IN THE SUPREME COURT OF THE STATE OF OREGON

TARA ELLYSSIA ZYST,
Plaintiff-Respondent
Petitioner on Review,

and

JAMIE MILLER, Superintendent, Snake River Correctional Institution,
Defendant-Appellant
Respondent on Review

Malheur County Circuit Court
Case No. 19CV19556
A183152
S072759

Petition to review the decision of the Court of Appeals, on an appeal from the Judgment of the Circuit Court for Malheur County
Honorable Jenefer S. Grant, Senior Judge
Court Decision Filed: February 4, 2026
Before: Kamins, Presiding Judge, Jacquot, Judge, and Armstrong, Senior Judge

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BRIEF OF *AMICI CURIAE* AMERICAN CIVIL LIBERTIES UNION FOUNDATION AND THE AMERICAN CIVIL LIBERTIES UNION OF OREGON IN SUPPORT OF PETITIONER ON REVIEW

Nadia H. Dahab, OSB No. 125630
SUGERMAN DAHAB
101 SW Main Street Ste. 910
Portland, OR 97204
Tel: (503) 228-6474
nadia@sugermandahab.com

Kelly Simon, OSB No. 154213
Eri Andriola, OSB No. 246500
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF OREGON, INC.
PO Box 40585
Portland, OR 97240
(503) 227-3186
ksimon@aclu-or.org
eandriola@aclu-or.org

Margaret Huntington, OSB No. 200636
EQUAL JUSTICE LAW
1500 SW First Avenue, Suite 1090
Portland, OR 97201
Tel: (503) 226-0923
meg@equaljusticelaw.org

Attorney for Petitioner on Review

Matthew Segal
Bridget Lavender
AMERICAN CIVIL
LIBERTIES UNION FOUNDATION
125 Broad Street
New York, NY 10004
msegal@aclu.org
belavender@aclu.org

Attorneys for Amici Curiae the American Civil Liberties Union of Oregon and the American Civil Liberties Union Foundation

Daniel A. Rayfield, OSB No. 064790
Benjamin Gutman, OSB No. 160599
Jentry Lanza, OSB No. 241211
OFFICE OF ATTORNEY GENERAL
1162 Court Street NE
Salem, Oregon 97301
Tel: (503) 378-6002
jentry.lanza@doj.oregon.gov

Attorneys for Respondents on Review

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BACKGROUND AND INTEREST OF *AMICI CURIAE*

The American Civil Liberties Union (ACLU) is a nationwide, nonprofit, nonpartisan organization with nearly two million members and supporters dedicated to defending the principles of liberty and equality embodied in the federal and state constitutions. The ACLU of Oregon is the Oregon affiliate of the national ACLU. It has over 52,000 members and supporters across Oregon and works in communities, at the state capitol, and in the courts to defend and advance the civil rights and civil liberties of Oregonians. *Amici* have an interest in this case because they have long advocated for the rights of adults in custody in prisons and jails, including in cases addressing medical and mental health care, safety, and housing placement for transgender adults in custody.

SUMMARY OF ARGUMENT

Although a habeas court cannot order any relief unless it finds a constitutional violation for which no other timely remedy is available, once a habeas court finds such a violation, its authority to fashion relief is sweepingly broad. Under ORS 34.670, a habeas court may "dispose of the party as the law and justice of the case may require." As Petitioner has persuasively shown, this statutory authority confers wide latitude, subject to appellate review only for abuse of discretion. *See* Pet Br 24–48; *cf. Shipman v. Gladden*, 253 Or 192, 453 P2d 921 (1969). *Amici* agree with Petitioner's proposed rule that a trial court exercising

habeas jurisdiction abuses its discretion to craft relief only "if its orders are based on an erroneous legal conclusion or factual determinations not supported by the evidence, or if its orders are clearly against all reason and evidence." Pet. Br. at 3. *Amici* write separately to provide this Court with additional evidence and analysis that has important implications not only for this case, but for the parties in untold numbers of habeas cases who depend on the courts to remedy violations of their rights.

As set forth below, when a habeas court confronts a constitutional violation that has already given rise to substantial harm, as happened here, it has broad discretion to craft a remedy that cures both the violation and the resulting harms. This includes ordering continuing oversight and multi-element, structured remedies, which are not exceptions to a habeas court's authority under ORS 34.670—but ordinary exercises of it, both under this Court's own caselaw and under the parallel federal habeas law. The Court of Appeals' "close connection" test, applied as it was here, risks being read by trial courts statewide as disfavoring precisely the type of relief that conditions cases often demand. This Court should not adopt it.

But beyond its incorrect legal conclusion, the factual premise underlying the Court of Appeals' decision to sever the trial court's psychiatric-evaluation and housing orders from the constitutional violations the trial court found—that those

components are too "attenuated" from the harm Petitioner suffered—is empirically wrong. Inadequately treated gender dysphoria can predictably lead to or exacerbate co-occurring risks such as depression, anxiety, self-harm, and suicidality, and clinical authority treats the assessment and management of those risks, together with safe housing placement, as an integrated treatment response. In this respect, the Court of Appeals further erred. Restricting courts from fashioning remedies to address co-occurring health and safety needs stemming from violations will systematically under-remedy adults in custody with compounding needs—the population most vulnerable and best served by habeas relief.

For those reasons, and the reasons set forth below, *amici* urge the Court to adopt Petitioner's proposed rule and reverse the Court of Appeals' decision.

FACTUAL BACKGROUND

Petitioner Tara Zyst is serving a life sentence at Snake River Correctional Institution. She is transgender, has been diagnosed with gender dysphoria, and has attempted suicide nineteen times—eighteen of them in Oregon Department of Corrections (ODOC) custody. *Zyst v. Miller*, 346 Or App 801, 805, 585 P3d 16 (2026). ODOC provided some gender-affirming treatment, but it relied on an internal policy that categorically excluded other interventions as merely "cosmetic," without ever conducting the individualized assessment that both Zyst's

psychiatrist and ODOC's medical director agreed was medically necessary. *Id.* at 805–07. At the same time, ODOC housed Petitioner in the Intensive Management Unit—its maximum-custody segregation unit—where she attempted suicide again. *Id.* at 807–08.

Zyst petitioned for habeas relief, alleging that ODOC's medical treatment of her gender dysphoria and failure to provide adequate conditions of housing violated the state and federal constitutional prohibitions against cruel and unusual punishment and unnecessary rigor. *Id.* at 804. After a trial, the habeas court found that ODOC's treatment of Zyst's gender dysphoria, and her placement in segregated housing, violated those constitutional protections. It ordered a range of relief to cure the violations, including removal from segregated housing, an individualized gender-affirming care assessment, a psychiatric evaluation, and identification of an appropriate cellmate. *Id.* at 808–09. The Court of Appeals affirmed the constitutional violations the trial court found relating to ODOC's treatment of Petitioner's gender dysphoria, but reversed based on the trial court's psychiatric-evaluation and cellmate orders, holding that those two pieces of the trial court's remedy were "too attenuated" from the violations to qualify as permissible habeas relief under ORS 34.670. *Id.* at 816–17.

ARGUMENT

I. The "law and justice of the case" standard grants trial courts broad discretion in crafting habeas remedies, including in conditions of confinement claims that cannot be adequately addressed by other remedies.

ORS 34.670 directs a habeas court, after hearing the evidence, "to dispose of the party as the law and justice of the case may require." This is a broad grant of remedial authority. Although this Court has never addressed the extent of that authority when a court seeks to remedy a constitutional violation in a conditions-of-confinement case, existing precedent makes clear that courts have broad discretion to craft a remedy that both cures the underlying constitutional violations and mitigates any resulting harms. In other words, when a trial court finds a violation of a habeas petitioner's rights, the court is not confined to a fixed set of remedies: discharge the person or deny the petition. Rather, it must answer more difficult questions, based on the evidence presented at trial: what does remedying *this* violation, as to *this* petitioner, require? What is the remedy that would put *this* petitioner back into the position they would have been in, but for the violation? Courts' answers to these questions are subject to an abuse of discretion standard. As Petitioner explains, a "court abuses its discretion to craft relief if its orders are based on an erroneous legal conclusion or factual determinations not supported by the evidence, or if its orders are clearly against all reason and evidence." Pet Br at 3.

Amici urge this Court to recognize that this standard applies in conditions-of-confinement claims. In 1978, the Court held that habeas relief applies to conditions-of-confinement claims precisely because ordinary remedies are inadequate to reach them. *See Penrod/Brown v. Cupp*, 283 Or 21, 26, 581 P2d 934 (1978). Narrowing the scope of available relief for these claims would undermine that holding and, by leaving those suffering from unconstitutional conditions of confinement without a remedy, reintroduce the very inadequacy that *Penrod/Brown* expanded the writ to solve.

A. This Court's precedent supports a broad view of permissible relief in habeas actions.

Although this Court has not yet addressed the question presented in the context of a conditions of confinement claim, it has endorsed a broad view of the relief that is permissible in habeas actions, while simultaneously rejecting the narrow view of habeas remedial authority that the Court of Appeals adopted.

This Court first addressed the standard for habeas relief in *Landreth v. Gladden*, 213 Or 205, 324 P2d 475 (1958). There, the State argued that habeas relief is narrow and limited: either the underlying judgment is void and the adult in custody goes free, or it is not and the petition must be denied. *Id.* at 210–13. This Court rejected that approach.

In *Landreth*, the petitioner's life sentence had rested on an erroneous habitual-criminal calculation, but a lesser sentence could have properly been

imposed. Discharge would have been unwarranted, but denial of relief would have left an unlawful sentence in place. *Id.* at 213–14, 222. The habeas court thus crafted a third form of relief: it held the life sentence void but stayed Landreth's release for thirty days to allow the state to return him to the sentencing court for imposition of a lawful sentence. *Id.* at 207–08. That relief was crafted to unwind the damage done by the violation and return Landreth to the position he would have been in had the erroneous habitual-criminal calculation not occurred.

This Court affirmed, rejecting the State's narrow view of permissible habeas relief: "The technical distinction between void and voidable should not be a shibboleth to separate those to whom justice may be denied." *Id.* at 222. "If to protect human rights it is necessary to adopt procedural changes," the Court explained, "we should not hesitate to do so." *Id.*

A decade later, in *Shipman v. Gladden*, this Court applied that same reasoning to a companion remedial statute. *Shipman* was a post-conviction case in which the petitioner's retained counsel had agreed to appeal his conviction but neglected to file the notice. 253 Or at 194. The question, then, was the appropriate remedy under the Post-Conviction Hearing Act for that violation. *Id.* at 194–95, 199. Neither of the traditional alternative remedies—discharge or a new trial—were appropriate: discharge would have overcorrected a filing error into a windfall, and a new trial did not make sense because the violation was the loss of an appeal,

not a defect in the trial itself. This Court recognized as much, explaining that either would be "a less desirable result" than a remedy that actually addressed and mitigated the harm that occurred—a delayed appeal—which would put petitioner "in the same position as if his counsel had timely filed the original notice of appeal." *Id.* at 204.

Exercising its broad remedial power, this Court afforded the delayed-appeal remedy even though the Post-Conviction Hearing Act did not expressly authorize it. As the Court explained, ORS 138.520's authorization of "such other relief as may be proper and just" "conveys the same meaning as ORS 34.670, which directs a habeas corpus court 'to dispose of the party as the law and justice of the case may require,' " and, "[a]s * * * pointed out in *Landreth v. Gladden*, 213 Or 205, 324 P2d 475 (1958), these phrases should be construed broadly to achieve the remedial purpose of the statutes." *Id.* at 204. In other words, the *Shipman* court held that ORS 34.670, the statute at issue in this case, should be construed broadly by appellate courts reviewing trial courts' remedial orders.

Twice, then, confronted with violations and resulting harms that traditional remedies could not adequately address, this Court read Oregon's "law and justice" standards to broadly authorize trial courts to afford tailored remedies that serve to cure both the particularized violation and the resulting harms. In both cases, the Court affirmed the relief that sought to mitigate those harms by putting the

petitioner back, insofar as possible, into the position he would have occupied had the unlawful action never occurred. Taken together, *Landreth* and *Shipman* establish that doubts about the scope of habeas relief are to be resolved in favor of the habeas trial court's judgment about what approach will best serve the statute's purpose of remedying constitutional violations and the harm that they cause—not, as the Court of Appeals held, in favor of whichever remedy stays closest to a narrowly framed description of the underlying violation. [1]

B. This Court extended habeas to conditions claims precisely because ordinary remedies are inadequate to reach them—a rationale that supports flexible, structured relief.

