Telepsychiatry ☐ Onsite Evaluation ☒ Other ☐ (identify):

Has offender been on Crisis Watch since last psychiatric visit? Yes ☐ No ☒

If yes, explain:

Source of Information: (Check all that apply)
☒ Offender ☐ Mental Health Staff ☐ Medical Staff ☒ Mental Health Progress Notes
☐ Medical Progress Notes ☐ Mental Health Evaluation dated:
☐ Crisis Records ☐ Other (identify):
☒ Previous Psychiatric Progress Note

Subjective/Objective

Trans gender female on hormones previously took Zoloft
"I think I need to go back on my Zoloft

LIST CURRENT PSYCHOTROPIC MEDICATIONS:

None

☐ Check if None

Pertinent medical medications:

Estradiol MOM MVI Klopenox
Fiber Lax singulair Spironolactone

Compliance: ☐ Good ☐ Poor (list details)

Side effects: ☐ None ☐ Yes (list details)

MAR reviewed: Yes ☐ No ☐

No psych meds

Is offender currently prescribed Involuntary Psychotropic Medication(s)? Yes ☐ No ☒

Lab Results: Comment on abnormal results and include drug levels. None ordered ☒

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: July 30, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Reed, Fadell **ID Number:** M38260 **Start Time:**

Medical/Mental Health – Female Specific: ☒ Not Applicable

Is the offender currently pregnant? No ☐ Yes ☐ Expected due date:

Mental Status Examination

Posture/Gait: ☐ Appropriate ☐ Inappropriate ☐ Slumped ☐ Tense ☐ Atypical ☐ Rigid ☐

Behavior: ☐ Unremarkable ☐ Poor physical boundaries ☐ Posturing aggressively
☐ Tensed muscles ☐ Closed body posture ☐ Guarded/protective posturing
☐ Psychomotor retardation ☐ Psychomotor agitation ☐

Eye contact: ☐ Appropriate ☐ Avoids eye contact ☐ Looks down in his/her lap
☐ Timid ☐ Unfocused ☐

Level of Appearance: ☐ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene ☐ Malodorous ☐

Level of Consciousness: ☐ Alert ☐ Clouded ☐ Lethargic ☐ Delirious ☐ Somnolent ☐

Level of Cooperation: ☐ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative ☐

Orientation: ☐ Ox4 (Time, place, person, reality) ☐ OX (list:) ☐ Disoriented

Attention: ☐ Appropriately focused ☐ Selective attention/inattention ☐ Distractible ☐ Unaware ☐

Speech: ☐ Unremarkable ☐ Slowed ☐ Rapid ☐ Inarticulate ☐ Pressured ☐

In tone: ☐ Unremarkable ☐ Impatience ☐ Irritability ☐ Terse ☐ Flatted tone ☐

Thought Processes: ☐ Circumstantial ☐ Disorganized ☐
☐ Clear/Coherent ☐ Tangential ☐ Loose Association ☐ Word Salad/Incoherent

Thought content: ☐ Unremarkable ☐ Paranoid ☐ Delusional ☐ Excessive religiosity ☐ Referential ☐

Explain:

Perceptions: ☐ Hallucination ☐ Auditory ☐ Visual ☐ Olfactory ☐ Somatic ☐ Illusions

Explain:

Affect: ☐ Unremarkable (Euthymic) ☐ Constricted ☐ Expansive ☐ Blunt/Inexpressive ☐ Flat
☐ Hyperthymic ☐ Euphoric ☐ Dysthymic ☐ Manic ☐ Inappropriate ☐

Mood: ☐ Euthymic ☐ Dysthymic ☐ Anxious ☐ Fearful ☐

Suicidal ideation: ☐ None ☐ Yes, details:

Homicidal ideation: ☐ None ☐ Yes, details:

Memory: Short-term ☐ Intact ☐ Long-term ☐ Intact ☐

Estimated Intelligence: ☐ Above average ☐ Average ☐ Below average

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: July 30, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Reed, Fadell **ID Number:** M38260 **Start Time:**

Insight: ☒ Adequate ☐ Poor ☐

Judgment: ☒ Adequate ☐ Poor ☐

Motivation: ☒ Good ☐ Adequate ☐ Poor ☐

Historian: ☒ Reliable ☐ Poor ☐ Inconsistent ☐ Unable to assess at this time

Diagnoses

Psychiatric Diagnosis: Transgender, on hormones feminizing
Depressive D/o

Medical Diagnosis:

Based upon today's evaluation:
Since last visit, offender's psychiatric symptoms have: Improved ☐ Remained same ☐ Worsened ☒

Modified Global Assessment 61 **to** 64

Based upon diagnosis, Modified GAF and need for supportive services, Offender is designated SMI? Yes ☐ No ☒

Narrative Summary

28 yo transgender Black female with hx depression, requesting resumption of Zoloft. Hopeful she will be transferred to female prison soon.

Psychiatric PLAN

Psychotropic Medication: ☒ Started (DOC 0541) ☐ Discontinued ☒ ~~Changed~~ 4/8/20

☐ Continue Current Medication 25 mg po ghs x 7 days, then increase

☐ Medication specifics and rationale: to 50 mg po ghs x 6 mo.

☐ AIMS completed today (if necessary) (DOC 0336) ☐ AIMS to be done by RN (if necessary)

☐ Labs ☐ CMP ☐ BMP ☐ CBC+Plts ☐ Thyroid Profile ☐ Lithium ☐ Carbamazepine
☐ VPA ☐ Lipid Profile ☐ A1C ☐ EKG ☐ Other: ☐ Other:

☐ Abdominal circumference: ☐ BMI ☐ BP/P

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: July 30, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Reed, Fadell **ID Number:** M38260 **Start Time:** 10:09 am

☐ Fill in values and measurements on Metabolic Screening and Monitoring form (DOC 0532)

☐ Needs medical referral for: _____

☐ Needs MHP referral (Complete DOC 0387) for:

☐ Sleep hygiene ☐ Anger management ☐ Trauma history ☐ Psychometric testing

☐ Other: _____

☐ Crush/float all Psychotropics due to ☐ Hx of non-compliance ☐ Hx of hoarding medications ☐ Abuse Potential

☐ Other _____

☒ Offender has been given a copy of the Psychotropic Medication Information brochure.

☒ I have verbally reviewed any medication changes, side-effects, risks and benefits of treatment or refusing treatment with the offender.

☐ Offender's psychiatric condition has been stable on the same psychotropic medication(s) at the same dose for the past 60 days - may be seen max OP - 3 months, RTU - 2 months, Enforced - 1 month.

☒ The offender has signed his/her Medication Consent Form.

☐ Treatment plan update needed based on change of diagnosis, direction of treatment, etc. (DOC 0546)

Designation: ☐ SMI ☐ Enforced Psychotropic to be continued (clinically necessary)

☐ Other (identify): _____

Disposition (Level of Care)

☒ Outpatient Level of Care ☐ Residential Treatment Unit ☐ Inpatient ☐ Crisis

Next Appointment: 30 days

Evaluation completed by:

DR. THENA POTEAT — Print Name

Thena Poteat MD — Signature

PSYCHIATRIST — Title

7/30/2020 — Date

10:30 am — End Time

noted 7/30/2020 Rabaut

ILLINOIS DEPARTMENT OF CORRECTIONS

Psychotropic Medication Consent

Offender Name: Reed, Fadell ID Number: M 38260

I am providing consent to receive treatment with the following Psychotropic Medication(s):

Medication	Intended Purpose
Zoloft	improve depressed mood

The Physician has discussed and given written information to me regarding:

1. **What** medication(s) I will be taking;
2. What the medication(s) is/are **intended** to do for me;
3. Whether the medication requires periodic **testing**/procedures to ensure safety/efficacy;
4. The possible **side effects** of the recommended medication(s) including: headache, nausea, sexual side effects
5. **Other** treatments and their effectiveness, availability and risks;
6. My right to **refuse** and what could happen if I refuse medication(s).

☒ Based upon the discussion with my Physician and the written materials given to me regarding my medication(s), **I agree to take** the medication(s) described above.

☐ Based upon the discussion with my Physician and the written materials given to me regarding my medication(s), **I do not agree to take** the medication(s) described above. If my refusal to take medication(s) results in my being a danger to myself or others, I understand that I may be given medication(s) under emergency conditions. I also understand that an Enforced Medication order may be sought for giving me this/these medication(s). If there is Enforced Medication approved by a Treatment Review Committee (TRC), I understand that this/these medication(s) will be given against my consent.

☒ I have been given the opportunity to ask questions.

☒ I understand that I can revoke this consent at any time.

Comments:

Individual Signature: Reed Date: 7/30/2020

☒ The patient has the capacity to make reasoned decision to consent for the medication(s) listed above.

Provider Signature: Athena Potts MD Date: 7/30/2020

☐ Check if individual gives consent to take medication(s), but refuses/is unable to sign this form.

Witness Signature: Date:

Witness signature required for verbal consent

Distribution: Offender Medical File

 DOC 0541 (Eff. 1/2019)

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Facility
Facility

Session Date: _____ **Time:** _____ **Session Duration:** 10

Offender Name: (Last, First) Fawell, Reed, Fadell **ID Number:** M38240

Part I: Offender Information

Level of Care: ☒ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: 9.10.21 **Discharge:** 3-Life

Check all that apply: ☐ Designated SMI ☐ Designated GBMI ☐ On Enforced Medication ☐ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation:	☒ Cooperative	☐ Guarded/Suspicious	☐ Hostile	☐ Uncooperative	
Orientation:	☒ Ox3 (Time, place, person)	☐ OX _____ (list:) _____	☐ Disoriented		
Affect:	☒ Unremarkable	☐ Constricted	☐ Blunt/Inexpressive	☐ Flat	☐ Labile
Appearance:	☒ Appropriately Groomed	☐ Disheveled	☐ Poor Hygiene		
Thought Process:	☒ Clear/Coherent	☐ Circumstantial	☐ Tangential	☐ Perseveration	
	☐ Loose Association	☐ Word Salad/Incoherent	☐ Thought Blocking		

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

S. Offender wanted to discuss transfer to Lincoln. Offender also stated there was a request to get female undergarments - however there is an understanding demonstrated by the Offender that this [commissary request] is in process. O: Offender presented with clear and coherent speech pattern, oriented x3. no observable preoccupations or internal stimuli A: Anti social P: Continue Current Course.

Clinician Name (Print): R. Draper LCSW Signature: R. Draper LCSW

Facility: Menard Correctional Facility Title: QMHP.

Distribution: Offender Medical File

Print Reset

DOC 0282 (Rev. 05/2016)

Illinois Department of Corrections

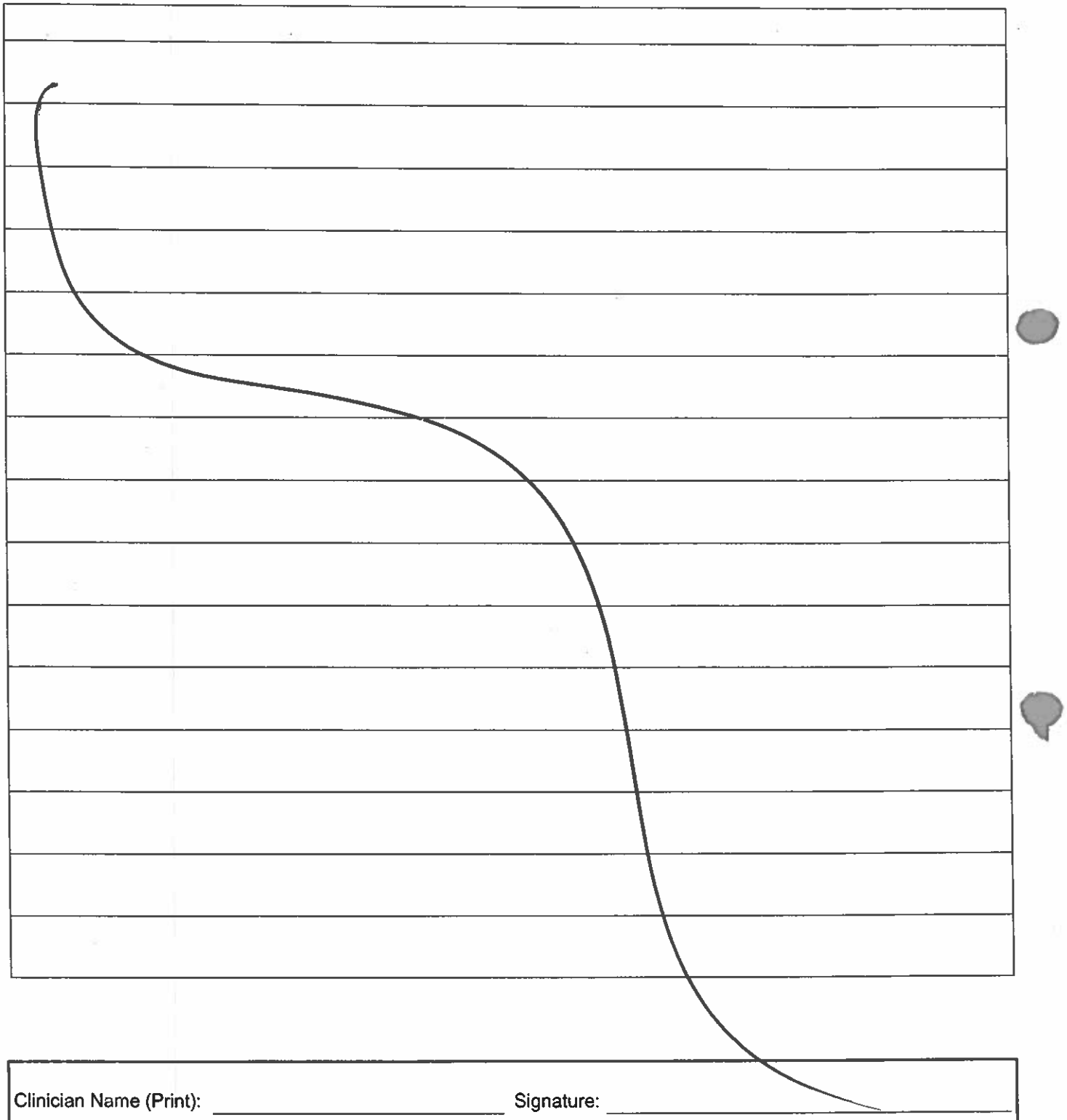
Mental Health Progress Note

_____

Facility

Session Date: _____ **Time:** _____ **Session Duration:** _____

Offender Name: (Last, First) _____ **ID Number:** _____



Clinician Name (Print): _____ Signature: _____

Facility: _____ Title: _____

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

ILLINOIS DEPARTMENT OF CORRECTIONS

Medical Services Refusal

Menard
Facility

705

☐ Employee

☒ Offender

Patient Information: Reed (Last Name) Jadell (First Name) (MI) M38260 (ID#:)

Date: 7 / 18 / 20

Time: 745 ☒ a.m. ☐ p.m.

☒ **Refusal of Services**

I refuse to authorize the performance upon myself or _____ (Name of Patient)

of the following treatment/medication NSC for Back pain (State nature and extent of treatment or medication and dosage instructions)

☐ **Discharge Demand**

I further demand DISCHARGE of myself or _____ (Name of Patient)

from _____ (Name of Medical Facility) against the advice of Dr. _____ (Name of Doctor)

Dr. Siddiqui (Name of Doctor) has explained the risks to me, possible complications and probable consequences of refusing treatment/medication or demanding discharge from this medical facility or both.

I hereby release the Attending Physician, the Menard (Name of Medical Facility), the Facility, and the Department of Corrections from all liability for damages or any injuries including to my health caused by or arising out of this refusal whether foreseen or unforeseen.

I certify that I have read and fully understand the above REFUSAL OF TREATMENT/MEDICATION OR DISCHARGE DEMAND FROM MEDICAL FACILITIES RELEASE OR BOTH, that the explanations therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.

Jadell Reed
Print Name of Patient

Reed
Signature of Patient

7 / 18 / 20
Date

When patient is a Minor or Incompetent to give consent:

_____
Print Name of Person Authorized to Consent

_____
Signature of Person Authorized to Consent

_____
Date

A Engelbrecht
Print Name of Witness

Signature of Witness

7 / 18 / 20
Date

Distribution: Patient's Medical Record or File

Printed on Recycled Paper

DOC 0880 (Rev.05/2019)

ILLINOIS DEPARTMENT OF CORRECTIONS

Consent for Medical Treatment

Menard Corr. Center

Date: 7/29/2020

Time: 925 ☒ a.m. ☐ p.m.

Patient Information:

Reed (Last Name) Fadell (First Name) ____ (MI) ID#: M35260

☒ I authorize the performance upon Self (Myself or Name of Patient) of the following treatment:

Breast Ultrasound (state the nature and extent of treatment)

to be performed by Dr. Mary Zimmer, A.P.N. (Name of Physician) or whomever he or she may designate as his or her assistants.

☒ The nature and extent of the intended treatment has been explained to me in detail, including its risk, possible complications, and probable consequences by Dr. Mary Zimmer, A.P.N. (Name of Physician).

I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

☒ I certify that I have read and fully understand the above Consent to Treatment, that the EXPLANATIONS therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in.

Fadell Reed	Reed	7/29/2020
Print Name of Patient	Signature of Patient	Date

When patient is a Minor or Incompetent to give consent:

Print Name of Person Authorized to Consent	Signature of Person Authorized to Consent	/ / Date
Mary Zimmer, A.P.N.	M. Zimmer APN	7/29/2020
Print Name of Witness	Signature of Witness	Date

Distribution: Patient's Medical Record

Printed on Recycled Paper

DOC 0094 (Eff. 9/2002) (Replaces DC 7130-A)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Center

Offender Information:

Reed (Last Name) Fadell (First Name) (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
8/11/20	X-RAY NOTE	
8A	S/O: Request sent to Precise Specialties for completion of ordered Ultrasound.	P: Request sent to Precise Specialties and will be scheduled when a date is given.
	A: Ultrasound	

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

COLD (UPPER RESPIRATORY INFECTION (URI)) Symptoms

Offender Information: Reed Jadeel M38260 (Last Name, First Name, MI, ID#:)

Date/Time	Subjective, Objective, Assessment RN NOTE / LPN/CMT NOTE	Plans
8/12/20 810am	S) - How long have symptoms been present? few days - What symptoms do you have? Runny nose, cough - History of Asthma or COPD? NO	P) **Refer to and call MD:** - If temp is 101 degrees F or above or - If symptoms not resolved in 10 days - Facial/ear pain - Productive cough with colored sputum - Red throat with exudate
	- Any allergies NO	**MD for Urgent Consultation:** NO Referral
	O) T 97 P R BP WT med guaifenesin - Pulse Oximeter Reading - 99 - Lung sound CTA - Sputum Sputum Color White - Nasal exam **Throat exam** - Red - Inflamed - Pustular	- Asthma complicating a URI - Wheezing or audible abnormal lung sounds - Shortness of breath - Uncertainty about patient condition - If pulse ox < 92% or a drop of 5% or more from prior reading regardless if on O2 or not **Nursing Intervention:** **(verify medications and allergies prior to treatment)** - If significant congestion with runny nose: OTM 4 mg, 1 tab t.i.d. PRN X 3 days (9 tabs)
		OVER

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

COLD (URI)

Cont.

Offender Information: Reed (Last Name) fadeel (First Name) ___ (MI) M38260 ID#: ___

Date/Time	Subjective, Objective, Assessment	Plans
	- Difficulty swallowing NW	**- For fever or aches offer:**
	- Drooling NW	Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets)
	- Dyspnea NW	Ibuprofen 200mg 1-2 tablet t.i.d. x 3 days (18 tabs)
	- Check ear canals for redness N/A	Guafenesin 200mg b.i.d for 7 days for cough (14 tabs)
	Neck	Coldonyl 2 tabs q.i.d. pm for 3 days (24 tabs)
	- Enlarged lymph nodes NW	**Patient Teaching:**
	- Tender lymph nodes NW	- Advise patient to get plenty of rest and increase fluid intake
	- Vital sign abnormalities (e.g. fever with tachycardia or increased respiratory rate) or abnormal pulse oximeter reading	- Instruct patient on proper hand washing technique & covering cough
		- Increase fluid intake
		- Medication Instruction
		Follow up:
		- Return to sick call if symptoms worsen or persist
		Nurse Signature
	A) R/O Upper Respiratory Infection (URI)	Payment voucher YES NO

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Distribution: Offender's Medical Record

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

MCC Center

Offender Information:

REED (Last Name) FADELL (First Name) (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
8-17-20	CMT Note	
10A	S/O Received lab results for HEP A⊕	P-Placed on referral board to be seen by MD
	A. HRCC	Christa Raglow

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Isadell (First Name) (MI) ID#: M38240

Date/Time	Subjective, Objective, Assessment	Plans
8.15.20 8AM	NP NOTE S: Scheduled for: Review ATP —— O: (NOTE) ONLY cell front health care d/t covid control. ~ I/M not being taken to call house infirmary. —— A: NOT SEEN ——	P: Rescheduled appointment. M Moldenhauer NP

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard CC CENTER

Offender Information

REED	FADELL	ID#: M38260
Last Name	First Name	

Date / Time	Subjective, Objective, Assessment	Plans
8/14/2020	**RN/LPN/Phlebotomist Note (Circle One)**	
	Lab Note :	
	Scheduled for NP-Zim	
	CMP/HEP PANEL/PROLACTIN LEVEL/LPD/CBC	
	Done : Yes No Signed Refusal : Yes No	
	Recall :	
	Unable / Ate / Work /Move / No Show / Security / Other _____	

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Breast Lump

Offender Information: Reed (Last Name) fadell (First Name) M38260 (ID#) (MI)

Date/Time	Subjective, Objective, Assessment	Plans
8/9/20 8AM	RN NOTE LPN/CMT NOTE S/x having Breast Discomfort	P) Refer to Zimmer
	S) When did you first notice the lump? No lump	- Moist heat (warm water) used during shower for discomfort
	- Any pain or discharge? no	- Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets)
	- Any redness? no	or
	- Has the lump changed since discovery Yes No n/a	- Ibuprofen 200 mg, 1-2 tablets t.i.d. x 3 days (18 tabs)
	- Any history of fibrocystic breast disease or cancer? no	
	- Any breast surgeries Yes (No)	**Refer to MD:**
	- Completes Self breast exam Yes (No)	- All self-reported breast lumps
	- How often?	
	- History of mammogram? no	**Patient Teaching:**
	- Last mammogram and results? n/a	- Take medications as instructed
	- Family history of breast cancer? n/a	- Instruction on Self breast exam
	- Last menstrual period? n/a	
	O) T P R BP WT Medical Quarantine	
	- General appearance of the breast n/a	
	- Breast change: Asymmetrical____ Symmetrical____	OVER

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Breast Lump (Cont.)

Offender Information:

Reed (Last Name) Jerdell (First Name) (MI) M38260 (ID#:)

Date/Time	Subjective, Objective, Assessment	Plans
	- Location of the lump along with description	
	- Size	
	- Consistency	
	- Movable	
	- Dimpling	
	- Tenderness	
	- Redness	
	- Discharge	
	- Scar	
	- Axillary Exam: Tenderness Swelling Mass	
		Nurse Signature
	A) Alteration of Breast Tissue	Payment Voucher YES NO

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Last Name: Reed First Name: Fadell MI: ID#: M35260

Date/Time	Subjective, Objective, Assessment	Plans
8/20/20 1:00p	XRay Note S) Scheduled for ~~xray~~ ultrasound (err) on 8/21/20. O) Not done due to Medical Quarantine. A) Ultrasound.	P) Recall due to Medical Quarantine. [signature]

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Jadell (First Name) ____ (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
8/24/20 "JR"	NP NOTE S: Scheduled on call line for: breast discomf.	P: Submitted collegial for US Breast per ATP
	O: (NOTE) "ONLY" cell front health care d/t covid contrl. Offender is not being taken to cell house medical exam room. Chart review completed for above scheduled "Reason or Concern" issue addressed and/or orders written accordingly (SEE PLAN) ———	Prolactin - per ATP Rescheduled
	A: Offender not seen face to face by this writer today -	memorandum to

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Last Name	First Name	MI	ID#:
Reed	**Fadell**		**M38260**

Date/Time	Subjective, Objective, Assessment	Plans
	Med Furlough Clerk Note:	
8/25/20 2:25pm	S)	P) Submit collegial referral for ultrasound of breast. This referral was already approved from an ATP.
	O) Received collegial referral for ultrasound of breast. This referral was already approved from an ATP.	
		E. Young Med Furlough Clerk
	A) Collegial referral	

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:
Reed (Last Name) Fadell (First Name) (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
8/31/20	NP NOTE S: Scheduled	P: P. reached
9 15 A	for ATP discussion	
	Informed I/M of ATP	
	O: C.O. said I/M on	
	a legal call	
	"Won't be here"	
	A) NOT SEEN	M Moldenhauer NP
	NOTE I/M was	
	brought to CL	8/31/20
9 25 A	NP NOTE: S. ATP	P follow up
98.3	decision informed	PRN
110/72	of ATP	
78	O: I/M asked extended	
20	level - level given (6/20)	
	A: Education/ATP	
		M Moldenhauer NP

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002
(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information: Reed (Last Name) Jodell (First Name) MI ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
9-2-20 8AM	Ont note	P) Refer
	S/O: Offender stopped this cnt during AM Rounds and stated she would like to be referred to NP Zimmer to discuss her Current doses of hormones	
	A: RX.	[signature]
9/8/20	Bil at Breast Sono Complete	/ B Lupp RN
9/14/2020	LPCL:	S: Admin
900A	S: f/u lab + meds.	↓ estradiol to
928	Prolactin 18.7. ↑	4mg in AM +
23	Ø US results yet.	2mg in pm DOT
18	O: NO x4. Ø acute distress	Recheck Prolactin
127/84	S/L W/D.	in 3 mo.
	A: ↑ Prolactin	M. Zimmer APN

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Jadell (First Name) ____ (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
9/16/2020	MEDICAL RECORDS NOTE: S. MEDICAL RECORDS SENT PER REQUEST. O. RECEIVED SIGNED AUTHORIZATION. A. RECEIVED COPIES. P. FORWARDED VOUCHER TO TRUST.	

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Non-Specific Discomfort

Offender Information: Reed (Last Name) Jordell (First Name) ___ (MI) M38260 (ID#)

Date/Time	Subjective, Objective, Assessment	Plans
9/21/20 8AM	**RN NOTE** ~~**LPN/CMT NOTE**~~	**P) MD Referral if:**
	S) - Any Allergies? None Noted	- Patient presents more than twice at NSC for c/o same discomfort within one month
	- Location of pain / discomfort?	- Patient presents with signs of acute, severe discomfort
	- Describe pain Stabbing Throbbing Constant Intermittent Etc.	- Patient has abnormal vital signs
	- Have you had this pain before and how was it treated?	
	- Rate pain level scale of 1 - 10?	
	- Duration of pain?	**No MD referral:**
	O) T 97.5 P 94 R 16 BP 138/84 WT 170	- Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets)
	- Signs of obvious discomfort	- Ibuprofen 200mg 1-2 tabs t.i.d. PRN for 3 days (18 tabs)
		Patient Teaching:
	- Observations related to body part affected Self Reports	- Return to see provider if symptoms worsen or interfere with daily functioning
		Nurse Signature
	A) Non-Specific Discomfort	~~Payment Voucher~~ ~~YES~~ ~~NO~~

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Printed on Recycled Paper

Wexford Health
SOURCES INCORPORATED

ALTERNATE TREATMENT PLAN

To: Site Medical Director and HSA
From: Utilization Management
Date/Time: 08/07/2020 / 18:34:44

Inmate Name / HSN: FADELL REED / M38260
Date of Birth: 01/22/1992
Site: MENARD
Service: 77067-SCR MAMMO BI INCL CAD

Based upon a review of the information provided, it is my medical opinion that:
1. The above requested service is not authorized at this time based on the following:

Comments: trangender patient on GAHT x 3-4 years. Reports sharp pain in bilateral breasts with occasional nipple discharge. Estradiol level 189. Testosterone 162 (L). _____ 8-7-20 Request for Mammogram reviewed in collegial between Dr. Ritz and Dr. Siddiqui. ATP made to obtain an onsite Breast US instead. Check prolactin level onsite.

From: _____
Dedicated Utilization Management Physician

---

2. ___ ATP Revisited (Date)
   a. ATP Information

   _____
   Signature of Appellant

   b. Appealed Decision: / /

From: _____
Dedicated Utilization Management Physician

3. I want a second opinion of the Alternate Treatment Plan.
   Signature: _____ Date/Time: _____.
4. I will re-consult upon completion of alternate medical plan, if indicated.
   Signature: _____ Date/Time: _____.

INFORMATION CONTAINED IN THIS DOCUMENT IS PRIVILEGED AND CONFIDENTIAL

Wexford Health Sources
Phone: 877-939-2884 -or- 800-353-8384
Fax: 412-937-9151
www.wexfordhealth.com

Wexford Health
SOURCES INCORPORATED

NOTICE OF APPROVAL

To: Site Medical Director and HSA
From: Utilization Management
Date/Time: 08/07/2020 / 14:03:30

Inmate Name / HSN: FADELL REED / M38260
Date of Birth: 01/22/1992
Site: MENARD
Service: 76641-ULTRASOUND BREAST COMPLETE
Authorization No: 752238884

Based upon a review of the information provided, Service is Approved.

Comments: 8-6-20 Onsite Breast US approved by Dr. Ritz in collegial with Dr. Siddiqui for a transgender patient on GAHT x 3-4 years. Reports sharp pain in bilateral breasts with occasional nipple discharge. Estradiol level 189. Testosterone 162 (L).

From: _____
Dedicated Utilization Management

INFORMATION CONTAINED IN THIS DOCUMENT IS PRIVILEGED AND CONFIDENTIAL

Wexford Health Sources
Phone: 877-939-2884 -or- 800-353-8384
Fax: 412-937-9151
www.wexfordhealth.com

ILLINOIS DEPARTMENT OF CORRECTIONS

Medical Special Service Referral Denial or Revision

Offender's Name: Reed, Fadell ID# M38260

Referral Date: 7/29/20

Initial Proposed Course of Action: Your case was presented in collegial by Dr. Siddiqui on 8/6/20 for a mammogram.

Alternative Care Recommended: Dr.Ritz, Wexford UM, has reviewed the case and has given the request for an alternative treatment plan made to obtain an onsite Breast US instead. Check prolactin level onsite.

The offender has the right to appeal any adverse decisions through the grievance procedure outlined in 20 Ill. Adm. Code 504: Subpart F.

.Dr. M. Siddiqui
Print Facility Medical Director's Name

Facility Medical Director's Signature

8/13/2
Date

Distribution: Offender, Offender's Medical File, and Heath Care Unit Administrator

(Printed on Recycled Paper)

DOC 0255 (Eff.4/2007)

ILLINOIS DEPARTMENT OF CORRECTIONS

Medical Special Services Referral and Report

Menard CC
(Facility)

Offender's Name: REED FADELL ID# M38260

Reason for Referral: ☐ Consult ☐ Non-Formulary Medications ☐ Medical Equipment
☐ Evaluation ☐ Management
☐ Procedure/service (specify)
☐ Other (specify)

Urgent: ☐ Yes ☒ No (ONSITE)

Referred to: Breast U.S. per ATP collegial (7/20)

Rationale for Referral: 40 breast discomfort / (40 on hormones) (TRANSgender)

M McLOANHAUER — Print Referring Practitioner's Name
M Mcloanhauer NP — Referring Practitioner's Signature
8-24-20 — Date

Report of Referral (Use Reverse Side, if necessary)

Findings:

Assessment:

Recommendations/Plans:

Print Practitioner's Name | Practitioner's Signature | Date

Facility Medical Director Use Only

I have reviewed the recommendations and:

☐ Approve.

☐ Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision, DOC 0255.

Print Facility Medical Director's Name | Facility Medical Director's Signature | Date

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Facility
Facility

Session Date: _____ **Time:** _____ **Session Duration:** 10

Offender Name: (Last, First) ~~Fadell~~, Reed, Fadell **ID Number:** M38240

Part I: Offender Information

Level of Care: ☒ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: 9-10-21 **Discharge:** 3-Life

Check all that apply: ☐ Designated SMI ☐ Designated GBMI ☐ On Enforced Medication ☐ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation:	☒ Cooperative	☐ Guarded/Suspicious	☐ Hostile	☐ Uncooperative
Orientation:	☒ Ox3 (Time, place, person)	☐ OX _____ (list:) _____		☐ Disoriented
Affect:	☒ Unremarkable	☐ Constricted	☐ Blunt/Inexpressive	☐ Flat ☐ Labile
Appearance:	☒ Appropriately Groomed	☐ Disheveled	☐ Poor Hygiene	
Thought Process:	☒ Clear/Coherent	☐ Circumstantial	☐ Tangential	☐ Perseveration
	☐ Loose Association	☐ Word Salad/Incoherent	☐ Thought Blocking	

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

S: Offender wanted to discuss transfer to Lewisburg. Offender also stated there was a request to get female underwear - however there is an understanding demonstrated by the Offender that this [comissary request] is in process. O: Offender presented with clear and coherent speech pattern, Oriented x3. no observable preoccupations or internal stimuli A: Anti social P: Continue Current Course.

Clinician Name (Print): R. Draper LCSW Signature: R. Draper LCSW

Facility: Menard Correctional Center Title: QMHP

Distribution: Offender Medical File

DOC 0332 (Rev. 05/2016)

Illinois Department of Corrections

Mental Health Progress Note

_____

Facility

Session Date: _____ **Time:** _____ **Session Duration:** _____

Offender Name: (Last, First) _____ **ID Number:** _____

Clinician Name (Print): _____ Signature: _____

Facility: _____ Title: _____

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Center

Facility

Session Date: 8.16.20 **Time:** 9:40 a.m. **Session Duration:** 8-10 min.

Offender Name: (Last, First) Reed, Tadell "Hazel" **ID Number:** M38260

Part I: Offender Information

Level of Care: ☒ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: 9/10/21 **Discharge:** 3-Life

Check all that apply: ☐ Designated SMI ☐ Designated GBMI ☐ On Enforced Medication ☐ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation: ☒ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative

Orientation: ☒ Ox3 (Time, place, person) ☐ OX _____ (list:) _____ ☐ Disoriented

Affect: ☒ Unremarkable ☐ Constricted ☐ Blunt/Inexpressive ☐ Flat ☐ Labile

Appearance: ☒ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene

Thought Process: ☒ Clear/Coherent ☐ Circumstantial ☐ Tangential ☐ Perseveration
☐ Loose Association ☐ Word Salad/Incoherent ☐ Thought Blocking

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

S: Offender's only statement/request was seeing if she could be moved to 7 gallery

O: Offender reported that she prefers the programs her/she. Offender was stable during session.

A: Anti social

P: This QMHP notified staff regarding the Offenders wanting a gallery change - The Offenders

Clinician Name (Print): R Draper LCSW Signature: R. Draper, LCSW

Facility: Menard Correctional Center Title: QMHP

Distribution: Offender Medical File

DOC-0282 (Rev. 05/2016)

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Center

Facility

Session Date: 8-14-20 **Time:** _____ **Session Duration:** _____

Offender Name: (Last, First) _____ **ID Number:** _____

reception and States they would address the issue.

Clinician Name (Print): _____ Signature: _____

Facility: Menard Correctional Center Title: _____

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

Distribution: Offender Medical File

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Center

Facility

Session Date: 9.11.20 **Time:** 9:40 **Session Duration:** 40 min.

Offender Name: (Last, First) Reed, [illegible] Fidell **ID Number:** M38266

Part I: Offender Information

Level of Care: ☑ General/Outpatient ☐ Special/Residential Treatment Unit ☒ Crisis Placement ☐ Inpatient

MSR: _____ **Discharge:** _____

Check all that apply: ☐ Designated SMI ☐ Designated GBMI ☐ On Enforced Medication ☑ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation: ☑ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative

Orientation: ☑ Ox3 (Time, place, person) ☐ OX _____ (list:) _____ ☐ Disoriented

Affect: ☑ Unremarkable ☐ Constricted ☐ Blunt/Inexpressive ☐ Flat ☐ Labile

Appearance: ☑ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene

Thought Process: ☑ Clear/Coherent ☐ Circumstantial ☐ Tangential ☐ Perseveration
☐ Loose Association ☐ Word Salad/Incoherent ☐ Thought Blocking

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

S: This QMHP met with offender in a confidential setting in Mental Health Office (Infirmary) on the above date at the approximate time. The offender was asked if he was suicidal or homicidal at this time. Offender stated "No"
No pressing issues.

O: Offender was stable @ the time of the meeting. No observable signs of depression. oriented x4, good rapport, good eye contact.

A: Anti-Social

P: Continue current course – Ask about Logan & Dixon where are we in the process.

Clinician Name (Print): R. Draper, LCSW QIDP Signature: R. Draper, LCSW

Facility: Menard Correctional Center Title: QMHP

Distribution: Offender Medical File

DOC 0233 (Rev. 05/2016)

Illinois Department of Corrections

Mental Health Progress Note

Menard Correctional Center

Facility

Session Date: 9.11.20 **Time:** 9:40AM **Session Duration:** Approx 15min

Offender Name: (Last, First) Reed, Fadell **ID Number:** M38260

E: Coping skills and triggers

Clinician Name (Print): R. Draper, LCSW QIDP Signature:

Facility: Menard Correctional Center Title: QMHP

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

ILLINOIS DEPARTMENT OF CORRECTIONS

EVALUATION OF SUICIDE POTENTIAL

Facility: Menard CC

Date: 9.11.2020

Offender Name: Reed (Last, First, MI) | M38260 (ID #) | Jan. 22. 1992 (DOB)

Section I: Risk Factors

1. Have there been reports that the offender may be at risk for suicide? Yes ☐ No ☑
2. Has the offender experienced a significant loss within the previous six months? Yes ☐ No ☑
   - If yes, describe: NA
3. Is the offender worried about any major problems other than his or her legal situation? Yes ☐ No ☑
   - yes, describe: NA
4. If the offender holds a position of respect in the community, is he or she having difficulty adjusting to the loss of freedom, status or privilege? Yes ☐ No ☑
5. Is this the offenders first involvement with the legal system? Yes ☑ No ☐
   - If yes, describe: "Aggravated assault" We had an incident - I dont really want to talk about it".
6. Does the offender appear to feel unusually embarrassed or ashamed? Yes ☐ No ☑
7. Does the offender express feelings of hopelessness or helplessness? Yes ☐ No ☑
8. Does the offender show signs of depression (i.e. crying, emotional flatness, etc.)? Yes ☐ No ☑
   - If yes, describe: NA
9. Does the offender seem overly anxious, afraid, or angry? Yes ☐ No ☑
   - If yes, describe: NA
10. Is the offender acting or talking in a strange manner (e.g. cannot focus his or her attention, hallucinating, etc.)? Yes ☐ No ☑
    - If yes, describe: NA
11. Has the offender made previous suicide attempts? Yes ☐ No ☑
    - If yes, How many attempts have been made previously? NA

Date and method of the most recent suicide attempt:

NA

ILLINOIS DEPARTMENT OF CORRECTIONS

EVALUATION OF SUICIDE POTENTIAL

Menard — Facility

9.11.20 — Date

Offender Name: Reed — Last, First, MI

M38260 — ID #

Jan. 22 1992 — DOB

12. Does the offender express thoughts of killing him or herself? Yes ☐ No ☑

13. Does the offender have a plan for suicide? Yes ☐ No ☑

- If yes, describe: NA

14. Does the offender have the means to carry out a suicide plan? Yes ☐ No ☑

15. Does the offender have a family member or significant other who has attempted or completed suicide? Yes ☐ No ☑

- If yes,
  What is the persons relationship to the offender? NO
  Identify the date and method of the attempted or completed suicide:
  NA

Calculate the total number of yes/no responses in each column: Yes 1 No 14

Section II: Protective Factors

1. Does the offender have a spiritual or cultural opposition to suicide? Yes ☐ No ☑
2. Does the offender display a positive future orientation or a sense of hope? Yes ☑ No ☐
3. Does the offender have an active, positive support system that includes family, spouse, friends or community ties? Yes ☑ No ☐
4. Does the offender appear to have good impulse control? Yes ☑ No ☐
5. Is the offender a caretaker or does he or she have a sense of responsibility to family or children? Yes ☑ No ☐
6. Is the offender able to identify multiple effective coping or problem solving skills? Yes ☑ No ☐
7. Is the offender compliant with psychotropic medications (self-report)? Zoloft Yes ☑ No ☐
8. Other? (identify): — Yes ☐ No ☑

Calculate the total number of yes/no responses in each column: Yes 6 No 1

Section III: Summary

- TOTAL NUMBER OF RISK FACTORS (FROM SECTION I): 1

If the number of affirmative responses is greater than five, the offender should be reviewed for crisis watch and referred for a mental health evaluation.

- TOTAL NUMBER OF PROTECTIVE FACTORS (FROM SECTION II): 6

The number of affirmative protective factors should be taken into consideration when reviewing for crisis watch.

Distribution: Offender Medical File

DOC 0379 (Rev. 9/2020)

ILLINOIS DEPARTMENT OF CORRECTIONS

EVALUATION OF SUICIDE POTENTIAL

Menard. — Facility

9.11.20 — Date

Offender Name: Reed, — Last, First, MI

M38216 — ID #

Jan. 22, 1982 — DOB

Section IV: Disposition

ALL CRISIS TEAM MEMBERS (CTMs) SHALL BE REQUIRED TO CONTACT A MENTAL HEALTH PROFESSIONAL (MHP) AFTER COMPLETING SECTION I, SECTION II AND SECTION III WITH THE OFFENDER. AFTER THE CTM RECEIVES THE ORDERS FROM THE MHP, HE OR SHE SHOULD RECORD THE MHPs ORDERS BELOW.

Crisis Team Member (if applicable): R. Draper — Print Name; 9.11.20 — Date/Time:

MHP/Crisis Team Leader Contacted (if applicable): _____ — Print Name; _____ — Date/Time:

Based on the evaluation, the MHP has made a determination of suicide risk level:

- Crisis Placement Indication (Check one):
  - ☐ Continuous Watch (**CW**)
  - ☐ Suicide Watch (10' **SW**)
  - ☐ Close Supervision (15' **CS**)
  - ☐ Observation Status (30' **OBS**)
  - ☑ No Crisis Status Ordered
- Housing Recommendation (Check one):
  - ☐ Place in **Crisis Care** area
  - ☐ Return to **Restrictive Housing**
  - ☐ Return to **General Population** housing
  - ☐ Return to **Reception Center** housing
  - ☐ Return to **Special/Residential Treatment Unit**
  - ☐ Other (specify): _____
- Referrals:
  - ☐ Referred to (specify): _____

Section V: Evaluator and Follow-Up Contact Information

Evaluation completed by:

- ☐ Crisis Team Member
- ☑ Mental Health Professional
- ☐ Psychiatric Provider/M.D
- ☐ Other: _____

R. Draper LCSW	R. Draper	9.11.20	9:20
Print Name	Signature	Date	Time

Follow-up

NOTE: If evaluation was completed by someone other than a MHP/Psychiatric Provider, follow-up must be completed by (MHP/Psychiatric Provider).

Print Name	Signature	Date	Time

ILLINOIS DEPARTMENT OF CORRECTIONS

EVALUATION OF SUICIDE POTENTIAL

Menard
Facility

Date

Offender Name: Reed
Last, First, MI

M38260
ID #

Jan 22, 1992
DOB

Summary of follow-up and interventions/recommendations (if any): offender was stable at the time of the assessment.

