Case Nos. 19-35017 & 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO, AKA Mason Edmo,
Plaintiff-Appellee,

v.

IDAHO DEPARTMENT OF CORRECTION, et al.,
Defendants-Appellants,

and

CORIZON, INC., et al.,
Defendants-Appellants

On Appeal from the United States District Court for the District of Idaho
The Honorable B. Lynn Winmill, *Chief Judge*
Case No. 1:17-cv-00151-BLW

MOTION FOR LEAVE TO FILE BRIEF OF *AMICI CURIAE* MEDICAL AND MENTAL HEALTH PROFESSIONAL ORGANIZATIONS IN SUPPORT OF PLAINTIFF-APPELLEE AND AFFIRMANCE

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MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE*

The eight medical and mental health professional organizations listed below ("proposed *amici*") move this Court for leave to participate as *amici curiae* in support of the Appellee, pursuant to Federal Rule of Appellate Procedure 29(a) and Circuit Rule 29-3. A proposed brief has been filed in conjunction with this motion. Proposed *amici* have endeavored to obtain the consent of all parties to file the brief. Only the Plaintiff-Appellee has consented.

INTEREST OF *AMICI CURIAE*

Proposed *amici* are eight leading medical, mental health, and other health care organizations: the American Medical Association ("AMA"); the American Medical Student Association ("AMSA"); the Endocrine Society; GLMA: Health Professionals Advancing LGBTQ Equality ("GLMA"); the HIV Medicine Association ("HIVMA"); the Lesbian, Bisexual, Gay and Transgender Physician Assistant Caucus ("LBGT PA Caucus"); Mental Health America ("MHA"); and the World Professional Association for Transgender Health ("WPATH").

Collectively, proposed *amici* represent thousands of medical and mental health professionals, including physicians and physician assistants, as well as specialists in internal medicine, mental health, and endocrinology. These potential *amici* share a commitment to improving the physical and mental health of all Americans—regardless of gender identity—and to informing and educating

lawmakers, the judiciary, and the public regarding the public health impacts of laws and policies.

ARGUMENT AND SUMMARY OF PROPOSED BRIEF

This Court "has broad discretion" to grant the participation of *amici curiae*, *see Hoptowit v. Ray*, 682 F.2d 1237, 1260 (9th Cir. 1982), *overruled on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995), and an *amicus* brief "should normally be allowed … when the amicus has unique information or perspective that can help the court beyond the help that the lawyers for the parties are able to provide," *Ryan v. Commodity Futures Trading Commission*, 125 F.3d 1062, 1063 (7th Cir. 1997) (citing *Miller-Wohl Co. v. Commissioner of Labor & Industry*, 694 F.2d 203 (9th Cir. 1982) (per curiam)); *see also Gerritsen v. de la Madrid Hurtado*, 819 F.2d 1511, 1514 n.3 (9th Cir. 1987) (granting "amicus status" in order to "avail[] ourselves of the benefit of ... thorough" arguments from an official with an important perspective).

In line with "the classic role of amicus curiae"—"assisting in a case of general public interest," *Miller-Wohl Co.*, 694 F.2d at 204—the proposed *amici* here desire to submit the enclosed brief to inform the Court of several issues uniquely within their expertise: the consensus among health care professionals regarding what it means to be transgender; the protocols for the treatment of people with gender dysphoria; and the potential predictable harms to the health and well-being of

inmates with gender dysphoria when they are denied adequate medical care. All of these issues are relevant to this appeal, yet no party has fully explored them in its briefing, and no party can speak to them with the same degree of expertise as the proposed *amici*. Thus, allowing amicus participation here would be desirable and help inform the Court as to matters relevant to the disposition of the case. *See* Fed. R. App. Proc. 29(a)(3)(B).

CONCLUSION

Prospective *amici* believe that their input may be of assistance to the Court in resolving the issues raised in this case and respectfully urge this Court to grant leave for *amici* to submit the attached brief.

Dated: April 10, 2019

Respectfully submitted,

JENNER & BLOCK LLP

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on April 10, 2019. Service on registered parties will be accomplished via the Court's ECF system.