In *Penrod/Brown v. Cupp*, 283 Or 21, 581 P2d 934 (1978), this Court held that an adult in custody may use habeas to challenge illegal restraints on liberty distinct from the validity of the underlying judgment of conviction. Specifically, the Court explained that the habeas writ

> "remains available to bring before a court * * * two kinds of cases[:] (1) When a petition makes allegations which, if true, show that the prisoner, though validly in custody, is subjected to a further 'imprisonment or restraint' of his person that would be unlawful if not justified to the court, and (2) when a petition alleges other deprivations of a prisoner's legal rights of a kind which, if true, would

[1] Federal courts applying the nearly identical command in 28 U.S.C. § 2243 to "dispose of the matter as law and justice require" have likewise made clear that habeas courts retain "broad discretion in conditioning a judgment granting habeas relief," *Hilton v. Braunskill*, 481 US 770, 775, 107 S Ct 2113, 95 L Ed 2d 724 (1987), including "relief short of release," *Wilkinson v. Dotson*, 544 US 74, 86, 125 S Ct 1242, 161 L Ed 2d 253 (2005) (Scalia, J., concurring).

> require immediate judicial scrutiny, if it also appears to the court that no other timely remedy is available to the prisoner."

Id. at 28. With respect to the second kind of claim, two essential elements must exist: "The need for immediate attention, * * *, and the practical inadequacy of an alternative remedy to meet this need." *Id.*

To be sure, the inadequacy requirement is not incidental, but part of the reason the writ applies. Where the deprivation involves a constitutionally protected right, this Court explained, "either Oregon's [remedy clause of] article I, section 10, or the federal fourteenth amendment obliges the state to provide some remedy in due course, or due process, of law," and for a person in custody with no other remedy, "the writ of habeas corpus remains the constitutionally guaranteed means to invoke judicial aid." *Id.* at 26. Thus, in *Penrod/Brown*, this Court extended the habeas remedy to conditions claims to provide a meaningful remedy to those with nowhere else to go.[2]

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[2] This Court's remedy clause jurisprudence further supports the construction that the Court adopted in *Penrod/Brown*. By its text, the remedy clause guarantees "that every [person] shall have remedy by due course of law for injury done [them] in [their] person, property, or reputation." Or Const, art I, § 10. The clause operates as a substantive limitation on the legislature's authority to alter or adjust remedies for injuries, including violations of the nature at issue here. *See Horton v. Or. Health & Sci. Univ.*, 359 Or 168, 173, 376 P3d 998 (2016). Under both *Penrod/Brown* and *Horton* and its progeny, the Court cannot and should not read the habeas statute to eliminate a remedy for a habeas petitioner, particularly where the common law would have provided one. *See, e.g.*, *Newton v. Cupp*, 3 Or App 434, 439, 474 P2d 532 (1970) ("To hold that habeas corpus is also unavailable

The Court of Appeals read *Penrod/Brown* to cut the other way. Relying on this Court's observation that "[a] central characteristic of the writ * * * is the speed with which it triggers a judicial inquiry," *id.* at 27, the Court of Appeals reasoned that the trial court's continuing-oversight and compliance orders ran contrary to the court's statutory authority "to promptly deliver plaintiff from the constitutional violation" and made "the process of providing relief in this habeas case too open-ended." *Zyst*, 346 Or App at 817. That, however, is not what *Penrod/Brown* commands, and the Court of Appeals erred in ruling otherwise.

Penrod/Brown explains when adults in custody may invoke the habeas remedy—as the faster alternative to an ordinary civil claim—not how much relief a trial court may order once the writ has properly issued and a violation has been found. Stated another way, *Penrod/Brown* explains why habeas—rather than a civil action—is the correct vehicle for conditions claims, but says nothing about the scope of relief a habeas court may order once it properly acquires habeas jurisdiction.

Adults in custody turn to habeas for conditions claims precisely because no other remedy reaches the harm quickly enough. A rule that artificially narrows what a habeas court can order only reintroduces the very inadequacy

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would be to leave petitioner in the medieval position of possessing a right for which there exists no remedy. This the Oregon Constitution forbids.").

Penrod/Brown expanded the writ to address; if habeas can reach the violation but cannot fashion a remedy sufficient to cure it, adults in custody are left precisely where *Penrod/Brown* and the cases that preceded it found intolerable: with a forum but no adequate remedy in it. *See id.* at 26; *cf. Newton*, 3 Or App at 439.

C. Broad remedial authority is consistent with the equitable nature of habeas relief.

Reading ORS 34.670 to grant broad discretion to trial courts is also consistent with the equitable nature of habeas relief. As the U.S. Supreme Court has long held, "habeas corpus, at its core, is an equitable remedy." *Schlup v. Delo*, 513 US 298, 319, 115 S Ct 851, 130 L Ed 2d 808 (1995); *see also Jones v. Cunningham*, 371 US 236, 243, 83 S Ct 373, 9 L Ed 2d 285 (1963) (Habeas is not "a static, narrow, formalistic remedy; its scope has grown to achieve its grand purpose"); *Gage v. Chappell*, 793 F3d 1159, 1167 (9th Cir 2015) ("Likewise, habeas corpus is 'at its core, an equitable remedy,' that is sensitive to the ends of justice." (quoting *Schlup*, 513 US at 319)). Equity, in turn, is a powerful and flexible authority that operates in pursuit of mercy and practicality. In that respect, and consistent with this Court's decision in *Shipman*, habeas relief often involves an exercise in discretion that works to the advantage of the petitioner when they encounter harsh, and otherwise inflexible, legal rules. *See, e.g.*, *Schlup*, 415 US at

319–20 (describing circumstances in which harsh procedural rules may yield to the equitable nature of habeas relief to further the "ends of justice").[3]

Modern caselaw bears this out. In one recent habeas case, for instance, the federal government conceded that it had removed a noncitizen from the United States to El Salvador even though he had been subject to a withholding order forbidding his removal. To remedy that illegal action, a federal district court issued an order designed to unwind that harm: it commanded the government to "facilitate" the noncitizen's return to the United States. *Abrego Garcia v. Noem,* No. 8:25-CV-00951-PX, 2025 WL 1024654, at *1 (D. Md. Apr. 4, 2025), *amended*, 2025 WL 1085601 (D. Md. Apr. 10, 2025). In resolving the government's later challenge to that remedy, the U.S. Supreme Court recognized that the district court had appropriately exercised its equitable authority to mitigate the harm of the government's illegal action and restore the noncitizen to the position he would have occupied had the action never occurred. The Supreme Court explained that the district court's order had "properly require[d] the

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[3] The common-law origins of the equitable remedy of habeas are discussed at length in the Brief of *Amici Curiae* Habeas Scholars filed in *Pitchford v. Cain*, No. 24-7351 (S Ct filed Feb 4, 2026) ("To the extent common law judges exercised 'equitable discretion' in habeas corpus cases, it was in aid of prisoners and to displace otherwise operable legal rules that stood as obstacles to mercy. * * * * In short, equity as incorporated into common law habeas corpus practice empowered judges to supersede or circumvent ordinary legal rules and procedure, and interpret penal statutes, in pursuit of mercy.").

Government to 'facilitate' Abrego Garcia's release from custody in El Salvador and to ensure that his case is handled as it would have been had he not been improperly sent to El Salvador." *Noem v. Abrego Garcia*, 604 US ---, 145 S Ct 1017, 1018, 225 L Ed 2d 655 (2025).

* * * * *

This Court's precedent leaves little room for the Court of Appeals' rule to stand. *Landreth* and *Shipman* establish that a habeas court, once it finds a violation, is not confined to a fixed menu of remedies but must ask what relief will actually cure the violation and the harm it has caused. *Penrod/Brown* confirms that this discretion applies with particular force to conditions-of-confinement claims, because the writ was extended to reach them precisely on the premise that no other remedy would. And the equitable character of habeas relief—recognized by this Court and by the U.S. Supreme Court alike—confirms that a habeas court's remedial authority does not impose the sort of rigid, formalistic limits the Court of Appeals imposed below. That court's "close connection" test revives the narrow view of habeas relief this Court has rejected twice before, and in precisely the setting where flexible, adequate relief matters most. This Court should reject it and hold, consistent with Petitioner's proposed rule, that a trial court's remedial choices are reviewed only for abuse of discretion, not for how closely each element of relief traces to a narrow description of the underlying violation.

II. The panel's conclusion—that psychiatric assessment and housing placement are severable from the violations it found—is not just an incorrect legal conclusion; it is empirically wrong.

Based on the evidence presented at trial, the habeas court in this case found that ODOC's treatment of Petitioner's gender dysphoria and its decision to house Petitioner in the Intensive Management Unit (IMU) inflicted cruel and unusual punishment under the state and federal constitutions and violated the state constitution's prohibition on unnecessary rigor. As a result of those violations, the trial court found that Petitioner had experienced "repeated instances of suicidality and of self harm, worsened depression, anxiety, and PTSD symptoms (including hallucinations and claustrophobia), and past sexual assault. ER-49, ER-51–52, ER-54. To remedy those violations and the resulting harm, the trial court ordered ODOC to conduct a gender-affirming care assessment, provide a psychiatric evaluation, identify an appropriate cellmate for Petitioner as approved by Petitioner's counsel, and move Petitioner out of the IMU. The Court of Appeals partially reversed, holding that certain aspects of that remedy lacked a "close connection" to the "constitutional violation." *Zyst*, 346 Or App at 816–17. That holding was wrong, not only because it applied the wrong legal standard, but also because, even under the Court of Appeals' narrow rule, the remedy *was* closely tailored to the harm Petitioner suffered. Contrary to the Court of Appeals' analysis, the trial court supportably found that psychological treatment and housing

safety are critical elements of addressing gender dysphoria in custody. Thus, even assuming the trial court's remedial authority was limited in the way the Court of Appeals perceived, the trial court's prescribed remedies hewed to that limited rule. This Court should reverse.

Untreated gender dysphoria predictably can lead to or exacerbate separate, co-occurring conditions—namely, "depression, anxiety and self-harm and suicidality"—that are themselves the proper subject of psychiatric assessment and treatment, distinct from the dysphoria itself. *See, e.g.*, Declaration of Dan H. Karasic, M.D. ("Karasic Decl.") ¶ 51, *Kingdom v. Trump*, No. 1:25-CV-00691 (DDC Mar 14, 2025).[4] That is why the national standard of care (referred to as "WPATH SOC 8," *see supra* n 4) requires an assessment conducted by a professional "trained in identifying gender dysphoria as well as co-existing mental health and psychosocial concerns"—because the assessment identifies and manages the distinct, co-occurring psychiatric risks. Karasic Decl. ¶ 67.[5] The

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[4] Dr. Dan H. Karasic is a Professor Emeritus of Psychiatry at University of California – San Francisco and the lead author of the Mental Health chapter of the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 8 (WPATH SOC 8).

[5] Psychotherapy, including psychiatric assessment and treatment, does not independently treat gender dysphoria. "For individuals for whom gender-affirming medical care is indicated, there are no alternative evidence-based treatments for gender dysphoria." Karasic Decl. ¶ 81. "Psychotherapy is a critical treatment modality for many patients, but it does not address the underlying gender

same is true of appropriate housing placement, which is integral to health and safety. Prison Rape Elimination Act standards require individualized, case-by-case housing decisions for transgender adults in custody, weighing health and safety against management and security. *See* 28 CFR § 115.42(c); Declaration of Dr. Alix McLearen ("McLearen Decl.") ¶¶ 15–17, *Doe v. Blanche*, No. 1:25-CV-00286 (DDC May 13, 2026). ODOC's own policies adopt this requirement. ODOC Policy 40.1.13 III.C.1.g.[6] And as explained by Dr. McLearen, former national administrator of transgender housing policy for the federal Bureau of Prisons, mental health and suicide risk are "core components of classification and housing decisions" for transgender adults in custody. If made without those

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dysphoria, which when persistent can only be addressed by bringing a patient's body and sex characteristics into alignment with the patient's gender identity." *Id.*

[6] "In deciding AIC housing and programming assignments for transgender or intersex AICs, the department shall consider on a case-by-case basis whether a placement would ensure the AIC's health and safety, and whether the placement would present management or security problems.

