

Fundamental Principles Inherent in the Comprehensive Care of Transgender Inmates

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The transgender inmate population presents unique challenges and opportunities in medical, psychiatric, and correctional systems of care worldwide. We present a review of both case law and efforts within the medical and psychiatric communities to address transgender needs more consistently over the past few decades. In addition, we discuss the standardized implementation of core principles within the correctional system that should provide comprehensive care to transgender inmates.

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As a sexual minority, the transgender inmate population presents unique challenges and opportunities in medical, psychiatric, and correctional systems of care worldwide. A review of the legal and medical literature demonstrates a constant struggle on the part of transgender individuals to combat discrimination and stigma and secure basic human rights. This process often occurs amid the threat of violence and intimidation. The correctional system has not been spared these threats and has made institutional efforts to meet the needs of a growing incarcerated transgender population. We present a review of legal precedents and efforts within the medical and psychiatric communities to address the needs of transgender individuals more comprehensively, as they play critical roles in guiding correctional system policies. We also propose a standardized approach to providing comprehensive care to transgender inmates to ensure that concerns about safety, housing, and medical and psychiatric care are properly addressed.

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Definition of Terms

Before an exegesis of legal precedents and their current applications in the management of transgender inmates can be undertaken, it is essential to define basic descriptive terms. Precision of language is important in the appropriate management of transgender inmates, as it may directly affect the dignity, safety, and bodily integrity of these prisoners, especially in the assignment of housing. Biological characteristics, including chromosomes, genitalia (sex organs), and gonads (testes, ovaries), determine an individual's *sex*. In contrast, *gender* refers to qualities and attributes associated with sexual roles and is socially constructed.¹ *Gender identity* describes the gender a person identifies as, whether or not that gender is the same as that assigned at birth. It describes a person's internal, deeply felt sense of being male or female.² *Gender expression* refers to the way an individual adopts or adapts certain behaviors and qualities traditionally defined as masculine or feminine, including dress, mannerisms, appearance, speech patterns, and social interactions.² *Gender non-conforming* describes individuals whose gender expression, role, or identity differs from cultural expectations of a particular sex.³ *Transgender* indicates a spectrum of individuals whose identity or lived experiences do not conform to the identity or experiences historically associated with sex at birth: those with

intersex conditions; non-, pre-, and postoperative transgender individuals; cross-dressers; feminine men and masculine women; and people who live as a gender other than that assigned to them at birth.⁴ A transgender person is one whose inner gender identity and outward gender expression differ from the physical characteristics of the body at birth. Male-to-female (MTF) transgender people are born with male bodies but have a female gender identity; female-to-male (FTM) transgender people are born with female bodies but possess a predominantly male gender identity. *Transsexual* specifically refers to a person who has undergone cosmetic and reconstructive procedures, or hormone therapies, or both, so that the individual's sex aligns with internal gender identity.² Although these two terms, transgender and transsexual, are used interchangeably in the literature, for the purpose of our discussion, we mainly use the term transgender, to be more inclusive.

For most individuals, gender and sex are congruent. Individuals with *gender identity disorder* (GID) (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision; DSM-IV-TR),⁵ however, do not equate sex and gender and exhibit a "strong and persistent cross-gender identification" and a "persistent discomfort with his or her sex or [a] sense of inappropriateness in the gender role of that sex," causing "clinically significant distress or impairment in social, occupational, or other important areas of functioning." *Gender dysphoria* refers to a significant level of distress an individual experiences when gender identity is incompatible with sex at birth and primary and secondary sexual characteristics.³ The distress is exacerbated by discrimination and lack of acceptance. Individuals with gender dysphoria often express the perception that they are trapped in the wrong body,⁶ and they often go to great lengths to align their gender and sex.⁷

Scope of Transgenderism

It is difficult to estimate the number of individuals who identify themselves as transgender in the correctional system, as well as worldwide. Although transgender people have existed throughout history, only limited statistics are available. Very few formal epidemiologic studies on the prevalence and incidence of transgenderism have been conducted. Even if epidemiologic studies have established that similar proportions of transgender persons exist throughout the world, it is believed that cultural differences between

different countries would affect not only behavioral expressions of disparate gender identities but also the extent of gender dysphoria.⁸ Still, initial data confirm that transgenderism is rare.⁹ In 10 studies involving eight countries, the prevalence of transgenderism ranged from 1:11,900 to 1:45,000 MTF individuals and 1:30,400 to 1:200,000 FTM individuals.¹⁰ International data demonstrate that more biological males than females are transgender, at a ratio of two to three males per one female. In Australia, estimates for MTF transgender range between 1 per 9,000 to 37,000 males and for FTM, 1 per 27,000 to 150,000 females.¹¹