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INTEREST OF *AMICI CURIAE*[1]

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Collectively, *amici* represent thousands of medical and mental health professionals, including physicians and physician assistants, as well as specialists in internal medicine, mental health, and endocrinology. *Amici* share a commitment to improving the physical and mental health of all Americans—regardless of gender identity—and to informing and educating lawmakers, the judiciary, and the public regarding the public health impacts of laws and policies.

Amici submit this brief to inform the Court of the consensus among health care professionals regarding what it means to be transgender; the protocols for the treatment of people with gender dysphoria; and the potential predictable harms to

[1] *Amici* hereby certify that no party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund preparation or submission of this brief; and no person other than *amici* and their counsel contributed money intended to fund preparation or submission of the brief.

the health and well-being of inmates with gender dysphoria when they are denied adequate medical care.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, *amici* state that none of them has a parent corporation, and that no publicly held corporation owns a 10% or more ownership interest in any of the *amici*.

SUMMARY OF ARGUMENT

Transgender individuals have a gender *identity* that is incongruent with the sex they were assigned at birth. The health care community's understanding of what it means to be transgender has advanced greatly over the past century. It is now well-understood that being transgender implies no impairment in a person's judgment, stability, or general social or vocational capabilities. According to recent estimates, approximately 1.4 million transgender adults live in the United States—0.6 percent of the adult population.

Gender *dysphoria*, in contrast, is a medical condition characterized by clinically significant distress and anxiety resulting from the incongruence between one's gender identity and the sex assigned at birth. Health care professionals that treat gender dysphoria have reached an international consensus: treatment should aim to assist the patient to live in accordance with his or her gender identity, and alleviate or avoid associated distress. Treatment may include any or all of the

following: counseling, social transition (through, *e.g.*, use of a new name and pronouns; new clothes and grooming; and use of single-sex facilities most consistent with the individual's gender identity), hormone therapy, and surgical interventions.

Proper care in the institutional context includes all of the range of treatments typically considered for patients with gender dysphoria, up to and including surgical intervention. The widely-accepted transgender health care protocols discussed extensively in this appeal (known as the "WPATH Standards of Care," as explained below) fully apply to the treatment of inmates at correctional facilities. Those protocols call for an individualized assessment of every patient with gender dysphoria, and recognize that a failure to follow an appropriate treatment plan can expose inmates with gender dysphoria to serious risks of psychological and even physical harm.

ARGUMENT

I. What It Means to Be Transgender and to Experience Gender Dysphoria

Transgender individuals have a "[g]ender identity"—a "deeply felt, inherent sense" of their gender—that is not aligned with the sex assigned to them at birth.[2]

[2] Am. Psychol. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psychologist 832, 834 (2015) [hereinafter "Am. Psychol. Ass'n Guidelines"]; *see also* David A. Levine & Comm. on Adolescence, Am. Acad. of Pediatrics Technical Report, *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, 132 Pediatrics e297, e298 (2013) [hereinafter "AAP Technical Report"]. Although most people have a gender identity that is male or female, some individuals have a gender identity that

Transgender people differ from cisgender (*i.e.*, non-transgender) individuals, whose gender identity aligns with the sex assigned at birth.[3]

Recent estimates suggest that approximately 1.4 million transgender adults live in the United States, or 0.6 percent of the adult population.[4] That said, "population estimates likely underreport the true number of [transgender] people."[5] People of all different races and ethnicities identify as transgender.[6] They live in every state, serve in our military, and raise children.[7] Gender identity is distinct from

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is "a blend of male or female[,] or an alternative gender." Am. Psychol. Ass'n Guidelines at 834.

[3] Am. Psychol. Ass'n Guidelines, *supra*, at 861.

[4] Andrew R. Flores et al., The Williams Inst., *How Many Adults Identify as Transgender in the United States?* 2 (2016), http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

[5] Am. Psychol. Ass'n Guidelines, *supra*, at 832.

[6] *See* Halley P. Crissman et al., *Transgender Demographics: A Household Probability Sample of US Adults*, 2014, 107 Am. J. Pub. Health 213, 214-15 (2017); Andrew R. Flores et al., The Williams Inst., *Race and Ethnicity of Adults Who Identify as Transgender in the United States* 2 (2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Race-and-Ethnicity-of-Transgender-Identified-Adults-in-the-US.pdf.

