IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA

ASHLEY DIAMOND,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. Action No. 5:15-cv-0050-MTT
	)	
BRIAN OWENS, et al.,	)	
	)	
Defendants.	)	

THIRD DECLARATION OF DR. RANDI C. ETTNER

1. I, Dr. Randi C. Ettner, am a clinical and forensic psychologist and an expert in the diagnosis and treatment of gender dysphoria with nearly 40 years of clinical experience. My experience and qualifications are set forth in my declaration of February 20, 2015, which also contains a copy of my curriculum vitae (*see* Doc. 2-1, Declaration of Dr. Randi C. Ettner), and in my declaration of May 18, 2015 (*see* Doc. 49-2, Second Declaration of Dr. Randi C. Ettner).

2. I have personally evaluated Ashley Diamond, the Plaintiff in this matter, and have reviewed Ms. Diamond's mental health and medical records.

3. I am over the age of 18, have actual knowledge of the matters stated herein, and could and would so testify if called as a witness.

Ms. Diamond's Treatment and Housing Plan

4. I have reviewed the treatment and housing plan developed for Ashley Diamond (the "Plan") as was filed under seal by the Georgia Department of Corrections and provided to me by counsel for Plaintiff on August 14, 2015.

5. The Plan, which purports to address Ms. Diamond's "problems," is diametrically opposed to evidence-based, best-practice medical care, to the WPATH Standards of Care, and to

the recommended treatment plan for this inmate. The adage that "the treatment is worse than the disease" is fully applicable in this case.

6. The proposed Plan belies an underlying ignorance of the clinical condition of gender dysphoria by presuming that "conflict . . . leads to self-injurious behavior and sporadic suicidal ideation," which is medically inaccurate.

7. The Plan's stated goal is that "Inmate Diamond will live with incongruity between his [sic] female gender identity and male anatomy without engaging in self-injurious behavior or suicide attempts for the next 6 months." Gender dysphoria is, by definition, the incongruity between female gender identity and male anatomy. That is the description of Ms. Diamond's diagnosis, not a treatment. It is as if, by analogy, one suggested that that the goal of treatment for the hypertensive patient is the live with the incongruity of a systolic blood pressure of 180 without cardiovascular accident.

8. Ms. Diamond's condition does not lead to self-injurious behavior and suicidal ideation. *It is the lack of appropriate treatment that leads to self-injurious behavior*.

9. Ms. Diamond transitioned to her affirmed gender (social role transition) and took feminizing hormones for decades prior to incarceration. That was—and remains—the medically-necessary treatment for her condition. It is only when deprived of this medically-indicated treatment that Ms. Diamond is at risk for self-injurious behavior.

10. To take the position that "coping strategies to include relaxations skills" and "cognitive behavioral therapy" are adequate or appropriate treatments for gender dysphoria is to mistake the symptom for the disorder.

11. The Plan's proposed treatment (i.e. relaxation and engaging in productive activities) has no medical efficacy or scientific basis. Indeed, a review of the literature fails to

yield a single study demonstrating any value in such behavioral strategies. Gender dysphoria is not a behavioral disorder. By analogy, the Plan is akin to treating a pulmonary fibrosis patient with relaxation techniques and counseling, but not providing oxygen.

The WPATH Standards of Care

12. The treatment of gender dysphoric patients is a specialized field of medicine, and is associated with a large body of scientific literature detailing ongoing improvements and refinements in care.

13. The standards of care for treating gender dysphoria are set forth in the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC). They are recognized as authoritative by the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the World Health Organization.

14. The National Commission on Correctional Health Care (NCCHC) also recommends treatment in accordance with the WPATH SOC for people in correctional settings.

15. The WPATH SOC identify (A) changes in gender expression and role and (2) hormone therapy to feminize the body as the most important components of treatment protocols.

16. The ability to live as a woman markedly attenuates psychopathology, which is why it is a crucial part of the medically-indicated treatment for gender dysphoria. It is widely recognized that the gender dysphoric individual suffers from the incongruity of appearance and identity, and the importance of living as female therefore cannot be minimized.

17. Counseling is not medically-indicated treatment for gender dysphoria. Although it can be useful in some cases, particularly in the very early stages of “discovery” and understanding the disorder, counseling cannot replace the medically-indicated treatment for gender dysphoria.

