IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHELSEA ELIZABETH MANNING, Plaintiff, v. CHUCK HAGEL, *et al.,* Defendants.	Civ. No. _____

PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION

Pursuant to Fed. R. Civ. P. 65, Plaintiff Chelsea Manning moves for the issuance of a preliminary injunction requiring Defendants to provide Plaintiff with clinically appropriate treatment under the *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* developed by the World Professional Association for Transgender Health, including, but not limited to, (1) providing hormone therapy for Plaintiff's gender dysphoria; (2) permitting Plaintiff to express her female gender by following female grooming standards, including dress and hair length; and (3) providing Plaintiff with treatment by a clinician who is qualified to treat gender dysphoria.

The grounds for this motion are that the denial of such treatment violates Plaintiff's rights under the Eighth Amendment to the Constitution, that the denial of such treatment is causing her irreparable injury and will continue to cause her irreparable injury, that providing such treatment will not harm the defendants, and that the public interest favors upholding the Constitution, including by providing necessary medical treatment to persons confined in correctional institutions.

In support of this application, Plaintiff respectfully refers the Court to the Complaint, the Memorandum in Support of Plaintiff's Motion for Preliminary Injunction, the Declaration of

Chelsea Elizabeth Manning, the Declaration of Dr. Randi C. Ettner, and the Declaration of Chase B. Strangio.

Plaintiff respectfully requests oral argument on this motion.

A proposed order is attached.

September 23, 2014

Respectfully submitted,

/s/ *Arthur B. Spitzer*

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FOR THE DISTRICT OF COLUMBIA

CHELSEA ELIZABETH MANNING, Plaintiff, v. CHUCK HAGEL, *et al.,* Defendants.	Civ. No. _____

MEMORANDUM IN SUPPORT OF
PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION

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September 23, 2014

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INTRODUCTION

This case concerns the serious pain and anguish caused by the denial of urgently-needed medical care to Plaintiff by the United States Department of Defense and the Department of the Army by and through the named defendants and their agents. Plaintiff Chelsea Manning is a prisoner at the United States Disciplinary Barracks at Fort Leavenworth, Kansas (USDB) who has gender dysphoria, a serious medical condition. Defendants are not providing her with medically necessary treatment for this condition. Specifically, she is being denied hormone therapy and prohibited from expressing her female gender by growing her hair and otherwise following female grooming standards. Plaintiff is experiencing escalating distress and is at serious risk of severe and imminent harm, including resorting to self-surgery (auto-castration) or suicide, because this medically necessary treatment is being withheld. She moves for a preliminary injunction requiring the Defendants to provide Plaintiff with clinically appropriate treatment under the *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* developed by the World Professional Association for Transgender Health, including, but not limited to, (1) providing hormone therapy for Plaintiff's gender dysphoria; (2) permitting Plaintiff to express her female gender by following female grooming standards, including dress and hair length; and (3) providing Plaintiff with treatment by a clinician who is qualified to treat gender dysphoria.

FACTS

Plaintiff Chelsea Manning is a well-known prisoner serving a thirty-five year sentence at the United States Disciplinary Barracks at Fort Leavenworth, Kansas. (Declaration of Chelsea Elizabeth Manning (Manning Decl.) ¶ 2). She was first diagnosed with gender dysphoria (what used to be called gender identity disorder (GID)) in 2010. (*Id*. ¶ 13). Since then, her gender

dysphoria diagnosis has been confirmed multiple times by Army medical providers and civilian experts. (*Id*. ¶¶ 17-19; Declaration of Dr. Randi C. Ettner (Ettner Decl.) ¶ 39). Yet, despite her well-documented diagnosis and the medical consensus about the proper treatment protocols for this condition, the Defendants have denied Ms. Manning urgently needed and medically necessary treatment for her gender dysphoria. (Ettner Decl. ¶¶ 46-47, 51, 56).

Gender Dysphoria

Gender dysphoria is a condition in which a person's gender identity – a person's innate sense of being male or female – differs from the sex the person was assigned at birth, causing clinically significant distress. (*Id*. ¶ 17). This condition is included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth ed. (2013) (DSM-V), and is recognized by the other major medical and mental health professional groups, including the American Medical Association and the American Psychological Association. (*Id*. ¶ 17-18).

The medical protocols for treating gender dysphoria are well established. The World Professional Association for Transgender Health (WPATH) is the leading medical authority on gender dysphoria and has developed Standards of Care for the treatment of the condition. (*Id*. ¶ 22-23). These standards, which are recognized as authoritative by every major medical and mental health association, provide for the following treatments, some or all of which will be required depending on the needs of the patient:

- 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.

(Ettner Decl. ¶ 23).

Changes to gender expression and role to feminize or masculinize one's appearance, often called the "real life experience," are an important part of treatment for the condition for many people. (*Id*. ¶ 30). The real life experience involves dressing, grooming and otherwise outwardly presenting oneself in a manner consistent with one's gender identity. (*Id*.). 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. (*Id*.). For individuals with persistent and well-documented gender dysphoria, hormone therapy is medically indicated. (*Id*. ¶ 31).

When necessary treatment for gender dysphoria is withheld, the consequences are both foreseeable and disastrous. (*Id*. ¶¶ 19-20). There is a medical consensus that without necessary treatment, gender dysphoria leads to serious medical problems, including clinically significant psychological distress, dysfunction, debilitating depression, and suicidality. (*Id*.). Transgender prisoners with long sentences, and male-to-female transsexuals in particular, are at an exceedingly high risk for severe consequences due to the hopelessness that can result when treatment is withheld indefinitely. (*Id*. ¶¶ 20-21, 52). Without adequate treatment, prisoners with gender dysphoria often resort to self-surgery to remove their testicles or even suicide. (*Id*. ¶¶ 19-20). 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 WPATH Standards of Care. (*Id*. ¶ 37).

Ms. Manning's History of Gender Dysphoria and Attempts to Obtain Treatment in Accordance with Medical Protocols

Though she was assigned male at birth, from a young age, Ms. Manning felt different from her male peers and was teased and bullied for being effeminate. (Manning Decl. ¶ 3). Throughout her childhood, adolescence and young adulthood, Ms. Manning would dress and express herself as female in private but would become overcome with guilt and shame afterwards. (*Id*. ¶ 5). These feelings of shame caused her to suppress her femininity and attempt to conform to expectations of how men should look and act. (*Id*. ¶ 4). Ms. Manning joined the United States Army as an all-source intelligence analyst in 2007 before coming to terms with her transgender identity in 2009. (*Id*. ¶ 8).

While deployed in Iraq and then in pre-trial confinement, Ms. Manning was diagnosed with gender identity disorder (GID) on multiple occasions. She was first diagnosed with GID on May 8, 2010 by Capt. Michael Worsely, an Army psychologist in Iraq. (Manning Decl. ¶ 17). After her arrest for unlawful disclosure of classified information on May 27, 2010, Ms. Manning was transferred from Iraq to Camp Arifjan, Kuwait where she was again diagnosed with GID by military doctors. (*Id*. ¶ 18). While in confinement at Camp Arifjan, Ms. Manning grew desperate fearing that she would not receive treatment for her gender dypshoria. (*Id*. ¶¶ 14, 18). She contemplated ways to remove her testicles and even planned to commit suicide in a moment of extreme distress. (*Id*. ¶ 14). Her plans were discovered and she was placed on suicide watch. (*Id*.). She did not receive treatment for her gender dysphoria in Iraq or Kuwait. (*Id*. ¶ 18).

From Kuwait she was transferred to Quantico, Virginia on July 29, 2010. (*Id*. ¶ 15). On April 22, 2011, Ms. Manning was diagnosed a third time with GID during her Rule 706 Board,

the body convened under the Rules for Court-Martial to assess her mental fitness to stand trial. (*Id*. ¶ 19). Ms. Manning was convicted at general court martial and on August 21, 2013 she was sentenced to serve thirty-five years in prison. (*Id*. ¶¶ 2, 16). The following day she was transferred to the United States Disciplinary Barracks at Fort Leavenworth (USDB), where she remains. (*Id*. ¶ 16). While in Quantico, Virginia, Ms. Manning did not receive treatment for her gender dysphoria. (*Id*. ¶ 18).

With her court-martial and sentencing final, Ms. Manning decided to come out publicly about her female gender identity and her desire to begin treatment as soon as possible. On August 22, 2013, the day she was transferred to the USDB, she announced, through her attorney, on NBC's *The Today Show*, "I am Chelsea Manning. I am a female. Given the way that I feel, and have felt since childhood, I want to begin hormone therapy as soon as possible." (Declaration of Chase B. Strangio (Strangio Decl.), Ex. I). In response to her public announcement that she is female and would be requesting treatment, the Department of the Army announced through a USDB spokesperson that it was the Army's policy not to provide hormone therapy to treat gender dysphoria. (*Id*.).

On the day she arrived at the USDB, Ms. Manning submitted a memorandum requesting an evaluation and treatment for gender dysphoria in accordance with the WPATH Standards of Care to the Directorate of Treatment Programs (DTP). (Manning Decl. ¶ 20). Shortly thereafter, during a routine treatment and risk assessment, when Ms. Manning inquired about treatment options for gender dysphoria, she was informed by John Lesniak, Chief, Assessment Division of the DTP, that it was USDB and Army policy to limit treatment for gender dysphoria to psychotherapy and anti-depressant and anti-anxiety medication. (*Id*. ¶ 21). On August 28, 2013, Ms. Manning again requested a mental health evaluation and treatment for gender dysphoria by

submitting a Department of Defense (DD) Form 510 to Lieutenant Colonel Nathan Keller, the Director of Treatment Programs at the USDB. (*Id*. ¶ 22).

In September 2013, Dr. Ellen Galloway, Chief of the Mental Health Division at the USDB, evaluated Ms. Manning and diagnosed her with gender dysphoria. (Manning Decl. ¶¶ 24, 27). Dr. Galloway's diagnosis was reviewed and confirmed by Dr. Patrick Armistead-Jehle, another Army psychologist, on October 1, 2013. (Strangio Decl., Ex. A).

On October 15, 2013, Lt. Col. Keller sent a memorandum to Steve Lynch, former Deputy Director of the Army Corrections Command (ACC), based in Washington, D.C., regarding available treatment for Ms. Manning at the USDB. In that memorandum, Lt. Col. Keller noted that treatment for gender dysphoria is governed by the WPATH Standards of Care but said "I see no way the USDB can provide a full course of therapy for Mr Manning's Gender Dysphoria … because the USDB cannot house a female or highly feminized inmate. Permitting Mr Manning to live as female, much less begin to feminize his body, will create operational challenges as the inmate population respond to these changes." (Strangio Decl., Ex. B). He recommended possible "stop-gap" treatment options that he identified as "at best stop-gaps [that] will not meet the need." (*Id*.). Those options included weekly therapy at the Transgender Institute in Kansas City or supervision of Dr. Galloway by the Transgender Institute. (*Id*.).

The following day, Dr. Galloway also sent a memorandum to Steve Lynch, ACC, regarding treatment available at the USDB for Ms. Manning. (Strangio Decl., Ex. C). In that memorandum she advised that the ethical principles of psychologists mandate that psychologists only provide services within the scope of their competence and that she does "not have the expertise to develop a treatment plan or provide treatment for individuals with [gender dysphoria]." (*Id*.).

On November 25, 2013, Dr. Galloway finalized a treatment plan for Ms. Manning's gender dysphoria based on recommendations made by Dr. Ricky Malone, whom she described as an expert provided by the Western Region of the Army Medical Department,[1] and sent it to the Army Corrections Command. (Strangio Decl., Ex. D). The treatment plan identified the proper treatment protocols for treating gender dysphoria as those outlined in the WPATH Standards of Care. (*Id*.). The plan stated that (as of November 1, 2013) Dr. Malone recommended psychotherapy and real life experience – a term used to refer to outward changes to gender expression and role to be consistent with one's gender identity – as the minimal acceptable therapeutic interventions. (Strangio Decl., Ex. D; Ettner Decl. ¶¶ 23, 30). Specifically, the plan recommended that Ms. Manning receive weekly psychotherapy with Dr. Galloway to address issues specific to gender dysphoria and to receive treatment in the form of the real life experience by being provided with female underwear and sports bras. (Strangio Decl., Ex. D). The plan also noted that "[i]t is likely that additional interventions will become necessary such as hormone replacement therapy (HRT) or gender reassignment surgery (GRS)." (*Id*.).

After approximately six weeks passed without any treatment being initiated, on January 5, 2014, Ms. Manning submitted another DD Form 510 to the Directorate of Treatment Programs requesting a status update on her care, but never received a response. (Manning Decl. ¶ 7).

On January 21, 2014, Ms. Manning submitted a request for redress to Col. Ledwith, the Commandant at the USDB at the time, and Capt. Byrd, her commander at the Personnel Control Facility in Fort Sill, Oklahoma pursuant to Army Regulation (AR) 27-10 and Article 138, Uniform Code of Military Justice (UCMJ). (*Id*. ¶ 35). In her request she alleged that the actions taken by Col. Ledwith and Capt. Byrd in refusing to implement a treatment plan for her gender

[1] Dr. Malone evaluated Plaintiff once between October 31, 2013 and November 1, 2013; he has not seen her since then. (Manning Decl. ¶ 28)

dysphoria were arbitrary and unreasonable and requested that a treatment plan consistent with the WPATH Standards of Care be implemented. (*Id.*). Having received no response to her request for redress, on March 4, 2014, she submitted a UCMJ Article 138 complaint of wrong against both Col. Ledwith and Capt. Byrd for their failure to implement a treatment plan in accordance with the WPATH Standards of Care. (*Id.* ¶ 37).

On May 7, 2014, Plaintiff learned through her civilian defense counsel that her Article 138 complaint of wrong had been deemed deficient on March 19, 2014, on the grounds that 1) Col. Ledwith was not Plaintiff's commanding officer; and 2) Capt. Byrd lacked the authority to approve the treatment plan. (Manning Decl. ¶ 38). Because Ms. Manning's chain of command, Capt. Byrd, was the only proper person against whom to bring an Article 138 complaint of wrong but he had no authority to approve her requested treatment, on May 29, 2014 she sought permission to file her complaint against the Commandant of the USDB. (*Id.* ¶ 39). On July 3, 2014, that request was denied. (*Id.* ¶ 40).

