The Development of a University-Based Specialty Program for State Prisoners with Gender Dysphoria

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Educational Goals & Objectives

By the end of the seminar/presentation, participants will be able to:

1) Identify essential DSM-5 diagnostic criteria related to gender dysphoria [(GD) formerly known as gender identity disorder]

2) Describe the history and current landscape of GD and transgender issues, to include relevant legal issues, within correctional settings

3) Highlight the clinical presentation, diagnostic evaluation, and treatment needs of incarcerated individuals with GD

4) Demonstrate an understanding of correctional barriers and evaluation and treatment challenges and opportunities
Brief Overview of the Texas Correctional Managed Health Care Program
What is Correctional Managed Health Care?

- **A Strategic Partnership between:**
  - The Texas Department of Criminal Justice
  - The University of Texas Medical Branch at Galveston
  - Texas Tech University Health Sciences Center

- **Focused upon a shared Mission:**
  - To develop a statewide health care network that provides TDCJ offenders with timely access to a constitutional level of health care while also controlling costs

- **Managed by a statutorily established body:**
  - The Correctional Managed Health Care Committee
Geographical Areas of Responsibility

Approximately 31,884 Offenders

Approximately 123,863 Offenders
Key Challenges for the CMHC System Today

- Maintain a constitutional level of care while facing significant resource needs

- Significant resource needs being driven by:
  - Increases in TDCJ overall population
  - An even more rapid growth in the aging offender population
  - Pent-up demand and changing standards of care, especially for infectious diseases such as HIV, Hepatitis C and mental illnesses
  - A shortage of medical professionals, especially nursing staff
  - Service equipment needs

- Increasing the financial accountability of the program- the 84th Texas Legislature appropriated $905,602,195 for offender health care in the Texas Department of Criminal Justice
Clinical Challenges

- Offender Population in Texas Prisons now over 150,000
- Increased Prevalence of HIV, TB, Hepatitis B and C, and other Communicable Diseases
- Offender special and chronic health care needs – dialysis, oncology, mental health, women’s health, rehab
- Aging Population (Geriatric Medicine)
- Offender Patient Compliance Issues
Phenomenology of Gender Dysphoria (GD)
DSM-V Criteria

Gender Dysphoria – Adults

- Incongruence between experienced/expressed gender and assigned gender
  - (2 indicators)
    - Incongruence between experienced/expressed gender and primary and/or secondary sex characteristics
    - Desire to get rid of primary and/or secondary sex characteristics because of an incongruence with one’s experienced/expressed gender
    - Desire for primary and/or secondary sex characteristics of other gender
    - Desire to be other gender
    - Desire to be treated as other gender
    - Has typical feelings and reactions of the other gender

- Distress and impairment in social, occupational or other areas of functioning
Gender Dysphoria (GD)

- DSM-5: “A marked difference between the individual’s expressed/experienced gender and the gender others would assign him or her”
  - Must continue for at least 6 months
  - Must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
Not Otherwise Specified (NOS) Gender Dysphoria

- Symptom criteria for gender dysphoria
- Time frame less than 6 months
# Epidemiology: Non-Incarcerated Populations (Meier et al 2013)

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Epidemiology: Using Broader Definition Non-Incarcerated Populations (2014)

- Conway 2002; 0.05%
- Williams Institute (Gates 2011): 0.3%
- National Transgender Advocacy Coalition 2-3%
- Iran 0.12 to 0.18%
Epidemiology: Incarcerated Populations

- Prevalence remains largely unknown
- No current data on incarcerated populations
Associated Mental Illness: Morbidity and Mortality

- Depression - suicide
- Bipolar
- History of abuse and neglect
- Social Anxiety
- Substance abuse
- Asperger's Syndrome (autism Spectrum Disorder)
- Eating disorder
- Adjustment disorders
- Family rejection
- Self-injury/self-mutilation
Veterans with GD (Transgendered)

VA: Largest health system in US
Sample size of 5135 (treated at VA between 1996-2013)

Results:
- More likely to have been homeless
- Reported sexual trauma while on active duty
- **Incarceration (Is GD/transgender a risk for incarceration?)**

Brown GR, Jones KT. Mental Health and Medical Health Disparities in 5135 Transgender Veterans Receiving Healthcare in the Veterans Health Administration: A Case-Control Study. LGBT Health 2015
Cultural Influences in Presentation

