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Challenges and opportunities for gender-affirming healthcare for transgender women in prison

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Abstract

Purpose – *The purpose of this paper is to briefly address three interrelated areas of concerns – victimization, housing placement and healthcare provision – related to the health and welfare of transgender women in jails, prisons and other types of detention facilities.*

Design/methodology/approach – *Drawing on a growing body of research on health risks for transgender women who are detained in facilities in California and elsewhere, the authors provide recommendations for policy and practice that constitutes gender-affirming healthcare for transgender women behind bars.*

Findings – *Policymakers, correctional leaders, and prison-based clinicians have a number of opportunities to address the welfare of transgender women in jails, prisons and other types of detention facilities.*

Originality/value – *This policy brief offers concrete steps government officials can take to better meet their professional and constitutional obligations, provide higher quality care for transgender women involved in the criminal justice system, and effectuate positive changes in transgender women's health and welfare both inside and outside of carceral environments.*

Keywords *Health in prison, Correctional healthcare, Health policy, Human rights, Women prisoners, Transgender*

Paper type *Viewpoint*

Introduction

Transgender people challenge one of the most basic assumptions of incarceration: segregation by sex, with sex (and corresponding gender identity) meaning male and female (and only male and female). Transgender people problematize the taken-for-granted status of sex-segregated detention facilities as a routine policy commitment and operational practice because their gender identity and/or gender expression do not align with the sex they were assigned at birth (see Box 1). Transgender people's gender expression may or may not align with their gender identity and often varies depending on their desire for and access to transition-related healthcare, such as hormones and surgeries; this in turn, results in challenges to long-standing classification systems in corrections. The binary system of classification has created a multitude of complications when it comes to caring for transgender people in contemporary correctional settings, including providing high-quality healthcare. In this historical context, transgender people in some jurisdictions technically have legal protection against discrimination, but they nonetheless confront significant threats to health and welfare as detainees, jailers and prisoners.

Transgender individuals "are more likely than the general population to experience multiple forms of violence across the life span" and "[t]hey are less likely to receive adequate medical and criminal justice interventions when this victimization occurs" (Witten and Eyler, 1999, p. 464; see also Lombardi *et al.*, 2001). With this in mind, we focus empirical, analytic and policy attention on transgender women who are subject to state control. Recognizing that transgender men also comprise an important population of concern, we focus on transgender women because

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Box 1: Terminology

Sex: the biological and physiological characteristics that are typically associated with males and females. Usually assumed to be binary and in the USA, newborns are assigned the “male” or “female” sex at birth.

Gender: the roles, behaviors, activities and attributes that are socially constructed by a given society, usually assigned to one’s sex assigned at birth.

Gender identity: an individual’s internal, personal sense of their own gender.

Gender expression: expression of masculine and/or feminine traits.

Gender non-conforming: people who express their gender in ways that are not aligned with normative expectations of male/female.

Transgender: an umbrella term for people whose gender identity and/or gender expression do not align with normative expectations of their assigned sex at birth. A transgender woman is someone who was assigned the male sex at birth but identifies as a woman, where as a transgender man was assigned female sex at birth but identifies as a man.

transgender women are disproportionately involved in criminal justice systems as compared to transgender men and because the bulk of the research to date focuses on transgender women. Thus, a growing body of knowledge on transgender women enables our assessment and attendant recommendations.

Transgender women, especially those of color, experience disproportionate rates of incarceration, high rates of victimization while incarcerated, and associated negative health-related indicators (Jenness and Fenstermaker, 2016; Sexton *et al.*, 2010; Reisner *et al.*, 2014; White Hughto *et al.*, 2015). The largest US-based national convenience sample of transgender women to date found that almost one-fifth reported having ever been incarcerated (Grant *et al.*, 2011; Reisner *et al.*, 2014). Among previously incarcerated transgender women, 47 percent reported victimization while incarcerated; Black, Latina and mixed race transgender women were more likely to report experiences of victimization while incarcerated (Reisner *et al.*, 2014). Transgender veterans in the USA. are more likely to be involved with criminal justice than matched control non-transgender veterans (Brown and Jones, 2015). In a recent survey of LGBTQ prisoners, 78 percent of transgender respondents reported experiencing emotional pain from hiding their gender identity during incarceration/throughout their interactions with the criminal justice system (Lydon *et al.*, 2015). These and similar findings have been corroborated by recent reports, including that of the US National Coalition of Anti-Violence Projects (NCAVP) (Waters *et al.*, 2016).

