The Present State of Housing and Treatment of Transgender Incarcerated Persons

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The care and housing of transgender (TGD) incarcerated persons is a complex concern that is growing because of the increased recognition and diagnosis of gender dysphoria in society. To remain current in this evolving landscape, there have been updates to federal manuals and state guidelines regarding the medical care and housing of the TGD population. Since the publication by Glezer and colleagues in 2013, there has not been a comprehensive overview of current federal and state guidelines, and legal and other considerations on this topic. We provide an update with special consideration given to housing practices, safety, and access to care. A review of the literature shows that the World Professional Association for Transgender Health (WPATH) standards and Prison Rape Elimination Act (PREA) requirements are not uniformly implemented and enforced on a state level. In fact, some states have policies that are in direct conflict with federal requirements. The safety and equitable treatment of both TGD and cisgender populations is an important topic that merits attention. As new challenges emerge, an increase in federal enforcement and consistency is needed to ensure the humane treatment and protection of TGD inmates.

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In 2013, Glezer and colleagues[1] published "Transgendered and Incarcerated: A Review of the Literature, Current Policies and Laws, and Ethics" in The Journal to address a gap in the literature regarding incarcerated TGD individuals. Since then, conceptions of gender identity in psychiatry and the law have evolved substantially, and progress has been made in many areas. For example, in January 2022, the Bureau of Prisons revised its *Transgender Offender Manual*, improving access to gender-affirming care and to housing placement consistent with the individual's gender identity, and requiring prison staff to use inmates' preferred names and pronouns.[2] Correctional facilities continue to struggle with how to manage classification, housing, and treatment. We describe the changes over the past 10 years, as well as the remaining challenges, with a focus on approaches to gender-affirming treatment and housing.

Terms and Definitions

"Transgender" is an umbrella term that is used to describe individuals whose gender identity is different from their external sexual anatomy at birth. In the DSM-IV-TR,[3] the associated diagnosis was "gender identity disorder" (GID).[3] This diagnosis was eliminated in the DSM-5 and replaced with "gender dysphoria."[4] This change focused on the gender identity-related distress that some TGD individuals experience and seek care for, rather than the TGD identity itself. This is an important distinction because, with this change, it is no longer considered pathological to be TGD. Instead, the dysphoria itself may be pathological,

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and appropriate treatment may include not only psychological interventions, but also gender-affirming medical and surgical interventions.

The term "sexual reassignment surgery" has been replaced with "gender affirmation surgery," which is preferred because it focuses on how the treatment brings individuals' external sexual characteristics into alignment with their gender identity, rather than "reassigning" something innate about the individual. It is important to note, however, that being TGD is not dependent upon the individual's physical appearance or medical transition.[5]

Another concept that has become increasingly recognized is "gender nonbinary" or simply "nonbinary." This term is used to describe individuals whose gender identity or expression do not fall within the binary gender identities of male or female. Given that this is a broad term that encompasses many different people with many different conceptions of their gender, nonbinary individuals may or may not consider themselves part of the TGD community. Because most carceral settings operate in a binary system, we will be focusing on TGD individuals, and we will consider nonbinary individuals as TGD for the purposes of this article.

Epidemiology

Although only .5 to .6 percent of the adult population is TGD, TGD people are disproportionately represented in correctional settings.[6–8] TGD individuals often face stigma beginning in childhood because of gender identity-based harassment, and many are rejected by their families. This marginalization often leads to homelessness and lack of employment, putting them at high risk not only for substance use and other mental health disorders, but also for relying on criminal activity such as sex work or selling illicit drugs to meet their basic needs.[9–10] In turn, substantial numbers of TGD inmates enter the correctional system.

