



 THE FENWAY INSTITUTE

**Emerging Best Practices for the Management and
Treatment of Incarcerated Lesbian, Gay, Bisexual,
Transgender, and Intersex (LGBTI) Individuals**

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Executive Summary

This report outlines promising practices and considerations for the management and treatment of inmates who identify as, or are perceived as being, lesbian, gay, bisexual, transgender, and intersex (LGBTI) or gender non-conforming (GNC) in correctional settings. It aims to support correctional administrators and staff in maintaining facilities that prioritize safety and security for all inmates.

Sexual and gender minority individuals who are incarcerated experience exceptionally high rates of sexual victimization in U.S. prisons and jails as compared to other inmates. The discrimination, ostracism, and victimization that LGBT people experience in broader society is often mirrored and intensified in the correctional environment. Gay or homosexual men are 11 times as likely as heterosexual men to report being sexually victimized by another inmate, and bisexual males are 10 times as likely. Bisexual women prisoners are more likely to report sexual assault by another prisoner than heterosexual or lesbian prisoners, and incarcerated bisexual and lesbian women report higher rates of sexual assault by prison staff. A 2015 national survey of transgender people found that of those who reported being incarcerated within the past year, 20% said that they were sexually assaulted while incarcerated. It is known that intersex prisoners can experience trauma as a result of voyeuristic strip searches conducted by staff and sexual harassment by staff and other inmates.

LGBT people are also disproportionately represented in corrections. Due to the historical criminalization of same-sex behavior and gender variance, the LGBT community has a particularly troubled relationship with the criminal justice system. Until the 1960s, all 50 states criminalized homosexual behavior. Anti-masquerade statutes dating from the 1910s and 1920s were often used to harass and arrest GNC individuals. While the overall legal situation facing LGBT individuals has greatly





improved since then, there are strong indications that LGBT individuals are still more likely to become involved in the criminal justice system than their heterosexual counterparts. Just 4.5% of U.S. adults identify as LGBT, yet 9.3% of men in prison, 6.2% of men in jail, 42.1% of women in prison, and 35.7% of women in jail identify as sexual minorities. The National Transgender Discrimination Survey found that 16% of survey respondents had been in jail or prison at least once.

Like all individuals held in prisons and jails, those who identify as LGBTI have rights under the U.S. Constitution and state and federal laws and regulations. The Prison Rape Elimination Act of 2003 (PREA) codified the right of inmates to be protected from sexual harassment and abuse, and it mandated the drafting of standards to accomplish this goal. The Department of Justice's PREA standards focus specifically on LGBTI status as one of several victimization risk factors. The PREA standards also underscore that the protection of vulnerable individuals in jails and prisons is central to the professional obligations of correctional administrators and staff.

It is critical for correctional institutions to adopt policies and practices that increase the safety of individuals in their care, especially those who have been historically victimized. Importantly, failing to do so may result in lawsuits or other legal challenges, as the full reach and meaning of PREA continues to be explored in the courts.

The practices set forth in this paper are largely based on policies already implemented in various correctional systems. These policies are emerging as best practices based on professional consensus. They cover intake, classification and housing placement, medical care, same-sex behavior, privacy and confidentiality, and group inmate management for incarcerated LGBTI individuals.

Key Recommendations

Institutional Culture

- **Professionalism:** Asking staff to develop, implement, and adhere to LGBTI-focused policy is, fundamentally, about being an effective correctional professional. Importantly, this process is not about asking anyone—administrator or staff—to change their personal or religious beliefs. The need to adopt policies that protect vulnerable individuals, including LGBTI people, stems directly from administrators' and correctional officers' duties and obligations as professional public safety officers. Leadership and staff must embrace their duty to prevent discrimination and harassment, to discourage a hostile environment, and to treat all inmate populations fairly. Correctional professionals—like other law enforcement professionals—should understand the need to act professionally and provide equitable protection to all when on duty, which can mean having to put personal beliefs and feelings aside.
- **Respect:** Administrators leading the effort to establish LGBTI policies should review their staff code of conduct and consider re-emphasizing that the policy extends to respect for LGBTI populations. Agency leaders should also strongly consider developing more specific guidance for staff regarding their interactions with LGBTI inmates, including identifying demeaning language and common slurs that should not be used. This kind of guidance should be included in any educational program developed as part of LGBTI policy development and implementation efforts. Correctional facilities can underscore their commitment to professionalism and respect by extending their nondiscrimination policy to cover LGBTI staff. If staff are being asked to show respect for LGBTI inmates, the same standard should apply to fellow staff members.
- **Effective Policy Development:** Prejudice and discriminatory attitudes toward sexual and gender minorities exist throughout the country—in blue states and red, inside and outside of correctional

facilities. Recommendations for policy change will undoubtedly be more challenging in some locales than in others. Policies cannot simply be copied directly from another jurisdiction and imposed by administrative decree. Effective policy development and implementation must include: 1) An assessment of current institutional culture, policies, attitude, and knowledge of LGBTI issues; 2) Direct staff involvement; 3) Outreach to local, state, or national LGBTI organizations and feedback from LGBTI inmates; 4) Frequent and mandatory staff training and education; 5) Enforcement mechanisms for new policies and disciplinary measures for staff who do not follow them.

Operations

- **Intake:** Intake is the correctional facility's first point of contact with inmates; therefore, it is the optimal time to identify inmates' particular vulnerabilities. Intake is an opportunity to minimize an inmate's risk of victimization while in custody and to optimize their sense of security. Information gathered during intake should inform subsequent decisions in classification, housing, health care, and program placement. The goal of LGBTI-focused intake policies is to identify vulnerable inmates, both by supporting self-disclosure through a respectful and non-judgmental intake process and by providing staff with the tools to assess inmates' vulnerability. This will ensure that an incoming inmate has an opportunity to inform facility staff of any concerns about vulnerability based on LGBTI identity, as well as any medical or accommodation needs that respect their gender identity.
- **Protective Custody:** Facilities may have policies in place that require LGBT prisoners to be segregated into solitary confinement to protect them from other prisoners who might harm or abuse them. These policies need to be reviewed to ensure they conform with PREA. PREA requires that inmates who are at higher risk for sexual victimization, such as LGBTI prisoners, should not be placed into seg-

gregated housing unless no available alternatives currently exist. If placed in segregated housing, prisoners should be kept there for no more than 24 hours while alternative options that adequately protect them from potential abusers are arranged.

- **Classification:** It is critically important that all classification decisions about a prisoner be documented. This will facilitate meeting PREA's requirement that all classification decisions and placement decisions for transgender prisoners be reassessed at least twice each year. LGBT prisoners should never be classified as sex offenders or housed with sex offenders based solely on their sexual orientation or gender identity. Classification of an LGBT prisoner as a sex offender should not occur without the same due process protections that exist for other prisoners, including a hearing, an evaluation by a mental health professional, and guidelines for an appeal process.

- **Housing:** PREA Standards require that housing decisions for transgender and intersex inmates be made on a case-by-case basis that "seriously consider" the inmates' own wishes regarding where they feel the safest. Transgender and intersex inmates should not be automatically housed based on biological sex, and facilities should have policies in place regarding the housing of transgender and intersex inmates that prioritize their safety. Under the Trump Administration, the federal Bureau of Prisons in 2018 adopted a policy that uses transgender prisoners' sex at birth to make initial housing assignments. This decision runs directly counter to the text and spirit of PREA and undermines the safety of one of a prison's most vulnerable populations. State prisons and local jails are not bound by the federal policy change, and should continue to follow PREA's guidelines for safely housing transgender and intersex prisoners.

- **Health:** Inmates have the right to appropriate clinical and mental health care. At a minimum, facilities must ensure that inmates have access to medical personnel who are knowledgeable about the

health needs of LGBTI individuals. LGBTI people have unique health risks and concerns that health care providers in correctional facilities should be equipped to address and treat in a competent and nondiscriminatory manner. Effective treatment of HIV, Hepatitis C, and gender dysphoria is critical to ensuring well-being and continuity of care. If the agency cannot provide the necessary care on site, then inmates should be transported to a properly skilled provider. For all prisoners, any previous treatment that they received prior to arriving at the facility should be continued upon arrival after appropriate consultation. Additionally, inmates' medical needs must be reassessed following arrival at the facility to ensure that all medical and mental health conditions are being treated in appropriately and effectively.

- **Same-sex Behavior in Prisons and Jails:** Many correctional facilities have simplistic, unilateral no-tolerance policies for sexual behavior; however, the phenomenon of same-sex sexual activity in prisons is inherently complex and ranges from entirely consensual to entirely coerced. Consensual same-sex behavior is not a violation of PREA, and should not be punished. Correctional officials are better able to serve and protect their incarcerated populations if they understand the motivations behind same-sex behavior in their facilities. Denying the existence of such behavior (or not understanding why it is occurring) leaves incarcerated individuals and correctional facilities vulnerable to systemic abuse and corrections officials liable to litigation. Correctional professionals should examine the merits of making condoms and lubricant available in correctional facilities.

- **Group Inmate Management:** Transgender prisoners should be allowed to express their gender identity and obtain certain clothing and personal items from commissary that align with their gender identity, as long as it does not interfere with their safety. Correctional professionals need to know how to discern valid gender expression from coerced gender abuse.

Introduction

Sexual and gender minorities are disproportionately likely to be incarcerated in the United States (U.S.). One in twenty (4.5%) U.S. adults identifies as lesbian, gay, bisexual, and transgender (LGBT);^{1,2} however analysis of the 2011–2012 National Inmate Survey shows that “9.3% of men in prison, 6.2% of men in jail, 42.1% of women in prison, and 35.7% of women in jail were sexual minorities.”³ Adults who are sexual minorities (that is, they identify as lesbian, gay, or bisexual or reported a same-sex sexual experience prior to incarceration) were incarcerated at rates more than three times higher than the U.S. adult population.⁴ The National Transgender Discrimination Survey, which included 6,456 transgender and gender nonconforming participants, found that 16% of survey respondents had been in jail or prison at least once.⁵ The over-representation of LGBT adults in prisons and jails underscores why it is critical for corrections professionals to develop policies and protocols that reflect the specific needs and concerns of this population.

Safety is a primary concern for incarcerated lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals.⁶ These individuals face substantial prejudice in their day-to-day lives based on their sexual orientation or gender identity. Prisons and jails are not immune to such prejudice. In the hyper-masculine environment of men’s prisons, physical, sexual, and verbal abuse and harassment can be especially pronounced. The Bureau of Justice Statistics (BJS) repeatedly documents that gay and bisexual men and transgender women inmates are about 10 times more likely to be sexually victimized in prison than heterosexual male inmates.^{7,8} Lesbian and bisexual women are also disproportionately victimized compared to heterosexual women.⁹ LGBT inmates report significantly higher rates of harassment and assault by both other inmates and staff.



The PREA standard protection of vulnerable persons and prisons is central to the obligations of correctional facilities and staff.

¹ Newport F (2018). In U.S., estimate of LGBT population rises to 4.5%. Gallup News. <https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx>

² See Glossary for definitions of these and other relevant terms.

³ Meyer I, Flores A, Stemple L et al. (2017). “Incarceration Rates and Traits of Sexual Minorities in the United States: National Inmate Survey, 2011–2012.” *Am J Public Health*. 107(2):234–240. The data that Meyer et al. analyze is from: Beck AJ, Berzofsky M and Krebs C (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12 National Inmate Survey, 2011–2012*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics <https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf>

⁴ Meyer I, Flores A, Stemple L et al. (2017).

⁵ Grant J, Mottet L and Tanis J (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force. https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf

⁶ Intersex refers to an uncommon condition in which a person is born with external genitalia, internal reproductive organs, chromosome patterns, or an endocrine system that does not fit typical definitions of male or female. For information on the terms lesbian, gay, bisexual, transgender, and other LGBTI-related terms, please see Glossary at the end of this paper.



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The Prison Rape Elimination Act of 2003 (PREA) codified the right of inmates to be protected from sexual harassment and abuse, including rape, and it mandated the drafting of standards to accomplish this goal.¹⁰ While the legislation was crafted to protect all inmates, the Department of Justice's PREA standards focus on LGBTI status as one of several victimization risk factors. Other risk factors include being young, being of slight build, race/ethnicity, and skin color/complexion.^{11,12} These risk factors must be assessed to determine vulnerability to sexual harassment and abuse. Furthermore, PREA requires careful and repeated assessment of housing assignments for transgender and intersex inmates.

The PREA standards underscore that the protection of vulnerable individuals in jails and prisons is central to the professional obligations of correctional administrators and staff. In order to fulfill those obligations, departments of correction and local jail systems need to assess potential vulnerability through strategies that will alert staff to potential risks and that will inform housing, classification and supervision decisions that contribute to minimizing these risks.

This document outlines promising practices and considerations for the management and treatment of inmates who identify as, or are perceived as being, LGBTI or gender non-conforming (GNC) in correctional settings. It aims to support corrections officials in maintaining facilities that prioritize safety for all inmates. Adopting such practices reflects an institution's investment in and commitment to safety for individuals who have been historically victimized and repeatedly ignored. Importantly, failing to do so may result in lawsuits or other legal challenges as the full reach and meaning of PREA continues to be explored in the courts.

⁷ Beck AJ and Johnson C (2012). *Sexual victimization reported by former state prisoners, 2008*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <http://www.bjs.gov/content/pub/pdf/svrfsp08.pdf>

⁸ Beck AJ, Berzofsky M and Krebs C (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12; National Inmate Survey, 2011–2012. Supplemental tables: Prevalence of sexual victimization among transgender adult inmates*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf>

⁹ Beck AJ and Johnson C (2012).

¹⁰ For resources related to PREA visit the PREA Resource Center at <http://www.preasourcecenter.org/about/prison-rape-elimination-act-prea>. The text of the Prison Rape Elimination Act of 2003 is available at <https://www.preasourcecenter.org/sites/default/files/library/prea.pdf>.

¹¹ Cahill S (2017). "From 'Don't drop the soap' to PREA standards: Reducing sexual victimization of LGBT people in the juvenile and criminal justice systems." *LGBTQ Politics: A Critical Reader*. New York: New York University Press. 134-152.

¹² Buchanan KS (2012). "E-race-ing gender: The racial construction of prison rape." In Cooper FR, McGinley AC, (editors), *Masculinities and the law: A multidimensional approach*. New York: New York University Press. 187-206.

In addition to issues related to sexual vulnerability, LGBTI and/or GNC individuals may present other challenges for correctional professionals. LGBTI and/or GNC individuals may need gender-specific housing or have gender-specific commissary needs. Prison officials will need to understand the unique health risks and health care needs of these populations. Although we generally refer to LGBTI together as a group, it is important to recognize that lesbians, gay men, bisexual people, transgender people, and intersex people each have unique health risks and needs. Additionally, research to date generally focuses on specific populations, such as LGB people or LGBT people. When specific studies focused on distinct populations are referenced in the text, the acronym used will reflect only the specific populations that are the subject of the study. In order to equitably care for these individuals, it is critical that institutions train their staff on the unique risks and needs of LGBTI inmates.

This best practices document provides insight into the health and other needs of LGBTI inmates and highlights the policies and protocols corrections officials can establish to enhance the safety and management of their institutions.

Note to readers:

The principal goal of this paper is to support prison, jail, and other corrections administrators, officers, and staff in establishing and running safe and secure facilities. The authors do not intend to single out any population or individual for special treatment; rather, the authors intend to raise awareness regarding potentially (and traditionally) vulnerable inmates, however they might identify themselves. The identification and incorporation of vulnerability risk factors into classification and housing decisions can help staff optimize the safety and security of all inmates in their charge.

The authors recognize that sexual orientation and gender identity remain polarizing issues. However, increased awareness of LGBTI issues has led to increased intervention on behalf of this population by legislatures and the courts. This paper does not seek to challenge personally held beliefs, but rather to provide guidance to corrections administrators and staff who are required to be responsive to PREA and other legal mandates.

Recent years have seen substantial expansion in legally recognized rights for LGBT adults and youth and a growing public acceptance of LGBT individuals. However, recent and widespread federal rule changes by the Trump Administration threaten to undermine the equal treatment, safety, and well-being of LGBT persons—particularly transgender individuals. This paper will discuss in detail the changes that impact LGBTI prisoners in federal institutions. We will focus especially on the Trump Administration's decision to use "biological sex" to make initial housing determinations for transgender and intersex prisoners in federal prisons.¹³ Note that these changes only affect federal prisons. State and local systems should continue to follow state and local rules, including best practices for housing transgender and intersex prisoners described herein.

The practices set forth in this paper are largely based on policies already implemented in various correctional systems. These policies are emerging as best practices based on professional consensus. Typically, a "best practice" is one that has been shown to be most effective in comparison to other practices. However, institutions have only recently begun to implement these practices, and levels of effective implementation vary across state and local systems, limiting the body of research in the area.

¹³ The May 11, 2018 revisions to the *Federal Bureau of Prisons Transgender Offender Manual* are set forth in the Change Notice posted by the Bureau at <https://www.documentcloud.org/documents/4459297-BOP-Change-Order-Transgender-Offender-Manual-5.html>.



It is our firm belief that many of the practices described throughout the paper will, over time and after appropriate evaluation, qualify as best practices.

This document reflects the collective advice and guidance of corrections professionals, policy makers, former prisoners, advocates, and researchers who provided input through a series of focus groups, meetings, and interviews in 2013, 2014, and 2015. Corrections professionals from Houston, Denver, and the states of California, New York, Rhode Island, Massachusetts, and elsewhere generously offered their advice and experience, as did others from across the country. We thank these colleagues for their guidance and input.

In addition, this document builds directly on several publications, including two important guides from the National Institute of Corrections and one important guide from the National Center for Transgender Equality:

- Brenda Smith and Jaime Yarussi. *Policy Review and Development Guide: Lesbian, Gay, Bisexual, Transgender, and Intersex Persons in Custodial Settings Second Edition* (Washington DC: U.S. Department of Justice, National Institute of Corrections), 2015. <https://info.nicic.gov/lgbti>.
- The Moss Group. *A Quick Guide for LGBTI Policy Development for Adult Prisons and Jails* (Washington DC: U.S. Department of Justice, National Institute of Corrections), 2012.
- Jody Marksamer and Harper Jean Tobin. *Standing with LGBTI Prisoners: An Advocate's Guide to Ending Abuse and Combating Imprisonment* (Washington, DC: National Center for Transgender Equality), 2014.

This paper does not seek to challenge personally held beliefs, but rather to provide guidance to corrections administrators and staff who are required to be responsive to PREA and other legal mandates.

I. Why focus on LGBTI prisoners?

LGBTI PRISONERS EXPERIENCE EXCEPTIONALLY HIGH RATES OF SEXUAL VICTIMIZATION IN US PRISONS AND JAILS.

The primary goal of all corrections administrators, officers, and staff is to operate institutions that are safe and secure for all individuals within their confines. This document focuses on LGBTI inmates specifically because of their heightened vulnerability to physical, sexual, and emotional harassment and abuse in correctional facilities.¹⁴

LGBT individuals who are incarcerated experience exceptionally high rates of sexual victimization in U.S. prisons and jails. A 2012 U.S. Bureau of Justice Statistics (BJS) report that surveyed former state prison inmates on sexual victimization found that gay or homosexual men were 11 times as likely as heterosexual men to report being sexually victimized by another inmate (39% of gay men versus 3.5% of heterosexual men); bisexual males were 10 times as likely (34% versus 3.5%). Bisexual women prisoners are more likely to report sexual assault by another prisoner than heterosexual or lesbian prisoners, and bisexual and lesbian women prisoners report higher rates of sexual assault by prison staff.¹⁵

While there is limited population-level data on the experiences of transgender people in prison, a national survey of transgender people conducted by the National Gay and Lesbian Task Force and the National Center for Transgender Equality found high rates of sexual victimization reported by former transgender prisoners.¹⁶ A 2013 BJS report found that transgender prisoners report sexual abuse at about 10 times the rate of heterosexual male prisoners, and at about 2.5 times the rate of heterosexual female prisoners.¹⁷

Very little research exists regarding intersex persons and their relationship to the criminal justice system. However, they are included in this discussion because their anatomy has created confusion and misunderstanding among staff and medical providers who are not familiar with this range of conditions. It is known that intersex prisoners can experience trauma as a result of voyeuristic strip searches conducted by staff and sexual harassment by staff and other inmates.¹⁸

¹⁴ Beck AJ and Johnson C (2012). *Sexual victimization reported by former state prisoners, 2008*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <http://www.bjs.gov/content/pub/pdf/svrfsp08.pdf>

¹⁵ Ibid.

¹⁶ Grant et al., 2011

¹⁷ Beck AJ, Berzofsky M and Krebs C (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12 National Inmate Survey, 2011–2012. Supplemental tables: Prevalence of sexual victimization among transgender adult inmates*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics <https://www.bjs.gov/content/pub/pdf/svpjr1112.pdf>.

¹⁸ Although little research exists regarding intersex persons and their experiences in the criminal justice system, they are included in this discussion because staff and medical providers are not familiar with the range of conditions that are covered by the term intersex. One of the paper's authors, Brad Brockmann, represented an intersex female inmate in Massachusetts who was regularly harassed over a period of six months by staff based solely on misunderstanding, confusion and fear about her intersex condition. In one ten-day period early in her incarceration, the inmate was subjected to seven strip searches that were unrelated to a security issue. These types of searches remained a regular occurrence even after administrative intervention.

Table 1. Sexual Abuse Reported by Men in State Prisons by Sexual Orientation

Heterosexual Men	3.5	5.2
Bisexual Men	33.7	17.5
Homosexual or Gay Men	38.6	11.8

Source: Beck AJ and Johnson C. (2012). Sexual victimization reported by former state prisoners, 2008. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <http://www.bjs.gov/content/pub/pdf/svrfsp08.pdf>

Table 2. Sexual Abuse Reported by Women in State Prisons by Sexual Orientation

Heterosexual Women	13.1	3.7
Bisexual Women	18.1	7.5
Homosexual or Lesbian Women	12.8	8.0

Source: Beck AJ and Johnson C. (2012). Sexual victimization reported by former state prisoners, 2008. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <http://www.bjs.gov/content/pub/pdf/svrfsp08.pdf>

Table 3. Sexual Abuse Reported by Transgender People in Prisons and Jails

State and Federal Prisons	34.6	24.1	16.7
Local jails	34.0	22.8	22.9

Source: Beck AJ, Berzofsky M and Krebs C (2013). Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12 National Inmate Survey, 2011–2012. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics <https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf>; Supplemental tables: Prevalence of sexual victimization among transgender adult inmates.

FACTORS THAT CONTRIBUTE TO EXCESS RISK OF SEXUAL VICTIMIZATION FOR LGBTI INMATES IN US PRISONS AND JAILS

Two primary factors contribute to higher victimization of incarcerated LGBTI individuals as compared to other inmates. First, the discrimination, ostracism, and victimization that LGBT people experience in broader society is mirrored and intensified in the correctional environment. Second, LGBT people are disproportionately represented in corrections.

Anti-LGBTI discrimination and prejudice in society carries over to prisons and jails

Many LGBT Americans in society experience prejudicial treatment from heterosexual peers and traditional institutions. A 2017 survey of a nationally representative sample of LGBT Americans found that 25% reported experiencing discrimination based on their sexual orientation or gender identity within the past year.¹⁹ Experiences of workplace discrimination include being fired, denied employment, denied promotions, and getting bad job ratings or evaluations.²⁰ Transgender people also experience widespread discrimination in employment, housing, and public accommodations.²¹ Many LGBT people also experience family and social rejection.