A. If requested, transgender and intersex AICs shall be given the opportunity to shower separately from other AICs.

B. A transgender or intersex AIC's own views with respect to their own safety shall be given serious consideration."

Oregon Department of Corrections, Policy No. 40.1.13 (Prison Rape Elimination Act), *available* at https://www.oregon.gov/doc/rules-and-policies/Documents/40-1-13-prea.pdf (last accessed Aug 12, 2026).

considerations, a housing decision carries "a high and foreseeable likelihood of causing significant psychological distress," including "worsening symptoms of gender dysphoria, anxiety, depression, and other mental health conditions, which may lead to suicidal ideation and self-harm." *Id.* ¶ 38.

Likewise, in 2017, the federal Bureau of Prisons adopted an integrated approach to treating transgender adults in custody after realizing that separating housing or psychiatric care decisions from medical ones was not working. *See* Declaration of Dr. Cathy Thompson ("Thompson Decl.") ¶¶ 27–28, *Kingdom v. Trump*, No. 1:25-CV-00691 (DDC Mar 17, 2025). BOP built a single decision-making body, the Transgender Executive Council (TEC), with "the senior psychologist, psychiatrist, security expert, and medical administrator" at the same table, *id.* ¶ 31, under clinical guidance requiring a multidisciplinary approach that folded housing into the same framework as psychiatric and medical care. That integration measurably improved safety and mental health outcomes. *Id.* ¶ 38.[7]

This factual, clinical, and regulatory record is contrary to the Court of Appeals' factual premise. Appropriate psychiatric assessment and housing placement are not free-standing elements of prison administration; they are part of

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[7] In early 2025, BOP reversed course, implementing Executive Order 14168, banning gender-affirming care for adults in BOP custody, and prohibiting transgender women from being housed in women's facilities. The effects of that reversal, and BOP's implementation of it pursuant to Executive Order 14168, are challenged in *Kingdom* and *Doe*.

the standard, integrated response to the very harm the trial court found that ODOC caused. WPATH's standard of care, PREA's own housing regulations, ODOC's own policy, and the Bureau of Prisons' history managing this population all have taken an integrated approach to address health and safety, not as disparate elements a habeas court can sever without consequence. The Court of Appeals' contrary holding is not a permissible reading of a difficult record; it is a factual error, and one that will result in documented harms. This Court should not adopt it.

CONCLUSION

The Court of Appeals' "close connection" test threatens to foreclose the very relief that habeas cases often require: multi-part, coordinated orders for people whose harms compound, or relief where compliance review or oversight is warranted. A standard that forces trial courts to parse a single violation into its narrowest element—and remedy only that element—risks leaving adults in custody unremedied, even after a court has found a constitutional violation and ordered relief. For these reasons, and the reasons set forth above, *amici* respectfully urge this Court to hold that a habeas court's remedial choices are broad and reviewed only for abuse of discretion, and reverse the Court of Appeals' decision insofar as it vacated the trial court's psychiatric-evaluation and cellmate orders.

DATED this 12th day of August, 2026.

Respectfully submitted,

By: s/ Nadia H. Dahab

Nadia H. Dahab, OSB No. 125630
SUGERMAN DAHAB
101 SW Main Street, Suite 910
Portland, OR 97204
Tel: (503) 228-6474
nadia@sugermandahab.com

Attorneys for Amici Curiae the American Civil Liberties Union of Oregon and the American Civil Liberties Union Foundation

APPENDIX

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiff, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691

DECLARATION OF DR. DAN H. KARASIC IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Dan H. Karasic, M.D., hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

4. I am a Professor Emeritus of Psychiatry at University of California – San Francisco (UCSF). I have been on faculty at UCSF since 1991. I have also had a telepsychiatry private practice since 2020.

5. I received my Doctor of Medicine (M.D.) degree from the Yale Medical School in 1987. In 1991, I completed my residency in psychiatry at the University of California – Los Angeles (UCLA) Neuropsychiatric Institute, and from 1990 to 1991, I was a postdoctoral fellow in a training program in mental health services for persons living with AIDS at UCLA.

6. For over 30 years, I have worked with patients with gender dysphoria. I am a Distinguished Life Fellow of the American Psychiatric Association and have been the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, as well as the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

7. Over the past 30 years, I have provided care for thousands of transgender patients.

8. I previously sat on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and am a co-author of WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7, and the lead author on the Mental Health chapter of Version 8. The WPATH Standards of Care are the internationally accepted guidelines designed to promote the health and welfare of transgender, transsexual, and gender variant persons. I remain active in the work of WPATH.

9. As a member of the WPATH Global Education Initiative, I helped develop a specialty certification program in transgender health and helped train over 2,000 health providers.

10. At UCSF, I developed protocols and outcome measures for the Transgender Surgery Program at the UCSF Medical Center. I also served on the Medical Advisory Board for the UCSF Center of Excellence for Transgender Care and co-wrote the mental health section of the original Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People and the revision in 2016.

11. I have worked with the San Francisco Department of Public Health, helping to develop and implement their program for the care of transgender patients and conducting mental health assessments for gender-affirming surgery. I served on the City and County of San

Francisco Human Rights Commission's LGBT Advisory Committee, and I have been an expert consultant for California state agencies and on multiple occasions for the United Nations Development Programme on international issues in transgender care.

12. I have held numerous clinical positions concurrent to my clinical professorship at UCSF. Among these, I served as an attending psychiatrist for San Francisco General Hospital's consultation-liaison service for AIDS care, as an outpatient psychiatrist for HIV-AIDS patients at UCSF, as a psychiatrist for the Transgender Life Care Program and the Dimensions Clinic at Castro Mission Health Center, and the founder and co-lead of the UCSF Alliance Health Project's Transgender Team. In these clinical roles, I specialized in the evaluation and treatment of transgender, gender dysphoric, and HIV-positive patients.

13. I also regularly provide consultation on challenging cases to psychologists and other psychotherapists working with transgender and gender dysphoric patients. I have been a consultant in transgender care to the California Department of State Hospitals, which treats patients held by forensic commitment and psychiatric patients from the state prisons, and have been a consultant for the California Department of Corrections and Rehabilitation on the care of incarcerated transgender people. I am currently a consultant in transgender mental health to the Alameda County Jails. In my 29 years working with transgender patients in San Francisco public health clinics, I worked with many formerly incarcerated people, including those who spoke of their experiences being denied care while incarcerated.

14. As part of my psychiatric practice treating individuals diagnosed with gender dysphoria and who receive other medical and surgical treatment for that condition, as well as a co-author of the WPATH Standards of Care and UCSF's Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, I am and must be familiar with

additional aspects of medical care for the diagnosis of gender dysphoria, beyond mental health treatment, assessment, and diagnosis.

15. In addition to this work, I have done research on the treatment of depression.

16. I have authored many articles and book chapters on the diagnosis and treatment of gender dysphoria and edited the book Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation.

17. Since 2018, I have performed over 130 independent medical reviews for the State of California to determine the medical necessity of transgender care in appeals of denial of insurance coverage.

18. My professional background, experiences, publications inclusive of those authored in the past ten years, and presentations are detailed in my curriculum vitae ("CV"). A true and correct copy of my most up-to-date CV is attached as Exhibit A.

B. Compensation

19. I am being compensated for my work on this matter at a rate of $400.00 per hour for preparation of declarations and expert reports. I will be compensated $3,200.00 per day for any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

C. Previous Testimony

20. Over the past four years, I have given expert testimony by deposition or trial in the following cases: *L.B. v. Premera Blue Cross*, No. 3:20-cv-06145-RJB (W.D. Wash.); *Misanin v. Wilson*, No. 2:24-cv-04734-BHH (D.S.C.); *Voe v. Mansfield*, No. 1:23-CV-864-LCB-LPA (M.D.N.C.); *Boe v. Marshall*, No. 2:22-cv-184-LCB (N.D. Ala.); *Doe v. Ladapo*, No. 4:23-cv-00114 (N.D. Fla.); *Dekker v. Weida*, No. 4:22-cv-00325 (N.D. Fla.); *K.C. v. The Individual Members of the Medical Licensing Board of Indiana*, No. 1:23-cv-00595 (S.D. Ind.); *Brandt v.*

Rutledge, No. 4:21-cv-00450 (E.D. Ark.); *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145 (W.D. Wash.); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.); and *Fain v. Crouch*, No. 3:20-cv-00740 (S.D. W. Va.). To the best of my recollection, I have not given expert testimony at a trial or at a deposition in any other case during this period.

II. BASIS FOR OPINIONS

21. In preparing this report, I have relied on my training and my decades clinical experience as a psychiatrist treating patients with gender dysphoria, as well as my experience conducting research, as set out in my curriculum vitae (attached hereto as Exhibit A).

22. I have also relied on my knowledge of the peer-reviewed research regarding the treatment of gender dysphoria, which reflects advancements in the field of transgender health. I have reviewed the materials listed in the bibliography attached hereto as Exhibit B. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report.

23. I have also relied on my knowledge of the clinical practice guidelines for the treatment of gender dysphoria, including my work as a contributing author of the WPATH Standards of Care, Versions 7 and 8, and the UCSF Guidelines.

24. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

25. Additionally, I have reviewed Executive Order 14168, titled "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to The Federal Government,"

issued on January 20, 2025 ("EO 14168").

III. SUMMARY OF EXPERT OPINIONS

26. Gender dysphoria is a serious condition which, if left untreated, can impair a person's ability to function and cause significant depression, anxiety, self-harm and suicidality.

27. EO 14168, by prohibiting "any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the "opposite sex," with "sex" being defined as immutable from the time of conception, prohibits treatments that are part of widely accepted protocols for the treatment of gender dysphoria that are supported by every major medical association in the country—social transition and gender-affirming medical care.

28. Decades of scientific research and clinical experience have demonstrated that social transition and gender-affirming medical care can significantly relieve the distress of gender dysphoria and are medically necessary for many people with this condition. I have seen first-hand, countless times over decades of practice, the many benefits of social transition and gender-affirming medical care.

29. For individuals for whom gender-affirming medical care is indicated, there are no alternative evidence-based treatments for gender dysphoria.

30. Prohibiting people with gender dysphoria from socially transitioning and withdrawing or denying gender-affirming medical care to those for whom it is indicated would put them at risk of significant harm to their health and well-being, including heightened risk of self-harm and suicidality.

31. When incarcerated people are unable to receive gender-affirming medical care to treat their gender dysphoria, some have resorted to self-castration or other self-harm to get relief, or have attempted to end their lives.

IV. EXPERT OPINIONS

A. Sex and Gender Identity

32. At birth, infants are assigned a sex, either male or female, based on the appearance of their external genitalia.

33. While the terms "male sex" and "female sex" are sometimes used in reference to a person's genitals, chromosomes, and hormones, the reality is that sex is complicated and multifactorial. Aside from external genital characteristics, chromosomes, and endogenous hormones, other factors related to sex include gonads, gender identity, and variations in brain structure and function.

34. EO 14168 defines "sex" as "an individual's immutable biological classification as either male or female," that "does not include the concept of 'gender identity.'" EO 14168 § 2(a). It further defines "Female" as "a person belonging, at conception, to the sex that produces the large reproductive cell," and "[m]ale" as "a person belonging, at conception, to the sex that produces the small reproductive cell." EO 14168 §§ 2(d), (e).

35. EO 14168's definition of "sex" is not consistent with how it is commonly understood in medicine. According to the American Medical Association, sex is made up of many diverse components. (AMA, 2023). Similarly, the Endocrine Society notes that because a person's sex characteristics "may not [always] be in line with each other …, the terms biological sex and biological male or female are imprecise and should be avoided." (Hembree, et al., 2017).

36. Gender identity is "a person's deeply felt, inherent sense of being a girl, woman, or female; a man, or male; a blend of male or female; or an alternative gender" (American Psychological Association, 2015, at 834).

37. Gender identity does not always align with sex assigned at birth.

38. Gender identity, which has biological bases (Fischer and Cocchetti, 2020), is not merely a product of external influence, nor is it subject to voluntary change.

39. As documented by multiple leading medical authorities, efforts to change a person's gender identity are ineffective, can cause harm, and are unethical. (American Psychological Association, 2021, Byne, et al., 2018, Coleman, et al., 2012).

40. EO 14168 defines "gender identity" as "a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex." EO 14168 § 2(g).

41. EO 14168's definition of "gender identity" differs from how this term is commonly understood and used in medicine and science. Gender identity does provide a meaningful basis for identification and has been a basis for identification federally as well as in most states, and in many other countries, for years.

42. For most people, their sex assigned at birth, or assigned sex, matches their gender identity. For transgender people, their assigned sex does not align with their gender identity.

43. Based on data from the Williams Institute, approximately 0.6% of the United States population age 13 or older, or about 1.6 million people, identify as transgender. (Herman, et al., 2022).

