UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, Plaintiffs, v. JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON, Defendants.	)	Civil No. 3:18-cv-00156-NJR-MAB

MOTION AND MEMORANDUM IN SUPPORT OF CLASS CERTIFICATION

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INTRODUCTION

Defendants are responsible for the systemic failure to provide constitutionally adequate medical care to transgender prisoners in the custody of the Illinois Department of Corrections ("IDOC"). Defendants' deliberate indifference to these systemic failures has harmed Plaintiffs and created a substantial risk of serious harm to them in violation of the Eighth Amendment to the United States Constitution.

Plaintiffs Janiah Monroe, Marilyn Melendez, Lydia Helena Vision, Sora Kuykendall, and Sasha Reed (collectively, the "Named Plaintiffs")[1] are transgender women currently incarcerated in IDOC facilities, who seek to represent a class of all prisoners in the custody of IDOC who have requested evaluation or treatment for gender dysphoria (the "Class"). By this motion, Plaintiffs seek an order certifying the case as a class action under Federal Rule of Civil Procedure 23(b)(2). Plaintiffs seek declaratory and injunctive relief, including an order compelling Defendants to develop and implement a plan to provide Plaintiffs and the proposed Class with constitutionally adequate medical care. Plaintiffs do not seek damages.

Defendants' chronic failure to provide even the most basic treatment for gender dysphoria has caused immense mental and physical anguish for Plaintiffs and proposed Class members. Gender dysphoria is not a novel medical condition, nor is its treatment unknown or untested. Indeed, decades of research establish that gender dysphoria is a serious medical condition that can be effectively treated through social transition, hormone therapy, and surgery. Nevertheless, to the extent Defendants provide any treatment at all for the condition, it is so inadequate as to fall far below what is constitutionally required.

[1] Ebony Stamps was named as a Plaintiff in the Complaint, but has since been released from IDOC custody.

ARGUMENT

I. LEGAL STANDARD AND SUMMARY OF ARGUMENT

Plaintiffs seek certification of a class of "all prisoners in the custody of IDOC who have requested from IDOC evaluation of treatment for gender dysphoria." District courts in the Seventh Circuit have certified similar classes of IDOC prisoners who have been deprived of adequate care or accommodations. *See Lippert v. Baldwin*, No. 10 C 4603, 2017 WL 1545672, at *10 (N.D. Ill. Apr. 28, 2017) (certifying class of "all prisoners in the custody of the Illinois Department of Corrections with serious medical or dental needs"); *Holmes v. Godinez*, 311 F.R.D. 177 (N.D. Ill. 2015) (certifying class of deaf or hard-of-hearing IDOC prisoners); Order on Pls.' Mot. for Class Certification Under Rule 23(b)(2) at 4, *Rasho v. Walker*, No. 07-1298-MMM, Dkt. 252 (C.D. Ill. Aug. 14, 2015) (certifying class of mentally ill IDOC prisoners).

For a class to be certified, it must satisfy the requirements of Federal Rules of Civil Procedure 23(a) and (b) ("Rule 23"). When making such a determination, courts may consider the merits of the case to the extent "they are relevant to determining whether the Rule 23 prerequisites for class certification are satisfied." *Amgen Inc. v. Conn. Ret. Plans & Trust Funds*, 133 S. Ct. 1184, 1194–95 (2013).

The proposed Class meets each of the requirements of Rule 23(a). First, the proposed Class consists of at least 100 current transgender prisoners who have been deprived of adequate medical treatment for gender dysphoria, which is sufficiently numerous under Rule 23(a)(1). Second, none of the transgender prisoners seeking treatment for gender dysphoria have received constitutionally adequate medical treatment for their condition, raising "questions of law or fact common to the class," as required by Rule 23(a)(2). Similarly, all of the proposed Class members are subject to Defendants' centralized policies, procedures, and practices, and medical care decisions are made by a single body – the Transgender Committee (formerly, the "Gender Identity Disorder

Committee" or "GID Committee"). Thus, Plaintiffs' claims are common to, and typical of, those of the Class. FED. R. CIV. P. 23 (a)(2), (3). Finally, Plaintiffs and their counsel adequately represent the Class, as required by Rule 23(a)(4). The Named Plaintiffs, as Class representatives, would benefit from the same relief as the rest of the Class, and their counsel are experienced in civil rights, class action, and complex civil litigation.

The proposed Class also satisfies the requirements of Rule 23(b). Defendants have "acted or refused to act on grounds that apply generally to the class, such that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole" by depriving Plaintiffs and proposed Class members of constitutionally adequate medical treatment for gender dysphoria through IDOC's system-wide policies and practices. FED. R. CIV. P. 23(b)(2). Accordingly, class certification is appropriate under Rule 23(b)(2).[2]

II. PLAINTIFFS SATISFY THE REQUIREMENTS OF RULE 23(A): NUMEROSITY, COMMONALITY, TYPICALITY, AND ADEQUACY

A. Numerosity

A class may be certified if it is "so numerous that joinder of all members is impracticable." FED. R. CIV. P. 23(a)(1). The Seventh Circuit has interpreted Rule 23 broadly to "permit a class suit where several persons jointly act to the injury of many persons so numerous that their voluntarily, unanimously joining in a suit is concededly improbable and impracticable." *Hohmann v. Packard Instrument Co.*, 399 F.2d 711, 715 (7th Cir. 1968). Courts typically presume joinder impracticable when the class exceeds 40 members. *See, e.g.*, *Swanson v. Am. Consumer Indus.,*

[2] While the proposed Class meets the Rule 23 requirements for class certification, the court may, in the exercise of its equitable authority, preliminarily enjoin unlawful conduct prior to ruling on a class certification motion. *See Lee v. Orr*, No. 13-cv-8719, 2013 WL 6490577, at *2 (N.D. Ill. Dec. 10, 2013) ("District courts have the power to order injunctive relief covering potential class members prior to class certification.") (citing *Ill. League of Advocates for the Developmentally Disabled v. Ill. Dep't of Human Servs.*, No. 13 C 1300, 2013 U.S. Dist. LEXIS 90977, at *9 (N.D. Ill. June 28, 2013)); *O.B. v. Norwood*, 170 F. Supp. 3d 1186, 1200 (N.D. Ill. 2016), *aff'd* (on appeal of preliminary injunction), 838 F.3d 837 (7th Cir. 2016); *but see, McKenzie v. City of Chicago*, 118 F.3d 552, 555 (7th Cir. 1997) (reversing injunction).

Inc., 415 F.2d 1326, 1333 (7th Cir. 1969) (finding a class of 40 members was sufficiently numerous); *Cima v. WellPoint Health Networks, Inc.*, 250 F.R.D. 374, 378 (S.D. Ill. 2008) ("A class of more than 40 individuals raises a presumption that joinder is impracticable . . . . [C]ourts have found the numerosity element satisfied where the putative class would number in the range of as few as ten to forty class members.") (internal quotation marks and citations omitted).

Here, there are over 100 members of the proposed Class, which easily satisfies the numerosity requirement of Rule 23(a)(1). Defendants report 106 putative class members in IDOC custody in May 2018 (Ex. 1, May 28, 2018 Transgender Population Totals By Facility, 004175–201), 110 putative class members in June 2018 (Ex. 2, June 28, 2018 Transgender Population Totals By Facility, 004202–28), and 113 in July 28, 2018 (Ex. 3, July 28, 2018 Transgender Population Totals By Facility, 004229–55).

When determining whether a proposed class meets the numerosity requirement of Rule 23(a), courts may also take into account practical considerations of litigating a matter through a single class: "[t]he crux of the numerosity requirement is not the number of interested persons per se, but the practicality of their joinder into a single suit." *Arenson v. Whitehall Convalescent & Nursing Home*, 164 F.R.D. 659, 663 (N.D. Ill. 1996) (quoting *Small v. Sullivan*, 820 F. Supp. 1098, 1109 (S.D. Ill. 1992)). Factors such as "judicial economy, the ability of class members to initiate individual suits, geographic dispersion of the putative class, and the practicability of relitigating a common core of issues" are relevant to the court's determination that joinder of all members is impracticable. *Brown v. Club Assist Rd. Serv. U.S., Inc.*, No. 12-cv-5710, 2015 WL 13650775, at *10 (N.D. Ill. Mar. 13, 2015) (quoting *Healey v. Int'l Bhd. of Elec. Workers, Local Union No. 134*, 296 F.R.D. 587, 593 (N.D. Ill. 2013)); *see Flanagan v. Allstate Ins. Co.*, 223 F.R.D. 489, 493 (N.D. Ill. 2004) ("When determining whether joinder is impracticable, the court considers not only the

size of the class, but also its geographic dispersion, the relief sought, and the ability of individuals to bring their own claims."). Relatedly, impracticability of joinder is determined based on the difficulty class members would face based on the particular circumstances. *See e.g., Fields v. Maram*, No. 04 C 0174, 2004 WL 1879997, at *5 (N.D. Ill. Aug. 17, 2004) (finding the numerosity requirement satisfied where "class members reside throughout the state, and because they are disabled and therefore are often of limited financial resources").

Under any metric, the proposed Class meets the numerosity requirements of Rule 23(a). First, the prisoners are located in IDOC facilities across the state. Ex. 3 (identifying 113 transgender prisoners across 21 different IDOC facilities). Second, most are likely to lack the resources and familiarity with the judicial process to effectively prosecute individual suits, and would face significant barriers to individual joinder, such as the resources required to hire experts. *See, e.g.*, CAROLINE WOLF HARLOW, EDUCATION AND CORRECTIONAL POPULATIONS, BUREAU OF JUSTICE STATISTICS: SPECIAL REPORT (2003) (finding that 18 percent of the general population age 18 or older had not finished the 12th grade whereas about 41 percent of incarcerated individuals had not completed high school or its equivalent); ADAM LOONEY & NICHOLAS TURNER, THE BROOKINGS INSTITUTION, WORK AND OPPORTUNITY BEFORE AND AFTER INCARCERATION 11–12 (2018) (incarcerated individuals are disproportionately from lower-income families).

B. Commonality

To meet the commonality requirement of Rule 23(a), Plaintiffs must show there are "questions of law or fact common to the class." FED. R. CIV. P. 23(a)(2). In particular, Plaintiffs must show that the Class members' claims "depend upon a common contention" that is "capable of classwide resolution." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011); *Bolden v. Walsh Constr. Co.*, 688 F.3d 893, 896 (7th Cir. 2012); *Brand v. Comcast Corp.*, 302 F.R.D. 201, 218 (N.D. Ill. 2014). The central inquiry is thus whether "a classwide proceeding [has the capacity]

to generate common answers apt to drive the resolution of the litigation." *Wal-Mart*, 564 U.S. at 350 (emphasis removed). Members of the class are not required to present identical claims. *Boundas v. Abercrombie & Fitch Stores, Inc.*, 280 F.R.D. 408, 413 (N.D. Ill. 2012) ("Rule 23(a)(2) does not demand that every member of the class have an identical claim.") (citation omitted). Indeed, "some degree of factual variation will not defeat commonality provided that common questions yielding common answers can be identified." *Id*.

Plaintiffs assert that Defendants' system-wide policies and practices have deprived all proposed Class members of constitutionally adequate medical care. Courts have held that the commonality requirement is met where, as here, "overarching systemic deficiencies" create "risk of harm" for all class members. *See Bolden*, 688 F.3d at 898 ("[A] single policy spanning all sites could be contested in a company-wide class"); *N.B. v. Hamos*, 26 F. Supp. 3d 756, 773 (N.D. Ill. 2014) (finding that the Seventh Circuit "specifically allows" for the finding of commonality "where a 'systemic failure' or an 'illegal policy' is alleged; . . . the policy is the 'glue' that unites otherwise individualized claims").

Courts routinely find commonality among classes of prisoners alleging chronic failures or system-wide practices. *See, e.g.*, *Lippert v. Baldwin*, No. 10 C 4603, 2017 WL 1545672, at *4 (N.D. Ill. Apr. 28, 2017) ("The question common to all plaintiffs . . . is whether each of defendants' policies and practices do in fact put prisoners with serious medical conditions at risk. As other courts have held, such a question satisfies Rule 23's commonality requirement."); Order on Pls.' Mot. for Class Certification Under Rule 23(b)(2) at 4, *Rasho v. Walker*, No. 07-1298-MMM, Dkt. 252 (C.D. Ill. Aug. 14, 2015) (certifying a class of mentally ill prisoners in IDOC and finding commonality where "the proposed class as a whole is subject to the same policies which foster inadequate mental health diagnosis and treatment"); *Holmes v. Godinez*, 311 F.R.D. 177, 220

(N.D. Ill. 2015) (certifying a class of deaf and hard-of-hearing prisoners in IDOC and finding commonality where plaintiffs alleged and "sufficiently proved the existence of the statewide policies and practices").

Here, each member of the proposed Class is seeking treatment for the same medical condition and, as a result of Defendants' policies and practices, has received wholly inadequate treatment for that condition. As a result of Defendants' actions and failures to act, each member of the proposed Class has been harmed and is at risk of additional harm.

While gender dysphoria treatment must be tailored to each individual's needs, there are clear standards and guidelines defining appropriate treatment. Declaration of Dr. Randi Ettner ("Ettner Decl.") ¶¶ 25–26. IDOC's systemic policies and practices have resulted in an utter failure to provide treatment in compliance with these standards, which extends across the proposed Class. Further, all treatment decisions for gender dysphoria are funneled through the Transgender Committee: a single, consolidated body tasked with evaluating prisoners seeking treatment for gender dysphoria, as well as overseeing these prisoners' treatment plans and "gender-related accommodation[s]." *See* Defs.' Answer ¶ 67. Treatment prescribed (or denied) by the Transgender Committee for members of the proposed Class share a host of common defects, and members are therefore seeking substantially similar remedies. Accordingly, and as further explained below, Plaintiffs raise questions of law and fact that are common to the proposed Class, as required by Rule 23(a)(2).

1. Defendants chronically permit under-qualified medical professionals and non-medical prison staff to evaluate and design treatment plans for IDOC prisoners who are seeking treatment for gender dysphoria.

Defendants have a policy and practice whereby medical decisions regarding gender dysphoria treatment are denied or delayed by the Transgender Committee, which consists of non-experts and laypeople. Each IDOC prisoner seeking treatment for gender dysphoria is channeled

through the "Transgender Committee," a single body responsible for "placements, security concerns, and overall health related treatment plans" for all transgender prisoners. *See* Defs.' Answer ¶ 66. Defendants' policies and procedures for the evaluation and treatment of prisoners with gender dysphoria, including the establishment of the Transgender Committee, are set forth by IDOC Administrative Directive 04.03.104, "Evaluation of Offenders with Gender Identity Disorders," effective as of May 1, 2013 (the "GID Directive"). *See id.* ¶¶ 64, 66. Despite the Transgender Committee's specific and specialized mandate, it has no members with even the most rudimentary expertise in treating gender dysphoria. *See* Ex. 4, Defs.' Resp. to Interrog. No. 4 (listing names of Transgender Committee members); *id.* at Defs.' Resp. to Interrog. No. 5 (listing "with specificity the medical or other qualifications to treat gender dysphoria" of the Transgender Committee members, and listing no qualifications at all for some members); Ettner Decl. ¶ 134.

The WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (the "Standards of Care") are recognized as the authoritative standards of care by leading medical organizations, the U.S. Department of Health and Human Services, and several courts. *See id.* ¶ 24. The current version of the Standards of Care, released in 2012, is the seventh update to the original 1979 document. THE WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER-NONCONFORMING PEOPLE n. 1 (2012), available at https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf. Under the Standards of Care, all mental health professionals should have certain minimum credentials before treating patients with gender dysphoria, including a master's degree (or equivalent) in a clinical behavioral science field; competencies in using the DSM-5 and/or the International Classification of Diseases for diagnostic purposes; ability to recognize and

diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; documented supervised training and competence in psychotherapy or counseling; knowledge of gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and continuing education in the assessment and treatment of gender dysphoria. Ettner Decl. ¶ 29.

Not a single member of the Transgender Committee meets these baseline criteria. *Id.* ¶¶ 134–35. For example, Dr. Steve Meeks, Chief of Health Services and former Chair of the Transgender Committee, admitted he is not an expert in providing care to transgender individuals. *See* Ex. 5, Meeks Evid. Hr'g Testimony (*Hampton v. Baldwin*) at 297:20–22 ("Q: You are no expert in providing care to transpeople, correct? A: I would not consider myself an expert in this area."). Similarly, when asked if he believed himself to be an expert in the treatment of gender dysphoria, Dr. William Puga, the Chief of Psychiatry and current Chair of the Transgender Committee, stated that "[he] would probably say [he has] more experience and . . . more working knowledge than the average person – the average psychiatrist," though he has only treated two transgender patients (and *not* for gender dysphoria) and does not prescribe hormone therapy. Ex. 6, Puga 30(b)(6) Dep. at 35:3–11, 31:4–33:23. Worse still, the Transgender Committee includes non-medical IDOC staff who are entirely unqualified to participate in decision-making about medical treatment plans. *Id.* at 26:16–27:17. The Transgender Committee also puts medical treatment decisions to a vote without regard to medical expertise or knowledge of the particular medical needs of an individual prisoner, which is a wholly inappropriate method of determining a medical treatment plan. *Id*. at 42:8–11.

IDOC medical professionals display a shocking lack of knowledge regarding gender dysphoria and its treatment. For instance, a basic tenet of working with transgender individuals is

the importance of respecting each individual's gender identity. Ettner Decl. ¶ 61. Refusing to use a transgender person's correct pronouns and preferred name can be psychologically damaging and can exacerbate the distress caused by the condition. *Id.* ¶ 62; Ex. 7, Reister 30(b)(6) Dep. at 125:1–8 (misgendering is "psychologically harmful, stressful, and interferes with treatment"). Nevertheless, IDOC treating clinicians and mental health professionals consistently misgender transgender prisoners. Ettner Decl. ¶ 134. Even more disconcerting, the Transgender Committee at times misgenders transgender prisoners in its notes and rarely, if ever, use their gender-consistent names. *Id*. The Transgender Committee notes also discuss gender dysphoria using outdated language, which reflects its lack of expertise and familiarity with the subject matter at hand. *Id*. For example, Transgender Committee notes describe transgender prisoners as "transgenders," which is offensive and outdated nomenclature, and refer to "gender identification disorder"—which is not and never has been a term for gender dysphoria (previously "gender *identity* disorder"). *Id*. IDOC personnel also call the condition "tg disorder," and "sex dysphoria," as well as and other incorrect and inaccurate names. *Id*. ¶ 135.

The consequences of the Transgender Committee's inadequacy reverberate across the proposed Class. Undeterred by lack of credentials, knowledge, or experience, the Transgender Committee provides recommendations regarding hormone therapy, clothing, showers, searches, housing, and other accommodations. *See* Defs.' Answer ¶¶ 64, 66. In making these recommendations, the Transgender Committee does not meet with the prisoners or the prisoners' treating clinicians, nor does it review the prisoners' medical records or mental health records. Ettner Decl. ¶ 138; Ex. 8, Hinton Dep. (*Hampton v. Baldwin*) at 92:20–93:3, 94:12–15. Instead, the Transgender Committee reviews a short "snapshot" update form filled out by mental health professionals. Ex. 6 at 42:22–44:9.

As a result of the Transgender Committee's lack of expertise, prisoners who have been diagnosed with gender dysphoria are frequently denied hormone therapy or other necessary medical care for reasons that directly contradict the Standards of Care. Ettner Decl. ¶ 139. Even when medical treatment is prescribed, it is often only after long delays, and is ultimately inadequate to meet the prisoner's medical needs. *Id.* ¶¶ 133, 139; Declaration of Dr. Vin Tangpricha ("Tangpricha Decl.") ¶ 21.

2. Defendants routinely deny or delay hormone treatment, including by imposing arbitrary, medically unnecessary requirements.

IDOC has a policy and practice whereby hormone therapy is denied and delayed for reasons that are not recognized as contraindications to treatment. For most transgender individuals, hormone therapy is "essential and medically indicated treatment" for gender dysphoria. Ettner Decl. ¶ 35. Hormone therapy in accordance with the Standards of Care is recognized by the American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association as safe, effective, and medically necessary treatment for many individuals with gender dysphoria. *Id.* ¶ 36. Without adequate medical treatment, adults with gender dysphoria "experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues." *Id.* ¶ 68. However, Plaintiffs and proposed Class members often experience delays of months – or even years – following a gender dysphoria diagnosis (sometimes, following multiple diagnoses of gender dysphoria) before receiving hormone therapy. *Id.* ¶ 126.

The Transgender Committee regularly delays or denies hormone therapy for reasons that have no medical basis. *Id.* ¶ 127. For example, the Transgender Committee frequently delays hormone treatment because it interprets a prisoner's *symptoms* of gender dysphoria (such as distress, anxiety, and depression) as a lack of "stability" that prevents *treating* the gender

dysphoria. *Id.* Although co-occurring mental health conditions should be evaluated when prescribing hormone therapy (or any medical treatment), such conditions would present no barrier to starting hormone therapy absent the most exceptional circumstances – for example, where the individual is so delusional as to be unable to consent to the initiation of hormone therapy. *Id.* ¶ 41; Tangpricha Decl. ¶ 21. But the majority of individuals with untreated gender dysphoria will exhibit other mental health conditions such as depression, anxiety, or suicidality, which are often in fact symptoms of the untreated or inadequately treated gender dysphoria, rather than an independent mental health condition. Ettner Decl. ¶¶ 39, 41; Tangpricha Decl. ¶ 21. By delaying hormone treatment until a prisoner is deemed "stable," the Transgender Committee fails to recognize that this purported instability may be *caused by* lack of adequate treatment for gender dysphoria. Ettner Decl. ¶ 127; Tangpricha ¶ 23. Necessary treatment of serious conditions is not ordinarily withheld from "unstable" individuals, and absent a medical basis, such a requirement is unconstitutional.

The Transgender Committee imposes myriad other non-clinical hurdles to obtaining hormones, and denies treatment for reasons that are not medically accepted contraindications. For instance, the Transgender Committee will delay treatment for prisoners to undergo "counseling," which is unnecessary to initiate hormone therapy. Tangpricha Decl. ¶ 21. The Transgender Committee also regularly denies or delays hormone treatment without providing any medical justification whatsoever. Ettner Decl. ¶¶ 129–32.

3. Defendants routinely fail to prescribe or administer appropriate hormones and dosages, as well as fail to provide sufficient monitoring of prisoners' health while receiving hormone treatment.

IDOC has a policy and practice whereby prisoners with gender dysphoria are given inadequate or inappropriate hormone doses or varieties, and whereby blood work necessary to ensure safety and efficacy is rarely and haphazardly done. For gender dysphoric prisoners who

are prescribed hormone therapy, often after long delays, Defendants routinely fail to provide appropriate treatment or adequate monitoring. Testosterone or estrogen levels should be sufficient to maintain the desired sex characteristics and relieve gender dysphoria, while within certain ranges to avoid potentially life-threatening health risks. Tangpricha Decl. ¶ 22. Defendants routinely prescribe low doses that often are insufficient to treat gender dysphoria, and consistently fail to perform blood work. *Id.* ¶¶ 66–69.

Failure to provide appropriate hormone therapy can have serious – and potentially fatal – consequences. For transgender women, estrogen levels that are too high or too low can cause osteoporosis, hot flashes, and mood disorders. *Id.* ¶ 26. Defendants frequently prescribe conjugated estrogen, which is not recommended under the Guidelines "because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease (also known as blood clots)." *Id.* ¶¶ 40, 70. Further, transgender women taking testosterone suppressants (*i.e.* spironolactone) must be regularly monitored to ensure potassium, creatinine, prolactin levels are within a safe range. *Id.* ¶¶ 36–38. Without proper monitoring, transgender women risk cardiac arrhythmia, kidney failure, loss of eyesight, and death. *Id.* Transgender men receiving testosterone injections must also be monitored to ensure testosterone levels are maintained within a safe range. Testosterone can cause high hemoglobin (red blood cells), which can cause blood clots, heart attack and stroke. *Id.* ¶ 42.

Defendants rarely conduct adequate monitoring of prisoners on hormone therapy. *Id.* ¶¶ 64–65. The Endocrine Society recommends "appropriate regular medical monitoring . . . for both transgender males and females during the endocrine transition and periodically thereafter." *Id.* ¶ 30. Typically, patients should be evaluated every 2–3 months during the first year of hormone treatment, and then 1–2 times per year afterwards. *Id.* However, Plaintiffs and proposed Class

members are infrequently and irregularly tested. *Id.* ¶¶ 64–65, 69. Similarly, many are prescribed a very low dose of hormones that is seldom, if ever, increased or adjusted. *Id.* ¶¶ 64, 68. When blood work is done, the vast majority of patients fall outside of the recommended range, which means their gender dysphoria is being inadequately treated, in addition to being exposed to serious medical risks. *Id.* ¶¶ 69, 71.

4. Defendants have a policy and practice of denying gender confirmation surgeries.

Defendants have a policy and practice whereby IDOC does not evaluate and consider surgery as a treatment option for gender dysphoria. Defendants disregard medical consensus surrounding the medical necessity of gender confirmation surgeries, and maintain a *de facto* policy of refusing to permit surgical treatment of gender dysphoria. Ettner Decl. ¶ 132. More than three decades of research confirms that gender confirmation surgery is effective treatment for gender dysphoria. Indeed, for many patients with severe gender dysphoria, gender confirmation surgery is the *only* effective treatment. *Id.* ¶ 45. Despite clear consensus by the major medical associations, the Transgender Committee, as a rule, does not even evaluate prisoners for gender confirmation surgery. IDOC's GID Directive states that "[t]he Department shall not perform or allow the performance of any surgery for the specific purpose of gender change, except in extraordinary circumstances as determined by the Director who has consulted with the Agency Medical Director." *See* Defs.' Answer ¶ 65. As a practical matter, this means that no IDOC prisoner is or ever has been approved for gender affirming surgery or has even been evaluated to determine whether they need gender affirming surgery to treat their gender dysphoria. *Id.* ¶ 100; Ex. 7 at 130:12–15.

Denying medically necessary surgical care can have dire consequences for prisoners with severe gender dysphoria. Without access to appropriate care, many transgender people experience

extreme depression and suicidality, with one recent study finding that 41% of transgender people unable to receive medically necessary care attempt suicide. Ettner Decl. ¶ 68. Some transgender women resort to life-threatening attempts at auto-castration – amputating one's own testicles – in the hopes of cutting off the flow of testosterone and removing a key source of dysphoria. *Id.* Indeed, many of the Plaintiffs and Class members have considered suicide, and some have either attempted to take their own lives or attempted to auto-castrate. *Id.* ¶¶ 75, 77, 91, 95, 119.

5. Defendants' policies and practices effectively prohibit prisoners with gender dysphoria from social transition.

Defendants have a policy and practice of depriving transgender prisoners of medically necessary social transition, including by mechanically assigning housing based on genitalia. For transgender individuals, living consistently with one's gender identity – or, social transition – is a key pillar of gender dysphoria treatment. *Id.* ¶¶ 34, 67. Social transition typically includes using names and pronouns associated with one's gender identity, using restrooms or other facilities consistently with one's gender identity, as well as expressing one's gender identity through grooming or clothing. *Id.* ¶ 34. Nevertheless, Defendants prevent prisoners with gender dysphoria from socially transitioning by using improper names and pronouns, cross-gender body searches, withholding access to gender-appropriate grooming (including permanent hair removal) and personal care items, and by refusing to evaluate prisoners for placement in correctional centers matching that correspond with their gender identity (except in rare circumstances—where litigation has been filed challenging placement of transgender women in male facilities). *See id.*

a. Defendants have a policy and practice of prohibiting or hindering social transition through use of improper pronouns and names, and cross-gender body searches.

Plaintiffs and proposed Class members are regularly misgendered by IDOC staff, including medical staff and mental health professionals. Ettner Decl. ¶¶ 134–35; Melendez Decl. ¶ 9;

Kuykendall Decl. ¶ 11; Reed Decl. ¶ 13. IDOC staff "find humor in calling coworkers 'faggots' in the armory or transgender offenders 'he/shes' or 'shemales.'" Ex. 9, 218620. Similarly, Transgender Committee members sometimes misgender prisoners, including referring to transgender women as "transgender males" – both disrespecting the prisoners' gender identity as well as indicating confusion over the definition of "transgender." *See* Ettner Decl. ¶ 134.

Prison officers and other IDOC staff similarly impede transgender prisoners' ability to socially transition, by refusing to respect their gender identity and subjecting them to cross-gender body searches. Despite the National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act (PREA) directive that prisons "shall not conduct cross-gender strip searches or cross-gender visual body cavity searches" except in exigent circumstances or when performed by medical practitioners, 28 C.F.R. § 115.15, transgender prisoners are regularly subjected to such searches. Melendez Decl. ¶ 9; Kuykendall Decl. ¶ 10; Reed Decl. ¶ 13; Vision Decl. ¶ 18. Strip searches of transgender prisoners conducted by officers of a different sex than those prisoners (*e.g.*, male officers strip searching female prisoners who are transgender), often in the presence of different-sex prisoners, is humiliating, degrading, often traumatizing. Ettner Decl. ¶ 63. This treatment is the result of IDOC personnel viewing transgender women as men.

b. Defendants have a policy and practice of hindering social transition by delaying or denying requests for gender affirming clothing, hygiene products, and grooming products.

Defendants have a policy and practice of delaying or denying requests for gender-affirming clothing and personal care products, which are necessary components of social transition. Gender-affirming clothing is an important component of social transition, as well as a physical necessity in many cases. Defendants have a policy and practice of denying all requests for gender affirming clothing except bras for some transgender women, and even then such requests are routinely denied

or delayed for illogical reasons or no reason at all. *Id.* ¶ 131. Similarly, Defendants have a policy and practice of denying requests for gender-appropriate personal care products, such as cosmetics and gender-appropriate lotions, deodorants and body washes available to non-transgender women in custody. *Id.*

Defendants also limit or outright deny the provision of hair removal products for transgender women. Face and body hair is a common source of gender dysphoria for transgender women, and being able to remove this hair is an critical component of social transition. *Id.* ¶ 60. Transgender women prisoners often have only limited access to razors or "magic shave," a chemical hair removal cream that is not recommended for use on the body. *See* Monroe Decl. ¶ 8; Melendez Decl. ¶ 7; Kuykendall Decl. ¶ 8; Vision Decl. ¶¶ 10–11. Defendants also summarily ignore requests for permanent hair removal procedures, which is a common medical treatment for gender dysphoria – indeed, IDOC has never approved permanent hair removal. Ex. 6 at 121:22–122:7.

c. Defendants have a policy and practice of hindering social transition by refusing to even evaluate transgender prisoners' transfer to a correction center that accords with their gender identity.

Social transition often includes the use of facilities that are consistent with one's gender identity. Ettner Decl. ¶ 67. Additionally, PREA recommendations state that "[i]n deciding whether to assign a transgender or intersex prisoner to a men's or women's facility, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the prisoner's health and safety, and whether the placement would present management or security problems." 28 C.F.R. § 115.42. However, despite this clear directive, Defendants do not make individualized assessments of whether to assign transgender prisoners to men's or women's correctional centers. Instead, IDOC's current policy – with only

limited exception as a result of litigation – is to house "all prisoners based on their genitalia." *See Hampton v. Baldwin*, No. 3:18-CV-550-NJR-RJD, 2018 WL 5830730, at *4 (S.D. Ill. Nov. 7, 2018) (noting that "currently all prisoners in the IDOC are housed based on their genitalia").