Despite significant changes in American society in recent decades, most LGBT youth report discrimination and harassment in school.²² Bias-motivated hate violence against LGBT people disproportionately burdens Black, Latino, and American Indian members of these populations. The over-representation of LGBT individuals in correctional facilities is compounded for LGBT people of color.²³ While we do not have good data on the extent of discrimination against intersex people in the U.S., intersex advocates report discrimination in employment and health care.



¹⁹ Singh S, Durso LE (2017) *Widespread discrimination continues to shape LGBT people's lives in both subtle and significant ways*. Center for American Progress. <https://www.americanprogress.org/issues/lgbt/news/2017/05/02/429529/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways/>

²⁰ Badgett L, Lau H, Sears B et al. (2007). *Bias in the workplace: Consistent evidence of sexual orientation and gender identity discrimination*. UCLA Williams Institute. <http://escholarship.org/uc/item/5h3731xr>.

²¹ James S.E., Herman J.L., Rankin S., Keisling M., Mottet L., Anafi M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality. <http://www.transequality.org/sites/default/files/docs/usts%20Full%20Report%20-%20FINAL%201.6.17.pdf>

²² Kosciw J, Greytak E, Zongrone A et al. (2018). *The 2017 National School Climate Survey: The experiences of lesbian, gay, bisexual, transgender and queer youth in our nation's schools*. Gay, Lesbian and Straight Education Network. <https://www.glsen.org/sites/default/files/GLSEN-2017-National-School-Climate-Survey-NSCS-Full-Report.pdf>



While prejudice and discriminatory beliefs are widespread in broader society, these views are intensified in the hyper-masculine prison setting. Gay and bisexual men and transgender women in male facilities particularly suffer the consequences of these social views. This is not surprising given that even in settings outside prison, males are much more likely to be homophobic and harbor negative attitudes toward homosexuality. These attitudes and findings among incarcerated heterosexual males were found to be mirrored in one study of a sample of men and women incarcerated in a large Southern prison.²⁴

LGBT people are more likely to become involved with the criminal justice system

Due to the historical criminalization of same-sex behavior and gender variance, the LGBT community has a particularly troubled relationship with the criminal justice system. Until the 1960s, all 50 states criminalized homosexual behavior.²⁵ Anti-masquerade statutes dating from the 1910s and 1920s were often used to harass and arrest cross-dressers.²⁶ While the overall legal situation facing LGBT individuals has greatly improved since then, there are strong indications that LGBT individuals are still more likely to become involved in the criminal justice system than their heterosexual counterparts.

The experience of LGBT youth helps to inform our understanding of LGBT pathways into the criminal justice system and the potential challenges LGBT adults face in their interactions with law enforcement. The overrepresentation of LGBT youth in detention is well documented, especially for girls and young women.²⁷ Family rejection of LGBT youth, harassment in school, and “survival” crimes, such as robbery or sex work, make LGBT youth more likely to become involved in the juvenile justice system.²⁸

²³ Tillery B, Ray A, Cruz E et al. (2018). *Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate and Intimate Partner Violence in 2017: A report from the National Coalition of Anti-Violence Programs*. New York City Anti-Violence Project. <http://avp.org/wp-content/uploads/2019/01/NCAVP-HV-IPV-2017-report.pdf>

²⁴ Blackburn A, Fowler S, Mullings J et al. (2011). “Too Close for Comfort: Exploring Gender Differences in Inmate Attitudes Toward Homosexuality in Prison.” *American Journal of Criminal Justice* 36(1):58–72 and in particular studies cited at pp. 60–61.

²⁵ D’Emilio J. (1998) *Sexual politics, sexual communities: The making of a homosexual minority in the United States, 1940-1970*. Chicago: University of Chicago Press. Chicago, IL

²⁶ Ibid.

²⁷ Majd K, Marksamer J, and Reyes C (2009). *Hidden injustice: Lesbian, gay, bisexual and transgender youth in juvenile courts*. Legal Services for Children, National Juvenile Defender Center, and National Center for Lesbian Rights. http://www.equityproject.org/wp-content/uploads/2014/08/hidden_injustice.pdf

²⁸ Ibid.

According to data from the 2017 national Youth Risk Behavior Survey (YRBS), lesbian, gay, and bisexual youth—when compared to heterosexual youth—reported higher levels of victimization and mental distress. LGB-identified youth were almost twice as likely to report having been bullied at school or to have carried a weapon to school, and nearly one in three reported having been electronically bullied. LGB-identified youth were also around three times as likely to have experienced unwanted sexual contact. Nearly half (47.7%) of LGB-identified youth in the US reported seriously considering suicide in the prior year vs. 13.3% of youth who identified as heterosexual. Twenty-three percent of LGB-identified youth made one or more suicide attempts in the prior year vs. 5.4% of heterosexual youth.²⁹

LGBT youth are more likely to be homeless than other youth.³⁰ A 2015 survey of homelessness service providers identified parental rejection because of their sexual orientation or gender identity as the most commonly cited reason for homelessness among LGBTQ youth. Other common reasons included substance abuse or mental illness in the family and aging out of the foster care system.³¹

The experience of homelessness is traumatic and often correlates with health risks, risk of victimization, and criminalized survival behavior. Homeless youth are at higher risk of violence, substance use, HIV, mental illness, and involvement in the criminal justice system.^{32,33} In particular, sexual minority homeless youth are more likely than heterosexual homeless youth to have a current depressive episode; to use cocaine, crack, and methamphetamines; and to have previously attempted suicide.^{34,35,36} They are also more likely to have engaged in survival sex and are at greater risk of being physically or sexually victimized.^{37,38,39}

The experience of LGBT youth helps to inform our understanding of LGBT pathways into the criminal justice system and the potential challenges LGBT adults face in their interactions with law enforcement.

²⁹ Kann L, McManus T, Harris W et al. (2018). "Youth Risk Behavior Surveillance — United States, 2017" *MMWR Surveillance Summaries* 2018 67(SS-8):18–27. <https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf>

³⁰ Institute of Medicine of the National Academies; Board on the Health of Select Populations; Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, D.C.: The National Academies Press. 4–16 – 4–17. <https://www.nap.edu/catalog/13128/the-health-of-lesbian-gay-bisexual-and-transgender-people-building>

³¹ Choi SK, Wilson BDM, Shelton J et al. (2015). *Serving Our Youth 2015: The Needs and Experiences of Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Experiencing Homelessness*. Los Angeles, CA.: The Williams Institute with True Colors Fund. <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Serving-Our-Youth-June-2015.pdf>

³² Edidin JP, Ganim Z, Hunter SJ et al. (2012). "The mental and physical health of homeless youth: a literature review" *Child Psychiatry Hum Dev* 43(354):354–75.

³³ Yoder JR, Bender K, Thompson SJ et al. (2014). "Explaining Homeless Youths' Criminal Justice Interactions: Childhood Trauma or Surviving Life on the Streets?" *Community Ment Health J* 50(135):135–144.

³⁴ Keuroghlian AS, Shtasel D, and EL Bassuk (2014). "Out on the street: a public health and policy agenda for lesbian, gay, bisexual, and transgender youth who are homeless" *The American Journal of Orthopsychiatry* 84(1):66–72.

³⁵ Whitbeck LB, Chen X, Hoyt D et al. (2004). "Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents" *Journal of Sex Research* 41(4):329–342.

An emerging body of literature indicates that LGB youth are punished more harshly than their heterosexual peers. A 2010 article in *Pediatrics* found that LGB youth are punished more harshly in schools and in the court system, even though they are less likely to engage in serious misdeeds—such as selling drugs or burglary—than their heterosexual peers.⁴⁰ LGB youth also report being expelled from school at higher rates than heterosexual students. This disparity in treatment by law enforcement is especially pronounced among girls and young women. Lesbian and bisexual girls and young women are 50% more likely to be stopped by police, and twice as likely to be arrested and convicted, even though they do not engage in higher levels of misconduct compared to heterosexual females.⁴¹

Recent research shows that juvenile incarceration results in large increases in the likelihood of adult incarceration, as well as large decreases in the likelihood of high school completion.⁴² Since many of the same problems that steer LGBT youth to the criminal justice system continue into adulthood, including drug use and sex work, it is not surprising that adult LGBT individuals are overrepresented in the criminal justice system.⁴³ A national survey of nearly 6,500 transgender and gender-nonconforming individuals found that 16% reported having been sent to jail or prison “for any reason,” compared to 2.7% of the general public.⁴⁴

³⁶ Cochran BN, Stewart AJ, Ginzler JA et al. (2002). “Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts” *American Journal of Public Health* 92(5):773-777.

³⁷ Keuroghlian AS et al., 2014

³⁸ Cochran BN et al., 2002

³⁹ Walls NE and Bell S (2011). “Correlates of engaging in survival sex among homeless youth and young adults” *Journal of sex research* 48(5):423-436.

⁴⁰ Himmelstein K and Brickner H (2011). “Criminal-Justice and School Sanctions Against Non-heterosexual Youth: A National Longitudinal Study” *Pediatrics* 127 (1) 49-57. <https://pediatrics.aappublications.org/content/127/1/49>.

⁴¹ Ibid.

⁴² Aizer A and Doyle J (2013). *Juvenile Incarceration, Human Capital and Future Crime: Evidence from Randomly-Assigned Judges*. National Bureau of Economic Research. <https://www.nber.org/papers/w19102.pdf>

⁴³ Meyer et al., 2017

⁴⁴ Grant et al., 2011

II. Legal developments, including legal responsibilities to incarcerated LGBTI individuals

Calls for action to stop prison sexual abuse date back at least as far as U.S. Supreme Court Justice Blackmun's dissent in U.S. vs. Bailey (1980), in which he was joined by Justice Brennan.⁴⁵ A 2001 Human Rights Watch report on the subject was titled, No escape: Male rape in U.S. prisons.⁴⁶ Two years later Congress unanimously passed PREA.

Like all individuals held in prisons and jails, those who identify as LGBTI have rights under the U.S. Constitution and state and federal laws and regulations, including PREA. Understanding the rights of LGBTI individuals in custody (and the concurrent responsibilities that correctional agencies have toward them) can assist administrators in developing policies and procedures that provide for the safety of this population while meeting the agency's—and their own—legal obligations.⁴⁷ Effective LGBTI policies and practices can help to lessen the risk of liability for a correctional agency and its staff.

CONSTITUTIONAL RIGHTS OF LGBTI INMATES

The Eighth Amendment of the U.S. Constitution protects incarcerated individuals against cruel and unusual punishment. This includes the right to be safe and to receive adequate medical care in prisons and jails.⁴⁸ Corrections officials can be liable if they do not take reasonable steps to protect inmates against physical and sexual harassment and abuse. The U.S. Supreme Court has ruled on multiple occasions that

a correctional agency's deliberate indifference to an inmate's serious medical needs violates the Eighth Amendment. This was first recognized in *Estelle v. Gamble*, a landmark ruling in 1976 that also established an incarcerated individual's right to receive adequate medical care.⁴⁹

The U.S. Supreme Court first established the right of prisoners to be free from sexual abuse by other inmates and staff in *Farmer v. Brennan* (1994), a case involving a transgender woman who was repeatedly raped and physically beaten in a men's prison.⁵⁰ In *Farmer*, the Supreme Court ruled that corrections officials cannot be "deliberately indifferent" to such abuse, but rather have an affirmative duty to protect prisoners in their custody against systematic abuse. The Court explained that prison administrators are liable for abuse of prisoners when they know of, and disregard, "an excessive risk to inmate health and safety."⁵¹ An excessive risk exists when an inmate belongs to "an identifiable group of people who are frequently singled out for violent attack by other inmates."⁵² As a result of that finding, numerous courts have found that a prisoner's LGBT status or gender nonconformity alone may be sufficient to

⁴⁵ *United States v. Bailey*, 444 U.S. 394 at 419 (1980).

⁴⁶ Mariner J (2001). *No Escape: Male Rape in U.S. Prisons*. New York, NY: Human Rights Watch. <https://www.hrw.org/reports/2001/prison/report.html>.

⁴⁷ Smith B and Yarussi J (2015). *Policy review and development guide: Lesbian, gay, bisexual, transgender, and intersex persons in custodial settings Second Edition* Washington, DC: National Institute of Corrections. 2015. https://info.nicic.gov/lgbti/print/5#_edn144

⁴⁸ *Estelle v. Gamble*, 429 U.S. 97 (1976).

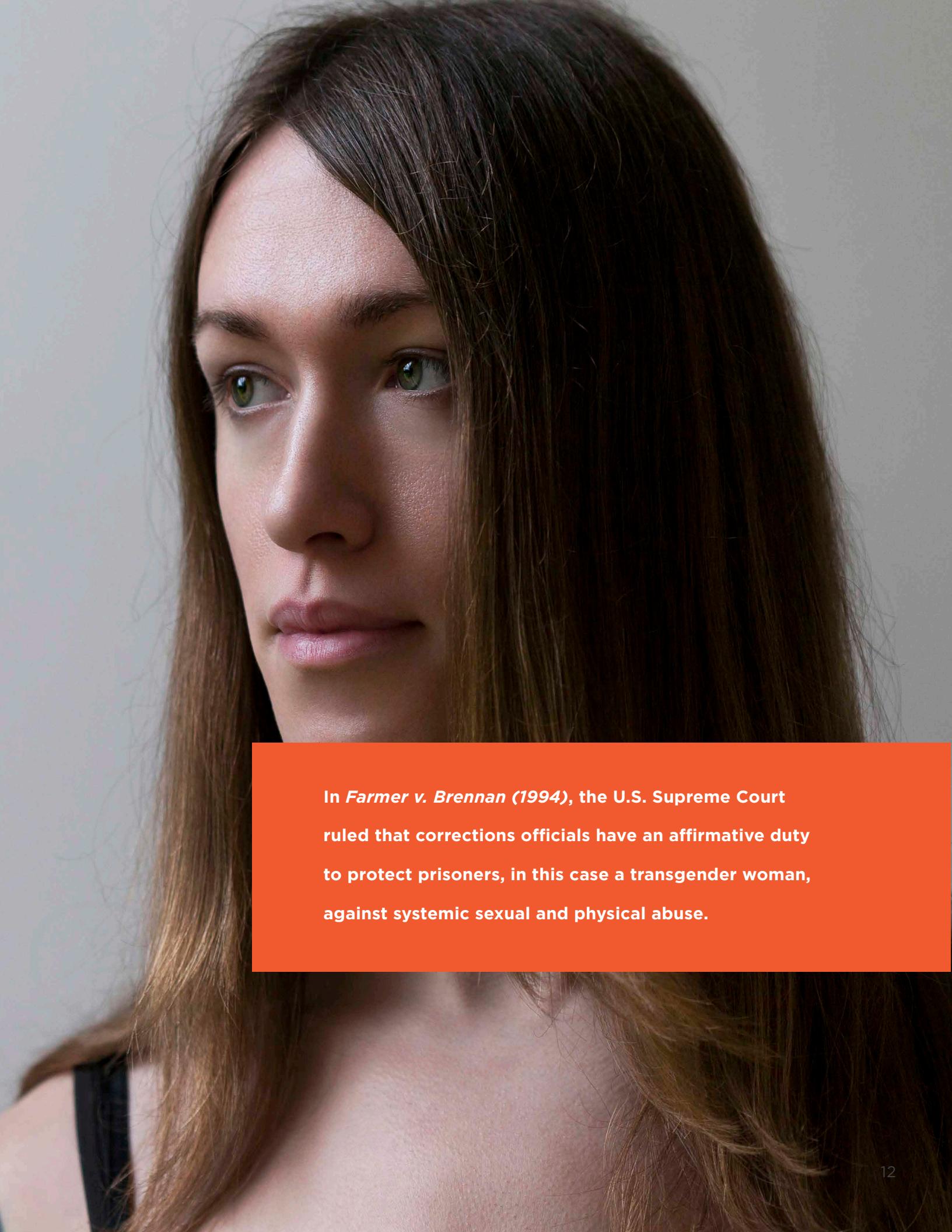
⁴⁹ *Ibid*.

⁵⁰ *Farmer v. Brennan*, 511 U.S. 825 (1994).

⁵¹ *Ibid* at 837.

⁵² *Ibid* at 843.

⁵³ Smith and Yarussi, 2015.



In *Farmer v. Brennan* (1994), the U.S. Supreme Court ruled that corrections officials have an affirmative duty to protect prisoners, in this case a transgender woman, against systemic sexual and physical abuse.



put agency officials on notice of the individual's vulnerability and need for protection.⁵³ Failure to take adequate protective measures while knowing this vulnerability exists can result in liability.

Since the *Farmer v. Brennan* decision in 1994, LGBTI individuals in diverse settings across the country have brought numerous lawsuits against correctional and other law enforcement agencies, pointing to the growing recognition of the rights of sexual minorities in criminal justice settings and the increased protection of those rights. Following are examples of lawsuits that have been filed on behalf of LGBTI individuals involved with the justice system:

Protection From Sexual Assault

- The Fifth Circuit Court of Appeals held prison officials in Texas liable after officials continued to house a gay inmate in general population, despite knowing he was being gang raped.⁵⁴
- In Michigan, courts allowed a case to proceed against a warden and other prison officials when a youthful looking inmate with mental illness was raped in their facility. This underscores the notion that many factors contribute to inmate vulnerability, and that prison officials are required to be aware of them and conduct periodic assessments.⁵⁵

Medical Care

- Transgender inmates have brought an increasing number of lawsuits requesting proper medical care.⁵⁶ Policies that ban cross-sex hormone therapy and gender reassignment surgery are inconsistent with the standard of care for transgender patients with gender dysphoria.^{57,58} Courts have recognized that transgender inmates with gender dysphoria have a serious medical condition, and that failure to treat them is a violation of the Eighth Amendment.⁵⁹ While not all courts have ruled in favor of hormone replacement therapy, courts have consistently ruled that gender dysphoria presents a serious medical need.⁶⁰
- In 2011, the Seventh Circuit Court of Appeals ruled that the Wisconsin Department of Corrections (DOC)'s Act 105, which prohibited use of DOC funds or other resources for hormone replacement therapy or gender reassignment surgery for transgender individuals, was unconstitutional "both as applied and on its face, under the Eighth and

⁵⁴ *Johnson v. Johnson*, 385 F.3d 503, 527 (5th Cir. 2004).

⁵⁵ *Taylor v. Michigan DOC*, 69 F.3d 76 (6th Cir. 1995).

⁵⁶ Brown GR. (2014). "Qualitative Analysis of Transgender Inmates' Correspondence: Implications for Departments of Correction. *Journal of Correctional Health Care* <https://nicic.gov/qualitative-analysis-transgender-inmates-correspondence-implications-departments-correction>

⁵⁷ World Professional Association for Transgender Health. *Standards of care*. <https://wpath.org/publications/soc>

⁵⁸ Gender dysphoria involves a conflict between a person's physical or assigned gender and the gender with which he/she/they identify. People with gender dysphoria often experience significant distress and discomfort that causes clinically significant impairment in functioning in all aspects of life. *American Psychiatric Association*. What is Gender Dysphoria? <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>

⁵⁹ See, e.g., *Kosilek v. Maloney*, 221 F.Supp.2d 156 (D.Mass.2002). Judge Wolf, who decided the case, wrote that "This court's decision puts [MA DOC Commissioner] Maloney on notice that Kosilek has a serious medical need which is not being properly treated. Therefore, he has a duty to respond reasonably to it. The court expects that he will." Kosilek began receiving hormone therapy one year after the decision in accordance with her doctor's recommendation.

Fourteenth Amendments.”⁶¹ Requests for hormone replacement therapy that do not pre-date incarceration cannot simply be denied, but must be based on sound medical judgment.⁶²

- In 2015, the US Department of Justice filed a statement of interest in favor of a transgender woman incarcerated in Georgia who had been denied medically necessary treatment when she was denied hormone therapy by GA DOC. In its statement of interest, US DOJ noted that a prison or jail that is on notice of an inmate’s gender dysphoria and denies necessary treatment has a high chance of being found liable under the Eighth Amendment to the U.S. Constitution, since courts have uniformly held that gender dysphoria is an “objectively serious medical need” for which treatment is medically necessary.⁶³ The former transgender inmate was released and reached a settlement with the Georgia DOC.
- In September 2018 the Massachusetts Department of Correction moved a transgender woman from MCI-Norfolk Men’s Prison to MCI-Framingham Women’s Prison under pressure from a federal lawsuit filed under the Americans with Disabilities Act that was based on the prisoner’s diagnosis with gender dysphoria.⁶⁴ Three months later in December 2018, the Illinois Department of Correction moved a transgender woman from a male facility to a female facility after a federal court in the state found that the inmate had a strong case that her equal protection rights were violated following repeated sexual harassment and threats in the male facility.⁶⁵
- In February 2019, a transgender women who had served a sentence at the Suffolk County Correctional Facility on Long Island, New York was unanimously awarded \$355,000 by a jury that found that doctors at the facility had violated her constitutional right to necessary medical care when they denied her hormone therapy for gender dysphoria. She had been on hormone therapy for two years prior to being incarcerated. The jury determined that the doctors had violated the plaintiff’s 14th Amendment right to equal protection under the law for access to necessary medical care. (Her lawyers were awarded a slightly larger amount, bringing the total award to more than \$700,000).⁶⁶



⁶⁰See, *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000) (assuming without deciding that gender identity disorder (GID) presents a serious medical need); *De'Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003); *Praylor v. Texas Dept. of Criminal Justice*, 430 F.3d 1208 (5th Cir. 2005). (Both the Cuoco and De'Lonta decisions assumed without deciding that GID presents a serious medical need. No circuit has held otherwise.)

⁶¹*Andrea Fields, et al., v. Judy P. Smith, et al.* Appeals from the United States District Court for the Eastern District of Wisconsin, No. 2:06-cv-00112-CNC, August 5, 2011. https://www.lambdalegal.org/in-court/legal-docs/fields_wi_20110805_decision-us-court-of-appeals-7th-circuit

⁶²*Kosilek v. Maloney*, 221 F. Supp. 2d 156 (D.Mass.2002); *Brooks v. Berg*, 270 F.Supp.2d 302 (N.D.N.Y.2003).

⁶³Statement of Interest of the United States at 1–2, *Diamond v. Owens*, No. 5:15-CV-50 (MTT), 2015 WL 5341015 (M.D. Ga. Sept. 14, 2015). Available at https://www.splcenter.org/sites/default/files/documents/doj_statement_of_interest_diamond.pdf.

⁶⁴Levenson, M., “Transgender inmate moved to women’s prison,” *Boston Globe*, January 24, 2019, https://www.bostonglobe.com/metro/2019/01/24/transgender-inmate-moved-women-prison/Nf2k50qa3OjnhlyH1IwWkL/story.html?p1=Article_Inline_Text_Link

⁶⁵Tarm, M., “Transgender inmate gets rare transfer to female prison,” *APNews*, December 27, 2018, <https://www.apnews.com/0054459b12b-54b48abfe45937efa1225>.

⁶⁶Leland, J., “How a Trans Soldier Took On the Jail That Denied Her Medication, and Won,” *New York Times*, February 15, 2019, <https://www.nytimes.com/2019/02/15/nyregion/transgender-jail-hormone-therapy.html>.