At the same time she submitted a request for redress to Col. Ledwith and Capt. Byrd, on January 21, 2014, Ms. Manning also submitted a comparable request for treatment in accordance with WPATH protocols through the Office of the Inspector General. (*Id.* ¶ 41). That request went from the Office of the Inspector General, United States Army Combined Armed Center, Fort Leavenworth, Kansas to the Western Regional Medical Command and ultimately to the Office of the Surgeon General for the Army. (*Id.* ¶¶ 42-43). Ms. Manning never received a response to that request. (*Id.* ¶ 44).

While her other treatment requests were pending, on April 2, 2014, Ms. Manning also submitted a request to the DTP for permission to follow the hair and grooming standards for female prisoners as part of her treatment for gender dysphoria. (*Id.* ¶ 33). On July 23, 2014,

having received no response to her April 2, 2014 request, she renewed that request to the DTP but never received a response to either request. (Manning Decl. ¶ 33).

On August 20, 2014, approximately six weeks after Defendants became aware that Ms. Manning was being represented by counsel regarding her health care and nine days after Ms. Manning sent a demand letter to Defendants, Dr. Galloway wrote a memorandum recommending that Plaintiff be provided with female undergarments (Strangio Decl., Ex. G), and they were provided shortly thereafter. (Manning Decl. ¶ 55). On September 3, 2014, Col. Erica Nelson, the Commandant of USDB, sent a letter to Ms. Manning's counsel responding to the demand letter sent on August 11, 2014. (Strangio Decl., Ex. H). In her letter, Col. Nelson stated that Ms. Manning's psychotherapy was expanded sometime after July 18, 2014 to include therapy for gender dysphoria and that she "has also been permitted to begin the 'real-life experience' treatment by being issued female undergarments, specifically female underwear and sports bras." (*Id*.).

According to Ms. Manning's medical records, her treating clinician, Dr. Galloway, had expected treatment per the November 25, 2013 plan to begin around Christmas of 2013. (Strangio Decl., Ex. E). But no treatment of *any* kind for gender dysphoria – let alone necessary and adequate treatment – was commenced until 8 months later (and more than four years after Army doctors in Iraq first diagnosed her with gender dysphoria). Dr. Galloway repeatedly told Ms. Manning that decisions regarding her treatment would move slowly because they were being made at the "SecDef" level, meaning the Secretary of Defense. (Manning Decl. ¶ 32; *see also* Strangio Decl., Ex. E).

Plaintiff continues to be denied permission to outwardly express her female gender by growing her hair and following other female grooming standards. (Manning Decl. ¶¶ 50-52). And she remains without hormone therapy. (*Id*. ¶ 52).

Plaintiff's Distress and Urgent Need for Hormone Therapy and Permission to Follow Female Grooming Standards

On August 27, 2014, Ms. Manning met with Dr. Randi Ettner, an expert in the diagnosis and treatment of gender dysphoria that she retained. (Ettner Decl. ¶ 38). Dr. Ettner confirmed Ms. Manning's gender dysphoria diagnosis and concluded that her condition was moderate to severe. (*Id*. ¶ 39). She noted that Ms. Manning is experiencing symptoms of anxiety, depression and hopelessness because she is not receiving necessary treatment for her gender dysphoria. (*Id*. ¶¶ 41-45). Because gender dysphoria intensifies over time, the longer an individual goes without treatment, the greater the risk of severe harms to her health, Dr. Ettner noted. (*Id*. ¶ 21). Dr. Ettner recommended that hormone therapy be initiated immediately and that Ms. Manning be treated by being permitted to outwardly express her female gender by growing her hair and following the grooming standards applied to female prisoners. (*Id*. ¶¶ 47-49).

Every day that goes by without appropriate treatment, Ms. Manning experiences escalating anxiety, distress, and depression. (Manning Decl. ¶ 55; Ettner Decl. ¶¶ 21, 58). She feels as though her body is being poisoned by testosterone and cannot imagine surviving without hormone therapy and the ability to present her gender outwardly in a manner consistent with her female gender. (Manning Decl. ¶ 53). Dr. Ettner opined that dire medical consequences, including possibly self-castration and suicide, are inevitable if hormone therapy and access to female grooming standards continue to be withheld. (Ettner Decl. ¶¶ 56, 59).

ARGUMENT

The D.C. Circuit applies the traditional four-part test for deciding whether to grant a request for a preliminary injunction. *See Weinberger v. Romero–Barcelo*, 456 U.S. 305, 312–13 (1982); *Nat'l Wildlife Fed'n v. Burford*, 835 F.2d 305 (D.C. Cir. 1987). The movant must establish that (1) she has a substantial likelihood of success on the merits; (2) she would suffer irreparable injury if the injunction is not granted; (3) an injunction would not substantially injure other interested parties; and (4) the public interest would be furthered by the injunction. *Katz v. Georgetown Univ.*, 246 F.3d 685, 687–88 (D.C. Cir. 2001).

Plaintiff meets all of the factors supporting a preliminary injunction. Her claim that Defendants are withholding necessary medical care in violation of the Eighth Amendment is extremely strong on the merits. She will suffer irreparable harm if the Defendants are permitted to continue to withhold medically necessary care. A preliminary injunction will not, however, harm Defendants. To the extent Defendants may claim safety concerns related to housing a female or feminized prisoner, they cannot substantiate such concerns given that Plaintiff is never left alone with other prisoners outside the presence of one or more staff members and is under constant surveillance. (Manning Decl. ¶ 26). The public interest also strongly favors upholding the United States Constitution and preventing avoidable injury to individuals held in government custody.

I. PLAINTIFF HAS A SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS

"A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society." *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011). Corrections officials inflict cruel and unusual treatment on a prisoner, in violation of the Eighth Amendment, when they are deliberately indifferent to a

prisoner's serious medical needs. *Estelle v. Gamble*, 429 U.S. 97 (1976). To establish an Eighth Amendment violation, a prisoner must prove (1) that her medical need was *objectively* sufficiently serious, and (2) that *subjectively* officials acted with a sufficiently culpable state of mind in failing to treat that need. *Id*. Plaintiff suffers from an objectively serious medical condition that Defendants, acting with deliberate indifference, have failed to treat in violation of the Eighth Amendment.

A. Plaintiff's Gender Dysphoria And Risk Of Engaging In Self-Harm Constitute Serious Medical Needs For Purposes Of The Eighth Amendment

To meet the objective requirement of the deliberate indifference standard, a prisoner must demonstrate the existence of a serious medical need, *Estelle*, 429 U.S. at 104, or demonstrate a substantial risk of future serious harm resulting from the action or inaction of prison officials, *Helling v. McKinney*, 509 U.S. 25, 35 (1993). Here, Plaintiff has established both a serious medical need – serious distress, anxiety and depression from untreated gender dysphoria – and a substantial risk of future serious harm – continued anguish, auto-castration and suicide – if her medically necessary treatment continues to be withheld.

Courts have routinely held that gender dysphoria (also referred to as gender identity disorder or transsexualism) is a serious medical need. *See*, *e.g.*, *Meriwether v. Faulkner*, 821 F.2d 408, 411 (7th Cir. 1987) (recognizing transsexualism as a serious medical need that should not be treated differently than any other psychiatric disorder); *Brown v. Zavaras*, 63 F.3d 967 (10th Cir. 1995) (prison officials must provide treatment to address the medical needs of prisoner with gender identity disorder); *Fields v. Smith*, 712 F. Supp. 2d 830, 855-56 (E.D. Wis. 2010) (gender identity disorder is a serious medical need for purposes of the Eighth Amendment), *aff'd* 653 F.3d 550 (7th Cir. 2011); *Battista v. Clarke*, 645 F.3d 449 (1st Cir. 2011) (upholding district court decision recognizing gender identity disorder as a serious medical need for purposes of the

Eighth Amendment); *Phillips v. Mich. Dep't of Corr.*, 731 F. Supp. 792, 799 (W.D. Mich. 1990) (complete refusal by prison officials to provide a person with GID with any treatment at all would state an Eighth Amendment claim); *cf. Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000) ("We assume for purposes of this appeal that transsexualism constitutes a serious medical need."). There is no question that Plaintiff has persistent and well-documented gender dysphoria that requires treatment and therefore meets the requirement that her medical need is objectively serious. (Manning Decl. ¶¶ 13, 17-19; Ettner Decl. ¶ 39; Strangio Decl., Ex. A-E).

Plaintiff's well-documented risk of engaging in self-harm in the absence of treatment constitutes an independent serious medical need for purposes of the Eighth Amendment deliberate indifference standard. Plaintiff feels like she is being poisoned by the testosterone in her body. (Manning Decl. ¶ 53). Like many individuals with persistent gender dysphoria, the pain and distress caused by this experience has led her to consider self-surgery to remove her testicles in order to free herself from the effects of testosterone and even to consider and, in the past to plan on, committing suicide. (Manning Decl. ¶ 14; Ettner Decl. ¶¶ 42, 53, 55). If hormone therapy and access to female grooming standards continue to be withheld, Plaintiff is at extremely high risk of resorting to self-harm. (Manning Decl. ¶ 55; Ettner Decl. ¶¶ 53, 55). In *De'lonta v. Angelone* (*De'lonta I*), 330 F.3d 630, 634 (4th Cir. 2003), the Fourth Circuit held that a prisoner with diagnosed gender dyphoria's "need for protection against continued self-mutilation constitutes a serious medical need to which prison officials may not be deliberately indifferent." *See also Lee v. Downs*, 641 F.2d 1117, 1121 (4th Cir. 1981) ("[P]rison officials have a duty to protect prisoners from self-destruction or self-injury."); *Soneeya v. Spencer*, 851 F. Supp. 2d 228 (D. Mass. 2012) (prisoner with GID and history of suicide attempts and self-mutilation has serious medical condition for which surgery must be considered); *Kosilek v.*

Maloney, 221 F. Supp. 2d 156, 184 (D. Mass 2002) (prisoner with gender identity disorder's risk of engaging in self-harm constituted serious medical need); *see generally* George R. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 Int'l J. of Transgenderism 31 (2010). The law is clear that "a remedy for unsafe conditions need not await a tragic event." *Helling v. McKinney*, 509 U.S. 25, 33 (1993).[2]

B. Defendants Have Acted With Deliberate Indifference To Plaintiff's Serious Medical Needs

The subjective prong is one of deliberate indifference, which "entails something more than mere negligence . . . [but] is satisfied by something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result." *Farmer v. Brennan*, 511 U.S. 825, 835 (1994). If Defendants knew that the risk existed and either intentionally or recklessly ignored it, and will continue to do so in the future, then the subjective test has been met. *Id*. at 837-47. This indifference is impermissible "whether … manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Estelle*, 429 U.S. at 105-06. Here, Defendants are aware of Plaintiff's gender dysphoria, her past suicide plans, her thoughts of self-castration, and her escalating distress at having treatment withheld. (Manning Decl. ¶ 32). Defendants' medical providers agree that the WPATH Standards of Care are the appropriate protocols for treating gender dysphoria. (Strangio Decl., Ex. B, D). Yet, despite this, Defendants have continued to deny treatment that the WPATH Standards of Care

[2] The Eighth Amendment protects against current health harms as well as future ones. *Roe v. Elyea*, 631 F.3d 843, 858 (7th Cir. 2011) ("the Eighth Amendment 'protects [an inmate] not only from deliberate indifference to his or her current serious health problems, but also from deliberate indifference to conditions posing an unreasonable risk of serious damage to future health.'" (internal citation omitted)).

identify as medically necessary for many individuals with gender dysphoria and which are medically necessary for Plaintiff according to Dr. Ettner, an expert in the treatment of this condition. (Strangio Decl. Ex. B; Ettner Decl. ¶¶ 30-31, 47-49).

1. Defendants Have Acted With Deliberate Indifference By Failing To Provide Adequate Treatment For Plaintiff's Serious Medical Needs

Government officials act with deliberate indifference when they refuse to provide medically necessary treatment to prisoners. *Estelle*, 429 U.S. 97. The relevant inquiry is not whether any care has been provided but whether "constitutionally adequate" care has been provided. *Id.* at 103-06 (prison officials may not adopt an "easier and less efficacious treatment" that does not adequately address a prisoner's serious medical needs); *Edwards v. Snyder*, 478 F.3d 827, 831 (7th Cir. 2007) (treatment cannot be "blatantly inappropriate"). It is well established that, while prisoners may not be entitled to any particular treatment of their choosing, medical care in prison cannot be "so cursory as to amount to no treatment at all." *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985). *See also Langford v. Norris*, 614 F.3d 445, 460 (8th Cir. 2010) ("a total deprivation of care is not a necessary condition for finding a constitutional violation"); *Jones v. Muskegon Ctny.*, 625 F.3d 935, 944 (6th Cir. 2010) (prison officials may not avoid liability "simply by providing some measure of treatment").[3]

These well-established principles apply just as strongly in the context of treatments for gender dysphoria. Courts have repeatedly held that limiting treatment for gender dysphoria to psychotherapy where hormone therapy is medically indicated violates the Eighth Amendment. *See*, *e.g.*, *Kothmann v. Rosario*, 558 F. App'x 907, 910 (11th Cir. 2014) (denying qualified

[3] The Eighth Amendment guarantees medical care "at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards." *United States v. DeCologero*, 821 F.2d 39, 43 (1st Cir. 1987); *see also Moore v. Duffy*, 255 F.3d 543, 545 (8th Cir. 2001) (Medical treatment may not "so deviate from the applicable standard of care as to evidence a physician's deliberate indifference.").

immunity to prison official who failed to treat transgender prisoner with hormone therapy who was treated with "anti-anxiety and anti-depression medications, mental health counseling, and psychotherapy treatments"); *Fields*, 653 F.3d 550, 556 (7th Cir. 2011) ("Although DOC can provide psychotherapy as well as antipsychotics and antidepressants, defendants failed to present evidence rebutting the testimony that these treatments do nothing to treat the underlying disorder."). In *De'lonta v. Johnson* (*De'lonta II*), 708 F.3d 520, 526 (4th Cir. 2013), the court held that "just because Appellees have provided De'lonta with *some* treatment consistent with the GID Standards of Care, it does not follow that they have necessarily provided her with constitutionally adequate treatment." (emphasis in original). The Defendants in this case have denied Plaintiff constitutionally adequate treatment by withholding the medical care that she needs, failing to have her treated by a professional qualified to treat gender dysphoria, and delaying her treatment for non-medical reasons.