- India - Hijra
- Papua New Guinea - Sambia
- Native American - berdaches; shaman
- Samoa - fa’affine and fa’afatama
- Tonga - fakaleiti
- Myanmar (Burma) – acault
Age of Gender Awareness

- 18 – 24 months: gender determined (John Money)
- Age 2: 4 out of 5 children give correct gender
- Age 3: 4 out of 5 children pick correct adult outcome
Treatment Issues: Gender Dysphoria
History

- 1952 Christine Jorgensen surgery
- 1963 Harry Benjamin, M.D., popularized term transsexualism
- 1965 Open Johns Hopkins Clinic
- 1978 Harry Benjamin International Gender Dysphoria Association is formed
- 1979 Paul Walker Ph.D. authored 1st Standards of Care
- 2011 7th edition Standards of Care of WPATH
- 2009 Guidelines done by Endocrine Society
- Both groups are now revising their standards of care
World Professional Association for Transgender Health (WPATH)

- Originally Harry Benjamin International Gender Dysphoria Association
- Multidisciplinary society of individuals committed to the care of individuals with gender identity concerns
- Membership: 598
- Countries: 31
- Biennial meetings: next June 15-17, 2016 in Amsterdam, Netherlands.
- Standards of Care based on Research Data Available and Consensus
Elements of Treatment

- Evaluate and Establish the Diagnosis
- Psychotherapy/Psychiatric treatment if needed
- Real life experience in the desired gender role
- Hormones of the desired gender
- Surgery to change the genitalia and other sex characteristics toward or to the desired gender
Real-life Experience

- Function in the community in new gender role
  - Full or part-time employment;
  - As a student;
  - In community-based volunteer activity
  - How can you do this in prison?

- Acquire a (legal) gender-identity appropriate first name

- Provide documentation that persons other than the therapist know that the patient functions in the desired gender role
Bath Room Issue

- School
- Work
- Public
- Letter to protect the patient
Real Life Experience in Prison

- Clothing
- Grooming
- Cosmetics
- Jobs
Sequence of Transition

- Hormones
- Real Life experience
- Legal recognition in new gender
- Surgery
Tasks of the Mental Health Professional

1. Diagnose the individual's gender disorder
2. Diagnose any co-morbid psychiatric conditions and see to their appropriate treatment
3. Counsel the individual about the range of treatment options and their implications
4. Engage in psychotherapy
5. Ascertain eligibility and readiness for hormone and surgical therapy
Tasks of the Mental Health Professional (cont)

6. Make formal recommendations in writing to medical and surgical colleagues
7. Be a colleague on a team of professionals with an interest in the gender identity disorders
8. Educate family members, employers, and institutions about gender identity disorders
9. Offer long term follow-up of previously seen gender patients
Tasks of MD managing Hormones

- Provide diagnostic evaluation to establish current endocrinologic status and the presence of any intersex condition
- Decrease hormone of birth sex
- Establish hormones of desired gender
- Monitor patient for side effects and interactions of hormone therapy with the patient’s medical condition
Hormone therapy for Adults
Eligible criteria

- Fulfill DSM 5 criteria
- Do not suffer from psychiatric co-morbidity that interferes with the diagnostic work up or treatment
- Demonstrate knowledge and understanding of the expected outcomes for hormone treatment as well as the medical and social risks and benefits
- Have experienced a documented Real life experience or psychotherapy for at least 3 months
Hormone therapy for Adults readiness criteria

- Has had further consolidation of gender identity during a real life experience or psychotherapy
- Has made some progress in mastering other identified problems leading to improvement or continuing stable mental health
- Is likely to take hormones in a responsible manner
Specific Hormone Goals

- Achieve normal adult sex hormone levels
- For MTF, that is adult female testosterone levels and adult female estrogen levels
- For FTM, that is adult male testosterone levels and adult male estrogen levels
Other Tasks of the MD managing the Hormones

- Monitor the patient for general physical health
- Monitor the patient for side effects of hormonal medications
- Long term medical follow-up
Gender Dysphoria and the Courts: A Legal Framework

- Right to access care
- Right to a professional medical judgment
- Right to the care that is ordered
Gender Dysphoria (GD)