C. Typicality

Because the Defendants' policies and practices raise common questions that satisfy Rule 23(a)(2)'s commonality requirement, Rule 23(a)(3)'s typicality requirement is presumed also to be met. Indeed, the U.S. Supreme Court has held that "the commonality and typicality requirements of Rule 23(a) tend to merge. Both serve as guideposts for determining whether under the particular circumstances maintenance of a class action is economical and whether the named plaintiff's claim and the class claims are so interrelated that the interests of the class members will be fairly and adequately protected in their absence." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 349 n.5 (2011) (quoting *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 157–58, n.13 (1982)).

Plaintiffs' claims in this case are "typical of the claims or defenses of the class, as required by Rule 23(a)(3). According to the Seventh Circuit, the typicality requirement ensures that "there [is] enough congruence between the named representative's claim and that of the unnamed members of the class to justify allowing the named party to litigate on behalf of the group." *Spano v. Boeing Co.*, 633 F.3d 574, 586 (7th Cir. 2011). The named Plaintiffs' claims must "arise[] from the same event or practice or course of conduct that gives rise to the claims of other class members and [be] based on the same legal theory." *Flynn v. FCA US LLC*, 327 F.R.D. 206, 223 (S.D. Ill. 2018) (quoting *Oshana v. Coca-Cola Co.*, 472 F.3d 506, 514 (7th Cir. 2006)). Nevertheless, "typicality does not require the facts underlying every claim to be identical" and the standard "'may be satisfied even if there are factual distinctions between the claims of the named plaintiffs and those of other class members.'" *Suchanek v. Sturm Foods, Inc.*, 311 F.R.D. 239, 255 (S.D. Ill. 2015) (citing *De La Fuente v. Stokely–Van Camp, Inc.*, 713 F.2d 225, 232 (7th Cir. 1983)); *see*

also Gaspar v. Linvatec Corp., 167 F.R.D. 51, 57 (N.D. Ill. 1996) ("[T]he typicality requirement is liberally construed."). Under Rule 23(a)(3), courts must "look to the defendant's conduct and the plaintiff's legal theory." *Rosario v. Livaditis*, 963 F.2d 1013, 1018 (7th Cir. 1992).

In this case, the claims of named Plaintiffs Janiah Monroe, Marilyn Melendez, Lydia Helena Vision, Sora Kuykendall, and Sasha Reed are typical of the proposed Class as a whole. For all of the proposed Class members and the named Plaintiffs, medical care is guided and overseen by the Transgender Committee, which is unqualified and has demonstrated an inability to provide constitutionally adequate care for gender dysphoria by inadequately treating class members and named Plaintiffs. Moreover, the Defendants' failure to institute appropriate policies or procedures to protect transgender prisoners has harmed and continues to harm everyone in the proposed class, including the named Plaintiffs. For example, IDOC mechanically places transgender women in facilities for men and routinely subjects them to demeaning and harmful strip-searches by male staff. Moreover, IDOC routinely misgenders transgender prisoners and demeans them with offensive and derogatory terms. IDOC also fails to provide gender affirming clothing and grooming items to prisoners with gender dysphoria, including by not making such items available in prison canteens and by specifically denying requests for such items.

1. Janiah Monroe

Janiah Monroe is a transgender woman incarcerated at Logan Correctional Center. Monroe Decl. ¶ 13. As is typical of the Class, Ms. Monroe experienced an unjustifiably long delay before receiving inadequate hormone therapy and subsequent monitoring, was denied even an evaluation for gender-affirming surgery, and has been unable to socially transition due to Defendants' policies and practices.

Ms. Monroe first requested hormone therapy from IDOC in 2008, during her intake at the Northern Reception Center. *Id.* ¶ 2. Despite her unequivocal request that she "needed hormone

therapy" and the fact that she had previously received hormone therapy, IDOC forced her to wait *four years*. *Id*. ¶¶ 2, 7. In the interim, Ms. Monroe filed multiple grievances and, increasingly desperate, resorted to several attempts at self-castration before IDOC provided her with hormones in mid-2012. *Id*. ¶¶ 3–4. Between her intake in 2008 and IDOC providing her with hormone treatment in 2012, IDOC mental health professionals repeatedly evaluated Ms. Monroe for gender dysphoria and reconfirmed her diagnosis. *Id*. ¶ 2. These medical professionals recommended that Ms. Monroe start hormone therapy, but the Transgender Committee continued to deny her hormone treatment. Ettner Decl. ¶ 78. Nothing in IDOC's medical records for Ms. Monroe justifies the approximately four-year delay in her treatment. Tangpricha Decl. ¶ 44; Ettner Decl. ¶ 82. Indeed, Dr. Tangpricha found that in his decades of professional experience, Ms. Monroe's "quality of care is among the worst cases [he has encountered]." Tangpricha Decl. ¶¶ 3–5, 51.

Despite ultimately being provided hormone therapy, Ms. Monroe has not been provided care or monitoring in accordance with accepted medical standards. Ms. Monroe's medical records show that since she started hormone therapy, IDOC has not monitored her hormone levels in accordance with the Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline ("Guidelines"). *Id.* ¶ 42. Over the course of six years, monitoring of her levels has been extremely rare, and the few blood tests that IDOC has performed indicate estradiol levels consistently measuring below the recommended physiologic range under the Guidelines. *Id.* ¶¶ 42, 49. Nevertheless, IDOC has not adjusted her dosage and IDOC is therefore failing to adequately treat her gender dysphoria. *Id*. ¶¶ 49–50.

As is universal across the Class, Defendants have refused to provide Ms. Monroe with gender-affirming surgery. Defendants have summarily dismissed her as "not a candidate for a reassignment surgery," despite remaining critically dysphoric for nearly seven years after starting

hormone therapy. Monroe Decl. ¶ 6. Ms. Monroe's multiple requests have been denied, and her subsequent grievances have been ignored. *Id.* ¶¶ 6, 8.

As is typical of the Class, Defendants have impeded Ms. Monroe's social transition in a variety of ways. For example, Defendants permit IDOC staff, including medical and mental health professional, to call her by a male name and to use male pronouns when referring to her. *Id.* ¶ 7. Defendants also hindered Ms. Monroe's social transition by denying her requests for feminine underwear, a bra, and a safe and reliable way to remove her facial and body hair. *Id.* ¶¶ 5–6. She eventually received a bra after filing multiple grievances. *Id.* ¶ 5. Defendants' unreasonable delay in providing her a bra, as well as its ongoing refusal to provide her with feminine underwear, electrolysis hair removal, and gender-appropriate clothing and personal grooming items are typical of the class' claim. *Id.* ¶¶ 5–6.

2. Marilyn Melendez

Marilyn Melendez is a transgender woman incarcerated at Pontiac Correctional Center. Melendez Decl. ¶ 9. As is typical of the Class, Ms. Melendez experienced an unjustifiably long delay before receiving inadequate hormone therapy and subsequent monitoring, was denied even an evaluation for gender-affirming surgery, and has been unable to socially transition due to Defendants' policies and practices.

Ms. Melendez was forced to wait several months before she was provided with hormone therapy, despite a gender dysphoria diagnosis. *Id.* ¶¶ 4–5. Nothing in Ms. Melendez's medical records justifies the delay in her treatment. Tangpricha Decl. ¶ 56; Ettner Decl. ¶ 121.

Even after finally receiving hormone therapy, Ms. Melendez has not been provided appropriate care or monitoring. IDOC personnel have prescribed Ms. Melendez Menest and Premarin, which are both conjugated estrogens. Tangpricha Decl. ¶ 53. This form of estrogen is completely inappropriate and highly risky for any transgender individual, due to the inability to

monitor for serious health risks. *Id.* ¶¶ 53–54. In addition to prescribing an inappropriate form of estrogen, Defendants have also failed to regularly test her hormone levels in accordance with the Guidelines. *Id.* ¶ 54. A blood test in April 2017 indicates an estradiol level of 82.9 pg/ml, falls below the acceptable therapeutic range. *Id.* However, because Ms. Melendez is on a conjugated estrogen, it is impossible to know if this result is accurate, meaning her estradiol levels could be even lower than this number or very far above the safe range, including even dangerously high. *Id*.

Ms. Melendez has also requested gender-affirming surgery because she is "disgusted" by her own body and would rather be dead that continue to live without surgery. Melendez Decl. ¶ 8. Her grievance was summarily denied. *Id.* Indeed, Ms. Melendez has never even been evaluated for surgery, despite meeting the criteria for surgery. Ettner Decl. ¶ 123.

Defendants have also impeded Ms. Melendez's ability to socially transition. For example, Defendants have denied her requests for feminine clothing; Ms. Melendez is not permitted to wear any women's clothing or undergarments except the sports bra she was issued. Melendez Decl. ¶¶ 6, 9. Defendants have also ignored her requests for access to better hair removal, such as a non-electric razor to use while showering, despite the fact that her facial and body hair are a source of significant distress to her. *Id.* ¶ 7.

Defendants also permit prisoners and IDOC staff, including some of the medical and mental health staff, to disrespect her female gender identity. *Id.* ¶ 9. Few officers refer to her as "Ms." or use female pronouns—many still refer to her with male pronouns, and will sometimes use offensive and dehumanizing terms like "sissy" or "fag." *Id.* During strip-searches, male officers have cupped her breasts or butt and called her names like "bitch" or "whore." *Id.*

Defendants refuse to recognize Ms. Melendez as the woman she is by keeping her in a facility for men. *Id*.

3. Lydia Helena Vision

Lydia Helena Vision is a transgender woman incarcerated at Centralia Correctional Center. Vision Decl. ¶ 2. As is typical of the Class, Ms. Vision experienced an unjustifiably long delay before receiving inadequate hormone therapy and subsequent monitoring, was denied even an evaluation for gender-affirming surgery, and has been unable to socially transition due to Defendants' policies and practices.

Ms. Vision began requesting hormone therapy to treat her gender dysphoria after being diagnosed in March 2016. *Id.* Prison officials required her to attend therapy sessions for an unrelated post-traumatic stress disorder ("PTSD") diagnosis before they would treat her gender dysphoria with hormone therapy. *Id.* Even if this dubious diagnosis were accurate, PTSD on its own is not a legitimate reason to delay or deny treatment. Ettner Decl. ¶¶ 41, 112. In its records, the Transgender Committee repeatedly used male pronouns to refer to her. *Id.* ¶ 106. Ms. Vision was again diagnosed with gender dysphoria in July 2016, but she did not begin to receive hormone therapy until November 2018, over *two-and-a-half years* after her first diagnosis and after *at least twenty* requests. *Id.* ¶¶ 4, 17, 19. Nothing in her medical records justifies this delay in treatment. Tangpricha Decl. ¶ 72; Ettner Decl. ¶ 112.

As is typical of the Class, Defendants have imposed significant barriers to Ms. Vision's ability to socially transition while in IDOC custody. Ms. Vision has repeatedly requested and grieved denials for gender-affirming clothes and grooming items. Vision Decl. ¶¶ 3, 4, 9. She requested a bra, women's underwear, feminine hygiene supplies, makeup, and body hair removal products, such as waxing strips. *Id*. ¶ 4. IDOC denied her request for a bra and ignored her other requests. *Id.* Ms. Vision was eventually approved for a bra, but did not receive one until February

2019, over *three months* after being *approved*. *Id*. ¶ 19. The bras, however, are the wrong size, causing them to cut into her ribs when she wears them. *Id*.

Ms. Vision is also prevented from socially transitioning because Defendants permit IDOC staff to treat her as if she were a man. Ms. Vision's mental health counselors regularly misgender her in person and in her records. *Id*. ¶¶ 4, 16, 21. She is also misgendered by other IDOC personnel and is searched by male officers, which is particularly traumatic. *Id*. ¶ 21. Ms. Vision feels ill when subjected to cross-gender searches and has to dissociate herself in order to cope with being touched by male officers. *Id.* She describes being in a men's correctional facility as "torture." *Id.*

4. Sora Kuykendall

Ms. Kuykendall is a transgender woman incarcerated at Menard Correctional Center. Kuykendall Decl. ¶ 10. As is typical of the Class, Ms. Kuykendall experienced an unjustifiably long delay before receiving inadequate hormone therapy and subsequent monitoring, was denied even an evaluation for gender-affirming surgery, and has been unable to socially transition due to Defendants' policies and practices.

Ms. Kuykendall requested hormone therapy within the first week of her incarceration in November 2014. *Id.* ¶ 3. IDOC denied her request without even evaluating her for gender dysphoria. *Id.* ¶ 4. With her dysphoria untreated, Ms. Kuykendall resorted to self-castration. *Id*. Only then did IDOC evaluate her for gender dysphoria. *Id*. IDOC recognized Ms. Kuykendall's gender dysphoria in February of 2015 and she began hormone therapy later that month. *Id.* ¶¶ 4–5. Nevertheless, Ms. Kuykendall has yet to receive adequate hormone therapy and monitoring. Ms. Kuykendall was prescribed Premarin, a conjugated estrogen. Tangpricha Decl. ¶ 62. Initially, Ms. Kuykendall received no blood testing of her hormone levels despite her repeated requests and the serious – and potentially lethal – health risks associated elevated hormone levels. *Id.* ¶ 63; Kuykendall Decl. ¶ 6. It was not until May 2017 that IDOC finally ordered laboratory work for

her blood, and the tests showed an estradiol level of 112 pg/ml. It is impossible to know if her estradiol level is within the acceptable therapeutic range because Ms. Kuykendall is being treated with a conjugated estrogen. Tangpricha Decl. ¶ 64.

Ms. Kuykendall first requested surgery in June 2015, and she has continued to do so. Kuykendall Decl. ¶ 9. She spoke with IDOC mental health professionals about surgery on at least three different occasions from 2016 to 2017, and filed a grievance requesting it to treat her ongoing distress and gender dysphoria. *Id.* Nevertheless, as with the other Class members, she has never even been evaluated for surgery. *Id.*

Due to Defendants' policies and practices, Ms. Kuykendall has also been prevented from socially transitioning. In June 2015, Ms. Kuykendall requested a bra due to her breast development, but did not receive a bra until *six months* later. *Id.* ¶ 7. She has also repeatedly requested other gender-affirming clothing and grooming items, filing formal grievances for these items. *Id.* All of her requests have been ignored or denied. *Id.* Ms. Kuykendall experiences severe distress from her body and facial hair and has requested hair removal treatment. *Id.* ¶ 8. She has not been provided adequate hair removal products, so has resorted to using nail clippers to painfully remove individual hairs, one-by-one, from her face each morning. *Id.*

Other prisoners and IDOC staff are consistently disrespectful of Ms. Kuykendall's gender identity, including by referring to her by a male name and with male pronouns. *Id.* ¶ 11. She is also subjected to inhumane search procedures, such as strip-searches conducted by male officers in the presence of male prisoners. *Id.* ¶ 10. These humiliating searches leave her feeling so violated and unsafe that she refuses visitors and opportunities to leave her cell in order to avoid being searched by male officers. *Id.* She has effectively cut herself off from human contact to prevent further trauma. Ettner Decl. ¶ 92. On March 14, 2017, she filed a grievance requesting

that strip searches only be conducted by a female officer away from the male prisoners. *Id*. She has not received a response to this grievance and continues to be subjected to these distressing searches. *Id*. Ms. Kuykendall is not able to be herself in a men's prison and would like IDOC to transfer her to a facility for women. *Id*. Being in a facility for men, as a woman, is causing her to slip into a deeper depression. *Id*.

5. Sasha Reed

Ms. Reed is a transgender woman incarcerated at Lawrence Correctional Center. Reed Decl. ¶¶ 2, 8. As is typical of the Class, Ms. Reed experienced an unjustifiably long delay before receiving inadequate hormone therapy and subsequent monitoring, was denied even an evaluation for gender-affirming surgery, and has been unable to socially transition due to Defendants' policies and practices.

Ms. Reed identified herself as transgender during her intake at Stateville in 2013, but IDOC provided her with no evaluation or treatment. *Id.* ¶ 2. In November 2015, Ms. Reed spoke with a mental health professional and requested hormone therapy. *Id.* ¶ 3. The mental health professional asked her to complete a questionnaire for the Transgender Committee to review. *Id*. Ms. Reed did so, but it was not until February 2016 that she received a response to her request for hormone therapy: the request was denied because IDOC needed to "rule out a psychotic process." *Id.* ¶ 2. The GID Committee, along with the mental health professional, misdiagnosed her gender dysphoria as schizophrenia and forced Ms. Reed to wait *another seventeen months* while doctors investigated her "conceptualization of gender identity." *Id.* ¶ 3; Ettner Decl. ¶ 102. Finally, in April 2017, she was allowed to begin hormone therapy. Reed Decl. ¶ 3. Ms. Reed's medical records contain no medical justification for this delay in treatment – or indeed, any indication of psychosis – even though such delays cause extreme suffering and put a patient at extreme risks for self-harm or suicide. Ettner Decl. ¶ 102; Tangpricha Decl. ¶¶ 60–61.

Ms. Reed was ultimately prescribed estradiol at 2 mg/d and spironolactone at 200 mg/d. Tangpricha Decl. ¶ 68. Her hormone levels have only been monitored *once* in the past *two years*. *Id*. ¶ 69. Ms. Reed had a blood test in July 2017 that showed a very low estradiol level at 45 pg/ml that is well below the recommended therapeutic range of 100–200 mg/pl, and her testosterone levels were at 400 ng/ml, well above the recommended therapeutic level of 50 ng/ml for patients with gender dysphoria. *Id.* Despite both of these results being far out of the range recommended by the Guidelines, there has been no documentation of a change in Ms. Reed's prescriptions, nor any follow up blood tests. *Id.* ¶ 70.

Ms. Reed has also repeatedly requested, grieved, and been denied gender-affirming surgery. Reed Decl. ¶ 12. She has never been evaluated to determine whether surgery is necessary to treat her gender dysphoria, despite being severely dysphoric and meeting the criteria for surgery. *Id*.; Ettner Decl. ¶ 103.

Defendants have also hindered Ms. Reed's ability to treat her gender dysphoria through social transition. Ms. Reed is not allowed to wear any women's clothing or undergarments except for the bra IDOC provided her after initially denying and delaying the request. Reed Decl. ¶¶ 5, 6, 13. Ms. Reed's female identity is consistently disrespected by prisoners and IDOC staff and she is continuously sexually harassed by other prisoners. *Id.* ¶ 1. She is also regularly subjected to distressing body searches by male officers. *Id*. Ms. Reed feels unsafe and believes she would be better able to live as a woman, without harassment or threats, if IDOC would transfer her to a facility for women. *Id*.

****

The named Plaintiffs and proposed Class experience nearly identical treatment and harm as a result of Defendants' failure to provide adequate medical care for gender dysphoria.

Accordingly, they seek the same injunctive relief: reform of the systemic deficiencies in the provision of healthcare to individuals suffering from gender dysphoria. Differences in the precise details of the named Plaintiff's injuries and those of the proposed class are irrelevant to the determination of typicality. *Suchanek v. Sturm Foods, Inc.*, 311 F.R.D. 239, 255 (S.D. Ill. 2015). S*ee also Smentek v. Sheriff of Cook Cty.*, No. 09 C 529, 2010 WL 4791509, at *7 (N.D. Ill. Nov. 18, 2010) ("Although differences in plaintiffs' and the class members' injuries and treatment times are undeniable, this is not fatal to a finding of typicality as typical does not mean identical.") (internal quotations and citation omitted); *Parsons v. Ryan*, 754 F.3d 657, 686 (9th Cir. 2014) ("It does not matter that the named plaintiffs may have in the past suffered varying injuries or that they may currently have different healthcare needs; Rule 23(a)(3) requires only that their claims be 'typical' of the class, not that they be identically positioned to each []other or to every class member."); *Gray v. Cty. of Riverside*, No. EDVC 13-00444-VAP (OPx), 2014 WL 5304915, at *35 (C.D. Cal. Sept. 2, 2014) (finding typicality where the named Plaintiffs' "alleged injury among the class members is that the Defendant's medical and mental health policies result in exposure to a substantial risk of serious harm," noting that "[a]ny differences in the named Plaintiffs' specific medical or mental needs do not defeat typicality"). Because the risk of injury arises from the same system-wide policies and practices, the Plaintiffs' claims are typical of those of the Class.

D. Adequacy

As with typicality, because Plaintiffs have demonstrated the commonality and typicality of their claims, Rule 23(a)(4)'s adequacy-of-representation requirement is presumed to be met with respect to Plaintiffs' ability to represent the interests of the Class. *See Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 349 n.5 (2011) ("Those requirements [of commonality and typicality] therefore also tend to merge with the adequacy-of-representation requirement, although the latter requirement also raises concerns about the competency of class counsel and conflicts of interest.")

(quoting *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 157–58 n.13 (1982)). Nevertheless, Plaintiffs meet all aspects of Rule 23(a)(4)'s adequacy requirement.

1. The named plaintiffs have no conflicts with the proposed class.

A class may be certified only if "the representative parties will fairly and adequately protect the interests of the class." FED. R. CIV. P. 23(a)(4). In analyzing the ability of the named Plaintiffs to represent the class, courts look to whether the named Plaintiffs have "sufficient interest in the outcome to ensure vigorous advocacy," *Riordan v. Smith Barney*, 113 F.R.D. 60, 64 (N.D. Ill. 1986), as well as any interests "antagonistic to the interests of the class." *Trainor v. Gebke*, No. 3:17-cv-00627-DRH-DGW, 2018 WL 3216045, at *3 (S.D. Ill. Jan. 22, 2018) (citing *Riordan v. Smith Barney*, 113 F.R.D. 60, 64 (N.D. Ill. 1986)). Here, named Plaintiffs' interests are coextensive with those of the Class. As transgender people living with gender dysphoria while incarcerated in IDOC facilities, the named Plaintiffs have a genuine concern with the outcome of this class action, and are committed to its vigorous prosecution. As discussed at length with respect to Rule 23's commonality and typicality requirements, the interests of the named Plaintiffs' and the class directly align. Plaintiffs' request for relief – that Defendants cease their policies and practices of denying care and implement a constitutionally sound system of healthcare for prisoners with gender dysphoria – benefits all class members. Nor are there any conflicts, whether actual or apparent, between the named Plaintiffs and the Class. The named Plaintiffs will therefore adequately and vigorously protect the class interests.

2. Proposed class counsel are qualified, experienced, and able to conduct the proposed litigation.

A court that certifies a class must appoint class counsel. FED. R. CIV. P. 23(g)(1). Rule 23(a)(4) requires that the named Plaintiffs' counsel be "qualified, experienced, and able to conduct the proposed litigation." *In re Sulfuric Acid Antitrust Litig.*, No. 03 C 4576, 2007 WL 898600, at

*5 (N.D. Ill. Mar. 21, 2007) (citing *Rosario*, 963 F.2d at 1018). Plaintiffs' counsel at the Roger Baldwin Foundation of ACLU, Inc., Kirkland & Ellis LLP, and Kennedy Hunt P.C. are highly experienced and knowledgeable in litigating class actions and other complex civil litigation, including on behalf of prisoners and transgender individuals. *See* Ex. 10, Counsel Qualifications and Experience. Plaintiffs' counsel also have committed and will continue to commit considerable staffing and resources to the case's prosecution. The requirements of Rule 23(a)(4) are satisfied, and Plaintiffs' counsel should be appointed as class counsel under Rule 23(g)(1).

III. PLAINTIFFS SATISFY THE REQUIREMENTS OF RULE 23(B)(2)

In addition to satisfying Rule 23(a), the proposed Class has the defining attributes of a Rule 23(b)(2) class: Defendants have "acted or refused to act on grounds that apply generally to the class such that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole" by failing to provide Plaintiffs and proposed Class members with constitutionally adequate medical treatment for gender dysphoria. FED. R. CIV. P. 23(b)(2). Class certification under Rule 23(b)(2) is "particularly appropriate in class actions brought to vindicate civil or constitutional rights," *Love v. City of Chi.*, No. 96 C 396, 1997 WL 120041, at *5 (N.D. Ill. Mar. 11, 1997); *Rodriguez v. Vill. of Montgomery*, No. 08 C 1826, 2009 WL 310893, at *4 (N.D. Ill. Feb. 9, 2009); *Patrykus v. Gomilla*, 121 F.R.D. 357, 362–63 (N.D. Ill. 1988), such as cases challenging conditions in prisons or jails. *See, e.g.*, *Lippert v. Baldwin*, No. 10 C 4603, 2017 WL 1545672 (N.D. Ill. Apr. 28, 2017); *Copeland v. Washington*, 162 F.R.D. 542, 543 (N.D. Ill. 1995); *Imasuen v. Moyer*, No. 91 C 5425, 1992 WL 26705, at *3 (N.D. Ill. Feb. 7, 1992); *Lewis v. Tully*, 96 F.R.D. 370, 378 (N.D. Ill. 1982).

First, Plaintiffs have alleged a host of actions and refusals to act on the part of Defendants, based on grounds generally applicable to the proposed Class, which have deprived Plaintiffs and the proposed Class of their constitutionally mandated right to adequate medical care. *See* FED. R.

CIV. P. 23(b)(2). Because the grounds are generally applicable to the class, Rule 23(b)(2) is satisfied, and this would be true "'even if [the action or inaction] has taken effect or is threatened only as to one or a few members of the class.'" *Massie v. Ill. Dep't of Transp.*, No. 96 C 4830, 1998 WL 312021, at *5 (N.D. Ill. June 5, 1998) (quoting advisory committee's note to 1966 amendment); *Metro. Area Hous. All. v. U.S. Dep't of Hous. & Urban Dev.*, 69 F.R.D. 633, 638 (N.D. Ill. 1976); *see also DG ex rel. Stricklin v. Devaughn*, 594 F.3d 1188, 1201 (10th Cir. 2010) (same).

In particular, Plaintiffs have alleged that Defendants' system-wide policies and practices have permitted the Class to be subjected to: (1) inadequate evaluation and medical treatment by under-qualified staff, (2) unreasonable delays or denials of medically necessary hormone therapy, (3) unsafe and inappropriate dosage and prescriptions of hormones, (4) summary denial of evaluation for gender confirmation surgeries, (5) refusal to provide the clothing and personal care products necessary to live consistently with their gender identity, (6) subjection to humiliating body searches by officers of a different gender, as well as failure to respect transgender prisoners names and pronouns, (7) refusal to provide individualized assessment for transfer to a correctional center that accords with transgender prisoners' gender identity.

Second, Defendants failure to provide adequate medical care applies "generally to the class, so that final injunctive relief . . . is appropriate respecting the class as a whole." FED. R. CIV. P. 23(b)(2). Under Rule 23(b)(2), certification is appropriate because "'a single injunction or declaratory judgment would provide relief to each member of the class.'" *Chi. Teachers Union, Local No. 1 v. Bd. of Educ. of City of Chi.*, 797 F.3d 426, 441–43 (7th Cir. 2015) (reversing denial of Rule 23(b)(2) certification where plaintiffs sought the same injunctive and declaratory relief for all) (quoting *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 355–56 (2011)); *see McReynolds v.*

Merrill Lynch, Pierce, Fenner & Smith, Inc., 672 F.3d 482, 487–90 (7th Cir. 2012) (affirming class certification under Rule 23(b)(2) where plaintiffs requested only injunctive relief when challenging company-wide policies common to all class members); s*ee* FED. R. CIV. P. 23(b)(2).

Here, Plaintiffs assert that Defendants' failure to provide adequate medical treatment for gender dysphoria has caused severe mental and physical anguish, and seek to reform Defendants' system-wide policies and practices that are common to all proposed Class members. Accordingly, Plaintiffs have prayed for injunctive relief to address these systemic failures, including, but not limited to, (i) ceasing the policy and practice whereby medical decisions regarding gender dysphoria are second-guessed and treatment is denied and delayed by the Transgender Committee, a committee of non-experts and laypeople; (ii) ceasing the policy and practice whereby hormone therapy is denied and delayed for reasons that are not recognized as contraindications to treatment; (iii) ceasing the policy and practice whereby IDOC does not evaluate and consider surgery as a treatment option for gender dysphoria; (iv) ceasing the policy and practice of depriving gender dysphoric prisoners of medically-necessary social transition, including by mechanically assigning housing based on genitalia. This relief would apply to and benefit all members of the proposed Class. As such, class certification is appropriate under Rule 23(b)(2).

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully move this Court to certify a class of "all prisoners in the custody of IDOC who have requested from IDOC evaluation of treatment for gender dysphoria," and to designate the Roger Baldwin Foundation of ACLU of Illinois, Inc., Kirkland & Ellis LLP, and Kennedy Hunt P.C. attorneys as Class counsel.

Dated: May 2, 2019

Respectfully submitted,

By: /s/ *Jordan M. Heinz*

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CERTIFICATE OF SERVICE

I certify that on May 2, 2019, I electronically filed the foregoing document and any attachments with the Clerk of this Court by using the CM/ECF system, which will accomplish service through the Notice of Electronic Filing for parties and attorneys who are Filing Users.

/s/ *Jordan M. Heinz*
Jordan M. Heinz

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, Plaintiffs, v. JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON, Defendants.	)	Civil No. 3:18-cv-00156-NJR-MAB

DECLARATION OF DR. RANDI ETTNER

I, Dr. Randi Ettner, hereby state:

1. I am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of Gender Dysphoria.

2. I have been retained by counsel for the named plaintiffs and putative class in this case to provide my expert evaluation and opinion regarding the appropriateness of the treatment for Gender Dysphoria provided by the Illinois Department of Corrections ("IDOC"). This declaration provides my opinions and conclusions, including (i) scientific information regarding Gender Dysphoria and its impact on the health and well-being of individuals living with the condition; (ii) information regarding best practices and the generally accepted standards of care for individuals with Gender Dysphoria; and (iii) the results of my review of both the named plaintiff and putative class members' treatment for Gender Dysphoria. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

I. QUALIFICATIONS

3. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my doctorate in psychology (with honors) from Northwestern University in 1979. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

4. During the course of my career, I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with Gender Dysphoria and mental health issues related to gender variance from 1977 to the present.

5. I have published four books related to the treatment of individuals with Gender Dysphoria, including the medical text entitled Principles of Transgender Medicine and Surgery (co-editors Monstrey & Eyler; Rutledge 2007); and the 2nd edition (co-editors Monstrey & Coleman; Routledge, 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.

6. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of The International Journal of Transgenderism and Transgender Health. I am the Secretary and a member of the Board of Directors of the World Professional Association of Transgender Health ("WPATH"), and an author of the WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People (7th version), published in 2011. WPATH is an international association of 2,000 medical and mental health professionals worldwide specializing in the treatment of gender diverse people. I chair the WPATH Committee for Incarcerated Persons, and provide training to medical professionals on healthcare for transgender inmates.

7. I have lectured throughout North America, Europe, and Asia on topics related to Gender Dysphoria and have given grand rounds on Gender Dysphoria at university hospitals. I am the honoree of the externally-funded Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of Gender Dysphoria. I received a commendation from the U.S. Congress House of Representatives on February 5, 2019 recognizing my work for WPATH and Gender Dysphoria in Illinois.

8. I have been retained as an expert regarding Gender Dysphoria and the treatment of Gender Dysphoria in multiple court cases and administrative proceedings, including cases involving the treatment of individuals with Gender Dysphoria in prison settings. I provided testimony and/or was deposed as an expert in the following cases over the past four years: *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Corr.*, No. 1:17-CV-00151-BLW (D. Idaho 2018); *Faiella v. Am. Med. Response*, No. HHD CV-15-6061263 (Conn. Super. Ct. 2015); *Broussard v. First Tower Loan*, No. 2:15-CV-011-61 (D. La. 2016); *Carrillo v. U.S. Dep't of Justice Exec. Office of Immgr. Rev*. (2017); *Jane Doe v. Clenchy, et al.*, No. CV-09-201 (Me. Super. Ct. 2011); *Kothmann v. Rosario*, No. 13-CV-28-OC22 (D. Fla. 2013).