In the correctional system, estimates of individuals who identify themselves as transgender are also rare, perhaps because transgender inmates are often reluctant to divulge their sexual identity because of institutional transphobia and vulnerability in the correctional system. Inmates who exhibit effeminate characteristics are more likely to become targets of sexual abuse.¹² However, it is clear that transgender individuals often pass through the criminal justice system. Deprived of opportunities for employment and often the victims of violence, discrimination, and harassment, many turn to prostitution and sex work. A recent study of the transgender community in San Francisco found that nearly 14 percent of transgender individuals had been incarcerated at least once, a figure that is double the average incarceration rate in the United States.¹³

According to the Transgender Law Center and National Center for Lesbian Rights, LGBT (lesbian, gay, bisexual, and transgender) inmates are at significantly higher risk of violence while incarcerated. Sixty-seven percent of LGBT prisoners in California report having been assaulted in the correctional system.¹⁴ Despite the ever-present threat to dignity, safety, bodily integrity, and life, few correctional systems in the United States have mobilized to propose comprehensive solutions.¹⁵

Evolving Concerns and Problems in the Management of Transgender Inmates

Legal Precedents

The foundation of the constitutional right to health care for inmates is built on the United States Supreme Court's decision in the 1976 landmark case, *Estelle v. Gamble*.¹⁶ In that case, the Supreme Court ruled that "deliberate indifference" to an in-

mate's "serious medical needs" violates that inmate's Eighth Amendment right to be free from cruel and unusual punishment. Serving as the foothold to an inmate's "constitutional right" to health care access, this case guaranteed three basic rights: the right to access to care, the right to care that is ordered, and the right to professional medical judgment.

During the 35-year period following *Estelle v. Gamble*, a body of case law specifically addressing the standard of care for transgender inmates in correctional settings has developed. The main points at issue in the forefront of these cases are classification of transgender inmates, access to health care, and safe housing. When reviewing the legal literature, including the following cases, it is important to note that preoperative transgender inmates are usually referred to as transsexual.

Eighteen years after *Estelle v. Gamble*, another landmark ruling was made, further elaborating on the term "deliberate indifference." In *Farmer v. Brennan*,¹⁷ a male-to-female preoperative transsexual was placed in the general population and subsequently sexually assaulted. The Supreme Court in this case held unanimously that prison officials can be liable for damages if they are deliberately indifferent in failing to protect prisoners from harm caused by other prisoners. However, it adopted a narrow definition of "deliberate indifference"; "the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw that inference." In other words, the Court declined to adopt an objective rule that would hold a prison official liable for violence inflicted on a prisoner when the risks are obvious enough that the official "should have known" that the prisoner was in danger. Instead, the Court ruled that, to violate the Eighth Amendment, an official must have actual subjective knowledge that the prisoner is at risk of violence and deliberately fails to act on that knowledge.

In *Meriwether v. Faulkner*,¹⁸ the United States Court of Appeals for the Seventh Circuit definitively recognized transsexualism as a very complex medical and psychological problem with a "serious medical need" for treatment. However, it made the distinction that, although the transsexual prisoner is constitutionally entitled to some type of medical treatment for the diagnosed condition of transsexualism, the inmate "does not have a right to any particular type of treatment, such as estrogen therapy."

In *Phillips v. Michigan Department of Corrections*,¹⁹ a preoperative transsexual prisoner with a long history of hormonal treatment was denied treatment after her transfer to a new prison. A Michigan federal court granted a preliminary injunction directing prison officials to provide estrogen therapy for her, holding that denying hormonal treatment in this case caused "irreparable harm" and violated the Eighth Amendment:

It is one thing to fail to provide an inmate with care that would improve his or her medical state, such as refusing sex reassignment surgery or to operate on a long-endured cyst. Taking measures which actually reverse the effects of years of healing medical treatment . . . is measurably worse, making the cruel and unusual determination much easier [Ref. 19, p 800].