Transgender women in custody are especially vulnerable to sexual assault. Sexual assault is 13 times more prevalent among transgender women in prisons for men (Jenness and Smyth, 2011); see also Jenness *et al.*, 2007). In two large-scale studies of sexual assault in California prisons, 59 percent of transgender prisoners reported being sexually assaulted while incarcerated, compared to slightly more than 4 percent of male prisoners (Jenness and Smyth, 2011; Sexton *et al.*, 2010). Official data collected by the Bureau of Justice Statistics confirm that transgender prisoners in jails and prisons experience exceptionally high rates of victimization relative to other prisoners. When examining rates of sexual misconduct (both by prison and jail staff and prisoner on prisoner), they found that almost 40 percent of transgender prisoners experienced sexual victimization while incarcerated compared to 4 percent of all prisoners (Bureau of Justice Statistics, 2007, 2008-2009, 2011-2012).

Furthermore, incarcerated transgender women experience significant health disparities. Struggling with more numerous, severe and complex health challenges than either non-incarcerated women or incarcerated men, criminalized women are in particular need of coordinated and continuous healthcare services (Amico and Orrell, 2013; Zierler and Krieger, 1997). While data on incarcerated transgender women are scarce, these disparities are likely to be even more apparent among transgender women who face multiple intersecting layers of stigma (Grant *et al.*, 2011).

In light of these findings some systems of corrections around the world have recently adopted gender-affirming policies on the management and care of transgender detainees. However, the vast majority of jail, prison and detention facilities have yet to do so. Further, many detention

facilities have yet to develop specific policies that codify obligations and expectations related to the custody and care of transgender detainees and correctional staff receive very little, if any, education and training related to the custody and care of transgender prisoners.

Gender affirmation framework

“Gender affirmation” refers to an interpersonal, interactive process whereby a person receives social recognition and support for their gender identity and expression, including in interactions with state officials responsible for the care of transgender people in custody. In addition to gender identity-based discrimination being prohibited by law, respecting a person’s assertion of their own gender identity is a critical part of respecting the dignity and promoting the well-being of transgender people. The model of gender affirmation posits that in the context of transphobia, a high need for gender affirmation among transgender women, coupled with low access to gender affirmation, results in an unmet need for gender affirmation; this circumstance constitutes identity threat (Major and O’Brien, 2005; Sevelius, 2013). Identity threat can result in numerous serious negative mental and physical health outcomes, for example, risky sexual behaviors or using street hormones and/or injection silicone to get one’s gender affirmation needs met (Sevelius, 2013). Increasing transgender women’s access to gender affirmation, especially in interactions with state officials, can increase quality of life, improve mental health, increase motivation for self-care and improve physical health in general. There is a growing body of evidence that indicates that training in gender-affirming practices for custody and health staff may result in improved conditions for incarcerated transgender people and reduce grievances filed (Brown, 2014; Jaffer *et al.*, 2016). Correctional facilities should develop gender-affirming policies, train staff to appropriately implement these policies, and put into place reporting and monitoring systems that permit tracking and evaluation of the care and health outcomes of transgender women in their custody.

Safety considerations

Housing placement

In response to the documented vulnerabilities transgender detainees face, policymakers, law enforcement officials and corrections practitioners are increasingly (re)considering how best to provide safe and secure housing for transgender people in custody. For example, in 2011 the Cook County jail in Chicago, Illinois made national news when it adopted a policy that established guidelines and procedures for managing the custody, safety and security of transgender prisoners (Hawkins, 2011). Prior to the new policy, transgender prisoners were treated as members of the gender that aligned with their sex at birth (i.e. prisoners with male genitalia were treated as males). In contrast, the new policy specifies that transgender prisoners can be housed, dressed and searched according to their gender identity rather than the sex/gender they were assigned at birth. Likewise, in a handful of other US jails, facility staff work under policies that require them to consider the detainee’s gender self-identification and an assessment of the effects of placement on the detainee’s health and safety, when making classification and housing decisions for transgender detainees.