9. In addition, I have been a consultant to news media and have been interviewed as an expert on Gender Dysphoria for hundreds of television, radio and print articles throughout the country.

10. A true and correct copy of my *Curriculum Vitae*, which provides a complete overview of my education, training, and work experience and a full list of my publications, is attached hereto as Appendix A.

II. MATERIALS CONSIDERED

11. I have considered information from various sources in forming my opinions enumerated herein, in addition to drawing on my extensive experience and review of the literature related to Gender Dysphoria over the past three decades. Attached as Appendix B is a bibliography of relevant medical and scientific materials related to transgender people and Gender Dysphoria. I generally rely on these materials when I provide expert testimony, in addition to the documents specifically cited as supportive examples in particular sections of this declaration.

12. The additional materials I have reviewed and relied on in this case are the following: the named Plaintiffs' medical records; the putative class members' medical records; Transgender Committee/GID Committee records; records of IDOC grievances; IDOC policies, procedures, and training materials related to transgender prisoners and prisoners with gender dysphoria; the responses of the Defendants in this litigation to the Plaintiffs' interrogatories; and the deposition transcript for Plaintiffs' deposition of IDOC's Rule 30(b)(6) designees. Finally, I conducted and relied on in-person interviews of the named plaintiffs in this case in May 2018. During those interviews, I conducted and subsequently reviewed and considered the following psychodiagnostic tests: the Beck Anxiety Inventory; the Beck Depression Inventory-II: the Beck Hopelessness Scale; and the Traumatic Symptom Inventory-II.

III. GENDER DYSPHORIA

13. The term "gender identity" is a well-established concept in medicine, referring to one's internal sense of oneself as belonging to a particular gender. All human beings develop this elemental internal conviction of belonging to a particular gender, such as male or female.

14. At birth, infants are typically classified as male or female. This classification becomes the person's birth-assigned gender. Typically, persons born with the external physical characteristics of males psychologically identify as men, and those with external physical characteristics of females psychologically identify as women. However, for transgender individuals, this is not the case. For transgender individuals, the sense of one's self—one's gender identity—differs from the birth-assigned gender, giving rise to a sense of being "wrongly embodied."

15. For some, the incongruence between gender identity and assigned gender does not create clinically significant distress. However, for others, the incongruence results in Gender Dysphoria, a serious medical condition characterized by a clinically significant and persistent feeling of stress and discomfort with one's assigned gender.

16. In 1980, the American Psychiatric Association introduced the diagnosis Gender Identity Disorder (GID) in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The diagnosis GID was maintained in a revised version of DSM, known as DSM-III-R (1987), as well as in DSM-IV which was issued in 1994.

17. In 2013, with the publication of DSM-5, the Gender Identity Disorder diagnosis was removed and replaced with Gender Dysphoria. This new diagnostic term was based on significant changes in the understanding of the condition of individuals whose birth-assigned sex differs from their gender identity. The change in nomenclature was intended to acknowledge that

gender incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's *identity* disordered. Rather, the diagnosis is based on the distress or *dysphoria* that some transgender people experience as a result of the incongruence between assigned sex and gender identity and the social problems that ensue. The DSM explained that the former GID diagnosis connoted "that the patient is 'disordered.'" American Psychiatric Association, Gender Dysphoria (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf. But, as the APA explained, "[i]t is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition." *Id*. By "focus[ing] on dysphoria as the clinical problem, not identity per se," the change from GID to Gender Dysphoria destigmatizes the diagnosis. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th ed. 2013).

18. In addition, the categorization of Gender Dysphoria and its placement in the DSM system is different for Gender Dysphoria than it was for GID. In every version of DSM prior to 2013, GIDs were a subclass of some broader classification, such as Disorders Usually First Evident in Infancy, Childhood, or Adolescence, or alongside other subclasses such as Developmental Disorders, Eating Disorders, and Tic Disorders. For the first time ever, DSM-5 categorizes the diagnosis separately from all other conditions. Under DSM-5, Gender Dysphoria is classified on its own. And as recently as June 16, 2018, the World Health Organization (WHO) likewise reclassified the gender incongruence diagnosis in the forthcoming International Classification of Diseases-11 ("ICD-11"). This is significant because the new classification removes gender incongruence form the chapter on mental and behavioral disorders, recognizing that it is not a mental illness.

19. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults in DSM-5 are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated sex characteristics).
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

20. In addition to renaming and reclassifying Gender Dysphoria, the medical research that supports the Gender Dysphoria diagnosis has evolved. Unlike DSM's treatment of GID, the DSM-5 includes a section entitled "Genetics and Physiology," which discusses the genetic and hormonal contributions to Gender Dysphoria. *See* DSM-5 at 457 ("For individuals with gender dysphoria . . . some genetic contribution is suggested by evidence for (weak) familiarity of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria").

21. There is now a scientific consensus that gender identity is biologically based and a significant body of scientific and medical research that Gender Dysphoria has a physiological and biological etiology. It has been demonstrated that transgender women, transgender men, non-transgender women, and non-transgender men have different brain composition, with respect to the white matter of the brain, the cortex (central to behavior), and subcortical structures. *See, e.g.,* Rametti et al., *White Matter Microstructure in Female to Male Transsexuals Before Cross-Sex Hormonal Treatment: A Diffusion Tensor Imaging Study*, 45 J. Psychiatric Res. 199–204 (2011); Rametti et al., *The Microstructure of White Matter in Male to Female Transsexuals Before Cross-Sex Hormonal Treatment: A DTI Study*, 45 J. Psychiatric Res. 949–54 (2011); Luders et al., *Gender effects on cortical thickness and the influence of scaling,* 2 J. Behav. & Brain Sci. 357, 360 (2006); Krujiver et al., *Male-to- female transsexuals have female neuron numbers in a limbic nucleus*, 85 J. Clin. Endocr. Met., 2034–41 (2000). Interestingly, differences between transgender and non-transgender individuals primarily involve the right hemisphere of the brain. The significance of the right hemisphere is important because that is the area that relates to attitudes about bodies in general, one's own body, and the link between the physical body and the psychological self.

22. In addition, scientific investigation has found a co-occurrence of Gender Dysphoria in families. Gomez-Gill et al. concluded that the probability of a sibling of a transgender individual also being transgender was 5 times higher than someone in the general population. Gomez- Gil et al., *Familiarity of gender identity disorder in non-twin siblings*, 39 Arch Sex Behav., 265–69 (2010). And, in identical twins, there was a very high likelihood (33%) of both twins being transgender, even when reared apart, demonstrating the role of genetics in the development of Gender Dysphoria. *See* Diamond, *Transsexuality among twins: identity concordance, transition, rearing, and orientation*, 14 Int'l J. Transgenderism 24 (2013) (abstract: "[t]he responses of our

twins relative to their rearing along with our findings regarding some of their experiences during childhood and adolescence show their [gender] identity was much more influenced by their genetics than their rearing."). *See also* Green, *Family co-occurrence of "gender dysphoria": ten siblings or parent-child pairs*, 29 Arch Sex Behav. 499–507 (2000).

23. It is now believed that Gender Dysphoria evolves as a result of the interaction of the developing brain and sex hormones. For example, one study found that:

> [d]uring the intrauterine period a testosterone surge masculinizes the fetal brain, whereas the absence of such a surge results in a feminine brain. As sexual differentiation of the brain takes place at a much later stage in the development than sexual differentiation of the genitals, these two processes can be influenced independently of each other. Sex differences in cognition, gender identity . . . , sexual orientation . . . , and the risks of developing neuropsychiatric disorders are programmed into our brain during early development. There is no evidence that one's postnatal social environment plays a crucial role in gender identity or sexual orientation.

Garcia-Falgueras & Swaab, *Sexual Hormones and the Brain: As Essential Alliance for Sexual Identity and Sexual Orientation*, 17 Pediatric Neuroendocrinology 22–25 (2010). Similarly, Lauren Hare et al. finds that:

> a decrease in testosterone levels in the brain during development might result in incomplete masculinization of the brain . . . , resulting in a more feminized brain and a female gender identity.

Hare et al., *Androgen Receptor Repeat Length Polymorphism Associated with Male-to- Female Transsexualism*, 65 Biological Psychiatry 93, 93, 96 (2009). Because Gender Dysphoria is biologically based, efforts to change a person's gender identity are futile, cause psychological harm, and are unethical.

IV. TREATMENT OF GENDER DYSPHORIA

A. WPATH Standards of Care

24. Gender Dysphoria can be ameliorated or even effectively cured through medical treatment. The standards of care for treatment of Gender Dysphoria are set forth in the *World*

Professional Association for Transgender Health (WPATH) Standards of Care (7th version, 2011). The WPATH promulgated Standards of Care (hereafter, "SOC") are the internationally recognized guidelines for the treatment of persons with Gender Dysphoria, and inform medical treatment throughout the world. The American Medical Association, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse protocols in accordance with the SOC. *See, e.g.*, American Medical Association (2008) Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).

25. As part of the SOC, many transgender individuals with Gender Dysphoria undergo a medically-indicated and supervised gender transition in order to ameliorate the debilitation of Gender Dysphoria and live life consistent with their gender identity. The SOC recommend an individualized approach to gender transition, consisting of one or more of the following protocol components of evidence-based care for Gender Dysphoria:

- 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.

SOC at 9–10.

26. The treatment of incarcerated persons with Gender Dysphoria has been addressed in the SOC since 1998. As with protocols for the treatment of diabetes or other medical disorders, medical management of Gender Dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the SOC expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients in prison (Section XIV) and the National Commission on Correctional Health (NCCHC) recommends treatment in accordance with the SOC for people in correctional settings. *See* NCCHC Position Statement, Transgender, Transsexual, and Gender Non-Conforming Health Care in Correctional Settings (October 18, 2009, reaffirmed with revisions April, 2015), http: //www.ncchc.org/transgender-transsexual-and gender-nonconforming health-care).

27. Under the SOC, while it is true that "[r]easonable accommodations to the institutional environment can be made in the delivery of care consistent with the [Standards of Care]," "[d]enial 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 …." SOC at 68.

28. Once a diagnosis of Gender Dysphoria is made, a treatment plan should be developed based on an individualized assessment of the medical needs of the particular patient.

29. The development of any treatment plan and all subsequent treatment must be administered by clinicians qualified in treating patients with Gender Dysphoria. The SOC specify the qualifications that professionals must meet in order to provide care to gender dysphoric patients. *See* Section VII. In particular, the SOC provide that all mental health professionals should

have certain minimum credentials before treating patients with Gender Dysphoria, including a master's degree (or equivalent) in a clinical behavioral science field; competencies in using the DSM-5 and/or the International Classification of Diseases for diagnostic purposes; ability to recognize and diagnose co-existing mental health concerns and to distinguish these from Gender Dysphoria; documented supervised training and competence in psychotherapy or counseling; knowledge of gender nonconforming identities and expressions, and the assessment and treatment of Gender Dysphoria; and continuing education in the assessment and treatment of Gender Dysphoria. SOC at 22.

30. Importantly, the SOC require that "[m]ental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria." *See* SOC at 22–23. Self-study cannot substitute for first-hand clinical experience in treating the range of clinical presentations of Gender Dysphoria, or the mentorship and supervision of an expert in this field.

31. In addition to these minimum credentials, clinicians working with gender dysphoric patients should develop and maintain cultural competence to provide optimal care. A growing body of scientific literature underlies this specialized area of medicine and presents advances in treatment that inform care.

32. Treatment plans generated by providers lacking the requisite experience can result in inappropriate care, or place patients at significant risk.

33. While psychotherapy or counseling can help with the personal and social aspects of a gender transition, they are not a substitute for medical intervention where medical intervention is needed, nor are they preconditions for such intervention. By analogy, in Type One diabetes,

counseling might provide psychoeducation about living with a chronic condition, and information about nutrition, but it does not obviate the need for insulin.

34. For many individuals with Gender Dysphoria, changes to gender expression and role to feminize or masculinize one's appearance, often called the "real life experience" or "social transition," are an important part of treatment for the condition. This involves dressing, grooming and otherwise outwardly presenting oneself through social signifiers of gender consistent with one's gender identity. This is an appropriate and necessary part of identity consolidation. Through this experience, the shame of growing up living as a "false self" and the grief of being born into the "wrong body" can be ameliorated. (Greenberg & Laurence 1981; Ettner 1999; Devor 2004.)

B. Hormone Therapy

35. For almost all individuals with persistent, well-documented Gender Dysphoria, hormone therapy is essential and medically indicated treatment to alleviate the distress of the condition. The Standards of Care specify that "feminizing/masculinizing hormone therapy—the administration of exogenous endocrine agents to induce feminizing or masculinizing changes—is a medically necessary intervention for many transsexual, transgender, and gender non-conforming individuals with gender dysphoria." SOC at Section VIII, p. 33.

36. Hormone therapy is a well-established and effective means of treating Gender Dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association all agree that hormone therapy in accordance with the WPATH Standards of Care is medically necessary treatment for many individuals with Gender Dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice

Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).

37. The goals of hormone therapy for individuals with Gender Dysphoria are (i) to significantly reduce hormone production associated with the person's sex assigned at birth and, thereby, the secondary sex characteristics of the individual's sex assigned at birth and (ii) to replace circulating sex hormones associated with the person's sex assigned at birth with feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (*i.e.*, non-transgender males born with insufficient testosterone or non-transgender females born with insufficient estrogen). *See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009).

38. The therapeutic effects of hormone therapy are twofold: (i) with endocrine treatment, the patient acquires congruent sex characteristics, *i.e.* for transgender women, breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (ii) hormones act directly on the brain, via receptors sites for sex steroids, which produces an attenuation of dysphoria and attendant psychiatric symptoms, and the promotion of a sense of well-being. *See, e.g.*, Cohen-Kettenis & Gooren 1993. Hormone therapy induces desired physical changes for transgender men as well, such as deepened voice, growth in facial and body hair, cessation of menses, and atrophy of breast tissue, among other changes. SOC at 36.

39. The efficacy of hormone therapy to treat Gender Dysphoria is clinically evident and is well documented in the literature. For example, in one study, researchers investigated 187 transgender individuals who had received hormones and compared them with a group of transgender individuals who did not. Untreated individuals showed much higher levels of

depression, anxiety, and social distress than those who received hormone therapy. *See* Rametti, et al. 2011; *see also* Colizzi et al. 2014; Gorin-Lazard et al. 2011.

40. Some individuals with Gender Dysphoria experience profound relief from hormone therapy alone such that further treatment, such as surgical intervention, is not required. *See* SOC at 8–9.

41. While the WPATH Standards indicate that significant mental health concerns must be reasonably well-controlled prior to initiation of hormone therapy, co-occurring mental health conditions should only be a reason to delay therapy in the most exceptional circumstances. For example, a physician would not initiate hormone therapy in a patient who is so delusional as to be unable to consent to the treatment plan. Otherwise, it is extremely common for gender dysphoric patients to present with co-existing mental health issues and past trauma, which usually are a result of their underlying gender dysphoria. There is no legitimate medical basis for denying treatment simply because a patient also has been diagnosed with, for example, anxiety, depression, or PTSD.

C. Gender-Affirming Surgery

42. For some individuals with severe Gender Dysphoria, hormone therapy alone is insufficient. Relief from their dysphoria cannot be achieved without surgical intervention. Under the contemporary understanding of gender identity, transition-related medical treatments confirm, not "change," an individual's sex by aligning primary and secondary sex characteristics with a person's gender identity. The WPATH Standards state: "While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria …. For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity." SOC at 54–55.

43. Genital reconstruction surgery for male-to-female transgender women has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains body congruence resulting from the uro-genital structures appearing and functioning as is typical for non-transgender women. Both are critical in alleviating or eliminating Gender Dysphoria. Other forms of gender-affirming surgeries, such as bilateral mastectomy for transgender men, allow the individual to attain body congruence with respect to secondary sex characteristics.

44. Decades of careful and methodologically sound scientific research have demonstrated that gender-affirming surgery is a safe and effective treatment for severe Gender Dysphoria and, indeed, for many people, it is the only effective treatment. *See, e.g.*, Pfäfflin & Junge 1998; Smith et al. 2005; Jarolím et al. 2009.

45. WPATH, the American Medical Association, the Endocrine Society, and the American Psychological Association all support surgery in accordance with the SOC as medically necessary treatment for individuals with severe Gender Dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009) ("For many transsexual adults, genital sex reassignment surgery may be the necessary step towards achieving their ultimate goal of living successfully in their desired gender role."); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009) (recognizing "the efficacy, benefit and medical necessity of gender transition treatments" and referencing studies demonstrating the effectiveness of sex-reassignment surgeries).

46. Surgeries are considered "effective" from a medical perspective if they "have a therapeutic effect." *See* Monstrey et al. 2007. More than three decades of research confirms that gender-affirming surgery is therapeutic and therefore an effective treatment for Gender Dysphoria.

47. In a 1998 meta-analysis, Pfäfflin and Junge reviewed data from 80 studies, spanning 30 years, from 12 countries. They concluded that "reassignment procedures were effective in relieving Gender Dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes" *See* Pfäfflin & Junge 1998.

48. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in The Netherlands concluded that after gender-affirming surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous conclusions that sex reassignment is effective" *See* Smith et al. 2005. Indeed, the authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, Gender Dysphoria, had decreased to such a degree that it had disappeared."

49. In 2007, Gijs and Brewayes analyzed 18 studies published between 1990 and 2007, encompassing 807 patients. The researchers concluded: "Summarizing the results from the 18 outcome studies of the last two decades, the conclusion that [gender-affirming surgery] is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals still stands: Ninety-six percent of the persons who underwent [surgery] were satisfied and regret was rare."

50. Studies conducted in countries throughout the world conclude that surgery is an extremely effective treatment for Gender Dysphoria. For example, a 2001 study published in

Sweden states: "The vast majority of studies addressing outcome have provided convincing evidence for the benefit of sex reassignment surgery in carefully selected cases" *See* Landen 2001. Similarly, urologists at the University Hospital in Prague, Czech Republic, in a Journal of Sexual Medicine article concluded, "Surgical conversion of the genitalia is a safe and important phase of the treatment of male-to-female transsexuals" *See* Jarolím 2009.

51. Patient satisfaction is an important measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of Gender Dysphoria and enables the patient to function in everyday life. Studies have shown that by alleviating the suffering and dysfunction caused by severe Gender Dysphoria, gender-affirming surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehman et al. 1999; Johansson et al. 2010; Hepp et al. 2002; Ainsworth & Spiegel 2010; Smith et al. 2005); improvement in self-image and satisfaction with body and physical appearance (Lawrence 2003; Smith et al. 2005; Weyers et al. 2009); and greater acceptance and integration into the family (Lobato et al. 2006).

52. Studies have also shown that surgery improves patients' abilities to initiate and maintain intimate relationships (Lobato et al. 2006; Lawrence 2005; Lawrence 2006; Imbimbo et al. 2009; Klein & Gorzalka 2009; Jarolím et al. 2009; Smith et al. 2005; Rehman et al. 1999; De Cuypere et al. 2005).

53. Multiple long term studies have confirmed these results. *See, e.g.*, "Transsexualism in Serbia: a twenty-year follow-up study" (Vujovic et al. 2009); "Long-term assessment of the physical, mental, and sexual health among transsexual women" (Weyers et al. 2009); "Treatment follow-up of transsexual patients" (Hepp et al. 2002); "A five-year follow-up study of Swedish adults with gender identity disorder" (Johansson et al. 2010); "A report from a single institute's 14

year experience in treatment of male-to-female transsexuals" (Imbimbo et al. 2009); 'Followup of sex reassignment surgery in transsexuals: a Brazilian cohort" (Lobato et al. 2006).

54. Given the extensive experience and research supporting the effectiveness of gender-affirming surgery spanning decades, it is clear that surgery is a medically necessary, not experimental, treatment for severe Gender Dysphoria as demonstrated by its inclusion as a medically necessary treatment in the SOC.

55. In 2008, WPATH issued a "Medical Necessity Statement" expressly stating: "These medical procedures and treatment protocols are not experimental: decades of both clinical and medical research show they are essential to achieving well-being for the transsexual patient."

56. Similarly, Resolution 122 (A-08) of the American Medical Association states: "Health experts in GID, including WPATH, have rejected the myth that these treatments are 'cosmetic' or 'experimental' and have recognized that these treatments can provide safe and effective treatment for a serious health condition."

57. On September 25, 2013 the Department of Health Care Services of the State of California Health and Human Services Agency issues All Plan Letter 13-011, which makes clear that gender confirmation surgery was a covered service for Medi-Cal beneficiaries when the surgery was not cosmetic in nature and referred providers to the WPATH Standards of Care for the "criteria for the medical necessity of transgender services." Illinois recently joined the states that will provide gender confirmation surgery for Medicaid recipients. *See* https://www.chicagotribune.com/business/ct-biz-medicaid-gender-reassignment-surgery-20190405-story.html.

58. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services issued decision number 2576, in which the

Board determined that a Medicare regulation denying coverage of "all transsexual surgery as a treatment for transsexualism" was not valid under the "reasonableness standard." The Board specifically concluded that "transsexual surgery is an effective treatment option for transsexualism in appropriate cases."

D. Living Consistently with Gender Identity

59. The SOC establish the therapeutic importance of changes in gender expression by means of social signifiers that align with gender identity. Gender Dysphoria, like many medical conditions, often requires more than a single intervention for effective treatment. For example, clothing and grooming that affirm one's gender identity, such as bras for transgender females, and the use of congruent pronouns are critically important components of treatment protocols. (Greenberg & Laurence 1981; Ettner 1999; Devor 2004.)

60. The SOC also specifically provide that permanent body hair removal, the elimination of a visible secondary sex characteristic, is significant in alleviating Gender Dysphoria for transgender women. Other gender-appropriate grooming items for transgender women such as feminine deodorant, moisturizer, and make-up may also be necessary for treatment. Similarly, male grooming items are important components of social role transition for transgender men. These accoutrements are critical to the mental well-being and social transition of gender dysphoric people.

61. "Mis-gendering"—the act or referring to a transgender person by the incorrect gender—is harmful to the mental health of transgender persons. It threatens their identity and can exacerbate the mental health problems attendant to Gender Dysphoria. It is therefore important, especially for those charged with the medical treatment and mental health care of transgender persons with Gender Dysphoria, to refer to transgender people using gender-affirming names and pronouns. (Bauer et al. 2015; Frost et al. 2015; Bockting 2014.)

62. Gender dysphoric prisoners are at heightened risk. In addition to the concerns outlined above, it is important for correctional facilities to consider appropriate housing and shower/bathroom facilities for transgender individuals. Each individual's gender identity and role, dignity, and personal safety should be taken into account in housing and other assignments. *See* SOC at 68. If the institution fails to do so, there can be serious consequences for mental and physical health. (Seelman, 2016.)

63. The act of showering with a person of a different gender or being subject to a pat-down or even strip search by an officer of a different gender can be a frightening and demeaning experience for transgender individuals. For those suffering from Gender Dysphoria, the experience can exacerbate their condition and lead to serious mental health complications, including worsening depression, anxiety, and hopelessness.

64. Moreover, transgender inmates who are housed in a facility that does not match their gender identity may be subject to increased instances of physical and sexual assault by other inmates and officers.

65. Clothing and grooming items are particularly important to provide to transgender patients with Gender Dysphoria who have initiated hormone therapy. The physical changes facilitated by hormones in these patients make gender-affirming clothing and grooming items necessary not only for the mental health of these patients, but also for their basic physical comfort and dignity. For example, for transgender women, female undergarments allow testicles to be tucked and less visible, reducing symptoms of gender dysphoria. Likewise, regardless of breast development, a bra may be an important and affirming symbol of femininity for gender dysphoric women. Similarly, transgender men should be provided with male undergarments and male clothing.

66. Transgender individuals in the correctional environment sometimes are disciplined for attempts at grooming that effectively amount to self-treatment of their Gender Dysphoria. For example, transgender women may be disciplined for tattooing makeup, modifying their clothing to fit their preferred gender, or for wearing a ponytail.

67. Social role transition—including, for example, transgender women appearing feminine—has an enormous impact in the treatment of Gender Dysphoria. An early seminal study emphasized the importance of aligning presentation and identity and its benefits to mental health. Greenberg and Laurence compared the psychiatric status of gender dysphoric individuals who had socially transitioned with those who had not. Those who had implemented a social transition showed "a notable absence of psychopathology" compared to those who were presenting in their birth-assigned sex role. *See* Greenberg & Laurence 1981. In addition, social transition should include use of facilities (restrooms, showers, etc.) that are consistent with one's gender identity.

E. Risks of Providing Inadequate Care

68. Without adequate treatment, adults with Gender Dysphoria experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues. They are frequently socially isolated as they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time proves ravaging to healthy personality development and interpersonal relationships. Without treatment, many gender dysphoric people are unable to adequately function in occupational, social or other areas of life. Many gender dysphoric women without access to appropriate care are often so desperate for relief that they resort to life-threatening attempts at auto-castration (the removal of one's testicles) in the hopes of eliminating the major source of testosterone that kindles the dysphoria. Brown & McDuffie 2009. (Brown, 2010.) A recent survey

found a 41% rate of suicide attempts among this population, which is far above the baseline rates for North America.

69. Gender dysphoria intensifies with age. As cortisol rises with normal aging, the ratio of DHEA to cortisol is affected, which acts to alter brain chemistry and intensify gender dysphoria. With the passage of time, inmates who require surgical treatment will experience greater distress, and no means of relief. *See* Ettner 2013; Ettner & Wiley 2013. This is particularly deleterious for transgender inmates serving long sentences.

70. Because Gender Dysphoria entails clinically significant and persistent feeling of stress and discomfort with one's assigned gender, if it is not treated, those feelings of stress and discomfort will increase and may become critical. The results are serious and debilitating symptoms of anxiety, depression, and hopelessness. Without treatment, these individuals may not be capable of accomplishing simple everyday tasks, and may become increasingly socially withdrawn and isolated, which only serves to further exacerbate their symptoms.

71. Gender Dysphoria left untreated or inadequately treated, will result in serious harm. The depression and hopelessness associated with the condition causes suicidal ideation, which will result in actual suicide for many individuals. SOC at 67. Research shows that the risk of suicide can be significantly diminished with prompt and effective treatment. Bauer 2015.

72. Moreover, gender dysphoric individuals have a profound discomfort with their genitalia. Without effective treatment as outlined above, this often leads to attempts at auto-castration, which can result in lasting physical trauma or even death in more serious cases. *See* Brown & McDuffie 2009.

73. In sum, the results of providing inadequate treatment are predictable and dire, and take one of three paths: profound psychological decompensation, surgical self-treatment, or suicide.

V. DEFICIENCIES IN THE TREATMENT FOR GENDER DYSPHORIA IDOC HAS PROVIDED TO THE NAMED PLAINTIFFS

74. I assessed whether the treatment provided to the named class representatives in this case by IDOC was appropriate, and below identify and describe deficiencies in that treatment and instances where the treatment deviated from the accepted standards set forth in the SOC. To undertake this analysis, I reviewed the named plaintiffs' medical records as kept by IDOC and the meeting minutes from IDOC's "Gender Identity Disorder Committee," or Transgender Committee, through which all treatment decisions for Gender Dysphoria are routed. I conducted in-person interviews, including a psychological evaluation and administration of psychological tests, for each named plaintiff in this matter in May 2018.

75. My analysis revealed that each of the named plaintiffs in this case is receiving treatment for Gender Dysphoria that deviates significantly from the well-accepted standards in the SOC, and that falls well below providing competent care. At bottom, none of the plaintiffs' Gender Dysphoria is being adequately treated. This means they continue to suffer unnecessarily, and also that they are at heightened risk of self-harm or suicide. There are commonalities among the deficiencies in care among the named plaintiffs, including: failure to timely initiated hormone therapy; failure to timely provide social transition, including through gender-affirming clothing and/or grooming items; and failure to evaluate plaintiffs for gender-affirming surgery.

A. Janiah Monroe

Review of IDOC Medical and GID Committee Records

76. Ms. Monroe is a 29-year-old transgender person currently incarcerated in Logan Correctional Center. She has identified as a female since a very young age, from the time she was a child living in the South Side of Chicago. Her family, and particularly her father, was hostile toward her female gender identity expression. Although she was never treated by a physician or other healthcare provider for Gender Dysphoria prior to entering IDOC, she took hormones when she could get access to them, and she informed IDOC of her status as a transgender female upon entering custody.

77. Ms. Monroe was diagnosed with Gender Dysphoria by an IDOC mental healthcare provider in November of 2011. This was only after she complained of symptoms of Gender Dysphoria for years to IDOC staff, including severe depression and hopelessness. Ms. Monroe's history of self-harm, suicidal ideation, and attempted suicide is well-documented in her IDOC records. She has attempted auto-castration and tried to commit suicide on multiple occasions. She described several different methods for attempting to commit suicide to me during our interview. The clinical term for attempted suicide by varying methods is called "method-switching," and it is a strong indicator that the person is likely to carry out a successful suicide in the future.

78. The GID Committee notes regarding Ms. Monroe acknowledge her history of Gender Dysphoria, documenting that she was diagnosed with dysphoria by an IDOC mental health professional in 2011. The Committee also acknowledges Ms. Monroe's suicide attempts and attempts at auto-castration. After Ms. Monroe requested hormone therapy to treat her diagnosed Gender Dysphoria, the GID Committee met in March of 2012 to discuss her case. Those records indicate that, despite her diagnosis and despite IDOC's own mental health professional opining

that hormone therapy should be considered, the Committee denied her hormone treatment. The Committee's only rationale was that if Ms. Monroe were to start hormone treatment, others might "follow [her] lead." The Committee met again in April of 2012 to discuss Ms. Monroe, and again denied her request for hormone therapy. The next available Committee records, from June 2015, indicate that Ms. Monroe was approved for hormone therapy at some point between April and June in 2012. Likewise, her medical records show that she began receiving cross-sex hormones sometime in mid-2012, after the Committee denied the therapy at least twice.

In-Person Interview and Psychological Examination

79. I administered an in-person psychological exam to Ms. Monroe on May 11, 2018 at Dixon Correctional Center, designed to measure her levels of anxiety, depression, and hopelessness. On the exam, Ms. Monroe demonstrated moderate levels of anxiety. On depression and hopelessness, which are the strongest predictors of whether a person will commit suicide, she scored extremely high. On hopelessness, she scored above a range at which a patient will normally go on to complete suicide.

80. Ms. Monroe showed no evidence of psychosis. It is my opinion that her severe mental health issues—namely, her depression and feelings of hopelessness—stem from her Gender Dysphoria, which roughly 8 years after her initial diagnosis by IDOC is still not being adequately treated. Ms. Monroe indicated that she would like to have gender-affirming surgery to treat her Gender Dysphoria. IDOC grievance records reflect that she has made formal requests for surgery, but that she has not even been evaluated, much less seriously considered, for such treatment. The reason, according to IDOC, is that "there is no policy in place" to provide surgery. Despite acknowledging that fact, the records also indicate that Ms. Monroe previously was denied

transfer to an all-female facility because she has not had gender-affirming surgery performed. I understand that Ms. Monroe recently was transferred to a female facility.

Deficiencies in Treatment and Related Risks

81. Ms. Monroe's treatment falls far outside of the WPATH guidelines and standards of care for gender dysphoric persons, and IDOC personnel have routinely ignored her serious medical needs.

82. The long delay in authorizing hormone treatment for Ms. Monroe is inexcusable and without any legitimate medical basis. The GID Committee records indicate treatment initially was denied because IDOC feared others would follow Ms. Monroe's lead. This is not a medically recognized or clinically appropriate reason, under WPATH guidelines or in my professional experience as a psychotherapist specializing in treatment of Gender Dysphoria, to deny hormone treatment to a gender dysphoric individual. This excuse does not even purport to relate to a medical concern.