The rationale set forth in *Phillips* was evidenced again in *South v. Gomez*,²⁰ a case in which a transsexual prisoner's course of hormone treatment was abruptly discontinued after transfer to a new prison. The United States Court of Appeals for the Ninth Circuit found an Eighth Amendment violation on the part of the prison officials in this case. It also distinguished between failing to provide hormonal therapy in the first instance and abruptly terminating an existing prescription, considering the latter context to be critically different and "far narrower."

Similarly, in *Wolfe v. Horn*,²¹ a Pennsylvania federal court ruled that abrupt termination of prescribed hormonal treatment and failure to treat severe withdrawal symptoms or aftereffects in a transsexual prisoner raised "at least a fact question as to whether each of the defendants was deliberately indifferent to treating Wolfe's gender identity disorder," allowing the Eighth Amendment claim to proceed to trial. The court also noted that, compared with other cases where there had been no prior hormonal treatment outside of the prison, "the case is different when prison officials terminate medical treatment that was previously recommended and administered by a medical professional."

In *Kosilek v. Maloney*,²² a Massachusetts district court found that the prisoner's transsexualism constituted a serious medical need and directed prison officials to provide adequate treatment. Treatment was recommended by a medical professional experienced with treating gender identity disorders and did not exclude the possibility that necessary treatment might include psychotherapy, hormones, or sex reassignment surgery. Although the court acknowledged that prisons may maintain a "presumptive freeze-

frame policy,” it opined that determinations of whether specific forms of treatment are called for “must be based on an individualized medical evaluation [of prisoners] rather than as a result of a blanket rule.”

In 2003, a New York district court case dispensed with the distinction, used by other courts, that centered on whether the prisoner was using hormonal therapy at the time of entry into prison. In *Brooks v. Berg*,²³ the prisoner had begun to identify herself officially as a transsexual person while in prison and therefore was not using hormonal therapy when she entered prison. The prison officials cited a blanket policy as the basis for their refusal of all medical treatment for her newly identified gender identity disorder, “The New York State Department of Correctional Services continues treating inmates for Gender Dysphoria identified prior to incarceration.” The court opined:

This blanket denial of medical treatment is contrary to a decided body of case law. . . . Prison officials are thus obliged to determine whether Plaintiff has a serious medical need and, if so, to provide him with at least some treatment. Prison officials cannot deny transsexual inmates all medical treatment simply by referring to a prison policy which makes a seemingly arbitrary distinction between inmates who were and were not diagnosed with GID prior to incarceration [Ref. 23, p 312].

Despite this body of progressive case law, the United States Bureau of Prisons articulated its policy regarding transsexual inmates in their 2005 Program Statement on Patient Care as, “Inmates who have undergone treatment for gender identity disorder will be maintained only at the level of change which existed when they were incarcerated in the Bureau.”²⁴ This freeze-frame policy effectively refused hormonal therapy for transsexual inmates who were not receiving treatment when they entered prison. A change in this policy was recently brought about after the ruling in *Adams v. Federal Bureau of Prisons*.²⁵ The new policy was promulgated via two memoranda, dated May 31, 2011, and June 15, 2010. It stated, “In summary, inmates in the custody of the Bureau with a possible diagnosis of GID will receive a current individualized assessment and evaluation. Treatment options will not be precluded solely due to level of services received, or lack of services, prior to incarceration,”²⁶ finally adopting the rationale expressed in *Brooks v. Berg*²³ on a federal level.

In *Kosilek v. Spencer*,²⁷ a U.S. district court judge in Massachusetts held that “The federal right vio-

lated in the instant case is Kosilek’s Eighth Amendment right to the only adequate treatment for his serious medical need, sex reassignment surgery. Therefore, the DOC is being ordered to provide Kosilek that treatment.” This unprecedented decision made the ruling in *Kosilek* the first to order a state to provide sex reassignment surgery for an inmate. The Massachusetts Department of Corrections is currently appealing the court’s decision.²⁸

In addition to the right to health care for transgender inmates, another area that warrants particular attention when reviewing legal precedents is the matter of safe housing. Few prison systems in the United States or worldwide have clearly articulated policies on how to address the housing needs of transgender inmates. The two most common responses are housing transgender prisoners on the basis of their birth gender or imposing protective measures that almost always involve punitive isolation and deprivation of rights.¹⁵

In *Tates v. Blanas*,²⁹ a California district court held that a transsexual inmate’s constitutional rights were violated by the jail’s blanket policy of automatically placing all transsexual detainees in “total separation,” needlessly depriving transsexual pretrial detainees of basic human needs and of privileges available to all other inmates and subjecting them to harsh conditions, normally reserved for the most dangerous inmates.