The Defendants are aware that Plaintiff has gender dysphoria requiring treatment and agree that the WPATH Standards of Care govern such treatment but have failed to provide treatment consistent with those standards to meet her medical needs. For patients like Plaintiff with well-documented and persistent gender dysphoria, hormone therapy is medically indicated to alleviate the significant distress caused by the condition. (Ettner Decl. ¶¶ 31, 47). Defendants claim that treatment has been provided in the form of psychotherapy and female undergarments. (Strangio Decl., Ex. H). But for the past year, Dr. Galloway has documented Plaintiff's escalating anxiety and depression caused by her gender dysphoria. (Manning Decl. ¶ 32; Strangio Decl., Ex. E). Non-medical interventions do not obviate the need for hormone therapy where such medical intervention is indicated. (Ettner Decl. ¶ 29); *see also Fields*, 653 F.3d at 556 (affirming district court finding that "for certain patients with GID, hormone therapy is the

only treatment that reduces dysphoria and can prevent the severe emotional and physical harms associated with it."). Dr. Ettner, an expert in treating gender dysphoria, *see Fields*, 712 F. Supp. 2d at 837-38, evaluated Plaintiff and confirmed that hormone therapy and access to female grooming standards to outwardly express her gender identity are medically necessary to treat her moderate-to-severe gender dysphoria. (Ettner Decl. ¶¶ 47-49).

The alleged treatments provided to Plaintiff are not constitutionally adequate. Defendants suggest that they have implemented the real life experience as part of Plaintiff's treatment. (Strangio Decl., Ex. D, G, H). However, the mere provision of undergarments is not treatment. (Ettner Decl. ¶ 50). The purpose of the real life experience is to mitigate distress caused by the gender dysphoria through dressing, grooming and otherwise outwardly presenting oneself through social signifiers of gender consistent with one's gender identity. (*Id*. ¶¶ 30, 50). This attempt to treat Plaintiff's gender dysphoria with undergarments only has had the opposite effect of mitigating her distress and has in fact worsened it, causing Plaintiff to feel like a "man in a bra." (Manning Decl. ¶ 53). Meanwhile, both Dr. Galloway and Lt. Col. Keller have recognized that hormone therapy will ultimately be necessary to treat Plaintiff's gender dysphoria but have provided no evaluation for such treatment by a medical professional qualified to assess and treat gender dysphoria patients. (Strangio Decl., Ex. B, D).

Where a condition requires specialized treatment or referral to a specialist for evaluation, failure to provide such treatment or referral constitutes deliberate indifference. Plaintiff's treating clinician at the USDB acknowledged in a memorandum made available to Plaintiff that she is not qualified to treat gender dysphoria. (Strangio Decl., Ex. C).[4] "'Adequate medical care'

[4] Dr. Malone, who Dr. Galloway referred to as an "expert," evaluated Plaintiff on October 21 and November 1, 2013, but has not seen her since then and has never treated her. (Manning Decl. ¶ 28).

requires treatment by qualified medical personnel who provide services that are of a quality acceptable when measured by prudent professional standards in the community, tailored to an inmate's particular medical needs, and that are based on medical considerations." *Barrett v. Coplan*, 292 F. Supp. 2d 281, 285 (D.N.H. 2003). This includes making referrals to specialists where appropriate. In *De'lonta II*, 708 F.3d at 524, the Fourth Circuit held that a prisoner with gender dysphoria made out a claim of deliberate indifference where prison officials failed to have her evaluated by a specialist to assess her need for sex reassignment surgery.[5]

Adequate care of a patient with gender dysphoria requires qualified, appropriately trained clinicians with clinical experience in the treatment of the condition. The WPATH Standards of Care emphasize the importance of supervised training and first-hand clinical experience. (Ettner Decl. ¶¶ 25-28). By having a doctor assess Plaintiff's treatment needs who herself recognizes that she is not qualified to do so, Defendants plainly act with deliberate indifference to Plaintiff's serious medical needs. Plaintiff's expert, who has expertise in treating gender dysphoria, has recommended that hormone therapy be initiated immediately and that Plaintiff be permitted to follow female grooming standards to prevent adverse health consequences. (*Id*. ¶¶ 47-49). If Defendants are permitted to continue to rely on unqualified providers to assess Plaintiff's medical needs, her treatment needs will never be properly assessed, she will continue to suffer, and grave medical and mental health consequences will inevitably flow from such indifference. (*Id*. ¶ 55-56); *see H.C. by Hewett v. Jarrard*, 786 F.2d 1080, 1086 (11th Cir.1986) ("The failure to provide diagnostic care" constitutes deliberate indifference).

[5] *See also Hayes v. Snyder*, 546 F.3d 516, 526 (7th Cir. 2008) (refusal to refer to a specialist where doctor did not know cause of reported extreme pain could support deliberate indifference finding); *Greeno v. Daley*, 414 F.3d 645, 655 (7th Cir. 2005) (doctor could be deliberately indifferent for refusing to send a prisoner to a specialist or to order an endoscopy despite prisoner's complaints of severe pain).

It is also well established that intentional delay in providing necessary medical care violates the Eighth Amendment. *See Brown v. District of Columbia*, 514 F.3d 1279, 1283 (D.C. Cir. 2008) (government officials act with deliberate indifference when delaying or denying access to medical care once prescribed); *Arnett v. Webster*, 658 F.3d 742, 752 (7th Cir. 2011) (failure of medical officials to provide prisoner medication to treat his rheumatoid arthritis over 10-month period despite his repeated requests was sufficient to allege deliberate indifference); *Jett v. Penner*, 439 F.3d 1091 (9th Cir. 2006) (delay of over a year before seeing a hand specialist); *Spruill v. Gillis*, 372 F.3d 218, 237 (3d Cir. 2004) (prisoner stated a claim for deliberate indifference where he alleged that prison doctor knew he had a serious back condition and refused to examine him on numerous occasions); *Natale v. Camden Cnty. Corr. Facility*, 318 F.3d 575, 582-83 (3d Cir. 2003) (delay of 21 hours in providing insulin to diabetic stated Eighth Amendment claim); *Wallin v. Norman*, 317 F.3d 558 (6th Cir. 2003) (delay of one week in treating urinary tract infection, and one day in treating leg injury stated claim of deliberate indifference under the Eighth Amendment); *McKenna v. Wright*, 386 F.3d 432, 437 (2d Cir. 2004) (extended delay in starting Hepatitis C treatment because prisoner might be released within twelve months of starting treatment stated claim of deliberate indifference under the Eighth Amendment).

Though Defendants have known for more than four years that Plaintiff suffers from gender dysphoria and a treatment plan was created in November of 2013 recognizing an urgent need for treatment, no action was taken on Plaintiff's treatment until August of 2014 – nine months later, and only after Plaintiff retained counsel. (Manning Decl. ¶ 50). The treatment that was ultimately provided was not only medically and constitutionally inadequate but has caused Plaintiff to suffer further distress. The delays in treating Plaintiff are undoubtedly caused, at

least in part, by the fact that decisions related to her treatment are being made by medical providers without the necessary expertise to assess her treatment needs and by administrative officials without medical training, contact with Plaintiff, or day-to-day knowledge of the USDB's operations. (Manning Decl. ¶ 32; Strangio Decl., Ex. E).

2. Plaintiff Has Been Categorically Denied Hormone Therapy And Other Medically Necessary Treatment For Non-Medical Reasons And With Deliberate Indifference To Her Serious Medical Needs

The Eighth Amendment requires that prisoners be provided with adequate medical care "based on an individualized assessment of an inmate's medical needs in light of relevant medical considerations." *Soneeya*, 851 F. Supp. 2d at 242. Given this need for individualized assessment, exclusionary policies that bar certain forms of medical treatment regardless of medical need for the treatment violate the Eighth Amendment. *See Johnson v. Wright*, 412 F.3d 398, 406 (2d Cir. 2005) (denial of hepatitis C treatment to a prisoner based on a policy that a particular drug could not be administered to inmates with recent history of substance abuse could constitute deliberate indifference since policy did not allow exceptions based on medical need); *Mahan v. Plymouth Cnty. House of Corr.*, 64 F.3d 14, 18 n.6 (1st Cir. 1995) ("inflexible" application of prescription policy may violate Eighth Amendment); *Jorden v. Farrier*, 788 F.2d 1347, 1349 (8th Cir. 1986) (application of prison pain medication policies must be instituted in a manner that allows individualized assessments of need).

Courts have routinely held prison policies that automatically exclude certain forms of treatment for gender dysphoria violate the Eighth Amendment. In *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011), the Seventh Circuit held that a state law that barred hormone therapy and sex reassignment surgery as possible treatments for prisoners with gender dysphoria facially violated the Eighth Amendment. Similarly, in *De'lonta I*, 330 F.3d 630, the Fourth Circuit held that a

prisoner with gender dysphoria stated a claim for deliberate indifference where the Department of Corrections withheld hormone therapy pursuant to a policy against providing such treatment and not the medical judgment of qualified providers. *See also Allard v. Gomez*, 9 Fed. App'x. 793, 795 (9th Cir. 2001) ("[T]here are at least triable issues as to whether hormone therapy was denied Allard on the basis of an individualized medical evaluation or as a result of a blanket rule, the application of which constituted deliberate indifference to Allard's medical needs."); *Soneeya*, 851 F. Supp. 2d at 249 (holding that a prison policy that "removes the decision of whether sex reassignment surgery is medically indicated for any individual inmate from the considered judgment of that inmate's medical providers" violated Eighth Amendment); *Houston v. Trella,* No. 04-1393, 2006 WL 2772748, at *8 (D.N.J. Sept. 22, 2006) (claim that prison doctor's decision not to provide hormone therapy to prisoner with GID based not on medical reason but policy restricting provision of hormones stated viable Eighth Amendment claim); *Barrett v. Coplan*, 292 F. Supp. 2d 281, 286 (D.N.H. 2003) ("A blanket policy that prohibits a prison's medical staff from making a medical determination of an individual inmate's medical needs [for treatment related to gender identity disorder] and prescribing and providing adequate care to treat those needs violates the Eighth Amendment."); *Brooks v. Berg*, 270 F. Supp. 2d 302, 312 (N.D.N.Y. 2003) (prison officials cannot deny inmates medical treatment for gender dysphoria based on a policy of limiting such treatments to inmates who were diagnosed prior to incarceration), *vacated in part on other grounds*, *Brooks v. Berg*, 289 F. Supp. 2d 286 (N.D.N.Y. 2003).

Since Plaintiff first requested treatment for gender dysphoria, Defendants have repeatedly stated to her and publicly that Army and USDB policy do not permit hormone therapy or other treatment that could outwardly feminize a prisoner at the USDB, (Strangio Decl. Ex. B, I, J;

Manning Decl. ¶ 21), which are treatments that are medically indicated for Plaintiff. (Ettner Decl. ¶¶ 47-49; Strangio Decl., Ex. B, D). Instead of exercising any informed medical judgment regarding Plaintiff's medical need for these particular treatments, Defendants have reflexively followed a policy that ensures that Plaintiff will never be meaningfully evaluated for or permitted to undergo treatment that could outwardly feminize her appearance regardless of the medical need for that treatment or the severity of her symptoms. Defendants' denial of medically necessary treatment based on a written or *de facto* administrative policy that leaves no room for medical judgment "is the very definition of deliberate indifference." *Colwell v. Bannister*, No. 12-15844, --- F.3d ----, 2014 WL 3953769 at *5 (9th Cir. Aug. 14, 2014) (holding that prison policy of barring cataract surgery where one eye would retain functionality without room for medical determination violated Eighth Amendment).

3. Prisoners' Medical Care Cannot Be Withheld Based On Pretextual Security Justifications

The Eighth Amendment does not permit wholesale deference to prison officials in the administration of prisoner medical care. While courts acknowledge that "'the realities of prison administration' are relevant to the issue of deliberate indifference," *Kosilek*, 221 F. Supp. 2d at 191 (quoting *Helling v. McKinney*, 509 U.S. 25, 37 (1993)), they repeatedly emphasize that "judgments concerning the care to be provided to inmates for their serious medical needs generally must be based on medical considerations." *Id*. (citing, *inter alia*, *Estelle*, 429 U.S. at 104 n.10; *Durmer v. O'Carroll*, 991 F.2d 64, 67-69 (3d Cir. 1993).

Defendants have suggested that their policy against providing hormone therapy and permitting Plaintiff to follow female grooming standards is based on an inability to house a feminized inmate, asserting concerns about reactions from other inmates and the ability to keep Plaintiff safe if she were to undergo feminizing treatments. (Strangio Decl., Ex. B). However,

these asserted concerns are pretextual, given that Plaintiff has already been identified as being vulnerable to sexual and physical violence, and the facility is already addressing that security concern by assuring that she is never in the presence of other prisoners without staff present. (Manning Decl. ¶¶ 21, 26). These same arguments have been raised by prison officials in other cases involving the medical treatment of prisoners with gender dysphoria and have not been credited by the courts. *See*, *e.g.*, *Battista v. Clarke*, 645 F.3d 449, 452 (1st Cir. 2011) (affirming district court holding that hormone therapy could be safely administered to prisoner despite security concerns raised by prison staff, which were undercut by "pretexts, delays, and misrepresentations"); *Fields* 653 F.3d at 557 (rejecting prison security argument because "transgender inmates may be targets for violence even without hormones" and defendants' expert "testified that it would be 'an incredible stretch' to conclude that banning the use of hormones could prevent sexual assaults"); *cf. Fields*, 712 F. Supp. 2d at 868 (in analyzing equal protection claim the court found that "no reasonably conceivable state of facts provides a rational tie between [the ban on hormone therapy] and prison safety and security.").

II. PLAINTIFF WILL SUFFER IRREPARABLE INJURY ABSENT AN INJUNCTION

To obtain a preliminary injunction, Plaintiff need not demonstrate that irreparable injury is inevitable, but only that it "is *likely* in the absence of an injunction." *Winter v. Nat'l Res. Def. Council*, 555 U.S. 7, 22 (2008) (emphasis in original). Plaintiff has already suffered serious distress, anxiety and depression, has contemplated self-surgery and planned for suicide. (Manning Decl. ¶¶ 14, 49-55; Ettner Decl. ¶¶ 53-55). As Dr. Randi Ettner explained, "Gender dysphoria intensifies over time. The longer an individual goes without treatment, the greater the risk of severe harms to her health." (Ettner Decl. ¶ 21). Plaintiff is at an exceedingly high risk for suicidality and auto-castration due to her past plans to commit suicide and thoughts of auto-

castration to relieve the distress caused by the testosterone that her body produces. (Ettner Decl. ¶¶ 53-55; Manning Decl. ¶¶ 49-55). Absent an injunction, Defendants' actions in withholding medically necessary care are likely to result in serious medical and psychological pain and suffering to Plaintiff, including possibly permanent injury or death. (Ettner Decl. ¶¶ 53-56).

