IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JESSICA HICKLIN, Plaintiff, *v.* GEORGE LOMBARDI, et al., Defendants.	Case No. 4:16-CV-01357-NCC

DECLARATION OF DR. RANDI C. ETTNER

1. I, Dr. Randi C. Ettner, am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria.

2. I have been retained by counsel for Jessica Hicklin ("Ms. Hicklin") to provide the Court with scientific information about gender dysphoria and the standard of care for treatment, and to perform a clinical evaluation of Jessica Hicklin. Except where noted, I have actual knowledge of the matters herein and could and would testify if called as a witness.

Qualifications and Basis of Opinion

3. I received my doctorate in psychology from Northwestern University in 1979. I have been the chief psychologist at the Chicago Gender Center since 2005, which specializes in the treatment of individuals with gender dysphoria. I have been involved in the treatment of patients with gender dysphoria since 1977, when I was at intern at Cook County Hospital in Chicago.

4. During the course of my career, I have evaluated and/or treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance.

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* (Ettner, Monstrey & Eyler, 2007) and the second edition (Ettner, Monstrey & Coleman, 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of care to this population. I serve as a member of the editorial boards for the *International Journal of Transgenderism* and *Transgender Health.*

6. I am the Secretary and member of the Executive Board of Directors of the World Professional Association for Transgender Health ("WPATH") (formerly the Harry Benjamin Gender Dysphoria Association) and an author of the *WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People*, 7th version, published in 2012. The WPATH promulgated Standards of Care ("Standards of Care") are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

7. I have lectured throughout North America, Europe, and Asia on topics related to gender dysphoria, and on numerous occasions I have presented grand rounds on gender dysphoria at medical hospitals. I am an honoree of the *Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota*, and have been an invited guest at the National Institutes of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities.

8. I have been retained as an expert regarding gender dysphoria and its treatment in multiple federal court proceedings involving the treatment of gender dysphoria in prison settings, and have repeatedly qualified as an expert.

9. My clinical consulting fee in this is case is $300 USD per hour.

10. In preparing this declaration, I have relied on my clinical interview and evaluation of Ms. Hicklin on January 27, 2017, the results of psychodiagnostic exams, Ms. Hicklin's mental health and medical records, my extensive professional experience, and my review of the medical literature, including my own, related to gender dysphoria over the past three decades. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

11. A true and accurate copy of my Curriculum Vitae is attached hereto as **Appendix A**. A bibliography of the materials reviewed in connection with this declaration is attached hereto as **Appendix B**.

Background on the Diagnosis and Treatment of Gender Dysphoria

12. Gender Dysphoria (previous nomenclature was gender identity disorder) is a serious medical condition codified in the *International Classification of Diseases* (10th revision: World Health Organization) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (DSM-5).

13. Individuals with gender dysphoria, who are often referred to as "transgender" or "transsexual," experience incongruence between their innate sense of belonging to a particular gender and the sex assigned to them at birth, along with clinically significant distress or impairment of functioning resulting from this incongruence. The suffering that arises from this condition has often been described as "being trapped in the wrong body." "Gender dysphoria" is the psychiatric term for the severe and unremitting emotional pain associated with this condition.

14. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six 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.

15. Without treatment, individuals with gender dysphoria experience anxiety, depression, suicidality and other attendant mental health issues (*See, e.g.*, Fraser, 2009; Schaefer & Wheeler, 2004; Ettner, 1999; Brown, 2000; DSM-V, 2013; Haas, *et al.*, 2014). Without

treatment, many gender dysphoric people are unable to adequately function in occupational, social or other areas of life. A recent survey found a 41% rate of suicide attempts among this population, which is far above the baseline rates for North America of 4.6% (Haas et al, 2014).

16. Gender dysphoric individuals without access to appropriate care, particularly those who are imprisoned, 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, 2010; Brown & McDuffie, 2014).

17. Gender dysphoria intensifies with age. Individuals commonly experience an intensification of symptoms at midlife, when cortisol rises and breaks down the precursors to circulating sex steroids (Ettner & Wylie, 2013; Ettner, 2013).