By the same token, in *DiMarco v. Wyoming Department of Corrections*,³⁰ a Wyoming district court opined that segregating an intersex prisoner from the general population of a male prison for 438 days in severe conditions for safety reasons and not as a result of disciplinary problems, without a hearing, violated her due process rights.

In *Greene v. Bowles*,³¹ the Sixth Circuit recognized an Eight Amendment deliberate indifference claim and held that a vulnerable (e.g., gay or transsexual) prisoner could prove that prison officials knew of a substantial risk to his safety by showing that the officials knew of the prisoner’s vulnerable status and of the general risk to his safety from other prisoners, even if they did not know of any specific danger.

Inadequacies of the current correctional system in dealing with transgender inmates were further highlighted in *R.G. v. Koller*.³² A Hawaii district court in this case opined that the practice of placing LGBT juvenile offenders in isolation to protect them from abuse by other wards “was not within the range of

acceptable professional practices and constitutes punishment in violation of the plaintiffs' Due Process rights." Furthermore, it found deliberate indifference in the prison officials' failure to maintain: "(1) policies and training necessary to protect LGBT youth; (2) adequate staffing and supervision; (3) a functioning grievance system; and (4) a classification system to protect vulnerable youth."³²

Transgender inmates are a particularly vulnerable group, not only because of their highly stigmatized expression of gender variance and associated mental distress, but also because of their incarcerated status and the limited resources available for adequately meeting their needs. Therefore, it is recommended that professionals of all disciplines who work with this vulnerable group be knowledgeable about the existing legal guidelines so as to safeguard their rights and promote a safe environment conducive to their physical and mental well-being in the correctional system.

Psychiatric Perspective

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, provides a common language and standard criteria for the classification of mental disorders. Transsexualism first appeared as a psychiatric diagnosis in the third edition (DSM-III)³³ in 1980. Also included in the DSM-III was gender identity disorder of childhood. In the 1987 revision of the DSM-III (DSM-III-R),³⁴ transsexualism was classified as an Axis II disorder, "typically beginning in infancy, childhood or adolescence." In addition, the diagnosis of gender identity disorder of adolescence or adulthood, nontranssexual type was added. This diagnosis proved to be short-lived as it was eliminated in the fourth edition (DSM-IV)³⁵ in 1994. In the DSM-IV, the diagnoses of gender identity disorder of childhood and transsexualism were consolidated into one diagnosis, gender identity disorder (GID), and different criteria sets were established for children versus adolescents and adults. The diagnosis gender identity disorder not otherwise specified was included for coding disorders in gender identity that are not classifiable as a specific gender identity disorder. In the 2000 text revision of the DSM-IV (DSM-IV-TR),⁵ the same framework was retained.

Historically, the DSM has been criticized for its consistent position that a divergence between the assigned or physical sex and the psychological sex, *per*

se, signals a psychiatric disorder. Gender identity, gender role, and other gender-related concerns are conceptualized dichotomously rather than dimensionally.³⁶ This classic binary view labels expressions of gender variance as symptoms of a mental disorder, unnecessarily pathologizing an already highly vulnerable and stigmatized group and raising a concern for the potential use of "reparative therapies."³⁷ Given the concern that the diagnosis of GID can be pathologizing, some members of the transgender community have called for the complete abolishment of this diagnosis. However, the dissenting voices within this community point out that insurance companies generally require the DSM-compliant diagnosis of GID for medical expense reimbursement pertaining to hormonal and surgical interventions.³⁸