- Failure to properly treat inmates with gender dysphoria can result in serious self-harm, including surgical self-treatment (i.e., auto-castration).⁶⁷ The Fourth Circuit Court of Appeals permitted a transgender inmate who engaged in self-mutilation to bring a lawsuit against correctional administrators who withdrew her hormone therapy based on their deliberate indifference to her serious medical need.⁶⁸ This constitutes a violation of the 8th Amendment right to be free of cruel or unusual punishment.
- In a case brought against the Idaho Board of Corrections, courts ordered prison officials to treat a transgender inmate for gender dysphoria following the inmate's self-castration.⁶⁹ The state appealed, and the case went before the Ninth Circuit Court of Appeals in 2019.⁷⁰ The court ruled August 23, 2019 that denying the inmate gender confirmation surgery constitutes "cruel and unusual punishment" in violation of the U.S. Constitution, and ordered the state of Idaho to provide the surgery to the inmate. Idaho Governor Brad Little said he would appeal the federal court ruling to the U.S. Supreme Court.⁷¹
- Denying inmates with gender dysphoria the ability to fully express the gender role and presentation consistent with their gender identity can constitute a denial of necessary medical care and an Eighth Amendment violation, with implications for commissary access, grooming, etc. U.S. District Courts have issued mixed rulings on whether an inmate has a constitutional right to live as a woman if they were born biologically male, and vice versa.⁷²
- Courts are also confronting the issue of gender reassignment surgery for inmates with gender dysphoria. The US District Court for the District of Massachusetts ruled in 2012 that a male inmate who identified as female had a constitutional right to gender reassignment surgery.⁷³ In January 2014, a three-judge panel of the US First Circuit Court of Appeals upheld the District Court's decision; in December 2014, the full First Circuit Court ruled against Kosilek 3-2.⁷⁴ The US District Court for the Western District of Virginia ruled that a female transgender inmate did not have a constitutional right to gender reassignment surgery. The Fourth Circuit Court reversed and remanded this ruling in 2013, finding that the transgender inmate was entitled to a hearing on the merits of her case.⁷⁵ In 2015, the California De-



⁶⁷ Brown, GR (2010) "Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder." *Int J of Transgenderism* 12(1):31-39.

⁶⁸ *De'Lonta v. Angelone*, 330 F.3d 630 (4th Cir.2003). <https://www.clearinghouse.net/detail.php?id=974>.

⁶⁹ *Gammett v. Idaho State Board of Corrections*, 2007 WL 2186896 (D.Idaho Jul.27,2007). <https://www.clearinghouse.net/detail.php?id=10262>

⁷⁰ *Edmo v Idaho Department of Correction and Corizon, Inc.* Case Nos. 19-35017 & 19-35019 (9th Cir. 2019).

⁷¹ Fitzsimons T (2019, August 26). Idaho must provide sex reassignment surgery for trans inmate, court rules. *NBC News*. <https://www.nbcnews.com/feature/nbc-out/idaho-must-provide-sex-reassignment-surgery-trans-inmate-court-rules-n1046501>

⁷² See e.g., *Konitzer v. Frank*, 711 F. Supp. 2d 874 (E.D. Wis. 2010) (holding that prison officials' denial of plaintiff's requests for makeup, women's undergarments, and facial hair remover might give rise to an 8th Amendment violation for deliberate indifference to a serious medical need); *Lamb v. Maschner*, 633 F. Supp. 351 (D. Kan. 1986)(holding that a a biologically male inmate did not have a constitutional right to receive cosmetics and female clothing).

⁷³ *Kosilek v. Spencer*, 221 F.Supp.2d 156 (2012).



partment of Corrections and Rehabilitation (CDCR) settled a lawsuit brought by a transgender female inmate and agreed to provide her necessary medical care, including gender reassignment surgery, for her and to revise its policies regarding providing necessary medical treatment for all transgender inmates.⁷⁶

Harassment

- Transgender and intersex inmates are at risk of repeated strip searches that are inappropriate or voyeuristic in manner. Courts have found such strip searches unconstitutional. The 10th Circuit ruled in 2002 that incarcerated individuals have a clearly established right “not to be subjected to a humiliating strip search in full view of several (or perhaps many) others unless the procedure is reasonably related to a legitimate penological interest.”⁷⁷ PREA standards explicitly state that agencies may not “search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate’s genital status.”⁷⁸

Civil Rights

- LGBTI prisoners must be accorded the same rights as other prisoners. These include the right to have visits by same-sex partners and spouses, and the right to exhibit the same displays of affection—such as hugging or kissing—that opposite-sex couples are allowed during visits.⁷⁹ Individual’s private medical information is also protected. LGBTI identity and HIV status should be disclosed only for legitimate penological reasons;⁸⁰ disclosing such information without a legitimate penological reason is unconstitutional.⁸¹ Prisoners have the right to access LGBT materials, such as *The Advocate*, a magazine catering to the LGBT community. The right to access such materials is protected by the First Amendment to the U.S. Constitution. However, this right does not extend to sexually explicit materials, such as pornography.⁸²

⁷⁴ *Kosilek v. Spencer*, 774 F.3d 63 (1st Cir. 2014). <http://media.cal.uscourts.gov/pdf.opinions/12-2194P2-01A.pdf>

⁷⁵ *De'Lonta v. Johnson*, 708 F.3d 520 (4th Cir. 2013). <https://www.leagle.com/decision/info20130128117>

⁷⁶ Transgender Law Center (2015) “State of CA and Transgender Law Center reach historic settlement over trans prisoner health care.” Published August 7, 2015. <http://transgenderlawcenter.org/archives/11861>

⁷⁷ *Farmer v. Perrill*, 288 F.3d 1254, 1260 (10th Cir. 2002) (transgender woman was regularly searched in full view of other inmates whenever she returned from the common area). Other courts are in accord; *Mays v. Springborn*, 575 F.3d 643 (7th Cir. 2009); *Elliott v. Lynn*, 38 F.3d 188 (5th Cir. 1994).

⁷⁸ 28 C.F.R. § 115.15(e).

⁷⁹ *Doe v. Sparks*, 733 F. Supp. 227 (W.D. Pa. 1990).

⁸⁰ *See, Powell v. Shriver*, 175 F.3d 107 (2d Cir. 1999). See also, *Doe v. Delie*, 257 F.3d 309, 317 (3d Cir. 2001) (holding that inmates have a privacy interest in HIV status).

⁸¹ *Powell*, 175 F.3d at 113–14.

⁸² *See, Mauro v. Arpaio*, 188 F.3d 1054, 1060 (9th Cir. 1999); *Allen v. Wood*, 970 F. Supp. 824, 831 (E.D. Wash. 1997).

LEGAL RESPONSIBILITIES TO LGBTI INMATES, INCLUDING OBLIGATIONS UNDER PREA

In addition to the legal responsibilities that courts have delineated to different classes of incarcerated individuals, as with the cases above, the PREA standards establish clear obligations for correctional officials to protect vulnerable inmates, particularly those who identify as, or are perceived to be, LGBTI and/or gender non-conforming (GNC). The standards require that prisons and jails conduct a screening of a new inmate within 72 hours of arrival. During screening, staff must consider “whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming.”⁸³

Housing placement for transgender and intersex inmates should be done with consideration to the “health and safety” of the inmate as well as potential “management or security problems.”⁸⁴ LGBTI inmates may not be placed in dedicated wings or units unless an existing consent decree or legal settlement or judgment exists.⁸⁵ PREA mandates training all employees who may have contact with incarcerated individuals on LGBTI issues.⁸⁶ This includes how “to communicate effectively and professionally” with LGBTI and gender nonconforming prisoners.⁸⁷

It is important to note that PREA does not prohibit consensual sexual activity and does not allow for punishment invoking PREA for such activity. The PREA final standards state, “[a]n agency may, in its discretion, prohibit all sexual activity between resi-

dents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.” While PREA allows bans on same-sex sexual activity to remain in place, the PREA standards state that same-sex activity should not be considered sexual abuse if the facility staff determine that the conduct was not coerced.⁸⁸

PREA requires correctional staff to be more aware of indicators of sexual violence and to respond accordingly. As a result, the requirement has led to increased surveillance of LGBTI prisoners. On one hand this can be helpful in achieving its policy goal, as LGBTI prisoners are at increased risk of sexual assault while incarcerated. On the other hand, this increased surveillance can lead to more trouble and stigma for LGBTI prisoners.

An agency’s overall culture is a key factor in shaping and defining the experiences of LGBTI inmates.

⁸³ 28 C.F.R. § 115.241(d)7.

⁸⁴ 28 C.F.R. § 115.242(c).

⁸⁵ 28 C.F.R. § 115.242(g).

⁸⁶ 28 C.F.R. § 115.231(a).

⁸⁷ 28 C.F.R. § 115.231(a)(9).

⁸⁸ 28 C.F.R. Part 115 § 115.278 §§ (g).

Unfortunately, when it comes to LGBT prisoners, PREA is not always implemented in the benevolent spirit in which it was written. Staff can sometimes misinterpret casual displays of affection (such as hugging or playful touching), incidental contact (such as talking closely or eating a meal together), or even the amount of time LGBT prisoners spend together as signs of sexual abuse. If staff misinterpret these acts, a prisoner can find themselves under investigation and held in solitary confinement. In other cases, homophobic or transphobic staff purposefully target LGBT prisoners by initiating PREA investigations. Occasionally, a malicious inmate will make a false accusation against another inmate (which also may be related to the accused's sexual orientation or gender identity). While an investigation is pending, the accused perpetrator is held in solitary confinement.

Some facilities have been reported to place an inmate in solitary confinement after the inmate reports being a victim of sexual violence. This practice is directly contrary to DOJ PREA guidelines. In a final rule clarifying national standards in accordance with PREA, DOJ states "To prevent sexual abuse, the standards require, among other things, that facilities restrict the use of solitary confinement as a means

of protecting vulnerable inmates."⁸⁹ There are less restrictive alternatives to solitary confinement, such as "housing unit restriction" or "cell restriction."

At the conclusion of every sexual abuse investigation (including where the allegation has not been substantiated) the facility shall conduct a sexual abuse incident review, unless the allegation has been determined to be unfounded.⁹⁰ The review team shall consider whether the incident or allegation was motivated by several factors, including LGBTI identification, status or perceived status.⁹¹

The growing body of legal obligations to protect LGBTI inmates and other potentially vulnerable incarcerated populations provides an incentive to corrections administrators to review their agencies' policies and procedures to determine their adequacy. More than just policies and procedures need to be reviewed, however, since an agency's overall culture is a key factor in shaping and defining the experiences of incarcerated individuals, including sexual and gender minorities.

⁸⁹ Department of Justice: Office of Public Affairs (2012). *Justice Department Releases Final Rule to Prevent, Detect and Respond to Prison Rape* <https://www.justice.gov/opa/pr/justice-department-releases-final-rule-prevent-detect-and-respond-prison-rape>

⁹⁰ 28 C.F.R. § 115.286(a).

⁹¹ 28 C.F.R. § 115.286(d)2.

TRUMP ADMINISTRATION SHIFT ON SUPPORTING AND ENFORCING LGBTI RIGHTS

Since taking office, the Trump Administration has systematically dismantled legal protections for LGBT people. Here are several examples:

- The Administration repealed the requirement that federal contractors not discriminate in hiring on the basis of sexual orientation or gender identity.⁹²
- In 2017, the U.S. Department of Housing and Urban Development (HUD) announced that it would withdraw two agency notices aimed at protecting LGBT people experiencing homelessness, including data collection on LGBT youth.⁹³ In 2019 HUD proposed a rule that would permit homeless shelters to refuse to house transgender individuals in accordance with their gender identity.⁹⁴ This would increase the vulnerability of homeless transgender women in particular to victimization.
- In June 2019, the Trump Administration officially released a proposed rule⁹⁵ that would reverse the 2016 final rule implementing Section 1557⁹⁶, the nondiscrimination provision of the Affordable Care Act (ACA). The 2016 Section 1557 rule explicitly prohibits gender identity discrimination, including discrimination against transgender, intersex and non-binary people,⁹⁷ in health care facilities and programs receiving federal funding. The rule also prohibits some forms of sexual orientation discrimination that take the form of sex stereotyping. In addition to reversing the 2016 ACA nondiscrimination rule, the Trump Administration is proposing to remove explicit sexual orientation and gender identity nondiscrimination language from half a dozen other federal health care regulations governing private health insurance, Medicaid, and elder health care and services.⁹⁸
- In March 2019, the Department of Defense released a memorandum “disqualifying” individuals with a history of gender dysphoria (transgender individuals) from enlisting in the military.⁹⁹



⁹² 3 F.R., E.O. No. 13782.

⁹³ 82 F.R. 13359.

⁹⁴ 24 F.R. 5.

⁹⁵ 84 F.R. 27846.

⁹⁶ 45 C.F.R. 92.

⁹⁷ Nonbinary describes a person whose gender identity falls outside the traditional gender binary of male and female. National LGBT Health Education Center (No date). *Providing affirming care for patients with non-binary gender identities*. Boston: The Fenway Institute.

⁹⁸ Laurila K (2019, July). *New rule proposes removal of LGBT nondiscrimination provisions from Section 1557 and other health care regulations*. Boston: The Fenway Institute.

⁹⁹ Directive-type Memorandum (DTM)-19-004 - Military Service by Transgender Persons and Persons with Gender Dysphoria.



In May 2018 the Trump Administration moved to counter existing federal policy directly impacting the safety and security of transgender prisoners. PREA requires that decisions regarding housing of transgender and intersex inmates be made on a case-by-case basis. This is done by providing an individual assessment that takes many factors into account—including the individual's own views about their safety.¹⁰⁰ Department of Justice guidance issued in 2016 made assigning a transgender prisoner to housing based solely on their sex assigned at birth a violation of federal law.¹⁰¹ The Federal Bureau of Prisons announced in May 2018 that while it will continue to make housing determinations on a case-by-case basis as required by PREA, it will use “biological sex” to make initial determinations in the type of housing transgender inmates are assigned, and will assign transgender prisoners to facilities conforming to their gender identity only “in rare cases.”¹⁰²

The authors believe that the BOP’s decision runs directly counter to the text and spirit of PREA, the PREA Standards, and a quarter century of jurisprudence going back to the U.S. Supreme Court’s 1994 *Farmer* decision. The decision will undermine the safety and security of one of the most vulnerable prison populations, and lead to increased sexual and physical victimization against transgender prisoners.

In 2018 the Trump Administration announced that it would assign transgender prisoners to housing based on their “biological sex,” not based on their gender identity.

¹⁰⁰ 28 C.F.R. 115.42(c), (e).

¹⁰¹ The text of the guidance is available at <https://www.prearesourcecenter.org/node/3927>

¹⁰² The May 11, 2018 revisions to the Federal Bureau of Prisons Transgender Offender Manual are set forth in the Change Notice posted by the Bureau at <https://www.documentcloud.org/documents/4459297-BOP-Change-Order-Transgender-Offender-Manual-5.html>.

III. Foundational issues: Professionalism and respect

The foundational issues addressed in this section underpin the specific solutions proposed throughout this paper. They should be considered and implemented by leadership at all levels and through all stages of the policy and procedure development process. They should also be considered when educating and training corrections officials.

KEY FOUNDATIONAL ISSUE #1: PROFESSIONALISM

Asking staff to develop, implement, and adhere to LGBTI-focused policy is, fundamentally, about being an effective corrections professional. Importantly, this process is not about asking anyone—administrator or staff—to change their personal or religious beliefs. The need to adopt LGBTI policies stems directly from administrators' and correctional officers' duties and obligations as professional public safety officers.

Leadership and staff must embrace their duty to prevent discrimination and harassment, to discourage a hostile environment, and to treat all inmate populations fairly. Corrections professionals—like other law enforcement professionals—should understand the need to put their personal feelings toward inmates aside in the name of acting professionally and providing equitable protection to all. The reality may be that some correctional administrators and officers are required to follow policies that may not square with their personal beliefs. But at work, professionalism needs to trump beliefs.

Rhode Island Department of Corrections

“We felt what we needed to do to get an LGBTI policy accepted by staff was to frame it in terms staff could understand, by not leading with or appealing to issues of civil rights or empathy, but principles of security and professionalism. People need to feel safe inside. All else is predicated on that. Inmates need to feel that all are concerned that they are kept safe. By emphasizing what is common to the profession and has always been a source of pride, we have received a lot of buy-in.”

– A.T. Wall, Director, Rhode Island
Department of Corrections (2000-2018)

KEY FOUNDATIONAL ISSUE #2: RESPECT

All staff should treat facility populations with respect. Respect is a key component of professionalism in correctional settings. Indeed most agencies have a staff code of conduct reflecting this core requirement. Two direct objectives to operating a safer and more secure facility can be met when the core professional duty to treat LGBTI populations with respect is followed and enforced:

Showing respect is the best and most effective way to elicit information necessary to establishing safety for LGBTI populations.

LGBTI populations often encounter bias and discrimination when they self-identify, when their status as LGBTI becomes known, or when they present themselves in a gender-nonconforming manner. In a correctional setting, LGBTI individuals can disclose vital information about facility safety and security, but only if they feel safe. This safety entails that they won't be bullied, harassed, or harmed as a result of acknowledging or otherwise allowing their sexual orientation or gender identity status to be known. Respectful treatment is a prerequisite to collecting accurate information about vulnerability and other issues that are critical for making the best classification and housing decisions. Appropriately classifying and housing incarcerated individuals goes to the heart of operating a safe and secure facility. A lack of respect shown to LGBTI populations will minimize self-disclosure and thereby contribute to unsafe and potentially dangerous placement decisions.

Showing respect creates a safer overall correctional environment.

Administrators and staff who exhibit respectful communication and attitudes toward LGBTI staff and inmates have a powerful positive impact on the overall climate of a facility. Conversely, unchecked homophobic and transphobic attitudes and behavior create a climate of discrimination, harassment, and abuse.



RECOMMENDED ACTIONS

Administrators leading the effort to establish LGBTI policies should review their staff code of conduct and consider re-emphasizing that the policy extends to respect for LGBTI populations. Agency leaders should also strongly consider developing more specific guidance for staff regarding their interactions with LGBTI inmates, including identifying demeaning language and common slurs that should not be used. This kind of guidance should be included in any educational program developed as part of LGBTI policy development and implementation efforts.

Correctional facilities can underscore their commitment to professionalism and respect by extending their nondiscrimination policy to cover LGBTI staff. If staff are being asked to show respect for LGBTI inmates, the same standard should apply to fellow staff members. Indeed, it may “get the ball rolling” to first expand the agency’s non-discrimination policy to LGBTI staff, as a precursor to a broader LGBTI policy for inmates. Creating a staff environment in which LGBTI workers feel comfortable expressing their identity goes a long way toward promoting an institutional environment in which all LGBTI people are treated with respect. The most effective way to change attitudes about LGBTI individuals is through personal relationships.

Respectful communication with transgender inmates includes acknowledgement of their gender identity and use of their preferred gender pronouns, taking appropriate security concerns into consideration. Showing respect to incarcerated LGBTI individuals is generally a prerequisite to obtaining the best and most pertinent information about an individual’s vulnerability to abuse or harassment. It will support staff’s efforts to create and sustain a safe environment for all.

Harris County Sheriff's Office, Houston

“While we were developing Harris County’s LGBTI inmate policy, one of our community advisors pointed out that we did not have any similar protections in place for our employees. After some research, I discovered that no Harris County department had such protections. I approached our agency head, Sheriff Adrian Garcia, with the idea of adding sexual orientation and gender identity to our existing discrimination in the workplace policy. He immediately granted the request. So on November 13, 2013, with no fanfare, history was made in Harris County.”*

- Asst. Chief Debra Schmidt,
Harris County Sheriff's Office, Houston

**The Harris County Sheriff's Office was the first agency in the country to adopt a comprehensive policy for incarcerated LGBTI individuals. The policy became effective that same month.*

Respectful treatment is a prerequisite to collecting accurate information about vulnerability and other issues that are critical for making the best classification and housing decisions.



Creating a staff environment in which LGBTI workers feel comfortable expressing their identity goes a long way toward promoting an institutional environment in which all LGBTI people are treated with respect.

IV. Institutional culture and effective policy development and implementation

Prejudice and discriminatory attitudes toward sexual and gender minorities exist throughout the country—in blue states and red, inside and outside of correctional facilities. Inmates and corrections staff alike may exhibit anti-LGBT prejudice or participate in abuse.¹⁰³ Indeed, sexual minorities face a heightened risk of abuse in correctional settings. As noted earlier in this paper, LGBT inmates are ten times more likely than heterosexual or cis-gender inmates to report sexual victimization in prison and seven times more likely to report sexual victimization in jails and juvenile facilities.¹⁰⁴

Under PREA, and in light of the growing support for LGBTI rights in the courts, senior administrators of correctional facilities must identify strategies that protect the wellbeing of LGBTI populations in their care, including protection from discrimination. However, changing a policy is not without its challenges. If policy change occurs without clearly articulated administrative support—or in an institutional culture that is not supportive of such change—the policy will be, at best, ineffective, and at worst, an invitation for abuse. Assessing institutional culture will have a direct impact on the institution’s ability to shape, implement, and enforce an effective policy.

Recommendations for policy change will undoubtedly be more challenging in some locales than in others. Policies cannot simply be copied directly from another jurisdiction and imposed by administrative decree. Change in this arena has been most effective when policies have been (i) championed by motivated, engaged leadership; (ii) developed with the active participation of staff, facilitating staff ownership of the policies; and (iii) accompanied by appropriate staff training programs.

¹⁰³ For example, testimony before the PREA Commission showed the discriminatory and sometimes abusive attitudes toward transgender prisoners held by many correctional officers and other staff members as well. Daly, Christopher (2005). *Testimony before the Commission in San Francisco, CA*. Transgender Law Center. <http://www.prearesourcecenter.org/sites/default/files/library/transgenderlawcenterpreatestimony05.pdf>

¹⁰⁴ National PREA Resource Center (2019). *Committing to Safety and Respect for LGBTI Youth and Adults in Confinement: Lessons From Two Agencies*. <https://www.prearesourcecenter.org/node/2868>



Houston, Texas: Developing Policies for Managing Transgender Inmates

"In Houston, the major impetus for developing policies for the management of transgender inmates was a series of lawsuits over the treatment of a transgender male and transgender female jail inmate. Leadership agreed that they could do better to treat transgender inmates with more respect. They met with community representatives, including legal counsel for the transgender man, who were then invited to be policy advisers, and worked particularly closely with a local transgender advocate. Recognizing the importance of hiring staff to increase staff ownership and acceptance of any resulting policy, they formed an internal policy development committee that included the jail medical director; representatives from the training academy, classification, legal department, detention; and line staff who would weigh in on how policies would work with the average person in jail. "We had to face changes in what we could and could not do, trying things and assessing what would happen with each. We reviewed 20-25 policies and took the best parts of each. Some didn't always work well together. It's still a work in progress."

- Asst. Chief Debra Schmidt,
Harris County (Houston) Sheriff's Office

ASSESS INSTITUTIONAL CULTURE

(This and following section adapted from NIC's A Quick Guide for LGBTI Policy Development for Adult Prisons and Jails)

In order to establish the nature and extent of issues facing LGBTI populations in the care and custody of an agency, three areas of inquiry should be assessed:

- The experiences, needs, and risks that LGBTI inmates face in their day-to-day lives within the agency's facilities.
- Staff and administration attitudes and knowledge about LGBTI issues.
- Informal or formal practices staff engage in when working with LGBTI populations and what (if any) policies or staff training the agency has on this topic.

This information will provide the agency with a clearer picture of the problems and practices that need to be addressed in developing policy and training.