44. Being transgender is widely accepted as a normal variation in human development. Simply being transgender or gender nonconforming is not a medical condition to be treated and is not considered a mental illness. People who are transgender have no impairment in their ability to be productive, contributing members of society simply because of their transgender status.

45. In the replacement of Gender Identity Disorder in DSM-IV with Gender Dysphoria in DSM-5, the American Psychiatric Association recognized that the clinically significant distress and social/occupational impairment of gender dysphoria is the disorder, not transgender identity. DSM-5 notes that diagnosis and treatment are "focus[ed] on dysphoria as the clinical problem, not identity per se." (DSM-5, at 451). The World Health Organization, in placing Gender Incongruence outside the chapter of mental health conditions, states, "trans-related and gender diverse identities are not conditions of mental ill-health." (World Health Organization, Gender Incongruence).

46. Similarly, WPATH's Standards of Care, Version 8 states: "The expression of gender characteristics, including identities, that are not stereotypically associated with one's sex assigned at birth is a common and a culturally diverse human phenomenon that should not be seen as inherently negative or pathological. … It should be recognized gender diversity is common to all human beings and is not pathological. However, gender incongruence that causes clinically significant distress and impairment often requires medically necessary clinical interventions." (Coleman, et al. 2022).

B. Gender Dysphoria

47. The term "gender dysphoria" is distress related to the incongruence between one's gender identity and attributes related to one's sex assigned at birth.

48. The diagnosis of Gender Dysphoria (capitalized) is a serious medical condition, and it is codified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The current version, known as the *Fifth Edition, Text Revision* (DSM-5-TR), was released in 2022.

49. The DSM's diagnosis of Gender Dysphoria in Adolescents and Adults involves two major diagnostic criteria:

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 (one of which must be Criterion A1):

1. A marked incongruence between one's experienced/expressed gender and primary or 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.
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.

50. Gender dysphoria is a condition that is highly amenable to treatment, and the prevailing treatment for it is highly effective.

51. When untreated, gender dysphoria can cause significant distress including increased risk of depression, anxiety, self-harm and suicidality. It can also impair individuals' ability to function in all aspects of life, including school or work, and in family and other personal relationships. These risks decline when transgender individuals are supported and live according to their gender identity.

52. With access to medically-indicated care, transgender people can experience significant and potentially complete relief from their symptoms of gender dysphoria. Not only is this documented in scientific literature and published data, but I have witnessed this in thousands of patients over three decades.

C. Evidence-Based Guidelines for Treatment of Gender Dysphoria

53. The World Professional Association of Transgender Health (WPATH) has issued *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* ("WPATH SOC") since 1979. The current version, published in 2022, is WPATH SOC 8. The SOC 8 provides guidelines for multidisciplinary care of transgender individuals and describes criteria for medical interventions to treat gender dysphoria, including hormone treatment and surgery when medically indicated.

54. The SOC 8 utilized a rigorous evidence-based approach to developing the guidelines. (Coleman, et al., 2022). The process of developing the SOC 8 was a multistep, several years long effort that started in 2017. This process is outlined in great detail in Appendix A to SOC 8.

55. This "process for development of the SOC-8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and the World Health Organization that addressed transparency, the conflict-of-interest policy, committee composition and group process." (Coleman, et al., 2022, at S247 (citing Institute of Medicine Committee on Standards for Developing Trustworthy Clinical Practice, 2011; World Health Organization, 2019)). And "[t]he SOC-8 revision committee was multidisciplinary and consisted of subject matter experts, health care professionals, researchers and stakeholders with diverse perspectives and geographic representation." (Coleman, et al., 2022, at S247).

56. WPATH SOC 8's evidence-based recommendations were drafted "based on the results of the systematic, and background literature reviews plus consensus-based expert opinions." (Coleman, et al., 2022, at S250). The recommendations were developed and are based on available evidence supporting interventions, a discussion of risks and harms, as well as feasibility and acceptability within different contexts and country settings. A consensus of the

final recommendations was attained using the Delphi process that included all members of the Standards of Care Revision committee, and supportive and explanatory text of the evidence for the statements was written.

57. The Delphi process is a procedure by which a panel of experts are asked for their opinion on a relevant issue, summarizing and presenting their collective responses and repeating this process for a certain number of rounds. (Shang, 2023; Hsu and Sanford, 2019). It is "a well-established approach to answering a research question through the identification of a consensus view across subject experts." (Barrett and Healey, 2020).

58. The recommendations submitted to a vote under the Delphi process required approval of 75% of the authors of SOC 8 as a whole. More specifically, for a recommendation to be approved, a minimum of 75% of the voters had to approve the statement. (Coleman, et al., 2022, at S250). With regards to SOC 8, every member of the SOC revision committee voted for each statement. Following the aforementioned process, recommendations contained in SOC 8, as published in 2022, were approved by 75% or more of the revision committee.

59. A clinical practice guideline from the Endocrine Society (the Endocrine Society Guideline) provides similar guidelines for clinicians to provide safe and effective treatment for gender dysphoria. (Hembree, et al., 2017).

60. Each of these guidelines are evidence-based and supported by scientific research and literature, as well as extensive clinical experience.

61. The evidence base supporting the recommendations in these guidelines is comparable to the evidence base supporting treatment for other conditions.

62. The protocols and policies set forth by the WPATH Standards of Care and the Endocrine Society Guideline are endorsed and cited as authoritative by the major professional

medical and mental health associations in the United States, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the American College of Obstetrics and Gynecology, the American College of Physicians, and the World Medical Association, among others. They are also relied upon by clinicians treating patients with gender dysphoria.

D. Treatment of Gender Dysphoria

63. Under the WPATH SOC and the Endocrine Society Guideline, the overarching goal of treatment is to eliminate the distress of gender dysphoria by helping the patient live consistently with their gender identity by aligning their presentation and body with their gender identity.

64. Social transition is an integral part of addressing gender dysphoria for transgender people. Social transition involves changing appearance (e.g. garments, hair, make-up) and social role, with change of signifiers of gender, including name and pronouns, and public presentation in the identified gender.

65. In earlier versions of the Standards of Care, social transition was required before medical interventions were considered. While the current WPATH SOC 8 recognizes the necessity for individualized paths for transition, social transition remains central to addressing gender dysphoria for many transgender people.

66. While social transition alone can adequately address gender dysphoria for some people, many individuals with gender dysphoria cannot obtain relief without also receiving medical interventions to align the body with their gender identity. In accordance with the WPATH SOC and the Endocrine Society Guidelines, medical interventions to treat adults with gender dysphoria may include hormone therapy and surgeries, based on a patient's individual needs.

67. For assessing an adult for gender-affirming medical care, WPATH SOC 8 states that the health professional should be licensed and trained in identifying gender dysphoria as well as co-existing mental health and psychosocial concerns, and that medical or surgical treatment should only be recommended when "gender incongruence is marked and sustained," when there is capacity for consent, when other conditions that might affect outcomes have been assessed, and when diagnostic criteria for Gender Dysphoria of DSM 5-TR (in the US) or Gender Incongruence of ICD-11(outside the US) are met.

68. If a patient is assessed to have a medical need for hormone therapy, gender-affirming hormone therapy involves administering testosterone for transgender men and estrogen and testosterone suppression for transgender women. The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person that matches as closely as possible to their gender identity. Gender-affirming hormone therapy is a partially reversible treatment.

69. Some transgender individuals need surgical interventions to help bring their phenotype into alignment with their gender. Surgical interventions may include, inter alia, vaginoplasty and orchiectomy for transgender female individuals, and chest reconstruction and hysterectomy for transgender male individuals.

70. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective.

71. The treatment protocols for gender dysphoria are comparable to those for other mental health and medical conditions. Indeed, these or similar procedures are provided for cisgender people with other diagnoses. For example, breast reduction surgery is much more commonly performed on cisgender males who have unwanted excess breast tissue

(gynecomastia), than on transgender males. Dai, et al. (2024) recently found that of the adolescents who had these surgeries, 97% were cisgender males and only 3% were transgender males. Testosterone treatment for transgender males, like for cisgender males with testosterone insufficiency (hypogonadism), involves administering testosterone to bring blood levels up to the normal male range.

E. Social Transition Has Been Shown to Help Alleviate Gender Dysphoria.

72. Social transition has been shown to positively affect mental health (Hughto, et al 2020). Bringing one's presentation into alignment with gender identity can help one see oneself and be recognized and treated by others consistent with one's gender identity. Recognition of chosen name with social transition has been associated with decreases in depression and suicidality. (Russell, et al 2018). In my work with thousands of transgender patients, social transition has been a critical step towards improved mental health. In patients who have been forced to socially detransition, while incarcerated or due to family or career, mental health impacts have been severe to my patients, with increased gender dysphoria, depression, anxiety and in some patients, suicidality and self-harm.

F. Gender-Affirming Medical Care Has Been Shown To Be Safe and Effective Treatment for Gender Dysphoria.

73. There is a substantial body of research and clinical evidence that gender-affirming medical care is effective in treating gender dysphoria. This evidence includes scientific studies assessing mental health outcomes for transgender people who are treated with these interventions, and decades of clinical experience, including my own.

74. The research and studies supporting the necessity, safety, and effectiveness of medical care for gender dysphoria are the same type of evidence that the medical community routinely relies upon when treating other medical conditions.

75. Medical treatment for gender dysphoria has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health.[1] There is also substantial evidence that the risks of these treatments are low and manageable, and comparable to the type of risks that exist in the same treatments when given to cisgender patients and in many other medical treatments. For example, the cardiovascular risks associated with estrogen apply whether the person is receiving treatment for gender dysphoria, menopause, or other conditions. Regret rates for gender-affirming surgeries are very low, often much lower than for similar surgeries in cisgender patients. (Thornton, et al 2024).

76. The studies on gender-affirming medical care for treatment of dysphoria are consistent with decades of clinical experience of mental health providers across the U.S. and around the world. At professional conferences and other settings in which I interact with colleagues, clinicians report that gender-affirming medical care, for those for whom it is indicated, provides great clinical benefit. In my over 30 years of clinical experience treating gender dysphoric patients, I have seen the benefits of gender-affirming medical care on my patients' health and well-being. I have seen many patients show improvements in mental health, as well as in performance in school and work, in social functioning with peers, and in family relationships when they experience relief from gender dysphoria with gender-affirming medical care.

77. As part of the treatment process for gender dysphoria, patients provide informed consent to their care. In addition, a treating doctor will not offer gender-affirming medical

[1] *See, e.g.*, Dopp, et al., 2024; Shelemy, et al., 2024; Ascha, et al., 2022; Aldridge, et al., 2021; Almazan, et al., 2021; Baker, et al., 2021; Murad, et al., 2010; Nobili, et al., 2018; Pfafflin & Junge, 1998; T'Sjoen et al. 2019; Turan, et al., 2018; van de Grift et al., 2018; Olson-Kennedy, et al., 2018; Cornell, What We Know, 2018; Nguyen, et al., 2018; Oda, et al.,2017; White, Hughto and Reisner, 2016; Fisher, et al., 2016; Keo-Meier, et al., 2015; Wierckx et al., 2014; Colizzi, et al., 2014; Colizzi, et al., 2013.

treatments unless they have concluded after weighing the risks and benefits of care that treatment is appropriate. The risks and benefits of care are discussed with the transgender patient, who must consent.

78. Gender-affirming medical interventions provided in accordance with the WPATH SOC 8 and Endocrine Society Guidelines are widely recognized in the medical community as safe, effective, and medically necessary for many people with gender dysphoria. (*See, e.g.*, the American Psychological Association, 2024 and 2021; American Academy of Pediatrics, 2018 (reaffirmed in 2023); the American Medical Association, 2021; the Pediatric Endocrine Society, 2021; the American College of Obstetricians and Gynecologists, 2021; the Endocrine Society, 2020; the American Academy of Family Physicians, 2020; the American Psychiatric Association, 2018; and WPATH, 2022).

79. For all the reasons above, I am aware of no basis in medicine or science for categorically prohibiting gender-affirming medical care.

G. Harms of a Blanket Prohibition Against Social Transition and Hormone Therapy[2]

80. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self. The denial of medically-indicated care to transgender people not only results in the prolonging of their gender dysphoria, but causes additional distress and poses other health risks, such as depression, post-traumatic stress disorder, and suicidality. In other words, lack of access to gender-affirming care directly contributes to poorer mental health outcomes for transgender people. (Owen-Smith, et al., 2018).