18. The medically accepted standards of care for treatment of gender dysphoria are set forth in the *WPATH Standards of Care* (7th version, 2011), first published in 1979. The WPATH promulgated Standards of Care are the internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform medical treatment throughout the world.

19. 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 *National Commission of Correctional Health Care,* 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 WPATH standards. (*See, e.g.*, American Medical Association (2008) Resolution 122 n(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).)

20. The Standards of Care identify the following treatment protocols for treating individuals with gender dysphoria, which should be tailored to the patient's individual medical needs:

- Changes in gender expression and role (which involves living in the gender role consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body in order to reduce the distress caused by the discordance between one's gender identity and sex assigned at birth;
- Surgery to change primary and/or secondary sex characteristics; and
- 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.

21. Once a diagnosis of gender dysphoria is established, individualized treatment should be initiated.

22. The Standards of Care specify the qualifications professionals must meet in order to provide care to gender dysphoric patients. In particular, the WPATH Standards of Care stipulate that a mental health professional must have "[k]nowledge about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria," and obtain continuing education in the assessment and treatment of gender dysphoria. The Standards of Care establish that professionals who are new to the field should work under the supervision of mental health professionals with established expertise in this area. Treatment plans generated by

providers lacking the requisite experience can result in inappropriate care or place patients at significant medical risk. (Standards of Care, Section VIII.)

23. The treatment of incarcerated persons with gender dysphoria has been addressed in the Standards of Care since 1998. As with protocols for the treatment of diabetes or other medical conditions, medical management of gender dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons.

24. For this reason, the WPATH Standards of Care expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients in prison, and appropriate candidates for cross-sex hormonal therapy should not be denied solely on their institutional status:

> The [Standards of Care] in their entirety apply to all transsexual, transgender and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments, such as prisons . . . (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community. All elements of assessment and treatment as described in the SOC [Standards of Care] can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess and/or treat people with gender dsyphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care . . . People with gender dysphoria who are deemed appropriate for hormone therapy should be started on such therapy. . . The lack of initiation of hormone therapy when medically necessary includes a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria and/or suicidality.
>
> (Section XIV.)

25. The Standards of Care have also been recognized by the National Commission on Correctional Health Care ("NCCHC") as the clinically accepted standards for the care of inmates with gender dysphoria. (NCCHC Policy Statement, Transgender Health Care in Correctional Settings (October 18, 2009), available at http://www.ncchc.org/transgender-health-care-in-correctional-settings.)

Changes in Gender Expression and Role

26. The Standards of Care establish the therapeutic importance of changes in gender expression by means of social signifiers that align with gender identity. Clothing and grooming that affirm one's gender identity and the use of congruent pronouns, are critically important components of treatment protocols. (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007.)

27. The Standards of Care also specifically provide that permanent body hair removal, the elimination of a visible secondary sex characteristic, is significant in alleviating gender dysphoria. (Section V.)

Hormone Therapy

28. For individuals with persistent, well-documented gender dysphoria, hormone therapy is an effective, essential, medically indicated treatment to alleviate the distress of the condition. (Section VIII.)

29. The medical and scientific community concur that hormone therapy, provided in accordance with the WPATH Standards of Care, is the medically necessary, evidence-based, best practice treatment modality for most patients with gender dysphoria.

30. The goals of hormone therapy in a transgender female person (i.e., someone assigned male at birth but whose gender identity is female) are to (1) significantly reduce

hormone production associated with the person's birth sex, causing the unwanted secondary sex characteristics to recede, and (2) to replace the natal, circulating sex hormones with feminizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (i.e., those born with insufficient sex steroid hormones). (*See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline; 2009.)

31. The therapeutic effects of hormone are twofold: (1) with endocrine treatment, the patient acquires congruent secondary sex characteristics, i.e., for transgender women, breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (2) hormones act directly on the brain, via receptor sites, attenuating the gender dysphoria and attendant psychiatric symptoms, including suicidality, anxiety, depression, and impulses to engage in auto-castration, autopenectomy, or other acts of self-harm. (*See, e.g.*, Cohen-Kettenis & Gooren, 1992.)