[7] Gary J. Gates & Jody L. Herman, The Williams Inst., *Transgender Military Service in the United States* (2014), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Transgender-Military-Service-May-2014.pdf; Sandy E. James et al., Nat'l Center for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 2 (2016), http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf; Rebecca L. Stotzer et al., The Williams Inst., *Transgender Parenting: A Review of Existing Research* (2014), http://williamsinstitute.law.ucla.edu/research/parenting/transgender-parenting-oct-2014.

and does not predict sexual orientation; transgender people, like cisgender people, may identify as heterosexual, gay, lesbian, bisexual, or asexual.[8]

The health care profession's understanding of gender has advanced considerably over the past fifty years. Throughout much of the twentieth century, transgender people were erroneously (but often) viewed as "perverse or deviant."[9] Medical practices during that period tried to "correct" this perceived deviance by attempting to force transgender people to live in accordance with the sex assigned to them at birth. These coercive efforts cause significant harm to the individuals subjected to them.[10] Such practices have since been explicitly rejected by leading medical professional organizations, and are now viewed as medically harmful and contrary to accepted treatment principles.[11]

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[8] Am. Psychol. Ass'n Guidelines, *supra*, at 835-36; James et al., Nat'l Center for Transgender Equality, *Report of the 2015 U.S. Transgender Survey*, *supra*, at 246.

[9] Am. Psychol. Ass'n, *Report of the APA Task Force on Gender Identity and Gender Variance* 26-27 (2008), https://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf [hereinafter "Am. Psychol. Ass'n Task Force Report"].

[10] Am. Psychol. Ass'n Task Force Report at 26-27; Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* 13, 25 (2015), https://store.samhsa.gov/system/files/sma15-4928.pdf.

[11] *See* Am. Med. Ass'n, Policy Number H-160.991, *Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations* (rev. 2018) ("Our AMA … opposes … the use of 'reparative' or 'conversion' therapy for sexual orientation or gender identity"), https://policysearch.ama-assn.org/policyfinder/detail/H-160.991?uri=%2FAMADoc%2FHOD.xml-0-805.xml; Hilary Daniel et al., *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians*, 163 Annals Internal Med. 135, 136 (2015) (same); AAP Technical Report, *supra*, at e301 ("An American

Much as the health care professions recognize that homosexuality is a normal form of human sexuality—and that stigmatizing gay people causes significant harm—we now recognize that being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[12]

A. Gender Identity

The term "[*g*]*ender identity* refers to a person's internal sense of being male, female," or another gender.[13] Every person has a gender identity,[14] which cannot be

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Psychological Association task force to review peer-reviewed studies on efforts to change sexual orientation concluded that conversion therapy is not effective and may be harmful to LGBT individuals by increasing internalized stigma, distress, and depression."); Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression* (2012) ("Psychoanalytic technique does not encompass purposeful attempts to 'convert,' 'repair,' change or shift an individual's sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes."), http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender.

[12] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2018), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Discrimination-Against-Transgender-and-Gender-Diverse-Individuals.pdf.

[13] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression* 1 (2014), https://www.apa.org/topics/lgbt/transgender.pdf.

[14] *See* Caitlin Ryan, Family Acceptance Project, *Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual, & Transgender Children*, 17 (2009), https://familyproject.sfsu.edu/sites/default/files/FAP_English%20Booklet_pst.pdf.

ascertained immediately after birth.[15] Many individuals develop stability in their gender identity between ages three and four.[16] But others may only "become aware of their transgender identities or begin to explore and experience gender-nonconforming attitudes and behaviors during adolescence or much later in life" after having "struggled to fit in adequately as their assigned sex."[17]

In contrast, "*gender expression* refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, voice, or body characteristics."[18] There are many individuals who depart from stereotypical male and female appearances and roles, but who are not transgender.[19] Indeed, most people who express their gender in a non-stereotypical or non-conforming manner are (or become comfortable with) the sex they were assigned at birth.[20] In contrast,

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[15] Am. Psychol. Ass'n Guidelines, *supra*, at 862.