[2] Because the preliminary injunction motion does not seek relief related to gender-affirming surgeries, this portion of the declaration does not address surgery.

81. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective. To the extent one proposed alternative is psychotherapeutic treatment to encourage identification with a person's assigned sex at birth, the American Psychological Association has stated that such efforts provide no benefit and instead do harm. (APA, 2021). Or if an alternative approach is to treat the worsening dysphoria only with therapy, that has not shown to be effective in any research. (Dopp, et al., 2024). Psychotherapy is a critical treatment modality for many patients, but it does not address the underlying gender dysphoria, which when persistent can only be addressed by bringing a patient's body and sex characteristics into alignment with the patient's gender identity.

82. Denying patients with gender dysphoria the ability to socially transition or obtain gender-affirming medical care where indicated predictably will lead to significant deterioration in mental health.

83. I have had patients over the years who were unable to access gender-affirming medical care when it was clinically indicated, including in the years before this care was more widely available. In many of these patients, delayed or denied care resulted in increased depression, anxiety, suicidal ideation and self-harm, increased substance use, and a deterioration in school or work performance. Some patients attempted to self-castrate or remove breasts. For patients with severe distress due to their gender dysphoria, psychotherapeutic approaches did not alleviate this distress absent medical intervention. Some of my patients had years of intensive mental health interventions, including long-term psychotherapy, without relief of gender dysphoria until receiving medical intervention.

84. Research documents the harms to incarcerated individuals with gender dysphoria who have not been able to receive necessary treatment, including attempts at self-castration.

(Brown, 2010, Aldrich et al, 2023). I have provided care for transgender patients after incarceration who had suffered severe mental health consequences, including intolerable gender dysphoria, depression, anxiety, self-harm and suicidality, from denial of the ability to socially and medically transition.

85. A blanket policy withdrawing hormone therapy and the ability to socially transition from individuals with gender dysphoria currently receiving that care would be expected to cause severe negative impact on patients' mental health. I have cared for or consulted on patients who were forced to socially and medically detransition and I've seen the suffering that it caused. For example, I consulted on a patient who, while in the long-term custody of a forensic psychiatry unit, was forced to detransition—both medically and socially. He severely decompensated and attempted suicide. After obtaining legal representation to request that the institution bring in an expert in the treatment of gender dysphoria, he was able to resume gender-affirming hormone therapy and live consistently with his male identity, and his mental health greatly improved. Eventually he was able to have gender affirming surgery, and then be released, and he has flourished in his life and work after release.

V. CONCLUSION

86. Executive Order 14168, which categorically prohibits gender-affirming medical care and social transition for individuals with gender dysphoria who are in the custody of the Bureau of Prisons, regardless of their medical needs, is contrary to widely accepted evidence-based medical protocols for the treatment of gender dysphoria and puts these individuals at risk of significant harm, including heightened risk of depression, self-harm, and suicidality.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 14th day of March, 2025

Dan H. Karasic

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiffs, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691 **DECLARATION OF DR. CATHY THOMPSON**

I, Cathy Thompson, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

INTRODUCTION AND SCOPE OF WORK

1. I am a licensed clinical psychologist and recently retired Federal law enforcement officer with more than 20 years' experience working in correctional settings. My experience includes providing direct mental health services to incarcerated individuals inside prison and jail facilities. I later served as a national administrator for the Department of Justice's Federal Bureau of Prisons (BOP) and therefore have extensive experience in developing programs and services and drafting and implementing policies specific to the safety and treatment of individuals in BOP custody. I was involved in the development and implementation of BOP's procedures for managing transgender inmates. I retired from federal service effective September 23, 2023, and I now work as a consultant.

2. I have been retained by counsel for Plaintiffs in the class action complaint for declaratory and injunctive relief in *Kingdom v. Trump* (Trump Administration and BOP's categorical ban on gender-affirming health care for people with gender dysphoria in the custody of the Federal Bureau of Prisons), Case No.: 1:25-cv-00691. I have been asked to provide expert testimony about BOP policies and practices for transgender people prior to the executive order, and my expert opinion on the current and future impact of BOP's recent policy changes pertaining to treatment and management of transgender individuals in BOP custody.

3. My opinion, which is explained in further detail below, addresses the history of BOP's approach to managing and treating transgender people and the ways in which the recent guidance and policy issued by the BOP 1) cause harm to both those individuals and the staff who work with them, and 2) are not consistent with standards and accepted practices applicable to BOP.

4. It is my understanding that since January 2025, the BOP has rescinded its policy about transgender individuals, issued guidance prohibiting accommodations for transgender people, and directed medical staff to cease provision of gender affirming care, including hormones for all persons in custody.

5. It is my opinion that (1) a blanket ban on treating individuals who are transgender or have gender dysphoria is neither safe nor consistent with accepted practices, and (2) providing gender affirming care promotes security efforts.

PROFESSIONAL BACKGROUND

6. In 2000, I obtained my doctorate in Clinical Psychology from Texas Tech

University. As part of this degree, I completed an internship with the BOP during 1999-2000. After graduating, I continued my career with the BOP which spanned over 23 years until my retirement in 2023.

7. During more than two decades with BOP, I held positions of increasing responsibility in both prisons and administrative offices across the United States wherein I not only practiced psychology, but worked collaboratively and closely with other disciplines to meet the agency's mission of operating facilities that were safe while also delivering quality, evidence-based services.

8. For approximately the first decade, I promoted through positions located inside prisons. I provided treatment to men and women with a wide range of presenting issues. I provided supportive counseling to individuals struggling with issues of gender identity and more intensive psychological interventions for comorbid gender dysphoria and depressive disorders, posttraumatic stress disorder (PTSD), or anxiety disorders. Consistent with the standards mandated by the Prison Rape Elimination Act (PREA), I conducted assessments and provided treatment to incarcerated victims of sexual abuse.

9. In 2009, I was chosen for my first administrative oversight position within the BOP. In this capacity, I began to not only provide safe treatment and management directly, but to start giving guidance to others on how to create and maintain proper correctional environments through reliance on policy and accepted practices.

10. Five years later, I was promoted to a national level mental health position. My primary responsibility was the oversight, development, and implementation of substance use and mental health treatment programs. My work included ensuring these

services were relevant and beneficial to all individuals in BOP custody and addressing the care of transgender individuals was a large part of that work.

11. I had primary responsibility for ensuring BOPs residential treatment programs operated as modified therapeutic communities (MTCs). This is an evidence-based approach to residential substance use treatment designed to maximize the positive benefits of a supportive community that welcomes all members.[1]

12. While serving in this role, I was asked to be the acting national administrator for psychology services. During this time, BOP's policies regarding transgender inmates advanced significantly, and I was part of those efforts. I advised both my supervisors and institution staff on the accepted practices in caring for this population. I also provided input on policy development, and as it was implemented, I provided consultation and expertise to BOP's Transgender Executive Committee (TEC) regarding placement for transgender people that maximized opportunities for access to mental health treatment, reentry programming, and personal safety. I collaborated with other subject matter experts to develop lesson plans for annual training provided to all BOP staff on a wide range of psychological issues, including the accepted practices in the management of transgender people in secure settings. Most importantly, I was in a national leadership role advising on the importance of providing individualized and affirming services to transgender people, and I saw the benefits of this approach firsthand.

[1] De Leon, George. (2000). *The Therapeutic Community*. Springer Publishing Company.

13. Throughout the course of my BOP career, I remained engaged in scientific research which I published and presented outside the agency. I also taught courses at the college level. I retired in 2023 and do part-time consulting and treatment work. **My resume is attached as Exhibit A**.

14. I am being compensated at the rate of $500 per hour for my time completing this declaration.

BASES FOR OPINIONS

15. In preparing this report, I have relied on my training; my years of experience working in correctional settings and my specific experience within the BOP making care decisions about individuals who are transgender; my knowledge of the policies and practices surrounding these issues in both BOP and other correctional systems; and my knowledge of the relevant literature and standards.

16. In addition, in preparing this report, I have reviewed the following information to inform my opinion: the class action complaint filed March 10, 2025 and the two associated exhibits. I also reviewed publicly available materials as cited in this document.

BRIEF HISTORY OF BOP'S TRANSGENDER PRACTICES AND STANDARDS

17. As part of operating safe facilities, over the last several decades correctional systems have begun to have a better understanding of how to provide care to transgender inmates, just as they have provided care to individuals with any other

medical, mental health, learning, or other need. These efforts are supported by data demonstrating transgender individuals are both more likely to become involved in the justice system, and also more likely to experience sexual assault while incarcerated.[2] [3] Thus, in service to operating a safe facility and meeting the agency mission, sound correctional practices have long included provision of individualized health care and accommodations to transgender or intersex persons.

18. In 2003, the Prison Rape Elimination Act (PREA) was signed into law, and in 2012, the Department of Justice published the PREA Final Rule, which included standards for implementing the statute.[4] [5] PREA drew national attention to the needs of the incarcerated transgender population, and was the first federal law identifying best care practices. Five standards specify requirements addressing transgender persons in carceral settings.

19. One of those standards, PREA standard 115.42(c) establishes the necessity of individualized assessments, stating, "the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems." The Department of Justice

[2] Grant, Jaime M.; Mottet, Lisa A.; Tanis, Justin; Harrison, Jack; Herman, Jody L.; Keisling, Mara (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey (PDF) (Report). Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.
[3] Beck, A. J., & Shandler, S. (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012*. U.S. Department of Justice, Bureau of Justice Statistics.
[4] 28 CFR Part 115 National Standards To Prevent, Detect, and Respond to Prison Rape; Final Rule.
[5] Prison Rape Elimination Act (PREA) of 2003 (P.L. 108-79).

also determined assigning housing to a transgender person based solely on genitalia is a violation of PREA.[6]

20. Mental health and medical treatment of transgender individuals was improving through the establishment of standards or accepted practices while PREA standards were being developed and issued. Research indicates, for example, that transgender individuals are at higher risk for suicide than non-transgender persons.[7] In 2015, the American Psychological Association issued guidance on working with transgender and non-binary individuals, including a key principle that "Psychologists strive to recognize the influence of institutional barriers on the lives of [transgender] people and to assist in developing [transgender]-affirmative environments."[8] [9] Similarly, the American Medical Association has made a number of public statements supporting the importance of and right to access gender affirming interventions.[10]

21. Meanwhile, BOP along with correctional systems across the country and world were developing procedures to ensure appropriate care for transgender inmates.

BOP POLICY AND PROCEDURES IMPACT

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[6] National PREA Resource Center. (2016). *FAQ: Does a policy that houses transgender or intersex inmates based exclusively on external genital anatomy violate Standard 115.42(c) & (e)*.
[7] Marshall E, Claes L, Bouman WP, et al. (2016). *Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature*. Int Rev Psychiatry. 28, 58–69.
[8] American Psychological Association. (2015). *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*. American Psychologist, 70 (9), 832-864. Retrieved from https://www.apa.org/practice/guidelines/transgender.pdf
[9] *Id.,* at 840.
[10] *See* https://transhealthproject.org/resources/medical-organization-statements/american-medical-association-statements/

22. The BOP is the largest correctional system in the United States and operates 122 prison facilities across the country. Facilities are classified into four security-level categories, and men and women are housed in separate units or facilities. Over 35,000 employees work for BOP.

23. BOP, like most correctional systems, utilizes policy and training as dual methods to ensure staff are complying with the law and using the most accepted and safest practices available. Any policy is developed in response to a need for guidance and grounded in science, law, and safety.

24. Going back to the beginning of my BOP career in 1999, BOP has recognized that individuals who are transgender or intersex may not easily fit into BOP's housing structure. Thus, senior officials at the agency have made decisions about the most appropriate housing for these persons, based on the safety of both the individual and others. Yet, BOP did not have a policy, and while transgender people did receive treatment and in some cases were housed in accordance with their gender identity, , the lack of agency directive raised questions as to how to best make such decisions.

25. Following the passage of PREA in 2003, BOP updated its policy on sexual abuse to ensure it was compliant with the statute and standards.[11] In particular, the policy included language from the PREA standards and explained to staff in clear language the importance of individualized decision-making about the safety of transgender inmates.

26. While staff became familiar with these standards and recognized the

[11] DOJ-BOP. (2015). Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention.

benefits of the individualized approaches, questions also arose as to how to make the best, fairest, and safest decisions with regard to housing and health care treatment. Many staff, particularly in remote locations, were not well acquainted with transgender terminology, for example, or were not familiar with external guidance documents, such as the standards from the World Professional Association for Transgender Health (WPATH).[12] Further, BOP data demonstrated a significant over-representation of transgender persons in restrictive housing settings, often for safety instead of disciplinary reasons.