In 2013, there were minimal data on this population. In 2014, Reisner and colleagues[9] analyzed data from the National Transgender Discrimination Survey (NTDS), which was a survey distributed to the largest convenience sample of TGD adults in the United States to date. Out of 3,879 TGD women, 19.3 percent reported histories of incarceration, in comparison to less than three percent of the general population. Black and Native American TGD women were more likely to report a history of incarceration than White, non-Hispanic respondents. Among TGD women who were previously incarcerated in either a jail or prison, 47 percent reported victimization, defined as harassment and physical or sexual assaults from other inmates or staff. A quarter reported being denied health care.[9]

Current Standards of Care

The World Professional Association for Transgender Health (WPATH) is a nonprofit organization dedicated to the health of TGD and gender-diverse individuals. The WPATH Standards of Care (SOC) are recognized by some U.S. courts as a benchmark for treating gender dysphoria[11] and are referenced by the National Commission on Correctional Health Care (NCCHC)[12] and the American Psychiatric Association (APA).[13] The guidelines outline best practices in the assessment and treatment of gender incongruence, founded on both a review of the available literature and consensus-based expert opinion. The eighth version of the guidelines (SOC8) was released in 2022.[14]

The new WPATH guidelines de-pathologize gender nonconformity and differentiate it from gender dysphoria. They draw attention to the concept of gender incongruence, a new term in the World Health Organization's International Classification of Diseases and Related Health Problems, 11th Version (ICD-11).[15] Whereas gender dysphoria requires clinically significant distress or impairment in functioning, gender incongruence points to the evolving understanding that diverse gender identities are not inherent states of ill health or dysfunction. SOC8 advances the principle that gender-affirming care (GAC) is essential for the health and wellbeing of all TGD persons, regardless of a diagnosis of gender dysphoria, which is often required by insurance companies to warrant gender-affirming treatments.

The main pillars of treatment for gender incongruence remain gender-affirming hormonal and surgical treatments. Hormone treatments involve the administering of feminizing or masculinizing hormones (estrogen and testosterone), alongside antiandrogen medications in some cases. In addition to "top surgeries" (double mastectomy, breast augmentation) and "bottom surgeries" (phalloplasty, metoidioplasty, and vaginoplasty), SOC8 includes an expanded list of medically necessary procedures including gender-affirming facial surgery, body contouring, and voice therapy or surgery. Some TGD

persons seek gender-affirming treatments, while some do not and may wish to transition without medical interventions.

The previous requirement of assessment by two medical providers prior to accessing gender-affirming medical or surgical treatments (GAMSTs) was changed to a single medical opinion in SOC8, as was the requirement of an assessment (or two for genital surgery) by a mental health professional. The previous recommendation that a person live in a gender-concordant manner publicly, known as social transition, for a period of 12 months prior to accessing GAMST is also changed; there is greater recognition that such a social transition may not be possible and should not be a barrier to care. This is especially salient in a correctional environment where living as, for example, a TGD woman housed in a male institution may pose safety concerns. The prior requirement of 12 months of hormonal treatment prior to surgical intervention has been reduced to six months and removed altogether for nonbinary persons not pursuing hormonal treatment. The guidelines provide new recommendations for the care of eunuchs, intersex, and nonbinary persons. Nonbinary individuals face greater barriers to accessing care than TGD individuals, and nonjudgmental exploration of treatment options is recommended, with caution against making assumptions about what options might fit each person.

The guidelines recommend TGD individuals who are institutionalized, including in carceral settings, be afforded treatment without delay and that people with gender dysphoria should be provided "medically necessary surgical treatments that contain similar elements provided to persons who reside outside institutions" (Ref. 14, p S106). There are expanded recommendations for gender-affirming practices in institutions, including the use of chosen names and pronouns, the availability of gender-affirming hygienic and grooming supplies, and the assignment of housing based on preference, gender identity, and safety considerations rather than on external genitalia or assigned gender. Nonbinary and other gender-diverse individuals are not easily fit into the dichotomous structure of correctional facilities, so flexibility is recommended when housing these individuals. Finally, TGD persons should not be placed in segregation or isolation solely based on their gender identity; this should only be done to address safety concerns.