Death and serious bodily injury are the very definition of irreparable injuries. *See*, *e.g.*, *Wilson v. Group Hospitalization & Med. Servs., Inc.*, 791 F. Supp. 309, 313-314 (D.D.C. 1992) (granting preliminary injunction where, absent injunctive relief preventing denial of medical benefits, plaintiff "faced nearly certain death, the ultimate irreparable injury"); *Qualls v. Rumsfeld*, 357 F. Supp. 2d 274, 286 (D.D.C. 2005) (finding irreparable harm where plaintiff faced a "great risk of harm and death as a result of his continuing service" on active duty in Iraq); *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958, 961 (8th Cir. 1995) ("It is hard to imagine a greater harm than losing a chance for potentially life-saving medical treatment." (citation omitted)); *Harris v. Bd. of Supervisors*, 366 F.3d 754, 766 (9th Cir. 2004) ("pain, infection, amputation, 0medical complications, and death" constitute irreparable harm).

In addition to the risk of psychological harm, serious bodily injury or possibly death absent an injunction, Plaintiff will also suffer irreparable harm in the deprivation of her constitutional rights. "'When an alleged constitutional right is involved, most courts hold that no further showing of irreparable injury is necessary.'" *Kikumura v. Hurley*, 242 F.3d 950, 963 (10th Cir. 2001) (citing 11A Charles Alan Wright, Arthur R. Miller & Mary Kay Kane, Federal Practice and Procedure § 2948.1 (2d ed. 1995)). "It has long been established that the loss of constitutional freedoms, 'for even minimal periods of time, unquestionably constitutes irreparable injury.'" *Mills v. District of Columbia*, 571 F.3d 1304, 1312 (D.C. Cir. 2009) (*quoting Elrod v. Burns*, 427 U.S. 347, 373 (1976) (plurality)); *Klayman v. Obama*, 957 F. Supp.

2d 1 (D.D.C. 2013) (same), *appeal docketed*, No. 14-5027 (D.C. Cir. Aug. 28, 2014). Here, Plaintiff has clearly shown a strong likelihood of success on the merits of her Eighth Amendment claim and that absent an injunction her constitutional right to be free from cruel and unusual punishment will be lost.

III. THE BALANCE OF HARMS STRONGLY FAVORS PLAINTIFF

The balance of harms strongly favors the Plaintiff. As Plaintiff has shown, the harm to her is significant. Every day that she goes without necessary treatment her mental health deteriorates and her risk of future suicidality and self-harm increases. The risk to her mental and physical health is both great and certain. (Ettner Decl. ¶¶ 56, 61). On the other side of the scale, Defendants will not suffer any harm – much less irreparable harm – from providing necessary medical care to Plaintiff consistent with their constitutional obligations. *See, e.g., Brugliera v. Comm'r of Mass. Dep't of Corr.,* No. 07-40323, 2009 U.S. Dist. LEXIS 131002 *34-5 (D. Mass. Dec. 16, 2009) (balance of harms favored plaintiff who would "suffer ongoing irreparable harm manifested by intense mental anguish" while defendants would experience minimal security risks); *Gammett v. Idaho State Bd. of Corrs.*, No. CV05–257, 2007 WL 2186896, at *15-16 (D. Idaho July 27, 2007) (balance of harms "sharply" favored plaintiff, who would experience extreme mental harm, including suicide attempts, without GID treatment, while defendants did not allege that they would suffer harm from providing such treatment). The government cannot suffer harm by being required to comply with the law. *Zepeda v. INS*, 753 F.2d 719, 727 (9th Cir. 1983).

IV. AN INJUNCTION IS IN THE PUBLIC INTEREST

It is in the public interest to uphold constitutional protections. *See*, *e.g.*, *O'Donnell Constr. Co. v. District of Columbia*, 963 F.2d 420, 429 (D.C. Cir. 1992) ("[I]ssuance of a

preliminary injunction would serve the public's interest in maintaining a system of laws free of unconstitutional racial classifications."); *Cortez III Serv. Corp. v. Nat'l Aeronautics & Space Admin.*, 950 F. Supp. 357, 363 (D.D.C. 1996) (public interest served by upholding the Constitution); *Kotz v. Lappin*, 515 F. Supp. 2d 143, 152 (D.D.C. 2007) ("The public certainly has an interest in the judiciary intervening when prisoners raise allegations of constitutional violations." (*citing Rhodes v. Chapman*, 452 U.S. 337, 362 (1981)); *Klayman*, 957 F. Supp. 2d at 42 ("'[I]t is always in the public interest to prevent the violation of a party's constitutional rights.'" (internal citations omitted)).

CONCLUSION

For these reasons, the Court should issue a preliminary injunction directing Defendants to provide Plaintiff with clinically appropriate treatment under the *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* developed by the World Professional Association for Transgender Health, including, but not limited to, (1) providing hormone therapy for Plaintiff's gender dysphoria; (2) permitting Plaintiff to express her female gender by following female grooming standards, including dress and hair length; and (3) providing Plaintiff with treatment by a clinician who is qualified to treat gender dysphoria.

The Court should require no bond or at most a nominal bond under Fed. R. Civ. P. 65(c). "The amount of security required is a matter for the discretion of the trial court; it may elect to require no security at all." *Corrigan Dispatch Co. v. Case Guzman, S.A*. 569 F.2d 300, 303 (5th Cir. 1978); *see also Cobell v. Norton*, 225 F.R.D. 41, 50 n. 4 (D.D.C. 2004) ("it is within the Court's discretion to waive Rule 65(c)'s security requirement where it finds such a waiver to be appropriate in the circumstances"). Plaintiff is in no position to post a bond, and her government-imposed poverty should not prevent the Court from enjoining the government's

ongoing violation of her constitutional rights. *See NRDC v. Morton*, 337 F. Supp. 167 (D.D.C. 1971).

Respectfully submitted,

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September 23, 2014

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHELSEA ELIZABETH MANNING, Plaintiff, v. CHUCK HAGEL, *et al.*, Defendants.	Civ. No. _____

DECLARATION OF CHELSEA E. MANNING

1. I, the undersigned declarant, Chelsea E. Manning, hereby state the following in support of this action.

BACKGROUND

2. My name is Chelsea Elizabeth Manning. I am 26 years old. I am presently incarcerated at the United States Disciplinary Barracks at Fort Leavenworth, Kansas (USDB), serving a thirty-five year sentence issued at a general court-martial for charges related to the unauthorized disclosure of classified and otherwise sensitive documents and information. I am currently appealing that conviction and my sentence.

3. I have struggled with my gender identity throughout my life. I have always known that I was "different" but it was not until adulthood that I connected this sense of being different to my gender identity. Growing up I was often picked on at home and in school for being effeminate. I was called "girly-boy," "faggy," and "queer" merely for being myself and having different interests and behaviors than my male peers at school and from what my teachers expected.

4. As I grew older, I desperately wanted to fit in at school. I engaged in traditionally masculine activities at school in an effort to fit in and presented myself in a masculine manner. I tried to suppress my interest in anything that could be considered feminine.

5. However, I secretly and frequently cross-dressed. Often, after cross-dressing in private, I would purge myself of anything feminine, throwing away any clothing or cosmetics that I had. Then, a few weeks later, I would cross-dress again.

6. By 2005, I openly identified as a gay male. But, even after coming out and after leaving school and living on my own, I continued to feel unsettled and a sense of my true identity would haunt me.

7. In the spring of 2007, I saw a psychologist to talk to about my "gender issues." But after seeing the psychologist a couple of times, I suppressed the desire to talk about my femininity and never brought it up.

8. In the summer of 2007, I enlisted in the United States Army as an all-source intelligence analyst.

9. It was not until 2009 that I truly came to terms with my identity as a transgender woman. At that time I was deployed in Iraq.

10. Unfortunately, I came to terms with my gender identity at a time when it was not safe to publicly come out as transgender or express my female identity. The military, and the conflict in Iraq in particular, was a very masculine and aggressive environment. Any expression of my female identity or any femininity would be frowned upon and ridiculed, and could have led to administrative or criminal sanctions.

11. I felt trapped, with nowhere to go, and no one to turn to. But, I finally knew who I was.

12. While on leave in the middle of my deployment, I finally gained the courage to live publicly as a woman, and I spent three days during that leave living as a woman. Those three days living publicly as a woman were transformative. For the first time, I felt a complete a sense of calm about who I was. However, I still had to return to Iraq, and I continued my deployment until the time I was placed under investigation and ordered into pre-trial confinement for the offenses for which I was convicted at my subsequent court-martial.

13. In May of 2010, I was first diagnosed with what was then still called gender identity disorder but was not provided any treatment.

14. In June and July 2010, while held in a cell at a temporary detention camp at Camp Arifjan, Kuwait, I began to openly identify as a female. During that time, I also grew depressed and desperate as I realized that I would be publicly known as male and pictures of me as a boy were being circulated. I was terrified that I was never going to receive treatment for my condition. I contemplated self-surgery and even planned to commit suicide. One of my plans was discovered, and I was placed on suicide watch for the remainder of my time at Camp Arifjan.

15. I was transferred from Kuwait to Quantico, Virginia on July 29, 2010. From Quantico, I was sent to the Joint Regional Correctional Facility at Fort Leavenworth, Kansas in April 2011.

16. After being sentenced on August 21, 2013, I was transferred to the USDB, also in Fort Leavenworth, on August 22, 2013. I have been at the USDB since then.

GENDER DYSPHORIA DIAGNOSES

17. I have been diagnosed with gender dysphoria (formerly known as gender identity disorder (GID)) by multiple doctors. I was first diagnosed with GID on May 8, 2010, by Captain Michael Worsely, a clinical psychologist, at Contingency Operating Station, Hammer, Iraq. I was not provided any treatment at that time.

18. Later, I received successive diagnoses of gender dysphoria/GID by multiple military mental health providers and experts while confined at Camp Arifjan, Kuwait; Marine Corps Base Quantico, Virginia; and Fort Leavenworth, Kansas. I was not provided with any treatment for gender dysphoria in Kuwait, at Quantico or at Fort Leavenworth.

19. My Rule 706 Board, convened under the Rules for Court-Martial to assess my mental fitness to stand trial, was conducted by Dr. Michael Sweda, Lieutenant Colonel Maria Hempill and Major Samantha Benesh on April 22, 2011. This Board confirmed my diagnosis of gender dysphoria and also documented my request for medical treatment for gender dysphoria including permission to express my gender in a manner consistent with my female gender identity (*i.e.*, through female clothing and grooming standards) and hormone therapy.

REQUESTS FOR TREATMENT TO THE DIRECTORATE OF TREATMENT PROGRAMS AT THE UNITED STATES DISCIPLINARY BARRACKS

20. I arrived at the USDB on August 22, 2013. At that time, I provided a memorandum to the USDB's Directorate of Treatment Programs (DTP) requesting that the United States Army provide me with a mental health assessment and treatment plan consistent with the standards of care for treating gender dysphoria. I gave this memorandum to Captain Varner, the officer who transported me from my court-martial at Fort Meade, Maryland to the USDB. As far as I am aware, Captain Varner then passed the memorandum on to the DTP staff when I arrived.

21. Later that same day, John Lesniak, Chief Assessment Division, DTP conducted a series of interviews and evaluations to assess my treatment needs and risk for sexual victimization at the USDB. During those assessments, Mr. Lesniak designated me as high risk for sexual victimization based on the fact that I am transgender, am effeminate and have a slight build, among other things. He also told me that the USDB and United States Army policy limit treatment for gender dysphoria to psychotherapy and, if prescribed by a psychiatrist, anti-anxiety and anti-depressant medication.

22. On August 28, 2013, I delivered a Military Corrections Complex (MCC) Department of Defense (DD) Form 510 requesting a "mental health evaluation and treatment plan for Gender Dysphoria/[GID]." I addressed the form to Lieutenant Colonel Nathan Keller, the USDB's Director of Treatment Programs and sent it through a Special Housing Unit Correctional Treatment Team member. I also attached a copy of my August 22, 2013 memorandum.

23. On September 12, 2013, I met with Dr. Ellen Galloway, the Chief of the Mental Health Division of the USDB's DTP. Dr. Galloway informed me that that she would conduct an assessment using psychological tests, interviews, medical records, and other documents and that following such tests she would write up a report including any diagnoses, which would be forwarded to the U.S. Army Western Regional Medical Command (WRMC) and the U.S. Army Corrections Command (ACC).

24. Over the course of two weeks in September 2013, Dr. Galloway conducted psychological tests and one-on-one interviews with me. It is my understanding that she also received the complete, unredacted version of the R.C.M. 706 Board findings from my civilian trial defense counsel.

25. During this time, Dr. Galloway also informed me that she reviewed a letter from Dr. David Moulton, Assistant Professor of Psychiatry at the Department of Psychiatry, University of Utah, which documented my gender dysphoria diagnosis and treatment needs. Dr. Moulton had evaluated me extensively as a defense forensic psychiatrist from August 2011 to August 2013.

26. On October 1, 2013, I was released from the Special Housing Unit where I had been placed upon my arrival, and entered the general population (GP). In GP, I was housed in a unit with approximately sixty single-person cells around a triangular common area, where I still live today. In this housing unit, I, and other prisoners, are free to move, mostly without escorts or restraints, but monitored constantly and never alone with other prisoners outside the sight and sound of staff. The only time I am out of view of staff is when using a single-person restroom or when inside my cell.

27. Later on October 1, 2013, Dr. Galloway notified me that she completed her assessment. She told me that I met the criteria for a diagnosis of gender dysphoria and that she would be diagnosing me with the condition. She also said that her report would be reviewed by another consulting psychologist, Dr. Patrick Armistead-Jehle, before being forwarded to the WRMC and ACC.

28. A few weeks later on October 31, 2013, Colonel Ricky Malone, an Army forensic psychiatrist from Bethesda, Maryland, conducted another interview of me as part of an additional psychiatric assessment for the establishment of a treatment plan. He continued this interview on November 1, 2013. I never saw or met with Col. Malone again.

29. On or about November 25, 2013, Dr. Galloway informed me that a proposed treatment plan was completed and sent to the WRMC, ACC, and the U.S. Army Office of the Surgeon General.