More recently, in 2015, the US Immigration and Customs Enforcement (ICE) garnered national headlines when it issued a memorandum that provided guidance on the care of transgender detainees. Among other things, this memorandum memorialized the requirement of a Transgender Classification and Care Committee charged with considering the range of possibilities for housing transgender detainees, including placing transgender women in housing units for women. This policy is now being implemented in multiple ICE facilities, including, most recently, Alvarado, Texas.

These kinds of protocols and attendant practices constitute a significant departure from decades of policy and practice that focused exclusively on the sex assigned at birth as the only relevant consideration. This departure – a focus on gender identity as a serious and significant consideration – reflects larger societal expectations and are often justified on the grounds that they can reduce victimization and enhance health and well-being of transgender detainees.

Unfortunately, there is very little work that systematically examines the relationship between housing assignment and vulnerability to violence among transgender women (c.f., Dolovich, 2011). Respondents in a study conducted by the Sylvia Rivera Law Project (2007) and Emmer *et al.* (2011) were not in agreement regarding housing preferences; some respondents felt it was better to manage prison life while in segregation most of the day, others prefer to be housed in the general population. Related, Jenness *et al.* (2007) found that the majority (65 percent) of transgender women in California's prisons for men expressed a preference to be housed in facilities for men rather than facilities for women. Drawing on these and other findings, we turn to a series of recommendations that begin with the importance of embracing gender-affirming healthcare policies and practices.

Gender-affirming healthcare provision

Gender-affirming healthcare begins with interacting with transgender women in ways that respect their self-identified gender by using their preferred names and pronouns at all times. Gender-affirming healthcare improves both mental and physical health outcomes among transgender women (Nuttbrock *et al.*, 2009; Sevelius, 2013). Transgender women have specific needs for gender-affirming healthcare, given that they are more likely to report negative interactions with healthcare providers that often result in avoidance of healthcare altogether (Sevelius *et al.*, 2010; Sevelius and Johnson, 2013). Transgender detainees should have the opportunity to disclose their gender identity, preferred name and pronoun and history of transition-related medical care at the initial medical screening; physical examination should never be performed solely to determine a person's genital status. If determination of genital status is required, the person should have the opportunity to self-disclose as an alternative. All custody and healthcare staff should be trained in and held accountable to this approach.

Transition-related medical care: gender dysphoria, hormones and gender-affirming surgeries

Gender dysphoria has been described by the psychiatric literature as severe and persistent discomfort with one's assigned sex and/or physical sex characteristics (American Psychiatric Association, 2013). Research has shown that gender dysphoria, if left untreated, can result in serious medical issues such as depression, suicidality and self-castration (Brown, 2014). Hormone therapy and gender-affirming surgeries are widely accepted as best practices for treating gender dysphoria when desired by the patient and not medically contraindicated (Coleman *et al.*, 2012). Recently, Mintz (2015) reported that 385 California prisoners were receiving cross-sex hormone therapy. To date, gender-affirming surgeries (sometimes referred to as "sex reassignment surgeries" or SRS) have not been offered by US correctional facilities unless or until it is ordered by a court.

When treating transgender prisoners, correctional health staff should be trained in transgender healthcare or have access to consultation with experts in transgender healthcare. Standards of care that have been developed by experts in transgender healthcare are available, such as the Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People which were developed at the University of California, San Francisco's Center of Excellence for Transgender Health (2016). The Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People (SOC; Coleman *et al.*, 2012) are the most recent guidelines published by the World Professional Association for Transgender Health. How well these guidelines apply to correctional populations has been a source of debate and suggestions for revision of the sections that discuss incarcerated transgender persons have been offered by experts in the field (Brown, 2009; Osborne and Lawrence, 2016). In 2015, California Correctional Health Care Services released a Care Guide for Gender Dysphoria that includes patient education and self-management materials (California Correctional Health Care Services, 2016).