[16] *Id*. at 841. "Although gender identity is usually established in childhood, individuals may become aware that their gender identity is not in full alignment with sex assigned at birth in childhood, adolescence, or adulthood." *Id*. at 836.

[17] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People*, *supra*, at 2.

[18] *Id*. at 1.

[19] *See id.*

[20] *See* World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* 5 (7th Version, 2012), https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf [hereinafter "WPATH Standards of Care"].

a transgender person "identif[ies] with a gender different from" the sex they were assigned at birth.[21]

B. Gender Dysphoria

Though not all transgender individuals experience it, many transgender individuals are diagnosed with gender dysphoria, a condition that is characterized by debilitating distress and anxiety resulting from the incongruence between an individual's gender identity and birth-assigned sex.[22] Because the patient's debilitating distress is the concern, medical intervention "focuses on dysphoria as the clinical problem, not identity."[23] Gender dysphoria is therefore "a description of something with which a person might struggle," like other medical conditions,[24] and is distinct from that person's identity.

1. The Diagnostic Criteria for and Seriousness of Gender Dysphoria

The Diagnostic and Statistical Manual of Mental Disorders codifies the diagnostic criteria for gender dysphoria as follows: "A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two" out of six criteria, *and* "clinically

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[21] Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 451 (5th ed. 2013) [hereinafter "DSM-5"].
[22] *Id.* at 451-53.
[23] *See id.*
[24] *See* WPATH Standards of Care at 5.

significant distress or impairment in social, occupational, or other important areas of functioning."[25] The six criteria include:

> (1) "A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics";
> (2) "A strong desire to be rid of one's primary and/or secondary 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[])";
> (5) "A strong desire to be treated" as a gender different from one's assigned gender; and,
> (6) "A strong conviction that one has the typical feelings and reactions" of a different gender.[26]

Similarly, the World Health Organization's International Classification of Diseases has recognized that gender dysphoria is "characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex."[27]

If untreated, gender dysphoria can contribute to debilitating distress, depression, impairment of function, substance use, self-mutilation to alter one's

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[25] DSM-5 at 452-53.

[26] *Id*. at 452.

[27] World Health Organization ("WHO"), International Classification of Diseases-10 F64.2 (2016 ed.), https://icd.who.int/browse10/2016/en#/F64.2. In its International Statistical Classification of Diseases-11, the WHO uses "gender incongruence" as the name for the gender identity-related diagnoses. Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clin. Endocrinology & Metabolism 3869, 3875 (2017).

genitals or secondary sex characteristics, other self-injurious behaviors, and suicide.[28] Transgender individuals also are frequently subjected to prejudice and discrimination in multiple areas of their lives, which exacerbates these negative health outcomes.[29]

2. The Accepted Treatment Protocols for Gender Dysphoria

Until the middle of the twentieth century, most mental health practitioners treated gender non-conforming people by attempting to make the patient's gender consistent with the sex assigned at birth.[30] There is no evidence that these methods alleviate gender dysphoria or that they can prevent someone from being transgender.[31] To the contrary, they can "often result in substantial psychological pain by reinforcing damaging internalized attitudes."[32] These methods can also

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[28] *See*, *e.g.*, DSM-5 at 455, 458.

[29] Michael L. Hendricks & Rylan J. Testa, *A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model*, 43 Prof'l Psychol.: Res. & Pract. 460 (2012); Jessica Xavier et al, Va. Dep't of Health, *The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians* (2007), http://www.vdh.virginia.gov/content/uploads/sites/10/2016/01/THISFINALREPORTVol1.pdf; Am. Psychol. Ass'n Guidelines, *supra*, at 832.

[30] Am. Psychol. Ass'n Guidelines, *supra*, at 835.

[31] *See* Substance Abuse and Mental Health Servs. Admin., *Ending Conversion Therapy*, *supra*, at 26.