30. After this discussion with Dr. Galloway, I did not hear anything about my treatment for over a month. I started to become anxious and fearful that I would not be provided treatment. This was my greatest fear.

31. On January 5, 2014 I submitted a Military Corrections Complex DD Form 510 to DTP requesting an update on the status of my treatment.

32. I continued to meet with Dr. Galloway regularly to discuss my mental health. During these meetings I expressed my ongoing distress over not being provided with treatment for gender dysphoria. Dr. Galloway repeatedly told me that the requests were being reviewed at various commands, then later she informed me that the requests were at "the highest levels," and ultimately, that decisions related to my health care would be decided by the Secretary of Defense.

33. While my other treatment requests were pending, on April 2, 2014, I submitted a request to the DTP at the USDB for permission to follow hair and grooming standards for female prisoners; female-specific issued clothing; and additional, female health and grooming items. On July 23, 2014, having received no response, I submitted a second request renewing the April 2, 2014 request.

34. I have not received a response to either my April 2, 2014 or my July 23, 2014 request. On August 21, 2014, I submitted a request for exception to Policy to Army Regulation 670-1 to the Deputy Chief of Staff, G-1, Department of the Army, for permission to use the female hair grooming, cosmetic, and nail grooming standards in Chapter 1-8 of AR

670-1 as part of my medically supervised treatment for gender dysphoria. I have received no response to that request either.

REQUESTS FOR TREATMENT THROUGH COMMANDANT AND CHAIN OF COMMAND

35. On January 21, 2014 I submitted a request for redress pursuant to Army Regulation (AR) 27-10 and Article 138, Uniform Code of Military Justice (UCMJ) (10 U.S.C. § 938) to Colonel Ledwith, the Commandant of the USDB, and Captain Andre D. Byrd, my commander at the Personnel Control Facility at Fort Sill, Oklahoma, requesting that I receive treatment for my diagnosed gender dysphoria in accordance with the World Professional Association for Transgender Health Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People (WPATH Standards of Care).

36. In an undated memorandum, Captain Byrd responded to my request and indicated that he did not have the authority to implement a treatment plan for me and therefore could not commit a "wrong" against me within the meaning of Article 138.

37. Without any other available recourse and fearful that I would continue to be denied treatment, on March 4, 2014, I submitted an Article 138 complaint of wrong against both Colonel Ledwith and Captain Byrd. I alleged that by withholding treatment for my diagnosed gender dysphoria, Colonel Ledwith and Captain Byrd had caused me significant harm. To remedy the ongoing harm, I requested treatment for my gender dysphoria in accordance with the WPATH Standards of Care.

38. After receiving no response for nearly two months, I requested an update on my complaint of wrong through counsel. On May 7, 2014, I learned that Major General James McDonald, the Fort Sill Commander, had found my complaint deficient on March 19, 2014. The two grounds for the deficiencies were 1) Colonel Ledwith is not my commanding

officer; and 2) Captain Byrd lacked the authority to approve the treatment plan. The deficiencies were deemed unwaivable.

39. On May 29, 2014, I filed a request with the U.S. Army Office of the Judge Advocate General (OTJAG) to allow me, and other inmates at the USDB, to file complaints under Article 138 about confinement conditions at Fort Leavenworth to the Commandant. Without such relief I would be unable to submit a complaint of wrong against an officer with the authority to remedy the wrongs.

40. This request was denied by the criminal division of OTJAG on July 3, 2014. According to OTJAG, the Commandant is not a commanding officer under Article 138 and therefore cannot receive complaints of wrong pursuant to this provision. Meanwhile, Captain Byrd, the only proper chain of command for such complaints, has no authority to approve my treatment plan.

ACTION REQUEST TO OFFICE OF THE INSPECTOR GENERAL

41. At the time I submitted my request for redress, on January 21, 2014, I also submitted an Inspector General Action Request to the Office of the Inspector General, U.S. Army Combined Arms Center, Fort Leavenworth, Kansas, alleging a denial of medical treatment by the DTP.

42. On January 30, 2014, the Office of the Inspector General responded that they were looking into my complaint, and on February 21, 2014, that office forwarded my complaint to the Western Regional Medical Command Inspector General (WRMC IG) at Joint Base Lewis McChord in Washington.

43. On April 4, 2014, the WRMC IG informed me that my action request had been sent to the Army Office of the Surgeon General and that the WRMC IG would take no further action on it.

44. To date, I have received no response from the Army Office of the Surgeon General.

LEGAL NAME CHANGE

45. I filed a petition on January 27, 2014, requesting a legal change of name from Bradley Edward Manning to Chelsea Elizabeth Manning in the District Court of Leavenworth County, Kansas.

46. In my petition, I stated that the request was being made because, while I was assigned male at birth, I identify as a female and felt uncomfortable with name I was given.

47. On April 23, 2014, my petition was granted and my name was ordered to be changed to Chelsea Elizabeth Manning.

48. In the weeks following the court order, I requested that my identification documents and military records be updated to reflect my new name. My name has been updated in my records at the USDB.

THE ARMY'S CONTINUED REFUSAL TO PROVIDE MEDICALLY NECESSARY TREATMENT

49. Despite my repeated efforts to follow each and every procedure to pursue medical treatment, I am not receiving hormone therapy or permission to follow to the hair, cosmetics, and nail grooming standards consistent with my female gender.

50. On August 20, 2014, approximately six weeks after my attorneys put in a request for my medical records from the USDB, I was informed that I would be issued sports

bras and female underwear. I received those items shortly thereafter but I have not been permitted follow female hair length and other female grooming standards that would allow me to outwardly feminize my appearance. And I have not been provided hormone therapy.

51. I have been receiving psychotherapy from Dr. Galloway, but she has informed me that she is not qualified to treat gender dysphoria.

52. Because I have not been treated with hormones or given permission to outwardly express my female gender by growing my hair and receiving permission to follow the other female grooming standards, I am becoming increasingly stressed, anxious and depressed.

53. Instead of feeling more like the woman I want to express myself as being, I feel like I am just a "man in a bra," and I feel as though I am slowly being poisoned by the testosterone that my body produces.

54. It has now been more than four years since I was first diagnosed with gender dysphoria, a condition that I have struggled with my entire life. It has been more than a year since I first requested treatment consistent with the WPATH Standards of Care at the USDB. My treatment request is, and has been, my highest priority since arriving at the USDB – even more than the appeal of my conviction and thirty-five year sentence. If my requests for medical treatment are ultimately denied, I do not believe I will be able to survive another year or two – let alone twenty to thirty years – without treatment.

55. Every day that goes by without appropriate treatment for my gender dysphoria, my stress and pain escalate and I fear for my long-term survival.

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

Executed: September 22, 2014.

/s/ *Chelsea E. Manning*
_____
CHELSEA E. MANNING

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHELSEA ELIZABETH MANNING, Plaintiff, v. CHUCK HAGEL, *et al.,* Defendants.	Civ. No. _____

DECLARATION OF DR. RANDI C. ETTNER

1. I, Randi C. Ettner, have been retained by counsel for Chelsea E. Manning to prepare this evaluation and declaration in connection with the above-referenced litigation. The purposes of this report are: i) to provide the Court with scientific information about gender dysphoria, the impact of this condition on the health and well-being of individuals who suffer from it, and the standard of care for treatment; and ii) to present the results of my evaluation of Ms. Manning, including my diagnosis and recommended treatment. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

Qualifications and Basis for Opinions

2. In arriving at the opinions and conclusions contained in this report, I have relied on a clinical interview with Ms. Manning, a psychodiagnostic assessment of Ms. Manning, a review of her medical records, my extensive experience diagnosing and treating gender dysphoria, and the body of research, including my own, in this area.

3. I began my work with transsexual patients in 1977, while an intern at Cook County Hospital.

4. I received my doctorate in psychology from Northwestern University in 1979.

5. I am the chief psychologist at the Chicago Gender Center, a position I have held since 2005. During the course of my career, I have evaluated or treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance.

6. I have published three books, including the medical text entitled *Principles of Transgender Medicine and Surgery* (co-editors Monstrey & Eyler; Routledge, 2007). I have authored numerous articles in peer-reviewed journals regarding the provision of health care to this population. I have served as a member of the University of Chicago Gender Board, and am a member of the editorial board for the *International Journal of Transgenderism*.

7. I am a member of the Board of Directors of the World Professional Association for Transgender Health (WPATH) (formerly the Harry Benjamin International 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 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.

8. I have lectured throughout North America and Europe on topics related to gender dysphoria.

9. I often give grand rounds presentations on gender dysphoria at medical hospitals.

10. I was deposed as an expert in the following cases over the past four years: *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).

11. I have been retained as an expert in gender dysphoria in multiple cases involving the treatment of gender dysphoria in prison settings.

12. In one of these cases, *Fields v. Smith*, No. 06-C-112 (E.D. Wisc. 2006), I gave testimony in court and was qualified as an expert.

13. I have appeared as an expert on gender dysphoria on hundreds of television and radio shows throughout the country, and I have been a consultant to news media.

14. My consulting fee is $250 per hour.

15. A true and correct copy of my Curriculum Vitae (CV), which includes all of my publications, is attached hereto as **Exhibit A**.

16. A bibliography of the sources referenced in this declaration is attached as **Exhibit B**.

Gender Dysphoria

17. Gender dysphoria, formerly known as gender identity disorder (GID), is a serious medical condition codified in the International Classification of Diseases (10^{th} revision; World Health Organization) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders–5^{th} edition (DSM-V). The condition is characterized by an incongruence between one's experienced/expressed gender and assigned sex at birth, and clinically significant distress or impairment of functioning as a result. The suffering that arises from this condition has often been

described as "being trapped in the wrong body." "Gender dysphoria" is also the psychiatric term used to describe the severe and unremitting emotional pain associated with the condition.

18. 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 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 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 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.

19. 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)). They are also frequently socially isolated because they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization that over time proves ravaging to healthy personality development and interpersonal

relationships. A recent survey shows a 41% rate of suicide attempts among transgender people, far above the baseline rates for North America. (Haas *et al.*, 2014).

20. Male-to-female transsexuals 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 distress. (Brown, 2010; Brown & McDuffie, 2009).

21. Gender dysphoria intensifies over time. The longer an individual goes without treatment, the greater the risk of severe harms to her health. (Ettner & Wylie, 2013; Ettner, 2013).

The Treatment of Gender Dysphoria

22. The standards of care for treating gender dysphoria are set forth in the World Professional Association for Transgender Health's *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (WPATH Standards of Care). The WPATH Standards of Care are recognized as authoritative by the American Medical Association, the American Psychiatric Association, and the American Psychological Association. (*See* American Medical Association (2008), Resolution 122 (A-08); American Psychiatric Association-DSM-V; American Psychological Association Policy Statement on Transgender, Gender Identity, and Gender Expression Non-discrimination (2009)).

23. The Standards of Care identify the following treatment protocols for treating individuals with 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.

24. 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.

25. The development of any treatment plan and all subsequent treatment must be administered by clinicians qualified in treating patients with gender dysphoria.

26. The WPATH Standards of Care specify the qualifications that professionals must meet in order to provide care to gender dysphoric patients. In addition to these minimum credentials, clinicians working with patients with gender dysphoria should develop and maintain cultural competence to facilitate their work. This specialized field of medicine is associated with a large amount of literature associated with ongoing improvements and refinements in care.

27. To develop competence in the assessment and treatment of gender dysphoria, clinicians should work under the supervision of mental health professionals with established expertise in this area and pursue self-study. Self-study, however, 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.

28. Treatment plans and decisions developed and made by individuals lacking the needed clinical experience can result in completely inadequate or even dangerous care for patients with gender dysphoria.

29. Psychotherapy or counseling can provide support and help with the many issues that arise in tandem with gender dysphoria. Counseling alone, however, is not a substitute for medical intervention where medical intervention is needed nor is it a precondition 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.

30. 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," 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 and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007).

31. For individuals with persistent, well-documented gender dysphoria, hormone therapy is essential and medically indicated treatment to alleviate the distress of the condition. 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)).

32. The goals of hormone therapy for individuals with gender dysphoria are 1) to significantly reduce hormone production associated with the person's birth sex and, thereby, the secondary sex characteristics of the individual's birth sex and 2) to replace circulating sex hormones associated with the person's birth sex with feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (i.e., males born with insufficient testosterone or females born with insufficient estrogen). (*See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009)).

33. The therapeutic effects of hormone therapy are twofold: 1) 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 2) 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, 1992).

34. The efficacy of hormone therapy to treat gender dysphoria is observed clinically and well documented in the literature. For example, in one study, researchers investigated 187 transsexual patients who had received hormones and compared them

with a group who did not. Untreated patients showed much higher levels of depression, anxiety, and social distress. (Rametti, *et al*., 2011; *see also* Colizzi, *et al*. 2014; Gorin-Lazard *et al*., 2011).

35. The beneficial physical and psychological effects of hormone therapy are so profound that individuals with gender dysphoria who lack access to medically supervised hormones often resort to procuring and using hormones without medical supervision. (Gooren, 2011).

36. For some individuals with gender dysphoria, relief cannot be achieved without surgical interventions to change primary or secondary sex characteristics, *e.g.* genital or chest reconstruction. The safety and efficacy of such treatments are observed clinically and well documented in the literature. (Pfafflin & Junge, 1998; Smith *et al*., 2005; Jarolim *et al*., 2009). Other individuals experience profound relief from hormone therapy alone and do not require surgical intervention. (WPATH Standards of Care, 2013).

37. Like 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 National Commission on Correctional Health Care (NCCHC) recommends treatment in accordance with the WPATH Standards of Care for people in correctional settings. (NCCHC Policy Statement, Transgender Health Care in Correctional Settings (October 18, 2009), http://www.ncchc.org/transgender-health-care-in-correctional-settings).

Evaluation of Chelsea Elizabeth Manning

38. I met with Chelsea Manning at the United States Disciplinary Barracks at Fort Leavenworth, Kansas on August 27, 2014. Prior to the meeting I reviewed Ms. Manning's medical records including: her Rule for Court Martial 706 evaluation; a July 29, 2010 Memorandum for Record signed by Jeffrey Barr, LCDR, USNR; Quantico observation notes from July 30, 2010 to April 15, 2011; and treatment records from Captain Worsely. During our meeting I administered four standardized psychometric indices with high levels of reliability and validity: the Beck Anxiety Inventory, the Beck Depression Inventory, the Traumatic Symptom Inventory, and the Beck Hopelessness Scale. I also conducted a clinical assessment of Ms. Manning's gender dysphoria and treatment needs.