Hormones are a serious medical necessity for many transgender women. Data from general populations of transgender people have documented that access to hormone therapy improves quality of life, reduces substance use, suicidality and symptoms of depression and anxiety (Ainsworth and Spiegel, 2010; Colton Meier *et al.*, 2011; Gorin-Lazard *et al.*, 2012). Transgender women who have been taking hormones prior to incarceration should not abruptly have their

hormone therapy discontinued, whether or not the hormones were obtained with a prescription, as this may result in hot flashes, dizziness, anxiety, suicidality, desire to engage in self-castration and other mental health effects that can have dire physical consequences. Transgender women often have varied levels of access to healthcare outside of correctional settings; thus, many policy advocates insist that transgender women should not be required to produce documentation of transition-related treatments prior to incarceration and access should not be restricted to those who were receiving treatment prior to incarceration. However, there continues to be some controversy around this recommendation as some correctional facility staff express concern that hormone therapy may be requested by prisoners who use it as a commodity to gain privileges they would not otherwise have access to. Ideally, transgender prisoners who have not received hormone therapy prior to incarceration should be evaluated by a qualified healthcare provider to determine their treatment needs.

Not all transgender women desire or seek gender-affirming surgeries, while others may require them for effective treatment (Coleman *et al.*, 2012). Generally speaking, gender-affirming surgeries have been found to be safe and effective treatment for serious dysphoria related to the incongruence between one's body and gender identity (Klein and Gorzalka, 2009). There is current controversy around access to gender-affirming surgeries for incarcerated transgender women due to concerns about the use of taxpayer money and very narrowly defined eligibility criteria. US courts are now consistently ruling that prohibition of gender-affirming surgeries as a matter of prison policy are unconstitutional (Osborne and Lawrence, 2016). Accordingly, prison authorities have been forced to consider whether provision of gender-affirming surgery is medically necessary for some transgender prisoners, which prisoners should be eligible for it, and what the probable outcomes of providing surgery would be, including implications for classification, housing placement and security. In a recent review, Osborne and Lawrence (2016) discuss gender-affirming surgeries for transgender women who are incarcerated, make suggestions for eligibility criteria and offer recommendations to facilitate provision of successful surgical outcomes (Osborne and Lawrence, 2016) and the California Department of Corrections and Rehabilitation recently issued formal Guidelines for Review of Requests for Sex Reassignment Surgery (California Correctional Health Care Services, 2015). Negative outcomes such as genital self-harm, including autocastration and/or autopenectomy, can arise when gender-affirming surgeries are delayed or denied (Brown, 2010).

Access to these services for transgender women who are incarcerated may be vital to improving health outcomes, increasing self-care behaviors and potentially reducing recidivism. However, little data exist on the needs of transgender women either during or post-incarceration and what facilitates improvement in health outcomes for this population. Thus, more research is needed on the transition-related health needs and outcomes among transgender women who are incarcerated.

HIV prevention and treatment, preventive healthcare and mental healthcare

Transgender women are more likely to be living with HIV and among those with a history of incarceration this disparity is even more pronounced (Baral *et al.*, 2013; Reisner *et al.*, 2014). Transgender women in prison are almost six times more likely to report having multiple sex partners, twice as likely to have been tattooed, four times more likely to have received STD treatment, and twice as likely to have used injection drugs (Stephens *et al.*, 1999). Healthcare screenings, including confidential HIV and STD testing and care, should consider the increased sexual health risks and exposure to blood borne pathogens faced by incarcerated transgender women. Whenever possible, condoms should be made available and the provision of pre-exposure prophylaxis and non-occupational post-exposure prophylaxis should be explored as HIV prevention options. Standards of preventive healthcare for transgender people suggest that, regardless of a person's gender identity, if a person possess a body part or organ and meets criteria for screening based on risk factors or symptoms, those body parts and/or organs should be screened (Center of Excellence for Transgender Health, 2016). Preventive healthcare screening should follow the established standards for transgender healthcare. Transgender people are more likely to experience depression, anxiety, post-traumatic stress disorder, serious mental illness and suicidal ideation and attempts (Bocking *et al.*, 2013; Brown and Jones, 2015;

Perez-Brumer *et al.*, 2015). Therefore, transgender women who are incarcerated should routinely and adequately be evaluated for mental health issues and provided appropriate counseling, if necessary. So-called “reparative” or “conversion” therapy is considered unethical and should never be attempted with transgender women in custody.