[32] Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression*, *supra*.

damage family relationships and individual functioning by increasing feelings of shame.[33]

In the last few decades, people with gender dysphoria have gained widespread access to gender-affirming psychological and medical support.[34] For over 30 years, the generally-accepted treatment protocols[35] have aimed to alleviate the distress associated with the incongruence between gender identity and birth-assigned sex.[36] These protocols are laid out in the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Version 7)* developed by *amicus curiae* the World Professional Association for Transgender Health ("WPATH"),[37]

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[33] Darryl B. Hill et al., *An Affirmative Intervention for Families with Gender Variant Children: Parental Ratings of Child Mental Health and Gender*, 36 J. Sex & Marital Therapy 6, 10 (2010); Robert Wallace & Hershel Russell, *Attachment and Shame in Gender-Nonconforming Children and Their Families: Toward a Theoretical Framework for Evaluating Clinical Interventions*, 14 Int'l J. Transgenderism 113, 119-20 (2013).

[34] Am. Psychol. Ass'n Guidelines, *supra*, at 835; WPATH Standards of Care, *supra*, at 8-9. While *amici* write here about treatment for transgender people diagnosed with gender dysphoria in accordance with DSM-5, these gender-affirming treatments are also often necessary for transgender people diagnosed with gender incongruence in accordance with the most recent Endocrine Society treatment guidelines. *See, e.g.*, Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3869-72.

[35] Earlier versions of the DSM used different terminology, *e.g.*, gender identity disorder, to refer to this condition. Am. Psychol. Ass'n Guidelines, *supra*, at 861. But the term gender dysphoria "is more descriptive than the previous DSM-IV term gender identity disorder" because the "clinical problem" is the distress or dysphoria, not the patent's gender identity. *See* DSM-5 at 451.

[36] Am. Med. Ass'n, Comm. on Human Sexuality, *Human Sexuality* 38 (1972).

[37] WPATH Standards of Care, *supra*, at 1.

and relied upon by the district court in this case.[38] Many of the major medical and mental health groups in the United States recognize the WPATH Standards of Care as representing the consensus of the medical and mental health community regarding the appropriate treatment for transgender and gender dysphoric people.[39]

While each patient requires an individualized treatment plan that accounts for the patient's specific needs,[40] the recommended treatments for people experiencing gender dysphoria include assessment, counseling, and, as appropriate, social transition, hormone therapy, and surgical interventions to bring the body into alignment with the patient's gender identity.[41] Social transition—*i.e.*, living one's life fully in accordance with one's gender identity—is often a critically important part of treatment. This typically includes publicly identifying oneself as that gender;

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[38] *See* ER006-010.

[39] *See*, *e.g.*, Am. Psychol. Ass'n Task Force Report, *supra*, at 32; AAP Technical Report, *supra*, at e307-09.

[40] Am. Psychol. Ass'n Task Force Report, *supra*, at 32-33; s*ee also* WPATH Standards of Care, *supra* at 8 ("while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither"); *id.* at 9 (the "number and type of interventions applied and the order in which these take place may differ from person to person").

[41] Am. Psychol. Ass'n Task Force Report, *supra*, at 32-36; Am. Psychol. Ass'n, *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools* (2015), http://www.apa.org/about/policy/orientation-diversity.aspx; Am. Psychiatric Ass'n Workgroup on Treatment of Gender Dysphoria, *Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists* 16-18 (2016); AAP Technical Report, *supra*, at e307-09.

adopting a new name; using different pronouns; grooming and dressing in a manner typically associated with one's gender identity; and using restrooms and other single-sex facilities consistent with that identity.[42] The goal in this process is for the patient to "find a gender role and expression that are comfortable for them" and that better aligns with their identity.[43] Psychotherapy can help with this psychosocial process and provide "a space for clients to begin to express themselves in ways that are congruent with their gender identity," but therapy is often not an exclusive method of alleviating gender dysphoria.[44]

Indeed, for some people with gender dysphoria, hormone treatment to feminize or masculinize the body may be medically necessary.[45] *Amicus curiae* the Endocrine Society considers these treatments to be appropriate for many gender dysphoric individuals.[46] Hormone treatment alters the appearance of the patient's

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[42] AAP Technical Report, *supra*, at e308; Am. Psychol. Ass'n Guidelines, *supra*, at 840.

[43] WPATH Standards of Care, *supra*, at 9.

[44] *See id.* at 28-30.