Experiences, Needs, and Risks of LGBTI Inmates and Agency Staff

The challenges LGBTI people in detention face are the result of a number of interlocking factors: prejudice; myths and stereotypes about the population that inform institutional culture and behavior toward inmates; and the general lack of agency guidance about how to work with this population. In order to assess agency culture and develop appropriate LGBTI policies, agency staff must be able to correctly identify these challenges. However, this can be difficult since it requires knowledge of inmates' sexual orientation and gender identity. Most agencies have not historically collected this information. Although practices are changing to align with PREA regulations, agencies will still have to rely on inmates' comfort with self-disclosure. Inmates may be reluctant to self-disclose if they perceive a risk to their safety in the facility. In the absence of this type of data, several other methods have been effectively used to collect information about LGBTI inmate risks and needs. Two have proven to be particularly useful in formulating policy in a number of jurisdictions. They are replicable in almost all settings. These are both promising practices.

Bringing staff into the process early and in a substantive way throughout the informed policy development, and implementation, leads to an even more important result: securing buy-in for any new policies developed or changes recommended at the facility-level practice.



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- Bring staff directly into the policy development and implementation phases of the agency's project. Involve staff in planning committees, roundtable discussions, or other structured venues, such as focus groups. Seek their active contributions to the development of the agency's policy and practice beginning with the culture assessment/information gathering phase. These practices can generate important dividends. Meaningful information regarding staff's perception of issues facing LGBTI inmates, including their understanding of institutional culture (staff/inmate and inmate/inmate) and problematic policies or practices that need to be addressed, is one dividend. In addition, individual staff might know LGBTI inmates who they can speak with as part of the information gathering process, providing critically important information. Bringing staff into the process early and soliciting their input in a substantive way throughout the information gathering, policy development, and implementation processes is critical to an even more important result: securing staff buy-in to any new policies developed or changes made to agency- or facility-level practice.
- Conduct outreach to local, state, or national LGBT and intersex organizations. Community and/or state organizations that provide services to, or advocate on behalf of, LGBTI individuals can provide needed insight into the specific challenges faced by incarcerated sexual minorities. For local jails in particular, reaching out to local LGBTI groups can also provide institutional benefits by improving relations with the LGBTI community and establishing reentry plans. For larger institutions or those located in more remote settings, outreach to statewide LGBTI groups can provide similar valuable insight and recommendations. Discussions with individuals in these organizations can elicit useful information, particularly if the group works with recently released LGBTI individuals. If so, the group could ask recently released LGBTI inmates to complete short, anonymous post-release surveys.

Whenever possible, corrections officials should consider including LGBTI inmate voices in the information gathering process. Strategies for doing this include:

- Surveying a randomly selected small group of inmates and asking them for their observations on the treatment of LGBTI inmates in the agency. Larger facilities may even be able to conduct anonymous surveys of current inmates who have identified themselves as LGBTI at intake, through medical treatment, or otherwise.
- Reviewing grievances filed by inmates reflecting LGBTI issues or concerns.
- Reviewing any complaints made by inmates to an ombudsman office reflecting LGBTI issues or concerns.
- Conducting focus groups of randomly selected inmates on their observations of the experiences of LGBTI inmates in their facility.

Current Knowledge and Attitudes of Staff and Administration Relating to Sexual Orientation and Gender Identity and Expression

Assessing an agency's culture and experience requires understanding the skills, knowledge, and comfort of agency staff and administrators working with LGBTI inmates. For smaller agencies, administrators may already have a good sense of agency culture based on conversations at staff meetings or discussions with management. For larger agencies, getting this information will require a broader and more deliberate effort. Focus groups and roundtable discussions with staff to explore attitudes may be effective. Online surveys can reach more staff, and provide an opportunity for staff to respond anonymously.

This assessment should include not only staff attitudes toward LGBTI inmates but staff attitudes toward LGBTI corrections colleagues, as well. Disrespectful behavior toward inmates or staff both has a powerful impact on institutional culture and can create an abusive climate, fostering an atmosphere of fear and lack of safety. This can often result in unmet safety and health needs of LGBTI individuals, since they will be much more reluctant to self-disclose if it involves an element of real or perceived risk. Creating policies to appropriately address these needs requires that staff understand the extent and prevalence of negative attitudes, expressions, and misconceptions toward LGBTI individuals in their institution.

General areas to consider in the information gathering process include:

KNOWLEDGE

- Familiarity with LGBTI terms
- Awareness of agency policies and trainings on LGBTI inmates
- Awareness of federal, state, and local nondiscrimination laws

ATTITUDES AND BELIEFS

- Attitudes and beliefs related to sexual orientation and gender identity
- Attitudes and beliefs concerning LGBTI people in general

COMFORT

- Ease with working with LGBTI staff and inmates
- Ease with interacting with LGBTI people outside of the workplace

EXPERIENCES

- Personal interactions with LGBTI staff and inmates
- Observations of other's interactions with LGBTI staff and inmates

WORKPLACE

- Overall culture
- Availability of supervision
- Training

Current Agency/Facility Norms, Informal Procedures, Written Policies, and Training Relating to LGBTI Inmates

An agency's written policies, informal procedures, facility norms, and training opportunities related to LGBTI inmates should be examined by administrators to determine how the agency currently serves LGBTI inmates. Below are some examples of the types of policies and areas of practice to examine:

- Nondiscrimination policy
- Intake and risk assessment
- Classification
- Operational issues specific to transgender and intersex inmates
- Communication
- Medical and mental health care
- Privacy and safety

The agency should consider evaluating any existing training relevant to these areas, reviewing individual LGBTI inmate files and records, observing staff interactions with LGBTI inmates, and making informal inquiries to staff. The findings from the survey on staff knowledge and attitudes may also be informative when attempting to establish current practice in this area.



ESTABLISH LGBTI POLICY DEVELOPMENT AND IMPLEMENTATION MECHANISMS

Agencies that have successfully navigated the process of developing formal policies related to LGBTI inmates, and experts who have advised them in the challenges of this work, point to five critical components that have each helped to maximize effectiveness.

- Leadership
- Active staff participation in the process
- Participation of an expert from outside the agency
- Staff education
- Enforcement and accountability

Leadership

Strong, clearly communicated, and unambiguous leadership support is critical to developing and implementing effective policies and procedures for any organization. This is particularly true for correctional facilities, which operate within a defined, strict chain of command. Leadership at the top of the agency sets the tone for the entire organization, while leadership at all institutional levels helps ensure implementation and oversight. Administrators charged with developing policy should seek and identify potential staff champions who can encourage implementation throughout the agency. Staff champions explain to other staff members the rationale behind the policy change and the anticipated results of the policy change. These champions are critical to successfully navigating the initiative through different parts of the agency.

Denver, Colorado: Sheriff Leads a Process to Develop a More Effective Policy

“In Denver, the process of creating a new policy and approach started at the top—our Sheriff wanted to build a policy with a different dynamic from how we’ve approached [such policies] in the past. All of the momentum and activities over the two years we worked on the policy wouldn’t have happened without the openness of the Sheriff, who felt it was his responsibility as Sheriff in a municipality as large as Denver to build a policy as comprehensive as possible to help everyone in the jails. He invited experts to the table and was committed to being at every meeting. The topic was new and difficult, but he was understanding of disagreement. He was clear to staff that change wouldn’t happen overnight. But he led the charge.”

– Capt. Paul Oliva, Denver Sheriff’s Office

Rhode Island: Leadership Is Needed at All Levels to Ensure Success

“Leaders need to model positive behavior, yes, but even more than them, those whom the line staff respect, and whoever is on charge on their shift. Working at the grassroots level to identify leaders is every bit as important as positive leadership at the top. Heads of department will set the tone, and top-level leadership can set things in place, but people on the ground who will actually implement the policy and lead by example are crucial too.”

– A.T. Wall, Director,
Rhode Island Department of Corrections

Staff Participation in LGBTI Policy Development and Implementation Process

Early in the policy development process, facility leadership must establish which agency players need to be at the table. Since staff acceptance of new policies is crucial to effective implementation, leaders should identify and engage representatives from across the agency—from administration to line staff. This inclusive approach allows staff to help shape the policies that impact their work environment, and it provides an ongoing opportunity for leadership and staff champions to respond to concerns and explain the rationale for proposed changes. This should result in a more effective policy—a policy grounded in, and responsive to, the particular realities, needs and constraints of affected staff. Involving staff in a meaningful way promotes staff understanding and ownership of evolving policy and practices.

Participation of an Outside Expert

An outside expert offers invaluable insight, experience, and expertise to the policy development process. Engaging community and/or state representatives of LGBTI organizations in shaping policy brings to the process a new set of tools and perspectives that ultimately strengthen the final product. Additionally, engaging technical assistance providers through the National Institute of Corrections (NIC) can help to learn from the experiences of other jurisdictions.

Correctional agencies (with which we are most familiar) that successfully navigated the policy process to improve LGBTI inmate safety all turned to outside experts to help inform and guide them through it. In Denver and Houston, agencies turned to local LGBTI organizations and advocates. The New York State DOC requested technical assistance from NIC.

The team developing policy—comprised of staff and experts—should also consider how the agency will create education modules and train staff on the policy. The team should also consider how the agency will evaluate its implementation.

Staff Education

Education is critical to increasing staff awareness and understanding of LGBTI inmates—their needs and the elevated risks they face. It helps staff to understand the need for responsive practices. The foundational issues of professionalism and respect (See Section III. Foundational Issues) underpin staff education efforts.

Education can go a long way to securing staff buy-in at every level, explaining why policies and practices are being incorporated, and how they impact the safety and security of the facility and its inmates. Consider incorporating the following strategies into staff education:

- Use personal stories. Powerful narratives illuminate others' needs to be treated fairly. Personal stories appeal to our shared humanity and can lead to change.
- Provide a safe space for staff to discuss their beliefs and reservations when it comes to the policy and the social issues involved.

"Initially we had a one hour in-house training, but we felt this needed to be more thoughtfully developed. So, we made a 12 hour online class which 3300 of 4500 of our staff have taken. We are currently working on in-classroom training."

—Assistant Chief Debra Schmidt, Harris County Sheriff's Office

Houston, Texas: Committee Approach

"The committee approach is the way to go. It brings critical components together. It gets community input, letting the community know they are valued and their thoughts appreciated, resulting in major community support."

— Asst. Chief Debra Schmidt,
Harris County Sheriff's Office





Involvement of Local Communities is Key to Success

Officers in Denver's Sheriff's Department report that after they announced their policy on Transgender inmates, jails and a lot of sheriffs from around the country reached out and expressed that they wanted to change but didn't want to take a really dynamic approach, as was done in Denver. Some reported reluctance to change at all, because unions were fighting the development of such policies in their jails. Some Sheriffs' offices have just taken Denver's policy and cut and pasted it, or asked us to "just send it to [them]." But the officers report that's not enough:

"To make this process work, you need community involvement and local buy-in as well as dynamic leadership and support. You need to be inviting local LGBTI people to be involved and to give input."

- Capt. Paul Oliva, Denver Sheriff's Office

Note: the following case study highlights different challenges to effective policy development and implementation.

THE IMPORTANCE OF INVESTING ALL LEADERS IN PREA IMPLEMENTATION: LEARNING FROM A FAILURE

A rural county jail on the West Coast developed and adopted a new classification policy reflecting PREA standards that included a mechanism to identify inmates who were potentially vulnerable or aggressive and to keep them separate. If, during initial screening, staff identified a transgender or gender non-conforming person, they were to place that person in a single cell (not a segregation cell) pending a review by the newly created Gender Identity Committee (GIC). The GIC members were staff who had received additional training and were charged to make the safest housing decisions for transgender or gender non-conforming people.

A supervisor in the classification unit disagreed with the change. The supervisor ignored the new process, placing a gender non-conforming, possibly transgender person, in a general population cell with a person who was classified as potentially aggressive. The supervisor did not inform the GIC. The inmate was sexually assaulted and, despite the disregard of policies put in place for this very reason, there were no repercussions for the classification supervisor or staff.

Failure to include serious consequences for not following policy, or failing to follow through with consequences that exist, can be worse than not having any policy at all. Part of the problem was that supervisors of departments were given tremendous discretion in running their departments. While the jail commander and sheriff would say they were in support of PREA and related changes, they were not active in enforcing such policies or in sending that message to all department heads. They left “PREA” up to the “PREA team,” who did not have authority over department leadership.

The case study above demonstrates a failure of leadership at all levels, as well as a failure to secure adequate staff buy-in of the new PREA policies. Importantly, it also underscores the need for real consequences for failure to follow policies and rules; what is punished or not punished is what people see, and it guides their actions. Accountability matters, especially in an institution focused on maintaining safety and security.

Enforcement and Accountability

As observed in the case study, policy must be designed to be enforceable, rather than merely aspirational. It is critical that enforcement mechanisms are built into policies, and that those mechanisms are actually followed. Staff must be held accountable for not enforcing or otherwise not following the new policy. If there are not consequences for failure to comply, the policy will be ignored, creating potentially dangerous situations that will increase agency liability rather than reduce it.

Frequent monitoring may be necessary during the implementation phase. Inmates will observe and take cues from what institutions do and do not tolerate. There must be consequences for staff and inmate behaviors deemed demeaning, harassing, or abusive. One goal of these policies is to enable policing from within, rather than relying on sanctions, by empowering inmates to hold one another accountable.

For staff, accountability is fundamentally about professionalism. If a policy or practice is adopted by an agency, it is staff's professional responsibility to follow and enforce the policy or practice. Failure to do so is—by definition—insubordinate, unprofessional behavior. Again, the key issue here is holding staff accountable for their professional responsibilities, rather than their personal values.



EMBEDDED VS. STAND-ALONE POLICY

When designing and implementing a new policy, leaders must consider whether i) a separate LGBTI policy should be created or ii) LGBTI-specific content should be embedded throughout existing institutional policies. As with much policy development, there is no correct answer here.

The agency is advised to make this decision based on which approach will be most operationally effective for the organization. Wherever and however LGBTI-relevant policy is codified, it should provide clear guidance to staff and administration. No matter how policy is structured, those charged with developing policy must consider how best to train staff regarding policy content.

One Approach:

Embed LGBTI Policies Within Existing Policies

“Cultures with a long history tend to move deliberately and not try to change too much at any one time. We have not yet put out one uniform policy addressing LGBTI issues but, rather, have embedded policies within other existing ones so it becomes ingrained throughout institutional culture. In this way we are ‘chipping away’ at the issue, working in LGBTI-specific policies incrementally, for example in medical treatment, gender-neutral undergarments policy, and frisk procedures. This is more challenging in some places than in others—the culture between facilities is highly variable.”

– Jason Effman, Associate Commissioner,
New York State Department of Corrections
and Community Supervision

V. Operations

INTAKE

Identifying Vulnerable Individuals

Intake is the correctional facility's first point of contact with inmates; therefore, it is the optimal time to identify inmates' particular vulnerabilities. Intake is an opportunity to minimize an inmate's risk of victimization while in custody and to optimize their sense of security. Information gathered during intake should inform subsequent decisions in classification, housing, health care, and program placement.

Conducting appropriate risk assessment at intake, including establishing LGBTI status or *perceived* LGBTI status, is vital to overall institutional safety and security. Appropriate risk assessment at intake informs staff of the specific privacy and healthcare needs of individual transgender inmates.¹⁰⁵ Not doing so increases the likelihood that staff will make improper decisions about inmate housing and care (such as placing a transgender woman in men's prisons). Such improper decisions can expose the inmate to safety risks and open the institution to potential liability.

The goal of LGBTI-focused intake policies is to identify vulnerable inmates, both by supporting self-disclosure through creation of a respectful and non-judgmental intake process, as well as by providing staff with the tools to independently assess inmates' vulnerability. Rather than requiring inmates to identify as LGBTI, policies should be designed to ensure that an incoming inmate has an opportunity

to inform facility staff of (i) any concerns about vulnerability based on LGBTI identity he or she might have, as well as (ii) any medical or accommodation needs that respect their gender identity.¹⁰⁶

Many LGBTI inmates will not be comfortable disclosing their status to correctional staff. Some inmates will face vulnerabilities similar to LGBTI inmates because they are perceived to be LGBTI but do not self-identify as such. Since inmates' appearance, mannerisms, and/or other characteristics may make them vulnerable to sexual or other abuse or harassment regardless of LGBTI status, intake staff must have proper and effective guidance on identifying inmates perceived to be LGBTI who do not otherwise indicate that they are LGBTI.¹⁰⁷

Interview Process

For intake assessments to be successful, they must be conducted in a way that elicits accurate information. To accomplish this, assessments must be conducted with respect for the individual, in a manner that makes clear the high priority placed on each inmate's safety. Accurate information provided at intake will equip staff to better provide for the physical and mental health and safety of those charged to their care; it will prevent future challenges and potential violations. Conversely, inaccurate information can place inmates at avoidable risk of sexual harassment and abuse, among other challenges. Therefore, it is critically important to create an intake protocol that helps to identify LGBTI inmates without singling them out or creating an identification process that is, itself, harassing.¹⁰⁸

¹⁰⁵ Marksamer J and Tobin HJ (2013). *Standing with LGBT prisoners: An advocate's guide to ending abuse and combating imprisonment* Washington, DC: National Center for Transgender Equality. <http://transequality.org/issues/resources/standing-lgbt-prisoners-advocate-s-guide-ending-abuse-and-combating-imprisonment>.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid.

¹⁰⁸ Ibid., p. 30.

Facility administrators will need to decide whether their agency should ask all inmates directly about their sexual orientation and gender identity.¹⁰⁹ PREA Standards require that an agency attempt to collect information on sexual orientation and gender identity so as to decrease the risk of sexual abuse for non-heterosexual and transgender inmates. PREA Standards also require that staff ask questions about prisoners' feelings of vulnerability, which can help open a conversation related to a prisoner's sexual orientation and gender identity.¹¹⁰ Though the Standards specify these requirements, the individual facility decides on the specific steps to accomplish these goals. Incorporating questions about sexuality and gender identity into an agency's intake protocol would make the questions routine.

If a facility decides to ask inmates directly about their sexual orientation and gender identity, the facility must also determine:¹¹¹

- a. Who will ask these questions? What kind of training will they receive to increase sensitivity to issues surrounding sexual orientation and gender identity and other risk factors for victimization?
- b. When should the questions be asked? How can questions best be integrated into the intake process? Should they stand alone or be embedded into another survey, such as a medical interview?
- c. What should the facility do to encourage prisoners to feel comfortable disclosing sensitive information? Agencies should understand that these questions can lead to emotionally difficult disclosures and should therefore consider conducting this portion of the interview at a time when privacy is possible, both to encourage honesty and to protect confidentiality.
- d. How should questions be asked? What terminology should be used?
- e. How and where will inmate responses to questions be recorded? Who will have access to this information?

¹⁰⁹ The Moss Group. *A Quick Guide for LGBTI Policy Development for Adult Prisons and Jails* pp. 7–8. Washington, DC: National Institute of Corrections. U.S. Department of Justice. 2012.

¹¹⁰ Marksamer & Tobin, p. 30.

¹¹¹ This section adapted from *A Quick Guide* (2012).

WHO WILL ASK THESE QUESTIONS?

THE HOUSTON SOLUTION: GENDER CLASSIFICATION SPECIALISTS

Understanding the need to conduct interviews that produce accurate and honest disclosure with respect to an inmate's sexual orientation and gender identity, the Harris County Sheriff's Office staff realized that it required an expert with specific training in this area. They introduced the concept of the Gender Classification Specialist (GCS), an individual on staff who is specially trained to ask sensitive questions of inmates who might identify as LGBTI, and to effectively communicate with LGBTI inmates. A GCS undergoes institutional training in sexuality and gender issues and successfully passes certification (and re-certification) procedures.

A GCS should be open and approachable, non-discriminatory and non-judgmental, and comfortable with LGBTI individuals. A GCS will:

- Interview inmates sensitively and with respect, asking about feelings of vulnerability including history/risk of past abuse and victimization;
- Emphasize that the point of questioning about these sensitive matters is first and foremost an issue of inmate safety;
- Determine the vulnerability of inmates to abuse, using this information to help other staff making classification and housing decisions;
- Be a resource to both inmates and fellow staff regarding current institutional LGBTI-specific policies and general policies as they impact LGBTI inmates. At intake in particular, GCS should acquaint LGBTI inmates with such protocols for housing, commissary, etc. and available help and resources;
- Be available as a contact person should an inmate want to report an incident.

Gender Classification Specialists are notified when an LGBTI inmate is received at intake and of the initial vulnerability assessment of an inmate. They then conduct private interviews with inmates to gather information that will be used in housing and classification assignments. A GCS will assess both an inmate's chances of being sexually abused and of being sexually abusive. Using this information, a GCS will represent LGBTI inmates' best interests and foresee risks in decisions regarding housing and classification. A GCS can supervise and manage intake screening processes so that they comply with the prison's LGBTI-specific policy.

Throughout their interactions with all incoming inmates, intake staff should be encouraged to:

- *Use respectful language and appropriate terminology. Minimize use of slang and jargon and explain terms that may not be familiar to an inmate.* Understand that inmates may use a variety of terminology to discuss their identity depending on their background. For example, younger inmates may be much more likely to describe themselves as queer, rather than LGBTI.
- *Be open and approachable, and emphasize confidentiality.* Staff should also assure inmates that they are not obligated to answer any questions they feel uncomfortable answering, nor will they be disciplined for opting to skip questions. Staff should assure that any information disclosed will be kept confidential and only shared on a need-to-know basis with other staff such as medical personnel and those involved in the inmate's safety (e.g. those responsible for determination of housing and placement).
- *Emphasize safety.* Staff conducting interviews should inform inmates of the routine nature of the questions and explain that their purpose and priority is to ensure safety by assessing and minimizing risk through established protocols and policies.
- *Avoid making assumptions.* Treat each inmate as an individual. Ask questions in a direct, yet respectful, manner. Avoid asking leading questions, instead using neutral language to avoid pressuring or otherwise compelling the interviewee to provide a particular answer.
- *Ask follow-up questions, particularly if appearance/body language does not appear to align with reported gender or sexual identity.*

Specific Questions

The purpose of incorporating questions on potential risk factors for victimization at intake is to assist staff in comprehensively and respectfully managing the health and safety needs of those under their care who may be at increased risk. In addition to questions focused on sexual orientation and gender identity (SOGI), topics to inquire about include:

- *Past sexual victimization and abuse:* Individuals who have previously experienced sexual abuse are more likely to experience sexual victimization and/or harassment in a detention facility.
- *Inmates' own feelings of vulnerability and concern for their own safety*
- *PREA risk assessment requirements:* Completion of a risk assessment is required within 72 hours of an inmate's entry into a facility. There is, of course, overlap in the goals of asking questions about sexual orientation and gender identity, and a PREA-related assessment. All of these questions should be incorporated into intake assessments to inform and expedite crucial risk minimization decisions related to classification, housing, and placement. Intake protocols should assure privacy and confidentiality for questions relating to an inmate's sexual orientation and gender identity as well as questions relating to past victimization and self-perceptions of vulnerability. Standard §115.41 sets forth the following minimum criteria for assessing the risk of sexual victimization in prisons and jails:
 - The presence of any mental, physical, or developmental disability
 - Age
 - Physical build
 - Whether the inmate has been previously incarcerated
 - Whether the inmate's criminal history is exclusively nonviolent
 - Whether the inmate has prior convictions for sex offenses against an adult or child
 - Whether the inmate is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming
 - Whether the inmate has ever experienced sexual victimization
 - The inmate's perception of their own vulnerability
 - Whether the inmate has been detained solely for civil immigration purposes

Intake Protocols That Do Not Ask About SOGI

The emerging best practice for intake interviews is to include specific questions about sexual orientation and gender identity. For facilities that determine not to include specific questions, a policy will need to be developed that provides guidance to staff on how to identify, at intake and later times, who is—or may be perceived to be—LGBTI through observation.¹¹² This policy can build on the PREA risk assessment criteria listed above (particularly the inquiry about an inmate's self-perception of vulnerability). Not all inmates will feel comfortable self-disclosing. When a staff member believes an inmate may be vulnerable, either due to self-disclosed LGBTI status or observed gender nonconforming or other behavior, policies need to be in place that direct staff members to privately discuss safety and vulnerability concerns with the inmate. Outside of intake, medical and mental health professionals can collect this information. It can also be collected through continued observation by staff, with appropriate follow-up for any inmate deemed vulnerable because of LGBTI status or being perceived to be LGBT.¹¹³

Thorough collection of accurate information is critical to a good intake process. Collecting detailed, comprehensive information from inmates, as mandated by PREA, allows facilities to minimize risk in housing placement, bathroom use, health care, and other practices. Asking inmates about their sexual orientation and gender identity in a direct, but also sensitive and culturally competent, manner demonstrates a facility's acknowledgement of the LGBTI population. Prior sexual victimization is highlighted because of the disproportionate rates of abuse experienced by the LGBTI population.¹¹⁴

The emerging best practice for intake interviews is to include specific questions about sexual orientation and gender identity.