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Fadell (First Name) ____ (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
8/10/2020	**S: Gender Dysphoria Disorder** ✓ No change from previous unless noted	**Labs**: Estradiol: Level 189 Last done _____ (< 200) Testosterone: Level 162 Last done _____ (<100) CMP (if on spironolactone) K Level / Cr _____ Last done _____ Other Lab: Level _____ Last done _____ Level _____ Last done _____ Level _____ Last done _____ (consider: periodic lipids, CBC, prolactin level)
1000	GDD Related Treatment in the Past? currently on x 4yr.	
	GDD Related Surgeries in the Past? 0	
Wt 174 98.6	Other:	
	Family History: ✓ No change from previous unless noted	**Imaging:** Mammogram: Not needed (Needed) Done _____ collected placed 7/29/20 (mammogram screening can be considered in any patient > 50 years of age who has had at least 5 years of hormone treatment)
91	Reproductive Cancers Early Atherosclerosis HTN Dyslipidemia DM2	
18	O: __ No change from previous unless noted __ Exam not done (not necessary at every clinic)	
132/88	Penis: (Present) ~~Normal~~ Abnormal _____	
	Testis: (Present) Normal (Atrophied) Abnormal _____	**Counseling:** ____ Not done (only needed prior to starting treatment and periodically there after)
	Breasts: See note on 7/29/20 No Finding Breast Bud Developed Breasts	**Risk of treatment:** Increased risk of: thromboembolic disease, gallstones, elevated liver enzymes, weight gain, hypertriglyceridemia, cardiovascular disease (in the presence of risk factors) Potential increased risk of: HTN, hyperprolactimenia or prolactinoma, DM2 Reasons treatment may be stopped without patient consent include but are not limited to the following: Non-compliance with medication Non-compliance with lab Monitoring Non-compliance with the GDD clinic Development of a contention that is a contraindication of treatment Decompensation of a condition that is a contraindication to treatment. **Patient teaching:** Verbalized or otherwise indicated understanding YES NO
	Note: breast growth usually stops after about 2-3 years of treatment and increased medication will not result in more growth.	
	Adams Apple Alterations: YES (NO)	
	Surgical alterations (NO) YES _____	
	Female Fat Distribution: (YES) NO	
	Reduced Body / Facial Hair: (YES) NO	
	Other:	

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Fadell (First Name) ___ (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
	Does the patient have: NO Hepatitis B Hepatitis C Cirrhosis HIV	Orders:
	Relative Contraindications to treatment: HTN/CAD Dyslipidemia Obesity	P Spironolactone, to (max dose 200 mg BID DOT x 1 yr.
	Diabetes Psychiatric Disorders (these need to be well controlled before beginning treatment)	
	Absolute Contraindications to treatment: ---- Active or recent DVT/PE	Estradiol 4mg BID (max dose) DOT
	---- Hypercoagulable state __ Breast or other estrogen dependent cancer	
	__ End stage chronic liver disease __ Gallbladder disease requiring surgery	
	__ Metabolic syndrome __ Refractory or focal migraine	Make all meds "DOT"
	__ Seizure disorder __ Drug addiction	
	__ Active smoker __ Untreated prolactinoma	Hep panel Prolactin level
	Medical Treatment: Wants medical treatment: YES NO	CBC
	Medical treatment approved by GDD Team: YES NO	Lipid
	List GDD medications if already on medical treatment: Sp: spironolactone 200mg TID Prenatal Estradiol 4mg BID	CMP.
		Next Clinic: ___
		Provider Signature: M. Zimmerman MD

Menard Correctional Center
711 Kaskaskia Street
PO Box 711
Menard, IL 62259
UNIT:NP ZIM

UNIVERSITY OF ILLINOIS
Hospital and Health Sciences System
Reference Laboratory

840 South Wood Street,
Room 170 (M/C 750)
Chicago, Illinois 60612
Ph# (877)FOR-LABS
Fredrick Behm, M.D., Director

PATIENT NAME	PATIENT ID	DOB	SEX	STATUS	DESTINATION
REED, FADELL M38260	A208-38260	01/22/1992	M	Final	D208

PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE	PRINTED ON	PAGE
SIDDIQUI, MOHAMMAD	08/14/2020 08:43	08/14/2020 23:23	08/17/2020 7:05	1

REQUISITION NO.	PT. LAB NO.	LAB REF NO.
A208.7737		

COMMENTS:

Diagnostic Procedure	Result In Range	Result Out of Range	Units	Reference Range
...HCVAB, LPD, PROL				
COMP METABOLIC PANEL				
BLOOD UREA NITROGEN	12		MG/DL	6-20
SODIUM	135		MMOL/L	135-145
POTASSIUM	3.9		MMOL/L	3.5-5.2
CHLORIDE	99		MMOL/L	98-108
GLUCOSE	70		MG/DL	65-110
CREATININE	1.21		MG/DL	0.50-1.50
CALCIUM	10.0		MG/DL	8.6-10.6
TOTAL PROTEIN	7.9		G/DL	6.0-8.0
ALBUMIN	4.4		GM/DL	3.4-5.0
BILIRUBIN,TOTAL	0.4		MG/DL	0-1.2
ALK PHOS	59		U/L	40-125
AST	19		U/L	10-40
CO2 CONTENT	25		MMOL/L	24-32
ANION GAP	11		MMOL/L	3-11
ALT	23		U/L	7-50
BUN/CREAT RATIO		9.9 L		12-20
HEP B CORE AB,TOTAL	NEGATIVE			NEG
(NOTE) The test is performed using Abbott Architect Chemiluminescent Microparticle Immunoassay.				
HEP A IGG AB		POSITIVE ✓		NEG
(NOTE) The test is performed using Abbott Architect Chemiluminescent Microparticle Immunoassay.				
HEP B SURFACE AB,QUA	67.6 ✓		mIU/mL	
(NOTE) <8.0 mIU/mL: Negative Individual is considered not to have immunity to HBV infection. 8.0-11.9 mIU/mL: Equivocal The immune status of the individual should be further assessed, such as clinical correlation, follow-up				

Continued on the next page

M.D. REVIEW 8/18
DATE
DOCTOR
PULL CHART
SEE PATIENT
FILE
SCIPCHEV

Menard Correctional Center
711 Kaskaskia Street
PO Box 711
Menard, IL 62259
UNIT:NP ZIM

UNIVERSITY OF ILLINOIS
Hospital and Health Sciences System
Reference Laboratory

840 South Wood Street,
Room 170 (M/C 750)
Chicago, Illinois 60612
Ph# (877)FOR-LABS
Fredrick Behm, M.D., Director

PATIENT NAME	PATIENT ID	DOB	SEX	STATUS	DESTINATION
REED, FADELL M38260	A208-38260	01/22/1992	M	Final	D208

PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE	PRINTED ON	PAGE
SIDDIQUI, MOHAMMAD	08/14/2020 08:43	08/14/2020 23:23	08/17/2020 7:05	2

REQUISITION NO.	PT. LAB NO.	LAB REF NO.
A208.7737		

COMMENTS:

Diagnostic Procedure	Result In Range	Result Out of Range	Units	Reference Range
...HCVAB, LPD, PROL				
				repeat testing.
	>=12.0 mIU/mL: Positive			Individual is considered to have
				immunity to HBV
	infection.			
	The test is performed using Abbott Architect Chemiluminescent			
	Microparticle Immunoassay.			
HEP C ANTIBODY	NEGATIVE			NEG
	(NOTE)			
	The test is performed using Abbott Architect Chemiluminescent			
	Microparticle Immunoassay.			
LIPIDS				
CHOLESTEROL		217 H	MG/DL	<200
	(NOTE)			
	Cholesterol(mg/dl):			
	<200	DESIRABLE		
	200-239	BORDERLINE HIGH		
	>239	HIGH		
TRIGLYCERIDE	72		MG/DL	<150
	(NOTE)			
	Triglycerides (mg/dl):			
	<150	NORMAL		
	150-199	BORDERLINE HIGH		
	200-499	HIGH		
	>499	VERY HIGH		
	Triglyceride measurement must be performed on a specimen obtained from a fasting individual.			
HDL	57		MG/DL	>40
	(NOTE)			
	HDL <40 mg/dl is low and constitutes a coronary heart disease risk factor.			
	HDL >59 mg/dl is a negative risk factor for			

Continued on the next page

M.D. REVIEW 8/18
DATE
DOCTOR
PULL CHART
SEE PATIENT
FILE
CC/PL/HV

Menard Correctional Center
711 Kaskaskia Street
PO Box 711
Menard, IL 62259
UNIT:NP ZIM

UNIVERSITY OF ILLINOIS
Hospital and Health Sciences System
Reference Laboratory

840 South Wood Street,
Room 170 (M/C 750)
Chicago, Illinois 60612
Ph# (877)FOR-LABS
Fredrick Behm, M.D., Director

PATIENT NAME	PATIENT ID	DOB	SEX	STATUS	DESTINATION
REED, FADELL M38260	A208-38260	01/22/1992	M	Final	D208

PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE	PRINTED ON	PAGE
SIDDIQUI, MOHAMMAD	08/14/2020 08:43	08/14/2020 23:23	08/17/2020 7:05	3

REQUISITION NO.	PT. LAB NO.	LAB REF NO.
A208.7737		

COMMENTS:

Diagnostic Procedure	Result In Range	Result Out of Range	Units	Reference Range
...HCVAB, LPD, PROL				

coronary heart disease.

LDL,CALCULATED — 146 H — MG/DL — <130

(NOTE)

LDL, Calculated(mg/dl):

<100	OPTIMAL
100-129	NEAR OPTIMAL
130-159	BORDERLINE HIGH
160-189	HIGH
>189	VERY HIGH

LDL cannot be calculated when triglycerides are >400 mg/dL.The UIMCC Core Laboratory also offers direct measurement of LDL which may be ordered separately (LDL Cholesterol, Direct).

RISK CATEGORY	LDL GOAL(mg/dl)
CHD or CHD risk equivalent[1]	<100
Multiple (2+) risk factors[2]	<130
Zero to one risk factor	<160

[1]CHD risk equivalents include diabetes, other forms of atherosclerotic disease and/or multiple risk factors that confer a 10-year risk for CHD >20%.

[2]Major Risk Factors:

+1	Cigarette smoking
+1	Hypertension(BP > or =140/90 mmHg or on antihypertensive meds)
+1	Low HDL cholesterol (<40 mg/dL)
+1	Family history of premature CHD
+1	Age: men 45 years and older women 55 years and older
-1	High HDL cholesterol (60 mg/dl or greater)

PROLACTIN		18.7 H	NG/ML	2.6-13.1
BLOOD COUNT				
WBC	9.8		K/UL	3.9-12.0
RBC	5.24		M/UL	4.00-6.10
HGB	13.9		GM/DL	13.2-18.0

Continued on the next page

M.D. REVIEW 8/18
DATE
DOCTOR
PULL CHART
SEE PATIENT
FILE CC/PL:1:V

Menard Correctional Center
711 Kaskaskia Street
PO Box 711
Menard, IL 62259
UNIT:NP ZIM

UNIVERSITY OF ILLINOIS
Hospital and Health Sciences System
Reference Laboratory

840 South Wood Street,
Room 170 (M/C 750)
Chicago, Illinois 60612
Ph# (877)FOR-LABS
Fredrick Behm, M.D., Director

PATIENT NAME	PATIENT ID	DOB	SEX	STATUS	DESTINATION
REED, FADELL M38260	A208-38260	01/22/1992	M	Final	D208

PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE	PRINTED ON	PAGE
SIDDIQUI, MOHAMMAD	08/14/2020 08:43	08/14/2020 23:23	08/17/2020 7:05	4

REQUISITION NO.	PT. LAB NO.	LAB REF NO.
A208.7737		

COMMENTS:

Diagnostic Procedure	Result In Range	Result Out of Range	Units	Reference Range
...HCVAB, LPD, PROL				
HCT	41.4		%	38.0-55.0
MCV		79.0 L	FL	80.0-99.0
MCH	26.5		PG	26.0-35.0
MCHC	33.6		GM/DL	32.0-37.0
RDW	13.7		%	11.6-15.0
PLT	427		K/UL	150-450
MPV	7.8		FL	6.5-11.0
DIFFERENTIAL				
METHOD	AUTOMATED DIFF			
% NEUTROPHIL	62.7		%	
% LYMPHOCYTE	28.3		%	
% MONOCYTE	8.0		%	
% EOSINOPHIL	0.1		%	
% BASOPHIL	0.9		%	
NEUTROPHIL	6.2		K/UL	1.3-7.5
LYMPHOCYTE	2.8		K/UL	1.3-4.2
MONOCYTE	0.8		K/UL	0.2-1.0
EOSINOPHIL	0.0		K/UL	0.0-0.5
BASOPHIL	0.1		K/UL	0.0-0.15

End of Report

REED, FADELL M38260 08/17/2020 07:04 D208

M.D. REVIEW
DATE 8/19
DOCTOR
PULL CHART
SEE PATIENT
FILE
CC/PLAINTIFF

University of Illinois Hospital & Health Sciences System
Reference Laboratory
840 South Wood Street Room 170 (M/C 750)
Chicago, IL 60612
Ph: 312.355.5800

Laboratory Director: Frederick G. Behm, MD

Menard Correctional Center
711 Kaskaskia St
PO Box 711
Menard Illinois 62259

PATIENT NAME	DOB	MRN	SEX	REQUISITION NO.
Reed, Fadell M38260	1/22/1992	200108561	male	*RQ6413*

PHYSICIAN	OUTSIDE MRN	PRINTED DATE
SIDDIQUI, MOHAMMED	*A208-M38260*	9/19/2020 6:01 AM

Laboratory Pathology Report

Final Report

See Values: PROLACTIN (H)

Authorizing Provider

Mohammed Siddiqui

Prolactin (Final result)

Component	Value	Ref. Range
PROLACTIN	**13.9 (H)**	2.6 - 13.1 NG/ML

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-263CH0026. Ordered by Unspecified. Authorized by Mohammed Siddiqui. Collected: 9/18/2020 0830 Received: 9/19/2020 0047.Verified: 9/19/2020 0145. Resulted by UI HEALTH PATHOLOGY LABORATORY.

HIV antibody/antigen screen with reflex (Final result)

Component	Value	Ref. Range
Screening, HIV-1 Antibody	Non-Reactive	Non-Reactive
Screening, HIV-1 Antigen	Non-Reactive	Non-Reactive
Screening, HIV-2 Antibody	Non-Reactive	Non-Reactive
Screening, 5th Generation HIV Antigen-Antibody	Non-Reactive	Non-Reactive

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-263SR0007. Ordered by Unspecified. Authorized by Mohammed Siddiqui. Collected: 9/18/2020 0830 Received: 9/19/2020 0047.Verified: 9/19/2020 0540. Resulted by UI HEALTH PATHOLOGY LABORATORY.

Resulting Labs

CLIA: **14D0664392**

UI HEALTH PATHOLOGY LABORATORY, 840 South Wood Street Room 215
BLDG 920 (CSB), Chicago IL 60612
Director: Frederick Behm M.D.

M.D. REVIEW
DATE 9/21/20
DOCTOR
PULL CHART
SEE PATIENT
FILE
COPY

UI Health | UIC

University of Illinois Hospital & Health Sciences System
Reference Laboratory
840 South Wood Street Room 170 (M/C 750)
Chicago, IL 60612
Ph: 312.355.5800

Laboratory Director: Frederick G. Behm, MD

Menard Correctional Center
711 Kaskaskia St
PO Box 711
Menard Illinois 62259

PATIENT NAME	DOB	MRN	SEX	REQUISITION NO.
Reed, Fadell M38260	1/22/1992	200108561	male	*RQ6413*

PHYSICIAN	OUTSIDE MRN	PRINTED DATE
SIDDIQUI, MOHAMMED	*A208-M38260*	9/19/2020 6:01 AM

Laboratory Pathology Report

gend
H - High

M.D. REVIEW
DATE
DOCTOR
PULL CHART
SEE PATIENT
FILE

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information: Reed (Last Name) Jodell (First Name) MI ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
9-2-20 7Am	Cmt note	P) Refer
	S/O: Offender stopped this cmt during AM Rounds and stated she would like to be referred to NP Zimmer to discuss her current doses of hormones	
	A: RX.	[signature]
9/8/20	Bal at Breast Scan Complete	[signature] / B Lupp RN
9/14/2020	UPCL:	S: Admin
9:00A	S: F/u labs + meds.	↓ estradiol to
97.8	Prolactin 18.7. ↑	4mg in AM +
83	Ø US results yet.	2mg in pm DOT
18	O: NO x4. Ø acute distress	Recheck Prolactin
127/84	S/L in w/ls.	in 3 mo.
	A: ↑ Prolactin	M. Zimmer APN

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Jadell (First Name) (MI) ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
9/16/2020	MEDICAL RECORDS NOTE: S. MEDICAL RECORDS SENT PER REQUEST. O. RECEIVED SIGNED AUTHORIZATION. A. RECEIVED COPIES. P. FORWARDED VOUCHER TO TRUST.	

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002)
(Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Non-Specific Discomfort

Offender Information: Reed (Last Name) Jordell (First Name) (MI) M38260 ID#:

Date/Time	Subjective, Objective, Assessment	Plans
9/21/20 8AM	**RN NOTE** **LPN/CMT NOTE**	**P) MD Referral if:**
	S) - Any Allergies?	
	- Location of pain / discomfort?	- Patient presents more than twice at NSC for c/o same discomfort within one month
	- Describe pain Stabbing Throbbing Constant Intermittent Etc.	- Patient presents with signs of acute, severe discomfort
	- Have you had this pain before and how was it treated? None	- Patient has abnormal vital signs
	- Rate pain level scale of 1 - 10? No	
	- Duration of pain?	**No MD referral:**
	O) T 97.5 P 94 R 16 BP 138/84 WT 170	- Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets)
	- Signs of obvious discomfort	- Ibuprofen 200mg 1-2 tabs t.i.d. PRN for 3 days (18 tabs)
		Patient Teaching:
	- Observations related to body part affected Self Reports	- Return to see provider if symptoms worsen or interfere with daily functioning
		Nurse Signature
	A) Non-Specific Discomfort	~~Payment voucher~~ ~~YES~~ ~~NO~~

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Fadell (First Name) M38260 (MI) ID#:

Date/Time	Subjective, Objective, Assessment	Plans
9/29/20 10am	Cmst Note Sto: Offender States Current order/permit for sports bras is too small. She states the large sports bra no longer fits. Offender is requesting (2) XL sports bras. A new permit needs written so they can be ordered A: Central Supply	P) Refer

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002 (Replaces DC 7147)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information: Reed (Last Name) Fadeel (First Name) MI ID#: M38260

Date/Time	Subjective, Objective, Assessment	Plans
10/5/20	NPCL	P: Admin Permit written for 2 sports bras XL.
1000A	S: F/u NSC for new permits for sports bras. I/m s/r current sports bra is too tight Requests new.	
	O: A&O. Skin w/o. sports bra tight	
	A: Sports bra (T6)	
		[signature] APN

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

Distribution: Offender's Medical Record

Printed on Recycled Paper

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Reed (Last Name) Jadell (First Name) M (MI) M38260 (ID#:)

Date/Time	Subjective, Objective, Assessment	Plans
10/12/20 8A	Cmt note	P) cpm
	Sta: leg. Blpv 124/76.	
	Wt 177 lbs	
	A: Blp ✓	

ILLINOIS DEPARTMENT OF CORRECTIONS

Mental Health Master Treatment Plan Update

Facility: Menard

Offender name: Reed IDOC #: M38260 DOB: 1.22.92

Treatment Plan Date: 9.11.20

Treatment Type: ☐ Crisis Watch Entry/7 days Seg Entry ☐ Routine Crisis Watch ☐ Crisis Watch upon discharge

Next Treatment Plan Due: ☑ Annually (OP) ☐ Monthly (SEG) ☐ Every 6 months (SDP) ☐ Weekly (Input, Crisis) ☐ Every 2 months (RTU)

Next Treatment Plan Due: 9.11.21

Diagnosis Change? ☑ No ☐ Yes

If yes, please add diagnosis and justification in the boxes below.

Diagnosis added or deleted:

✓

Justification for change:

✓

Medication(s):	Dose:	Frequency:	Indication:
Estdiol	8mg	BID	PO
~~Spar~~ Testosterone Blocker	400mg	BID	PO
Zoloft	25mg	daily	PO

Add Medication

Response to medication and other concurrent treatment: (Comment on enforced meds, compliance issues, lab follow-ups, etc.)

"Good"

Monroe et al. v. Rauner, et al. (18-156) Document No.: 361433

ILLINOIS DEPARTMENT OF CORRECTIONS

Mental Health Master Treatment Plan Update

Facility: Menard

Offender name: Reed | IDOC #: M38260 | DOB: Jan 22, 1992

Client long-term goals: (use client direct quote)

"Complete my full Transition."

Cosmetology, culinary Art

Short-term Objectives: (Must be specific, measurable, attainable within review period, realistic and time-bound)

Objective number: 1

Objective (Linked to documented functional impairment, symptoms & diagnosis):

Offender will continue to remain aggression free.

Clinical Interventions (Description, duration and staff responsible):

MHP / QMH will continue to meet with offender as scheduled.

Client initials: X Reed

Involvement (Client agrees to participate by):

Offender will not engage in aggression will not receive any tickets for agression.

ILLINOIS DEPARTMENT OF CORRECTIONS

Mental Health Master Treatment Plan Update

Facility: Menard

Offender name: Reed IDOC #: M38260 DOB: Jan 22 92

Short-term Objectives: (Must be specific, measurable, attainable within review period, realistic and time-bound)

Objective number:	Objective (Linked to documented functional impairment, symptoms & diagnosis):	Clinical Interventions (Description, duration and staff responsible):	Client initials:	Involvement (Client agrees to participate by):
2.	Offender will be able to name 2 benefits to taking her meds.	PA Psych will continue to prescribe, monitor and Educate on meds.	X Reed	Offender will come to each appointment report progress.

Distribution: Offender Medical File

ILLINOIS DEPARTMENT OF CORRECTIONS

Mental Health Master Treatment Plan Update

Facility: Menard

Offender name: Reed. IDOC #: M35260 DOB: Jan. 2292

Short-term Objectives: (Must be specific, measurable, attainable within review period, realistic and time-bound)

Objective number: 3

Objective (Linked to documented functional impairment, symptoms & diagnosis):

Offender will continue to work with Security to ~~complete~~ and facilitate cooperation

Clinical Interventions (Description, duration and staff responsible):

MHP QMHP will continue to meet with offender and process her interaction

Client initials: X FR

Involvement (Client agrees to participate by):

Offender will met with QMHP/MHP to when Scheduled

Primary QMHP (Print): R. Draper Signature: R. Draper Date: 9.11.20

Psychiatric Provider (Print): X Thena Potcatwala Signature: X Thena Potcatwala MD Date: X 9/28/20

Title: Print & Sign: Date:

Title: Print & Sign: Date:

Title: Print & Sign: Date:

Title: Print & Sign: Date:

☐ I agree with this treatment plan ☐ I do not agree with this treatment plan

Client Signature: X Reed Date: X 9.11.20

Distribution: Offender Medical File

DOC 0548 (Eff. 1/2019)

Rec'd 9-18-2020

N2 7:08

Illinois Department of Corrections

MENTAL HEALTH SERVICES REFERRAL

Menard Correctional Center

Facility

Offender's Name: Reed, Fadell ID #: M38260

Why is the offender being referred to the Office of Mental Health Management? (Include a summary of the observed behavior and any other information that may be useful in assessing the offender's status.)

I'm refusing Zoloft 50mg QHS.

E Knop — Print Referring Staff Name

09.17.20 — Date

[signature] — Referring Staff Signature

☐ **Check if Referring Individual is Security Staff.**

Distribution: Office of Mental Health Management
Offender Medical File

Printed on Recycled Paper

DOC 0387 (Rev. 10/2016)

wants off the Zoloft 9-29-20 _Conner.

Scheduled 10/13/20 w/ Dr. Pokorst CB

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: October 13, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Reed, Fadell **ID Number:** M38260 **Start Time:** 9:45AM

Allergies or Medication Sensitivities? ☒ No ☐ Yes If yes, then describe:

Scheduled Visit Type: Routine Follow Up ☒ Complex Follow Up Evaluation ☐

Level of Care: Outpatient ☒ Residential Treatment Unit ☐ Inpatient ☐ Crisis ☐

Type of Visit: Telepsychiatry ☐ Onsite Evaluation ☒ Other ☐ (identify):

Has offender been on Crisis Watch since last psychiatric visit? Yes ☐ No ☒

If yes, explain:

Source of Information: (Check all that apply)
☒ Offender ☐ Mental Health Staff ☐ Medical Staff ☒ Mental Health Progress Notes
☐ Medical Progress Notes ☐ Mental Health Evaluation dated:
☐ Crisis Records ☐ Other (identify):
☒ Previous Psychiatric Progress Note

Subjective/Objective

S: "I'm alright, just frustrated"
"Still can't get female products from commissary"
↳ eg makeup, undergarments available at Logan

LIST CURRENT PSYCHOTROPIC MEDICATIONS:

Zoloft 50mg po qhs (exp 2/3/2021)

☐ Check if None

Pertinent medical medications:

Estradiol Fiber Lax Singulair Kapanex
Spironolactone MOM Prenatal MVI

Compliance: ☐ Good ☐ Poor (list details) Fair - missed ~1/3 - 1/4 doses

Side effects: ☒ None ☐ Yes (list details)

MAR reviewed: Yes ☒ No ☐

Is offender currently prescribed Involuntary Psychotropic Medication(s)? Yes ☐ No ☒

Lab Results: Comment on abnormal results and include drug levels. None ordered ☐

9/18/2020 Prolactin 13.9
HIV neg
Antigen +Antibody

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: October 13, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Reed, Fadell **ID Number:** M38260 **Start Time:** 945 AM

Medical/Mental Health – Female Specific: ☒ Not Applicable

Is the offender currently pregnant? No ☐ Yes ☐ Expected due date: _____

Mental Status Examination

Posture/Gait: ☒ Appropriate ☐ Inappropriate ☐ Slumped ☐ Tense ☐ Atypical ☐ Rigid ☐ _____

Behavior: ☒ Unremarkable ☐ Poor physical boundaries ☐ Posturing aggressively
☐ Tensed muscles ☐ Closed body posture ☐ Guarded/protective posturing
☐ Psychomotor retardation ☐ Psychomotor agitation ☐ _____

Eye contact: ☒ Appropriate ☐ Avoids eye contact ☐ Looks down in his/her lap
☐ Timid ☐ Unfocused ☐ _____

Level of Appearance: ☒ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene ☐ Malodorous ☐ _____

Level of Consciousness: ☒ Alert ☐ Clouded ☐ Lethargic ☐ Delirious ☐ Somnolent ☐ _____

Level of Cooperation: ☒ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative ☐ _____

Orientation: ☒ Ox4 (Time, place, person, reality) ☐ OX _____ (list:) _____ ☐ Disoriented

Attention: ☒ Appropriately focused ☐ Selective attention/inattention ☐ Distractible ☐ Unaware ☐ _____

Speech: ☒ Unremarkable ☐ Slowed ☐ Rapid ☐ Inarticulate ☐ Pressured ☐ _____

In tone: ☒ Unremarkable ☐ Impatience ☐ Irritability ☐ Terse ☐ Flatted tone ☐ _____

Thought Processes: ☐ Circumstantial ☐ Disorganized ☐ _____
☒ Clear/Coherent ☐ Tangential ☐ Loose Association ☐ Word Salad/Incoherent

Thought content: ☒ Unremarkable ☐ Paranoid ☐ Delusional ☐ Excessive religiosity ☐ Referential ☐ _____

Explain: "I get frustrated"

Perceptions: ☐ Hallucination ☐ Auditory ☐ Visual ☐ Olfactory ☐ Somatic ☐ Illusions

Explain: No abnormal perception

Affect: ☒ Unremarkable (Euthymic) ☐ Constricted ☐ Expansive ☐ Blunt/Inexpressive ☐ Flat
☐ Hyperthymic ☐ Euphoric ☐ Dysthymic ☐ Manic ☐ Inappropriate ☐ _____

Mood: ☐ Euthymic ☐ Dysthymic ☐ Anxious ☐ Fearful ☒ "frustrated"

Suicidal ideation: ☒ None ☐ Yes, details: _____

Homicidal ideation: ☒ None ☐ Yes, details: _____

Memory: Short-term ☒ Intact ☐ _____ Long-term ☒ Intact ☐ _____

Estimated Intelligence: ☐ Above average ☒ Average ☐ Below average

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: October 13, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Reed, Fadell **ID Number:** M38260 **Start Time:** 9:45AM

Insight: ☒ Adequate ☐ Poor ☐

Judgment: ☒ Adequate ☐ Poor ☐

Motivation: ☒ Good ☐ Adequate ☐ Poor ☐

Historian: ☒ Reliable ☐ Poor ☐ Inconsistent ☐ Unable to assess at this time

Diagnoses Transgender female

Psychiatric Diagnosis: Depressive D/O (unspec)

Medical Diagnosis: taking feminizing hormones, Asthma

Based upon today's evaluation:
Since last visit, offender's psychiatric symptoms have: Improved ☐ Remained same ☒ Worsened ☐

Modified Global Assessment 60 to 66

Based upon diagnosis, Modified GAF and need for supportive services, Offender is designated SMI? Yes ☐ No ☒

Narrative Summary

28yo transfemale with depressive d/o, currently managed well with zoloft 50mg qhs. offender has ongoing issues related to transgender status and frustration re: written policies not being followed consistently. Will be seeing MHP today and will discuss then

Psychiatric PLAN

Psychotropic Medication: ☐ Started (DOC 0541) ☐ Discontinued ☐ Changed

☒ Continue Current Medication Zoloft 50mg po qhs (exp 2/3/21)

☐ Medication specifics and rationale:

☐ AIMS completed today (if necessary) (DOC 0336) ☐ AIMS to be done by RN (if necessary)

☐ Labs ☐ CMP ☐ BMP ☐ CBC+Plts ☐ Thyroid Profile ☐ Lithium ☐ Carbamazepine
☐ VPA ☐ Lipid Profile ☐ A1C ☐ EKG ☐ Other: ☐ Other:

☐ Abdominal circumference: ☐ BMI ☐ BP/P

Distribution: Offender Medical File

ILLINOIS DEPARTMENT OF CORRECTIONS

Date: October 13, 2020

Psychiatric Progress Note

Facility MENARD CORRECTIONAL CENTER

Offender Name:
Last, First Reed, Fadell **ID Number:** M38260 **Start Time:** 9:45 AM

☐ Fill in values and measurements on Metabolic Screening and Monitoring form (DOC 0532)

☐ Needs medical referral for: _____

☐ Needs MHP referral (Complete DOC 0387) for:

☐ Sleep hygiene ☐ Anger management ☐ Trauma history ☐ Psychometric testing

☐ Other: _____

☐ Crush/float all Psychotropics due to ☐ Hx of non-compliance ☐ Hx of hoarding medications ☐ Abuse Potential

☐ Other _____

☒ Offender has been given a copy of the Psychotropic Medication Information brochure. No change

☒ I have verbally reviewed any medication changes, side-effects, risks and benefits of treatment or refusing treatment with the offender.

☐ Offender's psychiatric condition has been stable on the same psychotropic medication(s) at the same dose for the past 60 days - may be seen max OP - 3 months, RTU - 2 months, Enforced - 1 month.

☒ The offender has signed his/her Medication Consent Form. No new meds

☐ Treatment plan update needed based on change of diagnosis, direction of treatment, etc. (DOC 0546)

Designation: ☐ SMI ☐ Enforced Psychotropic to be continued (clinically necessary)

☐ Other (identify): _____

Disposition (Level of Care)

☒ Outpatient Level of Care ☐ Residential Treatment Unit ☐ Inpatient ☐ Crisis

Next Appointment: 30 days

Evaluation completed by:

DR. THENA POTEAT — Print Name

Thena Poteat MD — Signature

PSYCHIATRIST — Title

10/13/2021 — Date

9:56 AM — End Time

10/13/21 9:56am

4.4.-10

Illinois Department of Corrections

Mental Health Progress Note

Menard CC
Facility

Session Date: 10.13.20 **Time:** 10:00 **Session Duration:** 3-5 Min

Offender Name: (Last, First) Reed, Fadell **ID Number:** N38260

Part I: Offender Information

Level of Care: ☑ General/Outpatient ☐ Special/Residential Treatment Unit ☐ Crisis Placement ☐ Inpatient

MSR: 9/10/21 **Discharge:** 3-Life

Check all that apply: ☐ Designated SMI ☐ Designated GBMI ☐ On Enforced Medication ☑ None

☐ No face-to-face contact occurred
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

☐ Completed by Behavioral Health Technician
(If checked, skip Brief Mental Status Evaluation section, document information in Part III)

Part II: Brief Mental Status Evaluation

Level of Cooperation: ☑ Cooperative ☐ Guarded/Suspicious ☐ Hostile ☐ Uncooperative

Orientation: ☑ Ox3 (Time, place, person) ☐ OX _____ (list:) _____ ☐ Disoriented

Affect: ☑ Unremarkable ☐ Constricted ☐ Blunt/Inexpressive ☐ Flat ☐ Labile

Appearance: ☑ Appropriately Groomed ☐ Disheveled ☐ Poor Hygiene

Thought Process: ☑ Clear/Coherent ☐ Circumstantial ☐ Tangential ☐ Perseveration
☐ Loose Association ☐ Word Salad/Incoherent ☐ Thought Blocking

Part III: S.O.A.P. Note

S = subjective, offender self-report of presenting problem; **O** = objective, clinician view of presenting problem;
A = assessment, clinician assessment of offender; **P** = plan, current plan, link to treatment plan

S: Offender was seen in N2 infirmary at the above date and approx. time. Offender denied any homicidal or suicidal thoughts.
O: Offender was stable at the time of the assessment: motor activity was within normal limits, good eye contact, judgement appeared to be good, support was good, attire

Clinician Name (Print): K. Draper, LCSW Signature: K. Draper LCSW

Facility: Menard CC Title: QMHP

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0282 (Rev. 05/2016)

Illinois Department of Corrections

Mental Health Progress Note

Menard CC
Facility

Session Date: 10.13.20 **Time:** 10:15am **Session Duration:** Approx 3-5

Offender Name: (Last, First) Reed, Fadell **ID Number:** M38260

Was appropriate, hygiene was good.
A: Anti-Social
P: Continue current course: Offender dismissed session early "I just want to know about transfer."

Clinician Name (Print): R. Draper Signature: R. Draper

Facility: Menard CC Title: LCSW

Distribution: Offender Medical File

DOC 0282 (Rev. 05/2016)

ILLINOIS DEPARTMENT OF CORRECTIONS
Laboratory and Radiology Summary

Menard Correctional Center
Facility

Date: 9.18.20

Offender/Patient Name: Reed Fidell

Offender ID Number: M35260

Housing Unit: N2 708

The following checked results were found to be normal or stable by Dr. Siddiqui, MD.

Laboratory completed: _____

Radiology completed: 9.8.20

Distribution: Offender Medical Record
Offender

Printed on Recycled Paper

OneRadiology
Normal, IL 61761
Date: 09/06/2018

Patient: Reed, Fadell
ID#: M38260
D.O.B.: 01/22/92
Ordered by: Dr. Shah
Lawrence Correctional Center

CHEST, TWO VIEWS 09/04/2018:
LEFT RIBS COMPLETE 09/04/2018:

HISTORY: Pain.

FINDINGS: Evaluation of the left ribs with multiple views demonstrate no acute bony fracture.

Evaluation of the chest demonstrates a slight dextroconvex scoliosis of the thoracic spine.

The heart, hila, and mediastinal structures are normal. The pulmonary vasculature, bony thorax, and soft tissues are unremarkable. The trachea is midline.

Minimal atelectasis may be present at the lung bases.

Signed _____
N. Yousuf, M.D.

NY: cah
DIC: 09/06/2018

Films from Lawrence Correctional Center

9.10.18

University of Illinois Hospital & Health Sciences System
Reference Laboratory
840 South Wood Street Room 170 (M/C 750)
Chicago, IL 60612
Ph: 312.355.5800

Laboratory Director: Frederick G. Behm, MD

UI Health | UIC

Menard Correctional Center
711 Kaskaskia St
PO Box 711
Menard Illinois 62259

PATIENT NAME	DOB	MRN	SEX	REQUISITION NO.
Reed, Fadell M38260	1/22/1992	200108561	male	*RQ6413*

PHYSICIAN	OUTSIDE MRN	PRINTED DATE
SIDDIQUI, MOHAMMED	*A208-M38260*	9/19/2020 6:01 AM

Laboratory Pathology Report

al Report

See Values: PROLACTIN (H)

Authorizing Provider

Mohammed Siddiqui

Prolactin (Final result)

Component	Value	Ref. Range
PROLACTIN	**13.9 (H)**	2.6 - 13.1 NG/ML

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-263CH0026. Ordered by Unspecified. Authorized by Mohammed Siddiqui. Collected: 9/18/2020 0830 Received: 9/19/2020 0047.Verified: 9/19/2020 0145. Resulted by UI HEALTH PATHOLOGY LABORATORY.

V antibody/antigen screen with reflex (Final result)

Component	Value	Ref. Range
Screening, HIV-1 Antibody	Non-Reactive	Non-Reactive
Screening, HIV-1 Antigen	Non-Reactive	Non-Reactive
Screening, HIV-2 Antibody	Non-Reactive	Non-Reactive
Screening, 5th Generation HIV Antigen-Antibody	Non-Reactive	Non-Reactive

Specimen Type: Blood Specimen Source: Blood, Venous Specimen: 20H-263SR0007. Ordered by Unspecified. Authorized by Mohammed Siddiqui. Collected: 9/18/2020 0830 Received: 9/19/2020 0047.Verified: 9/19/2020 0540. Resulted by UI HEALTH PATHOLOGY LABORATORY.

Resulting Labs

CLIA: **14D0664392**

UI HEALTH PATHOLOGY LABORATORY, 840 South Wood Street Room 215 BLDG 920 (CSB), Chicago IL 60612
Director: Frederick Behm M.D.

M.D. REVIEW
DATE 12/1/20
DOCTOR
PULL CHART
SEE PATIENT
FILE

UI Health | UIC

University of Illinois Hospital & Health Sciences System
Reference Laboratory
840 South Wood Street Room 170 (M/C 750)
Chicago, IL 60612
Ph: 312.355.5800

Laboratory Director: Frederick G. Behm, MD

Menard Correctional Center
711 Kaskaskia St
PO Box 711
Menard Illinois 62259

PATIENT NAME	DOB	MRN	SEX	REQUISITION NO.
Reed, Fadell M38260	1/22/1992	200108561	male	*RQ6413*

PHYSICIAN	OUTSIDE MRN	PRINTED DATE
SIDDIQUI, MOHAMMED	*A208-M38260*	9/19/2020 6:01 AM

Laboratory Pathology Report

Legend

H - High

M.D. REVIEW
DATE
DOCTOR
PULL CHART
SEE PATIENT
FILE
CORRECTION

Exhibit 13

LYDIA HELENA VISION 8/25/2020

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.

ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN,

Defendants.

) Case No. 18-156-NJR

The deposition via videoconference of ERIC PADILLA a.k.a LYDIA HELENA VISION, taken before Alyssa N. Kuipers, Certified Shorthand Reporter and Registered Professional Reporter, commencing at 9:00 a.m. on the 25th day of August, 2020.

I N D E X

E X H I B I T S

(NO EXHIBITS MARKED.)

APPEARANCES:

ACLU OF ILLINOIS
MR. GHIRLANDI GUIDETTI (via videoconference)
150 North Michigan Avenue
Suite 600
Chicago, Illinois 60601
Phone: (312) 201-9740
E-mail: gguidetti@aclu-il.org
On behalf of the Plaintiffs;

ILLINOIS ATTORNEY GENERAL
MS. LISA A. COOK (via videoconference)
500 South Second Street
Springfield, Illinois 62701
Phone: (217) 782-4445
E-mail: lcook@atg.state.il.us
On behalf of the Defendants.

* * * * * *

(Witness sworn.)

WHEREUPON:

ERIC PADILLA a.k.a LYDIA HELENA VISION, called as a witness herein, having been first duly sworn, was examined and testified via videoconference as follows:

DIRECT EXAMINATION

BY MS. COOK:

Q. Can you just start off by stating your name for the record; and you can say your preferred name, if you wish.

A. Lydia Helena Vision.

Q. Okay. So it's Vision?

A. Yeah.

Q. I've been adding the accent to it, so I apologize for that.

A. It's okay.

Q. Okay. So, Ms. Vision, we're here for your deposition for a case that you're a plaintiff in in the Southern District of Illinois, Case No. 18-156. Did you know that before we started today?

A. Yes.

Q. And are you having any problems

seeing or hearing me right now?
A. No.
Q. If you ever do, will you please let me know?
A. Yes.
Q. Have you had your deposition taken before?
A. No.
Q. Okay. So what a deposition is, it's my chance, as the counsel for the defendants, to ask you some questions about your background and your case under oath, okay?
A. Yes.
Q. Okay. And did you have the chance to speak with your attorney before the deposition today?
A. Yes.
Q. If you do not understand a question that I ask you, you may let me know that and I will rephrase it, okay?
A. Yes.
Q. And you're doing a very good job, but all of your answers to my questions need to be yes or no. When you shorten that to uh-huh,

we can't read that later in the transcript because the words look the same, so just continue with what you're doing, okay?
A. Yes.
Q. And if you need a break at any time, please let me know. I don't expect that it will take too much of your time, but if you need a break for whatever reason, you can let me know that, okay?
A. Yes.
Q. Did you read any documents to prepare for your deposition today?
A. No.
Q. Have you ever seen your IDOC medical or mental health records?
A. Yes.
Q. Okay. And when is the last time you reviewed those records?
A. I don't remember.
Q. Do you think it would have been in the past year?
A. Yes.
Q. How far did you go in school?
A. I just graduated for a second time,

college. I guess I have an associate's degree and a paralegal certificate.
Q. And when was that?
A. The paralegal certificate in December '19.
Q. And when did you get your associate's?
A. July of 2015.
Q. And did you have any particular study for your associate's degree or was it just a general degree?
A. Liberal studies.
Q. Are you currently taking any college classes?
A. No, I am not.
Q. Do you have any medical or mental health training?
A. No, I do not.
Q. Other than this lawsuit, have you filed any other civil lawsuits in state or Federal Court?
A. No, I have not.
Q. Can you tell me how many felonies you've been convicted of?

A. No, I cannot.
Q. On the IDOC website, it lists two felony convictions. Does that sound right?
A. I don't know. I can't review the site.
Q. Okay. What crime are you currently incarcerated for?
A. Attempted murder.
Q. Do you have any convictions at all, misdemeanors or felonies, for fraud or anything like that?
A. No, I do not.
Q. And for your current crime -- when were you first brought into the Illinois Department of Corrections?
A. 2004.
Q. When were you diagnosed with gender dysphoria?
A. 2016.
Q. Since 2016, what facilities have you been housed in?
A. Danville, Graham, and Centralia.
Q. And where are you currently?
A. Centralia.

Q. At Centralia, do you have a single cell?
A. Yes.
Q. When is the last time you had a cellmate?
A. 2018.
Q. Do you have -- Are you on a single-cell status where you're not going to have a cellmate or is it just, to your knowledge, chance that you haven't had a cellmate since 2018?
A. I've been to multiple joints of prison sentencing, so I'm not sure currently.
Q. Aside from gender dysphoria, which I'll ask you more about, do you have any current mental health diagnoses?
A. Can you clarify?
Q. Sure. Do you have any current mental health diagnoses, as diagnosed by the providers within IDOC?
A. I'm not sure.
Q. Is there any other mental health provider you've seen outside of the Department of Corrections?

A. No.
Q. Have you previously been diagnosed with post-traumatic stress disorder?
A. Can you clarify?
Q. Sure. Well, I guess, in the past five years, has anybody told you that you had a diagnosis of post-traumatic stress disorder?
A. I'm not sure if doctors told me that, if that's what you mean.
Q. A medical doctor?
A. I don't understand.
Q. Okay. Which doctor told you that?
A. None.
Q. Okay. So I'm sorry. I may have misunderstood. So no doctor has told you that you had a post-traumatic disorder diagnosis?
A. Correct.
Q. And has any doctor or other mental health provider, whether a social worker or a psychiatrist, psychologist, in the Department of Corrections told you any other diagnosis except for gender dysphoria?
A. Yes.
Q. And what was that?

A. Depression, anxiety, PTSD.
Q. Do you take any medication for any of those diagnoses?
A. No.
Q. When were you diagnosed with depression?
A. I don't recall.
Q. Was that in the past year or more than a year ago?
A. Both.
Q. So, to your knowledge, do you still suffer from depression?
A. Can you clarify to my "knowledge"?
Q. Do you believe that you still suffer from depression?
A. Yes.
Q. And the same with anxiety. Do you believe that you still suffer from anxiety?
A. Yes.
Q. Do you believe that you still suffer from PTSD?
A. No.
Q. And why do you not believe you suffer from PTSD?

A. Because I believe the diagnosis was false.
Q. What do you base that on?
A. Having studied the characteristics of PTSD and also discussing them with mental health providers, staff, whatever.
Q. And when did you come to believe that the PTSD diagnosis was false?
A. I never came to believe it was real.
Q. And so was one of the mental health providers you discussed it with, was that Dr. Randi Ettner?
A. Yes.
Q. Were there other mental health providers who agreed that the PTSD diagnosis was wrong?
A. Yes.
Q. And who were they?
A. Mrs. Delgante (phonetic) in Graham, others, but I don't remember their names.
Q. Were they all within the IDOC system?
A. Yes.
Q. Since you have been in IDOC custody,

have you made attempts at self-harm?
A. No.
Q. So I have some of -- you know, the complaint that was filed and a declaration that was filed for you that indicate you began to, you know, experience some gender dysphoria as a child; is that true?
A. Yes.
Q. When was that?
A. When I was still in single digits. I can't give you an exact date or year. I was young.
Q. And your family was not supportive of that; is that correct?
A. That is correct.
Q. So did you attempt to get any treatment for gender dysphoria when you were younger?
A. No.
Q. And then when you entered the Department of Corrections in 2004, when is the first time you expressed some gender dysphoria symptoms?
A. Symptoms? Can you clarify?