Results of assessment

39. Ms. Manning presents with well-documented, intractable and untreated gender dysphoria. She meets the full criteria for the DSM-V diagnosis of the condition. Her medical records indicate that a diagnosis of gender dysphoria has been confirmed many times since her first diagnosis in 2010. The gender dysphoria is moderate-to-severe based on a review of Ms. Manning's medical records and my clinical assessment.

40. Ms. Manning has presented as female in the past when she was able, and has legally changed her name to reflect her affirmed female gender identity. This has been a crucial, but incomplete part, of her identity consolidation.

41. Ms. Manning experiences symptoms associated with generalized anxiety. The intensity of the symptoms is moderate to severe, and the symptoms are predominately somatic aspects of anxiety. These include feeling hot, heart pounding,

discomfort in abdomen, and face flushing. This cluster of symptoms describes autonomic aspects of anxiety, not subject to voluntary control or cognitive reappraisal.

42. Ms. Manning also reveals affective symptoms of depression—crying, sadness, loss of interest, and suicidal ideation.

43. Ms. Manning scores high on scales measuring the extent of hopelessness. Hopelessness is a psychological construct that underlies a variety of mental health disorders. Hopeless individuals believe that their important goals cannot be attained and that their worst problems will never be solved. (Stotland, 1969). The Beck Hopelessness Scale has utility as an indirect indicator of suicidal risk in individuals who have prior suicide attempts and ideation. Ms. Manning scored an 11 on this instrument. Scores of 9 or more were predictive of eventual suicide, and hopelessness has been repeatedly found to be a better predictor of suicide than depression. (Beck, 1986). A study of 1,969 outpatients who were administered the Beck Hopelessness Scale found that of those who ultimately committed suicide, 93.8% had scores of 9 or higher. Clinicians are advised to monitor patients describing moderate to severe levels of hopelessness for suicidal potential.

44. Hopelessness and depression often overlap with but differ from demoralization. Demoralization is common among prison inmates. It is characterized by the individual's awareness that they have failed to meet their expectations and an inability to cope with the present reality of their incarceration. Ms. Manning shows a relatively robust ability to deal with her external reality, and has adapted to incarceration. Her symptoms arise predominately from her internal experience of gender dysphoria and

the inability to modulate, avoid, or soothe the negative state. This creates a tendency in patients to externalize distress through suicidality, aggression, or self-mutilation.

45. Were Ms. Manning's gender dysphoria to be properly treated all of these symptoms would be attenuated or eliminated.

Treatment Recommendations

46. Based on my evaluation, it is my professional opinion that Ms. Manning's gender dysphoria requires immediate treatment by a qualified provider. My treatment recommendations for her are based on my clinical experience in evaluating and treating gender dysphoria, my knowledge of the literature in the treatment of gender dysphoria, and my assessment of Ms. Manning's particular clinical needs.

47. Because Ms. Manning presents with moderate-to-severe gender dysphoria that has persisted and is associated with clinically significant distress, hormone therapy is necessary and should be initiated immediately.

48. An appropriate hormone protocol for Ms. Manning would consist of estrogens (transdermal or injectable), anti-androgens (e.g. spironolactone 100mg 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.

49. In addition, she should be immediately permitted to outwardly express her female gender through grooming standards that permit her to grow her hair and to access cosmetic and grooming items available to female prisoners.

50. The provision of female underwear and sports bras to Ms. Manning in August of 2014 is not, on its own, treatment for gender dysphoria. The purpose of the

real life experience, which is an important part of treatment for Ms. Manning, is to consolidate the individual's gender identity. This requires the patient to outwardly present herself through social signifiers of gender consistent with her gender identity. Because undergarments are not seen by others, they do not allow the patient to communicate her gender to others, which is the essential component of this aspect of treatment. Thus, they are not a part of the real life experience on their own and will not alleviate Ms. Manning's distress or treat her gender dysphoria.

51. It is my opinion that at this time Ms. Manning's treatment needs have not been properly identified by her current providers.

Consequences of Lack of Treatment

52. Given that prisoners with untreated gender dysphoria often perform auto-castration (or attempt to), lack of appropriate health care, particularly for prisoners serving long sentences, places them at extremely high risk.

53. In the case of Ms. Manning, her medical records reflect that the desperation caused by her lack of treatment for gender dysphoria has, on more than one occasion, prompted her to have thoughts of performing self-surgery to remove her testicles. In addition, in 2010, while in Kuwait, she seriously contemplated and made plans to commit suicide. She stated that she felt helpless and hopeless and "gave up."

54. Ms. Manning's hope that she will receive treatment including hormone therapy and the ability to outwardly express her female gender is what sustains her. She is concerned with her treatment needs, above all else, including the appeal of criminal convictions.

55. Given that she has a history of suicidal ideation, a past concrete plan to commit suicide, and recurrent thoughts of auto-castration (self-surgery), Ms. Manning is at extremely high future risk for self-injury or suicide if treatment is withheld.

56. There are no contraindications to the implementation of my recommended treatment plan for Ms. Manning. The potential consequences of denying this treatment, however, are predictable and dire.

Summary of Opinions and Recommendations

57. Gender dysphoria is a serious medical condition that is diagnosed using the criteria set forth in the DSM-V.

58. Withholding medically necessary treatment will cause acute and chronic medical and mental health dangers. Since gender dysphoria tends to intensify over time, every month that goes by without this treatment increases the risk of serious harm.

59. Based on my evaluation of Chelsea Manning, it is my professional opinion that she has persistent gender dysphoria, a serious and pernicious medical condition for which she is not receiving adequate treatment.

60. Ms. Manning's treatment needs are urgent and cannot be met without immediately providing her 1) hormone therapy; and 2) permission to follow female grooming standards (including growing her hair in particular) that permit her to outwardly express her female gender.

61. Continuing to withhold this necessary treatment from Ms. Manning puts her at significant risk of disastrous health consequences that can and should be avoided.

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

Executed on September 18, 2014.

/s/ *Randi C. Ettner*
Randi C. Ettner, Ph.D

Exhibit A

RANDI ETTNER, PHD

1214 Lake Street
Evanston, Illinois 60201
Tel 847-328-3433 Fax 847-328-5890
rettner@aol.com

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialities
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Board of Directors, World Professional Association of Transgender Health (WPATH)
Chair, Committee for Incarcerated Persons, WPATH
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Chicago Gender Center
Adjunct Faculty, Prescott College
Editorial Board, International Journal of Transgenderism
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical staff privileges attending psychologist Advocate Lutheran General Hospital

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois Major: Clinical Psychology
BA, 1969-72	Indiana University (cum laude) Bloomington, Indiana Major: psychology, Minor: sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social relation undergraduate summer program in

group dynamics and processes

CLINICAL AND PROFESSIONAL EXPERIENCE

Present	Psychologist: Chicago Gender Center 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

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 transgendered 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 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. Surgical treatments for the transgender population in Lesbian, Gay, Bisexual, Transgender, and Intersex Healthcare: A Clinical Guide to Preventative, Primary, and Specialist Care. Ehrenfeld & Eckstrand, (Eds.) Springer: MA, in press.

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"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
Advisory Board, Literature for All of Us
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Board of Directors, Chiaravalle Montessori School
Phi Beta Kappa

AWARDS AND HONORS

Phi Beta Kappa, 1971
Indiana University Women's Honor Society, 1969-1972
Indiana University Honors Program, 1969-1972
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

Exhibit B

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHELSEA ELIZABETH MANNING, Plaintiff, v. CHUCK HAGEL, *et al.,* Defendants.	Civ. No. _____

DECLARATION OF CHASE B. STRANGIO

I, Chase B. Strangio, hereby declare and state as follows:

1. I am an attorney at the American Civil Liberties Union Foundation, and I am co-counsel for Plaintiff in this case.

2. I submit this declaration in support of Plaintiff's Motion for a Preliminary Injunction. The purpose of this declaration is to bring to the Court's attention medical records, official government documents, as well as information in the public domain, about Defendants' treatment of Plaintiff's gender dysphoria.

3. Attached hereto are true and correct copies of the following:

Document	Exhibit
Memorandum from Patrick Armistead-Jehle, Ph.D to Lt. Col. Nathan Keller (Oct. 1, 2013)	A
Memorandum from Nathan Keller to Mr. Steve Lynch (Oct. 15, 2013)	B
Memorandum from Ellen Galloway, PsyD, to Mr. Steve Lynch (Oct. 16, 2013)	C

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

September 22, 2014

/s/ *Chase B. Strangio*

_____

CHASE B. STRANGIO

Exhibit A

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
550 POPE AVENUE
FORT LEAVENWORTH KS 66027-2332

MCXN-CBH

1 October 2013

MEMORANDUM FOR LTC Nathan Keller, Director Treatment Programs, Military Correctional Complex, Fort Leavenworth, KS

SUBJECT: Peer review of Psychologial Assessment of Mr Bradley E. Manning (SS #445-98-9504) by Dr. Ellen Galloway.

1. Dr. Galloway diagnosed Mr. Manning with the following conditions per DSM-V criteria: 302.85 Gender Dysphoria; 301.89 Other Specified Personality Disorder – Mixed Features from Cluster B and C – Traits; Problems with the Legal System. I have completed a review of Dr. Galloway's Psychological Assesment Report and supporting documentation to include Dr. Galloway's clinical notes (SF600s dated 12 September 2013 through 24 September 2013), Mr. Manning's 706 Board dated 22 April 2011, and reported results of standardized psychological testing. I concur with the diagnoses concluded by Dr. Galloway.

2. The primary diagnosis is supported by Mr. Manning appearing to meet the following DSM-V criteria for Gender Dysphoria in Adults: A1, A2, A3, A4, A5, A6, and B.

3. Point of Contact for this memorandum is below and can be reached by e-mail at Patrick.j.armistead-jehle.civ@Mail.mil or by telephone at (913) 684-6771

PATRICK ARMISTEAD-JEHLE, Ph.D, ABPP-CN
Department of Behavioral Health
Munson Army Health Center
Ft Leavenworth, KS

Exhibit B

DEPARTMENT OF THE ARMY
UNITED STATES DISCIPLINARY BARRACKS
1301 NORTH WAREHOUSE ROAD
FORT LEAVENWORTH, KANSAS 66027-2304

REPLY TO
ATTENTION OF:

PMCC-DB

15 October 2013

MEMORANDUM THRU Commandant, United States Disciplinary Barracks, Ft Leavenworth, KS 66027

FOR Mr Lynch, Deputy Director, Army Corrections Command, Alexandria, VA 22332

SUBJECT: Treatment available for Mr Bradley E. Manning, SS #445-98-9504

1. Mr Manning was diagnosed with Gender Dysphoria. According to the Standards of Care codified by the World Professional Association for Transgendered Health, there are a variety of options for care of individuals who have been diagnosed with Gender Dysphoria, they include:

- "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." (p 9 & 10)

The standards make clear that different individuals will benefit from different interventions and that there is no single treatment protocol for this disorder. Generally, individuals with Gender Dysphoria start with psychotherapy and gradual changes in gender expression prior to hormone therapy or surgical intervention.

2. Mr Manning is being seen weekly for psychotherapy. Therapy is currently focused on Mr Manning's feelings about himself and his struggle in his interactions with others. We are also addressing the long-term impact his alexithymia has had on his interpersonal relationships. Finally, we are working on remediating his alexithymia and improving his social interactions. He appears to have a sound therapeutic rapport with Dr Galloway and is not considered a currently threat to himself. Additionally, it is estimated that the strength of the therapeutic rapport will led him to address any impulses toward self-harm with Dr Galloway prior to him acting in them. Mr Manning is scheduled to attend Anger Management in February 2014 and Reasoning and Rehabilitation in May 2014.

3. During the diagnostic assessment, it became clear that Mr Manning has educated himself on Gender Dysphoria and the potential interventions. He spoke of desiring to be permitted to live as a female, have hormone replacement therapy (HRT) and eventually most likely having an orchiectomy (surgical removal of the testicles). He is aware that the orchiectomy and some of the changes secondary to HRT are irreversible. He also has thought of feminization surgery for his face and speech therapy to help him appear more feminine. Mr Manning has given a great deal of thought to his condition and I believe he will be unwilling to accept psychotherapy as his sole intervention.

PMCC-DB
SUBJECT: Treatment available for Mr Bradley E. Manning, SS #445-98-9504

4. I see no way the USDB can provide a full course of therapy for Mr Manning's Gender Dysphoria. I have identified two paths for Mr Manning to start treatment locally but they are at best stop-gaps and will not meet the need. Should the Army determine that Mr Manning requires treatment for Gender Dysphoria, neither of the local options will meet the long term requirements of that treatment because the USDB cannot house a female or highly feminized inmate. Permitting Mr Manning to live as a female, much less begin to feminize his body, will create operational challenges as the inmate population respond to these changes. This has the potential to create conflicts within the inmate population secondary to the inmate population having different reactions to his changes; it also has the potential to create conflicts within the inmate population as some of them start to complete for his attention. Additionally, should Mr Manning begin to appear more feminine, the USDB will need to identify a process to keep Mr Manning safe.

5. Stop-gap treatment options:

a. The Transgender Institute in Kansas City can ensure the psychotherapy and medical interventions. Individual psychotherapy would cost $150.00 for a 50 minute session and be conducted weekly. When the therapist believes it is clinically appropriate, Mr Manning would also be enrolled in group therapy which would entail a weekly 90 minute session involving vocal feminization and deportment as well as traditional talk therapy. Group therapy is $40.00 a session. The Transgender Institute works closely with an endocrinologist and would make the referral for HRT. It also works closely with a surgeon who conducts gender reassignment surgery when necessary. The Transgender Institute is willing to work with an inmate who may be restrained and accepts the need for correctional officers to be present at all times.

b. The Transgender Institute would also be willing to provide supervision to Dr Galloway so she can engage in the initial psychotherapy with Mr Manning. This can be conducted in-person or via Skype. It would involve a weekly, 50 minute session; the fee has not been identified but is likely to be $150.00 a week.

6. Direct impact of treatment on the USDB. Taking Mr Manning to the Transgender Institute first weekly, then twice a week, will reduce our ability to provide other inmates with access to external medical appointments. Having Dr Galloway provide psychotherapy under supervision will reduce the amount of time she is available to complete her other duties by an hour a week, assuming the Directorate of Information Systems Security can facilitate access to Skype.