¹¹² Marksamer & Tobin, 2014.

¹¹³ Ibid.

¹¹⁴ Smith et al., 2015

Specific Guidance for Identifying Transgender Prisoners*

Intake staff may need specific guidance to help them identify prisoners who may be transgender in the ordinary course of intake assessments. Guidelines might address some of the following points:

- A prisoner's gender identity and transgender status may be determined by: self-identification by the prisoner; statements regarding a prisoner's preferred name or pronouns; a prisoner's appearance; court, medical, identification, or other records or documentation; or other factors that may come to light during standard intake procedures.
- It is important to understand that while some prisoners may self-identify during intake questioning, prisoners may use a variety of terminology to describe their identity depending on their cultural background and age, e.g., a prisoner may self-identify as transgender, transsexual, gender nonconforming, or any one of many terms that have similar meanings in a prisoner's primary language if other than English. Some transgender prisoners may describe themselves simply as gay, regardless of their actual sexual orientation. Some prisoners may not use identity terms at all but instead will make statements along the lines of, "I am trapped in the wrong body," or "I am really a woman."
- When reviewing a prisoner's identification documents, court, or medical records, or other documentation, staff should determine whether these documents identify a prisoner as transgender or if they use a gender marker that is different from the gender the individual is living and outwardly presenting as. For transgender prisoners who have been transferred from a local jail, their transgender status is often noted in any accompanying paperwork, reports, or files. For transgender prisoners who were recently arrested, it is not uncommon for their arrest reports to note that they were dressed in women's clothing at the time of arrest.
- In other cases, an individual's appearance (e.g., clothing, wig, hair and grooming, makeup, breasts, etc.) or preferred name or AKA may indicate to staff that a prisoner may be transgender.

Immediate Decisions to be Made After Identifying a Transgender Prisoner

Once a facility identifies that a prisoner is transgender, there are some actions that must be taken in order to better protect the transgender prisoner's safety, dignity, and privacy before final decisions are made regarding classification, housing, and medical care. You may want to consider the following: specifying how to make immediate decisions related to temporary housing and assessment in your policy guidance for intake staff, making referrals to specific committees that will make longer term decisions, and using a screening form to help identify the transgender prisoner's preferences related to their specific privacy and safety needs. Numerous jurisdictions are now employing some version of a screening form for transgender prisoners that allows them to state their preferences related to some or all of the following: gender of individual who will search them in the event a search is necessary, pronoun, housing, and medical needs.

*from Marksamer & Tobin, *Standing with LGBT prisoners*, pp. 31-32

Specific Issues to Address When a Transgender or Intersex Inmate is Identified

Preferred Names, Pronouns, Gender Identity

When interacting with an inmate whose gender identity is unclear, staff may be unsure as how to refer to the inmate. Different facilities nationwide have adopted various policies for using preferred versus birth names or pronouns to address inmates who are transgender, intersex, or ambiguously-gendered. Optimally, the policy of the facility should also express that the use of a prisoner's preferred name and pronoun does not require that the prisoner have completed a legal name change or have changed his or her gender marker on official identification documents.

The Denver County Sheriff's Office, like an increasing number of jurisdictions, relies on an inmate's own preference, which is clearly indicated on blue cards all inmates carry and can present to staff. Each inmate's blue card indicates the inmate's particular search preference in terms of the gender of an officer conducting a pat down, the inmate's preferred pronoun, as well as other details such as criminal descriptor number, booking number, and booking name. By making preferences readily available, the blue card theoretically pre-empts a need for verbal clarification and may lessen the potential for harassment or discomfort associated with asking an inmate. By disclosing all inmates' preferences, staff avoid singling out individuals with uncommon preferences.

If use of a transgender, intersex, or ambiguously-gendered inmate's preferred name is not likely to be accepted in a particular facility, staff should refer to the inmate as "Inmate [last name]."

Expressing Gender Preference for Searches

Transgender and intersex inmates should be allowed to express their gender preference, if any, regarding who conducts searches. It is important to collect the search preference information as quickly as possible because of the risk of humiliation and trauma that can occur due to searches based on assumed preference rather than actual preference. The Denver County Sheriff's Office includes search preference information on the blue cards that all inmates carry.

When implementing this policy in individual facilities, we would encourage clearer terms than "cross-gender," because the intended gender may not always be apparent, particularly in the cases of transgender and intersex inmates. (See Section V, Operations, Subsection F, Group inmate management; search policy)

Clinical and Mental Health Assessments

Inmates have the right to appropriate clinical and mental health care. At a minimum, facilities must ensure that inmates have access to medical personnel who are knowledgeable about the health needs of LGBTI individuals. If the agency cannot provide the necessary care on site, then inmates should be transported to the provider. For all prisoners, any previous treatment that an inmate received prior to arriving at the facility should be continued upon arrival after appropriate consultation. Additionally, inmates must be reassessed upon intake of their medical needs to ensure that all conditions are being treated in the appropriate manner.¹¹⁵

¹¹⁵ Smith et al, 2015

¹¹⁶ Makadon H, Mayer K, Potter J, Goldhammer H (2015). *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. 2nd Edition. Philadelphia, PA: American College of Physicians.

¹¹⁷ Marksamer & Tobin, 2014.

In general, LGBTI inmates have many of the same health needs as other inmates. Keeping this in mind, facilities must also be aware of the unique health needs of this population, such as increased rates of HIV, social anxiety, and post-traumatic stress disorder. Intersex and transgender inmates each have their own special needs, including different preventive screening needs that may be atypical of the other inmates housed in the facility.¹¹⁶ For more information, see the “Medical and mental health care” section below.

CLASSIFICATION AND HOUSING PLACEMENT

Standing with LGBT Prisoners: An Advocate’s Guide to Ending Abuse and Combating Imprisonment by Jody Marksamer and Harper Jean Tobin provides excellent guidance for classification and housing best practices with regards to LGBT prisoners.¹¹⁷ Marksamer and Tobin recommend that facilities examine their existing classification and housing placement procedures for any policies or statements that may cause discrimination or harm to LGBT prisoners, such as policies requiring LGBT prisoners to be isolated into protective custody, classified as sex offenders, or housed based on genitalia or birth sex.

Protective Custody

Facilities may have policies in place that require LGBT prisoners to be segregated into solitary confinement to protect them from other prisoners who might harm or abuse them. While LGBT prisoners are at higher risk of abuse, isolating them in protective custody is generally not considered to be the

best way to address this problem. At many facilities, being placed into solitary confinement entails being locked away into a very small space for 22–24 hours a day with little to no human interaction. This can be psychologically damaging, especially in prisoners who have an existing history of mental illness or disability. Furthermore, prisoners in solitary confinement generally do not have access to the education, training, recreation, employment, and other support services that are available to the other prisoners in the facility. Placing LGBTI prisoners directly into solitary confinement for protection based solely on their sexual orientation or gender identity, and not for disciplinary issues, can thus be very damaging and traumatic.

PREA Standards regarding protective custody state that inmates who are at higher risk for sexual victimization, such as LGBTI prisoners, should not be placed into segregated housing unless no available alternatives currently exist. In that case, prisoners can be placed in segregated housing for no more than 24 hours while alternative options are assessed and arranged. While in segregated housing, inmates should have access to programs, privileges, education, and work opportunities to as great an extent as possible. Once alternative arrangements for separation from likely abusers have been made, inmates should be released from protective custody. Some alternatives to segregation that facilities can try include increased supervision or escorts for vulnerable prisoners, single-cell placement or placement with a similarly vulnerable cellmate, or transfer to a different facility. Policies should also include procedures for documenting the reasons and length of isolation so that the use of segregation as a means of protection can be regularly monitored and reviewed.

Classification

LGBT prisoners should never be classified as sex offenders or housed with sex offenders based solely on their sexual orientation or gender identity. Classification of an LGBT prisoner as a sex offender should not occur without the same due process protections that exist for other prisoners, including a hearing, an evaluation by a mental health professional, and guidelines for an appeal process.

A policy should be in place that ensures that reasons for all classification decisions are documented so that decisions can be reviewed and reassessed in the future if need be. This is especially important for transgender inmates who may have been misclassified and housed in gendered units that do not align with their gender identity. Without proper documentation, it will be much more difficult to review the classification decisions for transgender inmates in these situations, which can lead to increased risk for abuse for the transgender inmates. Furthermore, PREA Standards require that the classifications and placements for transgender inmates be reassessed at least twice a year to ensure safety.

Housing Placement

Facilities should have policies in place regarding the housing of transgender and intersex inmates so that their safety is the first priority. PREA Standards require that housing decisions for transgender and intersex inmates be made on an individualized, case-by-case basis that prioritize the inmates' own wishes regarding where they feel the safest. In making housing placement decisions for incoming transgender and intersex inmates, it can be helpful to have discussions with any transgender or intersex inmates currently in the facility regarding their thoughts on safety. For example,

bunk rooms and other group housing settings are generally very dangerous for transgender inmates, but there could be a chance that in some facilities, transgender inmates may actually appreciate the social aspect of being housed in a group setting. Each facility is different, so in creating an individualized plan for housing, it is important to discuss with inmates to understand what their wishes are for their own safety.

While the safety and wishes of the transgender and intersex inmates should be the top priority in making housing decisions, several other factors may be important in making an individualized decision for housing placement. Some of these factors include the inmates' charges, length of stay, history of discipline or violence issues, input from medical and mental health providers, and the safety of other inmates and staff. Discussing these other factors with transgender and intersex inmates can help facility staff make the most appropriate and safest housing placements.

Some facility staff or administrators may have concerns implementing new housing policies based on gender identity rather than birth sex or genitalia. For example, a common concern is that housing transgender women in a women's facility would pose a safety risk for the other inmates. However, housing a transgender woman in a women's facility is not the same as housing a man in a women's facility, and may not pose the same risks. Transgender women identify as women despite whatever genitalia they possess, and as such, they are typically uncomfortable with the genitalia they were born with and uninterested in having their bodies viewed by others.¹¹⁸ Additionally, many detained transgender women are not sexually attracted to women. A 2009 study involving interviews with 315 transgender women in California prisons found that 82% were sexually at-

¹¹⁸ Brown, 2010

¹¹⁹ Sexton L, Jenness V, and Sumner JM (2010). "Where the Margins Meet: A Demographic Assessment of Transgender Inmates in Men's Prisons." *Justice Quarterly*, 27:6.

¹²⁰ Beck AJ et al., 2013

tracted to men only, 16% to both men and women, and only 1% were attracted exclusively to women.¹¹⁹ It is also important to remember that any inmate is capable of engaging in abusive conduct. There is no reason to believe that transgender women will present any more risk to their fellow female inmates than other women would. In contrast, placing transgender women in a men's facility has been shown to create significant risk of sexual assault and harassment for the transgender woman.

A critical fact to consider in making housing decisions, and one that is underscored by PREA, is that transgender prisoners are at higher risk of being raped in prison than other prisoners. According to the Bureau of Justice Statistics, data from 2007 through 2012 indicate that 34.6% of transgender people in state and federal prisons and 34% in local jails reported some kind of sexual victimization while incarcerated.¹²⁰ Among cisgender heterosexual men, between 3.5% and 5.2% reported sexual victimization. Among cisgender heterosexual women, between 3.7% and 13.1% reported sexual victimization. Rates of sexual victimization by another prisoner against gay and bisexual men in prison are also very high, about 10 times the rate for heterosexual men.¹²¹ The Massachusetts State Legislature passed an excellent policy in 2018 that reflects best practices for managing transgender inmates (See Appendix B).

The Trump Administration's New Transgender Housing Policy for Federal Prisons

The Federal Bureau of Prisons (BOP) announced in May 2018 that, while it will continue to make housing determinations on a case-by-case basis as required by the Prison Rape Elimination Act (PREA), it will use "biological sex" to make initial determinations in the type of housing transgender inmates are assigned and will assign transgender prisoners to facilities conforming to their gender identity only "in rare cases."¹²² This reverses a 2016 BOP policy that housed adult prisoners based on their gender identity, not their birth sex.¹²³

The BOP's 2018 decision runs directly counter to the text and spirit of PREA, will undermine the safety and security of one of the most vulnerable prison populations, and negates decades of progress on LGBT rights and protections that were reflected in the issuance of PREA standards in 2012.¹²⁴

¹¹⁹ Beck AJ et al., 2012

¹²⁰ Federal Bureau of Prisons (2018). Change Notice to Transgender Offender Manual. <https://www.documentcloud.org/documents/4459297-BOP-Change-Order-Transgender-Offender-Manual-5.html>

¹²¹ National PREA Resource Center (2016, March 24). <https://www.praresourcecenter.org/node/3927>

¹²² Cahill S (2017). "From 'Don't drop the soap' to PREA standards: Reducing sexual victimization of LGBT people in the juvenile and criminal justice systems." *LGBTQ Politics: A Critical Reader*. New York: New York University Press. 134-152.

According to the National PREA Resource Center, the new policy violates PREA Standards:

Does a policy that houses transgender or intersex inmates based exclusively on external genital anatomy violate Standard 115.42(c) & (e)?

Yes. Standard 115.42(c) states:

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.

In addition, Standard 115.42(e) states:

A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.¹²⁵

It is important to point out that the Trump Administration policy change on housing transgender prisoners affects federal institutions only. State prisons and local jails should continue to follow the recommendations set forth in PREA and in this manual.

¹²⁵ National PREA Resource Center (2016, March 24). <https://www.prearesourcecenter.org/node/3927>

¹²⁶ Boehmer U, Bowen DJ, Bauer GR (2007). "Overweight and obesity in sexual minority women: evidence from population-based data." *Am J Pub Health*. 97:1134–1140. Cited in Mayer KH, Bradford JB, Makadon HJ, Stall R et al. (2008) "Sexual and gender minority health: What we know and what needs to be done" *Am J Public Health*. 98:989–995.

¹²⁷ Valanis BG, Bowen DJ, Bassford T et al. (2000). "Sexual orientation and health: Comparisons in the Women's Health Initiative sample." *Arch Fam Med*. 9(9):843–853.

¹²⁸ Kerker BD, Mostashari F, and Thorpe L (2006). "Health care access and utilization among women who have sex with women: Sexual behavior and identity" *J Urban Health*. 83(5):970–979.

¹²⁹ Conron KJ, Mimiaga MJ, and Landers SJ (2010). "A population-based study of sexual orientation identity and gender differences in adult health." *Am J Pub Health*. 100(10):1953–1960.

¹³⁰ Lee J, Griffin G, and Melvin C (2009). "Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review." *Tob Control*. 18(4):275–282.

¹³¹ Centers for Disease Control and Prevention (2010). *HIV Among Gay, Bisexual, and Other Men who Have Sex with Men (MSM): Fact Sheet*. <https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf>

MEDICAL CARE, INCLUDING MENTAL HEALTH CARE

The LGBT population experiences health disparities that are significant both from a clinical and a public health perspective. For instance, lesbians are more likely than heterosexual and bisexual women to be overweight and obese, increasing their risk for cardiovascular disease, lipid abnormalities, glucose intolerance, and morbidity related to inactivity.¹²⁶ Lesbians and bisexual women experience cervical cancer at the same rate as heterosexual women but are much less likely to get routine Pap tests to screen for cervical cancer.^{127,128} The Massachusetts Behavioral Risk Factor Surveillance Survey found poorer health among bisexual respondents compared with gay, lesbian, and heterosexual respondents, as well as higher rates of mental health issues and smoking.¹²⁹ Overall, LGBT people as a group are 1.5 to 2.5 times more likely than other Americans to smoke.¹³⁰ Gay and bisexual men¹³¹ and transgender women¹³² experience high rates of HIV and sexually transmitted infections, and transgender individuals experience high rates of minority stress and mental health burden.¹³³

LGBT people experience cultural barriers to accessing primary care. These barriers include a lack of providers trained to address the specific health care needs of LGBT people;¹³⁴ low rates of health insurance coverage for same-sex couples,¹³⁵ LGB individuals^{136,137,138,139} and transgender individuals, especially Black transgender people;¹⁴⁰ discrimination in health care;^{141,142} and a lack of access to culturally appropriate health care, including preventive services.¹⁴³

¹³² Centers for Disease Control and Prevention (2019). *HIV and Transgender People*. <https://www.cdc.gov/hiv/pdf/group/gender/transgender/cdc-hiv-transgender-factsheet.pdf>

¹³³ Institute of Medicine (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academies Press. <https://www.nap.edu/read/13128/chapter/1>

¹³⁴ Obedin-Maliver J, Goldsmith E, Stewart L, et al. (2011) "Lesbian, gay, bisexual and transgender-related content in undergraduate medical education" *JAMA*. 306:971–977.

¹³⁵ Ponce N, Cochran S, Pizer J et al. (2010) "The effects of unequal access to health insurance for same-sex couples in California" *Health Aff*. 29:1539–1548.

¹³⁶ Badgett L. (1994) "Civil rights, civilized research: Constructing a sexual orientation anti-discrimination policy based on the evidence." Paper presented at Association for Public Policy Analysis and Management Research Conference, San Francisco, 1994.

¹³⁷ Cochran S (2001). "Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter?" *American Psychologist*. 56(11):931–947.

¹³⁸ Diamant A, Wold C, Spritzer K et al. (2000) "Health behaviors, health status, and access to and use of health care: A population-based study of lesbian, bisexual, and heterosexual women" *Archives of Family Medicine*. 9(10):1043–1051.

¹³⁹ Durso L, Baker K, and Cray A (2013). *LGBT Communities and the Affordable Care Act: Findings from a National Survey*. Washington, DC: Center for American Progress <http://www.americanprogress.org/wp-content/uploads/2013/10/LGBT-ACASurvey-brief1.pdf>

¹⁴⁰ Grant et al., 2011

¹⁴¹ Lambda Legal (2010). *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV*. New York: Lambda Legal.

¹⁴² Smith D and Mathews W (2007). "Physicians' attitudes toward homosexuality and HIV: Survey of a California medical society-revisited (PATHH-II)" *Jnl Homosexuality*. 52(3–4):1–9.

¹⁴³ Mayer K, Bradford J, Makadon H, Stall R et al. (2008). "Sexual and gender minority health: What we know and what needs to be done" *Am J Public Health*. 98:989–995.

Mental Health Issues

The “hostile and stressful social environment” caused by anti-gay “stigma, prejudice, and discrimination” creates higher rates of mental illness among gay and bisexual men.¹⁴⁴ Gay-related stigma has been shown to diminish positive affect and increase depression among midlife and older gay men.¹⁴⁵ Minority stress is caused by external, objective events and conditions, expectations of such events, the internalization of societal attitudes, and concealment of one’s sexual orientation.^{146,147,148}

Some studies show higher rates of mental health burden among LGB populations compared to heterosexuals, including depression, anxiety, and suicidality.¹⁴⁹ The 2017 Youth Risk Behavior Survey shows that, nationally, LGB adolescent youth were four times as likely to report suicidal behaviors as compared to their heterosexual peers. Nearly half of LGB youth reported seriously considering attempting suicide; 40% reported making a plan to commit suicide; and one in five actually attempted suicide in the previous year.¹⁵⁰

Health risk surveys also show higher rates of substance use among gay and bisexual men.¹⁵¹ According to the 2017 YRBS, LGB adolescents were nearly twice as likely to report current use of tobacco products as compared to heterosexual youth (24.7% vs 12.5%). Sexual minority youth report cocaine use at near three times the rate of heterosexual youth (10.2% vs 3.6%). One in twelve (8.5%) LGB youth reported injected drug use, compared to 1.5% of heterosexual youth.¹⁵²

All subgroups within the LGBT population face well-documented mental health disparities; however, the amount differs between subgroups. Relative to cis-gender LGB individuals, transgender individuals have been shown to be even more likely to report discrimination, depression symptoms, and suicide attempts.¹⁵³

LGBT people experience barriers to accessing mental health services. One study found that experiences of discrimination among LGBT people made them less likely to seek needed mental health services: “Experiences of discrimination may engender negative expectations among stigmatized groups about how they will be treated within larger institutional systems, making them wary of entering those situations.” Compared with heterosexuals, LGBT people were more likely to report “that they did not receive mental health services, or that such services were delayed.”¹⁵⁴

Rural LGBT populations face additional barriers. Rural residents, especially LGBT rural residents, report difficulty accessing high quality mental health care due to limited supply.¹⁵⁵ Providers in rural settings often lack training on LGBT culture and healthcare needs, and they fail to recognize how minority stress affects LGBT people. Rural clinics and hospitals may lack safeguards to ensure that neither individual nor institutional bias influences care.¹⁵⁶ One study of mental health and substance use services in rural areas found widespread experiences of discrimination among LGBT clients, at the hands of both providers and heterosexual clients. LGBT clients were

¹⁴⁴ Meyer IH (2003). “Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence” *Psychol Bull.* 129(5):674–697.

¹⁴⁵ Wright RG, LeBlanc AJ, de Vries B et al. (2012). “Stress and mental health among midlife and older gay-identified men” *Amer J Pub Health.* 102(3):503–510.

¹⁴⁶ Meyer IH (1995). “Minority stress and mental health in gay men.” *J Health Soc Behav.* 36:38–56.

¹⁴⁷ Cole SW, Kemeny ME, Taylor SE, Visscher BR. Accelerated course of human immunodeficiency virus infection in gay men who conceal their homosexual identity. *Psychosomatic Medicine.* 58:219–231.

¹⁴⁸ Kemeny ME, Taylor SE, Visscher BR. Elevated physical health risk among gay men who conceal their homosexual identity. *Health Psychol.* 15:243–251. Cited in Meyer IH, 2003.

¹⁴⁹ King M, Semlyen J, Tai SS et al. (2008). “A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people.” *BMC Psychiatry.* 8:70. Cited in Committee on LGBT Health Issues (IOM), 2011, 190.