83. Moreover, based on my years of practice, research, and clinical expertise, people do not request hormone therapy unless they actually need it and believe it would help them overcome their Gender Dysphoria. There are no secondary gains to treatment with cross-sex hormones; and in fact, when they are used incorrectly, or used in the absence of a legitimate medical need, they can be harmful. A hormone therapy regimen in a non-transgender person would make that person ill and profoundly uncomfortable.

84. IDOC records show that Ms. Monroe repeatedly has been denied gender-appropriate clothing and grooming items. Without access to such items, she is unable to transition socially and her Gender Dysphoria is likely to be severely exacerbated. Without effective treatment of her persistent and worsening Gender Dysphoria, including but not limited to gender-

affirming surgery, it is my professional clinical opinion that Ms. Monroe is likely to commit suicide as a result of her symptoms and IDOC's mismanagement of her condition.

85. It is my understanding that on April 1, 2019, Ms. Monroe was transferred to Logan Correctional Facility, a correctional center housing women. This was a necessary step in facilitating her social role transition and will help alleviate the severe mental health symptoms she experiences from Gender Dysphoria. However, unless she receives the other necessary treatment, including ongoing and appropriate hormone therapy and gender-affirming surgery, she will continue to be at serious and immediate risk of self-harm and possible suicide.

B. Sora Kuykendall

Review of IDOC Medical and GID Committee Records

86. Ms. Kuykendall is a 26-year-old transgender female currently incarcerated in Menard Correctional Center. She first identified as a female at around 5 years of age. She told her family, but her brother treated her badly and bullied her for her female mannerisms, and she began hiding her gender identity. Her family did not provide her with any medical or mental health support, so she was never evaluated for hormones or any other treatment as a child or adolescent. Her feelings of depression and hopelessness increased as she reached puberty and her body began to change in ways she did not recognize and that were not consistent with her gender identity.

87. Ms. Kuykendall informed an IDOC mental health professional of her transgender identity when she entered IDOC custody in November of 2014. In December 2014, she requested hormones, and a mental health treatment plan from January 2015 indicates that she would "[b]egin transitioning process from male to female." A mental health progress note from February 2015 noted that Ms. Kuykendall was experiencing depression as a result of Gender Dysphoria. Since being incarcerated, she has attempted auto-castration.

88. The GID Committee met in February 2015 to discuss Ms. Kuykendall, and acknowledged her Gender Dysphoria diagnosis, her history of self-harm, and her request for treatment.

89. Ms. Kuykendall began receiving hormones on February 27, 2015. However, her records indicate that she continued to experience serious symptoms of Gender Dysphoria. In June 2015, she requested gender-affirming surgery and gender-appropriate clothing items. She also complained repeatedly of strip searches by male officers, and requested that her searches be conducted by female officers only.

90. In January and February 2017, she continued to make many of the same requests of mental health professionals in the prison, including requests for feminine grooming products, gender-appropriate clothing, and gender-affirming surgery. She renewed her request for surgery as recently as August of 2017. There is no record that she has been evaluated or otherwise considered by IDOC as a candidate for surgery.

In-Person Interview and Psychological Examination

91. I conducted an in-person evaluation of Ms. Kuykendall on May 22, 2018 at Menard Correctional Center. Ms. Kuykendall presents as self-aware and intelligent, with feminine physical characteristics. While she is happy to be on hormones and she believes they help her mood, she exhibits symptoms of severe anatomical dysphoria, which is confirmed by her acts of self-harm and attempts at auto-castration. On the psychological tests I administered, she exhibited extremely high anxiety and had high suicidal ideation. Her depression and feelings of hopelessness both measured at clinically significant levels.

92. Because of Ms. Kuykendall's discomfort around male inmates and correctional officers, she almost never leaves her cell, and she resides by herself. This self-imposed solitary

confinement has been harmful to her emotional well-being. She appears to be exceptionally pale and rarely showers.

Deficiencies in Treatment and Related Risks

93. Ms. Kuykendall's self-imposed solitary confinement is related to her Gender Dysphoria and the extreme discomfort she experiences around men, particularly during searches of her person by male correctional officers. Her clinically significant hopelessness and depression, and her high levels of anxiety, are all symptoms of her underlying Gender Dysphoria.

94. Ms. Kuykendall likely requires gender-affirming surgery, and should be evaluated for such surgery immediately. As of my meeting with her in May 2018, she met all the diagnostic criteria for surgery. As long as evaluation for surgery is delayed, Ms. Kuykendall will continue to be at serious risk for self-harm and suicide, and will continue to experience feelings of hopelessness, depression and anxiety.

C. Sasha Reed

Review of IDOC Medical and GID Committee Records

95. Ms. Reed is a 26-year-old female currently incarcerated in Lawrence Correctional Center. She identified starting at around 11 years old, but did not receive any mental health or medical treatment relating to transgender issues. Ms. Reed reported her transgender status and her desire for treatment to an IDOC mental health professional in November of 2015. She reported that prior to her incarceration, she had been dressing as a female. Her medical records indicate a history of self-harm and attempted suicide.

96. The GID Committee met on December 18, 2015 and, despite Ms. Reed's history and indications of related mental health issues, the Committee determined that she did not meet the criteria for Gender Dysphoria and denied her treatment, including denial of hormone therapy.

The Committee met next on February 19, 2016, and denied Ms. Reed therapy again. The Committee stated that rather than recommending hormones, it needed to "clearly rule out a psychotic process and investigate offender's conceptualization of gender identity."

97. Throughout 2016, Ms. Reed's records show she continued to report symptoms of mental distress attendant to her Gender Dysphoria. She also repeatedly requested hormone therapy and gender-appropriate clothing, and reported depression to mental health professionals. GID Committee records from a meeting in November 2016 show that the committee again denied hormone therapy for Ms. Reed's Gender Dysphoria, citing as the basis for denial mental health issues generally.

98. In December 2016, Ms. Reed filed a grievance for gender-affirming surgery and gender-appropriate clothing and grooming items, which was denied as "moot." The denial deferred entirely to the "Transgender Care Committee," providing no further rationale for the denial.

99. The Committee finally approved Ms. Reed for hormone therapy in March of 2017, well over a year after she first requested treatment.

In-Person Interview and Psychological Examination

100. I conducted an in-person evaluation of Ms. Reed on May 23, 2018 at Lawrenceville Correctional Center. She exhibited severe levels of depression on the tests I administered. In our interview, Ms. Reed described symptoms consistent with Gender Dysphoria that first manifested in childhood. She also expressed a desire for female grooming items that she was not receiving, including body-hair removal items and makeup. She reported extreme distress resulting from being strip-searched by men at Lawrenceville.

Deficiencies in Treatment and Related Risks

101. The delay in initiating hormone treatment in Ms. Reed was inexcusable, and the Committee's stated reasons for the delay have no basis whatsoever in the Guidelines. It is unclear what the committee meant when it wrote that it must "investigate offender's conceptualization of gender identity," but that is not a medically valid reason to deny treatment.

102. The Committee provided no specific evidence that Ms. Reed's mental health issues were not well-managed, and I did not identify any such evidence in my own review of Ms. Reed's medical records. Indeed, mental health professionals were actively prescribing her Zoloft, Sertraline, and Loxitane to alleviate her purported mental health issues. In my in-person evaluation of Ms. Reed in May 2018, I noted no indication of any psychosis, and it is my clinical opinion that her mental health symptoms are a result of her Gender Dysphoria, not the result of a "psychotic process."

103. Ms. Reed has repeatedly requested gender-affirming surgery and the records indicate that IDOC has consistently ignored or denied those requests. But she appears to meet the criteria for surgery, and should be evaluated immediately. If IDOC continues to ignore her requests, her Gender Dysphoria will persist and worsen, and Ms. Reed will remain at serious risk of self-harm and suicide.

D. Lydia Helena Vision

Review of IDOC Medical and GID Committee Records

104. Ms. Vision is a 39 year-old transgender female currently incarcerated in Graham Correctional Center. She identified as a female from a very young age, but her family did not support her gender identity. Around the age of 8 or 9, she attempted auto castration. Because of her family's lack of support, she suppressed her gender identity for many years afterward. Ms.

Vision informed IDOC as early as January 2015 that she was transgender. She told mental health professionals that she felt incapable of fully expressing her feminine side due to her environment in the prison and her past experiences of being stigmatized for her female characteristics.

105. The GID Committee met on March 18, 2016, and noted that Ms. Vision was "mentally stable per MHP opinion." Providing a short overview of Ms. Vision's medical history, the Committee noted that she identified as female for the previous 8 years and had been diagnosed with Gender Dysphoria by an IDOC psychiatrist.

106. Despite acknowledging her diagnosis of Gender Dysphoria, the Committee nevertheless denied her hormone therapy, stating that her Gender Dysphoria "may not fully manifest itself in the correctional environment." The Committee further noted, without elaboration, that it had concerns regarding her purported anger and aggression that "can be tied to PTSD." The Committee also repeatedly referred to Ms. Vision as "he," despite her identification as a female.

107. Ms. Vision continued to request hormones and gender-appropriate clothing and grooming items in 2016. The Committee met again in November of 2016 and again denied Ms. Vision hormone therapy. While still acknowledging her diagnosis of Gender Dysphoria, the Committee remained fixated on Ms. Vision's purported PTSD, indicating that she had admitted to being sexually abused as a child. The Committee wrote that it was concerned about the "potential for further victimization and isolation as the physical effects of feminizing hormones become apparent." The Committee did not explain the basis of its conclusion that Ms. Vision suffered from PTSD, nor elaborate on that diagnosis in any material way.

108. Ms. Vision's records show that after this Committee meeting, she continued to report increased depression and anxiety as a result of not being approved for hormone therapy.

The Committee met again in March of 2017. They acknowledged Ms. Vision's requests for female undergarments, feminine grooming supplies, and hormones, and continued to deny her treatment. The only explanation provided was that the Committee had "concerns about [Ms. Vision's] mental health and capacity to undergo the physiologic changes associated with feminizing hormones in an environment where she has little to no support."

109. Ms. Vision's records indicate she began receiving them around November of 2018, representing a delay of over 2 years after she first requested treatment for Gender Dysphoria.

In-Person Interview and Psychological Examination

110. My psychological evaluation of Ms. Vision revealed no clinically significant indicators of psychological symptomology of post-traumatic stress disorder (PTSD): she scored low on the tests I administered for anxiety, depression and feelings of hopelessness. She has also developed effective coping mechanisms, such as working out and reading, and has successfully implemented various self-improvement techniques while incarcerated. For example, she earned a college degree in prison.

111. Despite her excellent coping skills, she also fits the criteria for persistent and early-onset Gender Dysphoria. She does not feel "at home" in her own body, and she had attempted auto-castration at a very young age. During my evaluation, I administered a test to Ms. Vision designed to diagnose PTSD, and she does not have the disorder. One of the Committee's primary justifications for repeatedly delaying hormone therapy for Ms. Vision was her supposed PTSD, a condition that the members of the Committee did not even attempt to diagnose in person.

Deficiencies in Treatment and Related Risks

112. Even if Ms. Vision did suffer from PTSD, it was not a legitimate reason to delay or defer treatment for Gender Dysphoria. Chronic PTSD is persistent and is unlikely to resolve, even

with therapy and prescription drugs. None of the records explain why Ms. Vision's supposed PTSD should act as a contraindication to hormone therapy or other relief.

113. Given her severe and persistent anatomical Gender Dysphoria, Ms. Vision should be evaluated for gender-affirming surgery when she becomes eligible in November 2019. Failure to do so will put Ms. Vision at serious risk of self-harm, and amounts to effectively ignoring her serious medical needs.

E. Marilyn Melendez

Review of IDOC Medical and GID Committee Records

114. Ms. Melendez is a 24-year-old transgender woman currently incarcerated in Pontiac Correctional Center. She identified as a female from a young age, and only her mother was supportive of her gender identity. Ms. Melendez did not receive formal medical treatment or counseling for transgender issues, but she took cross-sex hormones on occasions, whenever her mother was able to provide them to her. She entered IDOC custody as a juvenile at the age of 14.

115. Ms. Melendez informed IDOC of her transgender status and began seeking hormone therapy as early as February of 2015. She began discussing feelings of depression and other issues with IDOC healthcare professionals and was diagnosed with Gender Dysphoria on March 6, 2015. An IDOC mental health professional recommended she be referred to the GID Committee for potential hormone therapy.

116. The Committee met on March 27, 2015 and acknowledged Ms. Melendez's history of living as a female and feeling as if she was in the "wrong body." The Committee nevertheless denied hormone therapy, stating only that Ms. Melendez "need[ed] counseling on real life situations of living as opposite gender."

117. Ms. Melendez promptly filed a grievance relating to the denial of her hormone therapy. That grievance was denied, and the denial deferred entirely to the GID Committee, without any further reasoning or explanation. The Committee ultimately approved hormone therapy in July of 2015, after a 4-month delay.

118. Ms. Melendez requested access to a bra in March of 2016, which IDOC did not approve until a full year later. Ms. Melendez also requested gender-affirming surgery in October of 2016. Her records indicate that IDOC refused that request and has not even evaluated her as a candidate for such surgery.

In-Person Interview and Psychological Examination

119. At our interview on May 25, 2018 at Pontiac Correctional Center, Ms. Melendez presented as intelligent, articulate, and self-assured. However, Ms. Melendez also has a history of attempted suicide. On the psychological tests I administered, she exhibited clinically significant anxiety and depression, and extremely high feelings of hopelessness with suicidal ideation.

120. Ms. Melendez expressed a strong feeling that she hated her male genitalia and wanted them removed. Her Gender Dysphoria has persisted despite the initiation of hormone therapy, and in fact is becoming more severe. Ms. Melendez also reported to me that she still had not received a bra from IDOC that fits her properly.

Deficiencies in Treatment and Related Risks

121. The 4-month delay in initiating hormone therapy for Ms. Melendez was without any legitimate medical basis. The Committee's stated reason for delay—that she needed "counseling on real life situations of living as opposite gender"—is not a rationale for denying therapy, nor should such a factor even play into a decision about whether to initiate hormones. It is not clear from the records that such "counseling" was ultimately provided to Ms. Melendez.

122. The mental symptoms that Ms. Melendez continues to exhibit—in particular her extreme feelings of hopelessness and suicidal ideation—are symptoms of her Gender Dysphoria, which is worsening without effective treatment. It is also important for gender dysphoric individuals to have the appropriate clothing and grooming items that affirm their genders. As with hormone treatment, there was no legitimate medical basis to deny Ms. Melendez a bra for a year after she was diagnosed by an IDOC mental health professional with Gender Dysphoria.

123. Further, Ms. Melendez exhibits severe anatomical dysphoria and spoke of hating her male genitalia. She meets the criteria for gender-affirming surgery and should be evaluated immediately for surgery.

124. It is my opinion that IDOC's failure to evaluate Ms. Melendez for surgery, its unjustified delay in initiating hormone therapy, and its unjustified delay in providing her with a bra have all needlessly exacerbated her already-severe Gender Dysphoria. As long as she continues to have requests for gender-affirming clothing and surgery denied, and as long as the pattern of ignoring or delaying her requests continues, Ms. Melendez will remain in severe mental distress and at risk of suicide.

F. Putative Class Members

125. In my review of the medical records and GID Committee records relevant to the class members, I observed many of the same deficiencies in treatment that I have discussed above regarding the named plaintiffs.

126. Many of the class member inmates have been diagnosed with Gender Dysphoria, but have hormone treatment arbitrarily or unreasonably withheld by the GID Committee. The unnecessary denial or delay of hormone therapy can have severe consequences to the mental health of gender dysphoric patients. Without effective treatment, the course of Gender Dysphoria leads

to one of three outcomes in patients: psychological decompensation, surgical self-treatment (such as auto-castration in transgender women), or suicide.

127. The Committee's reasons for denial of treatment vary, but in all cases I reviewed, their reasons were not recognized under the WPATH Standards for denying or delaying treatment, and were not medically sound. One of the most fundamental errors repeatedly made by the Committee is to confuse the symptoms of Gender Dysphoria with having a co-occurring mental illness, and then denying treatment for a lack of "stability" or the need to address prior "trauma" before treatment can commence. Other times, the Committee denies treatment simply because there has been no IDOC psychiatric evaluation of the putative class member.

128. One of the minimum criteria for treating Gender Dysphoria is the ability to "recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria." SOC at 22. The Committee, which has no contact with the patient, lacks the necessary information to make this determination—and in any event its members do not have the specialized training to make this critical distinction. Relatedly, the Committee misunderstands or misapplies the requirement that co-occurring conditions be "reasonably well-controlled." Absent a psychotic break, or a patient so delusional as to be unable to consent to the treatment plan, treatment for Gender Dysphoria almost always should promptly follow a diagnosis. It is expected that "trauma" will present in most gender dysphoric patients, and by no means should be weaponized as a reason to deny treatment. Relatedly, the Committee misunderstands and mischaracterizes self-injurious behavior as something other than a manifestation of Gender Dysphoria—when a specialist in the field would understand that behavior to be a symptom showing that the condition is untreated or poorly treated.

129. Additional common examples of inappropriate rationales for denial and delay that appeared repeatedly in the records of the putative class members include: need for historical corroboration of gender incongruence beyond the patient's medical records; the patient's disciplinary history; the patient's need for "community support" or the need for more "real-life experience" living as a transgender individual; and "sexual potency." None of these justifications have a basis in the SOC, and competent practitioners would not deny or delay treatment on these bases. The Committee routinely takes into account these and other irrelevant factors in rendering a treatment decision.

130. In some cases, the Committee improperly discounted a putative class member's claim of transgender status or Gender Dysphoria diagnosis because the person had only recently disclosed to IDOC that they were transgender, or because the Committee believes the individual is "confused," "faking," or seeking some kind of "secondary gain." The Committee overlooks or does not understand that transgender individuals often experience tremendous fear about revealing or displaying gender non-conformance. This is especially true in the correctional setting, and many of these putative class members' records indicate that transgender inmates are afraid of other inmates and correctional officers. The Committee also ignores the fact that Gender Dysphoria can have a late onset and intensifies with age. The skepticism with which IDOC approaches Gender Dysphoria is completely unfounded: it is virtually unheard of that a patient who is not gender dysphoric will seek treatment.

131. The Committee's decisions to deny treatment often include denial of requests for gender-appropriate clothing or grooming items. While the Committee has approved the use of bras in gender dysphoric women—albeit typically only after they have taken hormones and exhibited breast development—the Committee does not approve other items, including underwear,

gender-appropriate soaps, shampoos, and deodorants, makeup and cosmetic items, or hair removal. This is contrary to the Standards of Care and deprives prisoners the social transition that the medical community recognizes as medically necessary.

132. None of the Committee records I examined authorized or recommended a medical evaluation of a putative class member for gender-affirming surgery, despite the fact that many transgender inmates requested such surgery. I understand that IDOC never has provided gender-affirming surgery. The records suggest an ignorance on the part of IDOC officials of the fact that gender-affirming surgery may be a medically necessary treatment for Gender Dysphoria. Based on my review of the records in this case, IDOC, through the GID Committee and the actions of its health care professionals, maintains a de facto policy of summarily denying access to gender-affirming surgery, even in cases where it would be indicated as a medically necessary treatment.

133. Overall, the reasons for denying or delaying treatment, when given, may not even reflect medical judgments: they are often administrative decisions made by a deliberative body that provides minimal or cursory explanations regarding their decisions, which have the effect of depriving transgender individuals with serious medical needs of much-needed treatment. For example, there is no indication in the Committee notes that the Committee considered or even reviewed the medical administration records of the individual inmates before rendering decisions (and often denying hormone treatment or asserting that an individual is not gender dysphoric).

134. Further, the members of the Committee seemingly are not qualified to treat transgender patients with Gender Dysphoria. In response to an interrogatory asking for their qualifications to treat Gender Dysphoria, the Defendants responded that four past and present members of the Committee (Melvin Hinton, Steven Meeks, William Puga, and Louis Shicker) are either licensed clinical psychologists or licensed physicians and surgeons. *See* Resp. to

Interrog. 5. As discussed above, the WPATH Standards provide certain minimum criteria that healthcare providers should have before treating gender dysphoric patients. Simply being a licensed clinical psychologist or a licensed physician does not make a person qualified to practice this specialized area of medicine. The Committee repeatedly makes fundamental and egregious errors that qualified practitioners would not make. The Committee notes on their face demonstrate fundamental lack of knowledge about Gender Dysphoria. Patients are sometimes mis-gendered by the Committee, and rarely if ever referred to by their gender-consistent name. The Committee sometimes uses the term "transgenders," to refer to transgender people generally, which is an offensive term. Similarly, the records sometimes use the term "gender identification disorder," which has never been a term accepted by healthcare professionals to refer to Gender Dysphoria.

135. Similarly, IDOC's mental health professionals who directly treat gender dysphoric prisoners appear to lack the qualifications to do so. While I understand that those individuals have masters or doctorate level degrees, I have seen no indication that they have specific training and expertise in gender dysphoria. All indications, based on the care decisions I have seen, are that they do not. In fact, medical notes reflect that many practitioners do not even know the name of the condition—sometimes calling it "tg [transgender] disorder" and "sex dysphoria," among other names that never have been accepted in medical literature. These same practitioners routinely refer to their own patients with incorrect names and pronouns.

136. The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct directs psychologists to "provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence …." The Code of Ethics goes on to direct psychologists as follows: "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with … gender

[and] gender identity … is essential for effective implementation of their services or research, psychologists have or obtain the training, experience consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals…"

137. Relatedly, the SOC state that in an institutional setting, "[i]f the in-house expertise of health professionals … 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." SOC at 67. I understand that IDOC has not engaged outside specialists to advise the Committee or to evaluate specific gender dysphoric patients.

138. Despite lacking qualifications to diagnose and treat Gender Dysphoria, the records show that the Committee will often second-guess, ignore, or overrule a diagnosis of Gender Dysphoria by another health care professional. This is not accepted practice. *See, e.g.*, Principles of Medical Ethics, American Psychiatric Association, § 7.3 (2013). Mental health professionals should exercise caution in diagnosing individuals without having carefully reviewed all pertinent and available medical records and conducted an in-person evaluation, tasks that are not undertaken in the case of the Committee members' ad hoc diagnoses of and treatment decisions for transgender inmates.

139. Taken together, the records in this case form a clear pattern: IDOC, through the GID Committee, fundamentally misunderstands the serious medical condition of Gender Dysphoria, and lacks expertise and understanding to provide effective care. The care that is provided falls well outside the range of acceptable treatment, and puts patients' health in serious danger.

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

Dated: April 24, 2019

Dr. Randi Ettner, Ph.D.

APPENDIX A

RANDI ETTNER, PHD
1214 Lake Street
Evanston, Illinois 60201
847-328-3433

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association of Transgender Healthcare (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgenderism*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical staff Weiss Memorial Hospital, Chicago IL

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois
BA, 1969-73	Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes

CLINICAL AND PROFESSIONAL EXPERIENCE

2016-present	Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery Consultant: Walgreens; Tawani Enterprises Private practitioner
2011	Instructor, Prescott College: Gender-A multidimensional approach
2000	Instructor, Illinois Professional School of Psychology
1995-present	Supervision of clinicians in counseling gender non conforming clients
1993	Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
1992	Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
1983-1984	Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
1981-1984	Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
1976-1978	Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1975-1977	Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1971	Research Associate, Department of Psychology, Indiana University
1970-1972	Teaching Assistant in Experimental and Introductory Psychology Department of Psychology, Indiana University
1969-1971	Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS

Mental health issues in transgender health care, American Medical Student Association, webinar presentation, 2019

Sticks and stones: Childhood bullying experiences in lesbian women and transmen, Buenos Aires, 2018

Gender identity and the Standards of Care, American College of Surgeons, Boston, MA, 2018
The mental health professional in the multi-disciplinary team, pre-operative evaluation and assessment for gender confirmation surgery, American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

Navigating Transference and Countertransference Issues, WPATH global education initiative, Portland, OR; 2018

Psychological aspects of gender confirmation surgery International Continence Society, Philadelphia, PA 2018

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

Gender Dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, IL, 2017.

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, CA, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, Chicago, IL, 2017.

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016.

Tomboys Revisited: Replication and Implication; Models of Care; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, IL, 2015; Atlanta, GA, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017,

Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

Pre-operative evaluation in gender-affirming surgery-American Society of Plastic Surgeons, Boston, MA, 2015

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care-Fenway Health Clinic, Boston, 2015*Gender reassignment surgery*- Midwestern Association of Plastic Surgeons, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013

Role of the forensic psychologist in transgender care; *Care of the aging transgender patient*-University of California San Francisco, Center for Excellence, 2013

Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011; Roosevelt-St. Vincent Hospital, New York; Columbia Presbyterian Hospital, Columbia University, New York, 2011

Children of Transsexuals-International Association of Sex Researchers, Ottawa, Canada, 2005; Chicago School of Professional Psychology, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

Gender Identity, Gender Dysphoria and Clinical Issues –WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World

Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychonueroimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984

Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

The Role of Denial in Dialysis Patients - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

PUBLICATIONS

Ettner, R., White, T., Ettner, F., Friese, T., Schechter, L. (2018) Tomboys revisited: A retrospective comparison of childhood behaviors in lesbians and transmen. *Journal of Child and Adolescent Psychiatry*.

Narayan, S., Danker, S Esmonde, N., Guerriero, J., Carter, A., Dugi III, D., Ettner, R., Radix A., Bluebond-Langner, R., Schechter, L., Berli, J. (2018) A survey study of surgeons' experience with regret and reversal of gender-confirmation surgeries as a basis for a multidisciplinary approach to a rare but significant clinical occurrence, submitted.

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Monstrey, S. De Cuypere, G. and Ettner, R. Surgery: General principles in Principles of Transgender Medicine and Surgery, Ettner, R., Monstrey, S., and Eyler, E. (Eds.) Routledge Press, 2007.

Schechter, L., Boffa, J., Ettner, R., and Ettner, F. Revision vaginoplasty with sigmoid interposition: A reliable solution for a difficult problem. The World Professional Association for Transgender Health (WPATH), 2007, *XX Biennial Symposium,* 31-32.

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"Social and Psychological Issues of Aging in Transsexuals," proceedings, Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, 2005.

"The Role of Psychological Tests in Forensic Settings," *Chicago Daily Law Bulletin,* 1997.

Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the Transgender. Chicago Spectrum Press. 1996.

"Post-traumatic Stress Disorder," *Chicago Daily Law Bulletin*, 1995.

"Compensation for Mental Injury," *Chicago Daily Law Bulletin*, 1994.

"Workshop Model for the Inclusion and Treatment of the Families of Transsexuals," Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

"Transsexualism- The Phenotypic Variable," Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

"The Work of Worrying: Emotional Preparation for Labor," Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Phi Beta Kappa

AWARDS AND HONORS

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019

WPATH Distinguished Education and Advocacy Award, 2018
The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016
Phi Beta Kappa, 1972
Indiana University Women's Honor Society, 1970-1972
Indiana University Honors Program, 1970-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

APPENDIX B

BIBLIOGRAPHY

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De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., *et al.* (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34(6),* 679–90.

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, Plaintiffs, v. JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON, Defendants.	)	Civil No. 3:18-cv-00156-NJR-MAB

DECLARATION OF DR. VIN TANGPRICHA, M.D.

I, Dr. Vin Tangpricha, hereby state:

1. I am a medical doctor with special expertise in treatment of transgender patients with gender dysphoria. I currently serve as President of the World Professional Association for Transgender Health ("WPATH"), the preeminent professional organization dedicated to the understanding and treatment of gender dysphoria worldwide. I have published extensively on issues relating to treatment of individuals with gender dysphoria and I treat transgender patients as part of my clinical practice.

2. I have been retained by counsel for the named plaintiffs and the putative class in the above-captioned matter to provide the Court with scientific and medical information about gender dysphoria and the standard of care for treatment, and to evaluate the current hormone therapy provided by IDOC to the named plaintiffs and the putative class members based primarily upon analysis of their medical records.

Qualifications and Basis of Declaration

3. I received my M.D. from Tufts University School of Medicine in Boston, Massachusetts in 1996. I subsequently earned a Ph.D. in Molecular Medicine from Boston University School of Medicine in 2004. I am Board Certified in Internal Medicine and in Endocrinology, Diabetes, and Metabolism by the American Board of Internal Medicine.

4. Since January 2004, I have served as Professor of Medicine, Division of Endocrinology, Metabolism and Lipids at the Emory University School of Medicine in Atlanta, Georgia. I became a full professor in September 2017. I have also been the Director of the Transgender Clinic and a staff physician at Emory since 2004, and have treated patients as a staff physician at the Department of Veterans' Affairs Medical Center ("VA") in Atlanta, Georgia since 2006.

5. Over the past 10 years, in my capacity as an endocrinologist, I have treated approximately 260 transgender patients with gender dysphoria at Emory, and approximately 100 additional transgender patients with gender dysphoria at the Atlanta VA Medical Center. I also participate in an initiative known as the WPATH Global Education Initiative, in which I deliver lectures three to four times a year on topics relating to hormone therapy for transgender persons.

6. I have authored or co-authored numerous scholarly articles and contributed to several books on topics relating to endocrinology in general and treatment of transgender patients in particular, including several guideline publications relating to endocrine treatments for transgender patients. My CV containing a full list of my publications inclusive of the past 10 years is included with this declaration as Appendix A.

7. From 2007 to 2009, I served as one of eight authors on the first hormone guidelines for transgender persons as a member of the Endocrine Society Task for Transgender Health Guidelines. This was one of the first such set of guidelines for hormone treatment of transgender persons published by a professional society, and continues to be the authoritative reference regarding hormone therapy for transgender persons. I have also served on committees of other relevant professional organizations, including with the American Association of Clinical Endocrinologists.

8. I have not previously provided expert testimony at deposition or at trial.

9. My clinical consulting fee in this case is 400 USD per hour.

10. In preparing this declaration and expert report, I relied on my review of each of the named plaintiffs' medical records (including records of their prescriptions and laboratory results), the medical records of putative class members (including records of their prescriptions and laboratory results), my extensive medical expertise in the area of endocrinology, and my review of the relevant medical literature related to hormone therapy and treatment of gender dysphoria, including the WPATH Standards of Care and the Endocrine Society Guidelines. Additional medical literature on which I have relied is cited and referenced throughout this report. I have also reviewed and relied on the materials from IDOC's Transgender Committee/GID Committee, as well as my phone interviews with each of the named plaintiffs. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field regularly rely upon when forming opinions on these subjects.

Background on Gender Dysphoria

11. Gender dysphoria, previously known as gender identity disorder, is a serious medical condition recognized in both the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) and the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (11th rev. 2018).

12. Not all transgender individuals experience gender dysphoria. Rather, individuals with gender dysphoria are those transgender individuals who experience an incongruence between their innate sense of belonging to a particular gender and the sex assigned to them at birth, accompanied by clinically significant distress or impairment of functioning because of the incongruence. Transgender patients sometimes describe this feeling informally as not feeling "at home" in their own bodies.

General Guidelines for Treatment for Gender Dysphoria

13. The medically accepted standards of care for treatment of gender dysphoria are set out in the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (7th ed. 2011) (hereafter, "WPATH Standards"). These are internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform proper medical treatment for healthcare professionals around the world.

14. The Endocrine Society promulgates its own guidelines for hormone therapy for use in treating transgender persons with gender dysphoria. The Endocrine Society is a global group of healthcare professionals dedicated to the clinical practice of endocrinology and to researching and

advancing hormone therapy for treatment of a variety of hormone disorders, including those that may accompany gender dysphoria.

15. These guidelines, which I co-authored, are entitled Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (hereinafter, "Guidelines"), and they establish a framework for treatment of gender dysphoria, and in particular hormone therapy. The Guidelines are recognized around the world as the authoritative guide for hormone therapy in treatment of transgender persons with gender dysphoria. WPATH endorses the hormone regimens from the Guidelines.