[45] Am. Psychol. Ass'n Guidelines, *supra*, at 861, 862; Madeline B. Deutsch, Center of Excellence for Transgender Health, University of California, San Francisco, *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* 23 (Madeline B. Deutsch ed., 2d ed. 2016); WPATH Standards of Care, *supra*, at 33-34.

[46] *See* Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3869-70, 3870-72; *see also* Alessandra D. Fisher et al., *Cross-Sex Hormone Treatment and Psychobiological Changes in Transsexual Persons: Two-Year Follow-Up Data*, 101 J. Clinical Endocrinology & Metabolism 4260 (2016).

genitals and produces secondary sex characteristics such as increased muscle mass, increased facial hair, and a deepening of the voice in transgender men, and breast growth and decreased muscle mass in transgender women.[47]

Surgical interventions may also be an appropriate and medically necessary treatment for some patients.[48] These procedures could include chest reconstruction surgery for transgender men, breast augmentation (*i.e.* implants) for transgender women, or genital surgery.[49] Research indicates that surgical procedures can reduce

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[47] Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3888-89.

[48] One recent judicial opinion fails to accurately characterize the state of the medical profession's views on this subject. *See Gibson v. Collier*, No. 16-51148, __ F.3d __, 2019 WL 1417271 at *5-10 (5th Cir. Mar. 29, 2019) (drawing conclusions not from its own "sparse record" but rather from testimony presented more than a decade ago in the First Circuit); *but see id.* at *17-18 (Barksdale, J., dissenting) (explaining that the *Edmo* district court here gave "virtually no weight" to the views of "outliers in the field" on this factual matter (quotation marks omitted)); *see also Kosilek v. Spencer*, 889 F. Supp. 2d 190, 228-29 (D. Mass. 2012) (testimony concluded in 2008), *rev'd*, 774 F.3d 63 (1st Cir. 2014).

Peer-reviewed medical research establishes two vital points. First, where found appropriate for individual patients, "surgeries are medically necessary standard of care (SOC) treatment interventions" with a long history. Jordan D. Frey, et al., *A Historical Review of Gender-Affirming Medicine: Focus on Genital Reconstruction Surgery*, 14 J. Sexual Med. 991, 991 (2017). Second, empirical data show that surgery "is a safe modality for treating patients with gender dysphoria," one which has seen a "marked increase in case numbers" in the last decade likely due to "recent improvements in social climate and access to care." Bao Ngoc N. Tran, et al., *Gender Affirmation Surgery: A Synopsis Using American College of Surgeons National Surgery Quality Improvement Program and National Inpatient Sample Databases*, 80 Annals Plastic Surgery S229, S234 (2018).

[49] Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3893-95; *see also* WPATH Standards of Care, *supra*, at 57-58.

gender dysphoria and improve mental health.[50] Clinical assistance can thus take the form of "assessment, counseling, psychotherapy" and/or "hormonal and surgical treatments," depending on the needs of the individual patient.[51]

II. Failing to Extend Appropriate Services to Transgender Individuals in Correctional Institutions Endangers Their Health, Safety, and Well-Being

A. Transgender Inmates with Gender Dysphoria Must Receive Appropriate Treatment

Although the correctional context presents special challenges for transgender individuals, the appropriate medical treatments remain the same both in and out of prison: those set out in the WPATH Standards of Care including, when necessary, surgical intervention.

However, a transgender inmate's gender dysphoria may be exacerbated in prison. Incarcerated individuals—like Plaintiff Adree Edmo—are often assigned to correctional facilities based on the sex they were assigned at birth.[52] This means that

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[50] William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 Arch. Sexual Behav. 759, 778-81 (2012); Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014).

[51] WPATH Standards of Care, *supra* at 1.