32. Decades of scientific research have validated the many benefits of hormonal therapy for gender dysphoric patients. As early as 1980, researchers demonstrated that gender dysphoric patients living without hormonal treatment showed greater psychopathology than patients who received hormonal treatment; and greater adjustment was associated with longer periods of treatment (Leavitt et al). Untreated patients exhibit much higher levels of depression, anxiety, and social distress. (Rametti, *et al.*, 2011; *see also* Colizzi, *et al.* 2014; Gorin- Lazard *et al.*, 2011.) Hormonal treatment improves overall health in gender dysphoric patients and is associated with a better quality of life (Gomez-Gil et al. 2011; Colizzi et al 2013; Gorin-Lazard et al 2012).

33. The American Medical Association, the Endocrine Society, the American

Psychiatric Association and the American Psychological Association also all agree that hormone therapy 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).)

Surgical Interventions

34. The WPATH Standards acknowledge that while many gender dysphoric individuals experience profound relief with hormone therapy and changes in gender expression alone, for others, relief from gender dysphoria cannot be achieved absent gender confirmation surgery. Such surgical interventions modify primary/and or secondary sex characteristics, and more than three decades of scientific research have documented the safety and efficacy of surgical therapy. (See, eg., Pfafflin & Junge, 1998; Smith *et al*., 2005; Jarolim *et al*., 2009.) For those individuals who require surgical intervention, the Standards of Care set forth the eligibility and readiness criteria that precede referral. (Section XI.)

Psychotherapy

35. Psychotherapy can provide support for the many issues that arise in tandem with gender dysphoria. However, psychotherapy alone is not a substitute for medical intervention when medical intervention is required, nor is it a precondition for medically indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing psychoeducation about living with chronic illness and nutritional information, but counseling doesn't obviate the need for insulin.

36. Merely providing counseling and/or psychotropic medication to a severely gender dysphoric patient is a gross departure from medically accepted practice. Inadequate treatment of this disorder puts an individual at serious risk of psychological and physical harm (WPATH Medical Necessity Statement, 2016).

37. Individuals with gender dysphoria often have co-occurring psychiatric disorders. Such disorders should be treated appropriately, but do not obviate the need for medically necessary treatment for gender dysphoria.

Clinical Observations

38. At the request of counsel, I met with and conducted an approximately three-hour clinical assessment of Jessica Hicklin at the Potosi Correctional Facility in Mineral Point, Missouri on January 27, 2017. The interview took place in a visitors' area equipped with a table and chairs, and I was afforded all the necessary courtesies by staff.

39. My assessment consisted of a clinical interview and the administration of four standardized psychodiagnostic tests with high levels of validity and reliability: the Beck Depression Inventory-II, the Beck Anxiety Inventory, the Beck Hopelessness Scale, and the Traumatic Symptom Inventory-2.

40. In addition to the clinical assessment, which includes mental and physical history, behavioral observations and relevant background information, I also conducted a complete sex and gender history (Pomeroy, Flax & Wheeler, 1982).

Relevant Background History

41. Ms. Hicklin was the youngest of three children. Her parents divorced when she was 6 months old. Her childhood was tumultuous and marked by physical and sexual abuse. An abundance of research has found that childhood exposure to violence leads to negative outcomes

(Benhorin & McMahon, 2008; Henning et al, 1997; Kliewer et al, 2006; Mazefsky & Farrell, 2005; Sullivan, Kung, & Farrell, 2004; White & Smith, 2009).

42. Ms. Hicklin began using drugs at a young age and entered drug rehabilitation at 13, where she was diagnosed with bi-polar traits, conduct disorder, and poly-substance abuse. At 16, Ms. Hicklin was incarcerated and sentenced to life without parole.

Sexual and Gender History

43. Ms. Hicklin relates that by age 5 or 6 she was sneaking into her stepmother's and sister's closets. Her sister would dress Ms. Hicklin in female clothing, a game they both enjoyed. Although Ms. Hicklin's father insisted that she play sports, Ms. Hicklin always preferred female playmates and activities.

44. From an early age, Ms. Hicklin felt "different" than male peers, having the sense that her anatomy was "wrong." As a youngster, understandably, Ms. Hicklin did not know why these perplexing feelings of gender incongruence arose. Growing up in a small town, she was even unaware of the existence of "gay people." She had suffered sufficient abuse, however, to ensure she conformed to stereotypical gender roles and act "macho."