¹⁵⁰ Kann L et al., 2018

¹⁵¹ Centers for Disease Control and Prevention (2008). “HIV risk, prevention, and testing behaviors among men who have sex with men—National HIV Behavioral Surveillance System, 21 U.S. cities, 2008” *MMWR.* 60(14). <http://www.cdc.gov/mmwr/pdf/ss/ss6014.pdf>.

frequently silenced and told not to raise issues of sexuality or gender identity in group settings. Counselors expressed disapproval of homosexuality and sought to convert clients to heterosexuality. LGBT clients were refused entry into programs to “protect” them from discrimination or placed in isolation from other clients. Of 20 providers interviewed, only one had had formal training in LGBT mental health issues.¹⁵⁷

Transgender Health Care Needs

Transgender people have health needs that require access to nondiscriminatory health care. The widespread failure of most insurance plans to cover transgender health needs, including surgery and hormone therapy, is based on bias and misinformation, such as the commonly held misconception that treatment of transgender people is merely “cosmetic” or “elective” in nature. This exclusionary bias leads to denial of basic health care for transgender people even when unrelated to gender issues (i.e. Pap tests are routinely excluded for transgender men—people assigned a female sex at birth who identify as men). Most transgender men retain a cervix and are still at risk for cervical cancer; they need routine preventive sexual health screening per the U.S. Preventive Services Task Force guidelines applicable to all natal females with a cervix.¹⁵⁸

¹⁵² Kann L et al., 2018

¹⁵³ Su D, Irwin J, Fisher C et al. (2016). “Mental Health Disparities Within the LGBT Population: A Comparison Between Transgender and Non-transgender Individuals” *Transgender Health*. 1(1)

¹⁵⁴ Burgess D, Lee R, Tran A et al. (2007). “Effects of perceived discrimination on mental health and mental health services utilization among gay, lesbian, bisexual and transgender persons” *Journal of LGBT Health Research*. 3:1-14.

¹⁵⁵ Smalley KB, Warren JC, and Rainer JP (2012) *Rural Mental Health: Issues, Policies, and Best Practices*. New York, NY: Springer pp229-252; Williams I, Williams D, Pellegrino A et al. (2012). “Providing mental health services for racial, ethnic, and sexual orientation minority groups in rural areas.”

¹⁵⁶ Israel T, Willging C, and Ley D (2016). “Development and Evaluation of Training for Rural LGBTQ Mental Health Peer Advocates” *Rural Mental Health*. 40(1):40-62.

¹⁵⁷ Willging CE, Salvador M, and Kano M (2006) “Unequal treatment: Mental health care for sexual and gender minorities in a rural state” *Psychiatric Services*. 57:867-870.

¹⁵⁸ U.S. Preventive Services Task Force (2012). *Cervical cancer: Screening* <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening>

There is a consensus in the mainstream medical community that gender dysphoria is a recognized medical condition requiring medical and mental health care. *The American Medical Association Encyclopedia*¹⁵⁹, the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-5),¹⁶⁰ and all standard psychiatric texts have recognized gender dysphoria since 1980, when it was then named "transsexualism" (and subsequently, until 2013, known as "gender identity disorder"). The World Health Organization (WHO) also recognizes gender identity disorder in its ICD-10, "the standard diagnostic tool for epidemiology, health management and clinical purposes."¹⁶¹

Gender reassignment surgery and cross-sex hormone treatment are considered medically necessary by many physicians for their transgender patients. The American Medical Association adopted a resolution in 2008 supporting public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient's physician.¹⁶² The World Professional Association for Transgender Health, Inc. (WPATH) first developed the internationally accepted standards of care of individuals with gender dysphoria by medical and mental health professionals in 1979. These standards of care cover therapy, hormone treatments, and gender reassignment surgical procedures, as well as routine primary medical care. Care of individuals with gender dysphoria is based on individualized plans involving some or all of the following: 1) psychotherapy; 2) hormone treatment; 3) living full-time in the gender of identity; and 4) surgery to change primary and secondary sexual characteristics. Treatment plans are based on the accepted WPATH standards of care. These treatments have

been successfully used in medicine for more than 30 years.¹⁶³ We recommend that decisions regarding medical care for transgender inmates be made consistent with the recommendations of the American Medical Association and the World Professional Association for Transgender Health.

These treatments have also been shown to significantly improve transgender patients' long-term health outcomes—including significantly improving quality of life, general health, social functioning, and mental health.^{164,165} Many transgender people report that they are happier and more productive following their transition to express their current gender identity.¹⁶⁶ Better health outcomes for transgender individuals could, in the long run, actually lower costs for care. The APA's DSM-5 provides clear criteria for the diagnosis of gender dysphoria¹⁶⁷, which may be diagnosed by mental health and medical professionals.

In 2015 California became the first state to cover the cost of transitioning for a transgender inmate. In a settlement between a transgender woman being held in a men's facility and the California Department of Corrections and Rehabilitation (CDCR), the CDCR agreed to move the inmate to a women's facility and provide necessary medical care, including

Gender reassignment surgery and cross-sex hormone treatment are considered medically necessary by many physicians for their transgender patients.

¹⁵⁹ American Medical Association (2006). *AMA Encyclopedia*. Lipsky M (editor). Chicago, IL: Random House Reference. "Gender identity disorder (GID)" (303); "sex change" as "treatment" for GID (625).

¹⁶⁰ American Psychiatric Association (2013). Gender dysphoria. DSM-5. Arlington, VA. <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf>

¹⁶¹ WHO, *International Statistical Classification of Diseases and Related Health Problems*, version 10 (ICD-10). <http://www.who.int/classifications/icd/en/>

¹⁶² H-185.950 "Removing Financial Barriers to Care for Transgender Patients. Our AMA supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient's physician." (Res. 122; A-08) <https://policysearch.ama-assn.org/policyfind/detail/financial%20barriers%20transgender?uri=%2FAMADoc%2FHOD.xml-0-1128.xml>

¹⁶³ WPATH. *Standards of care*. <https://wpath.org/publications/soc>

¹⁶⁴ Murad MH, Elamin MB, Garcia MZ et al. (2010). "Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes" *Clinical Endocrinology*. 72(2):214-231.

gender-affirming surgery.¹⁶⁸ The state is also revising its policies to provide all transgender inmates with access to medically necessary treatments for gender dysphoria, as determined by medical and mental health providers, including surgery.¹⁶⁹

It is important to remember, however, that not every transgender person desires or seeks sex reassignment surgery. This is a very personal decision and can be governed by a variety of factors, including financial and general health considerations. Staff should never assume that surgery is a transgender person's ultimate goal.

Intersex Health Care Issues

One in 2,000 births involves a disorder of sexual development (DSD). Intersex people have genitalia, gonads, sex chromosomes, and reproductive ducts that do not look or correspond to classically male or classically female. *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health* has a helpful chapter on medical care of intersex patients.¹⁷⁰ Key health care issues affecting intersex individuals are: sexual function and satisfaction; fertility; therapy to support psychosocial adjustment; and sensitive, affirming, and culturally competent care.

Adult intersex individuals grew up when standard medical practice was to subject intersex children to irreversible genital surgeries without their consent or full knowledge. Intersex advocates for decades have decried these surgeries as unethical.¹⁷¹ That said, adults who have had surgeries to remove gonads may need to be on hormone replacement ther-

apy for the rest of their lives.¹⁷² Being incarcerated should not interfere with medically indicated hormone therapy. As discussed in Section II, denial of medically necessary care has been found by courts to be unconstitutional, and such denial of care places corrections facilities at risk of liability..

Intersex individuals, especially those with not classically male- or female-appearing genitalia, risk undergoing humiliating and unnecessary searches by corrections officials; being subject to discrimination and ridicule by inmates and staff; and may be targets of physical, sexual, or emotional victimization by other inmates. Historically, medical providers have conducted unnecessary examinations and exhibition of intersex people's bodies as medical "curiosities" to other medical staff or trainees. The experience of unnecessary examinations has been described as deeply traumatizing by intersex individuals for decades.¹⁷³ Such behavior by inmates, staff, or corrections medical providers is unacceptable and may result in substantial mental distress for intersex inmates. Access to appropriate mental health care should be available to all inmates, including intersex inmates.¹⁷⁴

Additionally, intersex patients (like all patients) have the right to access their medical records. They have the right to be told the truth about their intersex status, traits, and any related medical information, including any history of medical intervention.¹⁷⁵

¹⁶⁸ Keo-Meier CL, Herman LI, Reisner SL et al. (2015). "Testosterone treatment and MMPI-2 improvement in transgender men: A prospective controlled study" *J Consult Clin Psychol* 83(1):143–56.

¹⁶⁹ Grant et al., 2011

¹⁷⁰ Gender dysphoria is a persistently and deeply felt cross-gender identification including an enduring sense that a person's body is of the wrong sex. People with gender dysphoria experience distress and discomfort that causes clinically significant impairment in functioning in all aspects of life. American Psychiatric Association (2013) Gender dysphoria. *DSM-5*. Arlington, VA. <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf>

¹⁷¹ Transgender Law Center (2015). "State of CA and Transgender Law Center reach historic settlement over trans prisoner health care." Published August 7, 2015. Accessed at: <http://transgenderlawcenter.org/archives/11861>.

¹⁷² Ibid.

¹⁷³ Makadon H, Mayer K, Potter J, Goldhammer H. (2015). *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. 2nd Edition. American College of Physicians.

¹⁷⁴ Human Rights Watch and InterACT. (July 2017). "I want to be like nature made me": Medically Unnecessary Surgeries on Intersex Children in the US. <https://interactadvocates.org/wp-content/uploads/2017/07/Human-Rights-Watch-interACT-Report-Medically-Unnecessary-Surgery-on-Intersex-Children-in-the-US.pdf>

¹⁷⁵ Makadon H et al., 2015

¹⁷⁶ Ittelson A, Fraser S, and Levasseur MD (2018). *Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies*. InterACT and Lambda Legal <https://interactadvocates.org/wp-content/uploads/2018/09/interACT-Lambda-Legal-intersex-hospital-policies.pdf>

¹⁷⁷ *Estelle v. Gamble*, 429 U.S. 97 (1976).

¹⁷⁸ Ittelson A et al., 2018

HIV Care

The Bureau of Justice Statistics reports that 1.5% of prisoners in the U.S. are living with HIV, a rate four times that of the general population.¹⁷⁶ Of the more than 1.1 million adults and adolescents living with HIV in the U.S. in 2015, 63% received some HIV medical care, 49% were retained in continuous HIV care, and 51% were being treated effectively such that their HIV infection was fully suppressed.¹⁷⁷ Among the factors associated with non-adherence to anti-retroviral treatment for HIV disease are substance use, mental health issues, and housing instability. Many people entering prison who are HIV-infected have never been diagnosed with HIV or have been diagnosed but are not on anti-retroviral treatment. It is essential that people living with HIV in prison receive life-saving anti-retroviral medications, which can keep them relatively healthy and allow them to live a long life. Treatment adherence also has benefits for HIV prevention. Cohen et al. found that earlier treatment of HIV decreases HIV transmission among serodiscordant couples (couples in which one partner is HIV-uninfected and one is HIV-infected).¹⁷⁸ Suppressing the viral load of people living with HIV is essential to reducing new HIV infections, which remained stable at roughly 40,000 a year in the U.S. from 2012-2017.¹⁷⁹

Since the onset of the HIV epidemic in the U.S., gay and bisexual men and other men who have sex with men (MSM) have been disproportionately burdened by the virus and continue to experience disproportionate rates of HIV infection. In 2016, the Centers for Disease Control and Prevention (CDC) reported that MSM made up 80% of new HIV diagnoses in males from 2010-2015. One in four new HIV diagnoses in males were among those 13-24 years; 91% of HIV diagnoses in males aged 13-24 were attributed to male-to-male sexual contact.¹⁸⁰ These findings are alarming given that MSM only make up 2% of the U.S. adult population.¹⁸¹

For gay and bisexual men of color, the statistics are even more troubling; a startling 42% of new HIV diagnoses among MSM in the U.S. occur among Black MSM even though Black MSM represent only about 0.25% of the adult population.¹⁸² Since 2012, rates of new infection of HIV in

¹⁷⁵ Ittelson A et al, 2018

¹⁷⁶ Maruschak LM and Beavers R (2010). *HIV in Prisons, 2007–08*. U.S. Department of Justice, Bureau of Justice Statistics Bulletin. <https://www.bjs.gov/content/pub/pdf/hivp08.pdf>

¹⁷⁷ AIDS.gov, HIV/AIDS Care Continuum. <https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics>

¹⁷⁸ Cohen S, Van Handel M, Branson B et al. (2012). “Vital Signs: HIV Prevention Through Care and Treatment – United States” *MMWR*. 60(47):1618–1623

¹⁷⁹ Centers for Disease Control and Prevention (2019). *HIV in the United States and Dependent Areas*. <https://www.cdc.gov/hiv/statistics/overview/ataglance.html>

¹⁸⁰ Centers for Disease Control and Prevention. (2016) *HIV surveillance—Men Who Have Sex with Men (MSM), through 2016* HIV/AIDS Statistics and Surveillance <https://www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-slides-msm-2016.pdf>

¹⁸¹ Purcell DW, Johnson CH, Lansky A et al. (2012). “Estimating the population size of men who have sex with men in the United States to obtain HIV and syphilis rates” *Open AIDS J* 6:98–107

¹⁸² Ibid., 144

MSM have remained stable; however, when stratified by race, new infection in white MSM has decreased, remained stable for African-American MSM, and actually increased for Latino MSM.¹⁸³ Additionally, Black men in general represent a disproportionate percentage of those placed in correctional facilities, accounting for over 60% of the US male prison population.¹⁸⁴

Pre-exposure prophylaxis for HIV prevention, or PrEP, involves taking HIV medications that were developed to treat HIV infections for the purposes of prevention. An estimated 1.1 million people in the U.S., mostly men who have sex with men and disproportionately Black and Latino, could benefit from PrEP, according to the Centers for Disease Control and Prevention.¹⁸⁵ Increasingly, LGBT prison health advocates are urging corrections systems to make PrEP available to individuals at risk of HIV infection.

In addition to HIV, gay and bisexual men experience elevated rates of cigarette smoking, alcohol and recreational drug use; sexually transmitted infections (STIs), including viral hepatitis; eating disorders; cardiovascular disease; anal cancer, and AIDS-related cancers; and violence and trauma stemming from hate crimes, domestic violence, and sexual assault.¹⁸⁶

As of 2019, about half of the people living with HIV in the US are over age 50.¹⁸⁷ As people grow older with HIV and live decades with the virus, they are likely to develop comorbidities.¹⁸⁸ Common comorbid conditions among older adults living with HIV include liver, kidney, and cardiovascular disease, obesity, cognitive impairment, depression, neuropathy, osteoporosis, and a number of cancers.¹⁸⁹



¹⁸³ Centers for Disease Control and Prevention (2019). *HIV in the United States and Dependent Areas*. <https://www.cdc.gov/hiv/statistics/overview/ataglance.html>.

¹⁸⁴ Brewer RA, Magnus M, Kuo I et al. (2014) “Exploring the relationship between incarceration and HIV among Black men who have sex with men in the United States” *JAIDS Journal of Acquired Immune Deficiency Syndrome*. 65(2): 218–225

¹⁸⁵ Smith DK, Van Handle M, Grey JA. By race/ethnicity, blacks have highest number needing PrEP in the United States, 2015. Conference on Retroviruses and Opportunistic Infections, 6 March 2018, Hynes Convention Center, Boston, MA. Cited in Goldstein RH, Streed CG, Cahill SR (2018, September 19). Be PrEPared—Preexposure Prophylaxis and HIV Disparities. *NEJM*.

¹⁸⁶ The Fenway Institute. The Fenway Guide to LGBT Health, Module 3: Health promotion and disease prevention. <http://www.lgbthealtheducation.org/training/learning-modules/>

¹⁸⁷ Effros RB, Fletcher CV, Gebo K et al. (2008). “Aging and infectious diseases: Workshop on HIV infection and aging: What is known and future research directions” *Clin Infect Dis* 47(4):542–553.

¹⁸⁸ Deeks SG and Philips AN (2009). “HIV infection, antiretroviral treatment, aging, and non-AIDS related morbidity.” *BMJ* 338(7689):288–292.

¹⁸⁹ Cahill S, Darnell B, Guidry J et al. (2010). *HIV and aging: Growing older with the epidemic*. New York: Gay Men’s Health Crisis. http://www.gmhc.org/files/editor/file/a_pa_aging10_emb3.pdf.

Hepatitis C Care

Chronic hepatitis C (HCV) infection has long been a concern in prison systems, given that it is most commonly transmitted by sharing needles, and many injection drug users end up in prison. As such, recommendations for HCV screenings of prisoners have been in existence for quite some time. In its *Preventive Health Care Screening: Clinical Guidance*, the Federal Bureau of Prisons (BOP) notes that individuals at risk for Hepatitis C are those who:

- have ever injected illegal drugs and shared equipment
- received tattoos or body piercings while in jail or prison
- are HIV infected
- are Hepatitis B (HBV) infected (chronic)
- received a blood transfusion or organ transplant before 1992
- received a clotting factor transfusion prior to 1987
- exhibit percutaneous exposure to blood (all)
- were ever on hemodialysis (if currently, screen semiannually)

The BOP recommends that prisoners that meet any of these criteria be screened for Hepatitis C.^{189.5}

Until recently, the role of sexual transmission of HCV was not well defined. While sexual transmission of HCV is possible, it had previously been considered highly unlikely and sexual behavior had not been considered a risk factor. However, more-recent research has documented sexual transmission of HCV.

In particular, MSM are more likely than others to contract HCV through sexual contact, especially if they are HIV-positive. As CD4 cell counts decrease, risk of HCV infection rises.¹⁹⁰ There is also evidence that unprotected, receptive anal sex and engaging in sexual activity while on methamphetamines can put individuals at a greater risk for HCV infection.¹⁹¹

HCV is of particular concern given the course of treatment required for HCV-infected individuals. Since HCV is treated in accordance with the genotype of the virus itself, drug therapies and regimens have been evolving for the past few years. The lack of a “one-size-fits-all” treatment has its own set of challenges and complicates how to appropriately prescribe medications. Other difficulties arise when monitoring the disease and managing comorbidities, such as kidney disease, cirrhosis, and HIV infection.

Although the BOP has deemed it acceptable to delay treatment, the most complicated and expensive cases do require immediate attention.¹⁹² Correctional facilities are also obligated to provide treatment for inmates who were undergoing HCV drug therapy at the time that they enter the system.¹⁹³

Aside from the cost of treating prisoners, monitoring HCV infected individuals also requires a great deal of attention. Those who are also HIV positive may need to adjust their antiretroviral therapy as they start HCV treatment, as drug interactions may occur. Sofosbuvir and simeprevir are of particular concern in this regard.¹⁹⁴

^{189.5} Federal Bureau of Prisons (June 2018). *Preventive Health Care Screening: Clinical Guidelines*. <https://www.bop.gov/resources/pdfs/phc.pdf>

¹⁹⁰ Ard K, Goldhammer H, and Makadon H. (2014) *Emerging Clinical Issue: Hepatitis C infection in HIV-infected men who have sex with men*. First Edition. Boston: National LGBT Health Education Center, 2014

¹⁹¹ Centers for Disease Control and Prevention (2011). “Sexual transmission of hepatitis C virus among HIV-infected men who have sex with men – New York City, 2005–2010.” *MMWR*. 60(28):945–50.

¹⁹² Federal Bureau of Prisons (2014). “Interim Guidance for the Management of Chronic Hepatitis C Infection” *Clinical Practice Guidelines*.

Correctional facilities are also obligated to provide treatment for inmates who were undergoing HCV drug therapy at the time that they enter the system.

Since 2011, new drugs to treat chronic Hepatitis C infection have entered the market almost annually. Cure rate percentages have risen with new iterations, but the cost of treatment (up to \$84,000 for a full course) has proven to be a major barrier to accessing the medicine. Increased competition is finally resulting in some cost reduction, but the per patient treatment cost remains high as a percentage of a correctional institution's overall health care budget, and access to treatment while incarcerated remains limited. Prisoners with Hepatitis C have a right to access the cure. Just as state Medicaid departments negotiate with pharmaceutical companies to purchases medications at reduced cost, prison and jail systems should negotiate with manufacturers of Hepatitis C medications and provide this treatment to their HCV-infected inmates.

Other STIs

Syphilis

Like HIV, syphilis disproportionately affects gay and bisexual men in the US. In 2017, 57.9% of syphilis cases occurred among men who have sex with men (MSM).¹⁹⁵ Gay and bisexual men in prison should be routinely screened for syphilis, HIV, and other sexually transmitted infections.

Human Papilloma Virus

Human papilloma virus (HPV) is the most common STI in the US. As of 2017, 42.5% of US adults aged 18–59 have HPV, or 79 million people. Most cases of genital warts, found in about 1% of the US population (3 million people), are caused by specific HPV types. HPV also causes several forms of cancer; while most commonly associated with cervical cancer, HPV also causes anal cancer (estimated at 1600 cases per year in women and 900 cases per year in men).¹⁹⁶ Anal cancer is emerging as among the most important non-AIDS-defining malignancies affecting people living with HIV, especially gay and bisexual men.¹⁹⁷ MSM with HIV are at even greater risk for HPV and its related complications. Though rare among the general population, HPV-related anal cancer is 40–80 times more prevalent among HIV-infected MSM than among uninfected heterosexual men.¹⁹⁸ HPV vaccination is now recommended for all adults through age 45.¹⁹⁹ Prisons and jails should make this vaccination available as part of routine, preventive health care.

¹⁹³ Ibid.

¹⁹⁴ Ibid.

¹⁹⁵ Centers for Disease Control and Prevention (2017). *Sexually Transmitted Disease Surveillance 2017* https://www.cdc.gov/std/stats17/2017-STD-Surveillance-Report_CDC-clearance-9.10.18.pdf, in particular p25 and Figure 41.

¹⁹⁶ Ibid. p31

¹⁹⁷ Palefsky J (2009). "Human papillomavirus-related disease in people with HIV" *Curr Opin HIV AIDS* 4(1): 52–56.

¹⁹⁸ Silverberg MJ, Lau B, Justice A et al. (2012) "Risk of Anal Cancer in HIV-Infected and HIV-Uninfected Individuals in North America" *Clin Infect Dis* 54(7):1026–1034.

¹⁹⁹ Ingram I (2018, October 7). FDA Oks HPV vaccine for adults up to age 45. *MedPageToday*. www.medpagetoday.com

SAME-SEX BEHAVIOR, GENDER NON-CONFORMITY, CONSENT AND ABUSIVE BEHAVIOR: COMPLEX ISSUES

Although sexual activity between inmates is prohibited in prisons, sexual contact does occur. This is true for all inmates, not just those who identify as LGBTI. Same-sex sexual contact may satisfy a biological need, act as a transaction, or establish dominance in abusive circumstances. LGBTI prisoners are also at increased risk of sexual victimization. Because condoms are often prohibited in prison, sexual contact carries increased risk of acquiring STIs such as HIV or Hepatitis C.

Many correctional facilities have simplistic, unilateral no-tolerance policies for sexual behavior; however, the phenomenon of same-sex sexual behavior in prisons is inherently complex. This section will explore same-sex sexual behavior in correctional settings, discuss how to discern valid gender expression from coerced gender abuse, address the concept of consent in a correctional setting, and examine the merits of making condoms and lubricant available in correctional facilities.

Same-sex Behavior in Prisons and Jails

Corrections officials are better able to serve and protect their inmate populations if they understand the motivations behind same-sex behavior in their facilities. Denying the existence of such behavior (or not understanding why it is occurring) leaves inmates and corrections facilities vulnerable to systemic abuse and corrections officials liable to litigation.

Same-sex behavior in correctional settings ranges from entirely consensual to entirely coerced. Statistics show that sexual assault is common, especially for LGB individuals. As shown in Table 4, LGB inmates are 7-10 times as likely to report having been the victim of sexual assault by another inmate as compared to heterosexual inmates. Because of stigma associated with same-sex activity and sexual assault and because of the potential threat of retribution by the aggressor, these statistics likely underestimate the true prevalence of sexual assault for both groups.