Prison Rape Elimination Act

The Prison Rape Elimination Act (PREA)[16] was enacted in 2003 after a congressional inquiry was launched into sexual assault in the correctional system. PREA standards are intended to align practices across local, state, and federal institutions to eliminate sexual violence in prisons. The standards were implemented in 2012 and have jurisdiction over both state and federal correctional facilities, including privately operated facilities.[17] The standards include sections on prevention of sexual violence, responsive planning, training and education, screening for risk of sexual victimization and abusiveness, reporting, official response following report, investigations, discipline, and compliance.[17]

PREA contains 13 provisions specifically addressing TGD inmates, which are outlined in Table 1. There are definitions and requirements pertaining to staff training, prevention and response to abuse, and housing and classification. Regarding staff training, PREA states that no inmate will be physically examined for the "sole purpose of determining the inmate's genital status" (Ref. 17, § 115.15), and training must be provided in conducting respectful cross-gender pat-down searches. Employee training should also include instruction on communicating "effectively" with LGBT inmates, although the act does not describe effective communication or provide examples of such practices. In terms of prevention and response to abuse, staff must consider whether inmates' LGBT status or perceived status affects their risk of victimization or was a motivating factor in their abuse. With respect to housing and classification, there are three recommendations about using information on gender identity to assign a TGD inmate to a particular facility: decisions should be made on a case-by-case basis; decisions should be reassessed twice per year; and the TGD inmate's own views should "be given serious consideration" (Ref 17 §115.42). TGD inmates should be able to shower separately and not be placed into involuntary segregation solely because of their LGBT status.[16]

Finally, LGBT inmates should not be segregated into separate facilities, as this separation can be stigmatizing, lead to a decrease in access to programming and recreation, and in some cases be synonymous with solitary confinement, which causes psychological distress and has been recognized as a form of inhumane punishment.[18–21] PREA does allow an exemption of this statute under a consent decree or

Table 1 Thirteen Provisions of PREA[16] Related to Transgender Incarcerated Individuals

	Provisions	Description
1	§115.5 General definitions	Gender nonconforming means a person whose appearance or manner does not conform to traditional societal gender expectation.
2		Transgender means a person whose gender identity (i.e., internal sense of feeling male or female) is different from the person's assigned sex at birth.
3	§115.15 Limits to cross-gender searches	The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status.
4		The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.
5	§115.31 Employee training	The agency shall train all employees who may have contact with inmates on: How to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming inmates.
6	§115.41 Screening for risk of victimization and abusiveness	The intake screening shall consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization: Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming.
7	§115.42 Use of screening information	In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, 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.
8		Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.
9		A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.
10		Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates.
11		The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.
12	§115.43 Protective custody	Inmates at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers.
13		Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.

settlement agreement. For example, the K6G unit of the LA County Men's Central Jail has been operating since 1985 and described as an affirming and humanizing alternative for LGBT inmates.[22,23]

Malkin and DeJong[24] analyzed states' policies on TGD inmates with attention to each of the PREA provisions addressing TGD inmates. They found that only Indiana contained all 13 of the PREA provisions addressing TGD inmates, and only one-quarter of state policies included most of the provisions. Malkin and DeJong also found that 40 percent of states had policies that were incompatible with the TGD-related PREA provisions. For example, Hawaii and Idaho have blanket policies to house inmates based on their sex assigned at birth; and segregation or "protective custody" based on TGD identity is still commonly used in the District of Columbia, Virginia, and Oregon. Overall, the PREA provision least commonly included was the one preventing the use of segregation based solely on LGBT status.[24]

States not in compliance with PREA regulations must forfeit five percent of federal funding provided to the state correctional department unless the state can provide assurances that it is using the federal funds to work toward compliance. According to the Bureau of Justice, as of 2020, 21 states and the District of Columbia were fully compliant with PREA, and 30 provided assurances of working toward compliance.[25] Only two states (Alaska and Utah) provided neither. At the time of writing, Alaska was planning to provide an assurance, leaving Utah as the only state that continues to refuse the implementation of PREA.