Q. Yeah. I guess, I mean, they talk about incongruence, or not feeling like your identity matches your biological sex. You know, when did you raise that with the prison?
A. When did I raise it with the staff?
Q. Yeah.
A. 2015.
Q. Is there a reason you didn't raise it earlier?
A. Yes.
Q. And what was that?
A. I was conditioned not to.
Q. And when you finally raised it in 2015, was it something that was diagnosed right away or did it take some time?
A. I don't understand.
Q. So when you raised gender dysphoria in 2015 with prison staff, what reaction did you get?
A. I was told to look into it after I get out of prison.
Q. And who told you that?
A. A mental health staff named Ms. Lynch in Mount Sterling prison.

Q. Was that at Western Illinois Correctional Center?
A. If that is Mount Sterling prison.
Q. And so then did you see a different medical provider in 2015?
A. Yes.
Q. And who did you see next?
A. I don't remember their name.
Q. Did the next mental health provider respond to you in the same way?
A. No.
Q. What response did the next mental health provider give you?
A. They questioned me on the details, yeah.
Q. And so did the next mental health provider offer you any guidance?
A. No, they did not.
Q. Were you still at Western Illinois Correctional Center when you saw the second mental health provider?
A. No.
Q. Where were you then?
A. Danville.

Q. Was that provider named Nichols?
A. No.
Q. When did you start asking for hormonal therapy?
A. Either in late 2015 or early 2016. I don't remember exactly.
Q. And when did you start receiving hormonal therapy?
A. Late 2018, maybe November, December.
Q. And are you still currently on hormonal therapy?
A. Yes.
Q. Do you have any complaints about the hormones that you're taking?
A. Currently?
Q. Currently.
A. No.
Q. Had you had complaints in the past about the hormonal therapy?
A. Yes.
Q. And what were those?
A. When the doctor first prescribed me the hormones, he prescribed me a certain amount and the nurses or medical staff at the prison I

was in gave me 10 percent of that, so by not giving an adequate amount, it was a problem.

Q. And was the prescribing doctor your normal doctor at the facility?

A. Yes.

Q. Do you remember who that was?

A. I don't remember his name.

Q. Were you still at Danville then?

A. No. I was at Graham.

Q. How long did it take to get the dosages worked out for you?

A. About a month, maybe two.

Q. So in about early 2019, did you have no more complaints about the hormones you were receiving?

A. No.

Q. Okay. When did it get worked out?

A. Excuse me?

MR. GUIDETTI: Objection as to form.

BY MS. COOK:

Q. Yeah. I'm going to rephrase that because that was a bad question.

So was it about 2019 when the hormone dosages were worked out?

A. Yes.

Q. And have you had any complaints about your hormones since then?

A. No.

Q. Are labs taken to review the amount of hormones in your system?

A. Yes.

Q. How often have you had them taken?

A. I don't remember.

Q. Do you remember the last time you had labs drawn?

A. I believe it was in December, maybe November.

Q. Does anybody meet with you to discuss the results of your lab work?

A. Yes.

Q. And who is that?

A. The doctor that was here.

Q. When you shower at the facility, do you shower alone?

A. Yes.

Q. And are you allowed to shower in a place where you have privacy?

A. No.

Q. Where do you shower at Centralia?

A. In the shower. I don't understand.

Q. Is it a group shower or a single shower?

A. It's a single shower on the wing.

Q. Is there a hard door or a curtain for the shower?

A. A curtain.

Q. Does the curtain cover your body?

A. I don't understand.

Q. If you pull the curtain shut, does it shield your body from people looking in?

A. No.

Q. How can people see in?

A. By looking.

Q. Does the curtain go above your head?

A. No, it does not.

Q. Where does the curtain go up on your body when you shut it?

A. I don't understand.

Q. Well, maybe -- could you explain to me how people can see into the shower when you're showering if you close the curtain?

A. Yes. Only the bottom half of it or

so is where you can't see through it. So the top half is mesh and all you have to do is look over to see through it.

Q. And is the shower located in a place where people walk by?

A. Yes.

Q. And have you raised the lack of privacy with people who work at the prison?

A. Yes.

Q. Who have you raised it with?

A. At the time, Assistant Warden Stock, the head of mental health, Ms. Schulty (phonetic), and other mental health staff. I don't remember which ones.

Q. Have you received an explanation as to why they haven't changed your shower situation?

A. No. They gave me the option of walking across the camp to shower at another building.

Q. Are you interested in doing that?

A. No.

Q. Why not?

A. Because taking a half hour round

trip to take a shower in a place where I had to file a PREA complaint in a different prison doesn't real appeal to me.

Q. Okay. So at other facilities, were you given the option to shower in a more private setting?

A. Yes.

Q. Like, so at Danville, where would you shower?

A. At Danville, I did walk across the camp to shower in the medical unit, which led to, in my opinion, being assaulted by a lieutenant while naked in the shower, so you can see why I wouldn't want to do that anymore.

Q. So is it that you're worried that if you went to a different location, you could be at risk of assault?

A. I'm at risk of assault all the time.

Q. And when you say that, do you mean by other inmates or staff or both?

A. Both.

Q. Have you been having issues at Centralia with other inmates?

A. Can you please clarify?

Q. Like threats from other inmates at Centralia?

A. Yes.

Q. What kind of threats?

A. I don't understand.

Q. Are the threats related to your transgender status?

A. Yes.

MR. GUIDETTI: Objection, foundation.

BY MS. COOK:

Q. And have you been receiving threats from staff at Centralia Correctional Center?

A. I'm not at liberty to discuss it.

Q. And you requested a transfer to a female facility, correct?

A. Correct.

Q. And have you been told anything about that request?

A. Yes.

Q. And what have you been told?

A. It was intimated to me that it was approved in February, but because of the COVID thing, it didn't happen.

Q. Do you think that a transfer to a female facility will alleviate some of your concerns about threats?

A. Yes.

Q. Where you are currently, do you have access to transgender groups?

A. No.

Q. Have you made a request with IDOC staff for gender-affirming surgery?

A. Yes.

Q. And what surgery are you seeking?

A. An orchiectomy and electrolysis.

Q. And do you remember when you made those requests?

A. 2016 maybe.

Q. Do you remember when in 2016?

A. No. When I -- No, I don't remember.

Q. Have you requested surgery since 2016?

A. Yes.

Q. Do you remember when?

A. Can you clarify?

Q. Well, how many times since 2016 have you renewed your request?

A. Dozens.

Q. And how do you renew it? Do you write letters, grievances?

A. I've brought it up to the mental health staff, to the medical staff, written grievances.

Q. And so when you bring it up to medical and mental health staff, do you do that verbally?

A. I've done it verbally and in writing.

Q. And has mental health staff given you a response on your request?

A. No.

Q. Has medical staff given you a response on your request?

A. No.

Q. And in the grievances you write, do you get a response to those?

A. Sometimes, sometimes not.

Q. Do you keep copies of all the grievances that you send?

A. I've kept what I could.

Q. So has anybody told you, you know, a

definitive yes or no on your surgery requests?
A. No, they have not.
Q. What about requests for female clothing items? Have you requested female clothing items?
A. Yes.
Q. Have you received any women's clothing items?
A. Just two bras.
Q. Has anybody told you anything about changes in allowable property at male facilities to allow for female items?
A. Can you clarify?
Q. Yeah. So have you heard any -- from medical or mental health staff, have you heard there might be changes in the lists for allowable property at male facilities?
A. From them, on the issue, I always get a denial and a form of delay. "Wait. We're working on it." Things of that nature.
Q. And is that the same for like the administrative staff, like the warden, assistant wardens?
A. If they respond at all.

Q. Have you requested any female-specific hygiene items?
A. Yes.
Q. And what are those?
A. Any specific female hygiene items, soap, shampoos, deodorants, razors, things of that nature.
Q. And have you been allowed any of the hygiene items you've requested?
A. No.
Q. And, again, has any DOC staff, either, you know, on the medical/mental health side or the administrative side, told you of any upcoming changes?
A. In as much as they always say: Wait, wait, wait.
Q. At Centralia, are you strip-searched by staff?
A. Can you clarify?
Q. Yeah. Are there any times at Centralia where you've been strip-searched by staff?
A. Yes.
Q. How often does that occur?

A. When I first got here, any visits that I've had while I was here. I don't know exactly how often.
Q. And do male or female staff do the strip-searches?
A. Male.
Q. Have you asked for female staff to do it?
A. Yes.
Q. And when do you ask?
A. I asked when I first got here. I got transferred here, they strip-search you out; I asked right then.
Q. And do you remember the response you got?
A. It's not pleasant.
Q. So when you say "not pleasant," what do you mean?
A. I'm not at liberty to discuss security staff.
Q. Are you concerned because there's other staff in the room with you?
A. Correct.
Q. Well, I just want to know -- So, I

mean, when you've asked, has it been, you know, the search is just starting and then you ask, or have you asked like the warden or assistant wardens about the searching?
A. I don't understand the question.
Q. Have you raised your search concerns with the warden or assistant wardens?
A. I believe I've written a grievance on the issue.
Q. Do you remember when you wrote that?
A. No.
Q. Do you remember if you got a response?
A. No.
Q. Do you know if you have a copy of that grievance?
A. No, I do not. I don't know if I do or not. I would have to review my paperwork.
Q. Do you keep track of the grievances that you send?
A. As much as possible.
Q. Do you send any letters or kites?
A. Excuse me?
Q. Do you send any letters or kites to

the warden or assistant wardens?
A. No.
Q. Is there any other treatment that you've requested for gender dysphoria that you've not received?
A. I don't understand.
Q. Besides the items I've already asked you about, is there any treatment that you've requested that you have not received?
A. Yes.
Q. And what's that?
A. Mental health counseling in accordance with the WPATH standards.
Q. And what do you mean by that?
A. What do I mean by that? Excuse me?
Q. Yeah. What exactly do you mean?
A. Half of the staff here have hardly any knowledge on gender dysphoria, so, yeah.
Q. So you want treatment providers who have more experience with gender dysphoria?
A. Correct. I believe I also requested voice coaching also.
Q. And did you get a response on your request for voice coaching?

A. Same as always, no response, delayed, or denial.
Q. When you've gotten a response where staff say "we're working on it," you know, that type of thing, do they ever tell you what steps they're taking to work on it?
A. No. To be honest, some of them say it in a joking manner.
Q. At Centralia, does the staff misgender you?
A. Yes.
Q. Do you communicate, you know, that you wish to be called she/her?
A. Sometimes.
Q. And when you do let staff know, will they change how they refer to you?
A. Again, I don't feel comfortable talking about security staff.
Q. Well, I understand to a certain point, but I think that this has been enough of a topic. I do have to ask you about this. I'm not asking you about specific people right now. I just want to know, overall, like if you can give me a percentage, you know. When you let

people know that you want to be treated female, do they more often than not act respectfully towards you or disrespectfully?
A. They do not act respectfully of that request.
Q. Because of -- Well, I'm going to rephrase that.
Do you feel -- I think I saw somewhere in your records that maybe in the beginning, you thought you were on a spectrum of gender?
MR. GUIDETTI: Objection to form. You can answer if you understand the question.
BY THE WITNESS:
A. I don't understand.
Q. When you first described some of the symptoms of gender dysphoria, did you feel at that time like you fully associated as female?
A. Yes.
Q. And do you still feel that you fully associate as female?
A. Yes.
Q. In recent months, do you feel like

you want to harm yourself?
A. I don't understand.
Q. While I know you mentioned that you don't have a history of self-harm, but is that something that you feel currently or in recent months?
A. I don't believe -- I don't know.
Q. Have you felt suicidal in recent months?
A. Yes.
Q. When you feel suicidal, when has that occurred?
A. I don't know the dates. I don't understand the question. What do you mean?
Q. Well, I am looking for dates, but can you give me an approximate time?
A. Like time of the day? I don't understand.
Q. Like, you know, six months ago or --
A. Within six months.
Q. Within six months.
Were you able to reach out to any staff for assistance?
A. No, I was not.

Q. Did you take any steps to attempt suicide?
A. No, I did not.
Q. What were you feeling that made you feel suicidal?
A. I don't understand the question. What was I feeling? Suicidal, depressed.
Q. Was there any particular reason or was it just an overall feeling?
A. There's multiple reasons why I would feel that way. Yes, there were reasons.
Q. What were they?
A. Lack of treatment for gender dysphoria, having been in prison so long, worries about, when I get out, if I'll be able to successfully reintegrate into society, family issues, other issues I'm not at liberty to discuss.
Q. And, again, are you referring to staff issues?
A. Some.
Q. Is there another reason you wouldn't be able to discuss some of the other feelings you had?

A. Yes.
Q. Can you just tell me generally why you would be unable to discuss them?
A. No.
Q. When are you going to be released from IDOC custody?
A. 2012 -- or 2022, December 12th.
Q. Has your family become more supportive of you?
A. No.
Q. And so do you know the other plaintiffs in this action?
A. No.
Q. I saw in your declaration -- have you joined or become part of the organization Black and Pink?
A. Excuse me?
Q. Do you know what the Black and Pink organization is?
A. Yes.
Q. And have you joined that organization?
A. I don't understand.
Q. Are you a part of that organization?

A. I received a newsletter.
Q. Are there other transgender prisoners at Centralia?
A. Not that I'm aware of.
Q. At the facilities that you've been in since you've been diagnosed with gender dysphoria, have you ever been able to meet many other prisoners who also have gender dysphoria?
A. No.
Q. Aside from Dr. Ettner, have you spoken with or met with any other outside providers?
A. No.
MS. COOK: Okay. Give me a minute. I'm just going to look through my notes. Okay. I think we're almost done.
Okay. I don't have any further questions for you. I don't know if your attorney has any follow-up questions.
MR. GUIDETTI: Yeah. I just have a few. I'll try not to take up too much of your time.
CROSS-EXAMINATION
BY MR. GUIDETTI:

Q. Ms. Vision, you said that you've seen some of your mental health records; is that right?
A. I can't hear you.
Q. You said you've seen some of your medical and mental health records; is that right?
A. That's correct.
Q. Do you know specifically what records you've seen?
A. No, not specifically.
Q. Have you seen all of your medical and mental health records?
A. Up to a certain date.
Q. Up to what date?
A. I don't know. Maybe 2019.
Q. So after 2019, you have not necessarily seen all of your medical and mental health records?
A. No.
Q. You said you've had no medical or mental health training; is that right?
A. Yes.
Q. Have you done any self-study around

gender dysphoria?
A. Yes.
Q. Can you describe that for me, please?
A. Yes. I've read everything I can get my hands on related to the issue, everything, biographies, medical books, articles, you name it.
Q. And you mentioned the WPATH standards of care. Have you read those?
A. Yes.
Q. You said you've not had a cellmate since 2018; is that right?
A. That is right.
Q. When you did have a cellmate in 2018, do you know their sex or their gender?
A. Male.
Q. Have you ever had a female cellmate?
A. No. Wait, wait. I guess, in 2017, I had another transgender girl as a cellmate for a very short time when I was in Danville.
Q. Do you remember her name?
A. I do not. I mean, a very short time, just a couple of days.

Q. When you were discussing PTSD with Ms. Cook, you mentioned that you've studied the characteristics of PTSD and you discussed it with the mental health staff; is that right?
A. That is correct.
Q. Can you explain how you studied PTSD?
A. In the library, they have older DSMs, not current ones usually, but I've read those. I've asked them for printouts. I've asked the medical health staff for printouts. I've asked them to describe me the symptoms personally. That's what I mean. Learned as much as possible so I could understand if and what I may have had.
Q. You said, no, you have not attempted self-harm while in the Department of Corrections, but you have thought about it; is that right?
A. Yes.
Q. When you said that you first raised your symptoms of gender dysphoria with IDOC in 2015, Ms. Cook asked you why you didn't raise it earlier and you said you were conditioned

not to; is that right?
A. That's correct.
Q. Can you tell me more what you mean by being conditioned not to?
A. Yes. When I was young, people noticed that I didn't skew towards masculinity, so they forced it upon me and it lasted a very long time. And early in my prison sentence, I was still stuck in that mental and behavioral mode and wouldn't have discussed gender dysphoria with anybody for anything.
Q. You said you've requested hormones for the first time in late 2015 or early 2016; is that right?
A. Yes. When I told the staff that I had gender dysphoria, I requested everything right then. As soon as I got to Danville, I tried again, because in Mount Sterling, they told me wait until -- you know, they wouldn't even address the issue.
Q. And you didn't start getting the hormones until late 2018; is that right?
A. Yes.
Q. Did they ever explain why it was

taking so long?
A. Because the transgender committee kept denying my case due to what this guy Nichols was writing about me. That's why I was told I was being denied because they -- honestly, you know, I don't know why. They say things here, and I cannot ascertain any truth to what's being told to me at any given time.
Q. And during the time between 20- -- whenever it was that you first requested hormones and when you actually got them, did they ever say your request had been denied?
A. Yes. This guy Nichols told me that he put in for the transgender committee to review my request several times and I was denied several times, is what I was told. Later to find out that he only put in for it once.
Q. When you were discussing your shower access with Ms. Cook, you explained why you don't want to go to the other building. And I think you referenced that being the place where you had to file a PREA complaint. Did I hear that right?

A. Yes. Not in this prison, but in a different one. It's an even more hostile environment for me to walk over to the health care and shower there. Being looked at on the wing is less hostile than the potentials of that.

When I was in Graham, they gave us a permission slip, for lack of a better term, and allowed us to shower during the times when most of the inmates were locked up for count. They allowed us to come out and shower at those times. Here, not so much.

Q. You said at Danville that you would walk to the medical unit and you were assaulted by a lieutenant there; is that right?

A. That is correct.

Q. Can you describe that incident?

A. Yeah. So they harassed me when I was in the shower. Like I said, they created a hostile environment, that is the staff there at Danville. And "Hurry up, hurry up. You've been in there already five minutes" when I hadn't, things of this nature, to the point where they were playing this game. They joke

amongst themselves about it that, finally, one of the lieutenants got involved with the joking until it wasn't joking and he's screaming orders at me, walks into the shower, looks me up and down, specifically up and down like you would somebody to -- I don't know -- and then orders me out of the shower then.

Q. Ms. Cook asked you if you've requested a transfer to a female facility, and you said it's been intimated to you that you were approved in February but that it didn't happen because of COVID; is that right?

A. Yeah.

Q. Have you seen any prisoners being transferred in or out of your current facility?

A. Yes.

Q. And how long has that been going on?

A. Three weeks.

Q. Three weeks?

A. Yeah. They had a shipment every week for the last three weeks, people coming in.

Q. Ms. Cook asked if the transfer to a female facility would alleviate your concerns

about threats. Are there any other reasons that you want to be transferred to a female facility?

A. Yes. As a woman, I shouldn't be here, man. It's an oppressive environment for me constantly. You know -- Yeah.

Q. Ms. Cook asked if you've kept copies of your grievances. You said you kept what you could; is that right?

A. That's correct.

Q. Can you explain what you mean by that, by keeping what you can?

A. Yes. In some of the prisons I've been in, they shake down the cells and take these from you so you cannot use them. You know, that's the security staff doing that, retaliating against you, which is why I really don't like discussing it.

Q. Is it generally hard to keep legal documents and records in prison?

A. Yes. In my experience, yes.

Q. You told Ms. Cook that there was not a definitive yes or no regarding your request for surgery. What does that mean to you?

A. What does it mean, is they -- is a tactic of the medical staff here. Rather than give you a denial so you can file grievances and potentially lawsuits against them for denying you, they'll attempt to use a delay, "we're working on it, we're getting -- soon we'll have it, just wait, wait, wait," as a way of, in effect, denying you.

Q. Was coming out as transgender, as a woman, a process or was it like an overnight thing?

A. I don't understand. How do you mean? Coming out to who, to my own personal understanding or to the staff or to who?

Q. Let's do both. Let's start with your own understanding and then with family and then with prison officials.

A. My own understanding was a process. I chose to better myself in any and every way I possibly could. In some of the self-study, I came to understand what was one of my personal driving factors and it was the gender dysphoria. To staff, I came out to them pretty directly. My family also, I came out to them

pretty directly.

Q. Ms. Cook asked you about Black and Pink. Can you tell me what Black and Pink is?

A. Yeah. It's a -- I guess it's more of a collective of LGBT prisoners and outside allies that are there for support. The problem I have is she was asking me if I was a member, and I got the impression it was like a union I would have to join and sign papers for or something and it's not anything of that nature.

Q. So you don't understand it to be a membership organization?

A. More of a support organization, I would guess. I didn't sign any papers saying I was a member. I didn't take any oath of fealty to them. It's just something you can be a part of or not.

Q. Ms. Cook asked if you've seen or met other transgender prisoners at Centralia, and you said you're not aware of any. How big is Centralia, do you know?

A. Person-wise, I do not know how many people are here. Well, over 1,500.

Q. Is it possible there are other

transgender prisoners there, but you just don't know about them?

A. Yes. She also asked me if there were many transgender people I came across, and I had issue with the word "many." I've come across other transgender women since I've been in prison, but just not many, you know.

Q. How many, approximately, prisoners with gender dysphoria have you met during your time in IDOC?

A. Maybe a dozen.

Q. You said that other than Ms. Ettner -- Dr. Ettner -- I apologize -- you've not spoken with or met with any outside providers. I just want you to clarify. That's regarding gender dysphoria, right?

A. Correct.

Q. When was the last time you met with a medical provider regarding your hormone therapy?

A. Just a couple of months ago.

Q. And can you describe that visit for me, please?

A. Yeah. They had a doctor here named

Shah. He was bullying in nature, threatening me, and said it was within his power to deny me my hormones, said that people consider him generous because he allowed us to have them. Told me he was a Muslim for some reason. Generally, was a pretty nasty character with regards to my hormones besides when he said "have a nice day" when I fucking -- excuse me -- when I left.

Q. How did you understand Dr. Shah's statement to you?

A. He was attempting to be a bully to me. He was threatening me.

Q. Threatening to take away your hormones?

A. Yes. And just put himself in a position of threat over me. Why? I have no idea. I'm already an inmate in prison. He obviously has position over me.

Q. You said a number of times that you couldn't answer some of Ms. Cook's questions, you said, because of the presence of security staff. Other than the questions where you specifically said that you can't discuss

something, were you able to fully and truthfully answer all of the other questions?

A. Yes.

MR. GUIDETTI: That's all I have.

REDIRECT EXAMINATION

BY MS. COOK:

Q. I just have a couple questions about Dr. Shah.

A. Yes.

Q. Is it S H A H?

A. Yes.

Q. And is he the normal medical doctor at Centralia?

A. There was a doctor here named Santos who was very helpful. He, I guess, retired, and Shah filled in. I don't know if Shah is still here, so he might have just been temporary. I don't know.

Q. And did Dr. Shah actually change your hormones?

A. No, he did not.

MS. COOK: Okay. Those are all of the questions that I had.

(Witness excused, 10:16.)

Page 49

UNITED STATES OF AMERICA)
SOUTHERN DISTRICT OF ILLINOIS)
EAST ST. LOUIS DIVISION) SS.
STATE OF ILLINOIS)
COUNTY OF COOK)

I, Alyssa N. Kuipers, Certified Shorthand Reporter, Registered Professional Reporter, do hereby certify that ERIC PADILLA a.k.a LYDIA HELENA VISION was first duly sworn by me to testify to the whole truth and that the above deposition via videoconference was reported stenographically by me and reduced to typewriting under my personal direction.

I further certify that the said deposition was taken at the time and place specified and that the taking of said deposition commenced on the 25th day of August, 2020, at 9:00 a.m.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties, nor a relative or employee of such attorney or counsel, nor financially interested directly or indirectly in this action.

I witness my official signature on this 10th day of September, 2020.

____
ALYSSA N. KUIPERS, CSR, RPR

CSR No. 084-004857

Page 50

ALARIS LITIGATION SERVICES

September 10, 2020

MR. GHIRLANDI GUIDETTI
ACLU OF ILLINOIS
150 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

IN RE: JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED v. ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN

Dear Mr. Guidetti:

Please find enclosed your copies of the deposition of ERIC PADILLA a.k.a LYDIA HELENA VISION taken on August 25, 2020 in the above-referenced case. Also enclosed is the original signature page and errata sheets.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheets and notarized signature page within 30 days to our office at 711 N 11th Street, St. Louis, MO 63101 for filing.

Sincerely,

Alyssa N. Kuipers

Enclosures

Page 51

ERRATA SHEET

Witness Name: ERIC PADILLA a.k.a LYDIA HELENA VISION
Case Name: JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED v. ROB JEFFREYS, MELVIN HINTON, and STEVEN BOWMAN
Date Taken: AUGUST 25, 2020

Page #_____ Line #_____
Should read: ____________________________________
Reason for change: ______________________________

Page #_____ Line #_____
Should read: ____________________________________
Reason for change: ______________________________

Page #_____ Line #_____
Should read: ____________________________________
Reason for change: ______________________________

Page #_____ Line #_____
Should read: ____________________________________
Reason for change: ______________________________

Page #_____ Line #_____
Should read: ____________________________________
Reason for change: ______________________________

Witness Signature: ______________________________

Page 52

STATE OF ________________)

COUNTY OF _______________)

I, ERIC PADILLA a.k.a LYDIA HELENA VISION, do hereby certify:

That I have read the foregoing deposition;

That I have made such changes in form and/or substance to the within deposition as might be necessary to render the same true and correct;

That having made such changes thereon, I hereby subscribe my name to the deposition.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this _____ day of ________________, 20____, at _____________________________.

____
ERIC PADILLA a.k.a LYDIA HELENA VISION

____
NOTARY PUBLIC
My Commission Expires:

Exhibit 14

DR. VIN TANGPRICHA 10/5/2020

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION SORA KUYKENDALL and SASHA REED,

Plaintiffs,

V.) Case No. 18-156-NJR

JOHN BALDWIN, MELVIN HINTON, and STEVE MEEKS,

Defendants.

REMOTE DISCOVERY DEPOSITION OF DR. VIN TANGPRICHA
Taken on behalf of Defendants

The deposition of DR. VIN TANGPRICHA a witness called at the instance of the Defendants, for purposes of DISCOVERY taken on October 5, 2020, at 9:00 a.m., via Zoom, before Erikia Schuster, Illinois Certified Shorthand Reporter No. 084-004660, pursuant to notice.

INDEX OF EXAMINATION

INDEX OF EXHIBITS

Number	Description	Page

(No Exhibits Proffered.)

APPEARANCES

MS. AMELIA H. BAILEY
Kirland & Ellis, LLP
300 North LaSalle
Chicago, IL 60654
Amelia.bailey@kirkland.com
(312) 862-2765

On Behalf of the Plaintiffs,

MS. CARLA TOLBERT
Assistant Attorney General
201 West Point Drive, Suite 7
Swansea, IL 62226
(618) 236-8616
Ctolbert@atg.state.il.us
On Behalf of the Defendants.

IT IS HEREBY STIPULATED AND AGREED, that the deposition of DR. VIN TANGPRICHA may be taken in shorthand by Erikia Schuster, a Certified Shorthand Reporter, and afterwards transcribed into typewriting.

*****

DR. VIN TANGPRICHA,

of lawful age, being produced, sworn and examined on behalf of the Defendants deposes and says:

DIRECT EXAMINATION

BY MS. TOLBERT:

Q. Good morning, Dr. Tangpricha. We met earlier, but my name is Carla Tolbert and I'm here on behalf of Defendants Jeffries, Hinton and Meeks. Can you state your full name and spell it for the transcript, please?

A. Full name Vin, V-i-n, Tangpricha. That's T-a-n-g-p-r-i-c-h-a.

Q. Thank you. You may have heard these before, but we have kind of what we call ground rules of depositions. I need you to give verbal answers. No uh-huhs or head nods or head shakes. Speak up in a normal tone of voice. Sometimes we lose a little quality when we're doing this by

remote video and we want to make sure that our court reporter takes everything down.

I promise you at some point during this deposition, the court reporter will remind me not to speak too quickly. So if she reminds any of us those things, don't be offended. She just needs to get a clean transcript.

If you need a break at any time, just let me know. We can take breaks at any time. I just ask that you would answer any question that is pending before we go on break. If you don't understand a question that I ask, please tell me. But if you answer the question, I'll assume that you understood it; is that fair enough?

A. That's fair.

Q. Okay. You are a retained expert in this lawsuit, correct?

A. That's correct.

Q. And it is my understanding that this is the first time you've ever served as a retained expert in litigation; is that still true?

A. That's still true.

Q. Have you ever testified in court in any capacity?

A. I've never testified in court.

Q. The same question, but I probably know the answer, but is this your first deposition?

A. That's correct, yes.

Q. Okay. Now, you said you had never testified in court, but you did testify at a hearing, a preliminary injunction hearing in this case last year; that's correct?

A. Oh, I assumed that this is all part of the same case. I mean, I haven't been on any other case.

Q. Okay. Perfect. Thank you. And in a personal capacity, you never testified as a treating physician?

A. No. Never ever actually been in court. I mean, been in jury selection, but never been selected.

Q. Sure. Me too. Fair enough. When were you first contacted by any of Plaintiffs' attorneys in this case?

MS. BAILEY: You can answer this question. I'm just -- you know, don't talk about any of the contents of your conversation but you can just --

A. I would have to look back in my e-mails and everything. I don't know exactly the date, so, I mean, obviously before the first case, but if you want the exact date, I would have to go back and look.

MS. TOLBERT: I understand. Just so we're clear on what you're going to allow him to testify to, I am referring to the committee notes to the 2010 version of the Federal Rules. I can talk to him about any compensation and then under Rule 26 (b)(4)(c)(2), discovery is permitted to identify facts or data the parties' attorney provided to the expert and that the expert considered in forming the opinions to be expressed. Will you allow him to testify as to what materials he received and if he used them to form his opinions?

MS. BAILEY: Yes. That's fine. I just want to get that on the record and remind Vin, you know, not to discuss most of the contents of our conversation. But in terms of what we gave him to rely on, that's fine. I understand that that's fair game.

MS. TOLBERT: The other caveat from the committee notes from the 2010 version, and

that's in subsection three, discovery regarding attorney expert communications is permitted to identify any assumptions that counsel provided the expert and that the expert relied upon in forming the opinions to be expressed. So to the extent that question is asked, I assume you also won't object to that?

MS. BAILEY: Yeah. That's fine.

Q. Perfect. Doctor, I'm sorry about all that gibberish, but you said you don't recall when you were first contacted, correct?

A. I don't recall. I'd have to go look back. I mean, it's been a while.

Q. I understand. I understand this is not meant to be a memory test. Your retention letter in this case is dated -- hold on -- having it would have been helpful. I apologize -- January 17th, 2017. Does that sound right to you?

A. Okay. Yes. I have it in front of me. Yes, that's the correct date.

Q. Okay. Do you recall how long before you executed that retention letter you were contacted?

A. I know that I have to get any

agreements that I sign approved so it had to be, you know, a month maybe, two months. I don't know exactly.

Q. Sure. And when you say approved, that's by your employer?

A. Yes.

Q. Which is Emory University?

A. Yes.

Q. Thanks. Do you recall who contacted you first?

A. I don't recall. I mean if it's -- I don't see it in the agreement here, but -- I don't know. I don't want to say on the record. I would have to take a look at my notes.

Q. No. Fair enough. Do you recall if that initial contact was by telephone or e-mail?

A. I don't recall that.

Q. Okay. Do you recall with that first contact what facts you were given about this case?

A. I didn't really receive much -- much in terms of facts. I was told that this was a case that could use my expertise, and they wanted my expertise on the case.

Q. Okay. And did you accept the case

for review after that initial phone call, or did you ask for information or records before you accepted it?

A. I don't recall. I would have to go look, but I don't recall that.

Q. Okay. Fair enough. What were you asked to do in this case?

A. I was asked to give my medical expert opinion regarding the hormonal treatment of the members -- I don't know what the legal term is -- the Plaintiffs, the Plaintiffs -- the hormonal treatment of the Plaintiffs and the care surrounding their treatment for gender dysphoria.

Q. When you say the care surrounding treatment for gender dysphoria, what care other than hormone therapy were you asked to provide an opinion on?

A. Obviously, it's the hormones, but then there's the safety of the hormones and that's very important.

Q. Sure. So am I correct in stating that your opinions are confined to issues involving hormone treatments and no other aspects of their care?

A. Well, it's involving the impact of

the hormone treatment, that's obviously safety and what the hormones do, obviously, that involves the mental health of the Plaintiffs, and that's the expert area that I've been asked to look at.

Q. Okay. Thank you. Did you have to refer this case to your employer before you received the retention letter, or did they have to approve the letter itself?

A. Can you rephrase? I'm not sure what you mean.

Q. Sure. You said you had to get permission from your employer to take on this case, correct?

A. Any outside work from my employer has to be approved.

Q. Right. Did you request that approval from your employer before you received the retention letter, or did you submit the retention letter for their review?

A. I'd have to go look back in my records. I'm not sure about that.

Q. Okay. All right. Fair enough. Once you signed the retention letter, what records or documents did you receive?

A. I received all of the medical laboratory tests, medication lists, which include the hormones, and any pertinent notes and committee hearings that were related to -- there was some committee called the gender -- I forget the name of it -- committee. I'm trying to think. I think those were the primary records that I received.

Q. Okay. Do you know if you received the Plaintiffs' full medical records or only portions?

A. As far as I understand, I received full medical records provided to me at the time they were given to me, you know, everything that we asked for.

Q. Okay. So that was my next question, did you ask for specific records?

A. I mean, from -- can you clarify? From the individual or what do you mean?

Q. Well, did you say, okay, I want records of a certain type or a certain source? Did you specify the records?

MS. BAILEY: And I guess, Carla, I know it's a delicate line. I am going to object because I do think that this is crossing beyond

sort of what was given to him and the facts that he's relied on in going into our conversations.

MS. TOLBERT: Sure. Well, what I'm trying to get at is what records he received and did he request them or did you send them?

MS. BAILEY: You can answer that then.

A. As an endocrinologist hormone specialist, I wanted to see the hormone levels, obviously, and any lab tests that would support safety and hormone medications and any notes regarding hormonal treatment.

Q. Okay. Were there any records that you requested that you did not receive?

A. Can you -- can you restate the question again?

Q. For example, was there any category of record or type of record that you asked for but you did not receive for review?

A. I'd have to look back. I don't want to say obviously one way or the other. I definitely reviewed everything that I received. I would have to look back if there's some request of -- if I didn't receive something, but I reviewed everything that I received, but I would

have to go and see if I requested something.

Q. Okay. Fair enough. Sure. And then how long after you received those records did you speak with any of Plaintiffs' counsel?

A. Again, I would have to look. I can't recall. I don't want to say on record how long that was.

Q. Did you have a primary person -- a primary one of Plaintiffs' attorneys that you spoke with, or did you speak with more than one?

A. I work with many different attorneys.

Q. Okay. Your retention letter of January 24th, 2017 is on Kirkland and Ellis letterhead, but it says you were retained by the ACLU Foundation, the Robert Baldwin Foundation of the ACLU and Kirkland and Ellis. Prior to being contacted about this case, had you had any opportunity to meet or confer with any of those attorneys?

A. Prior to the retention letter?

Q. Correct.

A. I don't recall. I mean, as I said, our university has to approve any outside work, and there would be no reason for me to contact them.

Q. No. Sure. Fair enough. Was there any difficulty getting the University to approve?

A. I don't recall. I mean, obviously it was approved so I don't know -- what do you mean by difficulty?

Q. You know, I don't know, Doctor. Sometimes employers can be cagy about taking on additional work and just wondered if they were.

A. Well, I'm here today.

Q. You are, indeed. Thank you. All right. We talked earlier, you testified at a court hearing on Plaintiffs' motion for preliminary injunction, and your testimony was on August 8th, 2019, correct?

A. Let me go look. Do you want me to look up the date?

Q. No. No. That's fair enough. But you remember the hearing, right?

A. Yeah. I remember the hearing.

Q. And I wasn't there, so I apologize. That was by video, correct?

A. What was by video?

Q. The hearing that we were speaking of.

A. This is my first video in any kind of capacity in this court case, so I don't know what

you're talking about.

Q. When you testified at the hearing, did you come to East St. Louis in person?

A. Yes, I did.

Q. Okay. And I apologize. I just wasn't at that hearing so I'm just making sure. All right. Did you receive additional records or documents before that hearing date to prepare for the hearing?

A. Can you help clarify? What do you mean by additional?

Q. Well, you testified earlier you received some initial medical records after you accepted this case for review, correct?

A. So, yes, I received medical records that were current up to a certain date. I would have to, again, look at my records.

Q. Sure.

A. And then I -- that question is -- I'm not sure what you're asking.

Q. Well, your retention letter is January of 2017, and subsequent to that retention letter you received certain records or documents, correct?

A. Yes, I received some documents after

my retention letter.

Q. The hearing on the preliminary injunction was in August of 2019, more than two years later. Between the time that you received the initial set of records and documents and the hearing, did you receive additional documents?

A. I mean, there were -- I'd have to go back in my records. There were records sent to me at different times.

Q. Okay.

A. And so I'd have to see -- at some point, obviously, there was a date where they were the most current in time for that hearing.

Q. Okay. Fair enough. Fair enough. And do you recall what additional records specifically you received?

A. It's been a couple of years. I'd have to go back and look at my records.

Q. Did you review every record and document that you did receive?

A. Yes, I did.

Q. Okay. Prior to your testimony at the preliminary injunction hearing, had you spoken with any of the named plaintiffs in this case?

A. Prior to the court -- yes. By phone,

we did -- I did meet by phone the named Plaintiffs to speak with them.

Q. How many times?

A. I only recall talking to them once each.

Q. Okay. And what was the purpose for speaking to them before the preliminary injunction hearing?

A. Again, it was focused on their hormone treatment, outcomes of their hormone treatment, any potential delays in receiving hormones and any medical benefits or side affects from hormones.

Q. Did you find the information they gave you was generally consistent with the medical records?

A. That's speculative. I'd have to go -- I mean, I would say -- I can't answer that question. I don't recall off the top of my head, but they didn't raise any red flags for me.

Q. But when you say they --

A. I guess you could say it was consistent with -- it confirmed what I had reviewed already and supported my testimony and my declaration I sent to court. I guess that's

what I meant by red flags, support of what I had said in court.

Q. Okay. Perfect. When you said your declaration, are you talking about your declaration, the most recent one that is dated -- or did you have another document?

A. It was the one before -- I apologize. I don't know the legal ease, but I submitted some document before the first court hearing.

Q. Perfect. So --

A. And I think there's some -- there should be some -- there should be some -- I think it is in the declaration.

Q. Your declaration in this case is dated August 30th, 2020.

A. Uh-huh.

Q. So have you --

MS. BAILEY: Carla, he submitted two declarations in this case.

Q. Sure. I'm just trying to separate out what was in --

A. You asked me about the previous -- the first in person case.

Q. That was what I was trying -- you said it supported what was in your declaration.

I was trying to --

A. Yes, the pre- -- yes, I'm sorry.

Q. That's okay. One thing I didn't mention earlier, and we've both done it, so it's bad on me, too, is we need to be really careful of not talking over each other because the court reporter is going to say something to us, I promise.

A. Yeah.

Q. I know. It's easy to do. Okay. So you spoke with the named Plaintiffs before the preliminary injunction hearing and before your first declaration, correct?

A. That's correct.

Q. Okay. Since that initial telephone call, how many times have you spoken with the named Plaintiffs in this case?

A. I haven't spoken to them since the initial phone call.

Q. Okay. All right. Between the date of the preliminary injunction hearing and your report of August 30th, 2020, did you receive additional documents, information or records to review?

A. Yes.

Q. Okay. Do you know as you sit here today know what those documents and records were?

A. Again, very similar. They're hormone dosages, laboratory tests and any safety and efficacy notes around that.

Q. Okay. In addition to your own medical expertise, did you do any type of research or investigation in preparation for your declaration in this case? And I'm talking about the August 30th declaration. Literature review, speaking with colleagues, anything like that?

A. I obviously did not speak with any colleagues. That's for sure. I mean, I don't know what type of literature you're talking about.

Q. Well, did you perform a PubMed search? Did you go back in your specialty area research? Did you do any kind of literature search looking for --

A. I don't need to -- I write the -- you know, why would I do that? I write the --

Q. Again, Doctor, that was my original question. In additional to your own expertise, did you? So the answer is no, right?

A. No, because I'm very, very familiar

with the standards out there because I'm a coauthor on many of the documents.

Q. Then the answer to the question is no. Thank you.

Did you at any time during the course of this litigation speak with any other retained experts of the -- on behalf of the Plaintiffs?

A. No, not on behalf of the Plaintiffs. I have a professional relationship with Dr. Edna. I understand she's a retained expert, but not in regards to the case.

Q. Okay. Fair enough. According to your retention letter, you're charging $400 an hour. I just want to verify, is that for everything in the case?

A. Any work on the case, being, you know, paid the retaining -- the amount of money you said.

Q. Okay. So for your testimony here today, you are charging $400 an hour, correct?

A. Yes.

Q. Okay. Perfect. To date, how much have you billed Plaintiffs' counsel in this case?

A. I'd have to do look at my records to know exactly. They have the amount.

Q. Okay. But can you give any kind of an estimate?

A. I mean, this year, probably about $4,000.

Q. Okay. And do you have any sense of how many hours you have -- you have devoted to working on this case?

A. Over since when?

Q. If you could give me your total, that's great. If you can give me 2020, that's great.

A. I mean, totally up to this time probably about 10 to 15 hours, in that range has been devoted to this case.

Q. And that's for 2020, correct?

A. That's for 2020.

Q. Okay. Fair enough. I've looked at your CV and you're a pretty busy guy.

A. Yeah.

Q. You're currently the president of WPATH, right?

A. That's correct.

Q. And when did you take over your term as president?

A. In November of 2018.

Q. Okay. And what is the term? Is it two years?

A. Two-year term.

Q. So you're about to give that up, right?

A. Yes.

Q. Who is the president elect?

A. Walter Bowman.

Q. Is he another endocrinologist?

A. He's a medical practitioner.

Q. Okay. Now, is that an elected position or is it a board membership that you fleet up to be president?

A. No. It's an elected position by our members.

Q. Okay. Prior to being president, were you in another leadership position?

A. I was the secretary/treasurer of WPATH.

Q. That sounds terrible. I never liked being the treasurer. And I think I know this from your previous answer, did you consult with anyone at WPATH regarding this case?

A. No, because I'm the president.

Q. Okay. Fair enough. Fair enough. So

Page 25

I want to talk about your background and your medical practice. Is the CV that is included with your declaration complete and up to date?

A. Yes, I think there's a date on there. I believe September.

Q. September 1, 2020, but in hooking at the extent of your publication list, you know, just to make sure that there hadn't been anything added since the first of September.

A. The newest publication, I attached as an appendix. That's in press.

Q. Okay. Fair enough. Fair enough. And you're a board certified endocrinologist, right?

A. That's correct.

Q. What is training for endocrinology? Did you complete an internal medicine residency first?

A. I'm sorry. I lost you. It froze.

Q. That's okay. You're back now. What does endocrinology --

(Technical difficulties.)

(Discussion held off of the record.)

Q. Doctor, before our technical difficulty, I started to ask you some questions

Page 26

about your professional preparation. You are a board certified endocrinologist, correct?

A. That is correct.

Q. What does endocrinology training consist of? Did you have to complete an internal medicine residency first?

A. Yes.

Q. And that is three years, correct?

A. That's correct, three years.

Q. And then is endocrinology a fellowship?

A. Yes. Endocrinology is a fellowship.

Q. And how long is the fellowship?

A. It depends, but the minimum is two years.

Q. And how long was yours?

A. I did two years, and I was board certified and I stayed on as a research fellow.

Q. Got it. And how often do you have to recertify your endocrinology boards?

A. Every ten years.

Q. Okay. And when were you first certified?

A. 2001.

Q. And are you also board certified in

Page 27

internal medicine?

A. Not right now. My hospital doesn't require it if you maintain your subspecialty boards.

Q. Got it. Okay. So tell me about the training for an endocrinology fellowship. Is it inpatient and outpatient care?

A. Endocrinology fellowship?

Q. Correct.

A. Endocrinology fellowship involves endocrine treatment of patients in all settings inpatient/outpatient, yes.

Q. And what types of diseases and conditions are treated by an endocrinologist?

A. Any disease that requires hormone treatment.

Q. And you are speaking about hormones other than feminizing or masculinizing hormones in the transgender population, correct?

