NO. 17-36009

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

RYAN KARNOSKI, et al.,

Plaintiffs-Appellees,

STATE OF WASHINGTON,

Intervenor-Plaintiff-Appellee,

v.

DONALD J. TRUMP, President of the United States, et al.,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT WESTERN DISTRICT OF WASHINGTON AT SEATTLE
No. 2:17-cv-01297
The Honorable MARSHA J. PECHMAN
United States District Court Judge

STATE OF WASHINGTON'S ADDENDUM

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The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI; STAFF SEARGEANT CATHERINE SCHMID; D.L., formerly known as K.G., by his next friend and mother, LAURA GARZA; HUMAN RIGHTS CAMPAIGN; and GENDER JUSTICE LEAGUE, *Plaintiffs*, v. DONALD TRUMP, in his official capacity as President of the United States; the UNITED STATES OF AMERICA; JAMES N. MATTIS, in his official capacity as Secretary of Defense; and the UNITED STATES DEPARTMENT OF DEFENSE , *Defendants*.	Case No: 2:17-cv-1297-MJP STATE OF WASHINGTON'S MOTION TO INTERVENE NOTE ON MOTION CALENDAR: October 13, 2017 ORAL ARGUMENT REQUESTED

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I. INTRODUCTION

Instead of honoring the service and commitment of transgender military service members and recruits, President Trump adopted a facially discriminatory policy targeting them. The President's directive reinstitutes an outdated and discredited policy banning military accession by openly transgender individuals, and unfairly harms current transgender service members by prohibiting the Departments of Defense ("DoD") and Homeland Security ("DHS") to pay for certain medical services. The ban constitutes undisguised sex and gender identity discrimination that serves no legitimate purpose and its implementation will have significant, damaging impacts on the State of Washington and its residents. The State of Washington ("Washington" or "State") seeks to intervene to protect its quasi-sovereign, proprietary, and sovereign interests from a policy that unconstitutionally targets transgender Washingtonians. The State's motion should be granted.

II. FACTS

A. The President Reinstituted a Ban on Military Service by Openly Transgender Individuals

On August 25, 2017, President Donald Trump issued a memorandum to the Secretaries of Defense and Homeland Security directing them to: (1) return to the military's pre-2016 policy regarding transgender service members; (2) bar openly transgender individuals from accession, or joining the military; (3) ban the use of DoD and DHS funds to provide certain medical procedures for transgender service members unless service members are already in the process of receiving such treatment; and (4) require the Secretaries of Defense and Homeland Security to issue a plan to implement the above directives, including "how to address transgender individuals currently serving in the United States military." Military Service by

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Transgender Individuals, 82 Fed. Reg. 41,319 (Aug. 30, 2017) (hereinafter "Transgender Military Service Ban").[1] *See* L. Baker Decl. ¶ 3, Ex. A.

B. Military and National Guard Service in Washington State

Washington State is home to approximately 60,000 active, reserve, and National Guard members, approximately 45,000 of whom are active duty service members. Decl. L. Baker ¶ 4, Ex. B. Washington hosts six major military installations.[2] Military service members who live and work in Washington are active participants in Washington's communities and economy. Decl. L. Baker ¶ 6, Exs. D and E at 1, 4. The military is the second largest public employer in Washington State. *See* http://www.commerce.wa.gov/growing-the-economy/key-sectors/military-defense (last visited September 24, 2017). Military members participate in our housing and consumer markets, generate sales and property tax revenue, and support businesses statewide. Decl. L. Baker ¶ 7, Exs. D and E at 1, 4. In 2013, Washington's military and defense community supported over $13 billion dollars in annual procurement across the state, representing over 3% of the state's GDP. Decl. L. Baker ¶ 8, Ex. F.

In addition to the active duty U.S. military, there are more than 8,000 citizen soldiers and airmen in the Washington National Guard. Decl. D. Postman ¶ 8; Decl. L. Baker ¶ 9; Ex. G. These Guard members are dedicated to safeguarding lives, property and the economy of Washington State. Decl. D. Postman ¶¶ 6-11; Decl. L. Baker ¶ 9, Ex. G.[3]

[1] The effective dates on the provisions of the Transgender Military Service Ban vary—the accession ban goes into effect January 1, 2018, with the remaining provisions effective on March 23, 2018. Military Service by Transgender Individuals, 82 Fed. Reg. 41319.

[2] Locations include Fairchild Air Force Base, Joint Base Lewis-McChord, Whidbey Island Naval Air Stations, Naval Bases at Everett and Kitsap, and the Thirteenth Coast Guard District. Decl. L. Baker ¶¶ 5-6; Exs. C and D at 9.

