Issues in the Management of Transgender Inmates

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Scope of Transgendrism

- Few formal epidemiologic studies on the prevalence and incidence of transgenderism have been conducted
- In ten studies involving eight countries, the prevalence of transgenderism ranges from 1:11,900 to 1:45,000 MTF individuals and 1:30,400 to 1:200,000 FTM individuals[1]
- In Australia, estimates range between 1:9,000 to 1:37,000 MTF individuals and 1:27,000 to 1:150,000 FTM individuals[2]
- Nearly 14% of transgender individuals have been incarcerated at least once, a figure that is double the average incarceration rate in the United States[3]
- Although transgender individuals frequently pass through the criminal justice system, often secondary to charges related to prostitution and drugs, they are often reluctant to divulge their sexual identity due to institutional transphobia and vulnerability in the correctional system

Legal Precedents

- ***Estelle v. Gamble (1976)***: Established that "deliberate indifference" to an inmate's "serious medical needs" violates that inmate's Eighth Amendment right to be free from cruel and unusual punishment; Served as the foundation of an inmate's "constitutional right" to healthcare access[4]
- ***Meriwether v. Faulkner (1987)***: Transsexualism recognized as a very complex medical and psychological problem with a "serious medical need" for treatment; Made the distinction that, while a transsexual prisoner is constitutionally entitled to some type of medical treatment for the diagnosed condition of transsexualism, there is no "right to any particular type of treatment, such as estrogen therapy"[5]
- ***Phillips v. Michigan Department of Corrections (1990)***: Held that denying hormonal treatment in an inmate who had been on estrogen caused "irreparable harm" and violated the Eighth Amendment[6]
- ***Kosilek v. Maloney (2002)***: While acknowledging that prisons may maintain a "presumptive freeze-frame policy," the court 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"[7]
- ***Tates v. Blanas (2003)***: Held that a transsexual inmate's constitutional rights were violated by a jail's policy of automatically placing all transsexual detainees in "total separation," depriving transsexual pretrial detainees of basic human needs and of privileges available to all other inmates and subjecting them to harsh conditions[8]
- ***United States Bureau of Prisons (2005)***: "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"[9]
- ***United States Bureau of Prisons (2010)***: "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."[10]

Comprehensive Correctional System Care for Transgender Inmates

1. Initial Evaluation and Placement
- Verification of biological sex status with private physical exam
- Inquiry into inmate's preferences for housing
- Complete risk assessment for inmate's safety in open population
- Placement in protective custody (PC) for 72 hours, if requested or indicated, and evaluation by Transgender Advisory Committee (TAC)
- Full medical and psychiatric assessment to determine hormonal status, current medications, and mental health status

Goals: Ensure physical integrity and safety of inmate in determination of housing; Determine health status of new inmate and identify any immediate treatment needs

2. Ongoing Need Assessment and Treatment
- Provision of mental health and medical services including hormonal therapy when indicated
- Ongoing evaluation of safety in housing block, placement in PC during periods of heightened risk
- Periodic survey assessment and evaluation by community transgender representative
- Monthly meeting of multidisciplinary TAC

Goals: Ensure appropriate access to mental health and medical care; Facilitate communication between transgender inmate and prison officials

3. Aftercare Planning
- Pre-release assessment by community transgender representative
- Identification of case management needs (outpatient medical and psychiatric services, housing, etc.) on release

Goals: 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

Psychiatric Perspective

- 1980: Transsexualism first appeared as a psychiatric diagnosis in DSM-III[11]
- 1987: Transsexualism was classified as an Axis II disorder in DSM-III-R, as a condition "typically beginning in infancy, childhood or adolescence"[12]
- 1994: Diagnoses of Gender Identity Disorder of Childhood and Transsexualism were consolidated into one diagnosis, Gender Identity Disorder (GID), in DSM-IV[13]
- 2000: Same framework was retained in DSM-IV-TR[14]
- Historically, DSM has been criticized for its consistent position that a divergence between the assigned or physical sex and the psychological sex signals a psychiatric disorder[15]
- 2013: Proposed changes in DSM-V include a conceptual transition from Gender Identity Disorder to Gender Dysphoria, echoing a paradigm shift that the classic binary view labeling expressions of gender variance as symptoms of a mental disorder may unnecessarily pathologize an already highly vulnerable and stigmatized group[16]

References

1. De Cuypere G, Van Hemelrijck M, Michel A, *et al:* Prevalence and demography of transsexualism in Belgium. European Psychiatry 22(3): 137-141, 2007
2. Walters W: The Transgender Phenomenon: An Overview from an Australian Perspective. Venereology 10(3): 147, 1997
3. Minter S, Daley C: Trans Realities: A Legal Needs Assessment of San Francisco's Transgender Communities. The National Center for Lesbian Rights & the Transgender Law Center, 2003
4. Estelle v. Gamble, 429 U.S. 97, 104, 97 S. Ct. 285, 291, 50 L. Ed. 2d 251 (1976)
5. Meriwether v. Faulkner, 821 F.2d 408 (1987)
6. Phillips v. Michigan Department of Corrections, 731 F. Supp. 792 (1990)
7. Kosilek v. Maloney, 221 F. Supp. 2d 156 (2002)
8. Tates v. Blanas, No. CIV S-00-2539, 2003 U.S. Dist. LEXIS 26029 (2003)
9. U.S. Department of Justice, Federal Bureau of Prisons, Program Statement 6031.01Patient Care. Available at http://www.bop.gov/policy/progstat/6031_001.pdf
10. U.S. Department of Justice, Federal Bureau of Prisons, Memorandum on Gender Identity Disorder Evaluation and Treatment, available at http://nicic.gov/Library/025522
11. American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd edition). Washington, DC: American Psychiatric Association
12. American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed., revision). Washington, DC: American Psychiatric Association
13. American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th edition). Washington, DC: American Psychiatric Association
14. American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th edition, text revision). Washington, DC: American Psychiatric Association
15. American Psychiatric Association. DSM-5 Development (February 5, 2012), available at http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=482#
16. Drescher J. Queer diagnoses: parallels and contrasts in the history of homosexuality, gender variance, and the diagnostic and statistical manual. Archives of Sex Behavior 39; 427-60, 2010
17. Cohen-Kettenis PT, Pfafflin F. The DSM diagnostic criteria for gender identity disorder in adolescents and adults. Archives of Sex Behavior 39; 499-513, 2010
18. Coleman, E. Towards version 7 of the World Professional Association for Transgender Health's Standards of Care: An introduction. International Journal of Transgenderism 11;1-7, 2009
19. The World Professional Association for Transgender Health. (2011). Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People. (Place of publication unavailable): The World Professional Association for Transgender Health

Medical Perspective

- Availability of hormonal treatments and considerable progress in the field of genital surgery and anesthesiology preceded the appearance of the diagnosis Transsexualism in DSM-III
- Treatment quality and clinical outcomes varied widely in the early years without any standardized diagnostic procedures or sex reassignment treatments issued by a professional organization available
- 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[17]
  - Aimed to set minimal standards for the assessment and determination of eligibility for hormonal and surgical interventions, providing optimal care for transsexual individuals[18]
- 2011: SOC undergoes its seventh revision, updating comprehensive guidelines for assessment and treatment, spanning multiple medical disciplines including mental health, endocrine, surgery, reproductive health, preventive care, and primary care in pre-op, post-op, and lifelong settings[19]