A. I mean, there's kinds of hormones, insulin, thyroid hormone, that sort of thing.

Q. So an endocrinologist treats diabetics, correct?

A. Yeah, because I use insulin hormone, yes.

Page 28

Q. And thyroid conditions?

A. Yes.

Q. What other types of conditions or diseases are treated by endocrinology?

A. Pituitary diseases. Obviously, in this case, patients with transgender identity, adrenal diseases. I mean, we could go on and on, you know. Lipid disorders, bone diseases, parathyroid.

Q. What portion of your training was devoted to prescribing hormones for transgender individuals?

A. Are you talking about my fellowship training?

Q. Correct.

A. It's hard to put a number on it, but I was definitely exposed to people with transgender identity during fellowship training and wrote, if you look in my CV, an article on that during my fellowship.

Q. Okay. And what years were your fellowship?

A. Started in 1999 and completed the clinical component in 2001.

Q. Okay. So there's been a lot of

Page 29

changes in recommendations for hormones for transgender individuals since that time, correct?

A. What do you mean by lots of changes?

Q. Well, medicine, science has undergone significant changes since that period of time. For example, what were the hormone recommendations for transgender women during your training?

A. You would give Estradiol, and it was in my review paper. You give Estradiol.

Q. And I understand, Doctor, some of these answers are in your paper, but this is our only opportunity to question you on your opinions, to the extent that you're able, I would appreciate --

A. I mean, in my first paper, it was very clear, you give Estradiol because it's the hormone that can measured in blood. And I discourage people from giving conjugated estrogens. You could not measure it. And that's how I got you know -- that's been very consistent in my entire career, and that has not changed since 1999 so I can say that.

Q. Do you have any education or training in psychiatry?

Page 30

A. I mean, I did a rotation in medical school.

Q. Okay. Post medical school, do you have any education or training in psychiatry?

A. No.

Q. And the same question for psychology?

A. Psychology, no, I mean, the only -- I'm a practicing endocrinologist.

Q. All right. So looking at your CV your current position -- primary appointment is Profession of Medicine Division of Endocrinology, Metabolism and Lipids Department of Medicine at Emory -- Emory University School of Medicine; is that still correct?

A. Yes, that's still correct.

Q. And you list several joint and secondary appointments. Can you explain the difference between your primary and your secondary appointments?

A. Secondary appointments were mostly for teaching. I think one of my secondary appointments is in nutrition so I teach students in nutrition. I have another appointment at Morehouse School of Medicine. I teach, you know, their trainees. That's basically what those

Page 31

mean.

Q. When you say a teacher, are you talking about classroom teaching or clinical in the hospital or both?

A. It could be everything. Any person that needs education.

Q. Do you do lectures at the medical schools?

A. Yes.

Q. And do you conduct inpatient rounds with trainees?

A. Yes.

Q. And do you have trainees who work with you in any type of an outpatient clinic?

A. Yes.

Q. Do you currently see patients -- for example, do you have an active clinical practice?

A. Yes, of course.

Q. What percentage of your professional time is spent in strictly teaching versus seeing patients?

A. You know, it's hard to divide it all out because I'm also the program director for the fellowship training program and so that I'm in charge of all the clinical training of our

Page 32

endocrine fellows. Fellows are future endocrinologists. And I see patients on my own, and I supervise the fellows' patients. So if you were to ask -- are you asking the percent of time I am -- what is the exact question again?

Q. So what percentage of your time is spent in teaching activities versus seeing patients in clinic or in an inpatient setting?

A. It depends on the time of year. I mean, in July, I was on endocrine consult service so I was the main doc seeing all of the patients in the hospital with endocrine needs. In July I would say that was almost 100 percent, but it changes by month.

Q. And where do you see patients in clinic or in outpatient setting?

A. I see patients at the Emory Midtown Hospital, Emory Executive Park, Emory Clifton campus, Atlanta VA Medical Center. I'm trying to think. These are the main places.

Q. Do you have a certain schedule for your clinic days, your outpatient days?

A. Yes. It varies depending on if I'm on inpatient service, you know, different things, but there's usually a schedule.

Q. So excluding patients you see in the hospital, your consults there, how do patients come to see you? Can they make an appointment to you directly or is it always in referral with a consultation?

A. They can make an appointment directly to see me or physicians can refer them, a variety of ways.

Q. Okay. So even on an initial visit, a patient can self refer or can make their own appointment?

A. That's correct.

Q. Do you also receive patients in referral from other physicians?

A. Yes. Physicians will refer patients that need consultation regarding hormone treatment and I'll see them.

Q. Okay. And are those typically primary care providers?

A. It could be anyone, any physician, even physician extenders who feel their patient needs help who will refer their patients.

Q. When you say they refer to you for hormones, you are talking about hormones other than feminizing or masculinizing hormones,

correct?

A. As an endocrinologist, all hormones. I mean, I'm an expert in hormones.

Q. Sure. But for the purpose of this deposition, I would like -- I want to try to differentiate patients you get referred to -- for transgender patients for hormones as opposed to other endocrine conditions.

Do you get patients referred from primary care providers for feminizing hormones?

A. Yes, I do.

Q. Okay. What percentage of your current clinic population are transgender patients?

A. I would estimate probably 60 to 70 percent.

Q. Okay. And how do the transgender patients that you see in your clinic get to you?

A. Like I said before, they either make a self-appointment or get referred by a physician.

Q. Okay. Are you seeing them for any reason other than prescribing hormones?

A. They may have other coexisting medical conditions that require hormone treatment

so if their thyroid isn't working or their diabetes, and I will take care of those hormone conditions as well.

Q. Okay. Perfect. Do you -- are you able to estimate what percentage of those transgender patients you see are transgender women?

A. I would say probably 60 percent. I'm just estimating. I mean, we could probably look at the recent paper I published and it will have the exact breakdown for you.

Q. That's okay. 60 percent. All right. Are you aware of what other types of physicians or therapists your transgender patients are also seeing?

A. Can you clarify?

MS. BAILEY: Objection to foundation, butgdo ahead and answer.

Q. To your knowledge, are your transgender patients also seeing other types of physicians or therapists?

A. You know, they're seeing obviously primary care because everyone needs a primary care. They're seeing a mental health professional. I'm trying to think. We have a

whole bunch of services at Emory. Some are seeing reproductive endocrinology, not all. Some are seeing voice, but there's -- I don't know exactly. You'd have to have ask me exactly -- I'd have to look at the breakdown.

Q. That's fair enough. In your outpatient practice, is there a -- for lack of a better term, a transgender clinic that is a subspecialty?

A. We are starting one. We have one now virtually. We have a network of providers that we use, so we have a number of mental health people. We have obviously surgeons, just a whole network of providers. We are not located in one place, but we refer to each other virtually and we have a website that lists all of our people.

Q. And you said you're not all in one place. Are those people all in the Atlanta area?

A. They're in the Emory system. Sorry. I don't know if you know Emory. Emory is a very big hospital system, and we may live in different buildings.

Q. What is the website?

A. Emoryhealthcare.org. I don't know the exact site.

Q. No. I understand, but is there a website specific to this transgender group?

A. Yeah. If you go to Emoryhealthcare.org, you should be able to find something.

Q. Okay. We will do that. All right. In your various positions, do you also have administrative responsibilities?

A. As I mentioned, I'm the program director of the endocrine fellowship training program. That's my main position. I'm also the -- the director of the transgender clinic, and I think those are the main positions I have at Emory Healthcare.

Q. Okay. And do you have a sense of how much or what percentage of your time those administrative positions take up?

A. Well, for the program director of the endocrine fellowship training program, at least 25 percent. For the program -- for the transgender program, that overlaps with my clinical care, so that's my clinical care.

Q. Okay. Thanks. So based on your experiences with this group at Emory that you work with, do you have a sense of what percentage

of the transgender patients that are in the Atlanta area are actually treated by an endocrinologist?

A. I don't -- I can't speculate on that because I need to know the denominator, but we have a large number of transgender patients in the Atlanta area. I can guarantee you that not all of them are seen at Emory. They're all seen all over the city.

Q. In your experience, are all transgender patients being treated by an endocrinologist?

A. In my experience, no. We say that physicians who have the experience with giving hormone therapy can provide hormone therapy. So it can be a physician who is knowledgeable about hormone therapy that can give hormone therapy and hormones are not restricted to endocrinologists. Any physician is able to prescribe hormone therapy, provided they do it safely and know what regimes to use, and those are all public knowledge.

Q. Sure. Are you aware of what percentage of the transgender population are receiving hormones?

MS. BAILEY: Objection, foundation, but you can answer, Vin.

A. I mean, that's a difficult question because we -- I don't know the denominator again. We need to --

Q. Well, again, with just based on sort of your overall knowledge and your president of WPATH, you work with this transgender group at Emory, do you have an opinion or any knowledge based on your expertise and research as to what percentage of transgender patients are receiving hormones?

A. I would say the people who seek -- who want -- the number of transgender patients who want hormone therapy, nearly all of them get it. Nearly 100 percent. I don't want to say absolutes, but I would say a large vast majority of transgender patients who are seeking hormone therapy get hormone therapy because there are publicly available guidelines for physicians to do that.

Q. So nearly all of transgender patients who are seeking hormones get them, right?

A. There may be -- I mean, in my opinion, what I've seen -- I can't speculate

outside the Emory system. In the Emory Healthcare system, as far as I know, that people that are seeking hormone therapy, provided their medical contraindications, which are very few, people that are seeking hormone therapy usually get on hormone therapy, you know, provided they have the appropriate medical workup, they have the appropriate clearance for hormones and get on hormone therapy without much delay.

Q. What are the medical contraindications for receiving hormones in?

A. In my declaration, I listed out there are some contraindications like having a blood clot. And so when I say contraindication, that has to be taken care of first. That doesn't mean that person can't ever go on hormones, but those people have to get their blood clot taken care of and then they go on hormone therapy. Or if they have an active hormone sensitive cancer, obviously, you don't want to give someone hormones if there is a cancer that could get worse by hormones. So they have to get the cancer taken care of, removed, treated and then get on hormone therapy.

Q. Okay. So there's relative

contraindications, correct?

A. Relative, yes. Once the medical condition is taken care of, they can start on hormone therapy.

Q. Are there any absolute contraindications to prescribing hormones?

A. I mean they're very, very rare. The only one thing I can think of like in a trans man who may be pregnant, you obviously don't want to give a trans man who is pregnant hormones. That would not be good for the fetus. But in terms of absolutely, no, you can't go on hormones, I can't think of a situation that you can't go on hormones. You have to get the issue controlled and can start on hormones once everything is safe.

Q. Okay. So there are no chronic blood clotting disorders that would rule someone out?

A. If you have -- like I mentioned before, let's say you have a blood clot. You undergo therapy to dissolve the blood clot. So you go on blood thinning hormones so you don't develop a blot clot later and you can go on hormone therapy, because that's taken care of it. It is addressed.

Q. And you said earlier that primary care practitioners can prescribe hormones, correct?

A. That's correct. I mean, anyone who has a medical license can prescribe hormone therapy, yes.

Q. How about nurse practitioners?

A. I don't know the laws on what nurse practitioners can do and can't do. That probably depends state by state.

Q. And I guess my same question and probably the same answer, physician's assistants?

A. Yeah. I don't know enough about that field.

Q. So what would you consider to be the minimum level of education and training for a primary care practitioner to prescribe hormones to a transgender patient?

A. You know, they have to obviously know the risks of hormones. So that's just common sense. You have to know the risks and benefits of a medication you're prescribing to a person. And as long as you're able to articulate that, I think you could prescribe hormone therapy, at least continue it. If someone is already on

hormone therapy, at least continue the hormone therapy.

Q. Okay. Is there any objective criteria for determining in your opinion whether this primary care practitioner knows the risks?

A. Can you rephrase? I'm not quite clear what you're trying to ask here.

Q. Well, you said that if the primary care practitioner knows the risks and benefits and can articulate them, then they can prescribe or continue hormones; is that a fair statement?

A. I think for any patient when you're starting a therapy, it's called an informed consent. You have to be able to tell your patient what they're getting, what the pros and cons are. I think that's for any medication, you give an antibiotic and there's a chance of X, Y, Z. You have to say, well, there's a chance of X, Y, Z, but on the other hand, there's a chance to improve your infection. You can't just write it and not be able to understand what that is so I think that's the minimal.

Q. Sure. And so my question is, is there an objective mechanism for determining whether that primary care practitioner knows the

risks and benefits and can articulate them?

A. You mean like a test? Objective to me means test. What do you mean by objective?

Q. Well, you're telling me that if they have those -- if they can do those things, then they can safety provide the medication. So my question is how do you or how would you determine if they have that requisite level of knowledge and experience?

MS. BAILEY: Objection to form. You can answer.

Q. You can answer, Doctor.

A. Oh, okay. I'm still confused. I don't know what I'm answering.

Q. What I'm trying to determine is how would you determine if a primary care practitioner can administer -- can prescribe hormones to a transgender patient?

MS. BAILEY: Objection to form, but, Vin, you can answer.

A. I mean, you would probably have to -- if you're asking me, you would just --

Q. I am asking you, Doctor.

A. You would probably look at their credentials and see if they have the knowledge

base or maybe the experience. I mean, I think if you give me some credentials, I could tell you. Give me some resume or something and maybe I can talk to them and tell you if they're able to do it.

Q. Are you able to do that for every primary care practitioner in the Atlanta area who is prescribing hormones?

MS. BAILEY: Objection, foundation.

Q. Doctor, you can answer.

So is it fair to say you really don't know whether the level of education and training of the primary care providers who are prescribing hormones to transgender individuals?

MS. BAILEY: Objection to form. Misstates the testimony, but, Vin, you can answer.

A. I'm still confused what you're trying to ask here. I don't know what I would say.

Q. Doctor, you tell me that primary care practitioners with a certain requisite level of training and knowledge can safely provide hormones; is that correct?

A. Yes. If a primary care practitioner acquires the experience and knowledge on how to

prescribe hormone therapy, their medical license does not forbid them from giving hormone therapy.

Q. Okay. And the way you personally would determine that would be to look at their credentials, correct?

A. You could look at their credentials. You could see what kind of experience they've had. You know, you can see what courses they've gone to. That's just one way.

Q. But is it possible for you to know the experience or know the credentials of all primary care practitioners who are providing hormones?

MS. BAILEY: Objection, foundation.

Q. Is it possible, Doctor?

A. I'm sort of confused -- so if I was given -- are you saying if I'm given every single primary --

Q. Doctor --

MS. BAILEY: Sorry. Carla, let him finish his answer, please. Go ahead, Vin.

A. If you gave me all of the primary care physicians' background, training, education records, is that what you're asking? You could look at that and say, you know, yeah, this person

went to this course and has seen this many people, so they could do it.

Q. But you don't know that information for all primary care practitioners who are prescribing hormones to transgender patients, correct?

A. Why would I want to know that? It is not my --

Q. Doctor, I'm the one asking the questions, so the answer -- I just need an answer.

MS. BAILEY: Carla, again, let Vin finish his answer.

A. Again, I don't understand the question. Why would I want to know that?

Q. The answer to a question is not a question. Doctor, do you know the education and training of all primary care practitioners who are providing hormones to transgender patients?

MS. BAILEY: Objection, foundation. You can answer.

Q. I'm asking if he knows. If the answer is no, the answer is no, so that's why --

A. You're talking about in the Emory Healthcare system?

Q. Emory Healthcare system, do you know the qualification, the education and training of all primary care practitioners who are prescribing hormones to transgender patient?

A. I can't speak in absolutes because I only know the ones I work with. And the ones I work with refer them to me, obviously, because they need help so I will help them. And how can I speak in absolutes? There are over a thousand physicians in the healthcare system.

Q. So the answer to that question is no, then, correct? You don't know the qualifications, right?

MS. BAILEY: Objection, misstates the testimony. You can answer, Vin.

A. I don't know what the -- I can't answer questions I don't understand.

Q. Doctor, let me try again. Do you know the education and training of all primary care physicians who are prescribing hormones to know whether they have the requisite information that you believe makes them competent to treat patients with hormones?

MS. BAILEY: Objection, asked and answered. Foundation.

Page 49

MS. TOLBERT: It has not been answered.

MS. BAILEY: Answer to the best of your ability, Vin.

A. Is the question do I know the education and training of all the hormone -- the primary care physicians in the Emory Healthcare system? Like I said before, the primary care physicians who are needing assistance refer their patients to me, so I don't -- I'm just confused.

Q. I can see that. We'll move on. Do you feel that care not provided by an endocrinologist is substandard?

A. No. I mean there are physicians who if they go to certain courses can get the prerequisite training to be comfortable. Or some physicians can have years of expertise training or have a number of patients they see on their own and get the comfort and experience.

Q. What are these courses that you're referring to?

A. Many societies offer different courses that offer CME credit for how to treat transgender hormone therapy.

Q. What societies, Doctor?

Page 50

A. WPATH has sources. The Endocrine Soceity has lectures and CME programs. There's another American Association of Endocrinologists has articles, CME courses. There's other local societies. I mean, there's many ways you can get the education.

Q. And is there a minimum level of continuing medical education that you think that non-endocrinologists should have?

A. I can't express because I don't know what non-endocrinologists --

Q. Well, Doctor, we're talking about primary care practitioners who are prescribing hormones to transgender patients. So non-endocrinologists who are prescribing hormones to transgender patients, is there a minimum level of continuing medical education that you believe they should have?

A. On the topic? Number of CME credits on certain topics of hormone --

Q. Well, you just gave me a lengthy answer about CME courses that are available that might make a primary care practitioner competent to prescribe hormones, correct?

A. Yes. There are CME courses that cover various aspects of transgender hormone therapy, that's correct.

Q. With that answer in mind, is there a minimum level of education, training or CME that you think someone should have before prescribing hormones?

A. I can't answer because you're asking me a very specific question about CME, and I know what the CME requirements are so I can't throw out a number because I don't know the number. That's the thing.

Q. Let's try it this way, is there a minimum level of education or training that you think they should have?

A. For -- can you complete the rest of the question? What do you mean?

Q. Again, Doctor, this is the same topic that we've been on. Non-endocrinologists who are prescribing hormones to transgender patients, primary care practitioners, is there a minimum level of education, training, number of hours, certain topics, however you want to measure it, is there a minimum amount that you think they should have to make them competent?

A. Obviously, there is a minimum, yes.

Page 52

Q. And what would that be to you?

A. I can't answer. That's when you are asking me specifics. I can't say, because the CME, that's a totally different ball of wax.

Q. Let's take CME hours out of that question. Are there certain topics of education or training that you believe they should have attended?

A. You know --

MS. BAILEY: Object -- hold on. Objection to form. Go ahead, Vin.

A. They should obviously know what are the safe hormones to give, obviously, using the safe ones, knowing like any medical practitioner what should be monitored and how to talk about the risks and -- what the risks and benefits. I think that is for any medical treatment, you have to know what the risks and benefits are. You have to know a little bit about the time course of what happens with the treatment, different comorbid conditions that can go along with treatment. I think those are the basics for anything.

Q. It's my understanding that there is no certification for --- strike that. Is there a

Page 53

certification that can be achieved for non-endocrinologists who prescribe hormones to transgender patients?

A. There is.

MS. BAILEY: Objection, form. Go ahead.

A. Well, there is. WPATH does offer a course, certification course, but when you use the word certification, that can mean -- there's not like a law or anything. That says you finish the course.

Q. I'm not asking you about law, Doctor. That's not why you are here. So there is a certification of completion of certain educational requirements?

MS. BAILEY: Objection, form. Vague. Go ahead, Vin.

A. Yeah. If you complete a WPATH course and if you're certified, it just states that you've completed all of the requirements for the certificate.

Q. And what is that certificate in?

A. In transgender health, but as far as I understand, only very few have been certified because the course has just launched. So that's

Page 54

why I hesitate to say that because it's not really fully launched yet. I'm privy to the certification course, but some people have been certified but not many. It's not like -- that's all I can say about that.

Q. Are you aware of any other certifications that a non-endocrinologist who provides hormones to transgender individuals could achieve?

A. I mean, can you use a different word than certification because certification means something different to other people. I don't know what you are --

Q. Sure. What I mean by certification, a certification for completion of coursework. I'm not talking about board certification.

A. That's where the confusion is.

Q. And I don't mean to confuse you. I am not talking about board certification, but for example, there are a number of certifications of completion of specialty coursework that can be achieved in other specialties, other disciplines. Is there something analogous for someone who is trying to prepare themselves to prescribe hormones to transgender individuals?

Page 55

MS. BAILEY: Objection, form, vague, but go ahead, Vin.

A. There are -- as I mentioned, there are courses that people can get a certificate of completion. We'd have to look at the content. Not all of the courses are the same. I just don't know. You go to a weekend course. That's two hours and you get a certificate of completion. They might not equal a course that is 20 hours, 30 hours. That's why I have a difficult time answering that question.

Q. You mentioned the WPATH course, which is new, and then you said there are other courses. What to your knowledge are those other courses?

A. There's -- I can mention the Endocrine Society has some courses offered through their transgender special interest group. It's a monthly or bimonthly webinar. There's something called Endocrine University that I lecture at that has training for all fellows -- for all fellows in the country that are graduating on transgender medicine. I mean in those -- and there's ones and I just don't know. I'm not part of the other societies. There's

Page 56

other ones, but it hard for me to go into much detail in those other ones.

Q. So it's not a standardized educational process for people -- for primary care practitioners to learn how to prescribe hormones; is that true?

MS. BAILEY: Objection, misstates the testimony, but go ahead, Vin.

A. I mean, there are many paths to get training in -- to get training in dealing with people with transgender identity. But what I'm saying is not all of them are equal.

Q. Sure.

A. Can I take a break now before you ask another question? My mouth is parched and I just need a break.

Q. Absolutely. How about back in 10 or 15 minutes? You let me know.

A. How about back at what time, 11:20? You're in central.

Q. That's okay. We're good. So ten minutes?

A. Yeah. Ten minutes is good.

(Recess taken.)

Q. Yeah. Doctor, are you aware if

Page 57

whether hormone treatment for transgender patients is covered by insurance?

A. Yes.

MS. BAILEY: Objection.

Q. I'm sorry. The answer is yes, Doctor?

A. I'm aware, yes, there's some insurance plans that cover transgender hormone treatment, yes.

Q. And that's based on your practice and your patients?

A. Yes.

Q. Have you ever -- you personally ever had a patient's insurance company deny them hormones?

MS. BAILEY: Objection, form, but go ahead.

A. When you use the word hormones, that's very broad.

Q. Doctor, I understand that as an endocrinologist that you prescribe a lot of hormone medications, but I think we can all agree the reason that you are here today is to testify about hormone treatment in transgender patients; correct?

Page 58

A. That's correct, but the reason I paused a little bit, because there's many different hormones in transgender patients.

Q. Okay. So let's break it down. Of all the types of hormones that you can prescribe for transgenders, have you had any of them denied by the patient's insurance company?

MS. BAILEY: Objection, form, but go ahead, Vin.

A. We would have to go through each formulation. I mean, for the most part, if the patient has insurance there is at least some hormones that are covered, like some of the more -- the brand new ones or the really expensive ones that just come on the market, those aren't covered, but the basic hormones are covered.

Q. Fair enough. Have you ever had a patient who was not able to get their estrogen covered?

A. Like I said before, all the basic hormones, at least one form in the category is covered or a few. The new brand new fancy ones aren't usually covered.

Q. Okay. Do you know what percentage of

Page 59

your transgender patients are insured?

A. I don't handle the finances. I'm a faculty member here so I see patients that are on my schedule, and I take care of them. I don't look at their insurance as the first thing I do.

Q. I completely understand that, but that is not my question. My question is do you know?

A. I don't know the answer. I don't know the exact answer to that because I don't know that.

Q. Fair enough. Do you know if hormones for transgender people would be covered by Medicaid?

A. I take care of some -- I mean, again, I don't look at the insurance card and I do take care of some -- you said Medicaid or Medicare?

Q. Medicaid.

A. Medicaid, I'm not an insurance expert to be honest with you. I can't answer that, because I do take care of some Medicaid patients. They seem to get their hormones. You're asking the wrong -- I don't know anything about insurance stuff.

Q. So have you ever been asked to

Page 60

complete a prior authorization for insurance coverage for any of your patients for hormones?

A. As I mentioned, yes, I've filled out prior authorizations for -- there's a number of transgender hormones and like I said, some of them are fancy and new. Sometimes I fill those out. But not the basic ones, I never have filled out one for a basic ones.

Q. What do you consider to be the basic ones?

A. The standard like the oral Estradiol, testosterone injections, Spironolactone, those kind of things. Those are usually covered.

Q. All right. So you mentioned Estradiol, and I know in your report and in your prior hearing testimony that you were critical of conjugated estrogens, correct?

A. That's correct.

Q. Okay. So earlier you mentioned you were critical because you can't measure estrogen levels when the patient is prescribed conjugated estrogens, correct?

A. Not only that. You can't measure levels, but it's dangerous in that there have been some papers coming out showing increased

Page 61

risk with giving the conjugated estrogen -- I think I cited in my declaration in the British Medical Journal last year that even cisgender women getting conjugated estrogens had increased risk of complications.

Q. Okay. What are those complications that you're referring to?

A. The blood clots.

Q. Are there any other complications?

A. I don't want to speculate, but we know that long term there is eventually increased risk of stroke and heart attack in transgender women getting estrogen hormone therapy. And while it can't show the direct cause and effect for those, because those are long term events, we believe it's because you can't monitor the blood level and people are getting levels that might be too high and at risk for long term events. And we know there is data to support there are long term increased risks like the blood clots, heart attacks, strokes.

Q. Now, stroke and heart attack would be related to the blood clots, correct?

A. It's a separate phenomenon. I guess it could be related. Blood clots usually refer

Page 62

to deep venous thromboses or pulmonary embolism. Heart attacks, you know, it's probably a different -- that's probably more arthrosclerosis. Stroke, it could be a thrombotic event. It would be bleeding. There's many different reasons for strokes.

Q. Okay. Is there any increase or any higher risk of arthrosclerosis related to hormones?

A. Arthrosclerosis is a broad. Are you saying --

Q. Coronary?

A. As I mentioned before, we published a paper that is at least going out ten years we know that transgender women are at risk for those three things; heart attacks, blood clots, strokes. And as I mentioned earlier, it might be due to women getting the wrong estrogen, like conjugated estrogens, not able to monitor the blood levels, and we're doing research to really find that out. So I think the blood levels are very important to monitor to reduce the risk of those complications.

Q. Are those three complications any higher risk in the transgender women population

Page 63

as opposed to the cisgender population?

A. In our study, we compared to cisgender populations, and it seemed like it was higher risk to the cisgender population over the same period. But like I said before, it's probably related to not having the hormone levels monitored properly or in the right range. We don't have that information right now.

Q. So there are cis women who are receiving conjugated estrogen, correct?

MS. BAILEY: Objection, form and objection foundation, but go ahead, Vin.

Q. To your knowledge, yeah.

A. I don't prescribe it. I don't know. Probably in the world, yes. Somewhere in the world, but I don't prescribe conjugated estrogens to anyone.

Q. At any time has conjugated estrogen been an accepted estrogen medication for transgender women?

MS. BAILEY: Objection. Foundation, but you can answer based on your knowledge.

A. Accepted, I don't -- as I mentioned earlier in my review paper going back to I think it was 2001, I said it was not a good form of

Page 64

estrogen to give because you couldn't monitor the level. And I'm trying to think, there is no guideline that has existed in the past 20 years that said that conjugated estrogen was the preferred estrogen or considered -- accepted -- it wasn't really -- not accepted as a first line treatment for transgender women.

Q. Are the risks of heart attack, blood clots and strokes any higher in patients who are smokers?

MS. BAILEY: Objection to form, but go ahead, Vin.

A. Can you just say it again? I just missed the first part of that question.

Q. Are the risks of MI, blood clot and strokes higher in patients who are smokers?

MS. BAILEY: Again, objection to form.

A. I can answer?

Q. Yes.

A. Yeah. I mean, yeah, if you smoke, you're at increased risk for many different things, so those --

Q. Right. Based on your knowledge and your research, are you aware of how much higher

Page 65

risk smokers are than nonsmokers?
MS. BAILEY: Objection to form, but you can answer, Vin.
A. I can't cite that. I know it is higher. I can't cite the exact number.
Q. Are there any other side effects other than those three related to conjugated estrogens?
MS. BAILEY: Objection to form, but go ahead.
A. Well, fertility is reduced and we tell people that before you go on hormones, you have to think about future fertility. I'm trying to think. There is a tumor -- a pituitary tumor where the estrogen can increase the growth of a gland in the brain, and that can cause blindness, vision less, headaches and so that's another major side effect. You only asked me about hormones. That's why I'm very specific, but you didn't talk about Spironolactone that usually goes along with gender affirming hormone therapy, and the side effect of that is high potassium and worsening kidney function so those are also important things that should be mentioned.
Q. Sure. Well, I still have some

Page 66

questions about hormone therapy, but I appreciate that information. So future fertility and pituitary tumors. Are there any other side effects to estrogens?
A. If you're not -- well, if you give them too much, yeah. If you're giving them too much, as I mentioned, the blood clots, strokes, heart attacks, pituitary tumors. Sometimes if you're giving too little, you can have osteoporosis. As I mentioned in one of my declarations, if you're giving the hormones and it's inadequately dosed, you can develop bone issues. Osteoporosis leads into fractures. If you give someone hormones and it's not enough, the gender dysphoria could persist and get worse and if it is ignored, people could have anxiety, depression, self-harm. So there's both sides, too much, too little.
Q. How about risk of any type of cancer for patients taking estrogens?
MS. BAILEY: Objection, form, but go ahead, Vin.
A. As I mentioned, one of the relative contraindications of the hormones was having a cancer that is known to be hormone sensitive. So

Page 67

obviously, if you have a cancer that is known to be responsive to estrogen, you wouldn't want to give someone that. But to answer your question, there is -- as far as we know, the risks of cancer are the same as cisgender women and so you have to do the routine, you know, the mammograms and the screening for cancer just like any woman, any woman getting estrogen.
Q. When you talk about mammograms, you're talking about breast cancer, correct?
A. Yes, mammograms for screening of breast cancer.
Q. And you said that the risk of breast cancer would be the same for transgender women as cisgender women, correct?
A. Yeah. In our studies, we looked at the incidents of cancer, and it appeared to be the same as cisgender women. So if you look at the national guidelines, they say screen according to the guidelines for cisgender women.
Q. Okay. Is there any higher risk of breast cancer for patients received conjugated estrogen verus Estradiol?
A. I don't know if we have the data right now. Most of -- I think it's because the

Page 68

cancers take much longer time to form. The blood clots are just, you know, very quick and so we know that. I don't think we're ever going to get the long-term data for cancer because that's a 20-year sort of thing.
Q. Sure. Is there a higher risk of blood clots with conjugated estrogen versus Estradiol?
A. Yes. As I mentioned in my declaration, there is a very good study published in the British Medical Journal that looked at cisgender women comparing Estradiol, conjugated estrogen and showed that there was increased risk. And this is looking at many thousand of women and it was much higher in women taking conjugated estrogens.
Q. And you said that transgender women would require the same mammography as cisgender if they're on hormones, correct?
A. Can you repeat? There was one little thing I missed.
Q. Sure. I hear somebody's dog in the background?
A. Yeah. I'm sorry.
Q. No, that's okay. You talked about

Page 69

the need for transgender women to have mammography, the same as cisgender women, correct?

A. Yes.

Q. Okay. And that's transgender women who are taking estrogen hormones, correct?

A. Well, I mean, the guidelines say all transgender women should have the same screening as cisgender women. They don't specify only taking estrogen. It just says --

Q. Well, in your experience, would a transgender woman have breast tissue growth if she was not taking estrogen?

A. There is some growth if you're taking testosterone blockers because it's a balance between estrogen and testosterone, so you can have some breast growth without taking estrogen as well.

Q. Are you -- so it is possible for a transgender woman to develop breast cancer, correct?

A. Anyone with breasts can develop breast cancer.

Q. Are you aware in your experience or through your research what type of breast cancer

Page 70

a transgender would develop?

A. I'm not -- what do you mean by type? I'm not familiar.

Q. Sure. There's ductal cancer, correct?

A. That's -- I am not an oncologist so I can't speak to the different subtypes of breast cancer.

Q. Okay. Fair enough. Fair enough. Do you have any other criticisms of conjugated estrogen that you haven't talked about either in your declaration or discussed here?

A. I think it's covered pretty well in my declaration.

Q. Okay. And when we're talking about conjugated estrogens, I know there's Premarin. Are there any other types of conjugated estrogens in your experience?

A. There's something called Menest is also a conjugated estrogen. I'm sure there is a few others that have different brands, but if you look at the chemical, it will say conjugated estrogen.

Q. Okay. And are there any other estrogens other than Estradiol that you would

Page 71

recommend?

A. There's all kinds of Estradiols. There's Estradiols that are attached to esters like Estradiol Valerate, Estradiol Cypionate, just is just the plain, as I mentioned, Estradiol, which is 17 beta Estradiol. That's the most common form.

Q. And a few minutes ago you mentioned that treatment with Spironolactone can cause elevated potassium and decreased renal function, correct?

A. Yes, because Spironolactone is not a hormone but it is a testosterone blocker that lowers testosterone, but it also functions as a diuretic that spares potassium, and since it's a diuretic, it can make you lose water and get dehydrated.

Q. And what type of monitoring is necessary for a patient receiving Spironolactone?

A. Obviously, you should measure the potassium because as I mentioned, the potassium can rise. And also the kidney function because it's a diuretic so you should check the kidney function.

Q. Are there any patients that would not

Page 72

be able to receive Spironolactone?

MS. BAILEY: Object to form. But go ahead, Vin.

A. Obviously, if you have issues with kidney already or if you have potassium issues already. Some people can get dehydrated with it and not be able to take it. I mean, those are the main things. It's related to its potential side effects.

Q. In your practice, do you advise patients that they have to stay hydrated, for example, drink extra fluids or things like that?

A. Yeah. I tell them about the medication, how it works and tell them, you know, you just need to drink some water. You may urinate more, but drink some more water and watch the potassium containing foods because we know it increases. But I tell them we monitor their levels every three months until we get a good dose to make sure it's safe.

Q. Okay. In your report and in your prior testimony I know you also have some criticisms about the transgender care review committee; is that correct?

A. In the court testimony?

Page 73

Q. Correct.
A. Yes.
Q. Okay. Are you aware of planned changes to the structure of the transgender care review committee wherein hormones would not be recommended by the committee?
A. I need to get some more details about that, but I did hear -- I think that was -- I have to go -- I know something like that happened, but I don't know the -- I would have to go look at it carefully.
Q. Okay. Do you happen to know the date when those changes are supposed to go into effect?
MS. BAILEY: Objection, foundation but you can answer based on --
Q. If you know that.
A. I'd have to go back. If you want the exact date, I'd have to go back. It's probably in one of my declarations, it's in there.
Q. Okay. Do you consider that to be an appropriate change to the structure of the committee?
A. Can you rephrase what the change was again?

Page 74

Q. So that the committee would not be making recommendations on whether or not a transgender inmate would receive hormones?
MS. BAILEY: Objection, form and foundation, but answer to the best of your ability, Vin.
A. I think the issue was the committee did not have the expertise to be making that sort of medical decision, so I would agree with that change. I guess the question is who is now making the decision? Is it a person who has the expertise? I don't recall who that is now.
Q. So if when the committee no longer makes recommendations, if all medical treatment decisions were made by the onsite physicians at the various facilities, do you think that is an appropriate change?
MS. BAILEY: Objection, calls for speculation and a hypothetical, but you can answer, Vin.
A. I can't speculate. I don't know who this person is or who they are and what kind of training they have. You know, I can't make a blanket statement like that.
Q. Sure. Are you aware of who employs

Page 75

the treating physicians at IDOC facilities?
MS. BAILEY: Objection, foundation.
A. I don't know who employs them.
Q. Okay. All right. Are you aware of what training is provided to the onsite physicians regarding hormones for transgender offenders?
A. The current training, I haven't been given that information to review so I would have to look at that.
Q. Okay. Are you aware of newly implemented training by Wexford Health Sources who employs the onsite physicians?
MS. BAILEY: Objection, foundation, but you can answer.
A. I recall there is some attempt to do some training. I can't vouch right now because I don't know what the curriculum looks like and all the learning objectives. I'd have to look at the slides and I just know that there is some new training that was being provided but in terms of the quality, I can't comment on that.
Q. All right. You have not seen those documents, correct?
A. I haven't seen it to the level of

Page 76

detail that I could comfortably comment on.
Q. Got it. What training do you think the onsite treating physicians should receive?
MS. BAILEY: Objection. Calls for speculation. And just to clarify, I think this is outside the scope that -- the training the people at IDOC are receiving is outside the scope of Vin's report and our disclosures. If you want to ask another question or two, that's fine, but we are not offering him as an expert to opine on anything related to the training.
MS. TOLBERT: Well, he's got criticism that the providers are inadequately trained. So my question is what training does he think they should have?
MS. BAILEY: Vin, you can answer based on the best of your ability, but, again, we're not -- we're not giving an opinion on the sufficiency of the planned training that IDOC may provide in the future.
Q. Of course. Just to clarify, Doctor, you've opined that you think that the people who prescribed the hormones are not adequately trained, correct?
A. Which people are you talking about?

Page 77

Q. The people who are writing the order for the hormones, the onsite physicians.

A. I would have to -- before when it was done through a committee, there was nonclinical people in there. Are you talking about after the new plan? Or I don't understand.

Q. Doctor, is it your understanding that the committee ordered the hormones?

A. When you say ordered, I mean they're not the ones who sign and date the order. I don't know. I mean --

Q. Okay. If they're not the ones signing the order, are you aware of the capabilities, the qualifications of the people who are signing the order?

A. I would have to review their specific qualifications of who these people are.

Q. Okay. But it is your understanding that the committee is not actually writing the order for any particular transgender inmate to get the hormones, correct?

A. When you say order, that means something in the medical field. Order means you're writing a medical order and saying they're giving the go ahead. They're saying -- they're

Page 78

voting on all these decisions, and without that vote they're -- they can't get -- they can't even get an order, so they have to vote and get an order.

Q. And I understand all that. Doctor, I'm well aware of what an order is. You can use the analogy of a prescription. Is it your understanding that the committee is not writing a prescription or entering an order for a medication?

A. They are giving the approval for someone to do that, so that's why I'm a little confused. They are giving the approval for a person below them to do that, to give the prescription order. So they are in a way making those medical decisions.

Q. Okay. And we covered that. Would you think it appropriate for an onsite physician -- not the committee -- an onsite physician at a correctional center to order hormone medications for a transgender offender without getting an endocrinology consult?

A. If that physician had the appropriate background knowledge, could speak in terms of the pros and cons of hormones, can give the informed

Page 79

consent, monitor the levels, prescribe the right amount of hormones, yes, I would feel comfortable if that person could actually do that. My review of the records to date show that those physicians -- I don't know who these people are, but these physicians are not able to do that. They're not prescribing the correct hormones. They're not monitoring the levels the right and safe way.

Q. What are the most recent medical records of any of the named Plaintiffs that you reviewed?

A. I would have to refer to my most recent declaration. It probably has a date on there. Do you need the exact date?

Q. Yeah. If you would just take a look at it so you can testify as to what records you most recently received.

MS. BAILEY: If it helps, Carla, Dr. Tangpricha has not reviewed closely the medical records that you-all produced after he -- after we disclosed his report. He reserves the right to file a supplement report based on the medical records that were produced again after the expert disclosure, so if that helps with this line of

Page 80

questioning, that's the case.

Q. Okay. Doctor, just to close the loop on this, if you could tell me as of the date of your report, what would be the most recent records you had reviewed on the named Plaintiffs in this case?

A. I mean, I would be happy to review any additional records and add a supplement to my declaration. I just can't right now.

Q. Sure.

A. I don't have the exact date.

Q. And I understand that. So the last thing you said is as you sit here today, you can't tell the last date or the most recent records that you received?

A. I could tell you that what I had received was current to the time I submitted my declaration. So if there are any additional records, I would be happy to review them, and if it changes my opinion on my declaration I would be happy to submit a supplement.

Q. Sure. I'm sure that your attorneys will forward that. So I appreciate that. So the information that you received was current as of October -- I apologize -- August 30th, 2020,

Page 81

correct?
A. Is that the date of my declaration? If that's the --
Q. Well, you know --
A. I want to make sure.
Q. August 30th, 2020.
A. Yes. Everything that I received was current to that date.
Q. Okay. Thank you very much. I noticed in your testimony at the preliminary injunction hearing from August 8th, 2019, that you were critical of a note written by a psychiatrist using the term "gender identity disorder." Do you remember talking about that?
A. Yes, I do.
Q. Okay. And what were your criticisms of the term gender identity disorder?
A. It's a term that was used in the past, but no longer acceptable because it's not a term that reflects the modern terminology and that gender dysphoria is not a mental condition. It's not a disorder. It's a medical treatment, and that's why I was critical of it.
Q. Got it. It is my understanding that the terminology -- the change in the terminology

Page 82

was approved in December of 2012 and published in the DSM 5 in May of 2013. Do you have any reason to doubt that?
A. You're throwing out dates. I would have to go double check that, but it sounds about right.
Q. Sure. Are you aware of the date of the note containing the term gender identity disorder?
A. I'd have to go look at the transcript of the trial because I know they showed it to me in court, and I read the note.
Q. Sure. If it was before the date that the DSM 5 was published, would you still be critical of the use of that term?
A. Yes, because the Endocrine Society had guidelines before then, too.
Q. Okay.
A. The Endocrine Society had guidelines from 2009.
Q. The DMS 4 used the term gender identity disorder, correct?
MS. BAILEY: Objection.
A. Well, the DSM, again, is -- that's, again -- that's like a -- that's a coding

Page 83

document, and it takes time to update the language but the Endocrine Society guidelines in 2009 said not to use that term.
Q. Is gender dysphoria still considered to be a diagnosis?
A. Gender dysphoria is a term to describe someone who has this uneasy feeling between their identified gender expression and their assigned gender.
Q. Is it a diagnosis, Doctor?
A. When you say -- when you say a diagnosis, you're calling it a disease. So it is a symptom for sure. It's definitely a symptoms. It's a term, like I said, to use to describe someone's uneasiness between their gender identity and their assigned gender.
Q. Okay. Is the DSM, whatever version that you're on, is DSM a publication that you use in your endocrinology practice?
A. So, you know, DSM is -- once someone has made a determination that one is ready for gender affirming hormone therapy, I mean I provide the hormone care, so I mean I don't know what the question is you're trying to ask here. I --

Page 84

Q. Go ahead.
A. I mean -- I don't know. Rephrase again. I don't know.
Q. Is the DSM, in this case we're on the DSM 5, a publication or a source that you routinely use in your endocrinology practice?
MS. BAILEY: Objection, form. Go ahead, Vin.
A. I mean, I can tell you that the Endocrine Society guidelines take some excerpts from the DSM to define what gender dysphoria is, so indirectly I would say yeah, because the Endocrine Society guidelines refer to them.
Q. Okay. Do you remember the hearing that you testified in, you were critical because you said hormones had been denied to a particular inmate and it was brought to your attention that you would only look at the recommendation section of that note. Do you remember that testimony?
A. I would have to -- there was so many people that were denied hormones, I would have to go look at the transcript.
Q. In any of your professional positions, are you part of a committee that discusses patient care?

A. In regards to any -- I mean, there is -- I mean, there is a committee that discusses care for -- I also take care of cystic fibrosis. There is a committee that discusses the care of cystic fibrosis, yes.

Q. Okay. And are those multidisciplinary committees?

A. Yes. There's some -- there are primarily like 80 percent physicians and there's maybe one nurse and then maybe -- and then a respiratory technologist, but mostly physicians that are qualified to take care of cystic fibrosis.

Q. Does that committee that you're referring to put out minutes of their meetings?

A. I don't know the answer to that. I would have to go double check.

Q. Have you ever had the opportunity to take minutes and be the person who is responsible for distributing minutes of various committee meetings?

A. When I was a secretary/treasurer at WPATH, not this one, I took minutes.

Q. And were the minutes that -- did you distribute those minutes to the various committee

members at some point after the meeting?

A. When I was the secretary/treasurer at WPATH?

Q. Yeah.

A. Yeah. Obviously, when you took the minutes, you would have to distribute them, right?

Q. You would think. Were the minutes that you took and distributed, were they a verbatim transcript of everything that was said at the meeting?