Another subject that has been raised about the current diagnostic criteria for GID is diagnostic reliability. The diagnosis of gender identity disorder is built on the inherent notion that femininity and masculinity are clearly definable standards for all people. However, this standard fails to take into account the varying endorsements of traditional feminine and masculine norms based on life stage, gender, sexual orientation, race, and ethnicity, as well as the differences in degrees of tolerance and acceptance of gender variance in different cultures.^{39,40} Therefore, there is a potential concern that each clinician will make a different clinical judgment on where the line is drawn along these varying degrees that separate disordered and healthy.³⁹

As the psychiatric community is aware, the fifth edition of the DSM (DSM-5) is now available.⁴¹ A comprehensive analysis of the changes that were proposed by the APA subworkgroup on GID is beyond the scope of this article. We will limit our discussion on the proposed changes to those that pertain to some of the concerns mentioned herein.

One change lies in the very name of the diagnosis, from gender identity disorder to gender dysphoria.⁴¹ Many gender-variant persons, being part of a marginalized group, similar to gay, lesbian, and bisexual individuals, face prejudice, discrimination violence, undeserved shame, and denial of personal freedom.³⁹ One of the functions that this transition serves is removing the stigmatizing term disorder from the label of the clinical phenomenon, making it more acceptable for the general public as well as for the vulnerable group. It also reflects the revised concep-

tualization of the defining feature, which is “marked incongruence between one’s experienced/expressed gender and assigned gender.”^{41,42} In addition, it satisfies the insurance industry’s requirement of a DSM gender-related diagnosis for reimbursement of needed medical interventions.

Another proposed change aimed to address diagnostic reliability by adopting a specific number of required indicators, thereby attempting to provide a more clearly defined set of diagnostic criteria while still allowing flexibility and acknowledging the wide range of manifestations with which gender variance can present.^{41,42}

This is a particularly noteworthy time to be witnessing a major shift in how the field of psychiatry conceptualizes mental health in the transgender population. For those working with transgender inmates, it is important to become familiar with the changes in the DSM-5 that affect this population, as they may have paramount clinical and policy implications.

Medical Perspective

The availability of hormonal treatments and considerable progress in the field of genital surgery and anesthesiology preceded the appearance of the transsexualism diagnosis in the DSM-III. Without any standardized diagnostic procedures or sex reassignment treatments issued by a professional organization available in the early years, treatment quality and clinical outcome varied widely. The Harry Benjamin International Gender Dysphoria Association, the first international multidisciplinary professional organization in the field of transgender health, established the Standards of Care (SOC) for the treatment of gender dysphoric persons in 1979,³⁶ with an aim to set minimum standards for the assessment and determination of eligibility for hormonal and surgical interventions, thereby providing optimal care for transsexual individuals.⁴³

After the inclusion of transsexualism in the DSM-III by the American Psychiatric Association in 1980 to address the mental health of transsexual individuals,³³ the World Health Organization followed suit by including the diagnoses of transsexualism and gender identity disorder of childhood in the 1992 10th edition of International Classification of Diseases (ICD-10).^{37,44} The ICD-11 is slated to come out in 2015.⁴⁵ As outlined in the previous section, the DSM has undergone multiple updates since

1980, with the DSM-5 published in May 2013.⁴⁶ In addition, the Harry Benjamin International Gender Dysphoria Association, renamed in 2009 as the World Professional Association for Transgender Health (WPATH), has gone through multiple revisions of the Standards of Care (SOC). In the latest (seventh) version published in 2011, comprehensive guidelines were laid out for assessment and treatment spanning multiple medical disciplines, such as mental health, endocrine, surgery, reproductive health, preventive care, and primary care in preop, postop, and lifelong settings (Table 1).⁴⁷ As these standards are periodically revised according to the best available evidence in medicine, it is crucial for clinicians working with transgender inmates to stay current with the most recent version.

Processes Critical in the Comprehensive Care of Transgender Inmates

Processes fundamental in the care of incarcerated transgender individuals are broadly focused on three specific areas: placement, management, and treatment. Each contains complex legal and medical concerns that continue to evolve as the needs of transgender individuals become clearer during the incarceration period.