[52] Anna Glezer et al., *Transgendered and Incarcerated: A Review of the Literature, Current Policies and Laws, and Ethics*, 41 J. Am. Acad. Psychiatry Law 551, 557 (2013) ("The rule for placement used in many U.S. correctional institutions is based on biological gender."); *see also* ER018 ("Ms. Edmo has been incarcerated at [Idaho State Correctional Institution ("ISCI")] since April 2012"); Appellant Br. at 4-5 (ISCI is a male prison).

transgender prisoners are forced to live in accordance with a gender label that conflicts with their identity, and must cope continuously with that source of stress. Transgender inmates also report instances of "harassment, isolation, forced sex, and physical assault"[53] in prison. And, critically, obtaining appropriate medical and psychological treatments "become much more complex for those who are incarcerated."[54]

Patients in prison require the same access to treatment as their non-institutionalized peers. Indeed, for transgender inmates who also struggle with gender dysphoria, the lack of access to adequate care can be very harmful or even life-threatening. Left "undiagnosed and untreated," an inmate's struggle with gender dysphoria can lead to genital mutilation or other attempts at self-harm.[55] One study that examined this phenomena concluded "that the salient characteristic common to all of these cases is denial of access to appropriate psychological evaluation and treatment in an institutional setting" that did not properly serve "severely gender dysphoric inmates."[56] The "loss of hope that more traditional transgender health

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[53] Am. Psychol. Ass'n Guidelines, *supra*, at 839.
[54] Glezer et al., *Transgendered and Incarcerated*, *supra* at 558.
[55] George R. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 Int'l J. Transgenderism 31, 32 (2010).
[56] *Id.* at 38.

care would be forthcoming" led inmates to attempt to provide themselves with that care through self-surgery, a dangerous course of action with "lethal potential."[57]

The National Commission on Correctional Health Care ("NCCHC"), a leading professional organization in healthcare delivery in the correctional context, has specifically stated that because correctional facilities have a responsibility to ensure the physical and mental health and well-being of inmates with gender dysphoria, "[a]ccepted treatments for gender dysphoria"—*i.e.* the range of treatment approaches described above, including surgical intervention "when determined to be medically necessary"—"should be made available to people with gender dysphoria" without the interference of "blanket administrative or other policies that restrict specific medical treatments."[58] "Providing mental health care, while necessary, is not sufficient."[59] Instead, the NCCHC has concluded, the "management of medical or surgical transgender care should follow accepted standards developed by

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[57] *Id.* Such despair can also lead to other forms of physical risks. *See, e.g.*, *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 158, 164–65 (D. Mass. 2002) (finding that "absent adequate treatment," transgender inmate with past history of self-harm was at risk of future suicide attempts); *De'Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003) (transgender inmate's "need for protection against continued self-mutilation constitutes a serious medical need to which prison officials may not be deliberately indifferent").

[58] National Commission on Correctional Health Care, *Position Statement: Transgender, Transsexual and Gender Nonconforming Health Care in Correctional Settings* at 2 (April 2015), https://www.ncchc.org/filebin/Positions/Transgender-Transsexual-and-Gender-Nonconforming-Health-Care.pdf.

[59] *Id.*

professionals with expertise in transgender health"—the WPATH Standards of Care.[60] The district court here included this fact in its findings.[61]

Indeed, the Standards of Care unequivocally apply to institutionalized individuals. The Standards "in their entirety apply to all transsexual, transgender, and gender-nonconforming people, irrespective of their housing situation."[62] And the Standards of Care themselves explicitly recognize that a failure to provide interventions where "medically necessary" can lead to "a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality."[63]

Thus *amici* and other professional health organizations agree on the same fundamental principles—1) that the widely-accepted standards of care in this area require individual diagnosis, assessment, and treatment of individuals with gender dysphoria,[64] and 2) that a failure to follow an appropriate treatment plan can expose

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[60] *Id.* at 2-3 (footnote omitted).
[61] ER016.
[62] WPATH Standards of Care, *supra* at 67.
[63] *Id.*
[64] A recent decision by the Fifth Circuit suggests that "a blanket ban" on certain medical treatments is permissible under the Eighth Amendment, and that it "defies common sense" for prisoners to contend that they are entitled to receive individualized assessments for serious medical needs. *See Gibson*, 2019 WL 1417271, at *1. Not only is individualized care a cardinal principle of the medical profession, *e.g.* American Medical Ass'n, *Code of Medical Ethics Opinion 1.1.3* ("Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment."), https://www.ama-assn.org/

transgender inmates with gender dysphoria to a serious risk of psychological harm and even physical harm if an inmate sees no other alternative left besides surgical self-treatment.