A. They obviously be verbatim. I mean, it's going to be paraphrasing and saying the key points of what the discussion was during the committee meeting.

Q. Okay. Fair enough. I think I asked you this earlier, so at the risk of an asked and answered objection, are there any records or documents that you have asked to see in this case that you have not received?

MS. BAILEY: Objection, asked and answered, but you can answer.

A. I thought I answered this already.

Q. And again, Doctor, I prefaced my question by saying that, but I would like to ask

it again.

MS. BAILEY: You can answer again.

A. I think the same answer from before. I would have to go look back. I asked for many of the big picture pertinent things, and there was probably -- it was a while ago. I'd have to go look back if there was something that I didn't get.

Q. Okay.. sure. I understand. Doctor, are you aware of who Rob Jeffries is?

A. Rob Jeffries? Off the top of my head, I don't recall that. I mean, I don't recall the name.

Q. Okay. The same question, are you aware of who Melvin Hinton is?

A. Now, I'm remembering. These are the people in the case. These are the people that you represent, yes. I know these names.

Q. Okay. Who is Rob Jeffries?

A. Am employee, part of the -- do you mind if I take a break and let me look at my notes real quick here?

Q. That's fine. Do you want to take five minutes?

A. Yeah. That would be great.

Q. We'll take a five-minute break.

A. Thank you.

(Recess taken).

Q. Earlier, Doctor, I asked you, can you -- if you knew who Rob Jeffries was.

A. I do remember now. I believe he's listed on the court hearing. You represent them.

Q. Correct. But are you aware of what role he plays? Who he is?

A. He's with IDOC. He's one of the top -- I don't know what his exact position is.

Q. Okay. To the best of your knowledge, is he a participant in the transgender care review committee?

A. No. To the best of my knowledge, he's not.

Q. Are you aware of who Melvin Hinton is?

A. He is -- he works with IDOC. He's the medical director --

Q. Are you aware of who Steve Meeks is?

A. It's the other way around. Steve Meeks is the medical director. Hinton is the mental health director, and they both work for -- they work at this committee.

Page 89

Q. Okay. And are you aware of whether or not Dr. Meeks is still part of the committee?
A. I would have to look at the records. I don't know exactly.
Q. Fair enough. Fair enough. So did you review records where the name of the committee was the Gender Identity Committee?
A. In the past, I did, yes.
Q. Okay. And based on your previous testimony, you think that that's not an appropriate title for the committee?
A. Can you say the name of the committee again? I missed it.
Q. Gender Identity Disorder Committee.
A. Okay. No. Using current terminology, gender identity disorder, it should be gender dysphoria committee. That would probably be a more modern term.
Q. Okay. The committee now is known as the Transgender Care Review Committee. Do you consider that to be an appropriate title or terminology?
A. Transgender Care Review Committee? I don't see -- in terms of the title, I think that's fine.

Page 90

Q. Okay. Okay. And subject to any additional records or documents that you might review, does your testimony at the preliminary injunction hearing and your reports and your testimony today express all of your opinions in this case?
A. Yes. All of the declarations I've submitted plus the supplemental reports reflect what I -- my expert testimony in this case, yes, that's correct.
MS. TOLBERT: Okay. Amelia, that's all I have right now. Do you have any cross?
MS. BAILEY: Could we just take like two minutes, Carla, and I'll let you know?
MS. TOLBERT: Yeah.
MS. BAILEY: Just a two-minute break. I'll be right back.
(Recess taken.)
CROSS-EXAMINATION BY MS. BAILEY:
Q. So Vin, I just have one or two questions for you. Earlier today Carla was asking you about Spironolactone; do you remember that?
A. Yes.
Q. And you testified that there are some side effects with Spironolactone, right?
A. That's correct.
Q. If hormone levels are monitored properly, are the side effects of Spironolactone manageable?
A. No, because it's independent. It's another agent, and there should be another set of labs to be monitored, not just the hormone levels.
Q. And what are those additional labs that are need to be monitored in order to manage any potential side effects of Spironolactone?
A. So as I mentioned, that you have to measure the potassium because it can raise potassium and the kidney function because Spironolactone is a diuretic.
Q. And if those additional things are monitored, are the potential side effects of Spironolactone manageable?
A. Yes. I mean, if they're monitored properly then you don't have risks stemming from those side effects. The high potassium can be life threatening because very high potassium can cause your heart to go into arrhythmias and obviously your kidney has to be monitored because

Page 91

Page 92

if you get dehydrated your kidney could go into failure.
Q. And there are side effects with almost all medications, correct?
A. Yes. There's no perfect medication. There's always something that you have to talk about.
MS. BAILEY: That's all I have, Carla.
MS. TOLBERT: I have nothing, just read or waive?
MS. BAILEY: We're going to read. We're not going to waive.
(The deposition was concluded at 11:12 a.m.)

Page 93

CERTIFICATE OF REPORTER

I, ERIKIA SCHUSTER, a Certified Shorthand Reporter (IL), Missouri Notary No. 09561566, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me, that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under by direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

____

Certified Court Reporter

Page 94

ALARIS LITIGATION SERVICES

October 19, 2020

MS. AMELIA H. BAILEY
Kirland & Ellis, LLP
300 North LaSalle
Chicago, IL 60654

IN RE: JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION SORA KUYKENDALL and SASHA REED v. JOHN BALDWIN, MELVIN HINTON, and STEVE MEEKS

Dear Ms. Bailey,

Please find enclosed your copies of the deposition of DR. VIN TANGPRICHA taken on October 5, 2020 in the above-referenced case. Also enclosed is the original signature page and errata sheets.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheets and notarized signature page within 30 days to our office at 711 N 11th Street, St. Louis, MO 63101 for filing.

Sincerely,

Erikia Schuster

Page 95

ERRATA SHEET

Witness Name: DR. VIN TANGPRICHA

Case Name: JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION SORA KUYKENDALL and SASHA REED v. JOHN BALDWIN, MELVIN HINTON, and STEVE MEEKS

Date Taken: OCTOBER 5, 2020

Page #_____ Line #_____
Should read: ________________________
Reason for change: ____________________

Page #_____ Line #_____
Should read: ________________________
Reason for change: ____________________

Page #_____ Line #_____
Should read: ________________________
Reason for change: ____________________

Page #_____ Line #_____
Should read: ________________________
Reason for change: ____________________

Page #_____ Line #_____
Should read: ________________________
Reason for change: ____________________

Witness Signature: ____________________

Page 96

STATE OF ________________)

COUNTY OF _______________)

I, DR. VIN TANGPRICHA, do hereby certify:

That I have read the foregoing deposition;

That I have made such changes in form and/or substance to the within deposition as might be necessary to render the same true and correct;

That having made such changes thereon, I hereby subscribe my name to the deposition.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this ______ day of _________________, 20____, at ____________________________.

____

DR. VIN TANGPRICHA

____

NOTARY PUBLIC

My Commission Expires:

98391

WGLT.org (/) 89.1FM

Donate (https://hatch.illinoisstate.edu/project/20877)

Listen Live · WGLT
1A

LOADING...

Spring Fund Drive: Contribute Now (https://hatch.illinoisstate.edu/project/20877)

Central Illinois Transgender Community Benefiting from Closer Hormone Therapy Access

By TIM SHELLEY (/PEOPLE/TIM-SHELLEY) • SEP 30, 2019

Share (http://facebook.com/sharer.php?u=http%3A%2F%2Ftinyurl.com%2Fy23fl22o&t=Central%20Illinois%20Transgender%20Community%20Benefiting%20from%20Clo

(https://mediad.publicbroadcasting.net/p/shared/npr/styles/x_large/nprshared/201910/766015165.jpg)

Originally published on October 1, 2019 8:54 am

It's often a battle for transgender people to get access to healthcare services. That's especially true in Central Illinois, where gender-affirming hormone therapy only recently became available.

Dana Garber is the transgender intake coordinator for Planned Parenthood of Illinois in Peoria and Pekin. She began her own hormone therapy in Chicago, the nearest place that offered it at the time. But that option wasn't available to everyone.

In 2016, the Peoria Transgender Society reached out to various healthcare and mental health providers in the region to try to bring the services closer to home.

"We had a health forum, and we invited all these people to it. We had some mental health providers show up. The only medical provider that showed up was Planned Parenthood," said Garber.

Part of the struggle is finding someone willing and able to provide gender-affirming hormone therapy.

"Endocrinologists might work with people who have endocrine disorders and things like that, but not so much with transgender people. So, it's finding someone who's interested in helping our community. That's the difficult part."

Planned Parenthood has provided treatment for 1,200 patients since 2016. Garber says about two-thirds of them are downstate.

Listen

Copyright 2019 WCBU. To see more, visit WCBU (http://www.peoriapublicradio.org).

Share (http://facebook.com/sharer.php?u=http%3A%2F%2Ftinyurl.com%2Fy23fl22o&t=Central%20Illinois%20Transgender%20Community%20Benefiting%20from%20Clo

(https://www.facebook.com/WGLTFM)

(https://twitter.com/WGLTnews)

(http://www.npr.org)

(http://www.illinoisstate.edu/)

(http://www.prx.org)

(http://www.cpb.org)

(http://www.arts.illinois.gov/)

(https://www.bnadvantage.com/)

Contact WGLT (http://wglt.org/contact-glt)

EEO & FCC Public File Information (https://www.wglt.org/transparency-and-public-files#stream/0)

Contribute (http://wglt.org/contribute)

Privacy Statement (http://wglt.org/privacy-statement)

© 2020 WGLT

Exhibit 16

Almost 1 in 10 transgender Americans use nonprescribed hormones because they're uninsured or insurance won't cover the cost

By Scottie Andrew and Giulia Heyward,

Updated 3:44 PM ET, Tue November 17, 2020

Around 75,000 transgender people who use gender-affirming hormones are using hormones their doctor didn't prescribe them, according to a new study.

(CNN) — For the transgender people who seek it, gender-affirming hormone therapy can be lifesaving. But if they're uninsured or their insurance won't cover it, some bypass the health care system entirely to get the care they need.

Around 75,000 transgender Americans are likely using hormones that weren't prescribed -- close to 1 in 10 of the estimated 1.4 million transgender adults in the US -- says a study published this month in the Annals of Family Medicine.

Beyond the health risks of using nonprescription hormones, the findings indicate extensive barriers to care transgender Americans face, lead author Dr. Daphna Stroumsa told CNN.

"Trans people face a multitude of cultural and structural hurdles in staying safe and healthy," said Stroumsa, a clinical lecturer in the University of Michigan's Department of Obstetrics and Gynecology who specializes in LGBTQ health care. "We need to streamline care. We don't need to put barriers between patients and providers."

Lack of insurance and denied claims lead people to seek unprescribed hormones

Using data from the US Transgender Survey, a sample of almost 28,000 trans Americans from the National Center for Transgender Equality, the study focused on two groups: Uninsured trans people and trans people whose insurance company denied their claims for gender-affirming hormones. Both groups were more likely to seek out nonprescription hormones than insured transgender people, according to the study.

Trans Americans are more likely to be uninsured than the general population -- about 15.5% of respondents in the US Transgender Survey compared to 12.8% of US adults. And among uninsured respondents, around 21% said their insurance claims for gender-affirming care had been denied, according to the study.

About 84% of respondents to the US Transgender Survey said they were taking hormones, more than 9% of them said they were using nonprescribed hormones.

Related Article: This year, at least six states are trying to restrict transgender kids from getting gender reassignment treatments

On one hand, the fact that some trans people circumvent the healthcare system to access gender-affirming care shows their "resilience," Stroumsa said. But from a physician's perspective, that's a sign of failure, they said.

"This indicates that we have a problem in getting trans people lifesaving medication," they said.

Hormone therapy can be expensive out of pocket -- often around $30 a month, according to a 2013 CNN piece, though that amount can vary. It can also be dangerous when not regulated by a physician, Stroumsa said. Some hormone therapies can increase risk of heart problems or stroke. And without a doctor to monitor the dosage and components of the hormones they're receiving, trans patients may experience unforeseen health issues.

Insurance is one of several hurdles to health care

Mounting evidence shows that accessing gender-affirming health care can be lifesaving for trans people who seek it. UCLA's Williams Institute, a think tank that focuses on LGBTQ legal issues, reported that a lack of gender-affirming care likely contributed to high percentages of suicidal thoughts among transgender Americans.

And though it's illegal for most insurance companies to discriminate against trans Americans, 30 states permit health insurance plans to exclude some trans health services, NPR reported in 2019.

Stroumsa said insurance companies that cover such procedures often ask patients to provide proof that procedures or treatments are necessary. For example, a trans man's insurers may require him to provide two signed letters from mental health care providers when he seeks a gender-affirming hysterectomy, they said.

Insurance is just one hurdle trans people face in getting care. There's the discrimination they often face from physicians and health care providers who refuse them care or misstate their gender, and higher rates of homelessness and joblessness -- all likely reasons why some trans people bypass the health care system altogether.

Related Article: At least 22 transgender people have been killed this year. But numbers don't tell the full story

"Health care systems and physicians and health care providers have so often failed trans people, either with direct

discrimination or ignorance of trans people's health care needs," Stroumsa said. "We need to fix that."

One of the ways physicians can start to mend those gaps, they said, is by including trans people in the agenda-setting process and taking their needs into account when setting insurance policies. Some major medical associations, including the American Academy of Family Physicians, have announced their support for insurance coverage of gender-affirming care. More voices in support of gender-affirming health care coverage could remove at least one obstacle.

CNN health

LIVE TV

Search CNN...

US

World

Politics

Business

Opinion

Health

Entertainment

Tech

Style

Travel

Sports

Videos

Coupons

More

Weather

CNN health

FOLLOW CNN

Case 3:18-cv-00156-NJR Document 238-17 Filed 12/02/20 Pa Exhibit 17 6

Insurance Coverage and Use of Hormones Among Transgender Respondents to a National Survey

Daphna Stroumsa, MD, MPH[1,2]
Halley P. Crissman, MD, MPH[1]
Vanessa K. Dalton, MD, MPH[1-3]
Giselle Kolenic, MA[1]
Caroline R. Richardson, MD[2,4]

[1]Department of Obstetrics and Gynecology, University of Michigan, Ann Arbor, Michigan

[2]Institute for Healthcare Policy & Innovation, University of Michigan, Ann Arbor, Michigan

[3]Program on Women's Healthcare Effectiveness Research (PWHER), University of Michigan, Ann Arbor, Michigan

[4]Department of Family Medicine, University of Michigan Medical School, Ann Arbor, Michigan

Conflicts of interest: authors report none.

CORRESPONDING AUTHOR

Daphna Stroumsa, MD, MPH
Department of Obstetrics and Gynecology
University of Michigan
L4000 Women's Hospital
1500 E Medical Center Dr
Ann Arbor, MI 48109-5276
daphnast@med.umich.edu

ABSTRACT

PURPOSE We undertook a study to assess the associations between barriers to insurance coverage for gender-affirming hormones (either lack of insurance or claim denial) and patterns of hormone use among transgender adults.

METHODS We used data from the US Transgender Survey, a large national sample of 27,715 transgender adults, collected from August to September 2015. We calculated weighted proportions and performed multivariate logistic regression analyses.

RESULTS Of 12,037 transgender adults using hormones, 992 (9.17%) were using nonprescription hormones. Among insured respondents, 2,528 (20.81%) reported that their claims were denied. Use of nonprescription hormones was more common among respondents who were uninsured (odds ratio = 2.64; 95% CI, 1.88-3.71; P <.001) or whose claims were denied (odds ratio = 2.53; 95% CI, 1.61-3.97; P <.001). Uninsured respondents were also less likely to be using hormones (odds ratio = 0.37; 95% CI, 0.24-0.56; P <.001).

CONCLUSIONS Lack of insurance coverage for gender-affirming hormones is associated with lower overall odds of hormone use and higher odds of use of nonprescription hormones; such barriers may thus be linked to unmonitored and unsafe medication use, and increase the risks for adverse health outcomes. Ensuring access to hormones can decrease the economic burden transgender people face, and is an important part of harm-reduction strategies.

Ann Fam Med 2020;18:528-534. https://doi.org/10.1370/afm.2586.

INTRODUCTION

Over the last decade, transgender and nonbinary people have gained visibility, and considerable strides have been made toward addressing their health care disparities and needs.[1-5] Primary care physicians play an important role in the care of this population.[6,7] In addition to their routine health care needs, many transgender people seek gender-affirming or transition-related care. This care may include hormones, surgical procedures, or both. Clear guidelines support the provision of gender-affirming hormones for transgender people who seek them,[8-11] and their provision is associated with improved mental health outcomes.[12,13] Many of the major medical societies and associations in the United States, including the American Academy of Family Physicians,[14] have issued statements in support of insurance coverage for gender-affirming care.

Despite this clear need, transgender people face a host of structural barriers to accessing care, ranging from high rates of homelessness attributable to rejection and discrimination, through lack of knowledgeable and affirming clinicians,[15-17] to transphobia[18] and direct discrimination in health care settings.[19] In addition, many transgender people in the United States face barriers to insurance coverage for gender-affirming care.[8] Transgender people often face employment discrimination leading to uninsurance.[19] Those who are insured often encounter insurance policies with specific exclusions or barriers for coverage of gender-affirming therapy.[4,20-22] The Patient Protection and Affordable Care Act increased coverage specifically

for transgender people by prohibiting exclusions based on preexisting conditions[23] and through the nondiscrimination clause in section 1557; however, these and other regulatory and legislative changes are in constant flux, vary by state and insurance carrier, and have not eliminated the gaps in insurance coverage for gender-affirming care. The barriers to insurance coverage combine with the other structural barriers to care to limit access to gender-affirming hormones.

These limitations may have broad implications for the health of transgender people. In the face of such barriers, 2 alternatives to the use of prescribed hormones exist. People who need hormones for gender affirmation may forgo the hormones, along with the opportunity for affirmation and improvement in their mental health and well-being. Alternatively, if unable to fill a prescription through regulated pathways, transgender people may opt to acquire their medications through other sources; this practice may expose the hormone user to a variety of risks, including toxicity from unregulated substances, incorrect use of medication, and loss of opportunity for medication monitoring and risk mitigation.

We undertook a study to assess the relationship between insurance coverage and patterns of hormone use among transgender individuals in the United States.

METHODS

Our study was approved by the institutional review board at the University of Michigan, which granted an exemption of informed consent. We used deidentified data from the US Transgender Survey, a large nonprobability sample of 27,715 transgender adults in the United States, collected online from August to September 2015.[19] Respondents were aged 18 years or older, self-identified as transgender, and were recruited through a variety of venues to capture transgender respondents. Respondents were disproportionally young, White, highly educated and low income compared with the general US population. We applied survey weights based on age, race, and education from the Census Bureau's 2014 American Community Survey to help correct for this sampling bias, resulting in weights reflective of the US general population rather than the US transgender population. There is evidence to suggest that White respondents are likely overrepresented compared with the US transgender population under this weighting procedure, but bias based on age, educational attainment, or income is unclear. James et al[19] provide a full description of the data collection methodology and further detail. Weighted proportions were obtained and assessments were made with weighted multivariable logistic regression analyses. We performed analyses using Stata version 15 (StataCorp LLC, Stata Statistical Software, Release 15).

Our primary outcome was use of hormones obtained from a source other than a licensed professional. The 129 respondents on active duty in military service were excluded from this question because their potential sources of care, as well as barriers to care, were unique. Another 758 respondents who identified as crossdressers were excluded from our analyses given substantial differences between this group and all other gender groups, as well as concern for inaccurate conflation. A total of 12,037 participants who were taking hormones were asked: "Where do you currently get your hormones?" Respondents who answered either "In addition to licensed professionals, I also get hormones from friends, online, or other nonlicensed sources" or "I *only* get hormones from friends, online, or other nonlicensed sources" were coded as using nonprescription hormones. As our outcome of interest was the use of any hormones from an unlicensed source, we combined these responses for analyses.

Our secondary outcome was defined as rate of hormone use—people who answered yes to the question, "Are you currently taking hormones for your gender identity or gender transition?"—among those who indicated that they had prior interest in taking hormones.

We identified 2 key predictors for this study: lack of insurance and insurance denial of hormone coverage. All participants were asked, "Are you currently covered by any health insurance or health coverage plan?" Respondents were coded as uninsured if they responded no. Those who reported that they were currently insured were asked whether they had been denied any, or specific, services by their insurance company over the last year. Respondents who marked yes to the statement, "My health insurance company denied me hormone therapy for transition" were coded as having coverage for hormones denied.

A number of demographic characteristics were available for use as controls in the multivariate models. Age was coded as a continuous variable. Education was categorized based on the US Census Bureau for the American Community Survey (less than high school; high school graduate, including general equivalency diploma; some college; and bachelor's degree or higher). Race/ethnicity categories were similar to those used by the US Census Bureau, with the addition of coding Middle Eastern/North African respondents as separate from White.[14] Respondents were categorized as living at or near the poverty level if they had a personal income (or family income, for those sharing a household with family members) up to 124% of the federal poverty level for 2015. The survey used a 2-step approach to arrive at a measure

of gender identity by asking about gender identity and sex assigned at birth. We used 5 gender categories: trans man; trans woman; people assigned male at birth who identified as genderqueer or nonbinary; people assigned female at birth who identified as genderqueer or nonbinary; and crossdresser. Analysis was additionally performed by sex assigned at birth given prior evidence for differences by this variable.[14]

RESULTS

A total of 27,715 people responded to the survey, of whom 26,957 identified as a gender other than crossdresser. Table 1 shows summary statistics for respondent demographics, as well as hormone use and insurance coverage. All reported values are weighted. A total of 21,237 respondents (83.43%) were interested in using hormones and 12,037 respondents (55.04%) were using hormones; 992 (9.17%) of the hormone users were using nonprescription hormones.

Overall, 3,362 (15.51%) of respondents were uninsured, compared with 12.8% of US adults at the time of the survey.[24] Among insured respondents, 2,528 (20.81%) reported that their claims were denied. The proportion of respondents indicating that they had interest in using hormones for gender affirmation did not vary by insurance status (81.27% vs 83.83%; odds ratio [OR] = 1.19; 95% CI, 0.92-1.54; $P = .19$), but those who had insurance were more likely to be using hormones than those who lacked insurance (57.4% vs 41.5%; OR = 2.32; 95% CI, 1.57-3.45; $P < .001$).

When respondents were asked to evaluate the most pressing issues affecting transgender people in the United States, they deemed insurance coverage as one of the most important (selected by 44.11% of respondents). It ranked second only to violence against transgender people.

We conducted 4 weighted multivariate logistic regression analyses to assess the relationships between our 2 key predictors and 2 outcomes. Table 2 shows the associations between insurance status and use of nonprescription hormones and overall use of hormones. Table 3 shows the associations between insurance claim denial and use of nonprescription hormones and overall use of hormones.

Respondents who were uninsured were more likely to use nonprescription hormones than those who were insured (adjusted odds ratio [aOR] = 2.64; 95% CI, 1.88-3.71; $P < .001$). The odds of using nonprescription hormones were highest among respondents assigned male at birth (trans women and genderqueer or nonbinary individuals assigned male at birth combined compared with trans men, aOR = 3.95; 95% CI, 2.86-5.46; $P < .001$) and differed by race. Use of nonprescription hormones decreased with age (aOR = 0.986; 95% CI, 0.975-0.996; $P = .008$), but was not meaningfully associated with educational level or income. Among all who indicated prior interest in taking hormones, those who were uninsured were less likely to use hormones in general compared with insured counterparts (aOR = 0.37; 95% CI, 0.24-0.56; $P < .001$).

Among insured respondents, those who reported that their insurance denied coverage of gender-affirming hormones in the past year were more likely to use nonprescription hormones than peers whose insurance covered their hormones (aOR = 2.53; 95% CI, 1.61-3.97; $P < .001$). The odds of using hormones in general among insured respondents interested in hormone use did not differ substantively between those who reported that their insurance denied coverage of gender-affirming hormones and those who had not been denied coverage (aOR = 0.89; 95% CI, 0.57-1.39; $P = .60$).

Table 1. Characteristics of Respondents to the 2015 US Transgender Survey (N = 26,957)

Characteristic	Weighted Value
Age, mean (95% CI), y	42.1 (41.5-42.8)
Gender identity, No. (%)	
Trans woman	9,238 (56.09)
Trans man	7,950 (23.38)
Assigned female at birth, genderqueer/ nonbinary	7,844 (14.03)
Assigned male at birth, genderqueer/ nonbinary	1,925 (6.51)
Race, No. (%)	
White	21,980 (64.24)
Latinx/Hispanic	1,451 (15.17)
Black/African American	782 (14.80)
Asian/Native Hawaiian/Pacific Islander	767 (3.36)
Alaska Native/American Indian	314 (0.96)
Biracial/multiracial/not listed	1,533 (2.22)
Middle Eastern/North African	130 (0.23)
Education, No. (%)	
Less than high school	892 (13.85)
High school	3,384 (27.55)
Some college	12,544 (31.32)
Bachelor's degree or higher	10,137 (27.27)
At or near poverty level, No. (%)	8,563 (29.78)
Ever interested in hormones, No. (%)	21,237 (83.43)
Currently using hormones,[a] No. (%)	12,037 (55.04)
Uninsured, No. (%)	3,362 (15.51)
Insurance denied hormone claim,[b] No. (%)	2,528 (20.81)
Using nonprescription hormones,[c] No. (%)	992 (9.17)

Notes: Because of missing values, not all categories add up to 100%.

[a] Of respondents who were not in active military service. This group was excluded here because of their particular pathways and barriers to accessing hormone.
[b] Of insured respondents who requested coverage.
[c] Of respondents taking hormones.

Table 2. Association Between Insurance Status and Gender-Affirming Hormone Use Among Respondents to the 2015 US Transgender Survey

	Use of Nonprescription Hormones, Among Those Using Hormones[a] (n = 12,037)		Use of Hormones, Among Those Interested (n = 21,237)	
Characteristic	**aOR (95% CI)**	***P* Value**	**aOR (95% CI)**	***P* Value**
Uninsured (compared with insured)	2.64 (1.88-3.71)	<.001	0.37 (0.24-0.56)	<.001
Age (for each additional year)	0.986 (0.975-0.996)	.008	0.969 (0.96-0.98)	<.001
Gender identity (compared with trans man)				
Trans woman	3.71 (2.30-5.00)	<.001	0.56 (0.40-0.77)	<.001
Assigned female at birth, genderqueer/nonbinary	2.41 (1.25-4.65)	.009	0.16 (0.10-0.23)	<.001
Assigned male at birth, genderqueer/nonbinary	6.02 (2.82-12.82)	<.001	0.19 (0.10-0.39)	<.001
Race (compared with White)				
Alaska Native/American Indian	0.49 (0.22-1.09)	.08	0.93 (0.35-2.44)	.88
Asian/Native Hawaiian/Pacific Islander	2.72 (0.94-7.89)	.06	1.30 (0.65-2.62)	.45
Biracial/multiracial/not listed	3.28 (1.92-5.61)	<.001	1.23 (0.76-1.98)	.39
Black/African American	0.92 (0.55-1.56)	.77	0.75 (0.40-1.38)	.35
Latinx/Hispanic	1.07 (0.60-1.89)	.82	1.01 (0.51-1.97)	.98
Middle Eastern/North African	3.68 (0.66-20.45)	.14	2.06 (0.50-8.39)	.31
Education (compared with less than high school)				
High school	1.38 (0.62-3.08)	.43	0.47 (0.19-1.17)	.10
Some college	1.32 (0.63-2.78)	.46	0.56 (0.24-1.27)	.16
Bachelor's degree or higher	1.13 (0.51-2.50)	.76	0.50 (0.22-1.15)	.10
At or near poverty level	0.80 (0.57-1.13)	.20	0.76 (0.51-1.14)	.19

aOR = adjusted odds ratio.

Note: Data analyzed using weighted multivariable logistic regression. For all analyses, crossdressers were excluded from the overall sample because of their unique characteristics.

[a] Analysis excluded respondents currently in active military service, given their unique pathways to accessing gender-affirming hormones.

Both of our outcomes were associated with gender, age, and, in some of the models, race (Tables 2 and 3). Overall use of hormones was highest among trans men and lowest among respondents assigned female at birth who identified as genderqueer or nonbinary. Respondents assigned male at birth were more likely to be using nonprescription hormones. The odds of using hormones in general—and nonprescription hormones in particular—decreased with increasing age.

DISCUSSION

This study addresses gaps in our understanding of patterns of nonprescription hormone use, as well as the relationship between insurance barriers and hormone source. Overall, we found a high rate of nonprescription hormone use—9.17% of current hormone users, translating to approximately 75,000 people based on 2014 estimates of the US transgender population.[25] Although we have no data regarding the reasons for use of nonprescription hormones, this practice enables people to bypass the clinician, thus avoiding any potential discrimination, maltreatment, or exposure, as well as the cost associated with obtaining and filling the prescription.

In this study, we found a correlation between lack of insurance coverage and use of nonprescription hormones. Additionally, we found that uninsured transgender respondents were less likely to use hormones in general.

There was substantial variation in patterns of hormone use by gender and age. Trans men were more likely to be using hormones compared with trans women, regardless of insurance status. Genderqueer or nonbinary people were least likely to be taking hormones. Trans men were less likely than all other gender categories to be taking nonprescription hormones. Older age was correlated with a decrease in overall hormone use, as well as use of nonprescription hormones; cultural shifts, along with increasing health concerns, may be at play in explaining this trend. Both the age and gender differences in hormone use patterns have clinical implications for prescription and harm-reduction strategies and underscore the importance of dedicated research attention to the needs of the various subgroups in the broader transgender population.

Table 3. Association Between Insurance Claim Denial and Gender-Affirming Hormone Use Among Insured Respondents to the 2015 US Transgender Survey

	Use of Nonprescription Hormones, Among Those Using Hormones[a] (n = 10,841)		Use of Hormones, Among Those Interested (n = 18,516)	
Characteristic	**aOR (95% CI)**	***P* Value**	**aOR (95% CI)**	***P* Value**
Claim for hormones denied by insurance	2.53 (1.61-3.97)	<.001	0.89 (0.57-1.39)	.60
Age (for each additional year)	0.98 (0.96-0.99)	<.001	0.97 (0.95-0.99)	.02
Gender identity (compared with trans man)				
Trans woman	5.42 (3.56-8.25)	<.001	0.54 (0.34-0.86)	.009
Assigned female at birth, genderqueer/nonbinary	1.54 (0.83-2.86)	.17	0.13 (0.07-0.23)	<.001
Assigned male at birth, genderqueer/nonbinary	8.90 (3.22-24.62)	<.001	0.80 (0.25-2.30)	.70
Race (compared with White)				
Alaska Native/American Indian	0.55 (0.19-1.55)	.26	0.53 (0.15-1.80)	.30
Asian/Native Hawaiian/Pacific Islander	4.04 (0.95-17.29)	.06	1.05 (0.44-2.46)	.92
Biracial/multiracial/not listed	3.22 (1.76-5.90)	<.001	0.84 (0.42-1.69)	.62
Black/African American	1.33 (0.70-2.54)	.39	1.17 (0.60-2.27)	.65
Latinx/Hispanic	1.31 (0.63-2.73)	.47	1.05 (0.46-2.41)	.90
Middle Eastern/North African	6.49 (1.07-39.28)	.04	…	…
Education (compared with less than high school)				
High school	1.24 (0.37-4.11)	.72	0.34 (0.11-1.11)	.07
Some college	1.09 (0.35-3.37)	.87	0.56 (0.19-1.63)	.29
Bachelor's degree or higher	0.94 (0.28-3.20)	.92	0.40 (0.13-1.19)	.10
At or near poverty	0.72 (0.30-1.21)	.22	0.79 (0.50-1.25)	.32

aOR = adjusted odds ratio.

Note: Data analyzed using weighted multivariable logistic regression. For all analyses, crossdressers were excluded from the overall sample because of their unique characteristics.

[a] Analysis excluded respondents currently in active military service, given their unique pathways to accessing gender-affirming hormones.

Respondents from some, but not all, non-White racial/ethnic groups were more likely to use nonprescription hormones. Our study may have been underpowered to detect differences between distinct groups compared with White respondents. The positive findings could be explained, however, by historical and ongoing racism and bias, and decreased trust in the health care system, that along with reduced access to health care professionals, compound other barriers to care and encourage alternative resourcing of gender-affirming hormones.

Lack of access to insurance coverage for gender-affirming hormones has implications that extend beyond economic burdens and barriers to medical transitioning. Hormones accessed from an unlicensed source may be unmonitored for content and quality, and may differ in formulation and dose from those recommended. For example, transgender women who use estrogens prescribed to cisgender women may be at increased risk for thromboembolic complications when using ethinyl estradiol[26] instead of the recommended 17β-estradiol.[10] Additionally, use of nonprescription hormones likely entails decreased monitoring of hormone levels and less opportunity for mitigating risks or other forms of harm reduction, preventive care, and health improvement.[27]

Despite these risks, use of nonprescription hormones might also be interpreted as an expression of resilience and strength among transgender people. Faced with barriers to accessing needed care, some transgender people circumvent the barriers by finding alternative resources for acquiring their medications (which have been shown to improve mental health outcomes).[8,9] Future qualitative research may shed light on the reasoning and mechanisms by which transgender people navigate accessing hormones. In understanding these processes, health care clinicians can develop mechanisms for harm reduction, including institutional-level programs to ensure access to medications. Primary care physicians are ideally positioned to spearhead such efforts. As they address the practice- and clinician-level barriers to caring for transgender people, clinicians also need to be aware of the substantial cost barrier for patients without insurance or those who might have their claims denied. Insurers and policy makers should aim to eliminate these coverage gaps

by restructuring reimbursement for gender-affirming hormones and revising exclusionary policies. Beyond the low cost[28] and considerable potential benefit of gender-affirming hormone coverage, there are strong ethical arguments to ensuring access to these medically necessary interventions, including the principles of beneficence, nonmaleficence, and justice.[29]

Our study has a number of limitations. As this is a cross-sectional study, causality cannot be inferred. The survey was a nonprobability sample and is unlikely to be completely representative of the US transgender population. Although we used survey weights to reduce sampling bias, the weighting procedure is more reflective of the US general population than the US transgender population, where those identifying as transgender are more likely to be younger and people of color. Respondents may have underreported use of nonprescription hormones because of desirability bias. Additionally, differences between types of insurance and insurance policies between states were not assessed, thereby limiting our analyses. Another limitation was the questions as posed in the survey; we do not have further detail regarding such questions as the mechanism for claim denial and we cannot quantify the proportion of medication each respondent had obtained from an unlicensed source. We also lack information regarding the specifics of insurance plans; examining out-of-pocket costs may shed further light on interactions between costs and medication use patterns, especially with the rise of high-deductible plans; however, even with access to only more general categories, we believe our findings shed light on important patterns of hormone use in this population. More research is needed to identify and evaluate interventions that reduce the risks posed by these workarounds.

The findings of this study relate to ongoing policy debates, including the debates regarding the fate of the Patient Protection and Affordable Care Act and regulatory protections of gender identity or expression. In the meantime, it is clear that greater, not lesser, protections of transgender people and their access to care are needed.

To read or post commentaries in response to this article, see it online at https://www.AnnFamMed.org/content/18/6/528.

Submitted November 20, 2019; submitted, revised, April 14, 2020; accepted May 11, 2020.

Key words: transgender; insurance; LGBT; gender-affirming hormones; risk reduction; vulnerable populations; health services

Acknowledgments: Survey data for the study were provided by the National Center for Transgender Equality.

Prior presentation: Some of these findings have previously been presented as posters at the American College of Obstetrics and Gynecology Annual Meeting, Nashville, TN, May 3-6, 2019, and the AcademyHealth Annual Research Meeting, Washington, DC, June 2-4, 2019.

References

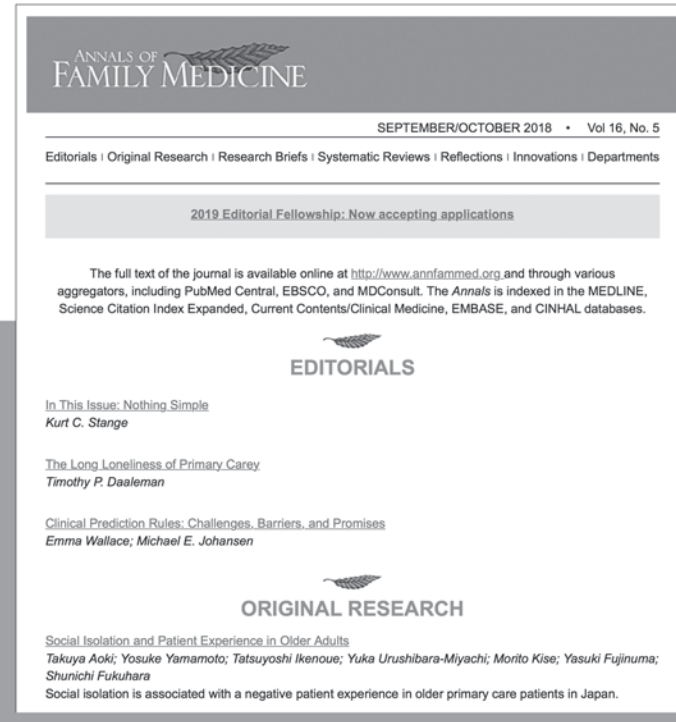
1. Stall R, Matthews DD, Friedman MR, et al. The continuing development of health disparities research on lesbian, gay, bisexual, and transgender individuals. *Am J Public Health*. 2016;106(5):787-789.
2. Wanta JW, Unger CA. Review of the transgender literature: where do we go from here? *Transgend Health*. 2017;2(1):119-128.
3. Human Rights Campaign. HRC Releases Healthcare Equality Index, Honors Record 626 Health Care Facilities for LGBTQ Inclusion. https://www.hrc.org/press/hrc-releases-healthcare-equality-index-honors-record-626-health-care-facili/. Accessed Dec 27, 2018.
4. Committee on Health Care for Underserved Women. Committee Opinion No. 512: health care for transgender individuals. *Obstet Gynecol*. 2011;118(6):1454-1458.
5. Committee on Adolescent Health Care. Committee Opinion No. 685: care for transgender adolescents. *Obstet Gynecol*. 2017;129(1):e11-e16.
6. Unger CA. Care of the transgender patient: the role of the gynecologist. *Am J Obstet Gynecol*. 2014;210(1):16-26.
7. Stroumsa D, Wu JP. Welcoming transgender and nonbinary patients: expanding the language of "women's health." *Am J Obstet Gynecol*. 2018;219(6):585.e1-585.e5.
8. Stroumsa D. The state of transgender health care: policy, law, and medical frameworks. *Am J Public Health*. 2014;104(3):e31-e38.
9. American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. *Am Psychol*. 2015;70(9):832-864.
10. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.
11. World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people. Version 7. https://www.wpath.org/publications/soc. Accessed Dec 26, 2018.
12. Cai X, Hughto JMW, Reisner SL, Pachankis JE, Levy BR. Benefit of gender-affirming medical treatment for transgender elders: later-life alignment of mind and body. *LGBT Health*. 2019;6(1):34-39.
13. White Hughto JM, Reisner SL. A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. *Transgend Health*. 2016;1(1):21-31.
14. American Academy of Family Physicians. Resolution No. 1004. Transgender care. https://www.aafp.org/dam/AAFP/documents/about_us/special_constituencies/2012RCAR_Advocacy.pdf. Accessed Mar 17, 2020.
15. Jaffee KD, Shires DA, Stroumsa D. Discrimination and delayed health care among transgender women and men: implications for improving medical education and health care delivery. *Med Care*. 2016;54(11):1010-1016.
16. Shires DA, Stroumsa D, Jaffee KD, Woodford MR. Primary care clinicians' willingness to care for transgender patients. *Ann Fam Med*. 2018;16(6):555-558.
17. Stroumsa D, Roberts EFS, Kinnear H, Harris LH. The power and limits of classification – a 32-year-old man with abdominal pain. *N Engl J Med*. 2019;380(20):1885-1888.
18. Stroumsa D, Shires DA, Richardson CR, Jaffee KD, Woodford MR. Transphobia rather than education predicts provider knowledge of transgender health care. *Med Educ*. 2019;53(4):398-407.
19. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: The National Center for Transgender Equality; 2016.
20. Learmonth C, Viloria R, Lambert C, Goldhammer H, Keuroghlian AS. Barriers to insurance coverage for transgender patients. *Am J Obstet Gynecol*. 2018;219(3):272.e1-272.e4.

21. Cavanaugh T, Hopwood R, Lambert C. Informed consent in the medical care of transgender and gender-nonconforming patients. *AMA J Ethics*. 2016;18(11):1147-1155.
22. Murphy TF. Should mental health screening and psychotherapy be required prior to body modification for gender expression? *AMA J Ethics*. 2016;18(11):1079-1085.
23. Baker KE. The future of transgender coverage. *N Engl J Med*. 2017; 376(19):1801-1804.
24. Cohen RA, Martinez ME, Zammitti EP. Health insurance coverage: early release of estimates from the National Health Interview Survey, 2015. National Center for Health Statistics. https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf. Accessed Oct 25, 2020.
25. Flores AR, Herman JL, Gates GJ, Brown TNT. *How Many Adults Identify as Transgender in the United States? Los* Angeles, CA: The Williams Institute; 2016.
26. Vinogradova Y, Coupland C, Hippisley-Cox J. Use of hormone replacement therapy and risk of venous thromboembolism: nested case-control studies using the QResearch and CPRD databases. *BMJ*. 2019;364:k4810.
27. Mepham N, Bouman WP, Arcelus J, Hayter M, Wylie KR. People with gender dysphoria who self-prescribe cross-sex hormones: prevalence, sources, and side effects knowledge. *J Sex Med*. 2014; 11(12):2995-3001.
28. Padula WV, Heru S, Campbell JD. Societal Implications of health insurance coverage for medically necessary services in the U.S. transgender population: a cost-effectiveness analysis. *J Gen Intern Med*. 2016;31(4):394-401.
29. Kuzon WM Jr, Sluiter E, Gast KM. Exclusion of medically necessary gender-affirming surgery for America's armed services veterans. *AMA J Ethics*. 2018;20(4):403-413.

Get the *Annals of Family Medicine* by E-mail

Make sure you see every new issue while it's fresh; have the table of contents sent to you by e-mail for easy access to articles of interest.

Don't miss important research. Request the e-mail table of contents at https://www.annfammed.org/


ANNALS OF FAMILY MEDICINE

SEPTEMBER/OCTOBER 2018 • Vol 16, No. 5

Editorials | Original Research | Research Briefs | Systematic Reviews | Reflections | Innovations | Departments

2019 Editorial Fellowship: Now accepting applications

The full text of the journal is available online at http://www.annfammed.org and through various aggregators, including PubMed Central, EBSCO, and MDConsult. The *Annals* is indexed in the MEDLINE, Science Citation Index Expanded, Current Contents/Clinical Medicine, EMBASE, and CINHAL databases.

EDITORIALS

In This Issue: Nothing Simple
Kurt C. Stange

The Long Loneliness of Primary Carey
Timothy P. Daaleman

Clinical Prediction Rules: Challenges, Barriers, and Promises
Emma Wallace; Michael E. Johansen

ORIGINAL RESEARCH

Social Isolation and Patient Experience in Older Adults
Takuya Aoki; Yosuke Yamamoto; Tatsuyoshi Ikenoue; Yuka Urushibara-Miyachi; Morito Kise; Yasuki Fujinuma; Shunichi Fukuhara
Social isolation is associated with a negative patient experience in older primary care patients in Japan.

Exhibit 18

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF ILLINOIS
EAST ST. LOUIS DIVISION

JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL, and SASHA REED,

Plaintiffs,

vs.) NO. 18-156-NJR

JOHN BALDWIN, MELVIN HINTON, and STEVE MEEKS,

Defendants.

DISCOVERY DEPOSITION OF DR. RANDI ETTNER

TUESDAY, OCTOBER 13, 2020
9:00 A.M.

Via Webex

INDEX

(No exhibits marked.)

APPEARANCES:

FOR THE PLAINTIFFS:
MS. CAROLYN M. WALD
ACLU of Illinois
150 North Michigan Avenue, Suite 600
Chicago, Illinois 60601
cwald@aclu-il.org

FOR THE DEFENDANTS:
MS. LISA COOK
Assistant Attorney General
500 South Second Street
Springfield, Illinois 62701
lcook@atg.state.il.us

ALSO PRESENT:
Joyce D. Lawrence, CSR, CCR, RPR
CSR# 84-1716 CCR# 1329
Alaris Litigation Service
15 South Old State Capitol Plaza
Springfield, Illinois 62701

IT IS HEREBY STIPULATED AND AGREED by and between Counsel for the Plaintiffs and Counsel for the Defendants that this deposition may be taken in shorthand by JOYCE D. LAWRENCE, an Illinois Certified Shorthand Reporter, and afterwards transcribed into typewriting, and the signature of the Witness is RESERVED.