- Is this a medical condition, or a lifestyle choice?
- Does every transgender inmate have GD?
  - Must be diagnosed
- Is GD a “serious medical need”?
  - Meriwether v. Faulkner, 821 F.2d 408, 413 (7th Cir. 1987)
Special Risks of Harm

- Common targets for violence
- Physical abuse, sexual assault, rape
  - Predatory inmates
- Harassment by inmates or correctional staff
- Higher risk for depression, suicide

- “placing a young, nonviolent woman within a violent male population”
  - “Should have known” she would be vulnerable
- Landmark holding: failure to prevent inmate attacks is deliberate indifference only if the corrections officials are criminally reckless

- Did the warden know there was a substantial risk of serious harm to her safety?
  - Never expressed safety concern
    - Established basic standard for deliberate indifference
- Generated PREA
“Because inmate-patients may be under different stages of care prior to incarceration, there should be no blanket administrative or other policies that restrict specific medical treatments of transgender people. Policies that make treatments available only to those who received them prior to incarceration or that limit GID treatment to psychotherapy should be avoided.”

- Freeze-frame policy
  - Inmates receiving hormone therapy prior to incarceration will continue to receive hormone therapy
  - Inmates not receiving hormone therapy prior to incarceration will not receive hormone therapy

“The healthcare decision was neither made by a medical professional nor based upon medical considerations”

“Inmate medical care must be based upon an individual professional evaluation, not a blanket rule”

- Updated BOP policy
  - Inmates receiving hormone therapy prior to incarceration will continue to receive hormone therapy *at the levels maintained prior to incarceration*
  - Inmates not receiving hormone therapy prior to incarceration *must obtain 2 things before starting hormone therapy:*
    - Diagnosis
    - Approval from medical director
Kosilek v. Spencer,

- Psychotherapy, hormones, and laser hair removal were not enough to relieve her anxiety or depression
- 2012 – landmark U.S. district court ruling: Kosilek is entitled to taxpayer-funded SRS as treatment for severe GD
- Massachusetts appealed

Federal Appeals Court Overturns Sex Change Surgery Ruling For Convicted Killer Kosilek
By Denise Lavoie, AP Legal Affairs Writer
December 16, 2014 1:26 PM

1st Circuit
- Maine
- Massachusetts
- New Hampshire
- Puerto Rico
- Rhode Island

Supreme Court petitioned to hear trans inmate’s lawsuit

An LGBT group has petitioned the U.S. Supreme Court to hear a trans inmate's lawsuit. (Washington Blade photo by Michael Key)

Supreme Court rejects inmate's appeal for sex-change surgery

BY MARK PRATT, ASSOCIATED PRESS May 4, 2015 at 3:04 PM EDT

Photo of U.S. Supreme Court building in Washington, D.C., by Chip Somodevilla/Getty Images
Federal Judge: California Must Provide Trans Inmate with Access to Gender-Affirming Surgery

A federal judge has ruled that a transgender inmate in California affirming surgery that her prison doctors have deemed medically

Governor allows parole for transgender California inmate

BY MITCH KELLAWAY  APRIL 06 2015 3:19 PM ET

Photo: Associated Press

This March 20, 2014 photo provided by the California Department of Corrections and Rehabilitation shows Michelle-Lael Norsworthy. A federal judge on Thursday, April 2, 2015, ordered California’s corrections department to provide the transsexual inmate with sex change surgery, the first time such an operation has been ordered in the state. (AP Photo/California Department of Corrections and Rehabilitation.)
Quine v. Brown,
N.D.Ca. 14-cv-02726-JST (PR)

In a first, California agrees to pay for transgender inmate's sex reassignment

Taxpayers to Pay for Murderer's Sex Change Operation

Rodney Quine was convicted of first-degree murder, kidnapping and robbery.

Originally posted on the Long Beach, CA Patch

By BEA KARNES (Patch Staff)  August 11, 2015
Gender Dysphoria: Policy Revision and Program Development
How Did TDCJ Respond?