18. The SOC mandate that once a diagnosis is made, a treatment plan should be developed based on an individualized assessment of the particular patient. That plan, and all subsequent treatment, must be administered by clinicians qualified in treating patients with gender dysphoria.

19. The SOC specify the qualifications that professionals must meet in order to provide care to gender dysphoric patients (*See* Section VIII). In particular, the SOC provide that a mental health professional must have "knowledge 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.

20. Also of note is that the WPATH SOC mandates that "mental 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."

21. In addition to the minimum credentials above, clinicians working with gender dysphoric patients should develop and maintain cultural competence to facilitate their work.

22. Treatment plans and decisions developed and implemented by individuals lacking the requisite clinical experience can result in completely inadequate—even dangerous—care for patients with gender dysphoria.

Analysis of Ms. Diamond's Institutional Treatment and Housing Plan

23. Health care for people living in institutional environments should not differ from the care available in non-institutional settings. The SOC are explicit in this regard: "All elements of assessment and treatment as described in the SOC can be provided to people living in institutions. Access to these medically necessary treatments should not be denied on the basis of

institutionalization or housing arrangements . . . Denial of needed changes in gender role or access to treatments . . . are not reasonable accommodations under the SOC" (Section XIV).

24. The "*Treatment plan to assist in the mental health treatment of Offender Diamond while in Protective Custody*"—which consists largely of completing worksheets and deep-breathing—is a staggering display of ignorance regarding a complex medical disorder. Mental health providers who employ these ineffectual techniques are guilty of practicing outside their area of expertise, violating professional ethics, and revealing an absence of the most basic, foundational knowledge of this multi-disciplinary area.

25. Although issues of safety are a legitimate concern, protective custody, administrative segregation, and supermax facilities are extremely isolating living situations and are widely recognized to be damaging to individuals. Limited human contact and interaction are profoundly damaging to mental stability, health, and well-being. Even short periods of isolation produce documented psychological damage, including "intense anxiety, confusion, lethargy, panic, impaired memory, psychotic behavior, hallucinations, perceptual distortion, difficulty eating, inability to communicate, hypersensitivity to external stimuli, violent fantasies, and reduced impulse control."

26. Placing Ms. Diamond, a gender dysphoric individual who also suffers from PTSD, in an isolated environment is tantamount to condemning her to an ingravescent course of mental illness, especially given her history of suicidal ideation and self-injurious behavior in such circumstances.

27. Instead, the medically-indicated treatment for Ms. Diamond's gender dysphoria includes needed changes in gender role, including what is routinely provided or made available to female prisoners housed with females. This typically consists of undergarments, grooming

tools, and hairstyle modification, all of which allow for a female presentation and social signifiers.

28. Denial of such needed changes jeopardizes care and is not a reasonable accommodation.

Summary and Conclusion

29. Decades ago, some considered gender dysphoria to be a mental disorder. Presently, advances in brain research, particularly functional magnetic resonance imaging, indicate otherwise. Differences in the brain, most notably in the right hemisphere and parietal area, suggest that the condition is neurodevelopmental.

30. As a clinical and forensic psychologist who specializes in gender conditions, I have visited numerous state, federal, and military prisons throughout the United States. I have also been a consultant to policy makers regarding appropriate care of transgender inmates.

31. In this capacity, I routinely encounter inmates with access to the grooming aids and accoutrements available to female prisoners. These individuals live safely and comfortably housed among men. In every case, they serve their sentences while receiving the medical care—social role transition *and* hormone therapy—that undergirds identity consolidation and emotional well-being.

32. I have also had the distressing experience of witnessing the despair, self-harm, physical deterioration, and disabling psychological decompensation of inmates who are untreated or mistreated, whether due to ignorance or deliberate indifference. Sadly, some of these individuals decide that life with unremitting pain is worse than death.

33. I therefore emphatically reiterate my opinion—which I am confident is accurate to a reasonable degree of medical certainty—that the treatment and housing plan outlined for Ashley Diamond is medically contraindicated, and places her at dire risk for lifelong harm.

Pursuant to 28 U.S.C. § 1746, I hereby declare and state under penalties of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

Dated: August 26, 2015

Respectfully submitted,

/s/ Randi C. Ettner

Dr. Randi C. Ettner