Placement

Correctional facilities operate on the principles that all people should be classified as either male or female and that gender remains constant throughout life and is assigned at birth. Few correctional facilities in the United States¹⁵ and worldwide have designed housing policies that go beyond placement based on biological sex or genitalia. Clearly, the lack of such policies may create difficulties for inmates identifying themselves as transgender. The biological approach has proven particularly controversial for MTF transgender prisoners, as it places them at greater risk of sexual assault from male inmates because of their perceived effeminate qualities.¹² There have been no successful legal challenges to such housing policies in the correctional system, arguing that it is unconstitutional and in violation of the Eighth Amendment that guarantees freedom from cruel and unusual punishment. The Supreme Court has repeatedly elected not to interfere in a prison administration’s choices about how to manage its institution and has maintained that prisoners do not possess a

Care of Transgender Inmates

Table 1 Therapeutic Modalities and Processes in the Treatment of Gender Dysphoria, as Outlined by World Professional Association for Transgender Health (WPATH)

Therapeutic Modalities	Processes
Psychotherapy (individual, couple, family, group)	<ul style="list-style-type: none"> Explore gender identity, role, and expression Address the negative impact of gender dysphoria and stigma on mental health Alleviate internalized transphobia Enhance social and peer support Improve body image Promote resilience
Hormone therapy to feminize or masculinize the body	<ul style="list-style-type: none"> Document persistent gender dysphoria and capacity to make a full informed decision and to consent for treatment Discuss the risk/benefit ratio of hormone therapy Minimize the development of side effects and new medical conditions (eg: venous thromboembolic disease, hyperlipidemia, hypertension)
Surgery to change primary and/or secondary sexual characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring)	<ul style="list-style-type: none"> Document that the patient has engaged in 12 continuous months of living in a gender role that is congruent with his or her gender identity, before undergoing definitive surgery Document persistent gender dysphoria and capacity to make a fully informed decision and to consent to treatment Discuss different surgical techniques available and the advantages/disadvantages of each Identify inherent risks and possible complications of the procedure, while ensuring adequate postoperative care

constitutional right to determine where they will be incarcerated.⁴⁸

Historically, administrative segregation has been used as the most prevalent procedure to protect transgender inmates from the general population. However, in many cases, this form of protection is equivalent to solitary confinement, placing the transgender inmates among more violent and dangerous offenders in the prison system. At the very least, the conditions of segregated cells are often inferior to those in the general population, and segregation may make an inmate ineligible for work detail and unable to have access to visitation and medical treatment, subjecting transgender inmates to a more restrictive environment unjustifiably.⁴⁹

Placement based on self-identification has been hailed by some advocates as an ideal resolution for transgender inmates. However, there are legitimate concerns surrounding this option as well: potential violence against FTM inmates in male prisons; potential violence perpetuated by MTF inmates in female prisons, especially considering the possibility that sexual predators may claim to be transgender to take advantage of the system; and violation of the rights of nontransgender inmates.⁴⁹

An example of a more progressive, thoughtful approach to inmate housing emerged in Australia in 2008, addressing some of the concerns mentioned herein. The Queensland Corrective Services' (QCS)

transgender management procedure of 2008 aligned itself with Australia's Births, Deaths, and Marriages Registration Act of 2003, which held that transgender persons are to be treated according to their choice of gender identity. The QCS procedure dictates that, on admission, prisoners who identify as transgender must be housed in a single-occupancy cell until a decision is made about the facility at which the inmate is to be placed. This decision is informed by several factors, including risk that the inmate may pose to the safety and security of the facility, the nature of the inmate's charges, the inmate's personal circumstances, risk to the inmate or to other inmates at the facility, recommendations of the inmate's physician or psychiatrist, hormone treatment status, inmate's preference for placement in either a male or a female facility, and any concerns about staff threats to the inmate's safety.⁵⁰ Although the QCS maintains a biological approach in the placement of transgender inmates, it attempts to validate concerns raised by transgender inmates by initially offering accommodation in single-occupancy cells.