The United States Appeals Courts have ruled differently with respect to inmate claims of Eighth Amendment violations for failures to conform policy to PREA guidelines. For example, in *Williams v.*

Kincaid,[26] the Fourth Circuit held that gender dysphoria is a protected disability under the Americans with Disabilities Act (ADA) and is different from its original exclusion of gender identity disorder. The diagnosis of gender identity disorder was excluded as qualifying as a disability in 42 U.S.C. § 12211. The court also held that Kesha Williams, a TGD woman imprisoned in Virginia in a men's facility, had been discriminated against and that the prison's blanket policy of housing inmates by genital status was in direct contravention of federal regulations under the Prison Rape Elimination Act that require determination be made on a case-by-case basis. Justice Quattlebaum dissented and argued that gender dysphoria was similar enough to gender identity disorder to be exempt from the ADA. He also argued that Sheriff Kincaid was not grossly negligent, as she demonstrated some degree of care in attempting to balance housing decisions with safety concerns of cis-gendered female inmates and correctional staff. In *Rivera v. Bonner,*[27] the Fifth Circuit held that while PREA was a helpful guideline, it did not establish a constitutional obligation for institutions to conform their policies and training to PREA.

Despite the very small number of TGD inmates who are housed based on their gender identity,[28] it is currently a matter of social controversy. In March 2023, Republican lawmakers introduced the "Preventing Violence Against Female Inmates Act of 2023" in the U.S. Senate and House of Representatives that would prohibit such housing in state and federal correctional institutions.[29] The case of a New Jersey trans woman impregnating two inmates garnered significant media attention and raised important considerations for such housing decisions, including the realities of consensual sexual interactions in such facilities, the difficulties of discerning consent in institutional settings, and the lack of available condoms in U.S. prisons and jails.[30]

Access to Treatment in U.S. Federal Prisons

The U.S. Federal Bureau of Prisons houses approximately 1,200 TGD inmates and has undergone several revisions to its TGD inmate policies following successive presidential administrations.[31] In 2017, the *Transgender Offender Manual* recommended TGD inmates be "hous(ed) by gender identity when appropriate" (Ref. 32, p 6). The manual also recommended that "hormone or other medical treatment may be provided after an individualized assessment" (Ref. 32, p 8). This policy was changed in 2018,[33] using biological sex as the initial determination for housing decisions as well as adding medical necessity for gender-affirming treatments. The manual was revised again in 2022.[2] The provision on the use of biological sex as the initial determinant of inmate placement was removed, as was the terminology of medical necessity. A new subsection was added specifically addressing access to gender-affirming surgery, noting that a case could be referred to the Transgender Executive Council for approval after "one year of clear conduct and compliance with mental health, medical, and programming services" (Ref. 2, p 9) The updated manual also contained a new provision outlining that staff must not deliberately misgender an inmate by using incorrect pronouns.[2]

Despite changes to formal policy, access to care still faces considerable barriers in practice, especially regarding surgical interventions. Cristina Nichole Iglesias was one of the first federal inmates to access gender-affirming surgery after the Federal Bureau of Prisons was ordered in 2022 to secure her surgery following three years of litigation by Ms. Iglesias.[34]

Access to Treatment in U.S. State Prisons

In 2017, Routh and colleagues[35] conducted a detailed review of state statutes and department of corrections (DOC) policies concerning TGD inmates' access to care, analyzing whether there were provisions for counseling, the continuation and initiation of hormone therapy, and sex-reassignment surgery. They found that most states had a policy that specifically considered TGD inmates, and of those that did, the policies generally recognized the diagnosis of gender identity disorder or gender dysphoria. The states that did not have a specific TGD policy recognized the Prison Rape Elimination Act, with its provisions for the protection of TGD prisoners from sexual violence. At the time of writing, 21 states had formally expanded access to care for TGD inmates. Only New Mexico, Tennessee, and Indiana disallowed all gender-affirming medical treatment once a person is incarcerated, down drastically from the 28 states that did so five years previously. Thirty-three states allowed for the continuation of hormone therapy, 28 allowed for the initiation of hormone therapy, and 13 allowed "sex reassignment surgery." The policies of eight states were either unknown or

not publicly available (Louisiana, Alaska, Florida, Kansas, Kentucky, Mississippi, Montana, and Utah).[35]