45. Ms. Hicklin relates three incidents of sexual assault by other inmates during her incarceration, and has a history of childhood sexual abuse. She denies paraphilic fantasies. Her sexual interest is limited to consenting adults.

46. Ms. Hicklin avoids contact with her genitals, and, typical of incarcerated gender dysphoric individuals without access to care, she has thoughts of removing them. On one occasion, Ms. Hicklin tried to amputate her testicles with a tourniquet, but was stopped by the awareness of the consequences--lengthy isolation in administrative segregation (which would,

among other things, prevent her from having weekly contact with her terminally ill mother) and a lack of necessary tissue for future surgical treatment.

47. A review of records indicates that providers in the correctional system have consistently diagnosed Ms. Hicklin with Gender Dysphoria (302.85 in DSM-5).

48. Many people do not come to the realization that they are transgender or are suffering from the recognized medical condition of gender dysphoria until later in life. This is particularly true for people who have been institutionalized from a young age.

Medical History

49. Ms. Hicklin's medical history is significant for tachycardia and vitamin D deficiency. During her incarceration she has been prescribed numerous psychotropic medications. Recently she was prescribed propranolol for tachycardia (propranolol slows heart rate). Propranolol has no efficacy in the anxiety pertaining to the symptom constellation of gender dysphoria.

History of Suicidality

50. Ms. Hicklin has a history of suicide ideation and two suicide attempts. At the behest of the Surgeon General, a plan for identifying populations at risk for suicide, and advancement of scientific methods to assess risk, has resulted in recent abundant scientific investigation. Several lines of research suggest that single suicide attempters differ significantly from multiple suicide attempters. Multiple attempters, and those who engage in method switching, as Ms. Hicklin has, are far more likely to die by suicide than are single attempters.

Mental Status Exam

51. Jessica Hicklin appeared well groomed, wearing prison-issued garments. At 6 feet, one inch and 175 pounds, with very long hair and shaped eyebrows, she makes an authentic

and decidedly female presentation. Ms. Hicklin was alert, cooperative, and oriented in all spheres. She was able to sit comfortably throughout the lengthy interview without a break, and with no agitation or restlessness. There are no disorders of thought or affect and thought processes were logical, goal directed and without distortion. Affect was appropriate to context. Ms. Hicklin maintained eye contact throughout, and rapport was easily established. Speech is well modulated and in a female range; language is fluent. Memory and abstract reasoning are well within normal limits. Intelligence (by estimation) is well above average. Ms. Hicklin is a high-functioning inmate, having used skill and intellect to create and implement various programs that benefit inmates and the institution.

Psychological Test Results

52. Four standardized psychometric indices with high levels of reliability and validity were administered to corroborate the clinical assessment. Ms. Hicklin experiences moderately severe depressive symptoms. These include changes in appetite and sleep irritability, loss of energy, suicidal thoughts, fatigue, and agitation. These symptoms represent somatic and affective symptoms of depression, not subject to voluntary control or cognitive reappraisal.

53. Research has shown that it is clinically imperative to be attentive to test responses that indicate suicide ideation; and patients admitting to suicide ideation and pessimism should be closely scrutinized for suicide potential. Ms. Hicklin scored a *26* on the *Beck Depression Inventory*. To put this in context, one study demonstrated that scores of *23* and above were predictive of patients who ultimately committed suicide.

54. Of equal concern is the high level of anxiety Ms. Hicklin is experiencing. Symptoms are predominantly somatic and panic-related aspects of anxiety, *e.g.* "numbness or tingling," "shaky," "difficulty breathing," etc. This symptom constellation also appears on

measures of trauma, and is associated with an overactivation of the sympathetic nervous system, such as jumpiness, hypervigilance, irritability and sleep disturbance. These scores signal muscle tension, hyperalertness and hyperreactivity to stress; states that are very aversive and motivate avoidance strategies, such as self-harm. Ms. Hicklin's level of responding is at a *T* score of *73.* To provide context, *T* scores from *60-64* are considered problematic (i.e., above average symptom endorsement that is likely to have clinical implications), and those above *65* are considered clinically elevated (i.e., symptom endorsement that is of sufficient extremity that it represents a significant clinical concern).