- TDCJ Correctional Managed Care created a multidisciplinary working group comprised of physicians, nurses, pharmacists, and administrators
- Previous policy was edited/modified to more accurately reflect community standards
- World renowned gender dysphoria expert at UTMB increased access for this population
- New GD Policy approved in August 2015
- Specialty referral process was created to improve primary care physicians’ understanding of their role at the units
Correctional Managed Healthcare Gender Dysphoria Program

Offender presents with suspected GD → Offender sees unit PCP → Physical exam conducted by PCP → Already on hormone therapy (HT)?

- Yes → Unit PCP continues patient on HT (enters dx code ROGD in Pearl) → Indefinite approvals entered for HT
- No → GD Lab panel** ordered by PCP → Obtain freeworld records from treating and diagnosing FW provider (if applicable) → Obtain Release of Information from patient

QMHP Conducts MH eval (to rule out all other acute psych conditions) → Referred to Mental Health Dept → PCP enters routine referral to GD Specialty consultant at HG (MSRS code GDIC) → Pt transported to Spec Clinic Appt ** → Diagnosis verified by UTMB GD consultant?

- Yes → GD Consultant finalizes GD dx in Pearl to 302.85 (ICD9) → Return per GD consultant recommendation
- No → No diagnosis

Pt referred to unit MH caseload

** Labs include:
1. FSH
2. LH
3. Testosterone (Total)
4. Estradiol
5. Prolactin
6. Lipids
7. Metabolic comprehensive panel
8. CBC

** Note: Unless patient suffers from suspected acute MH disorder in which they could harm themselves or others, they will be transported to specialty clinic appt.

Revised: 8/26/15
Gender Dysphoria: Unit Based Operational Issues
Provider Approach

- Self-awareness of personal reaction to diagnosis
- Training/familiarity with treatment
- Unit Process
- Ultimate goal: patient care
Unit Process

- Documentation of diagnosis
- Physical exam
  - Comorbidities
- Baseline labs
- Referral to GDIC
- Hormone therapy
- Ongoing Treatment
Documentation of Diagnosis

- Self-reported, subjective
- Prior medical records
- GDIC specialty confirmation
Physical Exam

- Refusal common
- Routine physical with focus external genitalia
- Detection of comorbidities
  - Hypertension/vascular disease
  - Liver disease: alcohol, hepatitis C
  - Thromboembolic disease
- Chronic Care Clinic for medical problems
  - Physical pathology vs. hormonal effect
Baseline labs

- CBC
- CMP (comprehensive metabolic profile)
- Lipid profile
- Testosterone (total)
- Estradiol
- FSH
- LH
- Prolactin
- Others as clinically indicated
Hormone Therapy

- Prior hormone therapy:
  - Documented
  - Prescribed or not
- Non-formulary
- Consent for hormone therapy
- Dosing level “uncomfortable”
- Dosage adjustment
Contraindication to Hormone Therapy for MTF

- Thromboembolic disease secondary to clotting abnormality
- Macroprolactinoma
- Severe liver dysfunction
- Breast cancer
- Coronary artery disease
- Cerebrovascular disease
- Severe migraine headaches
Ongoing Treatment

- Housing
- Special requests
  - Bras
  - Assistive devices
- Surgical requests
  - Cosmetic procedures
  - Sex-reassignment surgery requests
Gender Dysphoria:
Referral System, Specialty Clinic Referrals/
Monitoring/Tracking Initiatives
Post-Transition Follow-up

- Hormone therapy
- Primary medical care
Non Surgical Costs

- Breast forms 100 - 2,000
- Chest binders 30 - 75
- Electrolysis 800 - 5,000
- Packers 20 - 100
- Stand to pee devices 35 - 100
- Penile prostheses 700 - 2,000
- Vocal coaching 20 - 1500
Surgical Cost Issues

- Breast Augmentation: $3,000 - $6,000
- Breast Reduction/chest: $6,000 - $10,000
- MTF genital: $18,000 - $30,000
- FTM genital: $5,000 - $75,000
- Hysterectomy: $10,000 - $20,000
- Facial feminization: $5,000 - $100,000
ABOUT FACE

The biggest barrier to treating TRANSGENDER INDIVIDUALS is a lack of understanding and acceptance in the medical community. Education and empathy can facilitate treating these unique patients.

CUSHING’S DISEASE:
Missed Diagnoses

HELPING HANDS:
Using Advanced Practitioners
References


Thank you for your time and attention

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