Hormone Therapy Guidelines for Treatment of Gender Dysphoria

16. Both the WPATH Standards of Care and the Endocrine Society Guidelines identify hormone therapy as an important treatment for gender dysphoria, as such treatment is used to feminize or masculinize the body in order to reduce the distress caused by the discordance between a person's gender identity and their sex assigned at birth. WPATH Standards at 33; Guidelines at 3869.

17. Hormone therapy works to treat gender dysphoric persons by (1) suppressing endogenous sex hormone secretion determined by chromosomes and (2) maintaining sex hormone levels within the normal range for the person's affirmed gender. Endocrine Society Guidelines at 3869.

18. Hormone therapy in transgender adults is safe if it is correctly administered at proper therapeutic doses, and if patients are properly supervised according to the applicable guidelines. *See* Katrien Wierckx et al., *Cross-Sex Hormone Therapy in Trans Persons is Safe and Effective at Short-Time Follow-up: Results from the European Network for the Investigation of*

Gender Incongruence, 2014 J. SEX MED. 1999 (hereafter, "Cross-Sex Hormone Therapy"); *see also* Jamie D. Weinand & Joshua D. Safer, *Hormone Therapy in Transgender Adults is Safe with Provider Supervision; A Review of Hormone Therapy Sequelae for Transgender Individuals*, 2015 J. CLINICAL & TRANSLATIONAL ENDOCRINOLOGY 55.

19. The criteria for hormone therapy are (1) persistent, well-documented gender dysphoria; (2) capacity to make a fully informed decision and to consent for treatment; (3) being the age of majority; and (4) if significant medical or mental health concerns are present, then they are reasonably well-controlled. Guidelines at 3878; WPATH Standards at 34. Those criteria are the same for all transgender individuals.

20. The criteria's reference to "well-documented" gender dysphoria is not intended to screen out those people who have exhibited symptoms of gender dysphoria but were only recently diagnosed with the condition. Rather, this criterion in practice generally is understood to mean that the symptoms of gender dysphoria must have been present for at least 6 months. Typically when a patient is diagnosed as gender dysphoric, hormone therapy begins immediately because a person whose symptoms have reached the point that they have contacted a health care professional usually has experienced symptoms for greater than a 6-month period.

21. The presence of mental health concerns or other medical issues does not normally preclude access to hormone therapy. The accepted contraindications to starting hormone therapy are "previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease." WPATH Standards at 44. Mental health issues must be reasonably well-controlled prior to initiation of hormones, but should not prevent immediate initiation of hormone therapy, except in extreme circumstances.

WPATH Standards at 34; Guidelines at 3878. Indeed, given the nature of gender dysphoria, mental health concerns in patients are not uncommon, and effective treatment of mental health concerns may be inextricably linked to effective treatment of underlying gender dysphoria. Anxiety, depression and hopelessness are associated with gender dysphoria and are reasons to initiate hormone therapy rather than delay it. Unless a patient is unequipped to provide informed consent, hormone therapy typically should not be delayed. IDOC's practice of denying or delaying hormone therapy by requiring counseling beforehand is not a requirement that I require as a practitioner and is not medically accepted. IDOC's practice of denying or delaying hormone therapy on the basis of some co-existing mental illness is similarly misguided; symptoms such as depression and anxiety likely only can be addressed if the underlying gender dysphoria is addressed.

22. Once hormone therapy is initiated, clinicians should supervise their patients to maintain physiologic levels of the gender-appropriate hormones, and monitor patients for known risks and complications. For this and other reasons, it is important that clinicians treating gender dysphoria have expertise or training in transgender-specific diagnostic criteria, hormone treatment, and other treatments specific to transgender patient needs. Guidelines at 3869–70, 3877–78; WPATH Standards at 41.

23. In some instances, transgender patients will self-medicate by taking hormones purchased or given to them without a prescription. When treating physicians encounter such patients, it is important to continue hormone therapy, even if the patient's prior hormone regimen was sub-optimal. The physician should assess the information from the patient's self-reporting, available records and laboratory results, and any other available information and start a hormone regimen promptly, making modifications in the prescribed regimen as appropriate, until the patient

establishes care under a clinician who will institute a long-term plan for hormone therapy. This practice is known as "bridging." WPATH Standards at 43. Absent a medical contraindication, bridging care should be provided in order to ensure symptoms of gender dysphoria are addressed and the body is not re-feminized or masculinized (which can have cause significant distress in gender dysphoric patients), and in order to avoid effects of a lapse in hormones, which can include menopause-like symptoms such as hot flashes. In adolescents, bridging may be critical to avoid permanent changes to the body.

Medically Recommended Hormones for Transgender Females

24. Recommended hormone treatment for transgender females typically involves estrogen and a testosterone blocker (also known as an antiandrogen) called spironolactone. Guidelines at 3887–88.

25. The recommended hormones and dosages under the Guidelines for transgender females is an estrogen-derivative known as estradiol (if oral route, 2 to 6 mg/d, or milligrams per day) and spironolactone (if oral route, 100-300 mg/d). Research suggests that the most common effective therapeutic dose of estradiol for treatment of gender dysphoria is 4 mg/d, and that this generally is a safe and effective dosage under proper supervision. *See* Cross-Sex Hormone Therapy at 2008.

26. Ultimately, the optimal dose of estrogen will depend upon the patient. For some transgender females, 4 mg/d of estradiol may be insufficient to alleviate symptoms of gender dysphoria. The dose of estrogen should be at a level that maintains the desired sex characteristics and relieves gender dysphoria, but is also adequate to prevent osteoporosis, hot flashes, and mood disorders. *See* Vin Tangpricha & Martin den Heijer, *Oestrogen and Anti-androgen Therapy for*

Transgender Women, in LANCET DIABETES ENDOCRINOL (Apr. 2017) (hereafter, "Tangpricha Lancet Article"). If a particular dose is not meeting these goals, it may be medically necessary to increase the estradiol dosage beyond 4 mg/d. The only limiting factor in this regard is that a patient's estrogen levels should not exceed the peak level 400 pg/mL (pictograms per milliliter) typically seen in cisgender women. *See id.* at 5.

Medically Recommended Hormones for Transgender Males

27. Recommended hormone treatment for transgender males typically involves provision of testosterone, either parenterally (through injection) or transdermally (through the skin). Guidelines at 3887.

28. The recommended form and dosages of testosterone under the Guidelines for transgender males when delivered parenterally is either (1) 100-200 SQ (IM) every 2 weeks; or (2) testosterone undecanoate, 1000 mg every 12 weeks. When delivered transdermally, the recommended form and dosage of testosterone is either (1) 50-100 mg/d of testosterone gel of 1.6% concentration; or (2) 2.5-7.5 mg/d of testosterone through transdermal patch. Guidelines at 3887.

29. Ultimately, the optimal dose of testosterone will depend upon the patient. As with estradiol, it is often necessary to titrate the dose until blood tests and physical changes show the desired therapeutic goals are being met.

Medical Importance of Monitoring Hormone Levels

30. All transgender individuals receiving hormone therapy should receive regular clinical evaluation for potential adverse changes in response to treatment. The Standards of Care direct that "clinicians who prescribe hormone therapy . . . [p]rovide ongoing medical monitoring,

including regular physical and laboratory examination to monitor hormone effectiveness and side effects." Standards of Care at Section VIII, p. 42. Similarly, the Endocrine Society recommends "appropriate regular medical monitoring . . . [is] recommended for both transgender males and females during the endocrine transition and periodically thereafter," Guidelines at 3889, including patient evaluations every 2-3 months in the first year of hormone or endocrine treatment and then 1-2 times per year thereafter. Guidelines at 3871. The laboratory monitoring should include measurement of testosterone and estradiol (a derivative of estrogen) levels for females, and of testosterone levels for males. Guidelines at 3871, 3890.

31. Hematocrit and hemoglobin levels should be monitored as part of this testing in transgender patients receiving testosterone, because a testosterone level of above 55 ng/dL presents an increased risk of heart attack and stroke that can result in serious injury or death.

32. Testosterone may have side effects that lead to certain physiological changes in patients. Examples are clitoral enlargement and increased perspiration.

33. It is essential to monitor blood levels after hormone therapy begins. In addition to safety concerns, if the patient starts on the lower end of the range of a recommended dosage and gender dysphoria persists or worsens, it may be medically necessary to increase the dosage within the range to achieve the desired therapeutic outcome.

Monitoring in Transgender Females and Related Health Concerns

34. The recommended therapeutic range of testosterone levels for transgender females is less than 50 ng/dL. Guidelines at 3890.

35. The recommended estradiol levels for transgender females should rest within the physiologic range, which is between 100 to 200 pg/mL. Guidelines at 3890. However, if symptoms of Gender Dysphoria are not alleviated in this range, then a higher dosage of hormones should be provided, since estradiol levels higher than 200 pg/mL are safe for someone under qualified supervision for so long as they do not exceed 400 pg/mL. *See* Tangpricha Lancet Article at 5.

36. Transgender females on spironolactone should have their electrolytes tested as part of their regular evaluations, with potassium levels being particularly important. Potassium levels in excess of 5 mmol/L put patients at increased risk for cardiac arrhythmia/hyperkalemia, which can lead to cardiac arrest and even death.

37. Creatinine should also be monitored in these patients since spironolactone is a diuretic. Levels outside the acceptable range may indicate potential danger to kidney function that can lead to serious injury or even death in severe cases. Spironolactone also may cause dry skin, which should be addressed by lotions and moisturizing products.

38. Transgender females' prolactin levels should be monitored periodically as well. Without proper monitoring of prolactin levels, there is a risk of unchecked growth of the pituitary gland, which can cause serious complications, including loss of eyesight.

39. In addition to the potential adverse health effects described above relating to hormone levels outside of therapeutic ranges, it is also important to monitor hormone levels to know whether existing therapy is effectively treating gender dysphoria. For example, it may be necessary to increase a patient's estradiol dosage in order to induce the desired changes to secondary sex characteristics and to increase the patient's mental well-being. Guidelines at 3886.

40. Furthermore, certain formulations of hormones—namely, conjugated forms of estrogen—are inconsistent with the standards of care for treatment of gender dysphoria. Conjugated estrogens such as Premarin and Menest are not recommended because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease (also known as blood clots). *See, e.g.*, Guidelines at 3889; *id.* at Table 11 (recommended hormone regimens in transgender persons, reflecting variations of oral, transdermal, and parenteral estradiol, but no conjugated hormones); L. J. Seal et al., *Predictive Markers of Mammoplasty and a Comparison of Side Effect Profiles in Transwomen Taking Various Hormonal Regimens, in* 2012 J. CLINICAL ENDOCRINOL METABOLISM 4422; Yana Vinogradova et al., *Use of Hormone Replacement Therapy and Risks of Venous Thromboembolism: Nested Case-control Studies Using the QResearch and CPRD Databases*, 2019 BMJ 1, 13. Blood clots pose significant risk that can result in death. Thus, transgender female patients should not be treated with conjugated estrogens because of the serious risks caused by their use, and the lack of any countervailing benefit as compared with estradiol. Oral estradiol also happens to be much less expensive than conjugated estrogens.

Monitoring for Transgender Males

41. For transgender males, blood tests should measure levels of testosterone, in addition to hemoglobin. The physiological range for testosterone is 400-700 ng/dL.

42. Testosterone has a stimulating effect on hemoglobin (red blood cells). High hemoglobin can lead to severe adverse health outcomes, including blood clots, heart attack and stroke. These conditions can be fatal. It is therefore important to monitor testosterone levels to ensure they do not exceed the high end of the physiologic range, and to monitor hemoglobin specifically in transgender males.

Treatment of Named Plaintiffs

43. I have reviewed the medical records of the named plaintiffs, and observed severely inadequate provision of hormone therapy in many respects. I also conducted phone interviews of each named plaintiff during which we discussed their gender dysphoria, their medical histories, and the related medical care they were receiving while incarcerated. IDOC is providing each with hormone therapy that does not meet the Guidelines for treatment set forth by the Endocrine Society, which are the authoritative reference in the medical community regarding hormone therapy for transgender persons. Indeed, the treatment falls well outside of accepted medical practice standards. IDOC delayed providing hormone therapy to the named plaintiffs for reasons that are not medically accepted, and are not contraindications to treatment. Several plaintiffs are receiving inappropriate forms of hormones (conjugated hormones) that carry increased risks of serious adverse health consequences. Others are receiving appropriate forms of hormones but at inadequate dosages that are failing to provide effective treatment. Moreover, hormone level monitoring is not being provided in accordance with the Guidelines for any named plaintiff, meaning that clinicians will remain unaware of the appropriate therapeutic dose, thereby placing all plaintiffs at risk of extremely harmful health consequences.

Janiah Monroe

44. Ms. Monroe was diagnosed with gender dysphoria in November 2011 as recognized by IDOC's "Gender Identity Disorder" Committee. However, initiation of hormone therapy was delayed, resulting in extreme suffering and attempts at autocastration, as reflected in Ms. Monroe's medical records. Ms. Monroe was not approved for hormone therapy until mid-2012, without any explanation. I have not seen anything in Ms. Monroe's medical records that provides an accepted medical rationale for this delay. The Committee's stated reasoning that if

Ms. Monroe were to obtain treatment, other prisoners might also seek treatment, is not a medically accepted rationale for denying or delaying necessary treatment.

45. Ms. Monroe's medical records indicate that her hormone prescriptions have been constant over time: namely, 3 mg/d of estradiol; and 150 mg/d of spironolactone, which is below the typical therapeutic dosage of 4 mg estradiol and at the lower end of the recommended dosage for spironolactone.

46. Ms. Monroe's medical records show that her hormone levels have not been monitored in accordance with the Guidelines since she initiated therapy. In fact, over the course of six years, monitoring of her levels has been rare.

47. I have been provided and reviewed the medical records for Ms. Monroe as I understand they are maintained by IDOC. Based upon that review, I identified a few instances in which Ms. Monroe's bloodwork was checked for hormone levels. The first was done on April 23, 2015—roughly 3 years after she began her hormone regimen. Ms. Monroe's second hormone level test was on June 3, 2016, more than a year after the first test. The June 3, 2016 records indicate an estradiol level of 86.9 pg/ml, below the recommended physiologic range for transgender females of 100-200 pg/ml. Ms. Monroe's next blood test measuring hormone levels was on November 4, 2016. This record indicates an even lower estradiol level of 66.3 pg/ml, well below the recommended range for transgender females. The next hormone level test occurred on April 21, 2017. The relevant records indicate an estradiol level of 95.8 pg/ml, still below the recommended range for transgender females of 100-200 pg/ml. The final record of a blood test that I reviewed measuring Ms. Monroe's hormone levels was from October 20, 2017. This time her estradiol levels were even lower than in April, at 87 pg/ml. Despite consistently low readings,

and continued documented symptoms of gender dysphoria, Ms. Monroe's hormone prescriptions remained unchanged.

48. The amount and frequency of Ms. Monroe's testing falls well outside of recommended and accepted practice, which counsels for laboratory monitoring of hormone levels at least once every 3 months during the first year of treatment, and afterwards at least once or twice yearly. Ms. Monroe received no tests for years after initiating hormone therapy, and went for over a year without being tested after her initial test. The irregular testing of her hormone levels represents a serious departure from the Guidelines and puts Ms. Monroe's physical health at serious risk.

49. Despite estradiol levels consistently measuring below the low end of the recommended physiologic range under Endocrine Society Guidelines, Ms. Monroe's hormone prescriptions were not altered. She continued to receive 3mg/d of estradiol, which is below the recommended therapeutic dose of 4 mg/d. *See* Cross-Sex Hormone Therapy at 2008.

50. Ms. Monroe's labs show a consistent and grossly inadequate estradiol concentration that shows her hormone therapy is failing to adequately treat her gender dysphoria. Ms. Monroe's medical records demonstrate that she has experienced continued depression, anxiety, and increasing potential risks of suicidality that are likely the result of her gender dysphoria, further indicating that her hormone dosage is inadequate to effectively treat her gender dysphoria. The inadequate dosage in the face of persistent gender dysphoria, and IDOC's failure to react by increasing her dose, is another severe departure from the Guidelines and puts Ms. Monroe's physical and mental health at substantial risk. Indeed, Ms. Monroe's symptoms have actually worsened, and according to her medical records she continues to experience suicidal

ideation and self-harm because of her gender dysphoria. Given the fact that she has been on hormone therapy for roughly six years, and especially in light of her persistent acts of self harm, including attempts at auto-castration and suicide, IDOC health care staff should have addressed her low estradiol and irregular testing a long time ago.

51. Not addressing these deficiencies, especially in light of her ongoing gender dysphoria, is so far outside the clinical standards for treatment of this condition that I fear for Ms. Monroe's life. The quality of her care is among the worst cases I have encountered for an individual with gender dysphoria, and shows either a profound lack of knowledge about providing hormone therapy or indifference about treating gender dysphoria.

Marilyn Melendez

52. I have been provided and reviewed the medical records for Ms. Melendez as I understand they are maintained by IDOC. IDOC personnel officially diagnosed Ms. Melendez with gender dysphoria in March of 2015. After a delay of several months, IDOC personnel finally initiated hormone therapy to treat Ms. Melendez's gender dysphoria in August 2015. I have not seen anything in Ms. Melendez's medical records that offers an accepted medical rationale for this months-long delay. The rationale provided by the GID Committee—that Ms. Melendez first needed counseling about living as the opposite gender—is not a medically-accepted reason to deny or delay treatment.

53. IDOC personnel have prescribed Ms. Melendez Menest and Premarin, both conjugated estrogens. Her doses of Menest and Premarin have ranged from 1.25 mg/d to 5.0 mg/d. She also currently also takes spironolactone at 200 mg/d. As noted previously, conjugated

estrogens are not a recommended treatment for any transgender individual, and pose significant risks that estradiol does not.

54. Ms. Melendez's hormone levels have been tested irregularly and not in accordance with the Guidelines. A blood test in April 2017 indicates an estradiol level of 82.9 pg/ml, below the low end of the acceptable therapeutic range. However, because Ms. Melendez is on a conjugated estrogen, it is impossible to know if this result is accurate, meaning her estradiol levels could be even lower than this number or very far above the safe range, including dangerously high. I have seen no subsequent bloodwork done for Ms. Melendez, despite the fact that hormone levels should be monitored once or twice per year. I understand that Ms. Melendez has reported frequent erections in the morning and excessive face and body hair—which suggest that her testosterone is not adequately suppressed and her current dosage is failing to treat her gender dysphoria.

Sora Kuykendall

55. I have been provided and reviewed the medical records for Ms. Kuykendall as I understand they are maintained by IDOC. After an auto-castration attempt, IDOC diagnosed Ms. Kuykendall with gender dysphoria and began hormone therapy around February 2015. Ms. Kuykendall was prescribed Premarin, a conjugated estrogen, at 5 mg/d, and eventually spironolactone at 200 mg/d.

56. Initially, Ms. Kuykendall received no blood testing of her hormone levels. It was not until May 2017 that IDOC appears to have ordered laboratory work for her blood. The tests showed an estradiol level of 112 pg/ml. However, it is impossible to know if the estradiol level of 112 pg/ml is within the acceptable therapeutic range because Ms. Kuykendall is being treated with a conjugated estrogen, a departure from the Guidelines that puts her health and safety at risk.

Sasha Reed

57. I have been provided and reviewed the medical records for Ms. Reed as I understand they are maintained by IDOC. Ms. Reed was diagnosed by IDOC personnel with gender dysphoria in November of 2015. Despite well-documented and persistent gender dysphoria in her records, Ms. Reed was not provided hormone therapy for almost a year and a half until April of 2017. I have not seen anything in Ms. Reed's medical records that provides an accepted medical rationale for this long delay. The Transgender Committee's explanation that doctors first needed to investigate her conceptualization of gender identity is not a medically-recognized reason to deny or delay treatment. This unjustified delay represents an easily preventable failure to initiate much-needed medical treatment for Ms. Reed's recognized and serious medical need.

58. Ms. Reed was prescribed estradiol at 2 mg/d and spironolactone at 200 mg/d. The first records of a blood test are from July of 2017 and show a very low estradiol level at 45 pg/ml that is well below the recommended therapeutic range of 100-200 mg/pl, and her testosterone levels were at 400 ng/ml, well above the recommended therapeutic level of 50 ng/ml for patients with gender dysphoria.

59. In October of 2018—15 months after her initial blood test showed hormone levels far outside the therapeutic range—IDOC finally increased Ms. Reed's prescription to 3 mg/d of estradiol and 300 mg/d of spironolactone. A follow-up blood test a week later showed her estradiol at 281 pg/ml and her testosterone at 234 ng/ml. Thus even after the long delay in titrating her dosages, Ms. Reed's testosterone levels remained far above the 50 ng/ml recommended therapeutic level. The failure to regularly monitor Ms. Reed's bloodwork, and the failure to bring her levels within the therapeutic range, along with the long delay in starting her hormone treatment, amount

to grossly inadequate treatment of her gender dysphoria and needlessly put her health at serious risk.

Lydia Helena Vision

60. I have been provided and reviewed the medical records for Ms. Vision as I understand they are maintained by IDOC. Ms. Vision was diagnosed with gender dysphoria by IDOC in March of 2016. Despite repeated requests for hormone treatment, she was denied it for over two years. I have not seen anything in Ms. Vision's medical records that provides an accepted medical rationale for this long delay. Ms. Vision was denied hormones for numerous reasons that have no medical foundation and are not contraindications to treatment: that her gender dysphoria "may not fully manifest itself in the correctional environment"; that she had "potential for further victimization and isolation as the physical effect of feminizing hormones become apparent"; that she had insufficient support to "undergo the physiologic changes associated with feminizing hormones"; and a suggestion that she experienced post-traumatic stress syndrome as a result of prior sexual abuse. The delay in providing Ms. Vision with hormone therapy is entirely unjustified, and is a remarkable departure from accepted medical practice.

61. In November of 2018, IDOC finally prescribed Ms. Vision hormone therapy. I have not yet seen subsequent records to show whether the regimen prescribed to Ms. Vision places her in an appropriate hormone range to treat her gender dysphoria and avoid risks from hormone imbalances.

Conclusions Regarding Named Plaintiffs

62. None of the named plaintiffs has received even a baseline of medical care adequate to alleviate their gender dysphoria. The care, and specifically the hormone therapy, administered

by IDOC personnel is grossly inadequate in a number of ways and constitutes a severe departure from guidelines widely accepted by medical professionals in the field for treating patients with gender dysphoria. Not only does this poor treatment fail to treat plaintiffs' gender dysphoria, it puts their lives at risk, most notably by increasing their risk for blood clots and cardiac arrhythmia.

63. The named plaintiffs experienced unjustified delays in initiation of hormone therapy. Delays of months, or in some cases over a year, are completely unjustified. Generally, hormone therapy should immediately follow a gender dysphoria diagnosis. The presence of mental health issues typically should not preclude access to hormone therapy for gender dysphoric individuals who otherwise fit the diagnostic criteria for hormone treatment. WPATH Standards at 34. The reasons provided by the Transgender Committee for delaying hormone therapy for the named plaintiffs are not medically-accepted.

64. The plaintiffs' hormone dosages are inadequate and not properly monitored or administered. For example, although research suggests that the most common optimal therapeutic dose of estradiol for treatment of gender dysphoria is 4 mg/d, and that this is a safe dosage under supervision, none of the named plaintiffs received this dosage. *See* Cross-Sex Hormone Therapy at 2008. After plaintiffs' bloodwork revealed levels outside of the therapeutically accepted levels, titrating was not performed. In addition, two named plaintiffs inexplicably were prescribed a conjugated estrogen compound that cannot be measured in bloodwork and thus is not an accepted form of estrogen.

65. Finally, inadequate, sporadic, and ineffective hormone level testing puts plaintiffs' safety at risk. None of the named plaintiffs had bloodwork done with the frequency recommended by the Guidelines. Even when bloodwork was performed, critical tests to ensure the absence of

dangerous side effects, such as testing electrolytes, potassium, creatinine and prolactin, was not done or done irregularly for all plaintiffs. This lack of testing reveals gross inadequacies of the medical care for gender dysphoria.

Conclusions Regarding Putative Class Members

66. My review of the named plaintiffs' files revealed patterns of treatment: that IDOC delayed or denied hormone therapy for reasons that are not recognized by medical professionals; that IDOC failed to monitor hormone levels with anywhere near the regularity that is necessary to ensure that gender dysphoria is treated and that dangerous side effects are avoided; that IDOC failed to titrate plaintiffs' dosages to ensure that they were within therapeutically appropriate and effective ranges; and that IDOC prescribed to at least some patients outdated and unaccepted forms of estrogen.

67. In order to evaluate whether these deficiencies persisted throughout the putative class, I reviewed the relevant medical records produced by IDOC from the putative class members and observed the same deficiencies described above as to the named plaintiffs in this case. My review principally focused on reviewing prescription records and bloodwork testing, which is useful in evaluating whether IDOC has prescribed an effective course of hormone therapy and whether it is testing to ensure proper dosages and to guard against hormone imbalances and side effects that can result therefrom.

68. As with the named class representatives, the records of the putative class members show hormone levels that are insufficient to treat gender dysphoria; the continued use of conjugated estrogens; and irregular and infrequent testing of hormone levels.

69. The significant majority of putative class members who were on hormone therapy ***never once*** had bloodwork testing that demonstrated levels of estrogen and/or testosterone within the therapeutic ranges recommended under the Guidelines. In other words, every time IDOC tested these plaintiffs' hormone levels, they were out of range. This would signal to any knowledgeable medical professional that the dosages required titration and that follow-up testing should be done promptly to bring the levels within effective ranges. However, I rarely observed any such corrective action—and even if adjustments were made to hormone dosages, the patient's hormone levels remained out-of-range in the subsequent test. The fact that the vast majority of gender dysphoric patients' hormone levels consistently fall outside of the therapeutic range demonstrates that IDOC is providing treatment that is not treating their gender dysphoria and would not be expected to treat their gender dysphoria. At least 15 putative class members were receiving dosages of 2mg estradiol or less—which practitioners familiar with gender dysphoria would not expect to be effective and thus would not prescribe.

70. At least eight putative class members, excluding the named plaintiffs, were at some point while under the care of IDOC prescribed a conjugated estrogen, either Menest or Premarin. IDOC continued to prescribe several of those inmates conjugated estrogen as of the date of their most recent medical records, demonstrating that its medical staff continues to prescribe this outdated and unaccepted form of estrogen.

71. The putative class members' records further indicated infrequent testing that did not meet the standards set out in the Guidelines. The Guidelines indicate that testing should be performed every 2-3 months in the first year of hormone or endocrine treatment and then 1-2 times per year thereafter. At least ten putative class members receiving hormones had no record of having ever received any blood test measuring hormone levels—a remarkable departure from the

Guidelines that poses significant risk to these patients. Testing for electrolytes, potassium, creatinine, and prolactin, while performed occasionally, was not performed with regularity. Roughly half of the putative class had no record of ever being tested for these levels. Of those who received testing, some demonstrated unsafe creatinine, potassium, and/or prolactin levels, yet seemingly no responsive action to bring the levels within a safe range. In the vast majority of cases (over 90 percent), testing was not performed with the regularity dictated by the Guidelines.

72. My observations concerning the putative class members are consistent with the severe deficiencies in care that I identified as to the named plaintiffs in this case. As with the named plaintiffs, the grossly inadequate treatment of their gender dysphoria puts their physical and mental health at substantial risk.

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

Dated: 4/26/19

Dr. Vin Tangpricha, M.D.

APPENDIX A

EMORY UNIVERSITY SCHOOL OF MEDICINE
STANDARD CURRICULUM VITAE FORMAT

1. Name: Vin Tangpricha

2. Office Address:
Division of Endocrinology, Metabolism and Lipids
101 Woodruff Circle NE-Woodruff Memorial Research Building 1301
Atlanta, GA 30322

Telephone: 404-727-7254
Fax: 404-727-1300

3. E-mail Address: vin.tangpricha@emory.edu

4. Citizenship: United States of America

5. Current Titles and Affiliations:

a. Academic Appointments:

i. Primary Appointments:

Professor of Medicine, Division of Endocrinology, Metabolism and Lipids, Department of Medicine, Emory University School of Medicine, September 1, 2017-Present

ii. Joint and Secondary Appointments:
Faculty in Nutrition Health Sciences, Laney Graduate School, Emory University, 2005-Present

Adjunct Clinical Associate Professor, Department of Medicine, Morehouse School of Medicine, 2011-Present

b. Clinical Appointments:
i. Associate Director, Osteoporosis Clinic, The Emory Clinic, 2004-Present
ii. Director, Transgender Clinic, The Emory Clinic, 2004-Present
iii. Staff Physician, The Emory Clinic, 2004-Present
iv. Staff Physician, Veterans Administration (VA) Hospital, Atlanta, GA, 2006-Present
v. Director, Adult Endocrinology, Emory Cystic Fibrosis Center, 2007-Present

c. Other Administrative Appointments:
i. Director, Clinical Research Unit, Division of Endocrinology, Diabetes & Lipids, Emory Department of Medicine, 2004-2009
ii. Associate Program Director, Emory Endocrinology Fellowship Program, Division of Endocrinology, Diabetes & Lipids, Emory Department of Medicine,2007-2009
iii. Recruitment Coordinator, Nutrition Health Sciences Program, Graduate Division of Biological & Biomedical Sciences, 2009-2013
iv. Course Director, Translation to Clinical Medicine (EPI 501M), HHMI Med into Grad Program, Laney Graduate School, 2010-Present
v. Program Director, Emory Endocrinology Fellowship, Division of Endocrinology, Diabetes & Lipids, Emory Department of Medicine, 2011-Present
vi. Program Director, ABIM Clinician Scientist Pathway (Research Track), Internal Medicine Residency, Emory Department of Medicine, 2013-Present

6. Previous Academic and Professional Appointments:
   a. Instructor in Medicine, Boston University, 2002-2003
   b. Assistant Professor of Medicine, Division of Endocrinology, Metabolism and Lipids, Emory University, 2004-2009
   c. Associate Professor of Medicine, Division of Endocrinology, Metabolism and Lipids, Department of Medicine, Emory University School of Medicine, 2009-2017

7. Previous Administrative and/or Clinical Appointments:
   a. Staff Physician, Boston Medical Center, 2002-2003

8. Licensures/Boards:
   a. Massachusetts Medical License, 1998
   b. Georgia Medical License, 2003

9. Specialty Boards:
   a. ABIM, Board Certified in Internal Medicine, 1999
   b. ABIM, Board Certified in Endocrinology, Diabetes and Metabolism, 2001, Recertified 2011
   c. Certified Clinical Densitometrist, International Society for Clinical Densitometry, 2003

10. Education:
    1989 - 1992 **B.A.** (Anthropology and Biology, double major)
    Case Western Reserve University, Cleveland, Ohio

    1992 – 1996 **M.D.**
    Tufts University School of Medicine, Boston, Massachusetts

    2000 – 2003 **Ph.D.** (Molecular Medicine, Advisor Michael F. Holick)
    Boston University School of Medicine, Boston, Massachusetts

11. Postgraduate Training:
    1996 – 1999 Intern & Resident, Internal Medicine, Boston University/Boston Medical Center, Boston, MA, (Program Director: David Battinelli, M.D., Chair of Medicine: Joseph Loscalzo, M.D., Ph.D.)

    1999 – 2001 Clinical Fellow, Endocrinology, Diabetes & Nutrition, Boston University School of Medicine, Boston, MD, (Program Director: Alan Malabanan, M.D., Chief of Endo. Lewis E. Braverman, M.D.)