Clinical Assessment

55. Jessica Hicklin has intractable, untreated gender dysphoria (302.85; DSM-5), a serious medical condition.

56. Given that a high percentage of inmates with untreated gender dysphoria perform autocastration or commit suicide, lack of appropriate care places her at extremely high risk. This is compounded by Ms. Hicklin's other risk factors for self-harm and suicide.

57. Ms. Hicklin has been denied medically necessary treatment, despite a well-established diagnosis and the recommendation of at least two psychiatrists, as evidenced by communications to Ms. Hicklin from prison medical staff stating: "You received a mental health diagnosis of Gender Dysphoria on March 23, 2015. . . . You were educated at that time that you would not receive hormone therapy for this diagnosis."

58. Medical records show that, instead of medical treatment, Ms. Hicklin is offered psychotherapy for anxiety—*the anxiety that stems from lack of treatment*:

> The treatment team agrees with the Standards of Care, in regard to mental health professionals helping clients become psychologically prepared in every way as they consider hormone therapy. This preparation would also

> include recently being told that you would not receive hormone therapy treatment and being able to process this news.

This is akin to informing a diabetic patient that they will not be receiving insulin, but a therapist will assist with processing the distress of diabetic ketoacidosis and coma.

59. The medical records document that lack of appropriate treatment for gender dysphoria is causing Ms. Hicklin to experience serious psychological and physical symptoms including panic attacks, anxiety, racing heartbeat (tachycardia), shortness of breath, sleep disturbance, lack of appetite, headaches, and excessive sweating. She also experiences intrusive thoughts of cutting off her testicles, and has attempted to amputate them with a tourniquet, as she realistically worries about the prolonged effects of high levels of circulating testosterone, knowing it is the source of her anatomical dysphoria.

60. Ms. Hicklin's symptoms, including the intrusive thoughts about and attempt at auto-castration, are *a priori* evidence of severe untreated gender dysphoria, and are the inevitable and predictable consequences of denying the medically necessary treatment she requires. To date, no inmate receiving appropriate medical care has attempted auto-castration.

61. Results of psychodiagnostic testing confirm that Ms. Hicklin meets the criteria for moderately severe depression, with symptoms including changes in appetite and sleep, irritability, loss of energy, suicidal thoughts, fatigue, and agitation.

62. Ms. Hicklin also experiences a high level of anxiety with predominantly somatic and panic-related symptoms, including "numbness or tingling," "shaky," "difficulty breathing," etc. This symptom constellation also appears on measures of trauma, and is associated with an overactivation of the sympathetic nervous system, such as jumpiness, hypervigilance, irritability and sleep disturbance. These scores signal muscle tension, hyperalertness and hyperreactivity to stress; states that are very aversive and motivate avoidance strategies, such as self-harm.

63. With appropriate medical treatment for gender dysphoria, all of the aforementioned psychological symptoms would be attenuated or eliminated. Hormones regulate all bodily functions, and act primarily on the brain. The stimulus for hormone release is complex, originating in the hypothalamus and prompting the pituitary to act on the endocrine glands: the thyroid, parathyroid, pancreas, adrenals, and gonads. Those polypeptides then circulate in the blood stream, acting on organ systems such as the pancreas, to produce insulin, which in turn acts on a cellular level, mediating the response on target organs. The roles of the hormone insulin in diabetes, or cortisol in Addison's disease, are mundane examples of the intricate interplay of psychological and somatic disorders that rely on precisely titrated hormonal interventions.

64. The Standards of Care are disseminated worldwide for the purpose of issuing clinical guidance to health professionals who provide treatment. According to the Standards of Care, if and when an individual meets the criteria for gender dysphoria, a formal diagnosis is established.

65. Ms. Hicklin meets the diagnostic criteria for gender dysphoria, a fact corroborated by her medical records. Once a diagnosis is established, medical treatment options are initiated. The Standards of Care state that individuals "should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services." (Section VII.)

66. Ms. Hicklin has not received medical care in accordance with the Standards of Care. She received a diagnosis, but has been repeatedly denied indicated treatment. Continuing to withhold essential medical treatment places Ms. Hicklin at risk for irreparable psychological impairment, self-harm, and suicide.