B. The District Court's Order Aligns with These Principles

The district court's order in this case, supported by an extensive series of factual findings, aligns with these principles and should be affirmed. The district court ordered the defendants "to provide Plaintiff with adequate medical care" beginning immediately.[65] Defendants are to "take all actions reasonably necessary to provide Ms. Edmo gender confirmation surgery as promptly as possible and no later than six months from the date of this order,"[66] in light of the fact that they had failed "to provide her with available treatment that is generally accepted in the field as safe and effective."[67] The district court found that the defendants had continued to deny Ms. Edmo proper treatment even though that denial imposed "actual harm and ongoing risk of future harm" given her personal history.[68]

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delivering-care/ethics/patient-rights; DSM-5 at 19 (the DSM is to be used in reaching "a fully informed treatment plan for each individual"), this Court has already held that the Eighth Amendment requires prisons to provide individualized medical care, *Colwell v. Bannister*, 763 F.3d 1060, 1068 (9th Cir. 2014) (an administrative policy of denying treatment "in the face of medical recommendations to the contrary … is the very definition of deliberate indifference").

[65] ER045.

[66] *Id.*

[67] *Id.* at 040.

[68] *Id.*

The district court reached these conclusions after determining that "Defendants' evidence to the contrary is unconvincing and suggests a decided bias against approving gender confirmation surgery."[69] The district court found plaintiff's experts credible.[70] It also found that the opinions of defendants' experts regarding the application of the WPATH Standards of Care could not be relied upon, and that the defendants misapplied those standards in this case.[71]

Amici are not in a position to determine what Ms. Edmo's treatment plan should be and express no opinion on that subject here. But this is not "[a] case about a difference of opinion over whether treatment is medically warranted."[72] Rather, the district court conducted a careful, systematic review of the extensive evidence submitted by the parties, and essentially concluded that "the course of treatment the doctors chose was medically unacceptable under the circumstances and the defendants chose this course in conscious disregard of an excessive risk to plaintiff's health."[73] That conclusion is consistent with the widely-accepted health care

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[69] *Id.* at 037.
[70] *Id.* at 036.
[71] *Id.* at 037-39.
[72] *Colwell*, 763 F.3d at 1068.
[73] *Compare id.* (citation and internal quotation marks omitted) *with* ER041–42 ("the decision not to address her persistent symptoms was medically unacceptable under the circumstances" and "without surgery, Ms. Edmo is at serious risk of life-threatening self-harm" (citations omitted)). Indeed, the copious factual findings in this case—which rebut many of the factual conclusions of the *Gibson* court and stand in stark contrast to the "sparse record" on which that court acted, *see Gibson*, 2019 WL 1417271, at *6—provide a more than adequate basis for this Court to affirm.

principles for treating gender dysphoric patients that fully apply in the correctional context.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge this Court to affirm the judgment of the district court.

Dated: April 10, 2019

Respectfully submitted,

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CERTIFICATES

Devi M. Rao, counsel for *amici curiae* (the American Medical Association ("AMA"); the American Medical Student Association ("AMSA"); the Endocrine Society; GLMA: Health Professionals Advancing LGBTQ Equality ("GLMA"); the HIV Medicine Association ("HIVMA"); the Lesbian, Bisexual, Gay and Transgender Physician Assistant Caucus ("LBGT PA Caucus"); Mental Health America ("MHA"); and the World Professional Association for Transgender Health ("WPATH")), hereby certifies that:

1. I am a member in good standing of the Bar of the United States Court of Appeals for the Ninth Circuit.

2. This Brief complies with the type-volume limitation in Rules 29(a)(5) and 32(a)(7)(B) of the Federal Rules of Appellate Procedure because, excluding the parts of the document exempted by Rule 32(f), this document contains 4,861 words.

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4. On this date, the foregoing Brief of *Amici Curiae* (for the AMA, AMSA, the Endocrine Society, GLMA, the HIVMA, the LBGT PA Caucus, MHA,

and the WPATH), was filed electronically and served on the other parties via the Court's ECF system.

Dated: April 10, 2019

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