In the United States, there are few examples of correctional placement policies that address safety in housing for transgender inmates. Some notable exceptions include the housing and intake procedures used in San Francisco and the District of Columbia (DC). In San Francisco, transgender inmates, in addition to gay men identified as vulnerable, are housed

in separate facilities.⁵⁰ However, such segregated housing is usually unavailable. Riker's Island, New York City's largest jail, closed the segregated unit for LGBT prisoners, known as gay housing, in December 2005, citing a need to improve security.⁴⁹ At the DC Department of Corrections (DOC), a facility that houses pretrial offenders, those sentenced for misdemeanors, and convicted felons awaiting transfer to the federal system, transgender persons are initially placed in protective custody for a maximum of 72 hours, if requested, and are evaluated by an Institutional Transgender Advisory Committee. The Transgender Advisory Committee comprises the Medical Director, Mental Health Coordinator, an HIV Coordinator, and a transgender community representative. As a critical part of the intake process, transgender inmates also undergo a full medical and psychiatric assessment to determine hormonal status, current medications, and mental health needs. Furthermore, transgender inmates may be segregated from the general prison population if they express a preference or if prison officials believe that there are justifiable reasons to remove them from the open population. Placement in administrative segregation has been justified by the fact that transgender prisoners are more vulnerable to harassment and sexual assault and, as such, require an increased level of protection. If an inmate requests to be housed with the open population and later receives ill treatment, he may then request to be transferred to protective custody.

Management

The management of transgender inmates refers to their routine treatment in a correctional facility, including name used, forms of address, searches, attire, and possession of personal items.

There are no uniform guidelines on how to address transgender inmates and reflect their identities in official prison records. The most customary practice is to use the transgender inmate's birth name or legal name, instead of any adopted name. In some institutions such as the D.C. Department of Corrections, the transgender inmate is addressed as "Inmate last name" and is referred to by his legal name in the official records. Similarly, transgender inmates are usually referred to by pronouns associated with their birth gender rather than the ones more reflective of their gender identity.

If it is necessary for a transgender inmate to be searched by correctional facility officers, it is routinely conducted by an officer of the same sex. An MTF transgender inmate is generally searched by a male officer, and an FTM transgender inmate by a female officer, provided that neither has undergone sex-reassignment surgery. Because transgender prisoners identify themselves as being of a different gender than their biological sex, such a search may be unduly uncomfortable and distressing.⁵¹

Correctional systems worldwide have historically required transgender prisoners to observe the dress standards mandated at their respective facilities. In most prisons, transgender inmates are prevented from wearing gender-specific clothing and accessories (e.g., female undergarments, other clothes, or makeup in an MTF transgender inmate) and may only have access to clothing that serves a functional purpose, including brassieres.⁵¹

Treatment

Transgender inmates often present for gender-related mental health and medical care while in prison, including hormone treatment and gender reassignment surgery.

Transgender individuals are at increased risk for psychosis, depression, and HIV infection, and carry a nine-fold higher suicide risk than that found in the general U.S. population.⁵²⁻⁵⁴ For the correctional psychiatrist performing a mental health evaluation, special attention is given to documentation of gender dysphoria, assessment of an inmate's capacity to consent to treatment, and screening for Axis I and II disorders.

Historically, federal and state prison administrations have refused to provide hormone treatment to transgender inmates if they do not have documentation of treatment before incarceration. They continue hormone treatment only for individuals who can be documented as having received treatment. There has been a development of a series of case laws that denounce this freeze-frame approach. For inmates who have begun hormone therapy in the community, the abrupt discontinuation of treatment in the correctional system may cause psychological stress and undesirable, painful physical changes and amounts to cruel and unusual punishment.²⁰

A review of the legal literature demonstrates that historically the courts have not required correctional

Care of Transgender Inmates

Table 2 A Standardized Approach to Care and Housing of the Transgender Inmate

	Proposed procedures	Goals
Initial evaluation and placement	<p>Verification of biological sex status with private physical examination</p> <p>Inquiry into inmate's preferences for housing</p> <p>Complete risk assessment for inmate's safety in open population</p> <p>Placement in protective custody (PC) for 72 hours, if requested, and evaluation by Transgender Advisory Committee</p> <p>Full medical and psychiatric assessment to determine hormonal status, current medications, and mental health status</p>	<p>In determination of housing, ensure physical integrity and safety of inmate while taking both subjective and objective concerns into consideration</p> <p>Determine health status of new inmate and identify any immediate treatment needs</p>
Ongoing need assessment and treatment	<p>Provision of mental health and medical services of all modalities as indicated</p> <p>Ongoing evaluation of safety in housing block, placement in PC during periods of heightened risk</p> <p>Taking into consideration transgender (TG) inmate's gender identity when assigning officers for searches</p> <p>Monthly meeting of a multidisciplinary transgender advisory committee</p> <p>Periodic evaluation by community TG representative</p>	<p>Ensure appropriate access to mental health and medical care</p> <p>Continue to address potential safety concerns while developing safeguards to minimize the risk of unnecessary further restrictions</p> <p>Facilitate communication between TG inmate and prison officials</p>
Aftercare planning	<p>Identification of case management needs (e.g., outpatient medical and psychiatric services, housing) on release and arrangement of necessary follow-up services</p> <p>Prerelease assessment by community TG representative</p>	<p>Provide for smooth transition of care from correctional practitioners to outpatient providers, thereby increasing the odds of successful community reintegration and decreasing the risk of recidivism</p>