This expansion of services is likely in response to the legal success TGD inmates have had in gaining recognition of gender dysphoria as a serious medical concern, establishing grounds for deliberate indifference claims under the Eighth Amendment.[36] The Seventh Circuit ruled that blanket bans on treatment for gender dysphoria are unconstitutional.[37] There is, however, a circuit split on what constitutes deliberate indifference in the care of TGD inmates. The Fourth,[38] Seventh,[37] and Ninth Circuits[11] have ruled in favor of plaintiffs' claims, recognizing the WPATH SOC as the widely accepted guidelines for the treatment of gender dysphoria, and ordered access to care, including surgical treatments in some cases.[11,37,38] In contrast, the First, Fifth, and Eleventh Circuits have ruled in favor of defendants,[39–41] and held that less comprehensive gender-affirming care can negate the high bar for deliberate indifference,[39] that the WPATH SOC do not represent a medical consensus on the treatment for gender identity,[40] and that courts should defer to the safety concerns cited by correctional institutions in their reasons for providing or declining to provide certain elements of gender-affirming care.[41]

The Supreme Court has not directly addressed the matter of what constitutes medically necessary care for TGD inmates. It has denied applications for *certiorari* in the First, Seventh, Ninth, and Eleventh Circuits.

Despite this expansion of services, there have been an unprecedented number of bills introduced by Republican law makers banning aspects of gender-affirming medical care in 2023, including bills banning correctional departments from funding gender-affirming surgery,[42] and bills criminalizing gender-affirming care for youth in Florida, Idaho, North Dakota, and Oklahoma.[43] Practitioners should familiarize themselves with state policies and legislation governing gender affirming care, as it is an area that is rapidly evolving.

Housing and Safety

The 2022 *Transgender Offender Manual*[2] incorporates the thirteen PREA provisions related to TGD inmates. The manual states that housing should be considered on a case-by-case basis with some consideration given to the inmate's own gender identity. TGD inmates must have the opportunity to shower separately from the general population. It also establishes that TGD inmates cannot be placed in dedicated wings based on their gender identity unless established by separate legal action (e.g., consent decree) for safety purposes. If an inmate is transitioning, transfers to facilities concordant with their gender identity are considered upon the condition that the inmate has been compliant with programs, medications, and mental health treatment and is meeting hormone goal levels. These guidelines are consistent with PREA requirements.

As noted in our discussion of PREA implementation, states vary considerably in their implementation of the housing and safety standards, without recognizable patterns. For example, as of 2018 only Indiana contained all 13 provisions.[24] About half of the states contain at least seven; for example, California had seven, New York had eight, and Texas had 11.[24] A quarter of the states had less than four of the provisions.[24] Florida, Indiana, Illinois, and Mississippi contained no accessible data about their policies at the time of publication.[24]

Safety is an important factor in housing decisions, especially because TGD inmates are at considerably higher risk of physical and sexual violence than the general population.[44] Safety should also extend to protecting other inmates from potential violence perpetrated by a TGD individual. For example, there may be concern about the risk of victimization from an inmate assigned male at birth transitioning to female who is housed in a female facility. PREA includes standards that mandate screening to assess TGD inmates' vulnerability to attacks as well as the risk that they themselves will be physically or sexually abusive toward other inmates. It states, "The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing inmates for risk of being sexually abusive" (Ref. 16, § 115.41). The 2022 *Manual* includes provisions on initial housing screening and transfer requests protecting "the wellbeing of all inmates" (Ref. 2, p 6), which specifically incorporates the inmate's "criminal and behavioral/disciplinary history" and "likelihood of perpetuating abuse" (Ref. 2, p 6). On a state level, no comprehensive literature search has been published to date about specific protections afforded to cisgender inmates or the incidence of violence against the cisgender population.