****

(Deposition commenced at 9:02 a.m.)

DR. RANDI ETTNER,

called as a witness, being first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. COOK

Q. Okay. And Dr. Ettner, since this is remote, I know you've done depositions before, but if you have any problems hearing me, please let me know. And if you at any point need to take a break, just let me know. I'll ask that you finish whatever we're talking about at the time and then we can take a break whenever you need one, okay?

A. Thank you.

Q. And did you review any documents to

prepare for your deposition today?
A. Yes.
Q. And what were those?
A. I reviewed the declarations that I wrote, the mental health and medical records of the named and unnamed class members. I reviewed the deposition of Dr. Conway, the 30(b)(6) deposition, and I reviewed the supplemental deposition of Janiah Monroe.
Q. Okay. And about how long -- just to prepare for today, how much time did you spend reviewing all of those documents?
A. I reviewed those documents for approximately two hours.
Q. Okay. And so the most recent declaration that you did was in August of this year; is that correct?
A. Yes.
Q. And about how much time did you spend writing that declaration?
A. I would say about four hours.
Q. Okay. And a lot of my questions today are going to center around your most recent declaration. Do you have that with you somewhere?
A. I have it on my computer.

Q. Okay. Okay. You've already testified for this lawsuit once last year. I'm going to try not to overlap too much with that. There may be some questions that overlap with it, but I'm not going to go through all of that again, okay. So a lot of your qualifications, your expertise, that was discussed at length in your hearing testimony. I'm not going to ask you a lot about that again, okay?
A. That's okay with me.
Q. Okay. So I did want to ask you, and something that wasn't quite clear to me is, as far as your professional background, you have a PhD; is that correct?
A. Yes.
Q. Do you have a separate license of any sort?
A. Yes.
Q. What is that?
A. It's a license to practice psychology in the state.
Q. In the state of Illinois?
A. Correct.
Q. Do you have a license in any other state?
A. No.

Q. And do you still keep up with your licensing requirements?
A. Yes.
Q. Do you have any medical training?
A. By medical training, do you mean medical schooling?
Q. Yes. Like -- because you're not a -- you're not a -- are you a psychologist or a psychiatrist?
A. I'm a clinical psychologist and a forensic psychologist.
Q. And for that, you do not go to medical school; is that correct?
A. Yes.
Q. Do you have the ability to prescribe medications?
A. No.
Q. And there are some times -- instances in your declaration where you referred to medical needs or medically -- there is one time you note something was not medically sound. And so what do you mean when you say that?
A. Are you referring to the area of gender dysphoria?
Q. Well, I think it -- this specific

instance I'm referring to is on paragraph 141 of your declaration. Maybe it would help to look at that and I can pull it up on the screen, if that helps, too.
Okay. Are you able to see my screen?
A. Yes.
Q. Okay. Sorry about that. I need to pull that back up. And I'm sorry if this makes you dizzy. I will try to go as quickly as I can.
Okay. So -- okay. So on 141, the committee's reasons for denial of treatment vary; but, in all cases I reviewed, their reasons were not recognized under the SOC for denying or delaying treatment and were not medically sound.
And so I just want to know, when you use the term medical there, do you mean like MD medical or are you referring to mental health under the medical umbrella?
A. I'm referring to the medical treatment that the standards of care describe as the standard for patients who have gender dysphoria.
Q. Okay. And in the standards of care -- I can stop sharing that now.
In the standards of care, where medical treatment or medical interventions are discussed,

those aren't based on your expertise; is that correct?

MS. WALD: Objection. Form.

WITNESS: Could you rephrase the question, please?

MS. COOK: Of course.

BY MS. COOK:

Q. So who in the standards of care puts forth recommendations for medical treatment, things of that nature, whether something is medically sound? Who within the organization makes those recommendations?

A. The authors of the standards of care, of which I am one.

Q. And so do you make recommendations in the standards of care for medical care?

A. Gender dysphoria is a medical condition. So all recommendations are for medical care.

Q. So for, like, medical interventions, are those something that a psychologist would normally make recommendations for?

A. I'm sorry. Would you repeat that question, please?

Q. For medical interventions, like things that require a doctor's prescription or a referral,

are those normally the types of things that a psychologist would make a recommendation for?

MS. WALD: Objection. Form.

WITNESS: Are you asking in regards to gender dysphoria or in general?

BY MS. COOK:

Q. Well, I'll start in general.

A. Well, in general, if a psychologist sees a patient who -- he has, for example, a major depressive disorder, they would make a referral to a physician for medication.

Q. With gender dysphoria, is there much separation of -- between mental health treatment and medical intervention?

MS. WALD: Objection. Form.

WITNESS: I'm afraid I don't understand the question. Could you rephrase that?

MS. COOK: Sure.

BY MS. COOK:

Q. I'm just trying to understand. So for treatment of gender dysphoria, when you refer to medical needs, medical necessity, do you -- can you distinguish between what a medical intervention is and a mental health intervention, or are they kind of mixed together?

MS. WALD: Object to form.

WITNESS: The standards of care list the treatments for gender dysphoria, all of which are considered medical, including psychotherapy and social world transition.

BY MS. COOK:

Q. Okay. And so when you discuss whether something was medically sound in your declaration, some of that could be based on -- is it mostly just based on what the standards of care say?

A. It would be a departure from the standards of care and from the best practice for the treatment of gender dysphoria.

Q. Do you currently see patients?

A. Yes.

Q. And so do you have, like, a practice or do you see them through a clinic?

A. Currently, I see them through video or telephone.

Q. I see. I see. Things have moved remotely?

A. Yes.

Q. I see. And about how many patients do you have on your caseload right now?

A. That varies considerably. I have some

patients I see weekly, some I see biweekly and a few who are having emergencies, where I'll see them, actually, several times a week.

Q. Okay. And do you have a general figure of how many people you might talk to in a week?

A. It varies. I can tell you how many people I talked to last week, for instance.

Q. Oh, okay.

A. Last week, I talked to 13 patients.

Q. And then what does -- aside from seeing patients, what does a normal week look like for you right now?

A. Right now?

Q. Yeah.

A. Well, I continue to have several leadership positions in WPATH where I participate in board meetings. I'm still the secretary of the organization, so I participate in executive committee meetings, the steering committee, where we are planning our first virtual conference, and the awards committee. I also do research and I consult with surgeons at Weiss Hospital and the gender team there, and I also do some forensic work, such as this.

Q. And what kind -- is there a gender clinic

at Weiss Hospital?
A. Yes.
Q. And so what kind of consulting do you do with that team?
A. I do presentations for the team. I consult with the surgeon frequently about individual cases. I can evaluate people who are considering surgery at that facility. Often, I've seen people post-operatively at the facility. Prior to COVID, I might make rounds on people who have had surgery. I'm on the medical staff there.
Q. And so if somebody is considering surgery, do you write one of the recommendation letters, if you feel it's appropriate?
A. Are you asking specifically in the case of Weiss Memorial Hospital?
Q. Yes. I guess, what do you mean when you say you evaluate people for surgery?
A. Well, throughout my career, I have met with individuals who require surgery and will select surgeons who are performing the surgery throughout the world and I have often, in fact, many times, probably hundreds of times, done assessments and written referral letters for those people.
Q. And about how much of your time is doing

forensic work, like for this case?
A. Are you asking specifically for this case or in general? I'm sorry. I'm not clear about that.
Q. Oh, no, you should always ask for clarification.
I was actually asking in general, like an average. I'm sure some weeks are different than others.
A. Well, I would say that, in the past two to three years, with the new administration, that work has amplified.
Q. And so what -- as far as that work, how much time, you know, would you spend in an average week doing that forensic work?
A. In some weeks, no time at all. In other weeks, perhaps five to seven hours.
Q. And I think when you testified last year, you mentioned that you had maybe assessed 40 prisoners at that time. Do you think that it has changed since then?
MS. WALD: Objection. Form.
WITNESS: It's possible that it has, that I may have assessed additional patients since then. I can't say for certain.

BY MS. COOK:
Q. And so is most of the forensic work you do for litigation purposes?
A. Well, by definition, it would be for some aspect of legal work. It might be just consulting or providing an opinion, but it might not necessarily involve litigation.
Q. In the ones that do involve litigation of some sort, is most of your work in civil cases or criminal cases?
A. Both.
Q. In the criminal cases you're retained in, what percentage would you say you're retained for the criminal defendant?
A. I would say less than 10 percent. 8 percent, possibly.
Q. In the civil cases that you are retained in, what percentage would you say you're retained by a civil plaintiff?
A. I would say that I'm retained by the attorneys and not by the plaintiffs.
Q. That's fair. So in those civil cases, how many are you retained by the plaintiffs' attorneys?
A. Perhaps 70 percent.

Q. And so for civil cases, would the other 30 percent -- how many civil cases have you been retained by defense counsel? What is the percentage of that?
A. I'm a bit confused by the question. Could you rephrase that?
Q. Yes.
A. Are you talking specifically about in the area of transgender litigation or in general?
Q. Just in general.
A. Oh.
Q. Yeah. For civil cases that you're retained in, what percentage are you retained by defense counsel?
A. 20 to 25 percent, I'm estimating.
Q. And have you been retained before by a court as a neutral expert or a court's expert?
A. I've been a court-appointed expert, yes.
Q. How many times has that happened?
A. Once, to my knowledge.
Q. Where was that?
A. By where, do you mean what state or what case?
Q. Which state?

A. Massachusetts.
Q. How many times have you been retained in a civil lawsuit in the state of Illinois?
A. Over my entire career?
Q. Yeah. If you can remember.
A. I can't remember precisely. Are you asking in regards to in general whether I'm representing the defense or the plaintiffs?
Q. Yes. Just in general, if you have a number.
A. Dozens.
Q. In Illinois?
A. (Shakes head).
Q. Yes?
A. Dozens.
Q. I want to just ask you some other questions about WPATH. You mentioned you're still the secretary of WPATH. How long does your term last?
A. It ends next month.
Q. Okay. And then will you be taking on a new title?
A. No.
Q. Okay. You know, I know people on boards often just get a little burnt out, even if they keep

going through all of the titles. I don't know if you feel that same way and I'm not going to ask you about that, but I'm sure that you deserve a little time off.
So you've been working with WPATH for quite some time, correct?
A. Since the '90s.
Q. And you know, what -- can you just -- without, you know, going through the preamble of WPATH, just explain in your words what the organization does?
A. Does in terms of their mission or does in terms of the actual activities they carry out? Could you specify?
Q. Sure. The activities that it conducts.
A. They hold biannual meetings, symposiums. They promulgate the standards of care, which are now translated into, I believe, 18 different languages. They collaborate with organizations, such as the World Health Organization, and other bodies, such as the Endocrine Society. They maintain a list of providers that -- so that consumers can seek professional help in their area. They publish a journal, the International Journal of Transgender Health, which disseminates the recent and most

up-to-date research in the field. They provide a certification program through the Global Education Initiative. They have regional chapters throughout the world that meet and also have their own country's cultural considerations involved in their own conferences. We work with organizations, such as Starbucks, to provide information about the medical necessity for employees to have insurance to cover certain procedures. We, basically, are a group consisting now of 2,500 professionals, mental health, endocrinology, primary care, surgical, Weiss and communication experts, people who all work in this field and collaborate because gender dysphoria requires a multidisciplinary approach.
I'm sure I've only listed some of the activities that we do.
Q. I understand. And you mentioned the Global Education Initiative. You know, how does that work?
A. We formed this in 2014 in response to requests from providers throughout the world for training for professionals who either worked or wanted to work into this -- in this area. I am one of the original members and I actually created the curriculum for foundations in mental health.

Initially, we traveled throughout the country and actually to various parts of the world. In January of 2020, we brought training to Vietnam and presented to the physicians and mental health providers in Hanoi -- Hanoi Vietnam. The Global Health Initiative -- the Global Education Initiative, rather, is a path that can ultimately lead to certification. There are about nine steps in order for a WPATH member to be certified by the organization as having matriculated through this entire curriculum.
Q. Okay. So it's -- it's, you know -- might be a -- is it different than a conference or is the Global Education Initiative presented as part of the conference?
A. It is different than a conference.
Q. I understand.
Are most medical or mental health providers given much training for gender dysphoria in -- in their coursework, like through schooling?
A. I'm sorry. Would you repeat that?
Q. Through schooling, are most mental health and medical providers given training for gender dysphoria?
A. No.

MS. WALD: Objection. Form.
BY MS. COOK:
Q. And so, it's really up to the people who have an interest in it to seek out training, mentorship, you know, extra steps to learn about gender dysphoria and its treatment. Would that be fair to say?
MS. WALD: Objection. Form.
WITNESS: I would say it is similar to any other medical specialty. Advanced training, experience, mentorship are indeed required.
BY MS. COOK:
Q. And so even if somebody receives training through the Global Education Initiative, what other steps would they need for certification after the training?
A. What do you mean when you say training, because there are, perhaps, nine steps to the WPATH process of certifying individuals?
Q. Okay. And so you mentioned that Global Education Initiative could be part of the path that leads to certification. Would that be, you know -- where would that be within the nine steps?
A. All nine steps are part of the Global Education Initiative. The first step is the

foundation's training, which is typically eight hours. But then there are eight other components of the training.
Q. What are the eight other components?
A. They are four hours of an advanced course -- coursework. I'm sorry. I misspoke. There are eight hours of an advanced coursework, four hours of additional workshops, ten hours of outside approved WPATH workshops, two years of membership, five years of some community experience or work, evidence of knowledge or expertise in the field, such as publication in a peer review journal, 20 approved WPATH CE -- continuing education courses every two years, and two years of membership at the time that an individual sits to take the certification exam.
Q. Okay. And so is membership just like any organization, do you have to pay a fee for membership to WPATH?
A. Yes.
Q. And then the trainings that are WPATH approved, are those also run by WPATH?
A. The trainings that are WPATH approved in order to proceed along this pathway to certification, is that the question?

Q. Yes. Yes. The WPATH approved courses, are they through the organization or, like, an outside provider?
A. They would be courses provided by organizations that collaborate with WPATH. For instance, World Association of Sexology might be one. SSSS, a society for the scientific study of sexology, might offer courses. Those are examples of organizations that might offer coursework, but they may be in areas that are more related to policy or some other area that impacts the well-being of people who have nonconforming gender identities, but they would be approved by WPATH to count towards this certification.
Q. Okay. And so just so I'm clear, so there's the certification that you can go through all of these steps. There is also a way to grandfather in for some people; is that correct?
A. Yes.
Q. Okay. And then aside from this process, either grandfathering in or this certification, is there any other way to get this specialization for transgender care?
A. I would say that depends on the discipline you're talking about. For surgeons and

endocrinologists and primary care physicians, the trajectory might be different.
Q. I see. So they may have separate specializations or certifications that they need in their disciplines?
A. And they may have -- they may need separate licensing that I'm not aware of or board certification, but they also attend live and cadaver courses, which are held and sponsored through WPATH in connection with hospitals, such as Mt. Sinai in New York and Weiss Hospital in Chicago.
Q. Okay. But as far as the certification that WPATH offers, we've already discussed that process, correct?
A. That process, yes, which typically applies to people who want to take the entire coursework, culminating with the examination.
Q. How often is the examination held?
A. I don't know.
Q. Is it, like -- it's fair if you don't know this. But is it like, you know, a bar exam or something where you have to sit for two days in a hotel conference room?
A. No.
Q. Okay.

A. No.
Q. Now, a lot of -- so the certification also involves some sort of community work, usually with someone else who has the expertise for gender dysphoria; is that correct?
A. Well, community work could involve -- doesn't necessarily have to involve mentorship. It could just be documentation that someone has participated in community events and has an understanding of the various expressions of gender identity. Might involve participating or being -- attending gender -- an informed consent clinic, for instance, or some other outreach. Some knowledge of the actual events that occur within the population that we serve.
Q. In your work with WPATH, have you noticed a difference in the availability of competent providers in metropolitan versus rural areas?
A. I'm sorry. Would you repeat that?
Q. Yes. So in your work with WPATH, have you noticed a difference in the -- in the competence of the providers for gender dysphoria in metropolitan versus rural areas?
A. No.
Q. Are there, from what you've seen,

providers who have this specialty for gender dysphoria in more of the rural areas of -- of the areas that you've seen?
A. Could you rephrase that, please?
Q. Sure. So Chicago is a -- is a huge city. There are a number of clinics and treatment providers available in Chicago for gender dysphoria, correct?
A. Yes.
Q. Do you know about downstate Illinois, whether they have access to that, you know, in Springfield, where I am?
A. I don't think I understand the question, but I could say that I've noticed there are more available providers in metropolitan areas. But in terms of competency, I would have to determine that on an individual basis. We have very competent surgeons in Vietnam in a very rural part of Hanoi.
Q. Okay. So do you know anything about, you know, access to hormones in central and southern Illinois for people suffering from gender dysphoria?
A. When you ask if I know anything, I'm not sure I can answer that question. I may know something.

Q. Okay. Fair enough.
Well -- so last year, I saw an article out of Peoria discussing how people downstate -- so Peoria, Springfield areas really didn't have access to treatment providers who are willing to prescribe hormones for their gender dysphoria. You know, and it's my understanding that most people have to go to Chicago in this area to see a treatment provider for their gender dysphoria. Is that something that you hear much through your work through WPATH?
A. Aside from my work through WPATH, I would say that, ten years ago, there were far fewer providers in the United States and people would come from states as far away as Kentucky or farther for competent care. Part of the reason that the Gender Education Initiative was started was that we literally traveled to these areas and trained people. So we went to rural areas in Missouri, someplace in Canada -- I can't remember where exactly -- very remote areas to expand the competencies of the people that were either starting to learn about the field or wanted more in-depth information. And now that that information is being presented online, and will -- some of it will continue to be presented online, the hope is that

people will be trained and will be competent. We've gone to Brazil and areas where people had little or no access to qualified professionals.
Q. And, you know, through the Global Education Initiative, do you expect that, you know, all of the people who you begin the process with will complete the training and take the test for certification or is it just to get the foundational information to the people?
MS. WALD: Objection. Form.
WITNESS: Well, I would characterize the foundation's class or the foundation's content as an introduction to the field. Many of the people who take that are already people who have been practicing for many, many years, but just want that additional information by people who are trained to provide it. And they may not necessarily need or want certification. But the foundation is an overview of this really multifaceted condition and what I believe is the most misunderstood area of human behavior.
Q. When you say misunderstood area of human behavior, do you mean gender dysphoria?
A. All of gender nonconformity.
Q. Okay. Okay. So I want to move on to

your WPATH work on the Committee for Incarcerated Persons. What is that committee?

A. When you say what is that committee, do you mean what is it -- who does it consist of, what is its mission? I'm not sure what the question is.

Q. Sure. It was a very broad question. I kind of want to know, just generally, a little bit about it.

So how many people sit on it? You know, what is its purpose? How often does it meet? What does it do? So I'll break all of that down.

So how many people are on the Committee for Incarcerated Persons?

A. I'm not certain at this time how many people are on the committee. We are in the process of writing the Standards of Care 8, the newest iteration. So we have suspended many of our committees so that people can focus their energy on the standards of care and all of the really major work that's involved in producing the document.

I can tell you who is on the Institutionalized Persons Standard of Care Committee in terms of writing the Standards of Care 8, if you are asking that.

Q. Okay. Yeah, who is on that?

A. And that consists, I believe, of five WPATH members.

Q. How long has the Standards of Care No. 8 been in the works?

A. Can you define in the works?

Q. Sure. You know -- and I can't remember if this is one of the things where you started working on the next one immediately after you put out No. 7, but how long has it been in its, you know, all-hands-on-deck drafting?

A. By drafting, do you mean actually writing?

Q. Yes.

A. There -- the writing has not yet taken place.

Q. Okay. And then -- so how long ago were the committees suspended to focus on Standards of Care No. 8?

A. I'm guessing two years ago.

Q. And so for the members currently working on the standards of care related to incarcerated persons, how many of those people have, to your knowledge, worked in a prison?

A. All. Worked in a prison or in some capacity regarding prisons? Not all were employed by prisons.

Q. Okay. Well, I guess, how many have, like, actually worked, you know, day-to-day inside an institution walls, a prison wall?

MS. WALD: Objection. Form.

WITNESS: I don't know that they've worked day-to-day in a correctional facility. I know one spends quite a bit of time in a correctional facility. But day-by-day, I can't answer that question for someone else.

BY MS. COOK:

Q. And that's fair. But they all have had some interaction with incarcerated persons?

A. Yes.

Q. And so -- and are you one of those five, or are you talking about five people in addition to you?

A. I'm the co-chair.

Q. So you are counted as one of the five people?

A. Yes.

Q. Is there any additional training provided for individuals who work with incarcerated individuals who have gender dysphoria?

A. By any additional training, do you mean by WPATH or in general?

Q. By WPATH.

A. WPATH has at some of their GEI meetings held special sessions for individuals who work in the corrections system.

Q. And so the Illinois Department of Corrections contracted with WPATH for a GEI training. Is that the kind of specialized training, special sessions you're talking about, or are they done in a different way?

A. Well, I can't speak to what the Illinois Department of Corrections training is.

Q. The special sessions that are offered for people who work in correctional institutions, do you know how those are offered?

A. They were offered, I think, on two or three occasions. I did two of the presentations myself and they were offered because the people who had signed up for the GEI workshop, the particular training in that particular location, had asked for a focus on incarcerated individuals and there were enough of them present to offer a breakout session.

Q. Okay. And so the section in the WPATH

standards of care relating to incarcerated persons doesn't really -- there's no difference in the treatment for institutionalized persons and -- and those on the outside contained in the standards of care; is this accurate?

A. I think the wording is that the treatment should mirror that which is available in the community.

Q. And it doesn't -- it doesn't have any exceptions for security or anything like that; is that correct?

A. No, that is not correct.

Q. Okay. So what -- what exceptions are in the standards of care related to security?

A. There is a provision in there that, at certain times, accommodations may be required.

Q. Accommodations for security reasons?

A. I don't have that section in front of me.

Q. Okay. Is it in the standards related to incarcerated persons?

A. Yes.

Q. Okay. Give me one second.

Okay. I'm going to just share this with you so we can look at it together. If you're having

a problem reading it, please let me know; I can make it bigger, I think.

A. I can't read it. It's too small.

Q. Okay. I'm trying to make it bigger. Let me see if I move it over if that will help.

A. I can get my own copy of the standards of care, if you like.

Q. Okay. I just want to know -- I mean, this is not a memory test and I'm sure it's a large book. And so I was looking at page 67.

MS. WALD: What page did you say?

MS. COOK: 67.

MS. WALD: Okay.

WITNESS: It says reasonable accommodations to the institutional environment, on page 68, can be made in the delivery of care consistent with the standards of care, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria.

BY MS. COOK:

Q. Okay. And so I just want to know, how does that -- how should that be interpreted where, you know, you're talking about social transition, but there are concerns about moving the -- an inmate

to a facility consistent with their gender identity?

MS. WALD: Objection. Form.

WITNESS: Well, to answer that question, I would have to have more information about the individual and what the concerns are.

BY MS. COOK:

Q. Okay. Okay. So it wouldn't necessarily -- because I think that this could be read to say, you know, yes, security concerns may be taken into account. However, that should not conflict with, you know, care, which could include social transition. And so I didn't know if the standards of care -- you know, if there's any sort of other exceptions or information that should be taken into account under the standards of care.

MS. WALD: Objection. Form.

WITNESS: Yeah. Could you repeat that, please?

MS. COOK: Well, I'll ask it a different way. Hopefully, that will make more sense.

BY MS. COOK:

Q. So it's not clear to me in reading this, though, you know, what the standards of care -- if you're following the standards of care and you're

trying to follow it to a T, what you would do when you have to choose between denying somebody social transition and -- and security concerns. So if, let's say -- you know, a lot of the inmates with gender dysphoria want to go to a prison consistent with their gender identity, but what happens when, you know, somebody denies them based on certain criteria. Would that be inconsistent with the standards of care?

MS. WALD: Objection to form.

WITNESS: I'm sorry, but I don't understand the question and I've lost -- I think I've lost some connectivity here. I'm --

MS. WALD: Yeah. I don't know if it's my internet or what, but I've completely lost the video portion and it's struggling to connect.

MS. COOK: Okay. What would you guys think about a break and we can see if --

MS. WALD: That sounds good.

MS. COOK: Okay.

WITNESS: Sounds good.

MS. COOK: We'll take ten minutes.

WITNESS: Thank you.

(Recess taken from 10:10 a.m. to 10:21 a.m.)

BY MS. COOK:

Q. I'm going to try one more time to ask this question. Would it be inconsistent with the WPATH standards of care if housing assignments for an individual with gender dysphoria are made based on security reasons, even if it's necessary for social transition?

MS. WALD: Objection. Form.

WITNESS: I'm sorry. Could you try to rephrase that again? It's still not clear to me.

BY MS. COOK:

Q. Okay. So the standards of care do list some things, perhaps, where their institutional needs could, you know, change or be considered for gender dysphoria treatment. So you know, it mentions specifically the type of hormones that may be changed. A reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely. So it specifically mentions that.

What's not clear is when, perhaps, social transition may be denied because of a security reason. And in those instances, would that be inconsistent with the WPATH standards of care?

MS. WALD: Objection. Form.

WITNESS: I would say that denial of social role transition is placing a gender dysphoric prisoner at risk. And that if there is a question about making an accommodation that the institution cannot make, then the standards would suggest that they seek outside consultation.

BY MS. COOK:

Q. Okay. And what type of outside consultation should they seek?

A. Someone who has expertise in the assessment and treatment of gender dysphoria and in the context of a correctional setting.

Q. What -- in the free world, so in the normal outside of the institutional settings, what is, like, the normal rate of gender dysphoria?

A. By rate, do you mean incidents or prevalence or --

Q. Yeah, prevalence.

A. There have been various estimates, but I think -- of gender dysphoria or gender nonconformity? There is a difference.

Q. I'm just asking about gender dysphoria.

A. I don't think that I can answer that. I can say that there is a chapter in a book I wrote on the -- on the epidemiology that does answer that. I

would estimate 3 to 5 percent of the population.

Q. And to your knowledge -- if you don't know this, it's fine -- is the percentage higher in an institutionalized setting than out in free society?

A. I can't answer that question. I think that there is a disproportionate amount of people who are incarcerated in the United States who are gender nonconforming, but I don't know about the rest of the world.

Q. I'm sorry to go back. In the breakout sessions, the trainings that have been done focused more on institutional settings, how long would that training last?

A. Well, that wasn't a training. It was part of the -- either the advanced mental health or foundations, I don't recall which, where there were a large number of people in attendance who worked in correctional settings and wanted to network with one another and wanted to have some didactic information about that particular topic.

Q. Okay. And so is that different than in your declaration? In paragraph 6, it says: I chaired the WPATH Committee for Incarcerated Persons and provide training to medical professionals on

health care for transgender inmates. Are those different things, referring to the same breakout sessions?

A. Those are different things.

Q. Okay. What is involved in the training?

A. Well, the training is the entire coursework that we offer and I have taught many different topics in both the foundation's course and the advanced courses over the past few years.

Q. And those are specific to institutional settings?

A. No.

Q. What -- what specific training do you provide on health care for transgender inmates?

A. Do I personally or does the course? I have -- if you're asking what I have personally presented on at the GEI courses, I can answer that question, but I'm not certain that that's the question you're asking. So perhaps you can rephrase it or clarify it for me.

Q. Sure. And I'm just asking for clarification of your declaration.

A. I didn't hear that.

Q. Paragraph 6.

A. I'm looking at the declaration, so I don't know what paragraph 6 is.

Q. Okay. I'm going to share this with you. Can you see paragraph 6?

A. Yes.

Q. Okay. And I'm asking about the last sentence in paragraph 6, right at the top of page 3 here.

A. Yes.

Q. Okay. So I read that to mean -- when it says I chaired the WPATH Committee for Incarcerated Persons and provide training to medical professionals on health care for transgender inmates, I read that to mean that you personally provide the training on health care for transgender inmates.

A. I have provided some training to professionals on health care for transgender inmates. For example, I was invited to the Erasmus Medical School in Rotterdam and I presented a course on incarcerated persons and care in alignment with the Standards of Care 7.

Q. Okay. And have you provided us the same or similar training for transgender inmates in the United States?

A. As I mentioned before, yes. On two different occasions, we had sessions that dealt directly to medical and mental professionals on health care for transgender inmates. And in addition, I have done those presentations in various other places apart from the WPATH GEI training.

Q. Okay. And so those trainings are in addition to the networking sessions?

A. No. The networking sessions were part of trainings that were held during the GEI courses. Additionally, as in the example I gave, I was invited to the medical school/hospital in Rotterdam to present that information and I have presented that information in other places, as well, aside from the WPATH GEI training.

Q. When do you think the last time is that you gave one of those trainings?

A. Well, one of those trainings was given in Amsterdam in conjunction with my colleague who is the co-chair of the Institutionalized Persons Committee, the Incarcerated Person's Committee, and we also presented that at a conference in California in 2017 and at Weiss Hospital for the physicians.

Q. And are any of those trainings available publicly or are they all proprietary?

A. By publicly, do you mean are they on the -- are they on the web or something?

Q. Well, is it -- would there be a reason you couldn't share one of the trainings, the slides, or the materials?

A. Well, the ones that were done with my colleague, yes, there would be. And the ones that I've given myself are proprietary and they change depending on the audience. So they are not always the same slides.

Q. You know, are these hour-long discussions as part of a broader training or, when you do these specific ones on incarcerated persons, about how long do they last?

A. Well, Weiss Hospital has case conferences and those are an hour. I also presented that at a meeting for the -- I believe it's called the Academy of Physicians and Lawyers -- it's people who have both a law degree and a medical degree -- in Charleston, South Carolina. And that would have probably been an hour presentation.

Q. Okay. Have you heard any critiques that there is little clinical experience to support institutionalized person recommendations?

MS. WALD: Objection. Form.

WITNESS: I'm sorry. I don't understand the question.

BY MS. COOK:

Q. Sure. Have you heard of any critiques that there is little clinical experience to support WPATH's institutionalized person recommendations?

A. Critiques?

Q. Yes. Have you heard any?

A. By whom?

Q. I'm just asking if you have heard any critiques like that.

A. Well, I would say that there are certain attorneys who have critiqued that in litigation.

Q. Okay. Have you heard of any published journals with a critique like that?

A. I'm not aware of journals that critique that specifically, but I'm not certain that they don't exist.

Q. Okay. And then as far as your forensic work with prisoners, have you evaluated any prisoners in your forensic work who did not seem to be at high risk for self-harm?

A. Yes.

Q. What percentage do you think you've evaluated that were not at a serious risk of

self-harm?
A. Are you talking about at the moment that I evaluated them? Because I think that may be a time-dependent question.
Q. Okay. Yeah. I think -- I think my question is limited to when you evaluated them, when you, you know, made an opinion or created a report for the inmate.
MS. WALD: Objection. Form.
WITNESS: Yes, would you repeat that, please?
MS. COOK: Sure.
WITNESS: In its entirety.
BY MS. COOK:
Q. I can either rephrase it or we can have the court reporter read it back. Would you rather I rephrase it?
A. That's fine. That would be fine.
Q. Okay. Okay. So, you know, in this report, the declaration you did for the named plaintiffs here, you found -- you know, you found the majority of them -- all of them to be at a serious risk of self-harm in your declaration and I want to know, in your reports and opinions related to the other prisoners you've evaluated, what

percentage have you not found to be at a serious risk of self-harm?
MS. WALD: Objection. Form.
WITNESS: If you are speaking solely of self-harm, in terms of self-initiated physical harm, I would say that there are two prisoners that come to mind that, at the time I interviewed them, I could say were not at risk for self-harm.
BY MS. COOK:
Q. Okay. So two come to your mind right now. Do you think it could be more than that?
A. I don't know. I don't know the sequela of what happens to people long term after I no longer am in contact with them.
Q. Okay. I want to ask you some specific questions about the Illinois Department of Corrections. And you're aware that the department has consulted with Dr. Erica Anderson to help them with some of their mental health framework, yes?
A. Yes.
MS. WALD: Object to the form.
BY MS. COOK:
Q. And did you -- you read Dr. Anderson's deposition; is that correct?
A. Yes.

Q. Do you have any opinions as to Dr. Anderson's work for the Department of Corrections?
MS. WALD: Objection. Form.
WITNESS: Would you repeat the question? You broke up at the end. I'm sorry.
BY MS. COOK:
Q. Do you have any opinions as to Dr. Anderson's work for the Illinois Department of Corrections?
MS. WALD: Same objection.
WITNESS: I don't have an opinion.
BY MS. COOK:
Q. And the same with respect to Wendy Leach of the Moss Group? And I don't know. Did you read Ms. Leach's deposition?
A. I don't believe I did.
Q. Okay. So is it fair to say you don't have an opinion as to Ms. Leach's work?
A. I don't have an opinion.
Q. In your expert report and based on what you've seen in the materials, you know, you did discuss the two committee system that is anticipated in the Illinois Department of Corrections. What did you understand the different committees to be?
A. What I understood was that one committee

would deal with areas that they considered to be medical and one committee would deal with areas that were considered to be nonmedical or logistical.
Q. And do you agree that some of the logistical things are nonmedical?
A. I would have to know in detail what that entailed. I'm not sure that I understand the question.
Q. Okay. Well -- and I mean, one of the things that you discuss in your declaration is about hygiene items and clothing items for gender -- gender-related accommodation. Do you -- did you hear or in the materials see anything about the department's plan to just have a universal commissary list where anybody can purchase, you know, makeup, female items, or those types of things?
A. Yes.
Q. Okay. And do you have any thoughts about that change?
MS. WALD: Objection. Form.
WITNESS: I'm not sure what you mean by thoughts about change.
BY MS. COOK:
Q. Sure. Do you think that that anticipated

change to just, you know, take some of that decision-making away from the facilities and just leave it up to the individual prisoners will help with some of the gender dysphoria treatment?

A. If the question is do I believe that female accoutrements are a necessary part of the medical treatment for gender dysphoria and that individuals should have the right to that treatment, then the answer is yes. However, if the question is is that medical, the answer is yes.

Q. And so your -- as far as the logistical committee, which is going to be the administrative committee within the Illinois Department of Corrections, based on what you've said -- so if this administrative committee is going to oversee, you know, transfers of transgender inmates, do you believe that they will be making medical decisions in doing that?

A. Yes.

MS. WALD: Objection. Form.

BY MS. COOK:

Q. Okay. And it looked like one of the things that you took issue with was using aggression as a factor in deciding whether an inmate could be transferred consistent with his or her gender

identity. Why is that?

MS. WALD: Objection. Form.

WITNESS: My opinion is that it isn't clear how aggression is being determined and what specifically is meant by aggression, how transgender patients or prisoners differ in aggression from other prisoners, and the concern I have about the individual who would be making those decisions.

BY MS. COOK:

Q. Okay. So -- so part of the issue that you take with it is you are not clear on how aggression is determined. Would your opinion change regarding that if you knew it was like a, you know -- every inmate within the Department of Corrections has an aggression level that's calculated based on a series of factors applicable to everybody?

MS. WALD: Objection. Form. Calls for speculation.

WITNESS: Based on the deposition that I read of Mr. Chappell, he was making that decision and making decisions based on the height and weight and other physical characteristics of individuals and that is something I would object to.

BY MS. COOK:

Q. Okay. So it is not just the aggression level. It's the determination of the aggression level plus all of the other factors that Mr. Chappell outlined in his deposition?

MS. WALD: Objection. Form.

WITNESS: I'm -- pardon me.

MS. WALD: I objected, but you can go ahead.

WITNESS: I'm not aware of any metric that measures aggression in an individual as a trait versus state factor. So an individual may be aggressive on one occasion, but that might be an exception and may not at all be indicative of a global aggressive individual.

BY MS. COOK:

Q. Do you think there may be instances where a person's aggressiveness could be used to determine where they are housed, if they're seeking to be housed consistent with their gender identity?

A. I think that would have to be determined on an individual basis by someone who is qualified to make those assessments and determinations.

Q. Okay. And you also in your declaration discuss training, the training that's provided by IDOC. And so I -- first of all, I'll ask you some

questions about the training that you did review. And you noted that you reviewed Dr. Reister's training and then Wexford's specific training and found those to be inadequate, right?

MS. WALD: Objection. Form.

WITNESS: Training materials.

BY MS. COOK:

Q. I see, yes.

Did you -- Dr. Reister made a training with a voice-over. Did you -- did you watch that PowerPoint training with a voice speaking in it or did you just look through the PowerPoint materials?

A. I don't recall.

Q. Okay. So you don't believe that either of those trainings would be adequate to help IDOC staff with competency of care for transgender individuals?

MS. WALD: Objection. Form.

WITNESS: My opinion is not that they might not be helpful. My opinion is that they don't confer proficiency or expertise.

BY MS. COOK:

Q. Okay. And then you -- you're not aware of IDOC's Global Education Initiative training, are you?

A. I'm aware that the first part of it, four hours, has occurred online.

Q. Okay. And so is this -- it's through the Global Education Initiative, but is it WPATH approved training or is it just affiliated with WPATH in some way?

A. It's offered through WPATH by WPATH's trainers.

Q. And do you think that the four-hour training will assist providers with proficiency?

A. I think the four-hour training and the second day of the additional four-hour training is a good introduction and overview to the field.

Q. But do you consider it overall adequate training or a first step?

A. I consider it a first step.

MS. WALD: Objection. Form.

You can go ahead, Dr. Ettner.

WITNESS: I consider it a first step.

BY MS. COOK:

Q. Do you know of any other correctional systems in the United States that have brought the WPATH training into their facilities like this?

A. I know of other correctional facilities that have brought experts in, Care, who are

specialists and WPATH members of the Institutionalized Care Committee into their institutions to do training.

Q. Has the Global Education Initiative been brought into other state prison systems?

A. No.

Q. When the -- the examples that you gave that you know of providers, WPATH members, going into correctional institutions and doing trainings, are those part of WPATH or are they the providers, you know, going on their own time to do these trainings?

A. In alignment with the standards of care, the section that you referred to earlier, this aligns with the area where the correctional system did not have the in-house expertise to provide the necessary care and so they sought out individuals who were very knowledgeable about institutional care to come in and provide training.

Q. And as far as you know, are those consultants brought in just for training purposes or do they come --

MS. COOK: I think we lost Dr. Ettner.

MS. WALD: Yeah, I think we lost her.

WITNESS: Sorry. I think I blanked out

for a minute there.

MS. COOK: Yes, you did.

Do you all want to take another break or wait a bit? Is everybody doing all right?

MS. WALD: Dr. Ettner, do you need a break?

WITNESS: I don't.

MS. WALD: Lisa, what time were you thinking -- I'm not sure how much you have left or anything like that, but what are you thinking in terms of, like, a lunch break?

MS. COOK: I think that we could probably finish before lunch, but if you go and anybody gets hungry or needs a break at any time, just tell me.

MS. WALD: Okay. Thanks.

MS. COOK: Okay.

BY MS. COOK:

Q. Okay. So I think I was asking you, Doctor, if you know of instances -- you know, the examples that you were talking about. Do these consultants come in and provide training or do they provide training and then are available for questions or assistance?

A. It depends. I can provide an example, if you want.

Q. I would appreciate that.

A. So at one time, I was aware that the state of Texas was sending prisoners who needed assessments specifically for surgery to the hospital in Galveston, Texas, where Dr. Walter Meyer and his team were providing those assessments. There are other examples where people would have different roles, depending on the need of the institution.

Q. And did you see in the testimony you reviewed any references to attempts to work out a relationship with the University of Illinois Chicago Transgender Health Clinic?

A. I saw that there was mentioned that there were physicians and an endocrinologist and a urologist who work at the University of Illinois and a plastic surgeon who would potentially -- I believe it was to be considered to consult or provide some consultation or care.

Q. Okay. So you did see an illusion to it, even though nothing had been finalized; is that fair?

A. Yes.

Q. Do you think that after some of the things in the works are finalized, or the department's administrative directive is finalized,

Page 57

do you think that your opinion as to the care provided within the department will change at all?

A. I can't answer that. I would have to see details of the plan. I would have to know who was implementing it, how it was being implemented, and how the outcomes were being tracked.

Q. Okay. So do you think -- and this is -- I know this is speculative and it's fine if you can't answer. But do you think that, after, you know, some of the projects are finalized, your opinion really could not change until you saw the outcomes for the prisoners?

A. I can't make a determination of the adequacy of a plan unless I were to see the details of the plan itself and how that plan was going to be implemented and who was going to implement it. That's my opinion.

Q. Okay. Now, as far as the named plaintiffs, you know, you've outlined that you met with them all in May of 2018 and you've spoken with them all again as recently as August of 2020; is that correct?

A. Yes.

Q. Aside from the one in-person meeting, have you had any second in-person meetings with any

Page 58

of the named plaintiffs?

A. I saw three of the named plaintiffs at the hearing and I had a subsequent meeting at Logan with one of the named plaintiffs.

Q. And that was an in-person meeting?

A. Correct.

Q. Okay. And I assume that the prisoner at Logan Correctional Center who you met with was Ms. Janiah Monroe?

A. Yes.

Q. From the meeting that you had with her in May of 2018, until she was -- and then when you met with her again at the female facility, did you notice any positive changes in Ms. Monroe from that transfer?

A. Would you repeat that question, please?

Q. Sure. From -- you first met with Ms. Monroe at Dixon Correctional Center, which is a male facility. And then you met with her the second time in a female facility. During the second meeting, did you notice any positive changes in Ms. Monroe?

A. No.

Q. Did you notice negative changes?

A. Yes.

Page 59

Q. And what were those?

A. She had a deteriorated condition and an exacerbation of her gender dysphoria.

Q. When you spoke with Ms. Monroe this year, in August of 2020, had any of the negative changes you noticed been alleviated?

A. No, I believe that when I spoke with her, she had attempted suicide prior to our -- not immediately prior. But in a period prior to when I spoke to her, she had had a suicidal attempt.

Q. And that was when you spoke with her, in August of this year, she relayed that to you?

A. I also saw that in medical records.

Q. Do you have an opinion as to why her gender dysphoria has been exacerbated?

A. Yes.

Q. What is that?

A. My opinion is two-fold. First, she requires surgery, which she has not received. Secondly, she has experienced a destabilizing amount of segregation and discrimination, which she didn't anticipate when she was transferred to a female facility.

Q. And was that based on your conversation with her or her records or both?

Page 60

A. My conversation with her, what I read in the medical records, what I saw when I visited her in the prison. I've had another -- I had also another one or two conversations with her since she was transferred and what I read in her supplemental declaration.

Q. And do you read any of her disciplinary records?

A. They're alluded to in the medical records.

Q. Okay. But you don't -- you haven't seen the documentation of -- of, you know, who -- what discipline she is receiving, what time she is spending where, or the basis for the discipline? Are you seeing all of that?

MS. WALD: Objection. Form.

WITNESS: I don't know that I've seen all of that.

BY MS. COOK:

Q. And has Ms. Monroe spoken with you about her relationships with other inmates at the facility?

A. She spoke to me about that in the past.

Q. Do you think that the treatment that she has received by the other inmates is also

contributing to her gender dysphoria?

A. My opinion really is that gender dysphoria is a serious medical condition. She has a very severe degree of that condition. Segregation, regardless of the disciplinary infringements, is eroding her coping strategies and her medical need for surgery has been denied or delayed and I think she is at a very high risk for a lethal suicide attempt.

Q. Well -- so it sounds like there are two different things that you're -- that you're seeing, two different issues. And one is a medical need for surgery and then the other is related to her housing assignments. Is that -- is that true?

A. I see them both as being medically necessary. The need to socially role transition cannot occur when she's being isolated and treated unlike the other female prisoners. And as we know from the standards of care, which you referenced earlier, where care should mirror what occurs in the community, when people have a serious medical condition, a provider doesn't ask them or attempt to determine whether they've had disciplinary issues or legal problems or what their level of aggression is. We provide the necessary treatment. And I believe

that she's not receiving the necessary treatment.

WITNESS: Excuse me. Can we take a break? I need a snack.

MS. COOK: Of course. We'll take a ten-minute break.

WITNESS: Thank you.

MS. COOK: No problem.

(Recess taken from 11:14 a.m. to 11:26 a.m.)

BY MS. COOK:

Q. I was asking you about Ms. Monroe. I'm going to move on to Ms. Vision.

So in your -- in the declaration that you wrote, you noted that she had been denied transfer to a female facility. But were you aware she has actually been approved for a transfer to a female facility?