Table 4. Sexual victimization by sexual minority status in correctional facilities

	LGB	Heterosexual
Prisons²⁰⁰	12.2%	1.2%
Jails	8.5%	1.2%
Juvenile Facilities²⁰¹	10.3%	1.5%

Less is known about the prevalence of consensual sex in prisons, though most agree that it is widespread. Few studies have data on consensual sex in prisons. The studies that do exist do not measure the phenomenon in a uniform way; therefore, estimates range from 14% – 65% of prisoners who have engaged in consensual sex while incarcerated.²⁰²

A 2011 literature review²⁰³ described and classified a range of sexual behaviors observed in women's prison. The five categories that arose from the data are described in Table 5.

²⁰⁰ National PREA Resource Center (2019). *Committing to Safety and Respect for LGBTI Youth and Adults in Confinement: Lessons From Two Agencies*. <https://www.prearesourcecenter.org/node/2868>

²⁰¹ Beck AJ, Cantor D, Hartage J et al. (2013). *Sexual Victimization in Juvenile Facilities Reported by Youth, 2012 National Survey of Youth in Custody*. <https://www.bjs.gov/content/pub/pdf/svjfry12.pdf> The Bureau of Justice Statistics surveyed 273 state-operated juvenile facilities and 53 locally or privately operated facilities holding adjudicated youth on behalf of the state.

²⁰² Borchert J (2016). "Controlling Consensual Sex Among Prisoners" *Law & Social Inquiry* 41(3):595-615

²⁰³ Pardue A Arrigo BA and Murphy DS (2011). "Sex and Sexuality in Women's Prisons: A Preliminary Typological Investigation" *The Prison Journal* 91(3):279-304.

Table 5. A Continuum of Sexual Behavior in Female Prisons

Type of Behavior	Description	Range of Sexual Behaviors	Extent of Aggression
Suppressed Sexuality	No sexual activity at all; does not engage in sexual acts with self or others	Forming pseudo-families and kinships that are not sexual but instead provide a support network for female inmates	Not threatening to convict's well-being
Autoerotic	Sexual intimacy with self	Self-pleasure seeking; masturbation	Not threatening to convict's well-being
Consensual: True Homosexuality	The individual identified as homosexual prior to incarceration, homosexuality continues during and beyond incarceration	Consensual sexual acts, forming dyads/kinships	Poses some harm only when relationships become characterized by exploitation (i.e., participating in sexual acts for protection, economic gain, pressuring/threatening, using status, offering protection, in exchange for sex, labor, or commissary)
Consensual: Situational Homosexuality	The individual engages in homosexual behavior, in part, as a result of incarceration. (Argot: "turned out," "butches," "tricks," and "cherries.")	Consensual sexual acts, forming dyads/kinships; participating in homosexual relationships to compensate/adapt to unisex environment	Poses some harm only when relationships become characterized by exploitation (i.e., participating in sexual acts for protection, economic gain, pressuring/threatening, using status, offering protection, in exchange for sex, labor, or commissary)
Sexual Violence	Three forms of sexual violence: (a) manipulation, (b) compliance, and (c) coercion	Manipulation (sexual bartering), Compliance (acquiescence for safety/protection), and Coercion (pressure for sexual contact, sexual assault, rape, murder)	Increasingly threatening, violent, and harmful; characterized by prisoner-on-staff, convict-on-convict, and staff member-on-incarcerate sexual relationships

Source: Pardue A Arrigo BA and Murphy DS (2011). "Sex and Sexuality in Women's Prisons: A Preliminary Typological Investigation." The Prison Journal 91(3):279-304.

What is the typical correctional facility response to such prevalent behavior? Many correctional facilities do not permit sexual behavior of any kind (including masturbation). Even corrections systems that acknowledge the phenomenon across the board do not permit sexual conduct (see Condoms in correctional facilities: Different approaches across correctional systems subsection below). A 2016 qualitative study provides insight as to why this is the case. The study authors interviewed prison officials from 23 states in the U.S. The study concluded:

Findings show that correctional leaders frame prison sex as dangerous for the safety and security of the prison. Prison leaders are in nearly unanimous agreement that prison sex is dangerous, whether that sex is consensual or coercive. Yet, my interviewees reveal that they are unaware of empirical evidence that consensual prison sex produces little violence as opposed to coercive sex (Hensley and Tewksbury 2002, 236)...

... Furthermore, my findings show that prison officials fail to link actual risks of violence to perceived risks of violence in day-to-day prison life. For instance, penalties for gambling do not call for administrative segregation despite gambling's frequent association with violence among prisoners (Nixon, Leigh, and Nowatzki 2006; McEvoy and Spirgen 2012; Beauregard and Brochu 2013). By failing to compare the high levels of risk to institutional safety and security posed by gambling to the low levels of risk posed by consensual sex, correctional leaders are perpetuating a status regime that disproportionately punishes LGBT identity and desire, as well as samesex sex, and continues the legacy of homophobia in US prisons.²⁰⁴

“By failing to compare the high levels of risk to institutional safety and security posed by gambling to the low levels of risk posed by consensual sex, correctional leaders are perpetuating a status regime that disproportionately punishes LGBT identity and desire, as well as samesex sex, and continues the legacy of homophobia in US prisons.”

- Pardue, Arrigo, and Murphy. *The Prison Journal*, 2011.

²⁰⁴ Borchert J, 2016

In Massachusetts prisons, this pattern holds. Sexual assault is classified as a category one offense, along with murder and escape attempts. Consensual sex or “engaging in intimate acts and/or sexual acts with another” is classified as category two offense. Other category two offenses include making bomb threats, possessing unauthorized keys, and possessing drugs. Gambling, however, is a category three offense. Other category three offenses include threatening another with bodily harm or with any offense against another person, their property or their family; extortion or blackmail in exchange for protection; and fraud or embezzlement.²⁰⁵

Sanctions for category one and two acts include inmate loss of statutory good time. They also include longer stays in “restrictive housing” (i.e. solitary confinement) than category three offenses. For all inmates, consensual sex or loosely defined “intimate contact” (which could include hugging, kissing, or legs touching) could result in solitary confinement and a punishment worse than threatening another’s person or family with violence.²⁰⁶ For little penological reason, LGBTI inmates and inmates with substance use disorders are thus punished more harshly for their typical behaviors than inmates engaging in behaviors that promote violence against others and that threaten facility safety.²⁰⁷

Gender Non-conformity

Transgender inmates are even more vulnerable to sexual victimization than LGB inmates (Table 6). Over one in three transgender inmates report being the victim of sexual assault, either by inmates or by corrections officers.

Table 6. Sexual abuse reported by transgender people in prisons and jails

State and Federal Prisons	34.6	24.1	16.7
Local Jails	34.0	22.8	22.9

Source: Beck AJ (2013). Sexual victimization in prisons and jails reported by inmates, 2011–12. Supplemental tables: Prevalence of sexual victimization among transgender adult inmates. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf

²⁰⁵ Massachusetts Department of Correction (2019). 103 CMR 430.00: Inmate discipline. <https://www.mass.gov/regulations/103-CMR-43000-inmate-discipline>

²⁰⁶ Ibid.

²⁰⁷ Ibid.

Another consideration about gender non-conformity in inmates that is not related to transgender identity is the idea of “protective coupling.” Protective coupling occurs when an inmate engages in a same-sex relationship with another inmate in order to obtain protection from random sexual assault. Because of homophobia, sometimes the dominant prisoner forces the weaker partner to present as the opposite gender in order to make same-sex behavior more acceptable to the dominant partner (this is sometimes referred to as getting or being “turned out” in slang).

While administrators and corrections officers should refer to transgender inmates by their chosen names and pronouns and allow them to express their gender identity, they should make sure that this is a choice and not something that is being forced as part of a protective coupling relationship. To use opposite gender pronouns and names in the latter instance could inadvertently send the message of condoning exploitative relationships, which prison leaders should not do. It is important to make the distinction between transgender inmates expressing their gender identity and inmates being coerced in protective coupling relationships.

Consent

Consent is a complex issue outside of correctional facilities, and it is a particularly thorny concept inside jails and prisons. Many prisoners report engaging in consensual sex that is mutually not coercive. A spectrum logically exists from totally consensual to totally coercive sexual behavior (see Table 5 above). Importantly, PREA does not prohibit consensual sexual activity and does not allow for punishment invoking PREA for such activity. PREA standards state that same-sex activity should not be considered sexual abuse if the facility staff determine that the conduct was not coerced.^{207.5}

Trained PREA investigators should be able to assess the context of alleged sexual misconduct and infer from the information available as to whether a witnessed or reported sexual act was consensual. Importantly, sexual acts between corrections officials and inmates are never consensual given the mismatch in power dynamic.

Condoms in Prison

Provision of condoms in prisons has the potential to markedly reduce instances of unprotected sex between inmates, thereby decreasing the prevalence of sexually transmissible infections such as HIV/AIDS and hepatitis in prisons.

The topic of condoms being allowed in correctional facilities remains an open and heated debate. Prison administrators and some former prisoners are concerned that providing condoms and lubricant in prison—thereby tacitly acknowledging that sexual activity is occurring—could send the wrong message that this activity is being condoned and is acceptable to prison administrators and staff. At the same time, the high rates of HIV, STIs, and HCV among the prison population raise concerns about sexual transmission of infection and prisoners’ health.

The Bureau of Justice Statistics reported in 2010 that the US prison population had four times the rate of HIV as the general US population.²⁰⁸ Chronic hepatitis C (HCV) is also much more prevalent among inmates than in the general population. A 2014 estimate of HCV rates in US prisons estimates chronic infection to be between 12 and 35% versus approximately 2% of the US population generally.²⁰⁹

^{207.5} 28 C.F.R. Part 115 § 115.278 §§ (g).

²⁰⁸ Varan AK, Mercer DW, Stein MS et al. (2014) “Hepatitis C Seroprevalence Among Prison Inmates Since 2011: Still High but Declining” *Public Health Rep* 129(2):187–195.

²⁰⁹ Ibid.

In 1992, the WHO recommended that preventive measures, including safer sex education and condoms, be made available to prisoners in order to reduce the risk of HIV/AIDS transmission during detention. Despite the fact that HIV and STIs are more prevalent among US inmates,²¹⁰ allowing prisoners access to condoms in the US has remained controversial. As of 2010, only two state prisons in the US had implemented condom provisions.²¹¹ Major concerns exist among prison staff that condoms will be used to conceal contraband or as weapons.

Stigma surrounding homosexuality and sex between inmates also acts as a potential barrier to the success of condom access programs. The homophobic environment also exacerbates the issue of identifying HIV-positive prisoners. Some inmates are reluctant to be screened for HIV/AIDS for fear of judgment or harassment from other prisoners.²¹² Javanbakht et al. reported that, over a 5-year period (2000–2005), a voluntary HIV screening program was implemented at an MSM-specific jail unit in Los Angeles County. While 13.4% of prisoners were found to be HIV positive, researchers estimate that the true prevalence of HIV and other STIs were likely much higher.²¹³ In fact, a self-report survey distributed in the Los Angeles County Jail MSM unit between 2000 and 2001 showed that approximately 30% of prisoners said that they were HIV positive.

Several pilot programs have been carried out and monitored in which condoms were made available in prisons and jails. Some programs installed condom dispensers in various locations, while others focused on distributing condoms to targeted populations. Key considerations in broader implementation of such programs include the implications it may have for sexual activity levels, cost-effectiveness, and education.

A 2010 study²¹⁴ examined the effect of installing a condom-dispensing machine in a San Francisco jail. Though the city's jail system had been making condoms available to its inmates since 1989, they were only accessible via one-on-one counseling sessions. Stigma surrounding homosexuality among prisoners and a lack of confidentiality limited the reach of this program. Sexual health education was also offered along with condoms.



²¹⁰ Lovinger E (2012). *Fenced In: HIV/AIDS in the US Criminal Justice System*. New York, NY: Gay Men's Health Crisis Inc.

²¹¹ Harawa NT, Sweat J, George S et al. (2010). "Sex and condom use in a large jail unit for men who have sex with men (MSM) and male-to-female transgenders." *Journal of Health Care for the Poor and Underserved* 21(3):1071–87

²¹² Derlega VJ, Winstead BA and Brockington JE. (2008). "AIDS stigma among inmates and staff in a USA state prison." *International Journal of Sexually Transmitted Diseases and AIDS* 19(4):259–63.

²¹³ Javanbakht M, Murphy R, Harawa NT et al. (2009). "Sexually transmitted infections and HIV prevalence among incarcerated men who have sex with men, 2000–2005." *Sexually Transmitted Diseases* 36 (2 Suppl):S17–21

²¹⁴ Sylla M, Harawa N, and Reznick OG. (2010) "The first condom machine in a US jail: the challenge of harm reduction in a law and order environment." *American Journal of Public Health* 100 (6):982.



By the end of the study, most prisoners and staff were supportive of the provision of condoms. Some felt it resulted in greater sexual activity, though no evidence supported such opinions.²¹⁵ There was no difference in the rate of sexual activity before or after the condom distribution program was implemented. High-risk prisoners, including gay, bisexual, transgender, and HIV-positive inmates, reported higher utilization rates of condoms, and attitudes towards the condom dispensers were positive. No adverse effects were reported at the conclusion of the study.

Provision of condoms presents several advantages, from removing barriers to access to increasing safe-sex practices. In an assessment of a condom access pilot program carried out in a California state prison, researchers found that dispensers placed in more discreet areas of the facility were utilized more frequently and inmates were less likely to vandalize them.²¹⁶ The installation of dispensers, in this case, was also accompanied by a peer education program, which made it clear that condoms were a preventive measure and not an indicator of perceptions of sexuality. The educational component was especially important, as a pre-intervention survey showed that many prisoners did not believe that condoms could prevent STI and HIV transmission.²¹⁷

Some studies have evaluated condom access programs limited to prisoners who identify as gay or bisexual men or as transgender women. Risky sexual behavior has been found to be most common among young MSM prisoners who are HIV positive and often have multiple partners.²¹⁸ By providing this population of prisoners with condoms, there is significant opportunity to reduce HIV transmission during detention. In addition, education about safe sex practices should be included as part of the intervention to help reduce risk of transmission after their release. Researchers suggest that segregating gay and bisexual male prisoners and male-to-female transgender prisoners opens opportunities for targeted interventions.²¹⁹ These population-specific programs could yield maximum benefits by focusing on the highest risk prisoners while avoiding potential abuse or harassment from other inmates.²²⁰ According to PREA, however, segregated units in jails and prisons are only allowed under court order. Importantly, DOJ states “[t]o prevent sexual abuse, the [PREA] standards require, among other things, that facilities restrict the use of solitary confinement as a means of protecting vulnerable inmates.”²²¹

²¹⁶ Lucas KD, Miller JL, Eckert V et al. (2014). “Risk, Feasibility, and Cost Evaluation of a Prison Condom Access Pilot Program in One California State Prison.” *Journal of Correctional Health Care*. 20:184

²¹⁷ Ibid.

²¹⁸ Chen JL, Bovée MC, Kerndt PR (2003). “Sexually transmitted diseases surveillance among incarcerated men who have sex with men—an opportunity for HIV prevention” *AIDS Education and Prevention* 5 (1 Suppl A):117–26.

²¹⁹ Ibid.

²²⁰ Ibid.

An Australian study evaluated two state prisons in order to assess whether or not provision of condoms to prisoners increased sexual activity, both consensual and non-consensual. While no increase in sex among inmates was discovered, there was a significant increase in condom use, particularly during anal sex.²²² The study found that sexual coercion was rare, regardless of condom availability.

Another consideration for implementing condom access programs is the cost-effectiveness of providing condoms to prisoners. Several studies have sought to posit how many HIV transmissions would need to be prevented to make such programs cost-effective. Given the relatively low cost associated with condom distribution, data supports that just a few cases of HIV would need to be prevented to make such programs cost-effective.²²³ Researchers estimate that averting an HIV infection among someone in the general US population saves \$230,000 to \$338,000 over that person's lifetime.²²⁴

California implemented a pilot program placing condom-dispensing machines in Solano State Prison Facility II. The program was at the directive of the governor following the success of San Francisco Jail's condom distribution program. The Solano facility is one of four quadrants of a typical modern design, medium-security level (level III), general population men's prison. The pilot program ran for one year (November

2008 - November 2009). A pilot study was conducted "to 1) assess the potential impact of condom distribution on safety and security (risk), 2) assess whether condoms were readily available and barriers to accessing condoms (feasibility), and 3) estimate the costs of distributing condoms using the pilot project model."²²⁵

The pilot study found that condom distribution did not increase the incidence of contraband or drug-related violations or violent or sexual misconduct (i.e. risk). The study also found that "[t]he use of condom dispensing machines, if placed in discreet locations, is a feasible and acceptable option to prevent sexual transmission of HIV and STDs."²²⁶

Importantly, the authors estimated that prevention of 2.7-5.4 average cases of HIV infection in one year would cover the cost of supplying condoms to the

Given the stigma of homosexuality and misconceptions of condom efficacy, it is important that prisoners be well-informed as condoms become accessible.

²²¹ U.S. Department of Justice (May 17, 2012). "Justice Department releases final rule to prevent, detect, and respond to prison rape." Press Release.

²²² Butler T, Richters J, Yap L et al. (2013). "Condoms for prisoners: no evidence that they increase sex in prison, but they increase safe sex." *Sexually transmitted infections* 89(5):377-379

²²³ Lucas et al., 2014

²²⁴ McNeil D (February 25, 2015). "Study that paid patients to take HIV drugs fails." *New York Times*. P. A12.

²²⁵ Lucas et al., 2014

²²⁶ Ibid.

²²⁷ Lucas KD, Miller JL, Eckert V et al. (2011) *Evaluation of a Prisoner Condom Access Pilot Program Conducted in One California State Prison Facility*. California Correctional Health Care Services, California Department of Public Health. https://www.prisonlegalnews.org/media/publications/evaluation_prison_condom_access_pilot_ca_september2011.pdf

entire facility for one year.²²⁷ It is important to note that this study only estimated cost savings based on HIV prevention. There is potential for even greater cost savings if we take averting other STIs into consideration.

Another study at the Los Angeles County Jail estimated that hundreds of cases of chlamydia, gonorrhea, and syphilis, as well as three cases of HIV, were averted when screening, treatment, and condoms were provided for inmates and resulted in significant cost savings.²²⁸

Much of the literature states that education is also a key component to condom access programs. Given the stigma of homosexuality and misconceptions of condom efficacy, it is important that prisoners be well-informed as condoms become accessible. Chen et al. suggested that private providers and the on-site health services team should work together when implementing such programs, while others posited that peer-educators would prove effective as trusted informers.²²⁹

The majority of studies reported limitations associated with self-reporting and voluntary participation. Under-reporting of consensual and forced sexual interactions were of particular concern.²³⁰ While data exist regarding the prevalence of HIV and STIs in prison, precise and accurate estimates are difficult to obtain. This is due to the potential underreporting—often as a result of stigma—and the dynamic nature of the US inmate population. Since many

studies only examine the effects of condom access in one or two correctional facilities, results may not be generalizable to the broader prison population, given different facility security levels, the variability in facility conditions, and facility-specific regulations.²³¹

While limited in scope, these findings suggest that condom dispensers could benefit gay and bisexual male and male-to-female transgender prisoners in particular. Overall, studies do not show any association between condom access and increased misconduct. The literature suggests that provision of condoms and sexual education in prisons can be beneficial and poses minimal threat in terms of promoting sexual activity or increasing the rate of rape or coercive sex. Gay Men's Health Crisis and other HIV/AIDS organizations support the distribution of condoms as an effective means to preventing the transmission of HIV and other STIs among inmates.²³² Distribution of condoms should also be accompanied by an educational component, either led by health services staff or peer educators. Water-based lubricant should also be made available.²³³ If inmates use Vaseline, cooking oil, or another kind of lubricant, this can cause the condoms to become damaged and ineffective for HIV and STI prevention. There is evidence that condom access programs can be a cost-effective strategy to reducing the prevalence of HIV, HCV, and STIs in prisons and prevent further transmission as inmates are released from detention.

²²⁸ Tuli K, Kerndt PR (2009). "Preventing sexually transmitted infections among incarcerated men who have sex with men: a cost-effectiveness analysis." *Sexually Transmitted Diseases* 36(2 Suppl):S41-8

²²⁹ Derlega VJ et al., 2008

²³⁰ Lovinger, 2012

²³¹ Ibid.

²³² Ibid.

²³³ Planned Parenthood. "What do I need to know about anal sex?" 2010. <https://www.plannedparenthood.org/learn/teens/ask-experts/me-and-my-girlfriend-are-going-to-going-to-try-having-anal-sex-for-the-first-time-and-she-is-not-very-convinced-about-how-safe-is-anal-sex-can-pregnancy-be-achieved-by-anal-sex-what-are-the-con>

Condoms in Correctional Facilities: Different Approaches Across Correctional Systems

STATE CASE STUDIES

Vermont

- Program started in 1987.
- One condom is available through medical provider upon request.
- Consensual sex is prohibited; medical providers required to report disclosures of sex.
- Medical providers review safe sex, condom use, STI education.
- Text of “PREA & Staff Sexual Misconduct – Vermont Facilities”
 - “Can I get a condom?
 - Yes. Medical has condoms and will give them out if you ask for them. Health Services will review the importance of safe sex, use of a condom, and information about sexually transmitted diseases before giving you a condom. You may only get one condom at a time. Medical providers will not ask you what you are going to do with the condom. If you choose to tell the medical provider that you will or have engaged in any rule violating behavior to include sex, they must report it.”²³⁴

²³⁴ State of Vermont Agency of Human Services Department of Corrections (2012; current) *Prison Rape Elimination Act (PREA) & Staff Sexual Misconduct – Vermont Facilities* <https://doc.vermont.gov/about/policies/rpd/for-comment/prison-rape-elimination-act-prea-staff-sexual-misconduct-2013-vermont-facilities/view?searchterm=condom>

California

- Pilot program began in one state prison 2008-2009.²³⁵
- Conclusions from pilot program
 - “We found no evidence that providing condoms posed an increased risk to safety and security or resulted in injuries to staff or inmates in a general population prison setting. Providing condoms from dispensing machines is feasible and of relatively low cost to implement and maintain. Providing condoms would likely reduce the transmission of HIV, STDs, and hepatitis in CDCR prisons, thereby reducing medical costs in both CDCR and the community. Very few HIV infections (2.7 to 5.4) would need to be prevented for a cost-neutral program.”²³⁶
- Full-scale program started in 2014. Assembly Bill No. 966 “Prisoner Protections for Family and Community Health Act, 2014” mandated 5-year implementation plan across 34 state prison facilities.²³⁷
- Health agencies and non-profits allowed to provide condoms.
- Condom-dispensing machines located in semi-private areas.

²³⁵ Lucas et al., 2011.

²³⁶ Ibid.