Conclusions

Engagement with the criminal justice system is both a potential source of harm for transgender women as well as an opportunity to provide access to healthcare for transgender women and deliver on the promise of consequential public health delivery. Historically, much of the violence that has been inflicted on sexual and gender minorities has been undertaken by the state on the grounds that gender inappropriate behavior warranted extreme sanctions. Fortunately, things have improved insofar as laws have changed, public opinion has shifted toward acceptance, and agents of the state have been called upon to protect sexual and gender minority people rather than harm them. Unfortunately, this shift has not resulted in transgender people being safe while in the care of the state – while in detention facilities, jails and prisons around the world. When possible, policies related to the custody and care of transgender prisoners should be developed in partnership with local transgender communities, including formerly incarcerated transgender women. There are many key practices and policies that every facility can and should adopt to immediately improve care for transgender women; our recommendations to prison administrators and policymakers are described in the following:

1. General recommendations:

- Policies should acknowledge that transgender women are at a disproportionate risk for violence while in custody, affirm transgender women’s gender identity as a core policy consideration, and emphasize staff’s responsibility to provide safe environments for transgender women in custody.
- Training should be provided to all staff to understand the salience of gender identity both inside and outside carceral facilities, effectively attend to the vulnerabilities associated with being transgender in custody, and provide quality care for transgender women in custody.
- All staff should be held accountable to adhering to gender-affirming policies, procedures and practices that ensure that transgender women are treated with fairness, dignity and respect.

2. Specific recommendations:

- Transgender people’s gender identity should be respected at all times through use of the person’s preferred name and gender pronouns by all staff, including custody and medical staff.
- Housing assignments for transgender women should be made on a case-by-case basis and with serious consideration given to intake and classification information, gender identity and transgender women’s assessment of safety needs, including documented and self-reported history of sexual assault and victimization.
- Transgender women should be housed in the least restrictive environment possible; isolation and segregation should never be involuntary unless there are no viable and safe alternatives. Involuntary segregation should be minimized and should never exceed 14 days.
- Transgender detainees must be given the opportunity to shower separately from other detainees when operationally feasible. Likewise, transgender detainees must be provided with a reasonably private environment for bathing and toilet facilities, in accordance with safety and security needs.
- Transgender women in custody shall be provided with undergarments (e.g. brassieres) consistent with their gender identity and be allowed to purchase and possess hygiene and personal items that are consistent with their gender identity and do not interfere with safety and security.

- Standards for the healthcare of transgender women in correctional settings should be established in alignment with current standards of care and with a commitment to supporting transgender women's unique healthcare needs upon re-entry; mechanisms for accountability must be in place.
- Transgender women who have been taking hormones prior to incarceration should not abruptly have their hormone therapy discontinued, whether or not the hormones were obtained with a prescription.
- Policies should not restrict transition-related medical care, such as hormones, to those who were receiving treatment prior to incarceration. When determined to be appropriate for a particular patient, hormone therapy should be initiated and regular laboratory monitoring should be conducted according to the standards of care.
- Transgender women's expressed preference as to the gender of the officer that will perform any necessary pat-down and strip searches will be accommodated if at all possible. At no time shall any search be conducted solely for the purpose of determining a detainee's biological sex.
- Sensitive information, such as a detainee's gender identity, is not used to the detainee's detriment by facility personnel. This includes the prohibition on shared personal information related to one detainee with other detainees, and is shared with staff solely on a need-to-know basis.

Future research needs to provide systematic empirical assessments of the consequences of implementing what is coming to be understood as "best practices," including the recommendations provided in this paper. In particular, future research should focus on determining the impact of best practices for specific health outcomes, from vulnerability to assault to the acquisition of acute and chronic conditions that impact the health and well-being of transgender people in custody.

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