A. No.

Q. Okay. That was some time ago. However, transfers have been stopped because of COVID. But she is expected to transfer at some point in the near future. Would that change your opinion as to the care that Ms. Vision is receiving?

MS. WALD: Objection. Form.

WITNESS: I think Ms. Vision also requires additional care.

BY MS. COOK:

Q. Oh, of course.

Now, some of the prisoners seem to have issues aside from -- that contributes to gender dysphoria with bad experiences with staff and other inmates. Do you see that, those bad experiences, as something that exacerbates gender dysphoria or is separate?

MS. WALD: Objection. Form.

WITNESS: I would have to know about the individual and the incidences before I could answer that question.

BY MS. COOK:

Q. Okay. With the named plaintiffs, is that something that they discussed with you or that you saw in assessing them or their records?

A. I also saw in the unnamed plaintiffs on many occasions where people stated, and it was written in the records, they wanted to take hormones but didn't feel safe or they had been physically or sexually assaulted. But the word unsafe came up in numerous records and I think that that certainly contributes to a person's overall mental health and well-being. For the named plaintiffs who have transitioned, these circumstances, if they undermine

their medical treatment, would be very adverse.

Q. Have you interviewed any prisoners who were not named plaintiffs?

A. Yes.

Q. Prisoners in IDOC?

A. A prisoner who is no longer in IDOC.

Q. Okay. And was that one of the formerly named plaintiffs?

A. No.

Q. Okay. So they have been released since you spoke with them?

A. That's correct.

Q. Was he or she in IDOC when this -- I guess, do you know when he or she was released from IDOC?

A. Recently.

Q. Was the interview part of this case?

A. No.

Q. Did you have any different opinion of the treatment given to that prisoner than to the prisoners who you have interviewed in this case?

A. No.

Q. In your review of records and in the interviews you have done, have there been any instances where you agreed with the treatment that

Page 65

the prisoner had received?
A. With the treatment the prisoner received, are you talking about a particular prisoner or could you rephrase the question, please?
Q. Sure. In your review of -- of the records and the interviews you have done of IDOC inmates, were there any where you looked at them and thought, okay, this looks fine; I'll set this one aside?
MS. WALD: Objection. Form.
WITNESS: I saw instances where people who were receiving hormones appeared to be receiving the correct vehicle and administration of those hormones and appeared to be stable.
BY MS. COOK:
Q. Do you know -- could you estimate about how many times that you had that thought, where they appeared to be receiving -- receiving appropriate hormones and appeared to be stable?
A. I can't really estimate that.
Q. That's fair.
You know -- so your declaration as to the punitive class members -- I mean, the other unnamed class members, I mean, it's kind of general. So when you were going through those records, did you

Page 66

pull specific instances out?
A. Yes.
Q. Okay.
MS. WALD: Objection to form.
BY MS. COOK:
Q. And so did you intend to put some of those specific examples into your declaration?
MS. WALD: Objection. Form.
WITNESS: No, I -- I didn't. I think that I made general comments in my declaration that characterized the kind of instances that I pulled out.
BY MS. COOK:
Q. Well, the ones that you have pulled out, have you kept those together somewhere?
A. Yes, and made notes about those.
Q. Is there any way you could send at least some of those specifics through counsel to me so that we can have those?
A. Yes.
Q. Okay. And so you have worked with the attorneys in this action in other cases, correct?
A. I have not worked with Carolyn Wald in any other cases. I have not worked with anyone from Kirkland and Ellis in any other cases. And I have

Page 67

worked with John Knight previously.
Q. And have you worked with attorneys from the firm King and Spalding before?
A. Not that I'm aware of. I don't know.
Q. That's fair. But you have worked with other attorneys from the ACLU before in cases?
A. From the ACLU in states across the country.
Q. And how many cases have you worked with John Knight in?
A. I provided testimony in -- I think in two cases that come to mind, but there may have been another. I don't recall at the moment.
Q. It looked like, at least with the ACLU, you may have worked in more than a handful of cases. Would that be accurate?
A. In states across the country, yes.
Q. Do you give any sort of financial support to the ACLU for litigation?
A. No. But what do you mean by financial support?
Q. I mean money.
A. No.
Q. Do you donate your time to the ACLU --
A. No.

Page 68

Q. -- for these case?
After the hearing in this case last year, did you thank the attorneys for doing important work?
A. Did I?
MS. WALD: Objection. Form.
BY MS. COOK:
Q. Yes.
MS. WALD: Also, objection to the extent that it calls for privileged conversations.
But you can go ahead and answer, Dr. Ettner.
WITNESS: I don't remember. I may have.
BY MS. COOK:
Q. Yeah. And I'm not asking about privileged conversations. But in the courtroom afterwards, did you -- you don't remember thanking them for important work?
A. I don't remember.
Q. Okay. I just wanted to know what you meant.
Okay. Give me one second, please. Want to make sure I have asked you all of my questions.
Oh. So you mentioned that some of the work now you have been doing, you've been doing it

Page 69

virtually; is that correct?
A. Some of which work?
Q. Some of your clinical work you've been doing virtually?
A. All of my clinical work I now do virtually.
Q. Okay. And is that just while the COVID pandemic is still ongoing?
A. Yes.
Q. Has the COVID pandemic affected any of your other work?
A. I'm not sure. Could you rephrase the question?
Q. Sure. Well, has the COVID pandemic affected at least your individual work beyond, you know, meeting with patients remotely?
A. Yes.
Q. And in what ways?
A. Well, I'm no longer able to meet with my research partner in Europe or go to Europe to collaborate with my colleagues there. I'm no longer able to travel to interview people directly.
Q. And has it affected any of the work that you do with WPATH, the pandemic?
A. Well, it has in that we've gone to a

Page 70

completely virtual mode of communication. And so every two years, we've joined together and this year we were supposed to meet in Hong Kong for our symposium and that has now gone virtual, so I will not see my colleagues in person and have an opportunity to hear what they're doing and what their centers are doing. So it has narrowed some of my -- my contact with colleagues.
Q. Has the pandemic contributed to any disruption in the work that you do?
A. No. The work continues.
MS. COOK: Okay. Those are all the questions I had.
Ms. Wald, I didn't know if you had any follow-up or cross.
MS. WALD: I do. I'm going to have a couple follow-up questions. If we could just take a ten-minute break so I can take a peek at my notes and make sure I'm not missing anything.
MS. COOK: Okay. Sure.
MS. WALD: Great.
(Recess taken from 11:43 a.m. to 11:53 a.m.)
EXAMINATION
BY MS. WALD
Q. So I just have a couple questions.

Page 71

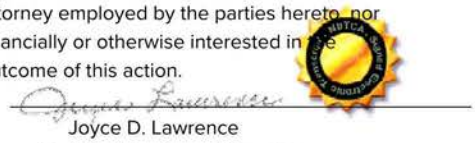
So Dr. Ettner, Ms. Cook previously asked you if you had an opinion on Dr. Anderson and her work with IDOC; is that right?
A. Yes.
Q. And you previously answered no to that question?
A. Correct.
Q. And what did you mean by that answer?
A. I don't have specific details about how Dr. Anderson would employ her expertise and I would need more information and then I could offer an opinion.
Q. And similarly, Ms. Cook asked you if you had an opinion on Dr. Leach and her work with IDOC; is that right?
A. Yes.
Q. And you previously answered no?
A. Correct.
Q. And what did you mean by that answer?
A. I don't have enough -- I don't have really information about the details of the -- of the work that they would do for the IDOC or other information I would need to form an opinion.
Q. And if you did receive additional information about that topic, you might be able to

Page 72

offer an opinion?
A. Yes.
MS. WALD: I have no further questions.
MS. COOK: I didn't have anything else.
MS. WALD: Great. Short one today.
MS. COOK: I'll take the original in whatever the cheapest format is that you have via email.
MS. WALD: Yes, we'll do an electronic copy, please, and we will reserve and review for signature.
MS. COOK: Thanks everyone.
MS. WALD: Thank you, Dr. Ettner.
WITNESS: Thank you.
(Deposition concluded at 11:56 a.m.)

CERTIFICATE OF REPORTER

I, JOYCE D. LAWRENCE, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.



Joyce D. Lawrence
Certified Shorthand Reporter
Registered Professional Reporter
State of Illinois CSR License #84-1716

My commission expires:
August 4, 2022

ALARIS LITIGATION SERVICES

October 23, 2020

MS. CAROLYN M. WALD
ACLU of Illinois
150 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

IN RE: JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL and SASHA REED v. JOHN BALDWIN, MELVIN HINTON and STEVE MEEKS

Dear Ms. Wald:

Please find enclosed your copies of the deposition of DR. RANDI ETTNER taken on October 13, 2020 in the above-referenced case. Also enclosed is the original signature page and errata sheets.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheets and notarized signature page within 30 days to our office at 711 N 11th Street, St. Louis, MO 63101 for filing.

Sincerely,

JOYCE D. LAWRENCE

Enclosures

ERRATA SHEET

Witness Name: DR. RANDI ETTNER
Case Name: JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL and SASHA REED v. JOHN BALDWIN, MELVIN HINTON and STEVE MEEKS
Date Taken: OCTOBER 13, 2020

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Witness Signature: _____

STATE OF _____)

COUNTY OF _____)

I, DR. RANDI ETTNER, do hereby certify:

That I have read the foregoing deposition;

That I have made such changes in form and/or substance to the within deposition as might be necessary to render the same true and correct;

That having made such changes thereon, I hereby subscribe my name to the deposition.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this _____ day of _____, 20___, at _____.

_____
DR. RANDI ETTNER

_____
NOTARY PUBLIC

My Commission Expires:

ERRATA

Page # 11 line # 5 should read: social **role** transition

Page # 19 line # 11 should read: Weiss should be **voice**

Page #22 line # 1 should read: **foundation** (not foundation's)

Page #22 line # 9 should read: **ten hours of mentorship** (not 2 years of membership).

Page # 28 line # 12: **foundation** (not foundation's)

Page # 51 line #14: should be **globally**

Page # 53 line # 25: the word "care" should be deleted

Page # 56 line # 14: the word "and" should be deleted

Page # 63 line # 11: should read **incidents**

CERTIFICATE OF REPORTER

I, JOYCE D. LAWRENCE, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Joyce D. Lawrence
Certified Shorthand Reporter
Registered Professional Reporter
State of Illinois CSR License #84-1716

My commission expires:
August 4, 2022

ALARIS LITIGATION SERVICES

October 23, 2020

MS. CAROLYN M. WALD
ACLU of Illinois
150 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

IN RE: JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL and SASHA REED v. JOHN BALDWIN, MELVIN HINTON and STEVE MEEKS

Dear Ms. Wald:

Please find enclosed your copies of the deposition of DR. RANDI ETTNER taken on October 13, 2020 in the above-referenced case. Also enclosed is the original signature page and errata sheets.

Please have the witness read your copy of the transcript, indicate any changes and/or corrections desired on the errata sheets, and sign the signature page before a notary public.

Please return the errata sheets and notarized signature page within 30 days to our office at 711 N 11th Street, St. Louis, MO 63101 for filing.

Sincerely,

JOYCE D. LAWRENCE

Enclosures

ERRATA SHEET

Witness Name: DR. RANDI ETTNER
Case Name: JANIAH MONROE, MARILYN MELENDEZ, EBONY STAMPS, LYDIA HELENA VISION, SORA KUYKENDALL and SASHA REED v. JOHN BALDWIN, MELVIN HINTON and STEVE MEEKS
Date Taken: OCTOBER 13, 2020

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Page #_____ Line #_____
Should read: _____
Reason for change: _____

Witness Signature: _____

STATE OF _____)

COUNTY OF _____)

I, DR. RANDI ETTNER, do hereby certify:

That I have read the foregoing deposition;

That I have made such changes in form and/or substance to the within deposition as might be necessary to render the same true and correct;

That having made such changes thereon, I hereby subscribe my name to the deposition.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 26 day of October 2020 at _____.

Dr. Randi Ettner
DR. RANDI ETTNER

_____
NOTARY PUBLIC

My Commission Expires:

Exhibit 19
Excerpts of WPATH Standards of Care, Ver. 7

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

Standards of Care

for the Health of Transsexual, Transgender, and Gender-Nonconforming People

The World Professional Association for Transgender Health

Version 7

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

Standards of Care

for the Health of Transsexual, Transgender, and Gender-Nonconforming People

Eli Coleman, Walter Bockting, Marsha Botzer, Peggy Cohen-Kettenis, Griet DeCuypere, Jamie Feldman, Lin Fraser, Jamison Green, Gail Knudson, Walter J. Meyer, Stan Monstrey, Richard K. Adler, George R. Brown, Aaron H. Devor, Randall Ehrbar, Randi Ettner, Evan Eyler, Rob Garofalo, Dan H. Karasic, Arlene Istar Lev, Gal Mayer, Heino Meyer-Bahlburg, Blaine Paxton Hall, Friedmann Pfäfflin, Katherine Rachlin, Bean Robinson, Loren S. Schechter, Vin Tangpricha, Mick van Trotsenburg, Anne Vitale, Sam Winter, Stephen Whittle, Kevan R. Wylie & Ken Zucker

© 2012 World Professional Association for Transgender Health (WPATH). All rights reserved.

7th Version[1] | www.wpath.org

ISBN: X-XXX-XXXXX-XX

1 This is the seventh version of the *Standards of Care* since the original 1979 document. Previous revisions were in 1980, 1981, 1990, 1998, and 2001. Version seven was published in the International Journal of Transgenderism, 13(4), 165–232. doi:10.1080/15532739.2011.700873

Table of Contents

Purpose and Use of the *Standards of Care*

The World Professional Association for Transgender Health (WPATH)[I] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health. The vision of WPATH is a world wherein transsexual, transgender, and gender-nonconforming people benefit from access to evidence-based health care, social services, justice, and equality.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[II] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this 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. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

I Formerly the Harry Benjamin International Gender Dysphoria Association

II The *Standards of Care (SOC), Version 7,* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender-nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The *Standards of Care* Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender-nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria—broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As in all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care—and the *SOC*—to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm-reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Global Applicability of the *Standards of Care*

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender-nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender-nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender-nonconforming people in these settings are forced to be hidden and, therefore, may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world—even in areas with limited resources and training opportunities—can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender-nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culture- and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender-Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender-nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender-nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender-nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender-nonconforming people may experience gender dysphoria at some points in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender-nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[III] and prevalence[IV] of transsexualism specifically or transgender and gender-nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender-nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria—distinct from one's gender identity—is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender-nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender-nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974),

III **incidence**—the number of new cases arising in a given period (e.g., a year)
IV **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1965 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (e.g., Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1–1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender-nonconforming individuals has come of age—many of whom have benefitted from different therapeutic approaches—they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender-nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves to be either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experiences that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that are comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatment options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological- and medical-treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- In-person and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- In-person and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents With Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the *Standards of Care* to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender-nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender-nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have coexisting mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations *(Kosilek v. Massachusetts Department of Corrections/Maloney,* C.A. No. 92–12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender-nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender-nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the *Standards of Care* to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES/ESPE Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to DSD during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term DSD in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains

Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE *STANDARDS OF CARE,* VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International*

Journal of Transgenderism (IJT). Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1–4) in 2009, making them available for discussion and debate.

After these articles were published, an *SOC* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender-nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision—both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion—and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized, it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revisions. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iterations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7,* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7,* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7,* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

Members of the *Standards of Care* Revision Committee†

Eli Coleman, PhD (USA)* - Committee chair
Richard Adler, PhD (USA)
Walter Bockting, PhD (USA)*
Marsha Botzer, MA (USA)*
George Brown, MD (USA)
Peggy Cohen-Kettenis, PhD (Netherlands)*
Griet DeCuypere, MD (Belgium)*
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Randi Ettner, PhD (USA)
Evan Eyler, MD (USA)
Jamie Feldman, MD, PhD (USA)*
Lin Fraser, EdD (USA)*
Rob Garofalo, MD, MPH (USA)
Jamison Green, PhD, MFA (USA)*
Dan Karasic, MD (USA)
Gail Knudson, MD (Canada)*
Arlene Istar Lev, LCSW-R (USA)
Gal Mayer, MD (USA)
Walter Meyer, MD (USA)*
Heino Meyer-Bahlburg, Dr. rer.nat. (USA)
Stan Monstrey, MD, PhD (Belgium)*
Blaine Paxton Hall, MHS-CL, PA-C (USA)
Friedmann Pfäfflin, MD, PhD (Germany)
Katherine Rachlin, PhD (USA)
Bean Robinson, PhD (USA)
Loren Schechter, MD (USA)
Vin Tangpricha, MD, PhD (USA)
Mick van Trotsenburg, MD (Netherlands)
Anne Vitale, PhD (USA)
Sam Winter, PhD (Hong Kong)
Stephen Whittle, OBE (UK)
Kevan Wylie, MB, MD (UK)
Ken Zucker, PhD (Canada)

---

* Writing Group member.
† All members of the *Standards of Care, Version 7 Revision Committee* donated their time to work on this revision.

International Advisory Group Selection Committee

Walter Bockting, PhD (USA)
Marsha Botzer, MA (USA)
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Evan Eyler, MD (USA)
Jamison Green, PhD, MFA (USA)
Blaine Paxton Hall, MHS-CL, PA-C (USA)

International Advisory Group

Tamara Adrian, LGBT Rights Venezuela (Venezuela)
Craig Andrews, FtM Australia (Australia)
Christine Burns, MBE, Plain Sense Ltd (UK)
Naomi Fontanos, Society for Transsexual Women's Rights in the Phillipines (Phillipines)
Tone Marie Hansen, Harry Benjamin Resource Center (Norway)
Rupert Raj, Sherbourne Health Center (Canada)
Masae Torai, FtM Japan (Japan)
Kelley Winters, GID Reform Advocates (USA)

Technical Writer

Anne Marie Weber-Main, PhD (USA)

Editorial Assistance

Heidi Fall (USA)

Exhibit 20

This website uses cookies to ensure you get the best experience on our website. Learn more
Accept

GEI

WPATH's Global Education Initiative (GEI)

WPATH offers our **Global Education Initiative (GEI) Certified Training Courses: Best Practices in Transgender Medical and Mental Health Care** first and foremost to increase access to knowledgable healthcare providers for the transgender community by training those providers globally in the context and priniciples of the WPATH Standards of Care, and their implementation into clinical practice. GEI Certified Training Courses are offered in an interdisciplinary, interactive, live format, providing ample opportunity for networking and building referral systems. These courses serve as the Core Curriculum for WPATH Members pursuing **WPATH GEI SOC7 Certification,** but are open to all healthcare professionals across all specialties, regardless of WPATH Membership Status.

GEI Core Curriculum Course Descriptions

GEI Timeline

What is WPATH Certification all about?

The WPATH Certification Program is an **optional benefit to our members** that signifies a provider is a WPATH member in good standing who has completed an additional rigorous educational curriculum specific to the most current Standards of Care. The certification indicates that the provider has a working understanding of the multidisciplinary care team and the translation of the Standards into practice. The extensive 50 -hour core competencies-based training program includes course work, mentorship and a minimum membership requirement before passing a certification exam. WPATH certification rewards

those members who are committing to stay on top of both the current evidence and consensus in the field through continuing education.

GEI Certification FAQ

The Path to Certification

The first step in starting your path to certification, is becoming a WPATH member, and completing and uploading your Letter of Intent (link below).

In order to become certified an applicant must:

1. **Be a member of WPATH** in good standing for 2 years at the time of final exam
2. Be licensed and board certified (if applicable) in your specialty or the global equivalent
3. Complete a minimum of 50 hours of credit as indicated below, in the WPATH Core Curriculum:
    - Completion of the WPATH Foundations Course (15)
    - Completion of the following WPATH Advanced Coursework:
        - Completion of WPATH Advanced Mental Health **or** WPATH Advanced Medical Course (8)
        - Completion of one of the WPATH Advanced Workshops (i.e., Child & Adolescent, Ethics, Planning & Documenting for Medical Transition). Offerings will vary (4)
    - 10 hours of accredited elective coursework outside of the WPATH Core Curriculum (this can include both WPATH GEI certified courses, and other accredited professional courses in the field), showing a mapping back to the core competencies (Caregiver – Care Receiver Relationship, Content Knowledge, Interdisciplinary Practice, and Professional Responsibility)
    - 10 hours of mentorship with a WPATH GEI SOC7 Certified Mentor*. Mentors are WPATH GEI SOC7 Certified Members, please see the MENTOR DIRECTORY below for current mentors
    - 5 additional hours listening to voices of the transgender and gender non-binary communities, examples include: attend town halls at WPATH conferences, attend community-focused sessions at WPATH conferences, attend community-led conferences/workshops, attend local community events, listen to/watch community-led and community-focused online content (online listening and virtual conferences can fulfill this requirement)
4. Provide evidence of knowledge, skill, and accomplishments in transgender health i.e. CV, publications, case studies, experience, learning initiatives
5. Agree to adhere to the WPATH SOC 7 or latest published revision
6. Agree to comply with the WPATH approved transgender and gender non-binary health related continuing (CE) requirements of 20 hours every two-years to maintain certification
7. Successfully pass the certification exam, which is given online, free of charge, in an open-book, multiple choice format.

Please Note: You MUST be a WPATH Member in order to begin your WPATH GEI SOC7 Mentoring hours, with a WPATH GEI SOC7 Certfied Mentor, please see link below for current mentors in the MENTOR

DIRECTORY, if you don't see a name listed, they are not certified WPATH mentors, and your mentoring hours WILL NOT count towards your certification.

If you have any questions about these requirements, please contact wpath@wpath.org.

CLICK HERE TO COMPLETE THE GEI LETTER OF INTENT

Mentor Directory

Apply to be a WPATH GEI SOC7 Certified Mentor

WPATH GRANDPARENTING

We are happy to recognize our members who have contributed to both the field as a whole and to WPATH specifically through the implementation of an accelerated path to certification. Qualified members in good standing may opt out of course requirements by choosing to demonstrate proficiency through documentation and completion of a certification exam as outlined below.

Individuals petitioning to be grandparented must:

To become grandparented an applicant must:

1. Meet all the criteria for certification with the exception of attending courses for which they can demonstrate proficiency.
2. Be licensed and board certified (if applicable) in your specialty or the global equivalent.
3. Agree to adhere to the WPATH SOC 7 or latest published revision.
4. Agree to comply with the WPATH approved related continuing (CE) requirements of 20 hours every two-years to maintain certification.
5. Successfully pass the certification exam.
6. Must have ten years' experience in their field of expertise.
7. Show experience in each of the relevant certification domains. This can be done through the submission of a CV, and a supplemental information form describing training and experience, workshops attended, supervision experience, participation in consultation groups, etc.
8. Be a Full Member of WPATH in good standing for a minimum of 5 years

CLICK HERE TO DOWNLOAD THE GRANDPARENTING INTENT FORM

Four Core Competencies

A Vision of Core Competencies

WPATH

World Professional Association for Transgender Health

© 2020 WPATH

- Contact
- Privacy
- Terms
- Donate

Powered By ConferenceBrain

Login | Register

- About
  - Mission and Vision
  - Ethics and Standards
  - EC and Board of Directors
  - Committees
  - Bylaws
  - History
  - Awards
  - Regional Organizations
  - Privacy Policy
- Conferences
- Education
  - Global Education Initiative
  - Student Initiative
  - Upcoming Courses
  - WPATH GEI Telehealth & COVID-19 Series
  - GEI Global Impact
- Resources
  - Legal
  - Recommended Reading
  - Find a Provider
  - Seniors, Youth, Schools, and Families
- Publications
  - Public Policies
  - Standards of Care
  - International Journal of Transgender Health
- Membership
  - Membership Information
  - Student Membership
  - Apply for Membership
  - Member Directory
  - Lower Income Economy Countries
- Newsroom
  - Global Impact
  - US-WPATH News
  - Members in the News
- Donate

Exhibit 21

Arch Sex Behav (2016) 45:1649–1663
DOI 10.1007/s10508-016-0700-z

ORIGINAL PAPER

Male Prison Inmates With Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?

Cynthia S. Osborne[1] · **Anne A. Lawrence**[2,3]

Received: 14 September 2015 / Revised: 12 January 2016 / Accepted: 18 January 2016 / Published online: 15 March 2016
© Springer Science+Business Media New York 2016

Abstract Gender dysphoria (GD), a feeling of persistent discomfort with one's biologic sex or assigned gender, is estimated to be more prevalent in male prison inmates than in nonincarcerated males; there may be 3000–4000 male inmates with GD in prisons in the United States. An increasing number of U.S. prison systems now offer gender dysphoric inmates diagnostic evaluation, psychotherapy, cross-sex hormone therapy, and opportunities, albeit limited, to enact their preferred gender role. Sex reassignment surgery (SRS), however, has not been offered to inmates except in response to litigation. In the first case of its kind, the California Department of Corrections and Rehabilitation recently agreed to provide SRS to an inmate and developed policy guidelines for its future provision. In other recent cases, U.S. courts have ruled that male inmates with GD are entitled to SRS when it is medically necessary. Although these decisions may facilitate the provision of SRS to inmates in the future, many U.S. prison systems will probably remain reluctant to offer SRS unless legally compelled to do so. In this review, we address the medical necessity of SRS for male inmates with GD. We also discuss eligibility criteria and the practical considerations involved in providing SRS to inmates. We conclude by offering recommendations for physicians, mental health professionals, and prison administrators, designed to facilitate provision of SRS to inmates with GD in a manner that provides humane treatment, maximizes the likelihood of successful outcomes, minimizes risk of regret, and generates data that can help inform future decisions.

Keywords Gender dysphoria · Transsexualism · Medical necessity · Sex reassignment surgery · Standards of care

Introduction

Gender dysphoria (GD) is a psychiatric disorder in which affected persons experience severe, persistent discomfort with their biologic sex or assigned gender (American Psychiatric Association [APA], 2013). GD was previously called gender identity disorder (GID; APA, 2000).

The most extreme form of GD is transsexualism (Blanchard, 1993), which is characterized by the intense desire to live as a member of the other sex and (usually) to undergo hormonal and surgical treatment to make one's primary and secondary sex characteristics resemble those of the other sex (World Health Organization, 1992). The term transgender defines a broader category of persons who experience cross-gender identification or display significant gender-variant behaviors but who may or may not meet diagnostic criteria for GD or transsexualism (Lawrence & Zucker, 2014). Cross-sex hormone treatment and sex reassignment surgery (SRS) are widely accepted treatments for GD or transsexualism in community-dwelling patients.

In Western countries, the estimated prevalence of male-to-female (MtF) transsexualism in community-dwelling adults is about 1 in 10,000 to 1 in 12,000 (e.g., Arcelus et al., 2015; De Cuypere et al., 2007; Judge, O'Donovan, Callaghan, Gaoatswe, & O'Shea, 2014). Among male prison inmates in the United States, the prevalence appears to be significantly higher (Glezer, McNeil, & Binder, 2013). In a study conducted in the California prison system, Sexton, Jenness, and Sumner (2010) interviewed

✉ Anne A. Lawrence
alawrence@mindspring.com

[1] Department of Psychiatry and Behavioral Sciences, Johns Hopkins Medical Institutions, Baltimore, MD, USA

[2] Department of Psychology, University of Lethbridge, Lethbridge, AB, Canada

[3] 6801 28th Ave NE, Seattle, WA 98115, USA

332 male inmates with transgender identification, out of a reported total male inmate population of 146,360; this represented a prevalence of about 1 in 440, albeit some of the inmates may not have met full diagnostic criteria for GD. More recently, Mintz (2015) reported that 385 California inmates, presumably both males and females, were receiving cross-sex hormone therapy, a strong indicator of GD. In 2013, the most recent year for which figures are available, there were 135,981 inmates, 95 % of whom were male, in state and federal prisons in California (Carson, 2014); this suggests a prevalence of cross-sex hormone therapy in California inmates of about 1 in 350. The first author, who has served as a consultant to the prison system of a large midwestern state, calculated a prevalence of transgender identification of about 1 in 500 in male inmates, based solely on the transgender inmates she had personally evaluated. Given that over 1.4 million male inmates were confined in U.S. state and federal prisons in 2013 (Carson, 2014), there could easily be 3000–4000 males with GD in U.S. prisons.

Following diagnostic evaluation, the recommended elements of treatment for GD include psychotherapy, cross-sex hormone therapy, adopting the desired gender role in everyday life, and SRS to make the individual's primary and secondary sex characteristics resemble those of the desired sex (Byne et al., 2012; Coleman et al., 2011). For males, SRS typically consists of orchiectomy, penectomy, and vaginoplasty. Not all persons with GD seek all of these treatments, but some persons with GD may need them all, including SRS, if their GD is to be effectively treated (Coleman et al., 2011).

Prison systems in the United States increasingly recognize the diagnosis of GD, provide psychological evaluation for it, and offer psychotherapy to inmates who have been diagnosed with GD. Many now offer feminizing hormone therapy to male inmates with GD, and some allow them to wear women's clothing and hairstyles and use women's cosmetics (Brown, 2014; Brown & McDuffie, 2009; Glezer et al., 2013; Sumner & Jenness, 2014). But providing SRS for male inmates with GD has been more controversial. We are aware of only one instance in which a U.S. prison system has agreed to provide SRS for an inmate (see *Quine v. Beard*, 2015). Nevertheless, the California Department of Corrections and Rehabilitation (CDCR) subsequently issued formal *Guidelines for Review of Requests for Sex Reassignment Surgery* (California Correctional Health Care Services [CCHCS], 2015), suggesting that it is prepared to provide SRS to some inmates with GD. Further, despite public and political objections to using taxpayer dollars to fund SRS for inmates, U.S. courts are now consistently ruling that prison polices that de facto prohibit SRS are unconstitutional. Accordingly, prison authorities have been forced to consider whether provision of SRS is medically necessary for some inmates with GD, which inmates should be eligible for it, and what the probable outcomes of providing SRS would be, including implications for prison assignment and security.

These questions and the conflicting opinions they evoke were recently brought into focus by four legal decisions. Two were in the case of *Kosilek v. Spencer* (2014a, 2014b). In January 2014, a three-judge panel of the U.S. Court of Appeals for the First Circuit ruled 2–1 (*Kosilek v. Spencer*, 2014a) that the Massachusetts Department of Correction (MDOC) was obliged to provide SRS for inmate Michelle (formerly Robert) Kosilek, a biologic male with a long history of GD who was serving a life sentence without possibility of parole for the strangulation murder of his wife. In December 2014, the entire Court of Appeals for the First Circuit ruled 3–2 (*Kosilek v. Spencer*, 2014b) to reverse that decision, effectively denying SRS to Kosilek. The U.S. Supreme Court subsequently declined to hear an appeal. A third decision was in the case of *Norsworthy v. Beard* (2015): In April 2015, the U.S. District Court for the Northern District of California ruled that the CDCR was obliged to provide SRS for inmate Michelle (formerly Jeffrey) Norsworthy, another biologic male with a long, well-documented history of GD who had been serving a sentence of 17 years-to-life for murder since 1987. This decision was rendered moot in August 2015 when Norsworthy was paroled ("Transgender California inmate," 2015). Also in August 2015, in a settlement agreement (*Quine v. Beard*, 2015), the CDCR agreed to provide SRS to inmate Shiloh (formerly Rodney James) Quine, a biologic male who is serving a life sentence for murder, kidnapping, and robbery (St. John, 2015), and to transfer Quine to a women's prison after SRS. If this agreement is carried out, it will represent the first instance we know of in which a U.S. prison system has actually provided SRS to an inmate.

In this article, we address the medical necessity of offering SRS to male inmates with GD within U.S. prisons, eligibility criteria for SRS, and related practical considerations. Our analysis reflects our experience in evaluating and treating community patients with GD, a review of the relevant literature, and the experience of the first author in evaluating more than 65 incarcerated or civilly committed males with known or suspected GD in three U.S. states.

Standards of Care

To meaningfully discuss the question of SRS for inmates, it is essential to examine the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (SOC; Coleman et al., 2011), the most recent guidelines promulgated by the World Professional Association for Transgender Health (WPATH), and how these guidelines apply to correctional populations. The SOC have been widely adopted by physicians and mental health professionals who treat community-dwelling persons with GD, and they have been regarded as authoritative by U.S. courts in cases involving prisoners with GD (e.g., *Kosilek v. Spencer*, 2012, 2014a, 2014b; *Norsworthy v. Beard*, 2015). But the SOC are not without controversy. Although they were formulated by experienced clinicians and scholars, most SOC recommendations are based on low-quality

evidence, such as case series and expert opinion (Byne et al., 2012; De Cuypere & Vercruysse, 2009). The SOC also do not represent the experiences and practices of all GD experts, and some provisions of the SOC seem to reflect political considerations rather than scientific evidence or clinical experience (Zucker, Lawrence, & Kreukels, 2016; see also Levine & Solomon, 2009).

Moreover, the SOC were not developed based on extensive clinical experience with incarcerated persons, many of whom have histories, characteristics, and vulnerabilities that differ substantially from community-dwelling persons with GD. The earliest version of the SOC was published in 1979 by WPATH's predecessor, the Harry Benjamin International Gender Dysphoria Association (HBIGDA; Walker et al., 1990); subsequent versions were published in 1980, 1981, 1990, 1998, 2001, and 2011 (Coleman et al., 2011; HBIGDA, 1998, 2001; Walker et al., 1990). But the SOC only began to explicitly address the treatment of prisoners in the 1998 version, nearly 20 years after the original publication, and this was only to recommend that persons who had been treated with cross-sex hormones before incarceration continue to receive them in prison. In the 2001 version, this recommendation was expanded to include other treatments begun before incarceration (e.g., psychotherapy); housing considerations for prisoners were also briefly addressed.

The situation changed dramatically in the 2011 version of the SOC, which explicitly asserted that all provisions of the SOC were applicable to all persons in prisons and other institutions:

> The SOC in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation…All elements of assessment and treatment as described in the SOC can be provided to people living in institutions…Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the SOC, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria…Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the SOC. (Coleman et al., 2011, pp. 206–207)

We have no disagreement with the aspirations set forth in this statement: We accept the ethical principle that living in prison or another institution does not, in and of itself, justify withholding medically necessary treatments that are available to community-dwelling persons. We also concur that, despite the complexities involved, prisons must make reasonable efforts to provide medically necessary treatments, including SRS, to inmates, and we would further emphasize that U.S. courts have consistently so ruled. Nevertheless, the unqualified statement that "all elements of assessment and treatment as described in the SOC can be provided to people living in institutions" (Coleman et al., 2011, p. 206) does not reflect extensive clinical experience. Indeed, it is fair to say that this assertion, while admirable in principle, remains to be demonstrated in practice in correctional environments. Its confident simplicity may not adequately take account of the clinical and contextual complexities that inmates with GD present.

Many inmates who seek treatment for GD in prison never sought treatment in the community. Many have lived troubled, chaotic lives characterized by early family and economic instability, substance abuse and other psychiatric problems, failed school and employment experiences, and early involvement in crime. Inmates who seek treatment for GD typically display little resemblance to the patients who present for treatment in the community, and prison life bears little resemblance to life in the community. The SOC were not developed with the complexities, vulnerabilities, and life circumstances of incarcerated persons in mind.

Is Sex Reassignment Surgery Medically Necessary for Some Inmates With Gender Dysphoria?

The medical necessity of SRS is a fundamental issue, because U.S. courts have consistently ruled that failure to provide inmates with necessary medical treatment, deliberate indifference to their medical needs, and disregard for the suffering resulting from unmet medical needs constitute violations of the Eighth Amendment's prohibition of cruel and unusual punishment (Glezer et al., 2013). We concur with the SOC's contention that SRS can be medically necessary for some, though not all, persons with GD, including some prison inmates.

In explicating our position, we emphasize four points. First, a determination of medical necessity reflects the exercise of professional judgment, but professionals sometimes disagree about the medical necessity of certain treatments—particularly SRS as a treatment for GD. Second, SRS is a safe, effective, and widely accepted treatment for GD; disputing the medical necessity of SRS based on assertions to the contrary is unsupportable. Third, SRS can be judged medically necessary for some persons with GD, especially males, when their GD reflects intense distress about the incongruence between their external genitalia and their gender identity; this incongruence can only be corrected through genital surgery. Finally, other grounds for asserting the medical necessity of SRS, such as treating suicidality or depression, are more problematic.

Determining Medical Necessity

In the United States, the term "medical necessity" is most commonly encountered in the context of the obligations of third-party payers (e.g., private health insurance companies, Medicare, and Medicaid) to cover the costs of medical treatment. The definition of medical necessity has effectively become standardized in the United States in recent years; here is one common definition:

> "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are
>
> (a) in accordance with generally accepted standards of medical practice;
> (b) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
> (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.
>
> For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment. (Kaminski, 2007, p. 3)

Thus, a recommended treatment is considered medically necessary if a qualified professional, exercising prudent clinical judgment, determines that it is necessary. But professionals sometimes disagree about the medical necessity of certain treatments, and this has been particularly true of SRS as a treatment for GD. Disagreements about the medical necessity of SRS have historically involved most of the fundamental issues mentioned previously: Whether a recommendation of SRS is consistent with the exercise of prudent clinical judgment; whether such a recommendation is consistent with accepted standards of practice; whether SRS constitutes an effective treatment for GD, or at least some types of GD; and whether alternatives to SRS would be as likely to produce equivalent therapeutic results. Accumulated evidence has demonstrated that for all but the last of these issues, objections to the medical necessity of SRS are difficult to sustain, and arguments based on them have increasingly been rejected in U.S. court cases. At present, most challenges to the medical necessity of SRS seem to rely on opinions by some professionals that alternatives to SRS can provide equally effective, or at least adequately effective, treatment for GD.

Safety, Efficacy, and Acceptance of Sex Reassignment Surgery

Efforts to contest the medical necessity of SRS on the grounds that it is unsafe, ineffective, or inconsistent with accepted standards of practice are unsupportable. SRS has been an accepted treatment for GD in every version of the SOC from their initial publication in 1979 (Coleman et al., 2011; HBIGDA, 1998, 2001; Walker et al., 1990). SRS, in conjunction with cross-sex hormone therapy, has repeatedly been demonstrated to be associated with substantial reduction in GD symptoms, high levels of patient satisfaction, few significant complications, and minimal instances of regret (Dhejne, Öberg, Arver, & Landén, 2014; Gijs & Brewaeys, 2007; Heylens, Verroken, De Cock, T'Sjoen, & De Cuypere, 2014; Kuiper & Cohen-Kettenis, 1988; Lawrence, 2003; Mate-Kole, Freschi, & Robin, 1990; Monstrey, Vercruysse, & De Cuypere, 2009; Murad et al., 2010; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005).

The Departmental Appeals Board of the United States Department of Health and Human Services (DHHS) reached these same conclusions when it determined that transsexual surgery was eligible for coverage under the Medicare program (DHHS Departmental Appeals Board, 2014), reversing the conclusions of a 1981 report that had questioned the safety and efficacy of SRS. Based on expert medical testimony and a review of the published literature, the Appeals Board stated that "We have no difficulty concluding that the new evidence, which includes medical studies published in the more than 32 years since issuance of the 1981 report… demonstrates that transsexual surgery is safe and effective and not experimental" (DHHS Departmental Appeals Board, 2014, p. 8).

We would caution, however, that these favorable conclusions are derived from experience with community-dwelling patients. Although it is reasonable to assume that they would also apply to prison inmates, empirical evidence to support this assumption is lacking. SRS remains untested in incarcerated persons, who often differ in significant ways from community patients.

Sex Reassignment Surgery for Dysphoria Related to Genital Anatomy

GD typically reflects intense distress about both one's anatomic sex characteristics and assigned gender role, but sometimes distress about anatomic sex is particularly intense. This is recognized in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; APA, 2013), which states that the diagnostic criteria for GD can be fulfilled solely on the basis of distress related to "a strong desire to be rid of one's primary and/or secondary sex characteristics" and "a strong desire for the primary and/or secondary sex characteristics of the other gender" (p. 452). The four previous editions of the DSM also emphasized the importance of distress related to anatomic sex characteristics, especially the external genitalia, in the earlier diagnoses of GID (APA, 1994, 2000) and transsexualism (APA, 1980, 1987). For clarity, we refer to GD that reflects intense distress about one's genital anatomy as *genital anatomic GD*. Genital anatomic GD, like other GD symptoms, can vary in intensity over time and can sometimes remit, temporarily or permanently. But when genital

anatomic GD has been unremitting and intense over a long time period, treatment becomes necessary.

The phenomenon of severe, persistent genital anatomic GD thus explains why SRS can sometimes be medically necessary for gender dysphoric males. Only SRS can eliminate what many of these individuals find particularly distressing: their male external genitalia, which act as powerful and incontrovertible indicators of maleness. SRS constitutes a specific and singularly effective treatment for unremitting genital anatomic GD, one that offers what no alternative treatment can provide. For males in whom this type of GD is intense and persistent, including some inmates, SRS can sometimes be medically necessary, and no alternative treatments are likely to be equally or adequately effective.

Much of the resistance to offering SRS to inmates with genital anatomic GD appears to reflect doubts about the legitimacy of the GD diagnosis itself or whether the distress that these inmates report is genuine. Such skepticism is not surprising: The phenomenon of genital anatomic GD is so inconsistent with ordinary experience that it is almost impossible to adequately comprehend. Consequently, there is a tendency to minimize the distress that inmates with genital anatomic GD report or to attribute their complaints to hysteria, psychosis, malingering, or exaggeration, especially given that these phenomena are prevalent in correctional environments. It is particularly hard to comprehend reports of genital anatomic GD by males whose appearance and behavior are not recognizably feminine, because their feelings of "wrong embodiment" (Prosser, 1998) appear so inconsistent with their physical and behavioral presentations. Such inconsistency does not, however, make their distress any less real. Only the repeated experience of hearing persons with genital anatomic GD describe their anguish is likely to help others understand the psychological reality of this condition and the medical necessity of SRS as a treatment for it.

Medical Necessity of Sex Reassignment Surgery to Treat Associated Psychiatric Conditions

SRS is demonstrably effective in treating GD, especially genital anatomic GD, in community populations (Heylens, Verroken, et al., 2014) and plausibly also in prison populations. But health professionals and attorneys commonly argue that the reason SRS is medically necessary for inmates is to prevent or treat other psychiatric conditions, such as depression or suicidality, which are assumed to be consequences of GD. Such arguments make intuitive sense, but they are problematic for several reasons.

Unfortunately, SRS is not very effective in treating associated psychiatric conditions. Community-dwelling persons with GD display an elevated prevalence of comorbid mental health problems, including mood disorders, anxiety disorders, and suicidality (Guzmán-Parra et al., 2015; Heylens, Elaut, et al., 2014), and these comorbid conditions do not significantly improve after SRS (Dhejne et al., 2011; see also Asscheman et al., 2011). Comorbid psychiatric conditions usually do improve, at least initially, after cross-sex hormone therapy. But while subsequent SRS usually ameliorates GD and increases overall life satisfaction, it appears to confer little or no additional improvement in other psychiatric symptoms (Heylens, Verroken, et al., 2014; see also Gómez-Gil et al., 2012; Udeze, Abdelmawla, Khoosal, & Terry, 2008).

The tendency to couch arguments for the medical necessity of SRS in terms of treating depression and suicidality is understandable: These conditions are familiar, and there is little disagreement that they deserve to be treated. In contrast, GD, especially genital anatomic GD, is unfamiliar, the distress it causes is often assumed to be feigned or exaggerated, and many citizens and lawmakers believe that inmates with GD simply do not deserve SRS (Leonard, 2014). But the argument that SRS is medically necessary primarily to treat or prevent depression or suicidality is not supported by empirical evidence, and it is also problematic for other reasons.

Such an argument invites the counterargument that inmates' complaints of depression or suicidal threats or gestures can simply be manipulative and that prison authorities cannot acquiesce to them without inviting further manipulation. For example, the decision in *Kosilek v. Spencer* (2014a) contains this summary of the MDOC's position: "providing Kosilek with [sex reassignment] surgery in response to her threats of suicide would be contrary to well-established correctional practices. Inmates should not be permitted to manipulate the system utilizing a 'do it or else' theory" (p. 48; some internal quotation marks omitted). Moreover, arguing that SRS is medically necessary to prevent suicide could establish an unhelpful precedent, with suicidal threats or gestures becoming de facto prerequisites for SRS. We were encouraged to note that both expert consultants in *Quine v. Beard* (2015) considered relief of GD to be the primary basis for recommending SRS for Quine, with reduced risk of suicidality a secondary consideration.