Ongoing Challenges

Safety

The topic of physical and sexual violence perpetuated by the TGD individual against the general population is controversial. It merits consideration, especially in the case of male to female facility transfers. The Eighth Amendment imposes a duty on prison officials to "protect prisoners from violence at the hands of other prisoners" (Ref. 45, p 825). This duty not only applies to protecting the TGD individual, but also the general population against possible violence committed by the TGD person. There are no readily accessible data on the incidence of such violence or the extent to which it is a problem.

An Illinois case demonstrates these safety concerns. Janiah Monroe, a TGD woman, allegedly raped a cisgender woman after being transferred to a female prison despite pretransfer concerns about her risk of violence.[46] Ms. Monroe was transferred from a male to a female facility in 2019 after she successfully sued the Illinois Department of Corrections alleging that she was sexually assaulted while housed in a male facility.[47–49] There was considerable controversy surrounding Ms. Monroe's transfer to female housing; prison officials raised concern about whether she was psychiatrically stable based on her previous attempts at suicide and efforts to castrate herself.[50,51] There was additional concern regarding her history of serious violence; she had been incarcerated since 2005 after shooting two people outside of a barbershop and was later convicted of murder after strangling her cellmate in 2006.[50,51] It should be noted that some of the rape allegations made by the cisgender woman were later retracted.[50] Nonetheless, the case illustrates a potential example of the possible risk of TGD inmates to the safety of others.

Diagnosis and Readiness for Treatment

Although mental health professionals are no longer required to provide letters in support of gender-affirming treatments by WPATH standards, a diagnosis of gender dysphoria is necessary to access gender-affirming medical and surgical treatment (GAMSTs) in the United States. Mental health symptoms that interfere with a person's capacity to consent to treatment, such as cognitive impairment and psychosis, must be prioritized for assessment and treatment prior to proceeding with gender-affirming treatments.[14] Other possible causes of apparent gender incongruence must be excluded. For example, in the presence of a psychotic illness, the evaluator must consider whether the gender incongruence predates or persists outside of an acute episode of psychosis. Mental health symptoms that do not affect the capacity to provide consent, including anxiety, depression, and self-harm, should not be a barrier to initiating gender-affirming treatment. In fact, research suggests that access to GAMST tends to improve such mental health symptoms.[52]

Some conditions, such as mania, severe depression, psychosis, and substance intoxication or withdrawal, may pose challenges to perioperative care. These can include complications arising from missed follow-up appointments, problems with frequent dressing changes, and other aspects of postoperative recovery such as vaginal dilation. In these cases, support should be offered to address these symptoms to reduce the potential negative affects on surgical outcomes. Overall, any delay in accessing gender-affirming treatments must be carefully weighed against the risks of delaying such treatment, including increased distress.[14]

Assessment of Malingering and Risk

There are no published data on the rates of malingering of gender dysphoria in the community or forensic settings. Despite recent regulatory and legal changes, less than one percent of the TGD population are housed according to their gender identity.[28,53–55] Because of the vulnerable nature of the female prison population and the fact that fewer TGD men request transfers to male facilities, consideration has been given primarily to the transfer of TGD women to all female facilities.[56] There has been considerable media attention toward such transfers, and many articles raise the possibility or outright assumption of malingering gender dysphoria to gain access to potential female victims, especially if the TGD woman has not undergone bottom surgery.[57,58]

Henrich[59] conducted a systematic review of assessments of gender dysphoria. He found no consensus, but recommended a structured approach to the evaluation that included an assessment of malingering. In correctional settings, psychiatrists should consider whether the expression of gender dysphoria and gender identity are sincere, and whether there are any ulterior motivations for expressing gender dysphoria. This is especially important for those with a history of sexual or violent offending. A motive to gain

access to potential victims is a major consideration. Comorbid disorders that affect identity processes, including personality disorders and histories of severe trauma, should be explored to understand their relevance, as should paraphilic disorders, including transvestitism.[60] Other information relevant to the assessment includes a thorough history of gender discordance, noting periods of social transition and collecting collateral information to supplement self-report. It is possible that TGD individuals outwardly express their gender discordance for the first time in institutional settings. Therefore, evaluators should not conclude that an individual is feigning gender dysphoria just because their first clinical presentation is in a correctional setting.