7. Point of Contact for this information is Dr Ellen Galloway. She can be reached at [redacted] or by calling [redacted]

NATHAN KELLER, Ph.D
Director, Treatment Programs
Military Correctional Complex
Ft Leavenworth, KS

Exhibit C

DEPARTMENT OF THE ARMY
UNITED STATES DISCIPLINARY BARRACKS
1301 NORTH WAREHOUSE ROAD
FORT LEAVENWORTH, KANSAS 66027-2304

REPLY TO
ATTENTION OF:

PMCC-DB

16 October 2013

MEMORANDUM THRU Commandant, United States Disciplinary Barracks, Ft Leavenworth, KS 66027

FOR Mr Lynch, Deputy Director, Army Corrections Command, Alexandria, VA 22332

SUBJECT: Treatment available for Inmate Bradley E. Manning

1. Inmate Manning is currently being seen weekly for psychotherapy. Generally speaking, we are addressing how Inmate Manning deals with his feelings and how he interacts with individuals in his environment. Inmate Manning is not currently considered a threat to himself or others and is capable of functioning in his current environment. We have established a therapeutic rapport and I believe he will address therapeutic issues with me before engaging in self-injurious behaviors. Inmate Manning is scheduled to attend Anger Management in February 2014 and Reasoning and Rehabilitation in May 2014.

2. Gender Dysphoria is a rare condition. According to the American Psychological Association's Ethical Principals of Psychologists and Code of Conduct (2010) psychologists only provide services within the scope of their competence. I do not have the expertise to develop a treatment plan or provide treatment for individuals with this disorder.

3. Point of Contact is the undersigned. I can be reached at [redacted] or by calling [redacted]

ELLEN H. GALLOWAY, PsyD
Chief, Mental Health Division
Directorate of Treatment Programs
Military Correctional Complex

Exhibit D

DEPARTMENT OF THE ARMY
UNITED STATES DISCIPLINARY BARRACKS
1301 NORTH WAREHOUSE ROAD
FORT LEAVENWORTH, KANSAS 66027-2304

REPLY TO
ATTENTION OF:

PMCC-DB

25 November 2013

27NOV13

MEMORANDUM THRU Commandant, United States Disciplinary Barracks,
Fort Leavenworth, Kansas 66027
Mr. Steve Lynch, Deputy Director, Army Corrections Command, Alexandria, Virginia 22332

FOR Commander, Army Corrections Command, Alexandria, Virginia 22332

SUBJECT: Treatment Plan for Inmate Bradley E. Manning

1. References:

U.S. Department of Justice, Federal Bureau of Prisons, Memorandum for Chief Executive Officers, Subject: Gender Identity Disorder Evaluation and Treatment, 31 May 2011

U.S. Department of Justice, Federal Bureau of Prisons, Memorandum for Chief Executive Officers, Subject: Gender Identity Disorder Evaluation and Treatment, 15 Jun 2010

U.S. Department of Justice, Federal Bureau of Prisons, Gender Dysphoria Resource Guide

Policy Review and Development Guide: Lesbian, Gay, Transgender and Intersex Persons in Custodial Settings, August 2013. U.S. Department of Justice, National Institute of Corrections

Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People, 2012, World Professional Association for Transgender Health

2. This treatment plan is based on recommendations made by Dr Ricky Malone, the expert provided by the Western Region of the Army Medical Department.

3. Treatment for individuals with Gender Dysphoria includes psychotherapy on Gender Dysphoria specific issues, real life experience (living as the internally experienced gender), hormone replacement therapy and gender reassignment surgery. Treatment for Gender Dysphoria is highly individualized. Treating an individual with Gender Dysphoria will involve one or more of the above interventions but may not require all of them. The specific interventions needed for any particular individual are usually identified through the therapeutic process. Generally the interventions are assumed to follow in the order listed above. Dr Malone recommended psychotherapy and real life experience as the minimal acceptable therapeutic interventions.

PMCC-DB
SUBJECT: Treatment Plan for Inmate Bradley E. Manning

4. Inmate Manning will receive weekly psychotherapy with myself to address issues specific to Gender Dysphoria. [redacted] I will continue to provide individual therapy on this and other issues for Inmate Manning as long as necessary.

5. Inmate Manning will be permitted Real Life Experience (RLE) by permitting him to purchase and wear standard Army issue underwear NSN 8425-01-515-9574 and sports bras NSN 8425-01-532-4526. These are projected NSN numbers, the actual NSN number will be determined once his size has been clarified.

6. Inmate Manning's mental health will be monitored to identify the impact of psychotherapy and real life experience. It is likely that additional interventions will become necessary such as hormone replacement therapy (HRT) or gender reassignment surgery (GRS). Should that occur, modifications will be made to this treatment plan and it will be submitted at that time.

7. POC for this treatment plan is the undersigned. I can be reached by calling [redacted]

ELLEN H. GALLOWAY, PsyD
Chief Mental Health Division
Directorate of Treatment Programs
Military Correctional Complex

Exhibit E

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Mar 14, 1400	**United States Disciplinary Barracks - Directorate of Treatment Programs**

Clinical Practice Guideline Queries 05/07

1. Does pt have pain? **No** Pain level: 1-10 _____ Pain location _____
Pain duration _____ Describe quality of pain: sharp dull stabbing throbbing other _____
Relieving factors _____ Exacerbating factors _____
Was pain addressed & intervention documented? **N/A** Was pt referred to sick call for pain? **N/A**
Was pain reported last session followed up on? **N/A**
2. Is the session post-deployment related? **No** Did you address / treat post-deployment issues **No NA**
3. Has pt used tobacco in the last 90 days? **No** Did you advise pt to quit tobacco **N/A**
Was pt. referred to sick call for tobacco cessation? **N/A**
4. In the past month has pt felt depressed, hopeless or anhedonic? **No** If "Yes" severity: 1-10_____
If 7+ did you consult with an ICP? **N/A** Was pt assessed for SI/HI and documented? **Yes**
If pt indicated "Yes" for SI/HI did you consult with an ICP? **N/A**
Was referral generated? **N/A**

S: Met with IM in my office. He's under less stress, somewhat, he got the bulk of his external requirements taken care of. Spoke with him about the Tx plan being somewhere up in the either. I had thought this might be resolved after Christmas. Told him I didn't know how much longer things would take, I am not in those teleconferences. Discussed, again, that these things take time and that it is either at ACC levels or above.

He has been working very hard to get everything done legally. People who are part of his support network ask for more from him than the can give. He's not getting enough sleep. He thought he'd be dome with his legal stuff by now but there's more to be done.

Ended up discussing perfectionism, needing to just feel like he's good enough, anxiety and stress management.

An additional part of his current stressors is the exhaustion of living in a way that's incongruent day after day after day. Remains unhappy with / uncomfortable with his body. Understands if he could have the HRT, etc, today he would still need work. Still, part of his exhaustion is from being his not-self every day.

O: IM was alert and oriented x4. He reported feeling stressed. His affect was fluid and appropriate to the topic being addressed. His thought process remained clear and basically logical. I saw no signs of a formal thought disorder.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*		REGISTER NO.	WARD NO.

Manning, B
Reg #89289

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	IM denied SI/HI and the presence of delusions was not noted. IM's insight appeared somewhat impaired and his judgment at this time is fair.
	A: Gender Dysphoria, R/O traits of Cluster B & C, need to explore this further.
	P: F/U next week.
	E: Looked at the relationship between schema and adult decisions. Also looked at what it will take for him to feel comfortable in his own skin.

Manning, B
Reg #89289

ELLEN H. GALLOWAY, PsyD
Chief, MHD

Manning, B

Exhibit F

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Jul 14, 1000	**United States Disciplinary Barracks - Directorate of Treatment Programs**

Administrative note

Received a letter from the ACLU enclosing a release information form requesting a copy all medical / mental health records be sent to the lawyer at the ACLU. Brought the letter and 2870 to the command suite who brought in CJA. I was told that the request would be staffed and I should wait for further guidance. I was given permission to inform IM Manning about the letter and process.

ELLEN H. GALLOWAY, PsyD
Chief, MHD

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*		REGISTER NO.	WARD NO.

Manning, B
Reg #89289

Exhibit G

DEPARTMENT OF THE ARMY
U.S. DISCIPLINARY HEALTH CLINIC
1301 N. WAREHOUSE ROAD
FORT LEAVENWORTH KS 66027-2332

REPLY TO
ATTENTION OF

MCXN-DCM-DB

20 AUG 2014

MEMORANDUM THRU DIRECTOR OF TREATMENT PROGRAMS

THRU DIRECTOR OF OPERATIONS

FOR USDB-DTP

SUBJECT: Medical Officer Recommendations for Inmate **Manning, Chelsea 89289**

1. I have assessed the medical case regarding the above-named inmate. Medical records were available for my review. Based on my assessment, I make the following recommendations:

- Allow I/M 12 pairs of female underwear
- Allow I/M 12 sports bras
- This profile must be kept on person at all times. IAW MGI.

2. **Any items issued to the inmate, by DTP, will be turned in upon expiration of profile.** Damaged and unserviceable items will not be thrown away. They are to be turned in to DTP for replacement.

3. The above recommendations are effective immediately, and will remain in effect until modified or rescinded by the DTP Counselor or other designated staff member from DTP.

4. Expires 14 AUG 2015

5. Point of Contact is Ms Clarrey, Administrative Assistant, DTP at 758-3751.

ELLEN H. GALLOWAY, PsyD
Chief Mental Health Division
Fort Leavenworth KS 66027

Distribution (4)
(1) USDB Health Clinic Files
(1) Individual Behavioral Health Record
(1) Control/Operations
(1) Individual

Exhibit H

DEPARTMENT OF THE ARMY
UNITED STATES DISCIPLINARY BARRACKS
1301 NORTH WAREHOUSE ROAD
FORT LEAVENWORTH, KANSAS 66027-2304

September 2, 2014

Mr. Chase Strangio
American Civil Liberties Union Foundation
125 Broad Street, 18th Floor
New York, NY 10004-2400

Dear Mr. Strangio:

I am writing on behalf of all addressees in response to your August 11, 2014 letter concerning medical treatment for Inmate Chelsea Manning. This response includes personal and medical information protected by law, and it is provided to you based on your legal representation of Inmate Manning and Manning's signed Privacy Act release. In your letter, you allege that the United States Disciplinary Barracks (USDB) is withholding medically necessary care from Inmate Manning. This is incorrect. The Army recognizes and fully accepts its responsibility to provide medically necessary care for each inmate at the USDB, based on an individualized assessment of each inmate's medical needs balanced against the Army's penological, security and disciplinary interests.

The U.S. Army is currently providing Inmate Manning with appropriate treatment for gender dysphoria, as recommended by Inmate Manning's authorized health care provider. Specifically, Inmate Manning continues to receive weekly psychotherapy sessions, and these sessions have been expanded to include therapy for gender dysphoria. Inmate Manning has also been permitted to begin the "real-life experience" treatment by being issued female undergarments, specifically female underwear and sports bras. This treatment is consistent with the current medical diagnosis and treatment plan recommended by Inmate Manning's authorized health care provider. To date, there has been no recommendation by Inmate Manning's authorized health care provider for any other medical treatment for gender dysphoria, including hormonal therapy. Should Inmate Manning's authorized health care provider make such a recommendation, it will be addressed at that time.

Please be advised that Inmate Manning was notified on July 18, 2014 that appropriate treatment for gender dysphoria would be provided. Inmate Manning was told that this treatment would include psychotherapy specific to gender dysphoria and the issuance of female undergarments. I will also provide Inmate Manning with a copy of this correspondence.

Sincerely,

Erica C. Nelson
Colonel, U.S. Army
Commandant

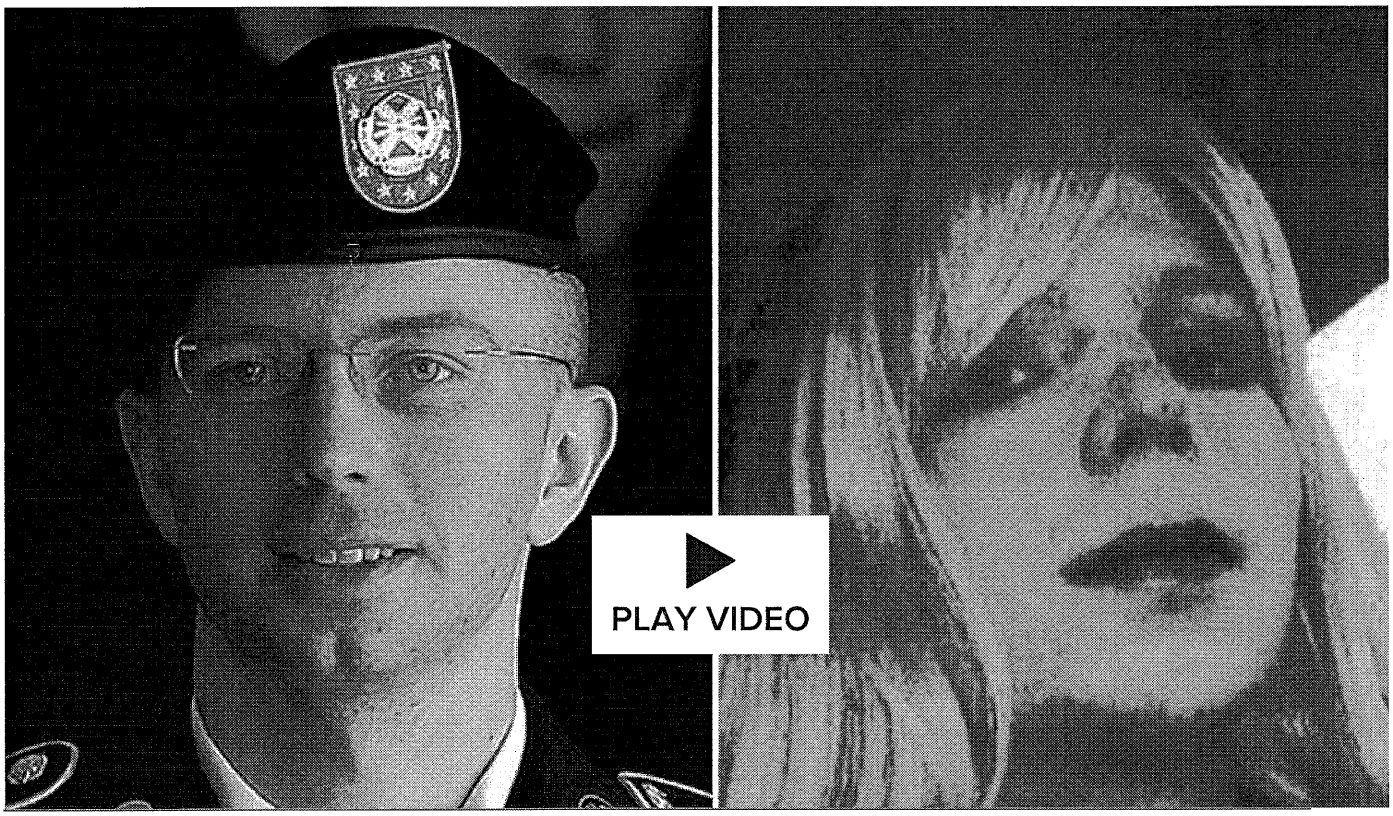
Exhibit I

Aug 22

Beginning gender change in prison is a long shot

COLLAPSE STORY

BY JONEL ALECCIA



Bradley Manning: I want to live as a woman

TODAY

Bradley Manning may want to live as a woman, but the young man sentenced to prison this week for leaking hundreds of thousands of secret government documents will face a difficult — if not impossible — task of beginning to switch his gender behind bars.