67. The records I reviewed corroborate my clinical assessment. At least two prison psychiatrists have determined that Ms. Hicklin requires medical treatment, *i.e.*, hormonal therapy. She also requires permanent body hair removal, and access to feminine commissary items. These psychiatrists have accurately assessed the likely risks of failing to provide medically indicated treatment: Ms. Hicklin is in imminent danger of severe mental health deterioration, self-harm, and suicide.

68. Based on records reviewed, including medical records and the court documents filed to date (including the Defendants' Answers to Ms. Hicklin's Complaint), it appears the Missouri Department of Corrections has a policy or practice of providing hormone therapy only to those transgender inmates who were receiving such therapy prior to incarceration. This is commonly referred to as a "freeze frame" policy.

69. The refusal to treat a medical condition because it wasn't treated or was improperly treated prior to incarceration is anathema to ethical health care delivery. By analogy, if a patient is diagnosed with diabetes while incarcerated, is insulin withheld because it wasn't provided prior to incarceration?

70. In recognition of the hazards of the "freeze frame" approach, the Standards of Care explicitly state that a "freeze frame" approach is not considered appropriate care:

> People with gender dysphoria who are deemed appropriate for hormone therapy (following the [Standards of Care]) should be started on such therapy. The consequences of . . . lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by auto-castration, depressed mood, dysphoria, and/or suicidality.

(Section XIV.)

71. The National Commission on Correctional Healthcare ("NCCHC") recommends that the medical management of prisoners with gender dysphoria "should follow accepted standards developed by professionals with expertise in transgender health," citing the Standards of Care. The NCCHC also explains that "policies that make treatments available only to those who received them prior to incarceration or that limit transition and/or maintenance are inappropriate and out of step with medical standards and should be avoided." (NCCHC Policy Statement, Transgender Health Care in Correctional Settings (adopted October 18, 2009 and reaffirmed with revision, April 2015), available at http://ncchc.org/transgender-transsexual-and-gender-nonconforming-health-care.)

72. Refusing to provide appropriate medical care to an individual because they did not receive treatment prior to incarceration is medically indefensible. Applying such a policy to Ms. Hicklin's case is particularly egregious because she entered prison in the 1990s, at age sixteen. Since evidence-based protocols for treatment of adolescents were not established in the U.S. until 2009 (Hembree), it would have been impossible for Ms. Hicklin to have received treatment before entering the Missouri Department of Corrections.

Treatment Recommendations

73. The treatment of Ms. Hicklin's gender dysphoria solely by means of psychotherapy and/or psychotropic drugs is a gross departure from the evidence-based Standards of Care.

74. Without proper treatment, Jessica Hicklin is at imminent risk for serious psychological harm. She is presently overloaded by symptoms that signal a highly disruptive state. Elevations of autonomic hyperarousal, and dysregulation of mood, left untreated in a

severely gender dysphoric individual become chronic aversive experiences that devolve into an ingravescent course.

75. Ms. Hicklin requires immediate initiation of feminizing hormone therapy to treat the dysphoria, concomitant depression, anxiety, intrusive thoughts of self-harm, and suicidal ideation. Hormone therapy is the safe, efficacious medically necessary treatment she now urgently requires. A typical protocol consists of estrogens (transdermal or injectable), anti-androgens (e.g. spironolactone 100 mg per day) and ongoing monitoring via appropriate laboratory follow-up. All clinical care should be provided by clinicians with training and experience in this specialized area of medicine.

76. Once this treatment is initiated, Ms. Hicklin's ongoing care needs to be monitored and she should continue to be provided with medically necessary treatment as determined by appropriate mental health and medical providers who are experienced in the treatment and management of gender dysphoria.

77. Integral to successful treatment of gender dysphoria is the ability to present as a female. Therefore, Ms. Hicklin should also be allowed access to items and clothing available to female inmates, and effective, permanent means of body hair removal. She should be referred to with congruent gender pronouns, *i.e.*, "she" and "her."

78. There are no contraindications to the implementation of an appropriate treatment plan for Ms. Hicklin. The potential consequences of denying treatment, however, are predictable and grave.

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

Dated: March 17, 2017

Dr. Randi C. Ettner