27. Individuals with gender dysphoria experience significant clinical distress and, as noted previously, are at increased risk for suicide. Before BOP implemented national policy that was consistent with the accepted practices in the care and management of transgender people in prison settings, it was my experience that transgender individuals in BOP custody were more likely to require services to manage mental health crises than incarcerated individuals who are not transgender. In cases of severe gender dysphoria, risks included attempts at self-surgery and suicide.

28. Thus, in 2016, BOP began to develop national policy and guidance on the management and treatment of transgender persons in custody. This meant that, consistent with BOP labor relationships agreements, agency leadership began meeting with union representatives to develop what would be published in January 2017 as the Transgender

[12] World Professional Association for Transgender Health. Standards of care. Retrieved from https://wpath.org/publications/soc8/

Offender Manual (TOM).[13] [14]

29. Until recently, all policies issued by BOP underwent significant negotiation and review by both management and bargaining unit staff. Following several months of this review, the first TOM provided a great deal of information and direction to BOP staff. In addition to providing definitions, the policy set requirements for training, accommodations, pronoun usage, medical treatment, and housing placement.

30. I worked alongside the person leading TOM policy development, providing input specific to treatment and later helping her ensure implementation. Speaking about policy development, she described it as, "just a safe practice that comported with the law."[15] The key components of the policy were identifying how to implement accepted practices and ensuring any gender affirming services were provided based on individual need.

31. The TOM also established clear parameters around a decision-making body, known as the Transgender Executive Council (TEC). Membership on this body included senior leaders from the Women and Special Populations Branch as well as the senior psychologist, psychiatrist, security expert, and medical administrator in the

[13] DOJ-BOP. (2017, 2018, 2020). Program Statement 5200.08, Transgender Offender Manual.
[14] The TOM was updated two times. The first update clarified factors in placement and the second elucidated surgery processes. The BOP has since deleted all versions of the TOM from its website as a result of President Trump's Executive Order. The most recent version, dated Jan. 13, 2022, is preserved and available at https://perma.cc/4BP6-YWRP and **is attached as Exhibit B**.
[15] Schwartzapfel, B. (January 23, 2025). *Trump's Order Takes Aim at Transgender People in Prison*. The Marshall Project.

agency.

32. Although BOP had provided mental health and medical care before the TOM was issued, once the policy was in place, national administrators began to roll out training and supports for staff to ensure implementation was done with fidelity. Training was delivered to all employees, and advanced continuing education sessions were delivered to clinicians who delivered therapy or prescribe hormones.

33. In keeping with these efforts to ensure treatment was tied to evidence and that guidance was available, the BOP's Health Services Division also created a Transgender Clinical Care Team (TCCT) made of experienced medical professionals who could offer guidance to prescribers working in the prisons who may not have expertise in endocrinology or the prescription of hormones. Importantly, clinical assessments for hormone medication or other medical treatments included assessments by both psychologists and medical providers for the presence of gender dysphoria. In other words, to receive medical treatment, a person must actually have a condition warranting such an approach. Hormones or surgeries were provided only based on individual clinical need. **Attached as Exhibit C** are the most recent version of the clinical guidelines for health care staff, dated June 2023. Again, these guidelines were taken down from the BOP website after President Trump's Executive Order, but are also preserved at https://perma.cc/U5UT-S9PN. These clinical guidelines were an update of the previous guidelines from health care staff that had been operative since December 2016.

34. At the same, mental health procedures were developed to guide psychologists in the best ways to treat transgender people. While psychologists do not

prescribe medication in BOP, they were taught the benefit of gender affirming care, including hormones, in improving safety and wellbeing. This same information was conveyed to all staff because gender affirming care can reduce distress.

35. Support groups and other types of mental health treatment were also developed, eventually becoming part of BOP's list of approved programs under the First Step Act.

36. Accommodations were also described in policy, again as ways to better care for and manage the inmate population. Accommodations included allowing for the use of preferred pronouns and the provision of undergarments to match gender identity. Individuals were also given the option to purchase gender affirming items other than medication and undergarments that were allowed inside prison but required the use of personal funds (such as make-up). As noted, these items were intended to improve individual functioning, decrease crises, and therefore not only improve individuals' health but also make prisons safer.

37. Finally, the TOM created clear processes and benchmarks for a transgender individual to potentially be housed at a facility that aligns with their gender identity. The TOM took an approach grounded in safety where decisions were made by the TEC based on a number of factors and requirements.

38. Within a few years of the TOM's issuance in January 2017, BOP staff had fully implemented the policy. Gender affirming care was consistently available when indicated, and transgender people were afforded greater opportunities for engagement and positive programming that reduced psychological distress, reduced sexual

victimization, increased personal and institutional safety, and improved reentry outcomes. Agency policies direct consistent practice across all components and are reinforced by positive outcomes, and the TOM was no different.

DISCUSSION AND ANALYSIS OF RECENT BOP POLICY CHANGES

39. In early 2025, BOP abruptly rescinded a number of policies, including the TOM, following a Presidential Executive Order. BOP staff were suddenly operating without a policy but no guidance about what services or practices were supposed to replace the policy.

40. On February 21, 2025, Dana DiGiacomo, Acting Assistant Director of the BOP Reentry Services Division, and Shane Salem, Assistant Director of the BOP Correctional Programs Division, two individuals with whom I worked at BOP, issued a memo clarifying that BOP had been temporarily blocked by legal action from removing medical and mental health care from transgender persons in custody, but was proceeding with other restrictions. (This memo is filed with the Court at Docket 1-1.) Specifically, the aforementioned accommodations of gender affirming pronouns, undergarments, and purchased personal items were to cease. Additionally, programs for transgender persons and training on accepted practices with them stopped. Finally, the TEC itself was renamed and repurposed. Despite being authored by two individuals with no professional expertise on transgender care and no clinical degrees, the memo also indicated the TEC would no longer refer people for surgery.

41. A week later, Chris Bina, a pharmacist who leads BOP's Health Services Division, issued a memo stating no BOP funds could be used to treat any transgender

person in a way that validates their gender identity. It specifically states that "no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex." (This memo is filed with the Court at Docket 1-2.)

42. The blanket ban on gender affirming care, is not only inconsistent with PREA and professional association guidance, it is also unsafe.

43. First, BOP's TOM was consistent with the law and medical standards. It served not only as a guide for BOP, but for other systems because it was effective.[16] The TOM was tied to PREA, whereas the new BOP approach is inconsistent with the individualized approach to housing required under PREA. Similarly, the new BOP approach is not consistent with psychological or medical association positions on the importance of delivering individualized gender affirming care and treatment to transgender persons who have a clinical need for that care.

44. Not only are these new BOP directives incompatible with accepted practices and law, they can cause significant harm and danger. Denying gender-affirming hormones to patients with a clinical need for such treatment has negative consequences, including causing or exacerbating distress and depression. Additionally, denying hormone therapy and access to other accommodations and treatments for gender dysphoria will bring about the return of the dysphoric symptoms, potentially causing

[16]Murphy, M., Et. al. (2023). *Implementing Gender-Affirming Care in Correctional Settings: A Review of Key Barriers and Action Steps for Change*. Journal of Correctional Health, 29(1).

attempts to self-castrate, self-harm, suicide, and aggression. All of these create safety concerns not only for people who are transgender, but for everyone who works or is incarcerated in the entire system. And with BOP's staffing crisis, there simply are not enough clinicians to manage the increased suicide watches and crisis, which could be deadly.[17]

45. Instead, BOP's former approach of providing gender affirming health care when indicated, as well as accommodations that support social transition under the TOM, was effective in maintaining transgender individuals' health and promoting institutional safety. Providing this care improves the agency goals of security and rehabilitation. Prohibiting such care undermines these goals.

CONCLUSION

46. BOP has the responsibility of managing and treating everyone in its custody, which means individuals with all sorts of health issues and conditions, including people who have gender dysphoria.

47. Treatment and care in BOP involves evidence-based approaches, and has

[17] Separate from the changes specific to transgender policies, BOP for years has experienced a crisis of custody and health care staffing shortages. Staffing shortages are evident across every job type, from psychologists to correctional officers. Moreover, under the new Administration, BOP announced that it will "greatly reduce, and in some cases eliminate, retention incentives across the agency, effective March 23, 2025." *See* Testimony of Kathleen Toomey, BOP Associate Deputy Director, before the U.S. House Appropriations Subcommittee on Commerce, Justice, Science, and Related Agencies during a hearing on Oversight of the Federal Bureau of Prisons, Feb. 26, 2025, at https://docs.house.gov/meetings/AP/AP19/20250226/117920/HHRG-119-AP19-Wstate-ToomeyK-20250226.pdf. This cut in salaries is likely to worsen staffing problems. As a result of these staffing shortages, all incarcerated individuals – not only those who are transgender - are likely to receive less medical and mental health care than they need.

always been individualized. Not only does it comport with the law, but it is also an accepted practice to provide treatment and accommodations based on individual factors. Prisons that support individual needs are safer and have fewer crises. I have grave concerns about the well-being of transgender individuals in BOP custody and the continued safe operations within BOP, should its ban on providing individualized care to transgender persons continue.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 17th day of March, 2025.

Cathy Thompson, PhD

Dr. Cathy Thompson

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

JANE DOE, et al., Plaintiffs, v. TODD BLANCHE, in his official capacity as Acting Attorney General of the United States, et al., Defendants.	Case No. 1:25-cv-00286-RCL
JANE JONES, et al., Plaintiffs, v. TODD BLANCHE, in his official capacity as Acting Attorney General of the United States, et al., Defendants.	Case No. 1:25-cv-00401-RCL
MARIA MOE, et al., Plaintiffs, v. DONALD TRUMP, in his official capacity as President of the United States, et al., Defendants.	Case No. 1:25-cv-00653-RCL

DECLARATION OF DR. ALIX MCLEAREN IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Dr. Alix McLearen, declare as follows:

1. I served as the National Administrator of the Women and Special Populations Branch at the Department of Justice's Bureau of Prisons (BOP) from 2014 to 2018, and as BOP's Acting Assistant Director and/or Senior Deputy Assistant Director for Reentry Services from 2018 through 2022. As a subject matter expert and member of BOP's senior executive team, I was responsible for the development, implementation, and oversight of policies balancing institutional safety, constitutional obligations, and rehabilitative goals. In addition to managing a wide variety of treatment and reentry workstreams, my responsibilities included drafting and operationalizing BOP policy governing the management and housing of transgender individuals, as well as reviewing and guiding hundreds of individualized determinations involving housing placement, medical and mental health care, and accommodations in secure correctional environments. My role required the integration of clinical judgment, correctional best practices, and evolving legal standards to ensure compliance and safety at the individual level, the facility level, and the system level.

2. Based on my experience as a BOP official and my nearly three decades of professional expertise in corrections, I can attest that transgender women must be individually evaluated for placement in women's or men's facilities. A categorical rule requiring transgender women to be housed in men's facilities would predictably endanger individuals who, based on their characteristics and circumstances, are at serious risk of severe physical and mental harm in men's facilities. Applying such a categorical rule to transfer transgender women from women's to men's facilities creates additional, distinct health and safety risks that are both significant and foreseeable.

BACKGROUND AND QUALIFICATIONS

3. I am a clinical psychologist with a doctorate in Clinical Psychology and the Law from the University of Alabama. I began working in justice settings in 1995 and completed my predoctoral internship at the Federal Bureau of Prisons' Medical Center for Federal Prisoners in 2003, after which I continued my career with BOP until my retirement nearly two years ago.

4. Over approximately 22 years with BOP, I held positions of increasing responsibility in institutions and at headquarters. In these roles, I provided clinical services, supervised multidisciplinary staff, and worked collaboratively with correctional, medical, and administrative personnel to support institutional safety, legal compliance, and rehabilitative programming.

5. After being chosen for and completing the Department of Justice's executive development program, I was appointed National Administrator of the Women and Special Populations Branch, where I provided guidance and oversight to all federal institutions on the management of specialized populations, including transgender individuals. In that role, I developed and implemented policy and training governing the management, housing, and care of transgender persons in federal custody. I was also responsible for updating and implementing national sexual safety policy following the 2012 publication of national regulatory standards under the Prison Rape Elimination Act (PREA). I served as the agency's PREA coordinator and participated in DOJ's PREA Working Group, which provided sexual safety and standard implementation technical guidance across correctional systems.