facilities to finance surgical procedures related to an inmate's gender expression, transition, or identity. In the 2005 Inmate Sex Change Prevention Act, Wisconsin legislated a prohibition on the use of government funds to provide gender reassignment surgery and hormone treatment while allowing access to the medical care necessary to treat any complications that arise from prior gender-related surgery.⁵⁵ However, in a lawsuit brought about by inmates with gender identity disorder, this law was struck down by the U.S. District Court for the Eastern District of Wisconsin in 2010, which found that it was unconstitutional.⁵⁶

A growing tide in favor of sex reassignment surgery for transgender inmates appears to be developing. Another case in point is the most recent and unprecedented decision on *Kosilek v. Spencer*,²⁷ in which a federal court judge ordered Massachusetts prisons officials to provide sex-reassignment surgery to an MTF transgender inmate who had attempted castration and tried to commit suicide twice while incarcerated. Although the case represents only one successful legal challenge, it is evident that the court system continues to attempt to define and address the medical needs of transgender inmates.

Given this shift in the legal tide, medical professionals working with transgender inmates should be well versed in appropriate procedures and medical guidelines in the provision of hormonal and surgical treatments as outlined in the WPATH Standards of Care (SOC). Particularly relevant is the Section XIV of the SOC, Applicability of the Standards of Care to People Living in Institutional Environments. In this section, WPATH calls for the availability of all elements of assessment and treatment in SOCs for people living in institutions. Specific mentions are made regarding the appropriateness of obtaining outside consultation from health care professionals if in-house expertise is not available, the potential danger of the freeze-frame approach when it comes to hormonal therapy, and ensuring the availability of all forms of treatment modalities, including sex reassignment surgery, where indicated.⁴⁷

Recommendations

The placement, management, and treatment of transgender inmates represent three complex processes in which the needs of certain inmates are balanced against those of prisons and other inmates in

the general population. Currently, there is no systematic, uniform way to manage such inmates, as demonstrated in a 2009 nationwide study.¹⁵ According to this study, 19 states reported the absence of any policy or directive on the placement, management, and treatment of transgender inmates; six states did not respond at all. There was a very wide variation across the 25 states, District of Columbia, and the Federal Bureau of Prisons in their policies and directives.

Against this backdrop, we recommend that a standardized approach be used, not only to support the legal rights of transgender inmates to medical care consistently, but also to provide them with opportunities for regular discussion of their safety and needs (Table 2). This approach is designed to promote collaboration among all stakeholders such as prison officials, inmates, health care providers, and advocates, and set clear goals for different phases of an inmate's incarceration.

Correctional care of transgender inmates, a population at high risk for violence and abuse, offers unique opportunities and challenges. It has only been within the past few decades that the needs and rights of transgender individuals have become better defined, owing largely to increased advocacy on the part of state, national, and international LGBT organizations. This advocacy has translated into a movement toward more equitable correctional system care for the transgender inmate, as policies continue to evolve to ensure the safety of more vulnerable populations. Clearly, legal cases such as *Farmer v. Brennan*¹⁷ have also guided the development of these policies. Upon review of both the medical and legal literature, we believe that a standardized approach to the care of transgender inmates is both necessary and feasible to implement. Sound knowledge of the legal, medical, and psychiatric perspectives inherent within the care of such inmates will serve to not only provide holistic care but also to highlight the physician's role in addressing the needs of underserved, vulnerable populations.

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Care of Transgender Inmates

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