Assessing sexual safety matters of prison transfers is a bidirectional concern. With respect to TGD individuals with a history of sexual offending, there are no specifically validated tools for assessing risk of re-offense. The STATIC-99R, one of the most widely used tools, is recommended only for use in adult males. According to its coding rules, TGD women are only considered "female" after undergoing bottom surgery and having socially transitioned for two years, while TGD men are not considered at all.[61,62] Jumper[63] summarized the state of the literature for the assessment, treatment, and management of TGD individuals who sexually harm, and advocates for treatment that emphasizes strengths as opposed to deficits and works within a framework that considers individuals' exposure to trauma. There is currently no research demonstrating that access to gender-affirming care reduces violence risk or recidivism in sex offenders; however, more research is needed.[64]

Prison Resources

Several factors have exacerbated already existing barriers to treatment and appropriate housing, including limited access to showers and commissary items, and caused interference with facility transfers. In some instances, prison infrastructure dates to the 19th century and building layout and limited funding may prevent the installation of separate showers. Single celling and transfers may likewise be limited by overcrowding. When coupled with staff shortages and physician availability, diagnosing gender dysphoria and other psychiatric conditions in a timely fashion may be challenging. The global supply chain disruption related to the COVID-19 pandemic resulted in national shortages of some items, including gender-affirming items like clothing and toiletries.[65–67] COVID-19 outbreaks and required quarantines disrupted movement in prisons, making it less likely for TGD inmates to be transferred to the most appropriate facilities. Segregating TGD inmates because of concern over communicable diseases may pose a disproportionate psychiatric burden related to TGD inmates' underlying vulnerabilities.

Equity

There are several considerations regarding equity when making housing and treatment decisions. As it pertains to housing, it may be necessary to separate a TGD inmate from the general population either because of a high risk of harm or in response to actual physical or sexual violence. The BOP does not place TGD inmates in separate facilities based on their gender identity unless "such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmate" (Ref. 2, p 6). If housed separately, this environment may be less equipped and underfunded compared with what is provided to the general population. Importantly, the psychological impact of separate housing could be considerable if it resembles extended solitary confinement for an already vulnerable population.

The concept of justice must also be considered in the fair adjudication of resources that are substantially limited within the penal system that has struggled with overcrowding and timely access to medical care in the general population. The TGD population is a small fraction of the general population, and an argument can be made that a disproportionate amount of time and resources are being spent addressing TGD inmates' housing and access to medical and psychiatric services. In some facilities, TGD individuals get their own committees, special assessments, and large amounts of clinical and administrative time.

Finally, equitable treatment requires education on the needs of TGD inmates. This is essential because TGD inmates report stigma and abuse from correctional officers in higher rates compared with the general population.[10,44,64,68] This can be addressed through staff training, which is already a requirement in PREA, though it has been implemented variably at the state level and only 38 percent of states had

these provisions.[24] Expanding these services is a crucial component of increasing equity of care.

Conclusions

The matter of housing and access to care in the TGD incarcerated population is a complex topic that will continue to evolve alongside the evolving standards of decency in our society. Despite updates in care standards and U.S. prison manuals regarding policies related to TGD inmates, there is a lack of uniformity, and enforcement of best practices varies widely across the United States. The ethics concerns of safety, housing, and equity are important, and proposed solutions continue to be debated. Safety concerns are bidirectional with regard to TGD incarcerated persons and the general population; although we focus on the question of safety of the general population from the TGD individual, the TGD population is at a much higher risk of victimization.[9] Expanding educational services to staff is fundamental to enacting such changes. Ultimately, expanding services and protections of the TGD population may ensure the humane treatment of all incarcerated persons.

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