Manning, 25, announced through his lawyer on TODAY Thursday that he intends to request hormone therapy while at Fort Leavenworth prison.

"I am Chelsea Manning. I am female," the Army private wrote in a statement read on TODAY Thursday.

Throughout Manning's court-martial for divulging government papers to the website WikiLeaks, the soldier's gender confusion was a factor used by the defense.

The move raises a host of questions about Manning, about transgender inmates in the U.S. -- and about the treatment itself. Here are answers from experts and advocates familiar with sex-change issues.

Can Manning get hormone therapy in a U.S. military prison?

Manning is being held at the military prison in Fort Leavenworth, Kan., where the now discharged soldier is expected to serve at least seven years and up to the full sentence of 35 years.

"The Army does not provide hormone therapy or sex-reassignment surgery for gender identity disorder," Kimberly Lewis, a spokeswoman for the prison, told NBC News.

Manning's lawyer, David Coombs, told TODAY that he's "hoping" Fort Leavenworth "would do the right thing" and provide hormone therapy for Manning. "If Fort Leavenworth does not, then I'm going to do everything in my power to make sure they are forced to do so."

Coombs said that Manning hasn't discussed whether to pursue sex-reassignment surgery while in prison.

Why would he need such treatment?

Manning reportedly expressed ongoing distress over gender confusion and created an identity dubbed "Breanna" while deployed, and now identifies as a "she" named "Chelsea." She was diagnosed with gender dysphoria, the preferred term for gender identity disorder, or GID, according to Dr. David Moulton, the defense's expert on forensic psychiatry. It's a rare condition in which people feel that their physical gender does not match who they are on the inside.

In a statement read on TODAY, Manning wrote: "Given the way that I feel, and have felt since childhood, I want to begin hormone therapy as soon as possible. I hope that you will support me in this transition."

Have other prisoners received hormone therapy or sex-change surgery?

No inmates have received sex-reassignment surgery while in U.S. prisons, though dozens of lawsuits have forced changes at the state and federal level that have opened the door to such treatment, said Jennifer Levi, director of the Transgender Rights Project for the Gay & Lesbian Advocates and Defenders, or GLAD.

In the highest-profile case so far, a Boston judge told Massachusetts officials to grant the procedure last year to a transgender prisoner, Michelle Kosilek. Kosilek, formerly known as Robert, is facing a life sentence for the 1990 murder of wife Cheryl Kosilek. Kosilek's doctors have said that surgery is the only treatment that will fully address her gender identity disorder; she attempted castration and tried to commit suicide twice while held in an all-male prison. That court decision is pending on appeal. Kosilek has already received hormone therapy and laser hair removal.

In this undated photo provided by the U.S. Army, Pfc. Bradley Manning poses for a photo wearing a wig and lipstick. Manning emailed his military therapist the photo with a letter titled, "My problem," in which he described his issues with gender identity and his hope that a military career would "get rid of it."

Other inmates have received hormone therapy and other care for transgender issues. Under old rules, transgender inmates housed by the federal Bureau of Prisons were treated only for their existing conditions when they were admitted to prison. If they took hormones, for instance, that was maintained. But in 2010, after a lawsuit, the prison bureau changed its policy to allow treatment and care for problems diagnosed after incarceration. “Treatment options will not be precluded solely due to the level of services received, or lack of services, prior to incarceration,” the new policy states. That opens the door to new options, including surgery.

Very little is known about transgender inmates in military prisons, advocates say. Manning's request may even be unprecedented.

How often does this happen?

No one knows how many of the nearly 2.3 million prisoners in the U.S. are identified as transgender. A 2010 study by the California Department of Corrections identified more than 330 transgender inmates in a population of about 160,000, equal to about 0.2 percent. But the National Center for Transgender Equality estimates that the actual figure may be much higher. When that group surveyed transgender people in 2011, officials found that 16 percent of nearly 6,500 respondents reported that they’d been jailed at some time in their lives.

Why is this the prison's problem?

Doctors who treat transgender people and advocates who lobby on their behalf say that inmates are legally entitled to health care while incarcerated -- including services for gender identity issues.

"Treatment for people with severe gender dysphoria is medically necessary," said Dr. Sherman Leis of the Philadelphia Center for Transgender Surgery, who performs sex-change operations three days a week.

Just as diabetics need insulin and people with heart problems need surgery, inmates with gender identity-related health problems require the most appropriate treatment, said Mara Keisling, executive director of the National Center for Transgender Equality.

"This is America; we do not deny prisoners health care," Keisling said. "What happens if they break a leg while they're in custody? What happens if they develop schizophrenia? It is illegal to withhold those treatments."

What kind of 'treatment' are we talking about?

For those in and out of prison, switching genders is a protracted, complicated process that involves years of psychiatric counseling, hormone therapy and -- sometimes, but not always -- surgery, experts say.

Male-to-female transgender people typically take the female hormone estrogen in sufficient doses to influence the development of breasts and other secondary sex characteristics. They must receive adequate regular doses for the rest of their lives to maintain their new gender. They often also undergo laser hair removal.

If surgery is indicated, it can involve a range of procedures including removal of the original sex organs and reconstruction of new genitals. Other surgeries can include removing or augmenting breasts and reshaping facial contours, Leis said.

Coombs, Manning's lawyer, told TODAY that his client's final goal is not necessarily surgery.

"No, I think the ultimate goal is to be comfortable in her skin and to be the person that she never had an opportunity to be," Coombs said.

How much does it cost? And who pays?

Cost ranges widely from $12,000 to $30,000 or more for surgery with ongoing costs of up to $200 a month for hormone therapy and more for psychotherapy.

If a prisoner receives care while incarcerated, the taxpayers would foot the bill, advocates say.

***Can this be a ploy for men to get into a women's* prison?**

GID is diagnosed by a doctor and the life-altering treatment must be prescribed. Besides, prisons usually go by birth gender when assigning inmates, so even after gender reassignment, a newly female prisoner could end up in a male population— or in isolation for her own protection.

Fort Leavenworth spokesman George Marcec told the Associated Press that Manning would need to petition for a transfer to a federal prison to receive hormone treatment. In addition, the prison staff can separate high-risk prisoners from the general population based on the level of security risk to the inmate and others, he added.

Officials with the United States Disciplinary Barracks said that they have procedures to ensure that Manning and any other transgender inmates are protected from abuse and assault while in custody.

"The USDB has implemented risk assessment protocols and safety procedures to address high risk factors identified

with the Prison Rape Elimination Act," the agency said in a statement.

First published August 22nd 2013, 9:28 am

Sierra Leone Begins Three-Day Ebola Lockdown

COLLAPSE STORY

Thousands of health workers knocked on doors across Sierra Leone on Friday in search of hidden Ebola cases as the entire West African nation was locked down in their homes in an unprecedented effort to combat the deadly disease.

Authorities hope to find and isolate Ebola patients who have resisted going to health centers, often seen only as places to die. UNICEF said the measure provides an opportunity to tell people how to protect themselves. "If people don't have access to the right information, we need to bring life-saving messages to them, where they live, at their doorsteps," said Roeland Monasch, UNICEF Representative in Sierra Leone.

Some international health experts have warned that such a strategy could backfire, especially if there are not enough beds at treatment centers for all the new patients found during the three-day lockdown which began Friday. During this first-ever Ebola outbreak in West Africa, some people have lashed out at health workers, accusing them of bringing the dreaded disease. Six people have been arrested in the killings of eight people in Guinea who had been on an Ebola awareness campaign there, the Guinean government said Friday.

Exhibit J

Chelsea Manning may be transferred to civilian prison for gender treatment

Defence secretary has given approval for army to try to work out transfer plan with Federal Bureau of Prisons, officials say

Associated Press in Washington
theguardian.com, Wednesday 14 May 2014 03.39 EDT

Chelsea Manning, convicted last year of passing classified documents to WikiLeaks, has asked for hormone therapy and to be able to live as a woman. Photograph: AP

The Pentagon is trying to transfer Chelsea Manning to a civilian prison so that she can get treatment for her gender disorder.

Manning, who was convicted last year of passing classified documents to WikiLeaks, has asked for hormone therapy and to be able to live as a woman.

It was the first such request by a transgender military inmate, and set up a dilemma for the US defence department: how to treat a soldier for a diagnosed disorder without violating longstanding military policy.

Transgender people are not allowed to serve in the US military, and the defence

department does not provide such treatment, but Manning cannot be discharged from the service while serving her 35-year prison sentence.

Some officials have said privately that keeping the soldier in a military prison and unable to have treatment could amount to cruel and unusual punishment.

Last month, the defence secretary, Chuck Hagel, gave the army approval to try to work out a transfer plan with the Federal Bureau of Prisons, which does provide such treatment, two Pentagon officials said. The two agencies were just starting discussions about prospects for a transfer, the officials said.

The Pentagon press secretary, Rear Admiral John Kirby, said: "No decision to transfer Private Manning to a civilian detention facility has been made, and any such decision will, of course, properly balance the soldier's medical needs with our obligation to ensure she remains behind bars."

The army has a memorandum of agreement with the Bureau of Prisons for use of several hundred beds and has sent an average of 15 to 20 prisoners a year to civilian prisons. But the circumstances are different in Manning's case. The army normally transfers some prisoners to federal prisons after all military appeals have been exhausted and discharge from military service has been executed. Cases of national security interest are not normally approved for transfer from military custody to the federal prison system.

Manning, a former intelligence analyst, was sentenced in August for six Espionage Act violations and 14 other offences for giving WikiLeaks more than 700,000 secret military and US state department documents, along with battlefield video, while working in Iraq in 2009 and 2010.

After the conviction, Manning announced the desire to live as a woman and to change her name from Bradley, which the military did not oppose and which was approved last month by a Leavenworth county district judge.

The soldier has been diagnosed by military doctors multiple times with gender dysphoria. By November, a military doctor had approved a treatment plan including hormone therapy, but it was sent higher up the chain of command for consideration, according to a complaint filed by Manning in March over the delay in getting treatment.

The plan the military was considering has not been publicly released, but Manning said in the complaint that she had specifically asked that the treatment plan consider three types of treatment.

They were "real-life experience" – a regimen in which the person tries dressing and

living as the gender they want to transition to (something not possible in the Leavenworth men's facility); hormone therapy, which changes some physical traits such as breast and hair growth; and gender reassignnment surgery. Manning has not been specific about possible surgery, but experts in transgender health say it can include any of a large number of procedures such as chest reconstruction, genital reconstruction and plastic surgery such as facial reconstruction.

Hagel said on Sunday that the prohibition on transgender individuals serving in the armed forces "continually should be reviewed". He did not indicate whether he believed the policy should be overturned, but said: "Every qualified American who wants to serve our country should have an opportunity if they fit the qualifications and can do it."

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Exhibit K

Chelsea Manning to begin gender treatment in US military custody

Bureau of Prisons rejected Army request, so military must begin treatment for Manning's gender-identity condition

Associated Press in Washington
theguardian.com, Thursday 17 July 2014 16.42 EDT

Manning has been diagnosed with gender dysphoria, the sense of being a woman in a man's body. Photograph: AP

The US Bureau of Prisons has rejected the Army's request to accept the transfer of national security leaker Private Chelsea Manning from a military prison. So the military will begin treatment for her gender-identity condition.

A defense official said Defense Secretary Chuck Hagel has approved the Army's recommendation to keepManning in military custody and start a rudimentary level of gender treatment.

The Army tried to get Manning transferred to the federal prison system, but officials said those discussions have ended.

Manning has been diagnosed with gender dysphoria, the sense of being a woman in a man's body. Civilian prisons can provide treatment, but the Defense Department doesn't have the medical expertise needed.

Officials spoke on condition of anonymity because they were not authorized to discuss the matter publicly by name.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHELSEA ELIZABETH MANNING,

Plaintiff,

v.

CHUCK HAGEL, *et al.,*

Defendants.

Civ. No. _____

[PROPOSED] PRELIMINARY INJUNCTION

Upon consideration of Plaintiff's motion for a preliminary injunction, of any opposition thereto, and of the entire record in this action;

It appearing to the Court that the Plaintiff is likely to succeed on the merits of her action, that she will suffer irreparable injury if the requested relief is not issued, that the Defendants will not be harmed if the requested relief is issued, and that the public interest favors the entry of such an order, it is, therefore,

ORDERED that Plaintiff's motion for a preliminary injunction is hereby GRANTED; and it is further

ORDERED that Defendants Chuck Hagel, David Quantock, Nathan Keller, Erica Nelson, U.S. Department of Defense, and all persons acting under their supervision or in concert with them, shall, pending further order of this Court, provide Plaintiff with clinically appropriate treatment under the *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* developed by the World Professional Association for Transgender Health, including, but not limited to, (1)

providing hormone therapy for Plaintiff's gender dysphoria; (2) permitting Plaintiff to express her female gender by following female grooming standards, including dress and hair length; and (3) providing Plaintiff with treatment by a clinician who is qualified to treat gender dysphoria; and it is further

ORDERED that this injunction shall be effective upon service on the defendants, and no bond shall be required.

Date: _____

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United States District Judge