²³⁷ California Penal Code Part 3 Ch 10.9 § 6500 (Chapter 10.9 added by Stats. 2014, Ch. 587, Sec. 2)

CITY / DISTRICT CASE STUDIES²³⁸

Los Angeles County Jail

- Program started in 2001.²³⁹
- Originally only distributed condoms to self-declared gay inmates,²⁴⁰ who were housed in a segregated unit for gay men.²⁴¹
- Consensual sex in prison is illegal under California law.²⁴²

San Francisco

- Program started in the 1980s.²⁴³
- There are a dozen condom machines placed in semi-private areas of jails.
- No limit on number of condoms that can be taken from machines.
- According to the Sheriff's Department, initial concerns about increased consensual sex and sexual assault have not materialized since the program has been in place.
- San Francisco model influenced the author of the California bill (Assembly Bill No. 966) Assemblyman Rob Bonta.
- Consensual sex in prison illegal under California law.²⁴⁴

²³⁸ In addition to the cities described here, the New York City Department of Corrections (NYC DOC) is reported to make condoms available in city jails. We sought to confirm this with the NYC DOC and the New York Civil Liberties Union. We did not hear back from either organization. Fine Maron D (2013, September 18). Condoms behind bars: A modest proposal to cut STIs in Calif. Prisons. *Scientific American blog*. <https://blogs.scientificamerican.com/observations/condoms-behind-bars-a-modest-proposal-to-cut-stis-in-calif-prisons/?print=true>

²³⁹ Nerenberg R and Wong M (2002). *Spotlight: Condoms in Correctional Settings* The Body Pro: For the HIV/AIDS workforce. <https://www.thebodypro.com/article/spotlight-condoms-correctional-settings>

²⁴⁰ Ibid.

²⁴¹ Bloomekatz A (2009). "L.A. County sheriff considers expanding condom distribution in jail" *Los Angeles Times*

²⁴² Section 286(e) California Penal Code

²⁴³ Basheda V (1989). "Condoms Handed Out to S.F. County Jails Inmates" *Los Angeles Times*.

²⁴⁴ Lavender G, 2014

²⁴⁵ Davis M (2006). *Fact Sheet in support of HB 686 AIDS Foundation of Chicago*

²⁴⁶ City of Philadelphia Philadelphia Prison System (2019). *Inmate Handbook* http://www.philadelphiabar.org/WebObjects/PBAReadOnly.woa/Contents/WebServerResources/CMSResources/PPS_Inmate_Handbook.pdf

²⁴⁷ Davis M, 2006

²⁴⁸ Washington D.C. Department of Corrections (2016). *INMATE HANDBOOK* (2015-2016) <https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DOC%20PS%204020.1C%20Inmate%20HandBook%202015.pdf>

²⁴⁹ May JP, Williams EL Jr (2002). "Acceptability of condom availability in a U.S. jail." *AIDS Educ Prev* 14(5 Suppl B):85-91

²⁵⁰ HIV Law Project (2014) *HIV PREVENTION IN PRISONS* <http://hivlawproject.org/wp-content/uploads/2014/11/Condoms-in-Prison-Bibliography-FINAL.pdf>

Philadelphia

- Condom Availability Program started in late 1980s; revitalized in 2006.²⁴⁵
- Supported by the Philadelphia Public Health Department AIDS Coordinating Office.
- Inmates are permitted to be in possession of six unopened condoms in their living quarters. They are responsible for the proper disposal of used condoms. Condoms are not treated as contraband.
- “Inmates are prohibited from engaging in sexual acts. Inmates observed in sexual acts will be issued an Inmate Misconduct Report. However, sexual acts do occur within prisons, so condoms are available for the inmate population at the following designated locations throughout the facility:
 - Medical Intake
 - Medication windows
 - Treatment/triage areas
 - Physician Sick Call rooms
 - AACO Health educators’ offices
 - Commissary
 - Prison Aids Project staff
- Health educators conduct health education programs and make lubricated condoms available for inmates along with prevention brochures
- Inmates (male and female) may purchase up to six condoms at one time from Commissary²⁴⁶

Washington D.C.

- Program started in 1993²⁴⁷
- “Condoms may be obtained during medical intake, at sick call, during medical visits, when participating in your discharge planning interview and at release. DOC strictly prohibits sexual activity between inmates, inmates and staff, and inmates and any other person working in, volunteering, or visiting the facility. However, as an added health precaution, condoms will be provided when requested.”²⁴⁸
- Consensual sex is prohibited
- Survey conducted to assess opinions²⁴⁹
 - 55% prisoners support
 - 87% correctional staff support

For more information on condoms in prison, see the following annotated bibliography:
HIV Law Project (2014), *HIV Prevention in Prisons*.²⁵⁰

PRIVACY AND CONFIDENTIALITY: RIGHTS AND RESPONSIBILITIES

While in a custodial setting, inmates have limited rights to privacy under the due process clause.²⁵¹ However, they still maintain basic privacy rights protecting information regarding their sexual orientation and gender identity (SOGI). Although information about an inmate's SOGI status acquired during intake is valuable in assessing vulnerability, this information should not become general knowledge among staff members or the inmate population. This information must be appropriately managed in order to respectfully protect the privacy of all inmates.

Information Management

It is critically important that correctional officers protect personal information, including sexual orientation, gender identity and HIV status of inmates within their institution. Courts have recognized that disclosure of an inmate's sexual orientation without a legitimate penological reason is clearly unconstitutional.²⁵² A good practice to manage information regarding sexual orientation and identity information should be to develop policies regarding confidentiality of patient information. These policies should identify the personnel that are to be included in the disclosures of various forms of information in order to prevent unnecessary spread of an inmate's personal information.²⁵³

Staff Need-to-Know

The information that is collected during intake can and should be used in making decisions for housing, security, and programming needs. These measures can be achieved without enlightening the entire prison staff to the sexual preferences and gender identity of inmates. The individuals performing the intake vulnerability assessment should proceed according to internal policy that reflects state laws dictating confidentiality. Correctional officers do not need to know the sexual orientation and surgical history of LGBTI inmates in order to respectfully interact with them in a custodial setting.

**Correctional officers do not need
to know the sexual orientation and
surgical history of LGBTI inmates in
order to respectfully interact with
them in a custodial setting.**

²⁵¹ Smith et al., 2015

²⁵² Powell v. Shriver, 175 F.3d 107 (2d Cir. 1999). See also, *Doe v. Delie*, 257 F.3d 309, 317 (3d Cir. 2001) (holding that inmates have a privacy interest in HIV status).

²⁵³ The Moss Group (2012). *A Quick Guide for LGBTI Policy Development for Adult Prisons and Jails*. Washington, DC: National Institute of Corrections. U.S. Department of Justice.

GROUP INMATE MANAGEMENT

This section is adapted from information provided in *Standing with LGBT Prisoners: An Advocate's Guide to Ending Abuse and Combating Imprisonment* by Jody Marksamer and Harper Jean Tobin, and NIC's *Policy Review and Development Guide: Lesbian, Gay, Bisexual, Transgender, and Intersex Persons in Custodial Settings Second Edition* (2015) written by Brenda Smith and Jaime Yarussi.

Search policy

Policies must be in place to ensure facility staff members follow procedure when administering pat downs and strip searches of LGBTI inmates. Strip searches can be especially humiliating for transgender and intersex inmates, and must be done in the most respectful and professional way possible. A number of federal court rulings have ruled that voyeuristic strip searches of transgender inmates by prison staff violate the Eighth Amendment's prohibition against cruel and unusual punishment.²⁵⁴ PREA standards prohibit cross-gender searches except in emergency situations and by medical personnel. Cross-gender pat-downs of female inmates are also prohibited.²⁵⁵ While NIC has not issued a best practice for searches of adult transgender inmates, the National Center for Transgender Equality suggests that transgender inmates be allowed to designate the gender of the corrections officer they prefer to do the search.²⁵⁶ This is the policy of the Massachusetts Department of Youth Services for both transgender and intersex youth.²⁵⁷ The gender preference of the corrections officer who will perform the search can be designated on an intake form alongside preferred name and pronoun (see Appendix A). It is vitally important to consider the safety and wishes of the inmate in order to improve the atmosphere of the facility as a whole.

There are many other private situations, such as when a prisoner must submit a urine test, where staff may need to view inmates' nudity in some form. In these situations, it is important to know and adhere to the needs of the inmate. Facilities must include provisions for these situations that limit cross-gender viewing so that staff members will treat transgender prisoners in alignment with their gender identity.

²⁵⁴ Smith et al., 2015

²⁵⁵ 28 C.F.R. § 115.15.

²⁵⁶ Marksamer & Tobin, 2014

²⁵⁷ Massachusetts Department of Youth Services. Policy of harassment and discrimination against youth. Policy # 03.04.09. Effective date: July 1, 2014. <https://docs.digital.mass.gov/dataset/030409-prohibition-harassment-and-discrimination-against-youth>.

**POLICY EXCERPT FROM THE DISTRICT OF COLUMBIA
METROPOLITAN POLICE DEPARTMENT—
GENERAL ORDER PCA 501-02— OCTOBER 16, 2007**

- a. When an arresting officer has reason to believe that the arrestee is a transgender individual, before searching that individual prior to transport to the station, the officer shall:
 - (1) Specifically inform the arrestee that he/she must, and will be, searched before being placed in a transport vehicle;
 - (2) Ask the arrestee if he/she has any objections to being searched by a male or female officer; and
 - (3) If the prisoner does object, inquire as to the nature of the objection.
- b. If the arrestee states an objection to either the male or female gender, then, absent exigent circumstances, the arresting officer shall:
 - (1) Ask an officer who is of the gender requested by the arrestee to conduct the search; and
 - (2) Document the arrestee's objection (either by writing it in his or her notebook or by advising the dispatcher over the radio), indicating that he/she requested to be searched by a male/female officer (specifically indicating the stated preference).

Commissary

It is important for transgender inmates to have access to clothing and personal items, such as make-up, in accordance with their gender identity, as long as it does not interfere with their safety or the safety of the institution. Correctional facilities will need to consider which specific clothing and personal items to make available, and which to restrict based on the safety needs of the inmates.

Transgender prisoners should be allowed to express their gender identity and obtain certain clothing and personal items that align with their gender identity. However, it is important to balance respect for inmates' gender identity with safety for those in protective coupling relationships when considering which items inmates will be allowed to obtain.

Communication between inmates

Staff should always use respectful language and terminology when interacting with prisoners to help create an affirming environment for LGBTI inmates. This includes using the preferred name and pronoun for transgender and intersex inmates, and never using terms such as "it" or "he-she." These terms are dehumanizing and hurtful to already vulnerable inmates, as well as other staff and inmates who have a transgender family member or close friend. If staff members use disrespectful language or incorrect terminology, they should be held accountable for their mistakes. This helps to set a positive example to encourage respectful communication between inmates.

If inmates frequently see or overhear staff members disregard the nondiscrimination policies by using disrespectful or demeaning language, the inmates will likely also disregard the non-discrimination policies. This could lead to disrespectful communication between inmates, which could escalate to create

safety concerns within the facility. Inmates should also be educated regarding existing nondiscrimination policies, including any policies relating to the use of demeaning or derogatory language in relation to LGBTI prisoners, and inmates should be held accountable appropriately when they violate these policies. Furthermore, inmates should be educated regarding use of proper pronouns and preferred names if they will be interacting with transgender prisoners.

Of course, staff will not be able to completely control how inmates communicate with each other all the time, but adhering to the non-discrimination policies regarding respectful communication, educating inmates about these policies, and holding inmates and other staff members accountable for violations of the policy are all good steps towards fostering respectful communication.

Visitation rules

Prisons should not have different visitation rules and policies for heterosexual and same-sex partners of inmates. Courts have ruled that it is discriminatory and unconstitutional for correctional facilities to prohibit visits or impose restrictions on affection by same-sex partners where the same restrictions do not apply to heterosexual partners. For example, in *Doe v. Sparks*, the court declared a prison's policy of denying visitation with same-sex partners to be constitutionally invalid.²⁵⁸ In addition, in *Whitmire v. Arizona*, a ninth circuit court denied a prison's motion to dismiss a challenge to the state's ban on same-sex hugging and kissing between inmates and visiting partners, rejecting the notion that the policy was a "common sense" regulation for prison security.²⁵⁹ In order to avoid making discriminatory and unconstitutional visitation policies, correctional facilities should enact the same rules regarding visitation and shows of affection between inmates and all visiting partners, whether same-sex or different sex.

²⁵⁸ *Doe v. Sparks*, 733 F. Supp. 227 (W.D. Pa. 1990).

²⁵⁹ *Whitmire v. State of Arizona*, 298 F.3d 1134 (9th Cir. 2002).

Showering and restrooms

Policies regarding use of the facilities—bathrooms, showers, etc.—should be focused on protecting the privacy, dignity, and safety of LGBTI inmates. Transgender inmates in particular are likely to face privacy and safety concerns when showering, changing, or using multi-user bathrooms. As such, specific policies need to be made regarding these activities to avoid subjecting transgender prisoners to unnecessary risk of physical or emotional harm. Decisions regarding use of the bathrooms and showers will need to be made on an individualized basis. For example, in a facility with separate, individual stalls for toilets and showers, transgender inmates may feel that they already have the level of privacy and security that they desire.

In facilities where transgender inmates feel that they are at risk while using the bathroom or showers, staff members should work with the transgender inmates to determine the best solution for accessing the bathrooms and showers. This could mean giving transgender inmates the option of using the bathrooms or showers at a different time than the rest of the inmates, or allowing transgender inmates to use bathrooms in a medical unit or somewhere else that may provide more privacy. However, it should be noted that singling out a transgender inmate by giving them private bathroom and shower time may also make the transgender inmate an isolated target for abuse. In addition, what works for one transgender inmate may not work for another. Overall, it is imperative to consult with any transgender inmates in order to develop an individualized plan for accessing showers and bathrooms in which the transgender inmates feel safe and secure.





STAFF TRAINING

New policies addressing the LGBTI population, nondiscrimination, and harassment should be updated and implemented in correctional facilities to protect LGBTI inmates or inmates who are perceived to be LGBTI. Staff should address the goals of the policy, outline how to manage LGBTI inmates in a respectful and nondiscriminatory way, and explicitly state how to respond to and prevent abuse against LGBTI inmates.²⁶⁰ It is especially important to train employees to understand the difference between giving special treatment to the LGBTI population, which is both unfair and leaves them vulnerable to additional harassment, and being culturally competent in the unique needs of LGBTI prisoners.

Staff, contractors, volunteers, management, and supervisors should be aware of new nondiscrimination and non-harassment policies as part of the policy's implementation process. Staff members should receive copies of the policy at work and be able to review copies online as well. Staff compliance is critical, since they work closely with inmates and set expectations for inmate behavior.

Staff must also be able to measure compliance during evaluation procedures. Staff members who are not as compliant or competent with new policies should receive extra training, supervision, and other individualized support. When making decisions surrounding promotion and termination, policy compliance must be taken into consideration. Procedures should be in place to ensure that contractors and volunteers are informed of the nondiscrimination and non-harassment policies and are required to abide by them when working with or in the facility.

Policies must be routinely reviewed in order to ensure that they are being complied with and are still in alignment with other laws as well as provide opportunities for improvement.

²⁶⁰ Marksamer & Tobin, 2014

PREA GUIDELINES STATE:

§ 115.31 Employee training.

- (a) The agency shall train all employees who may have contact with inmates on:
 - (1) Its zero-tolerance policy for sexual abuse and sexual harassment;
 - (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
 - (3) Inmates' right to be free from sexual abuse and sexual harassment;
 - (4) The right of inmates and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
 - (5) The dynamics of sexual abuse and sexual harassment in confinement;
 - (6) The common reactions of sexual abuse and sexual harassment victims;
 - (7) How to detect and respond to signs of threatened and actual sexual abuse;
 - (8) How to avoid inappropriate relationships with inmates;
 - (9) How to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming inmates; and
 - (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.
- (b) Such training shall be tailored to the gender of the inmates at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male inmates to a facility that houses only female inmates, or vice versa.
- (c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.
- (d) The agency shall document—through employee signature or electronic verification—that employees understand the training they have received.

§ 115.32 Volunteer and contractor training.

- (a) The agency shall ensure that all volunteers and contractors who have contact with inmates have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.
- (b) The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with inmates, but all volunteers and contractors who have contact with inmates shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.
- (c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

§ 115.33 Inmate education.

- (a) During the intake process, inmates shall receive information explaining the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.
- (b) Within 30 days of intake, the agency shall provide comprehensive education to inmates either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.
- (c) Current inmates who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the inmate's new facility differ from those of the previous facility.
- (d) The agency shall provide inmate education in formats accessible to all inmates, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to inmates who have limited reading skills.
- (e) The agency shall maintain documentation of inmate participation in these education sessions.
- (f) In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to inmates through posters, inmate handbooks, or other written formats.

§ 115.34 Specialized training: Investigations.

- (a) In addition to the general training provided to all employees pursuant to § 115.31, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.
- (b) Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.
- (c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.
- (d) Any State entity or Department of Justice component that investigates sexual abuse in confinement settings shall provide such training to its agents and investigators who conduct such investigations.

§ 115.35 Specialized training: Medical and mental health care.

- (a) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:
 - (1) How to detect and assess signs of sexual abuse and sexual harassment;
 - (2) How to preserve physical evidence of sexual abuse;
 - (3) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and
 - (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.
- (b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.
- (c) The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.
- (d) Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.31 or for contractors and volunteers under § 115.32, depending upon the practitioner's status at the agency.²⁶¹

²⁶¹National PREA Resource Center (2012). *Prisons and Jail Standards*. <http://www.prearesourcecenter.org/training-technical-assistance/prea-101/prisons-and-jail-standards>



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GLOSSARY

LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND INTERSEX INITIATIVE

Asexual: A person who is not romantically or sexually attracted to another person of any gender.

Bisexual: A person who is romantically or sexually attracted to both males and females.

Cross dresser: A person who wears clothing, jewelry, and/or makeup not traditionally associated with their anatomical sex, and who generally has no intention or desire to change their anatomical sex.

Gay: Exclusively attracted to others of the same sex. Most commonly used to refer to men who are attracted to other men, but may also be used to refer to women who are attracted to other women (lesbians).

Gender: A socially constructed concept classifying behavior as either “masculine” or “feminine,” unrelated to one’s genitalia.

Gender conforming: When gender identity, gender expression and sex assigned at birth “match” according to social norms.

Gender dysphoria: The formal diagnosis used by clinicians to describe persons who experience significant discontent with the sex they were assigned at birth and/or their gender roles associated with that sex. According to the American Psychiatric Association,

“Gender dysphoria involves a conflict between a person’s physical or assigned gender and the gender with which he/she/they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender.”²⁶²

Gender expression: A person’s external expression of their gender identity, including appearance, dress, mannerisms, speech, and social interactions.

Gender identity: Distinct from sexual orientation and refers to a person’s internal, deeply felt sense of being male, female or something else.

Gender non-conforming: Gender characteristics or behaviors that do not conform to those typically associated with a person’s biological sex.

Gender nonbinary: Gender nonbinary people are individuals whose gender identity falls outside the traditional gender binary of male and female.

Gender “norms”: The expectations associated with “masculine” or “feminine” conduct, based on how society commonly believes males and females should behave.

Gender variant behavior: Conduct that is not normatively associated with an individual’s biological sex.

Heterosexual: Sexual or romantic attraction to the opposite sex.

Homosexual: A clinical terms for sexual, emotional, or romantic attraction to persons of the same sex. This term is increasingly viewed as derogatory, in part due to its historically negative context. Because some may find it offensive, it is not recommended for use. “Gay” is a preferable term that means the same thing.

Intersex: An uncommon condition in which a person is born with external genitalia, internal reproductive organs, chromosome patterns, or an endocrine system that does not fit typical definitions of male or female.

LGBTI: Acronym for a group of sexual minorities including lesbian, gay, bisexual, transgender, and intersex individuals. Many variations of this acronym may be used depending on context.

Lesbian: Commonly refers to women typically attracted to other women (the term “gay” may also be used to describe these individuals).

Nonbinary: Nonbinary people are individuals whose gender identity falls outside the traditional gender binary of male and female.

Queer: Historically a negative, derogatory term, it has been reclaimed by some LGBT individuals particularly among youth. Its use is not recommended, especially in a professional environment.

Questioning: An active process in which a person explores his or her own sexual orientation or gender identity and questions the cultural assumptions that they are heterosexual or gender conforming. LGBTQ or LGBTQI is often associated with adolescents and young adults.

Sex: The designation of a person as either male or female based on anatomical make-up, including genitalia, chromosomes, and reproductive system.

Sexual and gender minority (SGM): A new term that often serves as a synonym for LGBTQI.

Sexual orientation: An enduring personal quality that inclines people to feel romantic or physical attraction to persons of the opposite sex or gender, the same sex or gender, or both.

SOGI: Acronym for sexual orientation and gender identity.

Transgender: An umbrella term for persons whose gender identity differs from their assigned sex at birth.

Transgender girl/woman: A person whose birth sex was male but who understands herself to be female and desires to live her life as a female.

Transgender boy/man: A person whose birth sex was female but who understands himself to be male and desires to live his life as a male.

Transition: Sometimes used to describe the process people go through to change their gender expression or physical appearance. May refer to everything from changing identity documents to medical intervention (e.g., hormones, surgery).

Transsexual: A person whose physical anatomy does not match his or her gender identity, and seeks medical treatment (sex reassignment surgery or hormones). May be used interchangeably with “transgender” depending on the context.

Transvestite: A person who mainly cross dresses for pleasure in appearance and sensation.

Two Spirit: A term used by some Native Americans (American Indians or Alaska Natives) to identify LGBTI and gender variant persons within their community. Historically, in some cultural traditions such as the Navajo, Two Spirit people were viewed as privileged and sacred.

²⁶² <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>

APPENDIX A: Example of Transgender Prisoner Preference Form

BOSTON POLICE DEPARTMENT

STATEMENT OF SEARCH PREFERENCE FORM

(This form is to be used when booking transgender individuals)

TO BE COMPLETED BY THE BOOKING OFFICER

Booking Name: _____

Legal Name: _____

C.R. Number: _____

Preferred Name (if different from master/legal name):_____

Preferred Pronoun (i.e. he/she):_____

TO BE COMPLETED BY PRISONER

For the purpose of searches conducted while in the custody of the Boston Police Department, I prefer to be searched by an officer of the gender indicated below. I understand that my preference will be respected unless there is no appropriate individual available and failure to conduct a search would jeopardize the safety of other prisoners or officers.

Female _____ Male _____

Prisoner Signature: _____

Date: _____

Witnessing Officer(s) Signature(s) _____

TO BE COMPLETED BY BOOKING OFFICER

1. Name: _____ ID#: _____

Signature: _____ Date: _____

2. Name: _____ ID#: _____

Signature: _____ Date: _____

APPENDIX B: Massachusetts General Laws

c.127 § 32A, Prisoner Gender Identity

UPDATES

Added by St.2018, c.69, §91, effective December 31, 2018

Section 32A

A prisoner of a correctional institution, jail or house of correction that has a gender identity, as defined in section 7 of chapter 4, that differs from the prisoner's sex assigned at birth, with or without a diagnosis of gender dysphoria or any other physical or mental health diagnosis, shall be: (i) addressed in a manner consistent with the prisoner's gender identity; (ii) provided with access to commissary items, clothing, programming, educational materials and personal property that is consistent with the prisoner's gender identity; (iii) searched by an officer of the same gender identity if the search requires an inmate to remove all clothing or includes a visual inspection of the anal cavity or genitals; provided, however, that the officer's gender identity shall be consistent with the prisoner's request; and provided further, that such search shall not be conducted for the sole purpose of determining genital status; and (iv) housed in a correctional facility with inmates with the same gender identity; provided further, that the placement shall be consistent with the prisoner's request, unless the commissioner, the sheriff or a designee of the commissioner or sheriff certifies in writing that the particular placement would not ensure the prisoner's health or safety or that the placement would present management or security problems.



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