Eligibility Requirements for Sex Reassignment Surgery

According to the SOC, persons for whom SRS has been determined to be medically necessary must still satisfy certain eligibility requirements before SRS can be performed. These can be either the usual or "standard" eligibility requirements or requirements that have been modified pursuant the provisions of the SOC that permit flexibility when indicated. The six standard eligibility requirements for SRS are:

(1) Persistent, well-documented gender dysphoria;
(2) Capacity to make a fully informed decision and to consent for treatment;

(3) Age of majority in a given country;
(4) If significant medical or mental health concerns are present, they must be well controlled;
(5) 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual);
(6) 12 continuous months of living in a gender role that is congruent with the patient's identity. (Coleman et al., 2011, p. 202)

For most male inmates, fulfillment of all of these standard eligibility requirements should be a precondition for SRS. We believe that many inmates can satisfy all of these requirements without undue difficulty, although their ability to fulfill the requirement of living for 12 months in a gender role congruent with their gender identity remains contentious. For a few inmates, we believe that the 12-month living requirement could legitimately be relaxed or waived. For all inmates, however, we believe it would be prudent to initially impose some additional eligibility requirements, given the current lack of experience in providing SRS to prisoners.

Of the six standard eligibility requirements, two—age of majority and 12 months of continuous cross-sex hormone therapy, the latter with some exceptions permitted—are neither complicated nor controversial. Hormone therapy is recognized to be an effective treatment for GD and one that typically would already have been provided to inmates who were being considered for SRS. The other standard eligibility requirements involve more complicated considerations as they relate to prison populations.

Persistent, Well-Documented Gender Dysphoria

Evaluating the genuineness, severity, and persistence of GD in inmates can be challenging, especially in persons who have significant comorbid mental health problems. Moreover, the phenomena to which inmates' complaints of GD are often attributed—psychosis, hysteria, malingering, and manipulative exaggeration—plausibly do account for some of these complaints. Deciding the genuineness, severity, and persistence of GD is ultimately an individual professional judgment, one that should be rendered by practitioners who are experienced in assessing both GD and comorbid psychopathology in correctional populations.

The importance of conducting a thorough evaluation of GD symptoms and comorbid conditions in inmates seeking SRS cannot be overstated. But assessment is not a quick or simple process in either community or correctional settings. In the community, mental health professionals who make primary recommendations for SRS typically see their patients on multiple occasions over several months or years in a process that often involves dozens of hours of face-to-face contact (Lawrence, 2003). In inmates seeking SRS, evaluation of GD symptoms and comorbid conditions is ordinarily conducted by outside consultants, because prison-based mental health providers rarely have the necessary expertise and experience. In the first author's experience, evaluations for SRS in correctional settings tend to be comparatively brief. Consultants often base their conclusions primarily on self-reported symptoms of GD elicited in a single interview and seldom engage in longitudinal assessment, even though inmates typically present greater diagnostic complexity than their community counterparts.

When conducting an initial evaluation for either hormone therapy or SRS, the first author spends an average of 6 hr face-to-face with an inmate, often with follow-up telephone interviews if additional information is required. If there are inadequate grounds for making a confident diagnosis of GD, she will defer diagnosis and recommend a year or more of psychotherapeutic treatment, followed by re-evaluation if the inmate's symptoms and requests for treatment persist. The evaluation process also includes a review of records, sometimes involving thousands of pages of clinical, institutional, and legal files. The author commonly recommends formal psychological testing, and she consults extensively with clinical providers and prison staff who are familiar with the inmate's day-to-day functioning. Whenever possible, she also consults with family members and other external informants to verify the inmate's self-reported history.

Although thoroughly documenting the severity and persistence of GD in inmates is a time-consuming and often difficult process, some features of inmates' medical and psychiatric histories can contribute to greater diagnostic confidence. Foremost among these would be documented evidence (not just self-report) of GD symptoms prior to entering prison, especially if there is also evidence of previous medically supervised hormone therapy; such evidence, however, is rarely available. Other features that can contribute to diagnostic confidence include a documented history of intense and unremitting GD symptoms in prison, an absence of significant comorbid psychopathology that could complicate differential diagnosis (e.g., schizophrenia or bipolar disorder), and evidence of a positive response to cross-sex hormone therapy and whatever elements of identity-congruent living (e.g., clothing, makeup, hairstyle) have been permitted.

Capacity to Give Informed Consent

Providing meaningful informed consent can be difficult for an incarcerated person. Inmates have limited access to current information and lack opportunities to learn about SRS from persons who have undergone it themselves. A few learn about GD, transsexualism, and SRS for the first time in prison; some are highly impressionable and are easily influenced by other inmates. Many have a simplistic or inaccurate understanding of the typical results of SRS, are unaware of potential com-

plications, and do not understand what will be required of them in terms of postoperative care and medical follow-up. Due to intellectual limitations, emotional immaturity, or severe personality disorders, some inmates have unrealistic expectations concerning life in a female gender role, either in prison or following release.

Providing informed consent for SRS does not require that candidates anticipate and consider every possible consequence of the sex reassignment process. For male inmates, however, one foreseeable consequence that deserves careful consideration is the likelihood of being assigned to a women's prison following SRS. Most inmates with GD would probably welcome this, but some might not, and a few might even decide to forgo SRS if this were a predictable consequence. A change in prison assignment after SRS could also adversely affect relationships with family members and friends. Assignment to a women's prison provides unequivocal evidence of having undergone sex reassignment. If family members and friends had not previously been aware of an inmate's desire for sex reassignment—and inmates sometimes attempt to conceal this—then assignment to a women's prison would make the inmate's circumstances obvious. While many inmates who have been incarcerated for years have lost all connections to family and community, some still have fragile threads of connection to a parent, a sibling, or a child. Disclosure could strain these tenuous but significant connections to the outside world, making inmates more vulnerable to feelings of isolation and hopelessness. The first author has observed that many inmates with GD can effectively face the challenge of disclosure to family members and friends and sometimes discover unexpected understanding and support for their desire to live as women. In other cases, however, they experience rejection. This variability in response is not unlike what nonincarcerated persons with GD encounter, but the risk of irreparable isolation is greater for inmates. On a purely practical level, transfer to a women's prison could also make visitation more challenging: Because there are comparatively few women's prisons, most inmates would probably be reassigned to a location more distant from their community of origin after SRS.

Satisfactory Control of Comorbid Mental Health Problems

Eligibility for SRS is conditional on satisfactory control of comorbid mental health conditions for three principal reasons: to guarantee that candidates have met the minimal prerequisites for providing meaningful informed consent (i.e., that their reality testing is unimpaired), to establish that they have the capacity to cooperate in preoperative and postoperative care, and to ensure that they possess sufficient mental and emotional stability to cope with the changed life circumstances they will face after SRS, which will usually include transfer to the unfamiliar environment of a women's prison. All of these rationales are explicitly set forth or strongly implied by language in the SOC (Coleman et al., 2011, pp. 202–203, 205). Fulfillment of this standard eligibility requirement implies satisfactory management of psychoses, significant mood and anxiety disorders, dissociative disorders, and severe personality disorders.

Antisocial personality disorder (ASPD) and its most extreme manifestation, psychopathy (Hare & Neumann, 2008), deserve specific consideration. These conditions are prevalent among inmates and constitute enduring aspects of personality that are difficult or impossible to modify and challenging to manage. Some clinicians would argue that these conditions are so resistant to treatment that they can never be considered "well controlled." It is also important to consider whether symptoms that appear to be adequately controlled in the structured environment of prison will remain so when inmates are released into the community, where sustained functional stability depends on internalized skills rather than external control. Inmates with psychopathy often engage in repeated patterns of aggression and conflict with staff and peers; they are difficult to manage and are frequently placed in disciplinary segregation for rule violations. They are commonly defiant, provocative, and litigious. Accordingly, we consider severe psychopathy a contraindication to SRS.

However, some inmates with ASPD and relatively mild psychopathy arguably can give valid informed consent and cooperate in their own care when it is in their interest to do so. A sustained history of compliance with recommended psychiatric and psychological treatment, cooperation with clinicians and prison officials, and a satisfactory disciplinary record should serve as reasonable indicators that their comorbid personality disorder does not dominate their affective, behavioral, or interpersonal functioning or impair their ability to cooperate in their own care.

As noted previously, inmates with GD not uncommonly experience depressive symptoms or suicidal ideation when treatment for GD is unavailable or when expression of their gender identity is constrained. Deciding whether these symptoms imply that comorbid mental health problems are not satisfactorily controlled is always an individual professional judgment. Eligibility for SRS does not require that comorbid mental health symptoms be completely absent, only that they do not interfere with the ability to provide informed consent, to cooperate in preoperative and postoperative care, and to face with some likelihood of success the changed life circumstances that will result from SRS. Some persons with GD who think about suicide or who are despondent about their inability to obtain treatment or express their gender identity can do all of these things.

Twelve Months of Living in a Gender Role Congruent With One's Gender Identity

This is the most misunderstood and contentious of the standard eligibility requirements for SRS. Requirements of this type were first adopted over 40 years ago at the Stanford University Gender

Reorientation Program. The Stanford clinicians recognized that providing SRS was controversial, and they "were avowedly seeking candidates who would have the best chances for success so that the overall program could or would be continued" (Fisk, 1974, p. 7). They might have preferred to offer SRS only to persons who could be diagnosed as "true transsexuals"—a diagnostic category no longer considered meaningful—but this proved impossible, because candidates for SRS often misrepresented or distorted their histories, confounding accurate diagnosis. Consequently, the Stanford clinicians chose to deemphasize diagnosis per se as an eligibility criterion and instead focused on whether prospective candidates could successfully live full-time in the gender role of the other sex for an extended period—typically 1 to 3 years. Laub and Fisk (1974) argued that:

> Indeed, for prognosis, it is probable that the diagnostic category is of much less importance than the patient's preoperative performance in a one- to 3[sic]-year therapeutic trial of living in the gender role of his choice—with demonstrable economic, social, psychological, and sexual success during that period. (pp. 401–402)

Five years later, in 1979, successfully living full-time "in the social role of the genetically other sex" (Walker et al., 1990, p. 5) for 12 months became a standard eligibility requirement for SRS in the first version of the SOC. A similar requirement has been included in all subsequent versions, including the present one. Although formal descriptions of this requirement have become increasingly ambiguous over the years, language explaining the rationale and suggested parameters of this requirement actually became more detailed in the most recent version of the SOC, implying that the requirement is not considered a mere formality.

The fifth version of the SOC (HBIGDA, 1998) introduced the term *real-life experience* to describe this 12-month period of living in the desired gender role; the term also appeared in the sixth version (HBIGDA, 2001), but not in the seventh and most recent version (Coleman et al., 2011). Nevertheless, the term continues to be widely used. The current version of the SOC merely states that candidates for SRS are required to live for 12 months "in a gender role that is congruent with the patient's identity" (p. 202). This formulation "would seem to be almost entirely open to individual interpretation" (Lawrence, 2014, p. 702) but is usually interpreted to mean living in a gender role typical of the other biologic sex.

We contend that some male inmates with GD can and do live in a gender role typical of the other biologic sex within men's prisons and therefore can technically fulfill this standard eligibility requirement. Inmates with GD often display remarkable tenacity and resourcefulness in their attempts to live in something resembling female-typical gender roles in men's prisons. They adopt female-typical names, vocal mannerisms, and ways of moving; they wear female-typical garments when these are obtainable and improvise them when they are not; they modify their bodies by shaping their eyebrows and shaving their faces and bodies; and they avail themselves of permanent epilation and feminizing hormone therapy when these treatments are made available. Moreover, inmates with GD often band together in informal groups for social and emotional support, thereby receiving validation of their cross-gender identities. Within the relative safety of these groups, they can practice behaving in a more overtly feminine manner, thereby enacting the gender role that is congruent with their gender identity. Their efforts to live in something resembling a female-typical gender role often equal or exceed those of males with GD who are not in prison.

However, we question whether this standard eligibility requirement has much practical or prognostic relevance for inmates. Whether or not one believes that fulfilling this requirement contributes to greater postoperative satisfaction or avoidance of regret in community-dwelling patients—and the evidence is slim to nonexistent (Bockting, 2008; Levine, 2009)—it at least provides community patients an opportunity to experience what their lives after SRS might be like before undergoing irreversible surgery. This would not be the case for inmates with GD who attempt to live in female-typical gender roles within men's prisons. If they were to undergo SRS, they would almost certainly be assigned thereafter to women's prisons, where their lives would immediately become dramatically different. Living in a female-typical role in a men's prison could not effectively prepare them for this. There is no way for inmates to know, first hand and in advance, what life in a women's prison would be like. Inmates who would eventually be released from prison similarly would have no way of knowing what life as a woman outside of a correctional environment would be like. Recognizing these facts, some prison officials have argued that inmates with GD cannot have a meaningful experience in a gender role typical of the other sex in men's prisons and therefore cannot fulfill this standard eligibility requirement (e.g., *Kosilek v. Spencer*, 2014a, pp. 31–32; *Kosilek v. Spencer*, 2014b, pp. 24–25, 27; *Norsworthy v. Beard*, 2015, p. 15). Other commentators (e.g., Alexander & Meshelemiah, 2010) have expressed similar opinions. In our view, their position reflects a misinterpretation of this standard eligibility requirement of the SOC; but the concerns they raise nevertheless deserve to be taken seriously.

Because inmates who undergo SRS will almost always be assigned to a women's prison thereafter, the immediate social consequences of SRS will be far greater for inmates than for their community counterparts. The first author has observed that most candidates she has evaluated for SRS appear to have realistic expectations concerning postoperative life in a women's prison, albeit acknowledging some anxiety and recognizing that they will face interpersonal challenges. But if an inmate were to regret assignment to a women's prison after SRS, returning to life in a men's prison would probably be difficult or impossible; the risk of psychological deterioration in such circumstances makes it essential to proceed cautiously.

The future availability of SRS for other inmates could be imperiled if early recipients were to experience regret or psy-

chological decompensation; therefore, it is crucial to avoid catastrophic outcomes, particularly early on. Accordingly, we believe it would be advisable for prison officials to initially impose additional eligibility requirements for SRS, at least until some clinical experience and outcome data have been acquired.

Standard Eligibility Requirements for Sex Reassignment Surgery Can Be Modified

The SOC explicitly allow the standard eligibility requirements for SRS to be modified when indicated:

> The criteria put forth in this document for…surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. (Coleman et al., 2011, p. 166)

This means that additional or more stringent eligibility requirements for SRS can be imposed in certain circumstances. Some community clinics impose more stringent requirements, such as a longer period of cross-living or hormonal treatment or required participation in individual or group psychotherapy. More stringent eligibility requirements would also be allowable in correctional settings. Because clinical experience with SRS in correctional settings is currently nonexistent, we believe that initially imposing additional eligibility requirements would be advisable. These should include:

(1) prominent genital anatomic GD;
(2) a long period of expected incarceration after SRS;
(3) a satisfactory disciplinary record and demonstrated capacity to cooperate with providers and comply with recommended treatment;
(4) a period of psychotherapy, if recommended by the responsible practitioner; and
(5) willingness to be assigned to a women's prison after SRS.

Most of these additional requirements have parallels in the criteria for recommending SRS set forth explicitly or implicitly in the CCHCS guidelines:

> No available, additional treatments other than SRS…are likely to alleviate the distress…At least two (2) years remaining before his/her anticipated parole or release date …Expected to successfully…adjust medically and psychologically to confinement postoperatively with inmates of his/her postoperative gender…The patient is cooperative and adherent with prescribed therapies and follows provider's orders. (CCHCS, 2015, pp. 3, 7)

There are two principal reasons that we recommend initially offering SRS only to inmates for whom a long period of incarceration is expected. First, although SRS is an effective treatment for GD, it is associated with a greatly increased postoperative risk of completed suicide and comorbid psychiatric conditions requiring hospitalization (Dhejne et al., 2011). Inmates who remain in prison for a long period after undergoing SRS would have guaranteed access to psychiatric services to address these potential problems, something that might not be true after release. Second, as we will discuss later, for inmates who undergo SRS and are subsequently released, there is a risk of remission of their feminine gender identification, possibly accompanied by regret about having undergone SRS. A lengthy period of time in which to consolidate one's new gender identity and gender role in prison could plausibly mitigate these risks.

Although a satisfactory disciplinary record was not explicitly included in the CCHCS guidelines as a decision criterion, we consider this to be an important indicator of willingness to cooperate with treatment. Consequently, we believe it should be an additional eligibility requirement for SRS, at least initially. We would emphasize, however, that imposing these or other additional eligibility requirements for SRS cannot merely be a pretext for making SRS de facto unavailable to inmates.

The standard eligibility requirements for SRS can also be relaxed or waived. Consider, for example, an inmate with prominent genital anatomic GD, incarcerated for a long term or for life, who had some experience living in a female-typical gender role prior to entering prison, whose response to hormonal treatment has been positive, but who has had limited opportunities to engage in female-typical gender role behavior while in prison. This is precisely the kind of unique situation that could justify relaxing or waiving the standard requirement of living for 12 months in a gender role congruent with one's gender identity. The first author has observed that some inmates clearly meet all the standard eligibility requirements for SRS other than having unambiguously fulfilled the 12-month cross-living requirement. In such circumstances, for appropriately selected inmates, the potential benefit of a flexible approach to this requirement—relief of genital anatomic GD—would almost certainly outweigh any possible risk of regret.

Consequences of Offering Sex Reassignment Surgery to Inmates

Although it is legally and ethically obligatory to make SRS available to inmates for whom it is medically necessary, it is also important to anticipate and address the practical consequences of doing so. These include the need to develop policies for prison assignment after SRS, anticipate possible safety and security concerns, and consider post-release issues. Some of these matters loom large in the minds of prison officials, but we contend that

none of them constitute insurmountable barriers to offering SRS to carefully selected inmates.

Prison Assignment After Sex Reassignment Surgery

Routine assignment to a women's prison after SRS would be the simplest, most rational, and most therapeutically beneficial policy. Not surprisingly, it is the policy that the CDCR guidelines implicitly adopted, stating that one criterion for recommending SRS would be whether "the patient can be expected to successfully and safely transfer and adjust medically and psychologically to confinement postoperatively with inmates of his/her postoperative gender" (CCHCS, 2015, p. 3). Routine reassignment to a women's prison would maintain consistency with current policies in nearly all U.S. correctional systems, in which assignment is based on external genital anatomy (Sumner & Jenness, 2014). It would also be consistent with how the few MtF transsexuals who have undergone SRS before entering prison have been assigned (e.g., "Prison near Purdy," 2003). From a therapeutic perspective, assigning inmates to a women's prison after SRS could be expected to ameliorate GD symptoms associated with inmates' limited ability to live and be treated as women while residing in male-only facilities.

Paradoxically, a policy of routine assignment to a women's prison after SRS might deter some inmates from seeking SRS. In the California prison system, 82 % of male transgender inmates report that they are exclusively sexually attracted to men (Jenness, 2010), and these inmates often derive significant satisfaction from the social, romantic, and sexual attentions of masculine male inmates. In summarizing interviews with several hundred male transgender inmates in the California prison system, some of whom might not meet full diagnostic criteria for GD, Jenness and Fenstermaker (2014) observed:

> Throughout the interviews, transgender prisoners expressed appreciation for caring interactions with real men that served to recognize them as women. These simple, but much desired, interactions include being walked across the yard, given cuts in the chow line, and having an umbrella held over your head in the rain. (pp. 24–25)

Knowing that they would forfeit these rewarding interactions with men if they were reassigned to a women's prison might cause some inmates to forgo SRS. Moreover, a few male transgender inmates appear to dislike the company of women and would prefer not to be housed with them:

> When a transgender prisoner…was asked whether she would prefer to be housed in a men's prison or a women's prison, she immediately replied, "Men's." She added, "That's a hard one. I don't want to be with women because they are vicious. They are worse than men. Their hormones are going all the time. Imagine being around 60 women and two are on their period at the same time! God. Imagine how bad that would be?". (Jenness & Fenstermaker, 2014, pp. 16–17)

Inmates might be forced to choose between SRS, with its potential to reduce their genital anatomic GD, and the opportunity to enact a feminine gender role in relation to men, with its potential to ameliorate the social or interpersonal components of their GD. Notwithstanding these considerations, the first author has observed that all seven inmates she has evaluated for SRS over the past 18 months, whether sexually attracted to men or to women, have indicated that they would welcome the opportunity to live among women, and in many cases to be free of the sexual tension they experience in relation to male inmates.

Some male prisoners for whom SRS is medically necessary have a history of violent behavior toward women. Kosilek, the plaintiff who sued the MDOC to obtain SRS, had been convicted of murdering a woman (*Kosilek v. Spencer*, 2014a). Norsworthy, the plaintiff who sued the CDCR to obtain SRS, had a history of domestic violence against women (*Norsworthy v. Beard*, 2015). Prison officials have sometimes interpreted such histories as effectively precluding assignment to a women's prison after SRS. In the Norsworthy case, CDCR official Kelly Harrington opined that:

> Norsworthy would be "at significant risk of being assaulted or victimized by female offenders" in a women's facility because of her history of domestic violence against her girlfriend before her arrest…Harrington is also concerned that "Norsworthy might herself victimize female inmates." (*Norsworthy v. Beard*, 2015, p. 17)

However, in what is perhaps the only known case in which a MtF transsexual who had undergone SRS was sent to a women's prison after committing a violent crime against a female victim, the offender—"Jo" Shandley, convicted of murdering her sister—was housed uneventfully in the Washington Correctional Center for Women ("Prison near Purdy," 2003; see also *Kosilek v. Spencer*, 2012, p. 108; *Kosilek v. Spencer*, 2014a, p. 49).

Moreover, natal women who have been convicted of violent crimes against other women, including victims they knew personally, are assigned to women's prisons as a matter of course. The most recent information from the U.S. Department of Justice (Greenfield & Snell, 1999) revealed that over three-quarters of violent crimes committed by female offenders involved female-on-female violence and that in about 8 % of these cases the victims were intimates or relatives of the perpetrator. Consequently, women's prisons can be assumed to have experience dealing with violent offenders whose victims have been other women. Judge Jon Tigar made this point when he wrote in *Norsworthy v. Beard* (2015):

> Any suggestion that housing a female inmate with a history of violence against women would be a novel security challenge is hard to square with the fact that CDCR already houses

> many women with a history of violence, including violence against their female partners. (p. 27)

The other options for prison assignment after SRS—assignment to a special facility for transgender inmates, administrative segregation, or continued assignment to a men's prison—are more problematic. Assignment to a special unit for transgender inmates could sometimes be a reasonable option, but such facilities are not available in most states, and transfer to a unit for transgender prisoners in another state, pursuant to the Interstate Compact on Adult Offender Supervision (Interstate Commission for Adult Offender Supervision, 2014), could not be guaranteed. Moreover, some inmates would probably reject and challenge being housed in units for transgender inmates, believing such an arrangement to be discriminatory and stigmatizing. Prolonged administrative segregation would be inhumane and probably would not stand up to legal challenge (Fleischaker, 2014). Continued assignment to a men's prison after SRS would be inconsistent with current genital-based assignment policies and would probably increase an already elevated risk of sexual victimization. In addition, all of these alternative assignment options would forgo the potential therapeutic benefits of placement in a women's prison, in which inmates with GD could more freely and fully enact their desired gender role.

Security Considerations Related to Sex Reassignment Surgery

We mention security considerations for reasons of completeness, not because we think they pose serious impediments to providing SRS. We have already addressed the most significant security issues related to housing inmates in women's prisons following SRS. Prison officials have sometimes expressed concern about the risk of escape attempts if inmates were transported to a distant location to undergo SRS and then transported back to prison. We consider these objections pretextual rather than substantive. In the *Kosilek* case, the MDOC initially raised this issue, but MDOC Commissioner Harold Clarke subsequently minimized these concerns in his testimony:

> Clarke too initially opined that Kosilek posed an unacceptable risk of flight if transported out of Massachusetts in part because he had fled the state after killing his wife… However, Clarke ultimately testified that he could say "[w]ith some degree of certainty" that the DOC would "take all the precautions necessary to secure that transport, secure the place where it's going to take place, and care for [Kosilek] in terms of providing appropriate custody prior to returning [Kosilek] back to the state." (*Kosilek v. Spencer*, 2012, p. 104)

Post-Release Considerations Following Sex Reassignment Surgery

Practitioners who recommend SRS for inmates who will eventually be released from prison should think carefully about how SRS might affect these inmates' lives after release. In particular, they should consider the risk of post-release regret about having undergone SRS. Clinicians have repeatedly observed that changes in life circumstances can affect the severity of GD symptoms and the intensity of the desire for sex reassignment and SRS (Levine, 1993; Lothstein, 1979; Marks, Green, & Mataix-Cols, 2000; Roback, Fellemann, & Abramowitz, 1984). Males with only minimal or moderate GD symptoms before entering prison sometimes experience an increase in the severity of their GD symptoms after incarceration, accompanied by the onset or intensification of cross-gender identification and the desire to undergo sex reassignment and SRS. This phenomenon raises the concern that, if these inmates were to undergo SRS and were subsequently released from prison, their feminine gender identification might diminish or remit entirely and their desire to live as women might decline or disappear. Practitioners must be mindful of the possibility that inmates who avidly sought and eventually underwent SRS in prison might regret having done so after being released.

Why is the prison environment sometimes associated with an increase in the severity of GD and an intensification of the desire for sex reassignment? Several factors plausibly contribute. Before entering prison, many inmates with incipient GD lived unstable or chaotic lives, characterized by familial and interpersonal instability, childhood abuse or neglect, out-of-home placements, poverty, school failure, substance abuse, untreated mental illness, and early and chronic criminality. In prison, some of these problems may resolve or remit, allowing inmates enough stability to seriously confront their GD for the first time. Other inmates may have had little or no information about the meaning of their GD symptoms or about their options for living in a gender role more congruent with their gender identity; some may have lacked language to describe their feelings, learning terms such as transgender for the first time in prison. Transgender subcultures within prisons provide information, descriptive language, and role models for inmates who are beginning to think about these issues. Although the natural history of GD in males often involves intensification of symptoms over time, social forces in the outside world can hold GD symptoms in check and deter individuals from pursuing sex reassignment. These restraining forces can include the desire to preserve relationships with spouses, children, and friends (Blanchard, 1994) and to maintain employment, legal or otherwise. When incarceration removes these social constraints, GD can intensify. The prison environment also offers inmates opportunities to enact female-

typical social and sexual behaviors in relation to masculine men; these interactions can strengthen or consolidate cross-gender identification in males with GD and can be associated with intensification of GD symptoms. Conversely, GD can sometimes intensify in prison as a result of constraints on feminine self-expression: Inmates who had cross-dressed, engaged in prostitution, or entertained as drag queens may only experience clinically significant GD once those activities have become impossible in the context of incarceration.

After release from prison, however, inmates' circumstances may revert to the status quo ante. Their lives can once again become chaotic in the face of joblessness, homelessness, substance abuse, or untreated mental illness. Opportunities for cross-gender expression that were unavailable during incarceration may again become available to them. Social forces that once constrained cross-gender expression may again exert their influence. In males with GD who are sexually attracted to women, the opportunity to engage in new romantic relationships with women is sometimes associated with remission of GD symptoms and loss of the desire to live as a woman (Lawrence, 2013; Marks et al., 2000; Shore, 1984; Steiner, 1985); release from prison would allow such opportunities. For inmates who had undergone SRS before being released, these forces could potentially be associated with partial or complete remission of their feminine gender identification and desire to live as women; some of these individuals might come to regret SRS. We believe it is plausible that having a longer period of time to consolidate one's feminine gender identity and gender role after SRS might make these outcomes, especially postoperative regret, less likely. Consequently, until more inmates have undergone SRS and more outcome data for this population have been accumulated, we believe it would be prudent to offer SRS only to those inmates for whom a long period of incarceration is anticipated (cf. Colopy, 2012, p. 267).

Regret following SRS is a rare but recognized phenomenon in nonincarcerated MtF transsexuals. A large longitudinal study in Sweden found that 2.2 % of MtF transsexuals regretted having undergone sex reassignment and SRS, as evidenced by application to return to male legal gender status (Dhejne et al., 2014). Factors associated with an increased risk of regret following SRS include poor family support, late-onset GD, inadequate differential diagnosis, and dissatisfaction with the physical and functional outcomes of surgery. Some of these factors, especially poor family support, could potentially increase the risk of post-release regret in inmates who underwent SRS while in prison.

It is important to acknowledge, however, that if an inmate were to undergo SRS in prison and subsequently revert to living in a male gender role after release, this would not necessarily indicate that the inmate regretted SRS, that GD had been incorrectly diagnosed, or that SRS had not been medically indicated or had been provided in error. Some persons who undergo SRS outside of correctional environments report that this treatment successfully ameliorated their GD symptoms but nevertheless revert to living in their original gender role, usually for complex social reasons. Kuiper and Cohen-Kettenis (1998) described three such MtF patients and observed that:

> [Some] individuals do not live any longer in the previously desired sex, but do not express any regret. Some may even state that they are happy about their decision, and still consider themselves transsexuals, but choose to live in the original gender role again for social reasons. (p. 2)

This is consistent with the perspective that the fundamental therapeutic value of SRS lies in its ability to alleviate genital anatomic GD and that SRS can provide this therapeutic benefit even when individuals decide to revert to their original gender role after surgery.

Recommendations for Providing Sex Reassignment Surgery to Male Inmates With Gender Dysphoria

We hope that prison systems will begin providing SRS for carefully selected inmates not because they are legally compelled to do so but because they recognize that SRS is an effective and ethically obligatory treatment for the particular form of suffering that some inmates with GD experience. We recognize that to do so, prison systems will have to address policy, security, and operational complexities as well as legislative, judicial, and public relations challenges. But the status quo of waiting for legal mandates not only leaves inmates with unmet treatment needs but is also prohibitively expensive. Based on our clinical experience and review of the relevant literature, we offer the following recommendations:

(1) Prison officials and physicians and mental health practitioners who evaluate and treat inmates should recognize that SRS can be medically necessary for some male inmates with GD. Prison systems should begin offering SRS to inmates for whom it is medically necessary, even when not faced with the threat of legal compulsion.

(2) The eligibility requirements for SRS for male inmates with GD should include the first five standard eligibility requirements set forth in the SOC (Coleman et al., 2011).

(3) The SOC standard eligibility requirement of 12 continuous months of living in a gender role congruent with the patient's gender identity should either have been

   (a) satisfied in the judgment of the responsible practitioner or
   (b) explicitly waived by the responsible practitioner, as permitted by the SOC.

(4) Until greater experience is accumulated, practitioners should initially impose some additional eligibility requirements, as permitted by the SOC, in order to maximize the likelihood of successful outcomes and minimize the likelihood of regrets. These should include

(a) prominent genital anatomic GD;
(b) a long period of expected incarceration after SRS;
(c) a satisfactory disciplinary record and demonstrated capacity to cooperate with providers and comply with recommended treatment;
(d) a period of psychotherapy, if recommended by the responsible practitioner; and
(e) willingness to be assigned to a women's prison after SRS.

(5) Inmates should routinely be assigned to a women's prison after SRS, although assignment to a specialized unit for transgender inmates might be acceptable in some cases.
(6) Consistent with inmate confidentiality, practitioners and the prison systems that employ them should collect, analyze, and publish the outcome data, for their own use and for the use of other prison systems.
(7) The additional eligibility requirements suggested above should be modified as indicated, based on accumulated experience and the outcome data.

References

Alexander, R., Jr., & Meshelemiah, J. C. A. (2010). Gender identity disorders in prisons: What are the legal implications for prison mental health professionals and administrators? *The Prison Journal, 90*, 269–287.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Arcelus, J., Bouman, W. P., Van Den Noortgate, W., Claes, L., Witcomb, G., & Fernandez- Aranda, F. (2015). Systematic review and meta-analysis of prevalence studies in transsexualism. *European Psychiatry, 30*, 807–815.

Asscheman, H., Giltay, E. J., Megens, J. A. J., de Ronde, W., van Trotsenburg, M. A. A., & Gooren, L. J. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology, 164*, 635–642.

Blanchard, R. (1993). Varieties of autogynephilia and their relationship to gender dysphoria. *Archives of Sexual Behavior, 22*, 241–251.

Blanchard, R. (1994). A structural equation model for age at clinical presentation in nonhomosexual male gender dysphorics. *Archives of Sexual Behavior, 23*, 311–320.

Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies, 17*, 211–221.

Brown, G. R. (2014). Qualitative analysis of transgender inmates' correspondence: Implications for departments of correction. *Journal of Correctional Health Care, 20*, 334–342.

Brown, G. R., & McDuffie, E. (2009). Health care policies addressing transgender inmates in prison systems in the United States. *Journal of Correctional Health Care, 15*, 280–291.

Byne, W., Bradley, S. J., Coleman, E., Eyler, A. E., Green, R., Menvielle, E. J., … Tompkins, D. A. (2012). Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. *Archives of Sexual Behavior, 41*, 759–796.

California Correctional Health Care Services. (2015). *Guidelines for review of requests for sex reassignment surgery* (*SRS*). Retrieved October 28, 2015 from http://www.cphcs.ca.gov/docs/careguides/Guidelines%20for%20Review%20of%20Requests%20for%20Sex%20Reassignment%20Surgery%20(SRS).pdf.

Carson, A. E. (2014, September). *Prisoners in 2013*. Bulletin NCJ 247 282, Bureau of Justice Statistics, U.S. Department of Justice. Retrieved September 13, 2015 from http://www.bjs.gov/content/pub/pdf/p13.pdf.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., De Cuypere, G., Feldman, J., … Zucker, K. (2011). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*, 165–232.

Colopy, T. W. (2012). Setting gender identity free: Expanding treatment for transsexual inmates. *Health Matrix, 22*, 227–272.

De Cuypere, G., Van Hemelrijck, M., Michel, A., Carael, B., Heylens, G., Rubens, R., … Monstrey, S. (2007). Prevalence and demography of transsexualism in Belgium. *European Psychiatry, 22*, 137–141.

De Cuypere, G., & Vercruysse, H., Jr. (2009). Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH Standards of Care. *International Journal of Transgenderism, 11*, 194–209.

Department of Health and Human Services Departmental Appeals Board. (2014, May). *National Coverage Determination 140.3, Transsexual Surgery. Decision No. 2576*. Retrieved September 13, 2015 from http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf.

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS One, 6*, e16885. doi:10.1371/journal.pone.0016885.

Dhejne, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior, 43*, 1535–1545.

Fisk, N. (1974). Gender dysphoria syndrome (the how, what, and why of a disease). In D. R. Laub & P. Gandy (Eds.), *Proceedings of the second interdisciplinary symposium on gender dysphoria syndrome* (pp. 7–14). Stanford, CA: Stanford University Press.

Fleischaker, E. T. (2014). The constitutionality of prolonged administrative segregation for inmates who have received sex reassignment surgery. *Hastings Constitutional Law Quarterly, 41*, 903–926.

Gijs, L., & Brewaeys, A. (2007). Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness, and challenges. *Annual Review of Sex Research, 18*, 178–224.

Glezer, A., McNeil, D. E., & Binder, R. L. (2013). Transgender and incarcerated: A review of the literature, current policies and laws, and ethics. *Journal of the American Academy of Psychiatry and Law, 41*, 551–559.

Gómez-Gil, E., Zubiaurre-Elorza, L., Esteva, I., Guillamon, A., Godás, T., Cruz Almaraz, M., … Salamero M. (2012). Hormone-treated transsexuals report less social distress, anxiety and depression. *Psychoneuroendocrinology, 37,* 66–670.

Greenfield, L. A., & Snell, T. L. (1999). *Women offenders*. Special Report NCJ 175688, Bureau of Justice Statistics, U.S. Department of Justice. Retrieved September 13, 2015 from http://www.bjs.gov/content/pub/pdf/wo.pdf.

Guzmán-Parra, J., Sánchez-Álvarez, N., de Diego-Otero, Y., Pérez-Costillas, L., Esteva de Antonio, I., Navais-Barranco, M., … Bergero-Miguel, T. (2015). Sociodemographic characteristics and psychological adjustment among transsexuals in Spain. *Archives of Sexual Behavior*. doi:10.1007/s10508-015-0557-6.

Hare, R. D., & Neumann, C. S. (2008). Psychopathy as a clinical and empirical construct. *Annual Review of Clinical Psychology, 4*, 217–246.
Harry Benjamin International Gender Dysphoria Association. (1998). *The standards of care for gender identity disorders, fifth version*. Düsseldorf: Symposion.
Harry Benjamin International Gender Dysphoria Association. (2001). *The standards of care for gender identity disorders, sixth version*. Düsseldorf: Symposion.
Heylens, G., Elaut, E., Kreukels, B. P., Paap, M. C., Cerwenka, S., Richter-Appelt, H., … De Cuypere, G. (2014). Psychiatric characteristics in transsexual individuals: Multicentre study in four European countries. *British Journal of Psychiatry, 204,* 151–156.
Heylens, G., Verroken, C., De Cock, S., T'Sjoen, G., & De Cuypere, G. (2014). Effects of different steps in gender reassignment therapy on psychopathology: A prospective study of persons with a gender identity disorder. *Journal of Sexual Medicine, 11*, 119–126.
Interstate Commission for Adult Offender Supervision. (2014). *FY 2014 annual report.* Retrieved September 13, 2015 from http://www.interstatecompact.org/Portals/0/library/publications/annual_reports/ICAOS_AnnualReport_FY2014.pdf.
Jenness, V. (2010). From policy to prisoners to people. *Journal of Contemporary Ethnography, 39*, 517–553.
Jenness, V., & Fenstermaker, S. (2014). Agnes goes to prison: Gender authenticity, transgender inmates in prisons for men, and pursuit of "the real deal." *Gender & Society, 28*, 5–31.
Judge, C., O'Donovan, C., Callaghan, G., Gaoatswe, G., & O'Shea, D. (2014). Gender dysphoria—Prevalence and co-morbidities in an Irish adult population. *Frontiers in Endocrinology, 5*, 87. doi:10.3389/fendo.2014.00087.
Kaminski, J. L. (2007). Defining medical necessity [Report to Connecticut General Assembly]. Retrieved September 13, 2015 from http://www.cga.ct.gov/2007/rpt/2007-r-0055.htm.
Kosilek v. Spencer, 889 F. Supp. 2d 190. (2012). Retrieved September 13, 2015 from http://casetext.com/case/kosilek-v-spencer-3.
Kosilek v. Spencer, 740 F.3d 733. (2014a). Retrieved September 13, 2015 from http://www.glad.org/uploads/docs/cases/kosilek-v-spencer/kosilek-decision-1st-circuit.pdf.
Kosilek v. Spencer, 774 F.3d 63. (2014b). Retrieved September 13, 2015 from http://www.glad.org/uploads/docs/cases/kosilek-v-spencer/kosilek-en-banc-decision-12-16-14.pdf.
Kuiper, B., & Cohen-Kettenis, P. T. (1988). Sex reassignment surgery: A study of 141 Dutch transsexuals. *Archives of Sexual Behavior, 17*, 439–457.
Kuiper, A. J., & Cohen-Kettenis, P. T. (1998). Gender role reversal among postoperative transsexuals. *International Journal of Transgenderism, 2*(3), 1–13.
Laub, D. R., & Fisk, N. M. (1974). A rehabilitation program for gender dysphoria syndrome by surgical sex change. *Plastic and Reconstructive Surgery, 53*, 388–403.
Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*, 299–315.
Lawrence, A. A. (2013). *Men trapped in men's bodies: Narratives of autogynephilic transsexualism*. New York: Springer.
Lawrence, A. A. (2014). Treatment of gender dysphoria. In G. O. Gabbard (Ed.), *Gabbard's treatments of psychiatric disorders* (5th ed., pp. 695–719). Arlington, VA: American Psychiatric Publishing.
Lawrence, A. A., & Zucker, K. J. (2014). Gender dysphoria. In D. C. Beidel, B. C. Frueh, & M. Hersen (Eds.), *Adult psychopathology and diagnosis* (7th ed., pp. 603–639). Hoboken, NJ: Wiley.
Leonard, L. (2014). Gender reassignment surgery in prisons: How the eighth amendment guarantees medical treatments not covered by private insurance or Medicare for law-abiding citizens. *Rutgers Journal of Law & Public Policy, 11*, 626–663.
Levine, S. B. (1993). Gender-disturbed males. *Journal of Sex and Marital Therapy, 19*, 131–141.
Levine, S. B. (2009). Real-life test experience: Recommendations for revisions to the Standards of Care of the World Professional Association for Transgender Health. *International Journal of Transgenderism, 11*, 186–193.
Levine, S. B., & Solomon, A. (2009). Meanings and political implications of "psychopathology" in a gender identity clinic: A report of 10 cases. *Journal of Sex and Marital Therapy, 35*, 40–57.
Lothstein, L. M. (1979). The aging gender dysphoria (transsexual) patient. *Archives of Sexual Behavior, 8*, 431–444.
Marks, I., Green, R., & Mataix-Cols, D. (2000). Adult gender identity disorder can remit. *Comprehensive Psychiatry, 41*, 273–275.
Mate-Kole, C., Freschi, M., & Robin, A. (1990). A controlled study of psychological and social change after surgical gender reassignment in selected male transsexuals. *British Journal of Psychiatry, 157*, 261–264.
Mintz, H. (2015, May 18). California transgender inmates fight for medical care. *San Jose Mercury News*. Retrieved September 13, 2015 from http://www.mercurynews.com/crime-courts/ci_28135538/california-transgender-inmates-fight-medical-care.
Monstrey, S., Vercruysse, H., Jr., & De Cuypere, G. (2009). Is gender reassignment surgery evidence based? Recommendation for the seventh version of the WPATH Standards of Care. *International Journal of Transgenderism, 11*, 206–214.
Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology, 72*, 214–231.
Norsworthy v. Beard, Case No. 3:14-cv-00695-JST (N.D. Cal.; 2015). Retrieved September 13, 2015 from http://transgenderlawcenter.org/wp-content/uploads/2015/04/Norsworthy-Order-on-PI.pdf.
Prison near Purdy houses transsexual murderer. (2003, December 7). *The Seattle Post-Intelligencer*. Retrieved September 13, 2015 from http://www.seattlepi.com/local/article/Prison-near-Purdy-houses-transsexual-murderer-1131533.php.
Prosser, J. (1998). *Second skins: The body narratives of transsexuality*. New York: Columbia University Press.
Quine v. Beard, Case No. C 14-02726 JST (N.D. Cal.: 2015) Notice of settlement agreement and release. Retrieved September 13, 2015 from http://transgenderlawcenter.org/wp-content/uploads/2015/08/Quine-settlement-doc.pdf.
Roback, H. B., Fellemann, E. S., & Abramowitz, S. I. (1984). The mid-life male sex-change applicant: A multiclinic survey. *Archives of Sexual Behavior, 13*, 141–153.
Sexton, L., Jenness, V., & Sumner, J. M. (2010). Where the margins meet: A demographic assessment of transgender inmates in men's prisons. *Justice Quarterly, 27*, 835–866.
Shore, E. S. (1984). The former transsexual: A case study. *Archives of Sexual Behavior, 13*, 277–285.
Smith, Y. L. S., van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine, 35*, 89–99.
St. John, P. (2015, August 10). In a first, California agrees to pay for transgender inmate's sex reassignment. *The Los Angeles Times*. Retrieved September 13, 2015 from http://www.latimes.com/local/california/la-me-inmate-transgender-20150810-story.html.
Steiner, B. W. (1985). Transsexuals, transvestites, and their partners. In B. W. Steiner (Ed.), *Gender dysphoria: Development, research, management* (pp. 351–364). New York: Plenum.
Sumner, J., & Jenness, V. (2014). Gender integration in sex-segregated U.S. prisons: The paradox of transgender correctional policy. In D. Peterson & V. R. Panfil (Eds.), *Handbook of LGBT communities, crime, and justice* (pp. 229–259). New York: Springer.
Transgender California inmate wins parole. (2015, August 8). *The Associated Press*. Retrieved September 13, 2015 from http://www.nytimes.com/2015/08/09/us/transgender-california-inmate-wins-parole.html.

Udeze, B., Abdelmawla, N., Khoosal, D., & Terry, T. (2008). Psychological functions in male- to-female transsexual people before and after surgery. *Sexual and Relationship Therapy, 23*, 141–145.

Walker, P. A., Berger, J. C., Green, R., Laub, D. A., Reynolds, C. L., & Wolman, L. (1990). *The Harry Benjamin International Gender Dysphoria Association's Standards of Care*. Sonoma, CA: Harry Benjamin International Gender Dysphoria Association.

World Health Organization. (1992). *International statistical classification of diseases and related health problems* (10th rev., Vol. 1). Geneva, Switzerland: World Health Organization.

Zucker, K. J., Lawrence, A. A., & Kreukels, B. P. C. (2016). Gender dysphoria in adults. *Annual Review of Clinical Psychology*. doi:10.1146/annurev-clinpsy-021815-093034.