12. Continuing Professional Development Activities:
    Physician Executive Program, Emory University, 2008-2009

13. Committee Memberships:

    a) National and International

    i) Member, Endocrine Society Task Force for Transgender Health Guidelines, 2007-2009
    I served as one of 8 authors on the first hormone guidelines for transgender persons released by a professional society. This task force published guidelines in 2009 for the hormone treatment of transgender persons, which is the current authoritative reference for hormone therapy.

    ii) Member, American Association of Clinical Endocrinologists, Publications Committee, 2008- 2017
    I served on this committee for 9. We reviewed all official position statements and guidelines of the American Association of Clinical Endocrinologists prior to publication.

iii) Member, National Council, American Federation for Medical Research, 2008-2010
I served on the national council for AFMR for 2 years.

iv) Co-chair, Vitamin D Guidelines Committee, Cystic Fibrosis Foundation, 2010-2012
I was the co-chair of the vitamin D guidelines that updated and revised recommendations on the diagnosis and treatment of vitamin D deficiency in children and adults with CF. This resulted in a guidelines publication for the CF Foundation.

v) Member, American Association of Clinical Endocrinologists (AACE), Reproductive Hormone Committee, 2010-2017
I was a member of this committee for 7 years. We provide input on behalf of AACE the on topics related to sex steroid hormones

vi) Member American Association of Clinical Endocrinologists, Nutrition Committee, 2010-2017
I have served on the nutrition committee for AACE for over 7 years. I was the expert on the committee focused on vitamin D and calcium. We provide educational modules for the association by publishing white papers and creating online learning modules on nutrition.

vii) Member, Cystic Fibrosis Therapeutics Development Network (TDN), Publications Committee, 2011-2014
I served a 3 year term on the CF TDN Publications committee. My role was to review manuscripts from clinical trials supported by the CF TDN (a clinical trials network) prior to their publication. We provided our input to these manuscripts to increase their chance for publication at national journals.

viii) Councilor, Association of Program Directors in Endocrinology and Metabolism (APDEM), 2012-2014
I was elected to a 3-year term as a councilor to this group that represents all of the endocrinology program directors in the United States.

ix) Member, Academic Endocrinologists Committee, American Association for Clinical Endocrinologists, 2012-2013, Chair, 2014-2015
I served as a member then chair of this committee that met quarterly for AACE to provide input to the association on topics related to academic endocrinology.

x) Chair, Communication and Technology Committee, World Professional Assoc. for Transgender Health, 2012-2013
I was appointed chair to this committee to help improve communications to the members of WPATH.

xi) Member, Endocrine Society Continuing Medical Education and Maintenance of Certification Committee, 2013-2016
I was appointed to 8 person committee to help with the medical education activities for the members of the Endocrine Society.

xv) Member, Domestic Membership Committee, American Association of Clinical Endocrinologists, 2015-2108
I served as a member of this committee for AACE which meets every 3 months by teleconference to discuss ways to recruit members and enhance benefits for members.

xvi) Member, Revision Committee for Guidelines for Hormone Therapy in Gender Dyphoria and Gender Incongruent Persons, Endocrine Society, 2015-2017
I was reappointed to the guidelines committee to update and revise the hormone therapy guidelines for the Endocrine Society. The new guidelines were published September

2017.

Chair, Education Oversight Committee, American Association for Clinical Endocrinologists, 2017-
I was appointed by the AACE president to serve a 3 year term to oversee all of the educational activities of our society.

b) Regional and State

i) Chairman, Southern Section, American Federation for Medical Research, 2008-2010
I served as the chairman of the Southern Section of the AFMR for 2 years. My role was to help with the membership of AFMR and to coordinate the planning of the Southern Regional Meeting.

ii) Vice-President, 2008-2009 then President, Georgia Chapter, American Association of Clinical Endocrinologists, 2009-2010
I have been active in my local endocrinology community as well as nationally.

iii) Chair, Website Committee, Southern Society for Clinical Investigation, 2015-Present
I was asked by the president of this society to chair the website committee to completely overhaul the society website which was successfully implemented in January 2016.

c) Institutional

i) Member, Emory Atlanta Clinical and Translational Institute Scientific Advisory Committee (ACTSI), 2005-Present
I have served on the SAC (formally GCRC) review committee for over 10 years. We review, discuss and approval protocols that are conducted in the ACTSI.

ii) Member, Endocrinology Fellow Curriculum and Selection Committee, 2005-Present
I have been involved in the endocrinology fellow selection committee for over 10 years. I interview 15-20 fellow candidates each year for our program.

iii) Enrichment Coordinator, Emory Center for Clinical and Molecular Nutrition, 2006-2009
I was the past coordinator for this monthly seminar series

iv) Emory World AIDS Day, Organizing Committee, 2007
I was a member of this committee and hosted former Surgeon General Jocelyn Elders as a guest speaker to speak at the event.

v) Member, Department of Medicine, Medical Student Education Committee, 2007-2010
I served as a member of this committee under Dr. Erica Brownfield. We reviewed and arbitrated academic cases related to students

vi) Member, Faculty Development Committee, Department of Medicine, 2008-2010
I served as a member of this committee under Dr. Kathy Griendling

vii) Chair, Awards Sub-Committee, Department of Medicine 2008-2010
I was the chair of the committee to recognize faculty in the DOM

viii) Member, Executive Committee, Emory Nutrition and Health Sciences Program, 2009-2013, I served for 4 years on the Executive committee for NHS

ix) Member, Rheumatology and Immunology Division Director Search Committee, 2010-

2011
I served on the DOM committee that led to the hiring of Dr. Sanz

x) Chair, Clinical Interactions Network (CIN), Scientific Review Panel, Emory ACTSI, 2010-Present
I am currently 1 or 3 co-chairs that review, triage and approve research protocols for the ACTSI.

xi) Member, Medical Student Research Committee, 2010-2015, I reviewed Discovery project proposals and final papers for 5 years

xii)Emory Physician Scientist Training Program (M.D./Ph.D.) Admissions Committee, 2015-Present
I am currently serving on the physician-scientist (M.D./Ph.D.) admissions committee.

xiii) Emory Department of Medicine, Promotions and Tenure Committee. 2018- present, We review all promotions packets for the DOM.

14. Peer Review Activities:

a. Grants:

i. National and International:

a) Ad Hoc Reviewer, NIH Special Emphasis Section, Chemo-Dietary Prevention (CDP), 2006
b) Ad Hoc Reviewer, Thrasher Foundation, 2009
c) Ad Hoc Reviewer, Diabetes UK, 2009
d) Ad Hoc Reviewer, UAB Diabetes Research Training Center, Pilot Grant Program, 2010
e) Ad Hoc Reviewer, Arthritis Research UK, 2010
f) Ad Hoc Reviewer, NIH Special Emphasis Section, Ancillary Studies in Clinical Trials, 2010-2011
g) Ad Hoc Reviewer, American Association for the Advancement of Science's Research Competitiveness Program, 2011
h) Regular reviewer, Clinical Research Awards, Cystic Fibrosis Foundation, 2011-Present, I have been a regular reviewer for the CF Foundation for their clinical research awards. We review letters of intent twice a year and then meet in person at the national CF Foundation headquarters to discuss grants in person.
i) Ad Hoc Reviewer, NIH/NHLBI SEP, Low Cost Pragmatic Clinical Trials, 2014
j) Ad hoc reviewer, NIH/SEP, Neurological, Aging and Musculoskeletal Epidemiology, 2014

ii. Institutional:
a) Reviewer, Emory University KL2 Grant Review Committee, 2008-2009
b) Reviewer, University Research Committee (URC), 2009 – 2010
c) Reviewer, Emory Egleston Children's Research Center, 2011

b. Manuscripts reviewer:

Endocrine Practice, 2004-present
American Journal of the Medical Sciences, 2008-present
European Journal of Clinical Nutrition, 2008-present
Journal of Nutrition, 2008-2013
Chest, 2008-2014
American Journal of Clinical Nutrition, 2008 - present

Journal of Sexual Medicine, 2009- present
Clinical Endocrinology, 2009-2011
Journal of Clinical Endocrinology and Metabolism 2011-present
Journal of Cystic Fibrosis, 2014-present

c. Conference Abstracts:
   i. National and International:
   1. Abstract reviewer, North American Cystic Fibrosis Conference Annual meeting, 2009-Present
   I have been a regular reviewer of the endocrine and/or diabetes abstracts submitted to the North American CF Conference for many years.

   2. Abstract reviewer, American Society of Nutrition, Experimental Biology Annual meeting, 2009-2011
   I reviewed abstracts for the American Society of Nutrition for 3 years for presentation at the Experimental Biology Meeting.

   3. Abstract reviewer, American Association for Clinical Endocrinologists (AACE) Annual Meeting, 2013-Present
   I review abstracts annually for the AACE annual meeting

   3. Abstract reviewer, National Transgender Health Summit, Oakland, CA, 2013, I served as an abstract reviewer for this transgender meeting

   4. Abstract reviewer, World Professional Association for Transgender Health (WPATH), Biennial Meetings, 2011, 2014, 2016. I have been a regular abstract reviewer for the Biennial Meeting for WPATH.

   ii. Regional:
   1. Abstract reviewer, Southern Society for Clinical Investigation, Annual Meeting, 2008-Present
   I have reviewed abstracts in endocrinology and nutrition topics for the SSCI/Southern Regional Meeting.

15. Consultantships:

   1. Member, AquADEK advisory Committee, Cystic Fibrosis Foundation, 2012-2014
   I was asked by the CF Foundation to become a member of a committee to advise the foundation on what vitamins should be included in their multivitamin preparations. We met at the foundation for the kick off meeting and regularly by telephone and email.

   2. World Anti-Doping Agency (WADA) Therapeutic Use Exemptions Expert Group, Testosterone use in transgender athletes, 2012
   I was asked by WADA to provide input regarding hormone use in transgender athletes and edit their policy manual.

16. Editorships and Editorial Boards:

   a. Editorships

   1. Guest Editor, Special Issue on “Vitamin D”, International Journal of Endocrinology, 2008
   I was invited to coordinate a special issue on vitamin D. This was the first special issue for this journal. I oversaw the review of 15 manuscripts that were eventually published. Our rejection rate was approximately 50%.

   2. Associate Editor, Journal of Sexual Medicine, 2008-2014

I was appointed by Editor in Chief, Irwin Goldstein, to be the Associate Editor to oversee the review of all manuscripts submitted on the topic of transgender or differences of sexual development (formally known as disorders of sexual development or DSD). During my term, I oversaw the review of over 100 manuscripts submitted to the journal.

3. Section Editor, Annual December issue on Disorders of Calcium and Bone, Current Opinion in Endocrinology, Diabetes, and Obesity, 2009-Present
I was appointed by Dr. Lewis Braverman, Editor in Chief, to oversee the December issue of Current Opinion in Endocrinology, Diabetes and Obesity. My role is to organize and invite authors to write reviews for this yearly issue focused on disorders of calcium, vitamin D and bone.

4. Guest Editor, Special Issue on "Vitamin D", Dermato-endocrinology, 2012
I was a special guest editor for this issue on vitamin D.

5. Editor in Chief, Journal of Clinical and Translational Endocrinology, 2013-Present
I was appointed by Elsevier to be the Editor in Chief of this new open access journal in endocrinology. This was one of the publisher's first open access endocrinology journals. We have published over 100 original research and review manuscripts over the past 3 years. We expect to have an ISI Impact Factor in the next 1-2 years.

6. Associate Editor, Sexual Medicine Reviews, 2015-Present
I am currently an associate editor for Sexual Medicine Reviews and oversee manuscripts dealing with transgender, hormone therapy or DSD.

7. Guest Editor, Reviews in Endocrine & Metabolic Disorders, 2018-
I am an invited guest editor for a special issue on transgender medicine.

8. Guest Editor, Endocrinology & Metabolism Clinics, 2018-
I am an invited guest editor for a special issue on transgender medicine.

b. Editorial Boards

1. Endocrine Practice, The Official Journal of the American Association for Clinical Endocrinologists, 2007-Present

2. International Journal of Endocrinology, 2009-2013

3. Nutrition and Food Science, 2015-Present

4. Transgender Health, 2017- Present

17. Honors and Awards:

2004	Fellow of the American Association of Clinical Endocrinologists (FACE)
2006	New Investigator Award, Emory Center for Clinical and Molecular Nutrition
2007	NIH K23 Mentored Physician-Scientist Award
2009	Gender Identity Research and Education Society, Scientific Citation Award
2011	Transgender Advocate Award, Emory University
2011	"We are Emory", 100 community builders at Emory University (only DOM awardee)
2011	U.S. News and World Report, Top Endocrinologist (top 10% of endocrinologists voted by peers)
2011	Gender Identity Research and Education Society, Scientific Citation Award
2012	Best Mentor Award, Thai-American Physicians Foundation
2013	One in 100, Outstanding Post-Doctoral Fellow Mentor, Emory University
2013	Academy of Medical Educators, Emory University Department of Medicine
2016	Outstanding Service Award for the Promotion of Endocrine Health of an Underserved

	Population (Transgender), American Association for Clinical Endocrinologists
2016	Top 90th percentile, Patient Satisfaction, Press Ganey, Atlanta VA Medical Center
2016-2018	"Top Doctors in Atlanta", Castle Connolly, Atlanta Magazine
2017	Distinguished Emory Physician
2017	Top 90th percentile, Patient Satisfaction, Press Ganey, Atlanta VA Medical Center
2018	Best Endocrinology Fellowship Mentor
2018	Top 99th percentile, Patient Satisfaction, Press Ganey, Emory Healthcare

18. Society Memberships:

1. Massachusetts Medical Society, 1996 – 2007

2. Endocrine Society, 2000-Present

3. American Association of Clinical Endocrinologists, 2000-Present

Advisory Member, Board of Directors, American Association for Clinical Endocrinologists, 2013. I served a 1 year term as an advisory member to AACE prior to my election to a full board member

Member, Board of Directors, American Association for Clinical Endocrinologists, 2014-present
I am currently serving a 3 year term as a member of the Board of Directors for AACE, an association that represents over 7,000 clinical endocrinologists in the U.S. and internationally (aace.com). We have in person meetings every 3 months across the United States to discuss important topics related to clinical endocrinology. I was re-elected for a second 3-year term in 2017 and will complete my term on the board in 2020.

4. World Professional Association for Transgender Health, 2000-Present

Secretary/Treasurer, World Professional Association for Transgender Health, 2014-2016
I was elected as an officer for WPATH as Secretary/Treasurer. In my position, I also served on the Executive Committee for WPATH

President Elect then President, World Professional Association for Transgender Health, 2016-Present
I was elected to become president of WPATH. My presidency term started in November 2018.

5. International Society for Clinical Densitometry, 2003-2006

6. American Society for Bone and Mineral Research, 2004-2016

7. American Society for Nutrition, 2007-2017

8. Southern Society of Clinical Investigation, 2008-Present

Councilor, Southern Society of Clinical Investigation, 2013-Present
I have served as a councilor for SSCI for the past 4 years

19. Organization of Conferences:

a. National and International:

Administrative positions:

2007 Member, Local Organizing Committee, 20th Biennial Symposium, World Professional Association for Transgender Health, **Chicago, IL**, September 5-10, 2007
Course Director, Contemporary Management of Transgender Patients, Emory CME,

Chicago, IL, September 5, 2007, As member of the local organizing committee of this international conference, I oversaw the CME program and the planning of the conference of this meeting. This conference was attended by over 600 people from around the world.

2008 Co-Program Chair, Annual Meeting, Georgia Chapter, American Association of Clinical Endocrinologists, February 1-3, 2008, **Atlanta, GA**

2009 Program Chair, Annual Meeting, Georgia Chapter, American Association of Clinical Endocrinologists, **Atlanta, GA**, Feb 14-15, 2009

2011 Chair, Local Organizing Committee, 22nd Biennial Symposium, World Professional Association for Transgender Health, **Atlanta, GA**, September 24 – 28, 2011
I received the winning bid to host the Biennial WPATH symposium at Emory. This was attended by over 1000 professionals from all over the world. President Wagner was the keynote speaker at this conference.

2012 Course Faculty and Judge, SSCI Osteoporosis & Bone Health Young Investigators' Forum, **New Orleans, LA,** February 8, 2012

2014 Scientific Co-Chair, World Professional Association for Transgender Health, **Bangkok, Thailand**, February 14-18, 2014
I was honored to be appointed as the scientific co-chair for this international meeting. My role was to organize the scientific programming for this meeting.

2015-present Member, Annual Program Committee, American Association of Clinical Endocrinologists
I was invited to be a member of the annual program committee in 2015 and 2016. The role of the committee members is to plan and organize the AACE annual meeting held in **Nashville and Orlando**, respectively.

2017 Annual Meeting Program, 2016-Present, Vice-Chair, American Association of Clinical Endocrinologists, **Austin, TX**.
I was invited to serve as 1 of 3 vice-chairs for the AACE annual meeting. The job of the vice-chairs is to oversee programming for the 2017 annual meeting. My specific task for this year has been to oversee the plenary talks at the annual meeting.

2017 U.S. Professional Association of Transgender Health (USPATH), annual program committee.
I served on the inaugural annual program committee for the USPATH annual meeting held in **Los Angeles, CA**. This was attended by over 600 professionals from all over the U.S.

2018 Annual Meeting Program, 2017-2018, Chair, American Association of Clinical Endocrinologists.
I was appointed by the president of the organization to serve as the annual program meeting chair for my clinical endocrinology association for the meeting in **Boston, MA** in May 2018.

Sessions as Chair

2007 and 2009 Course Director, Advances in Endocrinology for the Practicing Physician, Emory CME, **Atlanta, GA**
I raised funds and organized a CME program for practicing physicians in the Southeast United States. This was a full day program comprised of lectures from Emory Faculty in the endocrine division.

2008 Course Director, Comprehensive Review of Vitamin D for Optimal Health, Emory CME, **Atlanta, GA**

I raised funded and organized a special full day CME meeting on vitamin D attended by over 100 participants from all over the Southeast.

2009 Chair, World Professional Association for Transgender Health, Bi-ennial meeting, Endocrinology, Gynecology and Urology Session, June 17-20, 2009, **Olso, Norway**

2009 Co-Chair, North American Cystic Fibrosis Conference, Endocrinology and Bone Session, **Minneapolis, Minnesota**, October 21-23, 2009

2010 Co-Chair, Vitamin D Symposium, Experimental Biology Meeting, April 28, 2010, **Anaheim, CA**

2010 Course Director, Physician Career Development Conference, Emory CME**, Stone Mountain, GA**
This was a very special Emory CME career development program that I organized and raised funds that focused on early career physicians.

2011 Course Director, Advances in Pediatrics and Medicine (CME), Emory CME, **San Diego, CA**

2012 Course Director, Update in Medicine and Pediatrics (CME), Emory CME**, Las Vegas, NV**

2012 Co-chair, Adult Bone and Mineral Working Group, American Society for Bone and Mineral Research Annual Meeting, October 12, 2012, **Minneapolis, MN**

2013 Co-Chair, Transgender Medicine, 2013 Endocrine Society Annual Meeting, June 15 – 18, 2013, **San Francisco, CA**

2013 Co-chair, Adult Bone and Mineral Working Group, American Society for Bone and Mineral Research Annual Meeting, October 6, 2013, **Baltimore, MD**

2013 Co-Chair, North American Cystic Fibrosis Conference, Sex Steroids in Cystic Fibrosis, October 16 – 19, 2013, **Salt Lake City, UT**

2013 Course Director, Update in Medicine and Global Health (CME), Emory CME, **St. Louis, MO**

2014 Course Director, Advances in Medicine and Pediatrics (CME), Emory CME, **Anaheim, CA,**

2014 Co-Chair, Transgender Medicine, 2014 Endocrine Society Annual Meeting, June 20 – 24, 2014, **Chicago, IL**.

2014 Co-chair, Adult Bone and Mineral Working Group, American Society for Bone and Mineral Research Annual Meeting, September 14, 2014, **Houston, TX**

2014 Co-Chair, North American Cystic Fibrosis Conference, Endocrine and Diabetes Workshop, October 9-11, 2014, **Atlanta, GA**

2015 Course Director, Advances and Research in Medicine & Pediatrics, **Atlantic City, NJ**
I have organized an annual meeting focused on general topics in medicine and pediatrics for Emory CME for several years.

2015 Co-Chair, North American Cystic Fibrosis Conference, Endocrine and Bone Workshop, October 8-10, 2015, **Phoenix, AZ**

2016 Chair, Transgender Symposium: What an Endocrinologist Should Know, Annual Meeting for the American Association of Clinical Endocrinologists, May 27, 2016, **Orlando, FL**.

2016 Co-Chair, North American Cystic Fibrosis Conference, Endocrine Workshop, October 27-29, 2016, **Orlando, FL**

2017 Chair, Community Based Care Workshop, U.S. Professional Association of Transgender Health, February 2-5, 2017, **Los Angeles, CA.**

2018 Co-Chair, Endocrine Society, Adult Transgender, Sex Determination, and Reproductive Axis Development, March 19, 2018**, Chicago, IL.**

b. Regional
Administrative position:

2009 – 2016 Moderator, Endocrine Club, Annual Southern Regional Meeting
I was responsible for the Endocrine Club for several years. I organize the endocrine meeting with speaker as part of the SSCI/Southern Regional meeting.

Sessions as Chair

2009 Co-Chair, Endocrinology Session, Southern Regional Meeting, Southern Society for Clinical Investigation Annual Meeting, February 14, 2009. **New Orleans, LA**

2010 Co-Chair, Endocrinology Session, Southern Regional Meeting, Southern Society for Clinical Investigation Annual Meeting, February 26, 2010, **New Orleans, LA**

2012 Judge, Osteoporosis Young Investigators Forum, Southern Society for Clinical Investigation Annual Meeting, February 8, 2012, **New Orleans, LA**

c. Institutional
2008 - present Division of Endocrinology, Weekly Grand Rounds Conference
I have been the coordinator for our division's grand rounds since 2008. I am responsible for the schedule, obtaining CME credits for the course and evaluations.

2008 - 2009 Faculty Development, Monthly Seminar Series
As part of the DOM faculty development committee, I was a coordinator of a monthly seminar series focused on faculty development of junior faculty

2009 - 2013 Monthly Atlanta Vitamin D Research Group Seminars
I organized a monthly seminar on various topics on vitamin D for 4 years.

2009 – 2013 Coordinator, Department of Medicine Faculty Research Day, 2009-2013, I served 4 years as the DOM coordinator for research day

20. Clinical Service Contributions:

1. Transgender Medicine Clinic: I started the first transgender medicine clinic at Emory in 2004. We now service over 200 patients who are seeking gender reaffirming therapies. I have assisted the Grady Memorial Hospital in starting their own dedicated multi-specialty transgender clinic which will open in 2017. I have also started a smaller clinic at the Atlanta VA Medical Center in 2006 and at Emory Midtown in 2017.

2. Endocrinology Clinic in the Emory Cystic Fibrosis Clinic: I am one of the only adult trained endocrinologists in the United States who focuses on the care of endocrine issues in cystic fibrosis. I was recently awarded a grant from the CF Foundation to train other adult endocrinologists around the country.

21. Community Outreach:

1. Little League Baseball Head Coach, Druid Hills Youth Sports (Spring and Fall seasons), 2012-current, I have coached over 12 seasons of baseball and over 100 boys and girls

2. Basketball Coach, Glenn Memorial and Clairmont Presbyterian Church Leagues, 2012- 2017, I have coached over 4 seasons of baseball and over 40 boys and girls

3. Baseball League Director, Druid Hills Youth Sports, 2013-2014, I was responsible for organizing 3 seasons of baseball for children aged 7 years old

4. Registrar, Druid Hills Youth Sports, 2013-2015, I served as the registrar for the baseball program and oversaw registration of over 1000 children

5. Board of Directors, Druid Hills Youth Sports, 2013- 2017, I am a very active member of this local board of directors who organize youth baseball for children in Dekalb county

6. Chair, External Boosters, Druid Hills Youth Sports, 2015-2017, I have raised over $50,000 in sponsorships to help support youth baseball in Dekalb county

7. Atlanta Braves Fan Council (Appointed position by the Atlanta Braves), 2014-2017. I have been a critical member of this committee who provides input to the Atlanta Braves front office in terms of the move from Turner Field to Suntrust Park. I completed my term on opening day 2017 for the Braves.

8. Atlanta Hawks Diversity Committee (Appointed position by the Atlanta Hawks), 2015-Present, I was appointed by Atlanta Hawks CEO Steve Koonin to serve on this committee to help provide input to the team regarding issues surrounding diversity. We meet monthly on conference calls and quarterly in person and participate in community events. I was reappointed again in 2017.

22. Formal Teaching:

a. Undergraduate

1. Problem Based Learning (MEDI 556), small group leader, Emory M2 medical students, 3 hours of small group instruction monthly, 2005-2007
2. Endocrine section, Clinical Pharmacology (MED 640), small group leader, Emory M2 medical students, annually, 2 hours of small group instruction, 2005-2006
3. "Vitamin D", Course: Introduction to Predictive Health (Course Director: Dr. Michelle Lambl), upper class Emory undergraduate students, annually, 2 hour lecture, 2009-Present
4. Evidence Based Medicine, Emory 2nd year medical students, 2 hour group session, annually, 2016-Present

b. Graduate Program

1. "Vitamin D and Calcium", Course: Clinical Nutrition II, (Core course for Emory Ph.D. students in nutrition), annually, 2 hour lecture, 2006-Present

c. Medical Student Teaching

1. "Vitamin D", Course: Medical Nutrition (MEDI 651), required course for Emory M2 medical students, annually, 1 hour lecture, 2005-2008
2. "Disorders of Calcium/Parathyroid", Course: Medical Pathophysiology (MEDI 650), required course for Emory M2 medical students, annually, 1 hour lecture, 2005-2008
3. "Disorders of Endocrinology", Course: Introduction to Emory Third Year Clerkships (Course Director: Ercia Brownfield, MD), annually, 1 hour lecture, 4 times a year, 2006-2007.
4. "Disorders of Calcium", Course: Foundations Abnormal (MEDI111), Emory M2 medical students, annually, 2 hour lecture, 2008-2011

d. Residency Program
1. "Disorders of Vitamin D and Calcium", Emory Residency Noon conference, 1 hour lecture, annually, 2006-2010

e. Endocrinology Fellowship Program
1. Rotating topics on Vitamin D, Calcium, Transgender, Emory Endocrinology Fellowship Core Curriculum Lectures, 1 hour lecture annually, 2004-Present

f. Other: Examination Preparation and Grading
1) Emory Nutrition Health Sciences Program, Ph.D. Program, Qualifying examination, 2005-Present
2) Prepared, administered, and graded the Observed Structured Clinical Examinations for all Emory endocrinology fellows on an annual basis, 2011-Present

23. Supervisory Teaching:

Advisee	*Degree earned*	*Current Position*	*Years Mentored*
Ph.D. Thesis Mentor			
1. Suzanne E. Judd	Ph.D.	Associate Professor, and Assistant Dean of Undergraduate Education at UAB, 2006-2008	
2. Ruth E. Grossmann	Ph.D.	Assistant Professor, College of Nursing, University of Iowa, 2009-2012	
3. Ellen M. Smith	Ph.D.	Completed Ph.D., Defended Ph.D. 10/12, 2016; now working as a nutrition scientist at Kellogg	
Ph.D. Committee Member			
1. Veronika Fedirko	Ph.D.	Assistant Professor, Emory, 2008-2009	
2. Juna Konomi	Ph.D.	Post-Doc, Emory, 2012-2014	
3. Jennifer Frediani	Ph.D.	Post-Doc, Emory, 2012-present.	
4. Kathryn Coakley	Ph.D.	Assistant Professor, Univ of NM, 2013-2015	
Master's Students			
1. Prakash Chandra	M.S.	Private Practice, Canada	2005-2007
2. Wendy Hermes	M.S.	Registered Dietician, CA	2012-2015

Undergraduate, medical students, post-doctoral fellows, medical residents and fellows directly mentored. Number of publications in brackets.

Undergraduate Students:

Dates	*Trainee*	*Program*	*Current Position*
2006	Tia Renee Sides	SURE program	Technician, U of Maryland
2008 - 2009	Sara Raiser (1)	SURE program	Resident, University of Virginia
2008 - 2009	Cynthia Michael	Research Elective	Dentist
2009	Jim Lu	Research Elective	Dentist
2009 - 2010	Lindsey Colman	SURE program	Research Coordinator
2009 - 2010	Eric Gottlieb (2)	Research elective	Internist, Providence, RI
2010 - 2013	Aneesha Thobani (1)	SIRE program	Intern, Emory DOM
2011	Breanne Wright	SURE program	Ph.D. Graduate Student, Purdue
2012 - 2015	Moon Lee (4)	Student research	Medical Student, Hopkins
2013	Ivana Stojkic	Summer research	Senior, Emory University
2014 - 2015	Emily Galdun	Research elective	Medical Student, UT, Memphis
2015 - 2018	Shiven Patel	Research elective	Recent Emory Graduate

2016 –	Nick Lee	Research elective	Emory Undergrad

Medical Students:

2004 - 2007	Arun Krishnamoorthy, M.D.	Medical student	Cardiologist, Piedmont
2005 - 2013	Ken Sutha, M.D., Ph.D.	Medical student	Pediatric fellow, Univ of Wash
2012 - 2015	Malcolm Kearns, M.D. (5)	Medical student	Medicine resident, UPenn
2012 - 2015	Jennifer Whitehead, M.D.	Medical student	Medicine resident Northwestern
2014 - 2015	Supavit Chesdachai, M.D (4).	Medical student	Intern, University of MN
2017 -	Marta Bean M'2019	Medical student	

School of Public Health:

2013 - 2014	Daud Lodin (2)	M.P.H. Candidate	Medical student
2015 - 2017	Jiabei He	M.P.H. Candidate	Graduate student

Post-doctoral fellows directly supervised:

2006 - 2007	Era Shah, M.D. (1)	Fellow (NRSA)	Private Practice, Endocrinology
2006 - 2008	Natasha Khazai, M.D.(4)	Endocrine fellow	Instructor, Harvard, Joslin Clinic
2007 - 2009	Sasha Yamshchikov, M.D.(4)	ID fellow (NRSA)	Assistant Professor, Rochester
2007 - 2010	Meena Kumari, M.D. (10)	Fellow (NRSA)	Faculty, Morehouse Sch of Med
2008 - 2009	Yevgeniy Kantor, M.D.	Endocrine fellow	Private Practice, Endocrinology
2009 - 2011	Shabnam Seydafkan M.D.(6)	Research fellow	Post-Doctoral Fellow, Cardiology
2009 - 2012	Russell Kempker, M.D. (7)	ID fellow	Assistant Professor, Emory SOM
2009 - 2012	John Payne, M.D. (2)	Opthalmol. Fellow	Private Practice
2009 - 2012	Michael Witkamp, M.D. (1)	Peds Pulm Fellow	Instructor, University of Kentucky
2010 - 2012	James D. Finklea, M.D. (1)	Pulmonary fellow	Assistant Professor, UTSW
2011 - 2014	Saira Adeel, M.D. (2)	Endocrine fellow	Private Practice, Atlanta
2011 - 2014	Jessica Alvarez, Ph.D. (24)	Fellow (NRSA)	Assistant. Prof. Emory SOM
2011 - 2013	Jordan Kempker, M.D. (3)	Pulmonary fellow	Assist Professor, Emory SOM
2011 - 2014	Julia Rosebush, M.D. (1)	Peds ID fellow	Assist. Prof., Univ of Chicago
2012 - 2014	Shahid Nadeem, M.D.	Peds renal fellow	Assist. Prof., LSU Shreveport
2012 - 2014	Robert Simek, M.D. (1)	Peds GI fellow	Private Practice, Lubbock
2014 - 2016	Kelly Stephens, M.D. (1)	Endocrine fellow	Instr Harvard Brigham&Womans
2015 – 2017	Mansi Kanhere, M.D.	Peds Endo fellow	Assist. Prof. Virginia Comm. Univ
2017 -	Mary Stevenson	Endocrine fellow	Endocrine fellow
2017 -	Malinda Wu	Peds Endo fellow	Pediatric endocrine fellow

Internal Medicine Residency Program:

2006 - 2008	Kara Pepper, M.D. (2)	Research elective	Private Practice, Atlanta
2007 - 2008	Reshma Shah, M.D. (2)	Research elective	Private Practice, Atlanta
2007 - 2009	Aliya Heliyer, M.D. (1)	Research elective	Private Practice, Annapolis
2007 - 2009	Leo Jeng, M.D. (2)	Research elective	Private Practice, Dallas
2008 - 2010	Jennie Law, M.D. (1)	Research elective	Faculty, Emory St. Josephs
2008 - 2010	Nirali Desai, M.D.(2)	Research elective	Medicine Faculty, UPenn

Mentoring of Faculty:

2008 - 2013	Marian Evatt, M.D., M.S., Assistant Professor of Neurology
2008 - 2013	Ify Osunkwo, M.P.H., M.D., Assistant Professor of Pediatrics
2007 - 2010	Lindy Wolfenden, M.D., Assistant Professor of Medicine
2009 - 2014	Allison Ross, M.D., Assistant Professor of Pediatrics, NIH K grant award, co-sponsor
2010 - 2013	Susu Zughaier, Ph.D., Instructor of Pediatrics
2011 - 2013	Laura Delong, M.D., Assistant Professor of Dermatology
2011 - 2013	Oranan Siwamogsatham, M.D., Faculty on Sabbatical from Thailand
2013 – 2018	Corrilynn Hileman, M.D., Assistant Professor of Medicine, Case Western, NIH K-award, co-sponsor
2017 -	Jessica Abramowitz, M.D., Assistant Professor of Medicine, UTSW

Bedside Teaching
Endocrinology consult attending at Emory University Hospital and the Atlanta VA Medical Center, 8-12 weeks/year, student, residents and fellows, 2004-present

24. Lectureships, Seminar Invitations, and Visiting Professorships:

a. National and International:

1. Thammasat University, Visiting Professor, "Osteoporosis and Vitamin D", January 17-20, 2006, **Bangkok, Thailand.**

2. Mahidol University, Ramathibodi Hospital, Visiting Professor, "Vitamin D and Colon Cancer Prevention", January 21, 2006, **Bangkok, Thailand**.