6. I later served as Acting and Senior Deputy Assistant Director of the Reentry Services Division, and as Acting Assistant Director, where I oversaw national programs including psychology services, education, chaplaincy, and special populations, and was responsible for major policy and operational decisions across the federal system. In December

2022, I was appointed by the Attorney General as Acting Director of the National Institute of Corrections, the only federal agency mandated to shape corrections at the national level and assist 750,000 American corrections professionals.

7. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I am being compensated at the hourly rate of $500.00 for my time spent preparing this declaration, and I will be compensated at the same rate for any pre-deposition and/or pre-trial preparation. I will be compensated at a daily rate of $4,000 for any deposition testimony or trial testimony. I will be compensated at an hourly rate of $200 for any travel time to attend a deposition or trial and will be reimbursed for out-of-pocket travel expenses incurred for the purpose of providing expert testimony in this matter. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

8. I have previously testified as an expert at trial or by deposition in the following cases: *Janiah Monroe v. Latoya Hughes*, No. 19-cv-1060-JEH (S.D. Ill.); *Delisa Hernandez Reid, Administrator of the Estate of Damian Hernandez v. The GEO Group, Inc., et al.*, No. 3:24-cv-309 (E.D. Va.); *A.B.O. Comix v. San Mateo County*, No. 23-civ-01075 (N.D. Cal.); *Travis v. Behavioral Systems Southwest Inc.*, et al., No. 23-ST-CV-31227 (Cal. Super. Ct.).

BASES FOR OPINIONS

9. In preparing this declaration, I have relied on my experience as a BOP official and my decades of professional expertise in corrections, as well as my training and experience as a clinical psychologist, as set forth in my curriculum vitae (attached as Exhibit A).

10. In addition, in preparing this report, I have reviewed five declarations previously filed in these actions by Rick Stover, Senior Deputy Assistant Director of BOP's Designation and

Sentence Computation Center, one legal memorandum previously filed by Defendants in opposition to preliminary injunctive relief, and the materials cited in this document.

EXPERT OPINIONS

A. Men's facilities are distinct from women's facilities in ways that put transgender women at disproportionately high risk of sexual and physical violence.

11. Men's and women's facilities differ in ways that are directly relevant to safety for transgender women. Within BOP, men's facilities house populations with more extensive histories of violence, higher rates of serious and violent offenses, and greater involvement in organized groups and gangs. These factors shape the institutional environment and contribute to social dynamics in which dominance, reputation, and the use or threat of violence play a significant role.

12. In my professional experience, individuals in men's facilities are more likely to test boundaries, assess vulnerability, and engage in behavior intended to establish hierarchy or control. These dynamics affect how individuals are expected to present themselves and interact with others. Individuals who are perceived as physically smaller, feminine, or otherwise vulnerable are more likely to be identified as targets for physical and sexual violence.

13. Transgender women as a group face severely elevated risks of sexual abuse in men's prisons.[1] This elevated risk is well understood within the field of corrections and is not meaningfully disputed among practitioners responsible for classification, housing, or PREA compliance. Across systems, transgender women are consistently identified as among the most vulnerable populations in custody.

[1] Nat'l Prison Rape Elimination Comm'n, *National Prison Rape Elimination Commission Report* 73-74 (June 2009), https://www.govinfo.gov/content/pkg/GOVPUB-Y3-PURL-gpo91294/pdf/GOVPUB-Y3-PURL-gpo91294.pdf; Allen J. Beck, U.S. Dep't of Just. Bureau of Just. Stat., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12*, *Supplemental Tables: Prevalence of Sexual Victimization Among Transgender Adult Inmates* (December 2014), https://bjs.ojp.gov/content/pub/pdf/svpjri1112_st.pdf.

B. To ensure individual and institutional safety, housing placements for transgender women must be based on individual circumstances rather than a categorical rule.

14. Although transgender women as a group face extraordinarily high rates of violence and sexual victimization in men's facilities, the risks to individual transgender women are not uniform. Some transgender women face much higher risks, and other relevant circumstances vary as well. As a result, it is essential that corrections officials determine housing placements at the individual level.

15. The PREA National Standards require correctional facilities to make case-by-case decisions about whether to house individual transgender women in male or female facilities, considering the individual's health and safety as well as any management or security concerns that may result from the placement.

16. In addition to being required by law, such case-by-case determinations are necessary to protect the safety of individual transgender women and to ensure safety and security of the prison environment for all incarcerated people. Housing decisions for transgender women cannot be made categorically without increasing risk of harm.

17. In deciding whether to house a transgender woman in a male or female facility, corrections officials consider all relevant circumstances bearing on both individual health and safety and prison management and security. For example, corrections officials may look to the transgender woman's age, criminal record, disciplinary record and behavior while incarcerated, physical and mental health status, current functioning, education level, gang involvement, risks to other incarcerated people, propensity for sexual abuse of other incarcerated people, vulnerability to sexual abuse by other incarcerated people, vulnerability to violence by other incarcerated people, ability to function in the general population in a men's or women's facility, and the individual's own views regarding their safety.

18. Transgender status is relevant to an individual's risk of sexual victimization and other health and safety issues. But transgender status, standing alone, does not indicate that an individual presents a risk to others and does not raise management or security concerns.

19. Certain characteristics tend to put individual transgender women at especially high risk of violence and sexual victimization in men's facilities. For example, a transgender woman is likely to face severe risks of harm in a male facility if she has had a vaginoplasty; if she has had other feminizing surgeries; or if she has breasts and a female physique as a result of consistent hormone therapy. Within custodial environments, individuals who are perceived as female are more likely to be approached, pressured, exploited, and treated as potential targets.

20. Past sexual abuse is also a strong predictor of future sexual victimization in prisons. A transgender woman who has been raped or sexually assaulted in men's correctional facilities would likely be at an especially high risk of revictimization in men's facilities, especially if the individual was assaulted on multiple occasions, by multiple perpetrators, or in multiple men's facilities.

21. Prior experiences of sexual harassment in male correctional facilities may similarly indicate a high risk of victimization. In the prison environment, verbal sexual harassment often serves to identify individuals as potential targets and frequently precedes more serious forms of sexual abuse or rape.

22. Weighing all the relevant circumstances requires corrections officials to exercise discretion and decide, based on their expert judgment, what housing placement is most appropriate for the individual. This approach is designed to reduce harm by allowing correctional staff to make placement decisions based on individual risk rather than fixed classifications. Removing discretion and expert judgment from the equation creates foreseeable risks. In my

opinion, a categorical requirement that all transgender women must be housed in male facilities will lead to unsafe conditions for transgender women who are at serious risk of harm in male facilities due to their individual characteristics and circumstances.

C. Transferring transgender women from women's to men's facilities because of a categorical policy would predictably put them at high risk of sexual victimization.

23. Based on my professional experience, transgender women who are housed in BOP's women's facilities present with some or all of the characteristics that make individual transgender women especially vulnerable to sexual violence in men's facilities, such as female appearance, female body parts (breasts, female genitalia), and mannerisms and carriage consistent with having lived and functioned as a woman. These characteristics affect how an individual is perceived and may increase the likelihood that she will be identified and targeted as vulnerable in a men's facility.

24. Transgender women who are housed in women's BOP facilities also often have histories of past sexual abuse, including in men's correctional facilities. As already explained, transgender women who have been raped or assaulted in men's facilities would likely be at a high risk of physical and sexual violence if transferred back to men's facilities, in addition to facing significant mental health risks as detailed below.

25. In addition to their individual characteristics and histories of sexual abuse, transgender women would likely face an increased risk of sexual victimization in men's facilities simply because they were involuntarily transferred to men's facilities after adjusting to a female correctional environment. Women's facilities operate with different social expectations and patterns of interaction than men's facilities. Individuals who function appropriately in women's prison environments are likely to present in ways that are consistent with those norms. In my

experience, behaviors and presentation that are consistent with functioning in a women's facility are often interpreted as indicators of vulnerability in a men's facility.

26. It is also likely that male prisoners would become aware that a transgender woman was transferred from a women's facility. Within BOP, movement between institutions is known to staff and becomes known within the incarcerated population through routine intake procedures, staff communication, and interactions among individuals. Individuals who are new to a facility are commonly asked where they came from, and attempts to avoid answering can draw additional attention. Once that information becomes known, it increases the likelihood that an individual will be singled out, questioned, and targeted for exploitation, coercion, or sexual victimization. In my professional experience, predatory men in male facilities are skilled at identifying victims and would be likely to recognize specific vulnerabilities associated with transfer from a women's facility.

27. Transgender women without prior experience in men's facilities may be uniquely vulnerable because of their lack of familiarity with the social dynamics, expectations, and informal structures that influence safety in male prison settings. These individuals may be less able to recognize or respond to emerging threats and, as a result, may be singled out as especially easy targets.

28. For all these reasons, a transgender woman involuntarily transferred from women's to men's facilities is likely to face extraordinarily high risks of sexual violence and exploitation. Vulnerability may be particularly acute during the initial period following transfer, as the individual would not have any relationships or stability within the institution.

D. Assault rates in low-security men's facilities are not a reliable indicator of risk to individual transgender women if transferred to those facilities.

29. I am aware that BOP has cited overall assault rates and the low security level of certain men's facilities to support its argument that Plaintiffs would be safe in those facilities. Specifically, BOP has relied on "guilty findings" for assault-related disciplinary infractions. These data reflect only substantiated disciplinary outcomes and do not capture the full scope of harmful conduct within a facility. They exclude unreported incidents, allegations that cannot be substantiated, threats, coercion, and other forms of conduct that may significantly affect individual safety. In addition, the category of "assault" encompasses a range of behaviors of varying severity. Assault data do not distinguish between types of harm and do not provide information about sexual victimization or other serious abuse. As a result, these figures provide a limited and incomplete picture of institutional safety. They also have no direct relevance to the assessment of risk for a specific individual.

30. To the extent BOP relies on data related to sexual assault, as distinct from the general category of "assault," the data still would not tell the whole story. Reports and guilty findings of sexual assault would not be expected to reflect the full scope of abusive sexual conduct that can occur in custody, and they do not speak to the particular risks faced by transgender women in men's facilities. In custodial settings, it is well understood that transgender women are especially vulnerable to sexual and physical harm. To secure protection from these harms, transgender women may enter arrangements involving sexual activity that is not meaningfully consensual. These arrangements can involve coercion, control, or violence, but may not be reported or may not result in disciplinary findings due to fear of retaliation, concerns about credibility, or how the conduct is characterized.

31. Concerns about the reliability of these data are also informed by how allegations of sexual abuse are identified and investigated within BOP. Under PREA, facilities are required to respond to, document, and investigate allegations of sexual abuse, but substantiation depends on the availability of evidence, the ability to develop a case under those standards, and adequate staffing to conduct thorough investigations. In practice, not all incidents result in substantiated findings, and some forms of abuse, including coercion or exploitation, may not be reflected in disciplinary outcomes.

32. Moreover, in my experience, BOP does not rely on this type of disciplinary data to make individual placement decisions and has not historically used it in determining housing for transgender individuals. Rather, placement decisions have been made through individualized, multidisciplinary review processes that consider specific risk factors, institutional functioning, and management and security needs. If BOP is now relying on this data in this context, that departs from established practice and appears to be used to support a predetermined outcome rather than to inform a neutral assessment of risk.

33. The use of reported disciplinary findings to compare safety across men's and women's facilities is also misleading because it treats reported disciplinary findings across facilities as directly comparable measures of safety. Men's and women's facilities differ in population characteristics, reporting practices, staff responses, and enforcement standards, all of which affect how conduct is documented and adjudicated. Within BOP, women's facilities have historically reflected higher rates of reported incidents in part due to differences in how conduct is identified, reported, and adjudicated. These differences can result in higher documented rates of misconduct without indicating a higher underlying level of violence or risk. As a result,

comparing rates of disciplinary findings across men's and women's facilities presents an incomplete and potentially misleading picture of relative safety.

34. The comparison of assault data between certain women's and men's facilities also does not account for the differences in housing environments and population dynamics that are relevant to Plaintiffs' safety. Low-security men's facilities tend to have larger populations and more congregate living conditions than women's facilities. These changes increase the number and frequency of interactions with other incarcerated individuals and expand the range of potential risk. Men's facilities also tend to have lower levels of mental health and medical staffing resources relative to women's facilities. As a result, transfer from women's to men's facility results in increased exposure to potential risk factors without a corresponding increase in protective capacity.