3. Mahidol University, Siriraj Hospital, Visiting Professor, "Osteoporosis Update: 2006", January 23, 2006, **Bangkok, Thailand.**

4. Mahidol University, Siriraj Hospital, Visiting Professor, "T-cells and the RANKL Signaling System in Osteoporosis", July 2, 2007, **Bangkok, Thailand.**

5. Thammasat University, Visiting Professor, "Update in Vitamin D", July 4, 2007, **Bangkok, Thailand.**

6. Theptarin Hospital, Guest speaker, "Current Opinion in Osteoporosis", July 5, 2007, **Bangkok, Thailand.**

7. Mahidol University, Ramathibodi Hospital, Visiting Professor, "Role for T-cells and RANKL in Osteoporosis", July 6, 2007 **Bangkok. Thailand.**

8. Beth Israel Deaconess Medical Center, Harvard University, Visiting Professor, Endocrinology Grand Rounds, "Vitamin D and Cardiovascular Disease", September 19, 2008, **Boston, MA.**

9. Brown University, Visiting Professor, Endocrinology Grand Rounds, "Vitamin D Insufficiency: Importance to Cystic Fibrosis", October 15, 2008, **Providence, RI.**

10. Boston University, Visiting Professor, Endocrinology Grand Rounds, "Vitamin D Insufficiency: Importance to Cystic Fibrosis", October 20, 2008, **Boston, MA.**

11. Tufts University School of Medicine, Endocrinology Grand Rounds, "Vitamin D Deficiency and Risk for Cardiovascular Disease", March 23, 2009, **Boston, MA.**

12. Massachusetts Institute of Technology, Knight Science Journalism Program, Medical Evidence Boot Camp, Guest Speaker, "Advances in the Field of Vitamin D", March 24, 2009, **Cambridge, MA.**

13. Vitamin D Deficiency and Risk of TB, US-Georgia Workshop: Infectious Disease Research Conference, "Implementation Science and Strengthening In-Country Partnerships", May 27-28, 2009. **Tbilisi, Republic of Georgia.**

14. Endocrinology Grand Rounds, Case Western Reserve University, Guest Speaker, "Vitamin D: An update in the guidelines and importance for cystic fibrosis", October 12, 2011, **Cleveland, OH.**

15. Weekly Cystic Fibrosis Conference, Case Western Reserve University, Guest Speaker, "An Overview of Vitamin D Metabolism in Cystic Fibrosis", October 14, 2011, **Cleveland, OH.**

16. Monthly HIV/AIDS Conference, Dartmouth Medical School, Guest Speaker, "Vitamin D in HIV Infection", May 14, 2012, **Lebanon, NH.**

17. Endocrinology Grand Rounds, Guest Speaker, Henry Ford Hospital, "Transgender Medicine", January 9, 2015, **Detroit, MI.**

18. Endocrinology Grand Rounds, Guest Speaker, Boston University School of Medicine, "Update on Vitamin D Clinical Trials", April 13, 2015, **Boston, MA**.

19. Endocrinology Conference, Guest Speaker, Mahidol University, Division of Endocrinology, Ramathibodi Hospital, "Update on Transgender: 2016", January 26, 2016, **Bangkok, Thailand**.

20. Prince Mahidol Scholars Award Program, "Vitamin D in Infections", January 27, 2016, **Bangkok, Thailand**
I was honored to be invited to provide seminars in a conference in the name of the grandfather of the King of Thailand and was hosted at the Grand Palace by the Thai Royal family

22. University of Texas, Southwestern, Endocrinology Grand Rounds, "Transgender Medicine: What An Endocrinologist Needs to Know", March 10, 2017, **Dallas, TX**.

23. Brown University, Endocrinology Grand Rounds, "Transgender Medicine 2018", March 19, 2018, **Providence, RI.**

23. Robert M. Levin Memorial Lecture, Boston University Medical Grand Rounds, "Vitamin D: A Bright Future For Cystic Fibrosis?", September 15, 2017, **Boston, MA.**

b. Regional:

1. The Medical Center, Visiting Professor, Medical Grand Rounds, "Vitamin D: An Update". August 17, 2004. ***Columbus, GA.***

2. Atlanta Bone Club, Guest Speaker (CME). "Clinical Uses of BMD 2005", July 22, 2005, ***Atlanta, GA.***

3. The University of Tennessee, Visiting Professor, Metabolic Bone Conference, "Vitamin D and Skeletal Health", July 13, 2005, ***Memphis, TN.***

4. Atlanta Medical Center, Visiting Professor, Internal Medicine Residency, "Osteoporosis: Diagnosis, Treatment and Therapy". August 2, 2005, ***Atlanta, GA.***

5. Southern Comfort Conference Guest speaker, "Osteoporosis Prevention and Treatment in the Transgendered Community", September 22, 2005, **Atlanta, GA.**

6. Medical University of South Carolina, Visiting Professor, Endocrine Grand Rounds, "Vitamin D: Skeletal and Non-Skeletal Health", May 18, 2006, ***Charleston, SC.***

7. Ochsner Clinic, Visiting Professor, Weekly Endocrinology Conference, "Vitamin D: Skeletal and Non-Skeletal Health", November 29, 2006, ***New Orleans, LA.*** .

8. Ochsner Clinic, Visiting Professor, Rheumatology Grand Rounds, Vitamin D: Skeletal and Non-Skeletal Health", November 29, 2006, ***New Orleans, LA.***

9. Wake Forest University, Symposium on Vitamin D: Classical and Emerging Roles in Health, May 18, 2007, **Asheville, NC.**

10. Solvay Pharmaceucticals, Guest Speaker, Annual Meeting, "Endocrine and Exocrine Dysfunction in

Cystic Fibrosis", June 29, 2007, **Stone Mountain, GA**.

11. Mercer University School of Medicine, Obstetrics and Gynecology Grand Rounds, Guest Speaker, "Osteoporosis Update 2008", September 19, 2008. **Macon, GA**.

12. Georgia State Nutrient Fortification Group, "Challenges in Improving Vitamin D Status by Fortification and Supplementation", April 22, 2011, **Atlanta, GA.**

c. Institutional:

1. Wesley Woods Hospital, weekly conference, Guest speaker, "Vitamin D Deficiency: A Silent Epidemic in the Elderly", February 8, 2006, **Atlanta, GA**.

2. Emory University School of Medicine. Annual Internal Medicine Board Review (CME) Course, Disorders of Calcium, August 2, 2006, **Atlanta, GA.**

3. Understanding Bone Imaging and Bone Strength, Atlanta Bone Club Symposium moderator, November 16, 2006, **Atlanta, GA.**

4. Emory University School of Medicine. Annual Internal Medicine Board Review (CME) Course, Disorders of Calcium, August 8, 2007, **Atlanta, GA.**

5. Cystic Fibrosis Family Education Day, Emory University, Guest Speaker, "Cystic Fibrosis Related Diabetes", February 10, 2007, **Atlanta, GA.**

6. Emory Rheumatology Grand Rounds, Guest speaker, "Vitamin D: Bones and More". March 7, 2007, **Atlanta, GA.**

7. Emory Department of Pediatrics, Division of Pulmonary, Monthly Research Conference. Guest speaker, "Translational Vitamin D Research: Importance in Cystic Fibrosis and Respiratory Diseases", February 20, 2008, **Atlanta, GA.**

8. Emory University Hospital Nursing Staff, Guest speaker, "Cystic Fibrosis Related Diabetes", July 30, 2008, **Atlanta, GA.**

9. Emory University School of Medicine. Annual Internal Medicine Board Review (CME) Course, Disorders of Calcium, August 6, 2008, **Atlanta, GA.**

10. Emory Clinical Outcomes and Epidemiology Conference, Guest speaker, "Vitamin D and Cardiovascular Diseases", August 15, 2008, **Atlanta, GA**.

11. Southern Comfort Conference, Guest speaker, "Low dose hormone therapy for MTF and FTM transgendered individuals", October 3, 2008, **Atlanta, GA.**

12. Emory University, Division of General Medicine, 1525 Practice, Guest Speaker, "Vitamin D: Skeletal and Extra-skeletal Health", October 28, 2008, **Atlanta, GA.**

13. Morehouse School of Medicine, Department of Family Medicine, Grand Rounds, "Vitamin D for Optimal Health", April 28, 2009, **Atlanta, GA.**

14. Emory Rheumatology Grand Rounds, "Vitamin D: Skeletal and Extra-Skeletal Health", May 6, 2009, **Atlanta, GA.**

15. Emory University Medicine Grand Rounds, “Vitamin D Insufficiency Increases the Risk of Chronic Medical Disease: Fact or Fiction”, May 12, 2009, **Atlanta, GA.**

16. Geriatric Medicine Updates, Emory/VA Weekly Geriatric Conference, “Vitamin D and Its Implications in the Elderly”, September 24, 2009, **Atlanta, GA.**

17. Emory Division of Infectious Diseases Weekly Research Conference, “Vitamin D Deficiency and Risk of Infections”, March 11, 2010, **Atlanta, GA.**

18. Centers for Disease Control, Influenza Division, “Vitamin D Deficiency and Risk for Infections”, June 9, 2010, **Atlanta, GA**.

19. Emory Rheumatology Grand Rounds, “Vitamin D Update on Clinical Trials at Emory”, May 27, 2015, **Atlanta, GA.**

20. Emory Geriatrics Grand Rounds, “Vitamin D Update on Clinical Trials at Emory”, August 20, 2015, **Atlanta, GA.**

21. Emory GI Grand Rounds, “"Clinical Trials in Vitamin D at Emory: What have we learned?", September 28, 2015, **Atlanta, GA.**

22. Emory Endocrinology Grand Rounds, “Transgender Medicine: 2015”, October 19, 2015, **Atlanta, GA**.

23. Emory DOM Grand Rounds, “Transgender Medicine: What an Internist Needs to Know”, April 11, 2017, **Atlanta, GA**.

24. Emory Endocrinology Grand Rounds, “Vitamin D for Cystic Fibrosis, September 18, 2017**, Atlanta, GA.**

25. 25th Anniversary of the Emory Nutrition Health Sciences Program, Faculty Speaker, “Vitamin D for Cystic Fibrosis: A Bright Future”, February 1, 2018, **Atlanta, GA.**

25. Invitations to National/International, Regional, and Institutional Conferences:

a. National and International:

1. Society of Nuclear Medicine 53rd Annual Meeting, Update in Diagnosis and Treatment of Osteoporosis: Beyond T-scores and New Therapies, June 6, 2006, **San Diego, CA.**

2. North American Cystic Fibrosis Conference, Vitamin D and Mineral Workshop, Invited speaker, “Evaluation of ergocalciferol, cholecalciferol and UV light to treat vitamin D insufficiency in CF patients”, October 23, 2008, **Orlando, FL.**

3. North American Cystic Fibrosis Conference, Bone Symposium, “Re-thinking the Vitamin D guidelines: What was right and what was wrong?”, October 14, 2009, **Minneapolis, MN.**

4. American Academy of Physician Assistants, 38th Annual Meeting, “Review of Hypercalcemia and Hypocalcemia”, June 2, 2010, **Atlanta, GA**.

5. American Academy of Physician Assistants, 38th Annual Meeting, “Medical Therapy of Transgender Patients”, June 2, 2010, **Atlanta, GA**.

6. Infectious Disease Society of America, 48th Annual Meeting, "Vitamin D Deficiency and Risk for Infections", October 24, 2010, **Vancouver, Canada**.

7. American Society of Nutrition, Advances and Controversies in Nutrition, "Assessment and Management of Vitamin D", February 25, 2011, **San Francisco, CA**.

8. North American Cystic Fibrosis Conference, 25th Annual Meeting, "An Overview of Vitamin D Metabolism", November 3, 2011, **Anaheim, CA.**

9. Killarney 13th Annual Cystic Fibrosis Meeting, "Vitamin D in Cystic Fibrosis: A review of the guidelines and future directions", January 31, 2013, **Killarney, Ireland**.

10. 7th Annual Cystic Fibrosis Nutrition & Social Work Consortium, Cystic Fibrosis Foundation, "Vitamin D for Cystic Fibrosis", March 22, 2013, **Atlanta, GA.**

11. 12th Colombian Congress of Endocrinology, "Vitamin D for Skeletal and Extra-Skeletal Health", "Drug Combinations for the Treatment of Osteoporosis", "Endocrine Management of the Transgender Patient", May 30-31, 2013, **Medellin, Colombia**.

12. Endocrine Society, 2015 Annual Meeting, Transgender Symposium, "Challenging Transgender Cases", March 8, 2015, **San Diego, CA**.

13. European Professional Association for Transgender Health, Annual Meeting, "Update on the Endocrine Standards of Care", Panelist, March 13, 2015, **Ghent, Belgium**.

14. 18th Vitamin D Workshop, "Vitamin D in Cystic Fibrosis", April 22, 2015, **Delft, The Netherlands**.

15. 5th Annual International Conference on Vitamin D Deficiency, "Vitamin D in Infections" and "Vitamin D in Chronic Kidney Disease", March 23-24, 2016**, Abu Dhabi, United Arab Emirates**.

16. American Academy of Insurance Medicine, 126th annual meeting, "Transgender Medicine", October 18, 2017, **Atlanta, GA**

17. North American Cystic Fibrosis Conference, "Vitamin D in Cystic Fibrosis", November 2, 2017, **Indianapolis, IN**.

18. Brazilian Association for Transgender Health, "Update on Endocrine Guidelines for Transgender Medicine", November 4, 2017, **Sao Paolo, Brazil.**

19. Endocrine University, American Association of Clinical Endocrinologists, "Transgender Medicine", March 6, 2018, Mayo Clinic, **Rochester, MN**.

20. Endocrine Society, "Guidelines for Gender Dysphoria/Gender Incongruence", March 19, 2018, **Chicago, IL**.

21. American Society for Colposcopy and Cervical Pathology Annual Meeting 2018, "Transgender Medicine: How to Provide Gender Affirming Care", Keynote Plenary Address, April 20, 2018, **Las Vegas, NV**.

22. American Society of Andrology Annual Meeting 2018, "Transgender: Epidemiology, Etiology, and Endocrinology", April 21, 2018, **Portland, OR**.

23. National Lipid Association Annual Meeting 2018, "Management of Lipids and CVD in Transgender Populations", April 27, 2018, **Las Vegas, NV**.

24. Cleveland Clinic Board Review Course, "Transgender Medicine", September 22, 2018, **Cleveland, OH.**

b. Regional:

1. Houston Bone Club, Guest Speaker, "Vitamin D: Bones and More", March 5, 2007, ***Houston, TX.***

2. Georgia Chapter, American Association of Clinical Endocrinologists, Guest Speaker (CME), "An update in vitamin D: Skeletal and Non-Skeletal Health", September 27, 2007, **Atlanta, GA.**

3. Southern States Chapter Annual Meeting, American Association for Clinical Endocrinologists, Guest Speaker, "Vitamin D for Health", March 13-15, 2008, **Birmingham, AL.**

4. Internal Medicine News®: Endocrinology in the News, "Differential Diagnosis of Osteoporosis: How to Evaluate Low Bone Mineral Density in Adults", April 13, 2008, **Philadelphia, PA.**

5. Boston University, 24th Annual Controversies in Internal Medicine, "Vitamin D: Is there an epidemic?", "Paget's Disease of Bone", "Osteoporosis", "Chronic Kidney Disease: an Endocrine Perspective", May 5-7, 2008, **Hilton Head Island, SC.**

6. Genzyme Corporation, Medical Education Partners Program, Guest Speaker, "Vitamin D and Cardiovascular Disease", September 4, 2008, **Cambridge, MA.**

7. Southern Regional Meeting, "State of the Art: Vitamin D and the Heart". February 12-14, 2009, **New Orleans, LA.**

8. 53rd Annual Greenville Postgraduate Seminar: A Primary Care Update (CME course), Guest Speaker, "What is New in Osteoporosis", April 23, 2009, **Greenville, SC.**

9. Delaware Chapter, American College of Physicians Annual Meeting, Guest Speaker, "Vitamin D Increases Risk for Chronic Disease: Fact or Fiction", February 20, 2010, **Wilmington, DE.**

10. Southern Regional Meeting, Mentored Abstract Discussion, "Vitamin D Deficiency in Children: What are the Long Term Implications", February 26, 2010, **New Orleans, LA**.

11. 54rd Annual Greenville Postgraduate Seminar: A Primary Care Update (CME course), Guest Speaker, "Vitamin D Deficiency: How Common Is It?", April 14, 2010, **Greenville, SC.**

12. Georgia Chapter, American Society for Enteral and Parenteral Nutrition, Guest Speaker, "Vitamin in Health and Disease: 2010 Update", June 3, 2010, **Atlanta, GA.**

13. 55nd Annual Greenville Postgraduate Seminar: A Primary Care Update (CME course), Guest Speaker, "Osteoporosis: Update Diagnosis and Treatment", April 13, 2011, **Greenville, SC.**

14. Greater Atlanta Dietetic Association, "Vitamin D: 2011 Update", September 21, 2011, **Atlanta, GA.**

15. Southern States Chapter of the American Association of Clinical Endocrinologists, Annual Meeting, "Vitamin D: Hope or Hype", March 4, 2012, **New Orleans, LA.**

16. 56th Annual Greenville Postgraduate Seminar: A Primary Care Update (CME course), Guest Speaker, "Vitamin D Deficiency and Treatment", April19, 2012, **Greenville, SC.**

17. Division of Laboratory Science Summer Symposium, Centers for Disease Control, Keynote speaker, "Vitamin D Testing: Is this just a fad?", August 14, 2013, **Atlanta, GA**.

18. Southern Comfort Conference, Guest speaker, "Guidelines for Treatment of Transgendered Individuals", September 5, 2013, **Atlanta, GA.**

19. Michigan Chapter Annual Meeting, American Association of Clinical Endocrinologists, "Transgender Medicine: What an Endocrinologist Should Know", October 31, 2015, **Lansing, MI**.

20. World Professional Associate for Transgender Health, Certified Training Course for Healthcare Providers, "Advanced Hormones Therapy", November 6, 2015, **Chicago, IL**.

21. World Professional Associate for Transgender Health, Certified Training Course for Healthcare Providers, "Introduction and Advanced Hormones Therapy", January 20, 2016, **Atlanta, GA**.

22. Rheumatology Alliance of Louisiana, 4th Annual Meeting, "Vitamin D for the Skeleton and Beyond", August 28, 2016, **New Orleans, LA**.

23. Wake Forest School of Medicine, Transgender Health Conference, "Hormone Therapy for Trans* Populations", September 29, 2017, **Winston-Salem, NC.**

24. Georgia Chapter, American Association of Clinical Endocrinologists, Guest Speaker (CME), Transgender Medicine 2018: What an Endocrinologist Needs to Know", January 26, 2018, **Atlanta, GA.**

26. Abstract Presentations at National/International, Regional, and Institutional Conferences:

a. National and International:

1. Endocrine Society Annual Meeting, Turner A, Chen TC, Barber TW, Malabanan AO, Holick MF, **Tangpricha V***. Testosterone Increases Bone Mineral Density at the Hip and Spine in Female to Male Transsexuals, June 16-19, 2004, **New Orleans, LA.**

2. **Tangpricha V***. Harris M. Harry Benjamin International Gender Dysphoria Association Annual Meeting, Congenital Adrenal Hyperplasia in a FTM transsexual patient, April 6-9, 2005, **Bologna, Italy.**

27. Research Focus:

My research focus is translational research in areas of vitamin D, chronic kidney disease and cystic fibrosis. I am interested in the impact of vitamin D supplementation on extra-skeletal diseases such as infections and anemia. I am also interested in the endocrine care of patients with gender dysphoria and non-conforming gender identity.

28. Grant Support:

ACTIVE

Federally funded:

Source and Title	**Dates, yearly direct costs, % effort**
UL1 RR025008 (PI: David Stephens)	09/17/2007 - 05/31/2022*
NIH/NCRR, Atlanta Clinical and Translational Science Institute (ACTSI), $5,147,598,	13%

Dr. Tangpricha serves as a scientific advisory committee chair. His committee reviews protocols submitted to the ACTSI Clinical Interactions Network sites for approval.
Role: **Scientific Advisory Committee Co-Chair**
*renewed in 2017

NIH/1R01DK115473 (PI: Markland) 04/01/2018-03/31/2019
Role of Vitamin D in the Prevention and Progression of Urinary Incontinence
The aim of this grant is to investigate the role of vitamin D on the risk of urinary incontinence using two large prospective cohorts, including the Nurses Health Study and the VITAL trial.
Role: **Co-investigator**

NIH/R01HD079603-01A1 (PI: Walter Bockting) 09/25/2014 – 06/30/2019
Identity Development, Risk and Resilience among Gender Diverse Populations, $2000 per annum
The goal of this study is to describe the process of transgender identity development based on qualitative lifeline interviews with a sample of 90 transgender individuals ages 16 and older, and identify periods of acute vulnerability and characteristics of resilience.
Role: **Consultant**

Private foundation funded:
Cystic Fibrosis Foundation Center Grant (PI: Hunt) 07/01/2007 – 06/30/2017
"Emory University Cystic Fibrosis Center" $310,320 4.5%
Dr. Tangpricha serves as a co-investigator on this center grant. He is the director of adult endocrinology for the Emory CF center.
Role: **Co-Investigator**

Cystic Fibrosis Foundation (PI:Tangpricha) 10/01/2016 – 09/30/2019
Emerging Leaders in CF Endocrinology Program $48,546 10%
The purpose of this award is to provide support for Dr. Tangpricha to train early career academic endocrinologists in research and clinical care of patients with CF across the United States. He has been assigned three mentees from VCU, Harvard, and University of Kansas.
Role: **Co-Investigator**

PREVIOUS SUPPORT (in chronological order)
NIH T32DK007201 (PI Ruderman) 4/1/00 – 3/1/03
Metabolism, Endocrinology and Obesity Training Grant
Boston University School of Medicine,
Role: **Trainee**

Clinical Research Feasibility Funds (CReFF) Award 10/1/03 – 12/31/03
Boston University/GCRC $10,000
"Vitamin D Deficiency in Cancer Patients"
The aim of this grant was to determine the prevalence of vitamin D insufficiency in patients with cancer
Role: **Principal Investigator**

UV Foundation 05/01/05 – 12/31/07
Physician-Scientist Research Career Development Award $45,000
The aim of this grant was to support the research career of Dr. Tangpricha in becoming a physician-scientist
Role: **Principal Investigator**

Novartis Pharmaceuticals 11/01/04 – 04/30/07
"Study to Compare the Effect of 24 weeks Treatment with Vildagliptin to Placebo as Add-On Therapy" $19,038
Role: **Site Principal Investigator**

Atlanta Research and Education Foundation 07/01/2006 –6/30/2008
"A Randomized Controlled Double Blinded Trial to Evaluate Cholecalciferol Treatment on Reducing Blood Pressure in Middle Aged Men with Stage I Hypertension and Vitamin D Deficiency" $50,000 5%
The aim of this grant was to examine the effect of vitamin D treatment on blood pressure
Role: **Principal Investigator**

Proctor and Gamble Pharmaceuticals 12/01/06 – 11/30/07
"Prevalence of osteoporosis and vertebral fractures and its impact on pulmonary function in cystic fibrosis patients: A cross sectional study" $13,000
The aim of this grant was to determine the prevalence of vitamin D insufficiency and osteoporosis in patients with CF
Role: **Principal Investigator**

Emory University Research Committee 07/01/2007 –6/30/2008
"Optimizing Vitamin D Status in Cystic Fibrosis Patients" $30,000
The aim of this grant was to determine the optimal replacement strategy for vitamin D in cystic fibrosis patients.
Role: **Principal Investigator**

Emory Center for Clinical and Molecular Nutrition 01/1/07 – 12/31/07
"Tumor Necrosis Factor α induces vitamin D resistance in small intestinal calcium absorption" $15,000
The aim of this grant was to determine the effect of inflammation that occurs in IBD on calcium absorption
Role: **Principal Investigator**

K23 AR054334 02/01/2007 – 1/31/2013
NIH/NIAMS $641,250 75%
Mentored Research Career Development Award, "Role of T-cells in Post-Menopausal Osteoporosis in Women Undergoing Surgical Menopause"
The aims of this grant are to examine the role of T-cells in post-menopausal osteoporosis and to support Dr. Tangpricha's career as a physician scientist
Role: **Principal Investigator**

Emory University Research Committee (PI: Evatt) 03/01/2008 –2/28/2009
Emory University $30,000 1%
"Vitamin D Repletion for Optimal Health in Patients with Parkinson's disease"
The aims of this grant are to 1) to determine the prevalence of vitamin D insufficiency in patients with Parkinson's disease 2) to perform a randomized placebo controlled trial to determine whether optimal vitamin D status improves neurocognitive function in patients with Parkinson's disease
Role: **Co-Investigator**

Parkinson Study Group (PI: Evatt) 07/01/2008 – 06/30/2009
"Vitamin D Insufficiency: Prevalence & Clinical Correlates in DATATOP Cohort" $50,000 1%
The aims of this grant is to correlate vitamin D status with clinical outcomes in a cohort of subjects with Parkinson's disease.
Role: **Co-Investigator**

Emory Global Health Institute (PI: Ziegler) 07/01/2008 – 6/30/2011
Emory University $250,000 2.5%
Impact of Vitamin D Supplementation on Host Immunity to Mycobacterium Tuberculosis and Response to Treatment: Building Translational Research Capacity in Nutrition and Infectious Diseases in the Republic of Georgia"
The aims of this grant are to: 1) evaluate the role of vitamin D as an adjunctive therapy in patients

infected with TB and 2) enhance the research infrastructure in the Republic of Georgia
Role: **Co-Principal Investigator**

Emory University Research Committee (PI: Wasse) 02/01/2009– 1/31/2010
Emory University $30,000 1%
"Impact of Extra-renal 1-alpha hydroxylase expression and vitamin D polymorphisms on arteriovenous fistula maturation"
The aims of this grant are to 1) to demonstrate that serum vitamin D predicts AVF maturation, 2) to demonstrate that greater local expression of vitamin D activity and responsiveness increases likelihood of AVF maturation, to demonstrate that patients with activating VDR polymorphisms are more likely to experience AVF maturation.
Role: **Co-Investigator**

Emory Center for Aids Research (CFAR) (PI: Ross) 03/15/2010 – 3/14/2011
Emory University
"Prevalence and predictors of vitamin D deficiency and vitamin D's relationship to inflammatory and endothelial activation markers in a cohort of HIV-infected children and young adults."
The aims of this grant are to examine vitamin D status and their relationship to CVD risk factors in HIV infected children and adults
Role: **Co-Investigator**

GlaxoSmithKline (PI: Ross) 06/01/10-05/31/11
HIV Collaborative Investigator Research Award
Vitamin D and cardiovascular biomarkers in HIV-infected children and young adults.
This study evaluates the relationship between vitamin D levels and cardiovascular biomarkers in HIV-infected children and young adults from 1-25 years of age.
Role: Co-investigator

Emory University Research Committee (PI: Ross) 07/01/2011 – 6/30/2012
Emory University
Establishing Optimal Vitamin D Repletion Strategies in HIV-Infected Children and Young Adults: a Pilot Study
Role: **Co-Investigator**

R21HL110044-01/NIH/NHLBI (PI: Gregory Martin) 08/01/2011– 07/31/2014
High-dose vitamin D and antimicrobial peptide expression in lung failure
The major aim of this grant is to demonstrate a beneficial effect of high dose vitamin D given to subjects admitted to intensive care units with critical illness.
Role: **Co-Investigator**

R01HD070490 09/01/2011 – 08/30/2016
NIH/NICHD (PI: Grace McComsey) $1,709,989 5%
Vitamin D, drug metabolism, and cardiovascular complications in pediatric HIV
The aims of this grant are to examine the role of vitamin D on cardiovascular risk in adolescents with HIV disease
Role: **Sub-Contract to Emory, Co-investigator**

P30AR047363 (PI: Susan Thompson, Site-PI: Angela Robinson)
"Vitamin D and Response to Atorvastatin in Pediatric SLE" 4/1/2012 – 6/30/2016
The aims of this subaward are to determine the relationship between vitamin D status and markers of innate immunity in pediatric subjects with SLE.
Role: **Sub-contract awardee**

R21DK096201 (PI: Alayne Markland) 09/19/2013 – 05/31/2015

Vitamin D Supplementation in Older Adults with Urinary Incontinence
The aims of this grant are to examine the role of vitamin D treatment in elderly patients and its impact on urinary incontinence.
Role: **Co-Investigator**

R21HD076387-01 (PI: Michael Goodman) 08/01/2013 – 05/31/2015
Cohort study of mortality and morbidity in transgender persons $261,359 2%
The goal of this study is to establish a cohort of transgender persons in the VA and Kaiser Healthcare systems and to determine the risk of a number of co-morbid conditions and to obtain data on the rates of mortality.
Role: **Co-Investigator**

PCORI (PI: Michael Goodman) 01/01/2013 – 12/31/2016
Comparative Risks and Benefits of Gender Reassignment Therapies $2,103,856 5%
The goal of this study is to understand the short- and long-term health issues among transgender persons who had or are planning to have a sex change treatment.
Role: **Co-Investigator**

Cystic Fibrosis Foundation 07/01/2011 – 06/30/2018
Clinical Research Award $780,000 25%
"Vitamin D for enhancing the immune system in cystic fibrosis"
The aims of this grant are to examine the role of vitamin D in improving the host defense system in adult and adolescent patients with CF and who are admitted with an acute pulmonary exacerbation in a randomized, multi-center trial design.
Role: **Principal Investigator**

26. Bibliography:

Published and accepted research articles in refereed journals:

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2. Tangpricha V. Flanagan JN. Whitlatch LW. Tseng CC. Chen TC. Holt PR. Lipkin MS. Holick MF. 25-hydroxyvitamin D-1α-hydroxylase in normal and malignant colon tissue. The Lancet. May 26, 2001. 357 (9269):1673-4
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8. Turner A. Chen TC. Barber TW. Malabanan AO. Holick MF. **Tangpricha V.** Testosterone increases BMD of the Hip and Spine in Female to Male Transsexuals: A Case Series. Clinical Endocrinology (Oxf) 2004 Nov;61(5):560-6. PMID: 15521957
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15. Tangpricha V. Luo M. Fernandez-Estivariz C. Gu LH. Bazargan N. Klapproth JM. Sitaraman SV. Galloway JR. Leader JM. Ziegler TR. Effects of Growth Hormone Therapy on Bone Density and Bone Turnover in Short Bowel Syndrome. Journal of Parenteral and Enteral Nutrition. 2006 November/December; 30 (6): 480-486.
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1. Transgender Hormone Therapy, Up to Date, 2010-Present
   I have written, edited, and updated the Up to Date section on Transgender for over 5 years.