35. Overall assault data in identified men's facilities has limited relevance for another reason. Even if Plaintiffs are initially placed in the low-security male facilities identified by BOP in prior court filings, there is no assurance that they would remain there. In light of the risks described above, they may be placed in restrictive housing or seek protective custody in response to safety threats, or may experience incidents that affect their institutional adjustment. In addition, disruption of established supports, including medical, mental health, and social stability, may affect functioning and adjustment. These factors can lead to changes in classification and placement and could result in transfer to higher-security facilities. The analysis presented by BOP does not account for the foreseeable potential for placement in more restrictive or higher-risk environments.

36. For these reasons, the data and comparisons relied upon by BOP do not provide a sound basis for evaluating the safety of a categorical policy requiring transfers from women's to

men's facilities. Reliance on this information to support a categorical placement approach is inconsistent with established correctional practice and does not provide a rational basis for assessing safety in individual cases.

E. Forcibly transferring transgender women from female facilities to male facilities creates unnecessary and severe mental health risks, which could potentially lead to self-harm or suicide.

37. In addition to increasing victimization risks, transferring transgender women from women's to men's facilities against their will under a categorical policy raises major health and safety concerns. Within BOP, mental health and suicide risk are core components of classification and housing decisions, and changes in housing environment are recognized as clinically significant events. Under that framework, individuals who have been assessed, placed, and functioning appropriately in a given environment are not reassigned absent a safety, security, or clinical justification.

38. A categorical reassignment to a male facility, without regard to those individualized determinations, represents a departure from standard practice. As a result of such a reassignment, a transgender woman would lose continuity in healthcare, mental health provider relationships, social supports and relationships, and programming—in addition to facing an unfamiliar and dangerous institutional and social environment that is dramatically different from the women's correctional environment. In my professional judgment, such a change has a high and foreseeable likelihood of causing significant psychological distress. Risks include worsening symptoms of gender dysphoria, anxiety, depression, and other mental health conditions, which may lead to suicidal ideation and self-harm.

39. Individuals who have previously experienced rape or sexual assault in male facilities are particularly vulnerable. They are likely to experience worsening mental health

symptoms from being returned to the environment associated with that harm. Potential consequences of a deliberate exposure to the initial stressor without cause can reactivate trauma symptoms, increase anxiety, and cause hypervigilance and other functional impairments.

40. In addition, transgender women who have never been housed in men's correctional environments may experience severe disorientation and functional impairments in a men's facility. Resulting psychological damage and trauma could have significant and lasting mental and physical health consequences.

41. The destabilizing effect of transfer from women's to men's facilities could be further exacerbated by the implementation of recently published BOP medical policies. Under those policies, transgender people must be tapered off hormone therapy and denied other medical treatments for gender dysphoria. Restricting access to medical interventions that have alleviated an individual's symptoms of gender dysphoria and promoted healthy functioning—in combination with removing that individual from an appropriate women's correctional environment and placing her in a men's facility where she faces high risks of sexual and physical violence—will predictably cause grave harm.

42. Deteriorating mental health is a serious health and safety issue. Worsening mental health symptoms and trauma can lead to suicidality, violence to the self, and possibly even death. To prevent these outcomes, corrections officials must account for mental health risks when determining whether to house a transgender person in a men's or women's facility. Transferring transgender women from women's to men's facilities regardless of these risks is likely to cause severe harm.

F. The risks of transferring transgender women from women's to men's facilities cannot be sufficiently mitigated through protective measures.

43. Protective measures available in BOP facilities are not capable of meaningfully reducing the risks to transgender women who are transferred from women's to men's facilities, and some protective measures may cause harm.

44. The most powerful protective measure in place for transgender women is a proactive assessment of their individual risk factors and other relevant characteristics to determine their housing placement, including whether they should be placed in men's or women's facilities, consistent with PREA National Standards. A categorical policy prohibiting case-by-case assessment limits the ability of staff to manage risk through appropriate housing decisions, effectively eliminating the primary mechanism that correctional systems rely on to prevent harm to incarcerated transgender people.

45. The remaining safeguards are left to address risk after it has already been created rather than prevent it through informed placement. For example, BOP's sexual abuse prevention policy focuses on how staff respond to risk and incidents of misconduct. These safeguards are important, but they depend on staff identifying risk, observing behavior, or receiving a report. They are not designed to reduce individual vulnerability and may not prevent sexual violence in the first instance.

46. BOP policies requiring staff to monitor interactions, intervene in incidents, and investigate allegations of sexual abuse are also important safeguards. But they rely on consistent staffing, visibility, and timely reporting. Unfortunately, over the past several years, understaffing in BOP facilities has been a major cause for concern, as detailed in multiple reports by the Office

of Inspector General and the Government Accountability Office.[2] And even with adequate staffing, staff cannot continuously monitor all interactions, and visibility is often constrained by facility layout, blind spots, security system weaknesses,[3] movement patterns, competing responsibilities, and the pace of institutional operations. These constraints make it difficult to prevent victimization in real time.

47. Placement in protective custody or the Special Housing Unit (SHU) is frequently used to separate vulnerable individuals from the general population, but this approach is not a long-term solution and may itself result in significant harm, including social isolation, restricted movement, reduced access to programming, and deterioration in mental health. Prolonged or repeated use of such placements for vulnerable individuals can increase the risk of death by suicide and contribute to worsening mental health symptoms, including anxiety, depression, and increased risk of self-harm. In addition, protective custody is not a guarantee of safety. The same types of victimization risks that exist for transgender women in the general population of a male facility can exist in SHU as well. Within BOP, individuals may be placed in SHU for a range of reasons unrelated to protective custody, such as a pending transfer; an upcoming medical procedure; or an investigation into an individual's behavior or risk of victimization. As a result, transgender women placed in SHU for their own protection may still share space, or even share a

[2] *Ongoing Challenges Facing the Federal Bureau of Prisons*, U.S. Dep't of Just. Off. of the Inspector Gen. (last accessed May 11, 2026), https://oig.justice.gov/tmpc/challenge-1; U.S. Dep't of Just. Off. of the Inspector Gen., *Top Management and Performance Challenges Facing the Department of Justice 2025*, https://oig.justice.gov/sites/default/files/2026-01/TMPC-2025.pdf; U.S. Gov't Accountability Off., GAO-21-123, *Bureau of Prisons: Opportunities Exist to Better Analyze Staffing Data and Improve Employee Wellness Programs* (Feb. 24, 2021), https://www.gao.gov/products/gao-21-123.

[3] *DOJ OIG Releases Management Advisory Memorandum on Needed Upgrades to the Federal Bureau of Prisons' Security Camera System*, U.S. Dep't of Just. Off. of the Inspector Gen. (Oct. 28, 2021), https://oig.justice.gov/news/doj-oig-releases-management-advisory-memorandum-needed-upgrades-federal-bureau-prisons; U.S. Dep't of Just. Off. of the Inspector Gen., *Top Management and Performance Challenges Facing the Department of Justice 2025*, https://oig.justice.gov/sites/default/files/2026-01/TMPC-2025.pdf.

cell, with men who have histories of predatory or assaultive behavior or who are otherwise likely to target them for abuse.

48. Similar limitations apply to measures intended to address risks of self-harm and suicide. Within BOP, suicide prevention efforts rely heavily on staff observation, screening, and responses to expressed distress. These measures are important but inherently reactive and depend on individuals disclosing symptoms or staff identifying warning signs. In practice, psychological distress may not be visible or may escalate rapidly, particularly following a destabilizing event such as involuntary transfer to a higher-risk environment. As a result, once risk has been created, available interventions may not be sufficient to prevent serious harm. A recent report by the Office of the Inspector General found that "suicide represents a significant risk area for the BOP," and that "a combination of recurring policy violations and operational failures contributed to inmate suicides."[4]

49. For the most vulnerable transgender women, no available combination of protective measures is sufficient to mitigate the severe safety risks in a male facility. The most vulnerable transgender women have historically been subjected to serious harms in male facilities, including physical and sexual violence; long-term or frequent placements in the SHU or protective custody, leading to deterioration in mental health and overall functioning; or both.

50. In my professional opinion, the protective measures available in BOP facilities cannot adequately prevent harm to transgender women who are reassigned from female to male facilities based on a categorical housing policy unrelated to any individual circumstances.

[4] U.S. Dep't of Just. Off. of the Inspector Gen., *Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions* 10-11 (Feb. 2024), https://oig.justice.gov/sites/default/files/reports/24-041.pdf.

G. Serious risks of harm are also likely to result from transferring transgender women from female to male halfway houses.

51. Transfers from women's halfway houses to men's halfway houses would also foreseeably increase the risks of harm to transgender women. BOP uses the term "residential reentry centers (RRCs)" to refer to halfway houses.

52. Male RRCs receive men from prisons of all security levels. It is not uncommon for individuals leaving low-security facilities to be placed in RRCs alongside men with histories of violent and predatory behavior. Residents of male RRCs are typically required to share bedrooms and other spaces and interact with each other in close quarters. In addition, RRC residents experience relatively more freedom and less oversight than individuals who are incarcerated, as appropriate to facilitate their reentry into the community. As a result, RRC staff do not continuously monitor interactions among residents and may not directly observe threatening, abusive, or violent conduct. Based on these factors, in my opinion, transgender women with the distinct vulnerabilities described above would foreseeably face an increased risk of victimization if transferred from women's RRCs to men's RRCs.

53. The mental health consequences of transfer from a female RRC to a male RRC are both predictable and significant. A transgender woman who is presenting as female in the community, including at work and medical appointments, would likely experience a deterioration in mental health if transferred to a housing environment where she is not recognized or treated as a woman. In addition, placement in a male RRC would cause employers and healthcare providers to learn she is transgender, which could expose her to harassment and discrimination and could prevent her safe reintegration into the community. All these circumstances are very likely to trigger increased anxiety, depression, and gender dysphoria and could lead to suicidal ideation or self-harm—especially if combined with denials of medical care for gender dysphoria.

CONCLUSION

54. The core mission of the Bureau of Prisons is to "foster a humane and secure environment and ensure public safety by preparing individuals for successful reentry into our communities."[5] Adopting a categorical policy requiring reassignment of transgender women from women's to men's facilities is inconsistent with this mission and is a deliberate decision that will cause egregious and unnecessary harms to some of the most vulnerable individuals in BOP custody.

[5] *About our Agency*, Federal Bureau of Prisons (last accessed May 11, 2026), https://www.bop.gov/about/agency/agency_pillars.jsp.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 11 th day of May, 2026.

Dr. Alix McLearen

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the word-count limitation in ORAP 5.05(1)(b)(ii)(B) because the word count on this brief (as described in ORAP 5.05(1)(d)(i)) is 4,684.

I certify that the size of the type in this brief is not smaller than fourteen points for both the text of the brief and footnotes, as required under ORAP 5.05(3)(b)(ii).

DATED this 12th day of August, 2026.

By: s/ Nadia H. Dahab
Nadia H. Dahab, OSB No. 125630
SUGERMAN DAHAB
101 SW Main Street, Suite 910
Portland, OR 97204
Tel: (503) 228-6474
nadia@sugermandahab.com

Attorneys for Amici Curiae the American Civil Liberties Union of Oregon and the American Civil Liberties Union Foundation

CERTIFICATE OF FILING AND SERVICE

I hereby certify that on August 12, 2026, I directed the original **BRIEF OF AMICI CURIAE AMERICAN CIVIL LIBERTIES UNION FOUNDATION AND THE AMERICAN CIVIL LIBERTIES UNION OF OREGON IN SUPPORT OF PETITIONER ON REVIEW** to be electronically filed with the Appellate Court Administrator, Appellate Records Section and electronically served upon the following using the court's electronic filing system:

Margaret Huntington, OSB No. 200636
EQUAL JUSTICE LAW
1500 SW First Avenue, Suite 1090
Portland, OR 97201
(503) 226-0923
meg@equaljusticelaw.org

Attorney for Petition on Review

Daniel Rayfield, OSB No. 064790
Attorney General
Paul L Smith, OSB No. 001870
Solicitor General
Jentry Lanza, OSB No. 241211
Assistant Attorney General
OREGON DEPT. OF JUSTICE
1162 Court Street NE
Salem, OR 97301
(503) 378-4402
jentry.lanza@doj.oregon.gov

Attorneys for Respondent on Review

DATED this 12th day of August, 2026.

By: s/ Nadia H. Dahab
Nadia H. Dahab, OSB No. 125630
SUGERMAN DAHAB
101 SW Main Street, Suite 910
Portland, OR 97204
Tel: (503) 228-6474
nadia@sugermandahab.com

Attorneys for *Amici Curiae*