2. Dyamed Plus, Scoping Document, Transgender Hormone Therapy for Adolescents and Adults and Osteoporosis, 2016-Present
   I have been asked to assist with the Dyamed Plus evidence based web search engine for topics related to transgender.

3. Vitamin D Deficiency and Related Disorders., Web MD (formally eMedicine), 2006-Present
   I have written, edited, and updated the section on vitamin D on Web MD for over 10 years

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, Plaintiffs, v. JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON, Defendants.	)	Civil No. 3:18-cv-00156-NJR-MAB

DECLARATION OF JANIAH MONROE

I, Janiah Monroe, hereby state:

1. I am a 29-year-old woman from the South Side of Chicago. From a young age, I knew that I was a girl. However, my family was not supportive of my gender identity. My father was especially hostile toward me after I told him that I am a girl. Around the time I was 12 years old, I began dressing as a girl and began taking hormones.

2. I entered the custody of the Illinois Department of Corrections ("IDOC") in 2008. During my intake at the Northern Reception and Classification Center, I told prison officials that I am transgender and needed hormone therapy. Before entering IDOC custody, I had been taking hormones when I was able to get them. I knew how important it was to continue taking them. But I was not evaluated for gender dysphoria and was not prescribed hormones. Instead, IDOC repeatedly delayed providing me any treatment for gender dysphoria, even though I was extremely depressed and suicidal because I was unable to get any treatment. For years, IDOC mental health professionals repeatedly evaluated me and reconfirmed my diagnosis of gender dysphoria. They

also recommended that I start hormone therapy, but their recommendations were ignored or overruled by IDOC.

3. Instead of being treated, I was forced to wait. I submitted my first of many grievances relating to being denied treatment for gender dysphoria in February of 2010 while incarcerated at Pontiac Correctional Facility. In that grievance, I complained that I had been denied medical attention for my gender dysphoria. I specifically requested hormone therapy and gender affirming surgery. I also recounted times when I had harmed myself physically because of my gender dysphoria. IDOC denied my grievance.

4. I continued to experience increased distress relating to my gender dysphoria. I have tried to cut off my genitals several times, beginning in 2010. I explained to IDOC medical staff the reason why I was doing this: I was trying to cut off my genitals because of the deep disgust I felt for that part of my body, as well as to cut off the flow of testosterone. Each time I tried and failed to perform surgery on myself, IDOC medical staff stitched my genitals back together. On more than one occasion, I pulled out the stitches and refused to take antibiotics, hoping that my genitalia would get infected need to be amputated. I was put in restraints and told that IDOC would not amputate my genitalia.

5. I have also tried to kill myself many times, including in the past year. In August 2018, I tried to kill myself by not eating or drinking. I eventually blacked out and was taken to the hospital. Other times, I tried to hang myself or chew through my arm. I often feel that I would rather be dead than continue living with this body.

6. In November 2011, I was evaluated by a psychiatrist named Dr. Matthews, and he confirmed that I met the DSM criteria for gender dysphoria. However, I was not given hormone therapy at that time.

7. Although I finally began receiving hormone therapy sometime in mid-2012, I do not believe IDOC is giving me the correct hormones or dosage. I have not seen much change in my body since starting hormone therapy. I also do not believe IDOC is correctly monitoring my hormone levels. I rarely have bloodwork done and IDOC has refused most of my requests for increased hormone dosages. I continue to feel very anxious, depressed, and hopeless due to my body.

8. IDOC also refused for several years to give me a bra and women's underwear, although they recently finally gave me a bra after I continued to file grievances. I have also requested and been denied a safe and effective way to remove my face and body hair: my request for electrolysis hair removal was denied and I was given limited access to "Magic Shave," a chemical hair removal cream. The Magic Shave burns my skin and I cannot use it regularly to remove my body hair. The hair on my face and body make me feel terrible.

9. I continued to file grievances, including in December 2012 and February of 2013, requesting, among other things, gender affirming surgery and gender-appropriate clothing and cosmetic items. These grievances were denied. The only reasons IDOC provided were that I had no medical need for a bra or female cosmetic items, and that I was "not a candidate for a reassignment surgery," without further explanation. I have continued to grieve these issues, and while IDOC finally provided me a bra it has continued to deny my requests for gender affirming surgery.

10. In addition to the distress I feel related to gender dysphoria, I have also had to cope with constant harassment and abuse. IDOC staff, including medical staff, and other prisoners often refer to me by male pronouns and a male name. I have also been searched by male guards, even though I am a woman. I have been sexually harassed on a regular basis, and have been assaulted,

by other prisoners and IDOC personnel, because I am a woman with a feminine way of looking and expressing myself. I have filed a complaint under the Prison Rape Elimination Act (PREA) relating to one of these incidents, in which an IDOC officer forced me to perform oral sex on him. Because of the PREA complaint, I experienced retaliation, including removal of my phone privileges and a restriction on my visitors.

11. I requested a transfer to a female facility in January 2017 and again in May 2017. In the January 2017 grievance, I described the sexual assault by the officer mentioned above. That grievance was ignored - IDOC stated that my PREA complaint was being investigated by state police and that "[d]iscipline of staff is an administrative decision." My May 2017 grievance for gender affirming surgery and transfer to a female facility was also denied. IDOC denied me reassignment surgery because "there is no policy in place" at IDOC to provide surgery, and my transfer to a female facility was denied because reassignment surgery had not been performed.

12. Because IDOC has not given me the treatment I need, my gender dysphoria has gotten worse. I feel depressed, hopeless, and suicidal. I do not have access to professional counseling specific to transgender issues and gender dysphoria at the prison. I think about hurting myself or killing myself every day. I feel hopeless and empty because I am not allowed to be the woman I know I am. I am not "at home" in my body; it does not match who I know myself to be. I do not feel I can continue living without the treatment I need for gender dysphoria.

13. On April 1, 2019, I was transferred to an IDOC female facility. At Logan Correctional Center, I hope to be subject to less violence and harassment, and to have the opportunity to live more consistently with my gender identity. But I still have not been evaluated for gender-affirming surgery, and my medical care has not otherwise changed. Unless IDOC provides me with the medical treatment I need for my gender dysphoria, I will continue to suffer.

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

Dated: 5/2/2019

/s/ *Janiah Monroe*
Janiah Monroe

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, Plaintiffs, v. JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON, Defendants.	)	Civil No. 3:18-cv-00156-NJR-MAB

DECLARATION OF MARILYN MELENDEZ

I, Marilyn Melendez, hereby state:

1. I am a 24-year-old woman. I grew up in Waukegan, Illinois. From a young age, I knew that I was a girl. As a child, I often went into my mother's room and tried on her clothes and makeup. I attempted to pierce my own ears. When my mother asked me whether I preferred to play with toys for boys or girls, I always chose the ones I thought were the girls' toys. While many of my family members tried to make me dress and "act like a boy," my mother was supportive of my female identity.

2. I took estrogen and a testosterone blocker in my pre-teen years. My ability to get hormones was interrupted when I was 13 because my mother could no longer afford them. My mother warned me that my body would start changing as a result. I became extremely depressed and suffered from serious anxiety when my body began to change and become more masculine in appearance because of puberty. I became distraught when my shoulders began to broaden and I started experiencing more frequent erections; I no longer looked and felt like myself. I felt

confused and upset by the changes in my body, and the teasing from other kids led me to stand up for myself and get into fights.

3. I entered the juvenile detention system at age 14. The juvenile detention facility denied me access to hormone therapy. When I turned 17, I was transferred from the juvenile facility to the IDOC adult prison system.

4. I was diagnosed with gender dysphoria by an IDOC medical professional in March 2015. I explained to an IDOC mental health professional how my stress and depression related to feeling trapped in the wrong body, and my severe discomfort and distress that I was unable to remove my facial hair and how deep my voice was at the time. Despite a diagnosis of gender dysphoria, the GID Committee initially refused my request for hormone therapy because, as I understood their explanation, there were no records of my prior hormone therapy and they believed I needed additional counseling before initiating hormone therapy. I filed a grievance to protest the fact that IDOC refused to provide me with hormone therapy. In my grievance, I pleaded for the people in charge to consider what they would want if a loved one was transgender and requesting treatment. During the time when I was unable to access hormone therapy, I felt extremely depressed about my body. I wrote in my grievance that without treatment I would rather be dead so that my pain and heartache would be no more.

5. After waiting several months, I eventually was able to start on hormone therapy. While the hormone therapy did help my suffering, to this day I still do not believe that I am receiving the proper dosage of hormones, and I have inquired about receiving a different type of hormone therapy than the one I am prescribed. I filed a grievance seeking a higher hormone dosage in June 2016, or clinical testing to confirm whether my dosage was too low, and repeatedly requested an increased dosage from IDOC medical personnel. As of August 2016—almost 1.5

years after IDOC diagnosed me with gender dysphoria—I still had erections when I would wake up as well as excessive face and body hair—leading me to believe that my dosage was insufficient. These things made me feel extremely depressed and disgusted; I did not want to be the person I saw in the mirror. IDOC did not take my request seriously and still does not regularly test my hormone levels to make sure I am on the right dosage to be safe and to treat my gender dysphoria effectively.

6. Shortly after beginning hormone therapy in the fall of 2015, I requested a bra from IDOC. When I still had not been provided a bra by June 2016, I filed a grievance to obtain one. I explained that not having a bra is linked to back strain, depression, and suicidal thoughts, and that the lack of a bra made the movement of my breasts more noticeable and led to increased harassment. It was not until June of 2017 that IDOC finally provided a bra.

7. Even with hormone therapy and a bra, however, I continue to be denied medical treatment that I believe would ease my suffering and gender dysphoria. I continue to be repulsed by my genitalia and by the amount of facial and body hair that I have. I have requested access to better hair removal, including a non-electric razor that I can use in the shower to shave my body, but have not been provided with one.

8. I also have requested gender-affirming surgery, and filed a grievance requesting it, but it does not seem like IDOC takes my request or my need for surgery seriously. I was told that IDOC does not perform gender affirming surgery, and despite my many requests I have never even been evaluated for surgery. I feel disgusted that I have male genitalia – it makes me feel like a freak or abomination when I see my body. I would rather kill myself than be forced to live in a man's body for the rest of my life.

9. I am not truly able to experience life as a woman in my current circumstances at IDOC. I am not allowed to wear any female clothing or undergarments except for the sports bra I was issued. I have had limited support for dealing with being a transgender woman in a men's prison, and I filed a grievance asking for access to gender-affirming commissary items as well as for additional counseling programs for transgender inmates. Both inmates and IDOC staff, including medical staff, are disrespectful of my gender identity. Most mental health professionals I have seen do not seem to know much about treating gender dysphoria at all. Some officers refer to me as "Ms." or use female pronouns, but others consistently refer to me with male pronouns, and will sometimes use offensive terms like "fag" or "sissy," which to me is disrespectful and dehumanizing. During strip searches, I am searched by male officers who have cupped my breasts or butt and called me names like "bitch" or "whore." Being placed in a female facility, and getting good medical care for my gender dysphoria, including gender-affirming surgery, would mean that I would finally be recognized as the woman I am.

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

Dated: 5/2/2019

/s/ *Marilyn Melendez*
Marilyn Melendez

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, Plaintiffs, v. JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON, Defendants.	)	Civil No. 3:18-cv-00156-NJR-MAB

DECLARATION OF LYDIA HELENA VISION

I, Lydia Heléna Vision, hereby state:

1. I am a 39-year-old woman. I was raised in Granite City, Illinois. From a young age, I knew that I was a girl. I felt like a girl on the inside and expressed myself in a feminine way. When I was a child, I attempted to cut off my penis. My family used to tell me that I needed to "man up" and "act more masculine." Because of my family's lack of support, I hid my femininity and transgender identity until years later.

2. I entered IDOC custody in June 2004. I have taken advantage of the educational opportunities offered by IDOC, earning my associate's degree while in custody. I was transferred to Danville Correctional Center in December 2015 so that I could continue my education. I am currently in Centralia Correctional Center, where I am taking a paralegal certificate course. I hope to help and advocate for other transgender people in the future.

3. In 2015, while I was at Danville, I informed IDOC personnel that I am transgender and was diagnosed with gender dysphoria in March 2016. At that time, I began requesting

treatment for gender dysphoria, including hormone therapy, female clothing such as a bra and female underwear, and gender-affirming grooming items. Despite my diagnosis, IDOC repeatedly denied these requests. IDOC staff instead told me I had to attend sessions for post-traumatic stress disorder before being treated with hormone therapy.

4. In July 2016, I was referred to an IDOC psychiatrist who evaluated me via Skype and confirmed the prior diagnosis of gender dysphoria. During the evaluation, the psychiatrist also confirmed that my continued lack of hormone therapy was causing me extreme distress and recommended I have a medical follow-up meeting to talk about starting hormone therapy. Despite this second diagnosis and evaluation, which confirmed what I had already told IDOC about the severity of my gender dysphoria and my need for hormone therapy, IDOC refused to provide me with any treatment. IDOC did not provide hormone therapy, surgery or gender affirming clothing. Instead, my "treatment plan" consisted of monthly counselling sessions with counselors who misgendered me (referring to me as a man) and were unfamiliar with transgender issues.

5. I was also forced to continue showering in general population for several months after my confirmed gender dysphoria diagnosis. In both August and September 2016, I requested a private shower arrangement so that I did not have to shower with male prisoners and to help keep me safe. During this time, I suffered a panic attack in the showers.

6. In November 2016, I again requested—and IDOC refused to provide—treatment for my gender dysphoria. At this time, I attended individual therapy sessions with staff unfamiliar with transgender issues and received no treatment specific to gender dysphoria. IDOC staff said they would reconsider treating my gender dysphoria once I "developed a peer group for support" and went to regular therapy.

7. Although Danville did not have a transgender therapy group for some time, once a transgender group was started, I attended the sessions. I also attended regular therapy sessions and requested more materials for information related to gender dysphoria. I joined Black and Pink, an outside organization that supports LGBTQ inmates and made an effort to reach out in writing to other transgender people and a family friend.

8. While waiting for gender dysphoria treatment, I tried to do whatever was in my control to feel more feminine and reconcile my appearance with my gender identity. For example, I followed a special weightlifting regimen to try to enhance the size of my breasts, and I did whatever I could to remove my body hair and pluck my eyebrows. But, I felt increasingly depressed and anxious because it felt like a façade; it is so difficult to feel feminine without access to hormone treatment and feminine products.

9. In February 2017, I filed three grievances requesting treatment for my gender dysphoria, including hormones, gender-affirming clothes and grooming products, and placement in a cell with another transgender inmate because I feared for my safety. As part of my request for gender-affirming products, I requested a bra, women's underwear, feminine grooming products, makeup, and body hair removal products like waxing strips. IDOC acknowledged and denied my request for a bra, but ignored the rest.

10. In March 2017, IDOC's Gender Identity Disorder Committee again refused to provide me hormone therapy and gender-affirming clothes and grooming products. Despite multiple medical diagnoses supporting my gender dysphoria, repeated requests for treatment, my diligence in attending counselling, and my efforts to find support within the transgender community, IDOC denied treatment for the same reasons they gave before. After I was denied treatment, I continued trying to do what I could to feel feminine, but without treatment I sank into

severe depression and anxiety. Every day, I looked in the mirror and saw a woman with a five o'clock shadow and a body that I hated but could not change without the treatment I was being denied. I quit my job in the laundry room because I felt too depressed to continue working.

11. In October 2017, I was evaluated by another psychiatrist. IDOC's continued refusal to provide me hormone treatment and access to feminine items was causing me extreme distress, and I was feeling severely depressed. The psychiatrist recommended that I be considered by IDOC for hormone therapy, recognizing that hormone therapy would likely improve my mood and anxiety. However, after the evaluation and recommendation, I still did not receive hormone therapy or gender affirming products. I told my family and friends about my transition and was happy to receive replies addressing me by my preferred name, Lydia. I continued to meet monthly with staff for counselling, and during almost every meeting I pleaded for hormone therapy. I grew increasingly discouraged and depressed. I could not understand why I was still being denied treatment.

12. In January 2018, I was evaluated by another psychiatrist. We discussed at length my need to access hormone treatment and feminine products. I was again diagnosed with gender dysphoria, as well as anxiety and depression. The psychiatrist discussed prescribing antidepressant medication, but did not provide a medical treatment plan for my gender dysphoria.

13. By March 2018, two years after my initial gender dysphoria diagnosis, I still had no access to hormone therapy or feminine products. I felt depressed and I started to feel hopeless about ever receiving treatment for my gender dysphoria.

14. I was transferred to Graham Correctional Center in May 2018, and I felt somewhat hopeful that Graham might be different from Danville. I thought maybe I would finally get the treatment I need in order to feel like I belong in my body. In June 2018, a psychiatrist at Graham

evaluated me. I expressed my need to transition fully to living as a woman and my disgust with my body. The psychiatrist confirmed my gender dysphoria diagnosis for a fourth time. A month later, in July 2018, I still did not know whether or not my case would be presented before the Committee for approval of hormone therapy. As a result, my anxiety and depression worsened, and I had trouble eating and sleeping.

15. In August 2018, I was sent for bloodwork without any further explanation from IDOC. At the end of October 2018, a Mental Health Professional ("MHP") told me that I was finally approved by the Committee to begin hormone therapy.

16. As of December 2018, it had been 32 months since my first diagnosis in IDOC custody. Over those 32 months, I was diagnosed with gender dysphoria multiple times. I made over 20 requests for hormones to IDOC medical personnel and staff. I made multiple requests for female items such as a bra, female underwear, and other feminine products. Several doctors recommended I receive hormone therapy. For me, the delay has been excruciating. In late 2018, I finally began receiving the hormone therapy that I had requested for so long. I received two bras on February 2, 2019, over three months after they were prescribed and over two years since my first request. The bras IDOC ordered are the wrong size and cut into my ribs when I wear them.

17. Even though I have finally been approved for hormone therapy, I am terrified that I will never actually receive the treatment I need. I see other transgender inmates who show little to no signs of development even though they have been on hormone therapy for years or who go long periods of time without being monitored. I have had trouble accessing information about my treatment and have had problems with prescription changes and getting the correct dosage. I am exhausted from having to fight with IDOC for years to get any treatment for my gender dysphoria.

All these years without hormone therapy and gender-affirming clothing and items made me want to kill myself.

18. Every day I am forced to dress, smell and look like "a man" because I cannot get the gender affirming clothes, grooming items and medical care I need. IDOC personnel and medical and mental health staff persistently misgender me. I feel hopeless and completely alone in a constant battle for treatment. It is so painful to watch my facial hair grow knowing there is nothing I can do. IDOC's refusal to provide me proper treatment for my gender dysphoria including appropriate placement in a women's facility is torture for me. I know that gender dysphoria is the cause of many emotional problems for me, and I feel sick that I have no way of doing anything about it. I am trapped in a male prison where I do not feel safe and I am not fully able to transition. Because I am in a male facility, when IDOC searches me I get searched by a man. If I were in a women's facility I believe that these kinds of searches would be performed by women. To have a male touch me makes me feel sick—my anxiety goes through the roof and I have no way to control it. I have to dissociate myself. If I allowed myself to feel I would be crying all day because I am a woman in stuck in a male facility.

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

Dated: 4/25/19

Lydia H. V.

Lydia Heléna Vision

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, Plaintiffs, v. JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON, Defendants.	)	Civil No. 3:18-cv-00156-NJR-MAB

DECLARATION OF SORA KUYKENDALL

I, Sora Kuykendall, hereby state:

1. I am a 26-year-old woman. I grew up in Columbia, Illinois. From a young age, I knew that I was a girl. I first identified as a girl when I was around five years old and I asked my family to call me by my preferred feminine name at the time, Kaitlyn. My brother began to bully me for using a girl name and expressing myself in a feminine way. Because of this bullying, I tried to hide my identity and stopped trying to present as a girl.

2. I was 11 or 12 when I finally had a way of describing what I was feeling with my gender identity. But my family thought I was going through a phase, and they were in denial about the reality of my female gender. During my teenage years, I kept my gender identity hidden due to repeated bullying by my family and classmates. I grew my hair long and was often perceived as a girl, but I never told people I was a girl. Because of my family's lack of support, I was not evaluated by a medical professional for my gender dysphoria or prescribed hormones during my teenage years. I became extremely depressed when my body began to change and become more

masculine in appearance because of puberty. During my teenage years, I attempted suicide because of the despair I felt from being trapped in a man's body.

3. I entered IDOC custody in November 2014 at the age of 22. During intake at Menard Correctional Center, a social worker asked me, "You're a boy, right?" I responded that I was not a boy, and within the first week of my incarceration, I asked for hormone therapy and explained that I wanted to present as a woman and receive the right medical care to make my body match my gender.

4. IDOC officials denied my request for hormone therapy and refused to evaluate me for gender dysphoria. The feeling of being trapped inside the wrong body was agonizing. In the midst of my despair, I attempted to castrate myself by tying my testicles in order to stop the flow of testosterone. It was only after my castration attempt that IDOC finally evaluated me and diagnosed me with gender dysphoria in February 2015.

5. I began taking hormones on approximately February 28, 2015. I was prescribed 100 mg of Spironolactone and 5mg of Menest to take daily. My prescribed hormone dosages have have fluctuated since then. For example, in October 2015, my dosage of Spironolactone was increased to 200 mg.

6. I have repeatedly requested that IDOC officials conduct blood and laboratory tests to monitor my hormone levels to make sure that I am receiving the appropriate hormone dosages to support my transition and keep me healthy. Despite my repeated requests, I have never received regular monitoring or bloodwork.

7. In June 2015, I requested a bra due to my breast development. I did not receive one until six months later. I have repeatedly requested other gender affirming clothing and grooming

items. I also filed formal grievances requesting feminine grooming and cosmetic products and women's clothing. All of my requests have been ignored or denied.

8. Even with hormone therapy and a bra, I continue to be denied medical treatment that I believe would ease my suffering and gender dysphoria. I continue to be disturbed by my genitalia and by the amount of facial and body hair that I have. I have resorted to using nail clippers each morning to painfully remove the individual hairs on my face. I have requested hair removal treatment, but IDOC has not provided it.

9. I have also made repeated requests for gender affirming surgery. I first requested surgery in June 2015, and have continued to raise the issue with IDOC officials. I spoke with IDOC mental health professionals on at least three different occasions from 2016-2017 about surgery, and filed a grievance requesting it to treat my ongoing distress and gender dysphoria. One IDOC mental health professional said she would advocate for me to receive gender affirming surgery. Despite my repeated requests, I have never even been evaluated for surgery. Even though I am currently taking hormones, I continue to feel extremely depressed and anxious because of my genitalia, and have frequent thoughts of self-harm. I believe that surgery would make me feel less depressed and distressed.

10. During my incarceration at Menard, I have also been subjected to inhumane search procedures. Strip searches conducted by male officers in the presence of male inmates are humiliating and leave me feeling violated and unsafe. I have refused visitors because I was terrified of the violating experience of being searched by male officers. I filed a grievance on March 14, 2017 requesting that if strip searches are necessary, that I be strip-searched by a female guard away from the male inmates. I have not received a response to this grievance, and I continue to be subjected to these distressing searches.

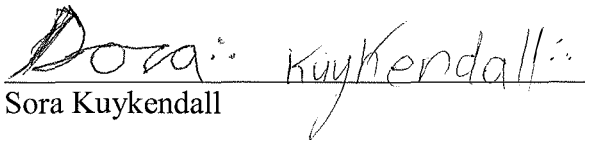
11. I am not truly able to experience life as a woman in my current circumstances at IDOC, and my mental and physical health are suffering because of it. IDOC has also denied my repeated requests to legally change the name on my birth certificate to accurately reflect my true gender identity. I am housed in a male facility for men and am not allowed access to gender affirming grooming items and clothing that are available to other women. I am not allowed to wear any female clothing or undergarments except for the sports bra I was issued. Both inmates and IDOC staff are consistently disrespectful of my gender identity, using male pronouns and my old male name or "it" to refer to me. Even the mental health professionals ("MHP's") and other medical staff often misgender me. They do not seem to know very much at all about treating gender dysphoria.

12. I feel unsafe on my cell block and I'm verbally harassed on a daily basis because I am a woman in a men's facility and am targeted in multiple ways. This harassment makes me fear for my physical safety and it is dehumanizing. I eat all my meals in my cell because I am afraid of being harassed, attacked, or even raped.

13. Every day my requests for gender affirming surgery, hormone monitoring, gender affirming clothing, and being able to be myself in a women's facility go ignored, I feel myself slipping into a deeper depression. I am struggling with constant thoughts of self-harm because IDOC continues to deny me medical treatment I need for my gender dysphoria.

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

Dated: 4/26/19



Sora Kuykendall

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, and SASHA REED, Plaintiffs, v. JOHN BALDWIN, STEVE MEEKS, and MELVIN HINTON, Defendants.	)	Civil No. 3:18-cv-00156-NJR-MAB

DECLARATION OF SASHA REED

I, Sasha Reed, hereby state:

1. I am a 27-year-old woman raised outside of Chicago, Illinois. When I was three years old, the Department of Child and Family Services ("DCFS") took me away from my mother after a fire broke out in our home. My aunt adopted me in 1999. Two years later, I was sent to Maryville Academy, a residential institution for children who have experienced abuse, located in Des Plaines, Illinois. I was later moved to Allendale Association, another residential institution for children who have experienced abuse, in Lake Villa, Illinois. Around 2004, while I was living at Allendale Association, I started to identify and present in private as female, and I told a therapist that I felt I was female. In 2011, I was moved to a transitional living program in Chicago, Illinois. By that time, I was consistently presenting as female in private, but not in public.

2. I entered the Illinois Department of Corrections ("IDOC") in July 2013. During the intake process at Stateville Correctional Center, I told a female corrections officer that I am transgender. However, IDOC never referred me to a Mental Health Professional ("MHP") at

Stateville, and my gender dysphoria was left untreated. Because I was not getting treatment, I tried to hurt myself on several occasions, including a suicide attempt in July 2013.

3. In March 2015, I was transferred to Menard Correctional Center. In November 2015, I told a MHP that I am transgender and requested hormone therapy. The MHP asked me to fill out a questionnaire and told me that it would be reviewed by IDOC's Gender Identity Committee ("GID Committee"). In February 2016, the GID Committee denied my request for hormone therapy because they said they needed to "rule out a psychotic process." The GID Committee, along with the MHP, misdiagnosed my gender dysphoria as schizophrenia. The GID Committee told me I had to wait six weeks while they investigated my "conceptualization of gender identity." Instead of six weeks, IDOC made me wait sixteen months before finally starting hormone therapy in March 2017.

4. During the months I waited to receive hormone therapy, my MHP told me that the GID Committee was reviewing my request, but there were delays because the GID Committee often cancelled their meetings. My MHP also told me that I was required to be off of Zoloft, Sertraline and Loxitane for before I started hormone therapy to evaluate any psychotic behaviors or symptoms. Even after I stopped taking these medications for over 3 months and showed no psychotic symptoms or behaviors, the GID Committee did not approve hormone therapy.

5. In December 2016, I filed a grievance requesting gender-affirming surgery, private shower accommodations, feminine grooming and cosmetic products, and a bra. While I was given access to a private shower, IDOC denied the rest of my grievance because the GID Committee should be the one making recommendations regarding my care, rather than my MHP. However, the GID Committee did not address these requests. My MHP told me I was not allowed to have a bra until I was on hormone therapy.

6. In February 2017, I filed an additional grievance requesting feminine grooming products and a bra. My grievance was denied because these things were not considered a "medical necessity" and because I was in a male facility.

7. In March 2017, the GID Committee approved hormone therapy after a sixteen-month delay from the date I first requested it.

8. In June 2017, I was transferred to Lawrence Correctional Center, where I was designated as vulnerable and housed in a single cell. I felt unsafe and uncomfortable in any unit. The sexual harassment and lack of treatment for my gender dysphoria made me feel unsafe and overwhelmed, and I was placed on crisis watch. While the hormone therapy did make me feel less depressed and anxious, to this day I still do not believe that I am receiving the proper dosage of hormones. I have repeatedly made requests to increase my hormone dosage, including when I was on crisis, but my requests were denied. IDOC does not routinely perform bloodwork to monitor my hormone levels to make sure they are safe and effective to treat my gender dysphoria.

9. I experience constant harassment from other inmates, who make sexual comments to me, try to grab my body, and ask to touch my breasts. In October 2017, I filed a Prison Rape Elimination Act ("PREA") complaint about this harassment.

10. Around March 2018, I was removed from crisis watch and returned to general population housing. I regularly took hormones, attended school, and did not have thoughts of self-harm. I requested to be removed from vulnerable status so that I would be able to get a job and have a cellmate. My primary MHP advised me to submit a written request, but explained that the process would take time. I am still classified as vulnerable, making it difficult for me to get a job. I also have not been assigned a cellmate and often feel lonely and very isolated. I believe that my gender identity contributes to my lack of options regarding jobs and cellmates.

11. In April 2018, I requested a new primary MHP because I did not believe my current MHP was properly addressing my needs and requests regarding my hormone dosage and options for jobs and cellmates. I was told that I must continue to work with my current MHP, even though the MHP seems to know very little about how to treat gender dysphoria.

12. I also have requested gender-affirming surgery, and filed multiple grievances requesting it, but IDOC has not taken any of my requests seriously. Despite my requests and grievances, I have never even been evaluated for surgery. I hate having male genitalia because I feel like I am in the wrong body. I am desperate to have surgery because I believe it will make me feel less depressed about my body.

13. It is extremely hard for me not to receive the treatment I need to be able to experience life as a woman at IDOC. Even with hormone therapy and a bra, I continue to be denied additional medical treatment that I believe would help my gender dysphoria. I continue to be extremely disturbed by my genitalia. I am housed in a male facility, regularly searched by male guards, and am not allowed access to gender-affirming grooming items. I am not allowed to wear any female clothing or undergarments except for a bra. Both inmates and IDOC staff are consistently disrespectful of my gender identity, calling me by male pronouns and a male name. There are only a couple of officers that refer to me as a woman. I am continuously sexually harassed by inmates. I often feel unsafe because I am housed in a male facility. I believe that I would be able to live as a woman and without harassment and threats in a female facility.

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

Dated: 04-25-19

Sasha Reed