[3] However, at any time, Guard members may be called into active duty service in the U.S. military. 32 U.S.C. § 102. This occurs when there is a determination that more units are needed for national security than are in the regular components of the federal ground and air forces. *Id.* When this occurs the National Guard may be mobilized and ordered to active federal duty for as long as necessary. *Id.*

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As Commander-in-Chief of the National Guard, the Governor may deploy the Guard to state active service to respond to emergencies and disasters in Washington. Wash. Rev. Code §§ 38.04.010; 38.04.040; Decl. D. Postman ¶ 7. When the Governor deploys the Guard for state service, Guard members fall under the State's command and the State pays their wages and provides for disability and life insurance benefits related to their service. Wash. Rev. Code § 38.24.050; Decl. D. Postman ¶ 9; Decl. L. Baker ¶ 10, Ex. H. The Governor has an obligation to make sure that the National Guard conforms to all federal laws and regulations, including both state and federal constitutions, when it operates under the control of the State. Wash. Rev. Code § 38.08.010; Decl. D. Postman ¶ 4.

The Washington National Guard is an integral part of Washington's emergency preparedness and disaster recovery planning. Decl. D. Postman ¶¶ 6-11; Decl. L. Baker ¶ 9, Ex. G. Due to the State's reliance on the Washington National Guard for assistance in emergent situations, the State provides the Washington National Guard $605,615.00 to fund three full-time positions: Adjutant General and two Assistant Adjutant Generals. Decl. D. Postman ¶ 12. The State also provides $2,795,512 per year to maintain the buildings utilized by the Washington National Guard. Decl. D. Postman ¶ 13. The State also spends $392,000 to fund a special Fire Land training for Washington National Guard members to ensure that Guard members have appropriate knowledge, tools, and training when utilized in wildfire response. Decl. D. Postman ¶ 11.

Since 2007, the Guard has been deployed at least eight times intrastate to fight forest fires, battle flooding, and provide rescue services to communities devastated by landslides. Decl. D. Postman ¶ 10.

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YEAR	DEPLOYMENT	ACTIVATED WASHINGTON NAT'L GUARD MEMBERS	NG STATE ACTIVE DUTY EXPENDITURE
2007-2008	Flooding – Western Washington	480	$272,232.00
2009	Flooding - Thurston and Pierce Counties	340	$401,775.00
2012	Taylor Bridge Fire Complex	15	$396,410.00
2014	SR530 Landslide (Oso Mudslide)	700	$1,969,570.00
2014	Wildfire Support	800	$4,969,045.00
2015	Wildfire Support	1500	$8,058,795.00
2017	March Flooding Eastern WA	41	$59,526.00
2017	Sep 2017 Wildfire Activation (Note - includes the total for all fires)	356	Currently mobilized and costs not available yet

In 2017, the Washington Guard met 81% of its recruiting goals and 74% of its retention goals. Decl. L. Baker ¶ 11, Ex. I. However, the Washington National Guard expects recruitment challenges in the upcoming years due to changes in United States Army Recruiting Command practices, high recruiter turnover rates, limited recruiting access to certain schools, and potential changes to programs like Military Accessions Vital to National Interest. *Id.*

III. ARGUMENT

This Court should permit Washington to intervene. "Intervention is governed by Fed. R. Civ. Proc. 24(a) and (b)." *In re Estate of Ferdinand E. Marcos Human Rts. Litig.*, 536 F.3d 980, 984 (9th Cir. 2008). In determining whether an applicant should be permitted to intervene, courts "follow[] the guidance of Rule 24 advisory committee notes that state that 'if an absentee would be substantially affected in a practical sense by the determination made in an action, [it] should, as a general rule, be entitled to intervene.'" *Arakaki v. Cayetano*, 324 F.3d 1078, 1086 (9th Cir. 2003) (quoting *Sw. Center for Biological Diversity v. Berg*, 268 F.3d 810, 822 (9th Cir. 2001)). The Ninth Circuit has held that "[a] liberal policy in favor of intervention serves both efficient resolution of issues and broadened access to the courts."

Wilderness Soc. v. U.S. Forest Serv., 630 F.3d 1173, 1179 (9th Cir. 2011) (en banc) (quoting *United States v. City of Los Angeles*, 288 F.3d 391, 397–98 (9th Cir. 2002)). Pursuant to Rule 24(a), Washington is entitled to intervene as a matter of right to protect its interests. Alternatively, if the Court determines that Washington does not have a right to intervene, the Court should grant permissive intervention pursuant to Rule 24(b).

A. Washington Has a Right to Intervene

Intervention as a matter of right should be granted where a party claims an interest in the action and is so situated that "disposing of the action may as a practical matter impair or impede the movant's ability to protect its interest, unless existing parties adequately represent that interest." Fed. R. Civ. P. 24(a)(2). Further, the Ninth Circuit "construe[s] Rule 24(a) liberally in favor of potential intervenors." *California ex rel. Lockyer v. United States*, 450 F.3d 436, 440 (9th Cir. 2006) (citing *Sw. Ctr. for Biological Diversity*, 268 F.3d at 818).

When seeking intervention as of right, an applicant must show: (1) a significant protectable interest relating to the property or transaction that is the subject of the action; (2) the disposition of the action may, as a practical matter, impair or impede the applicant's ability to protect its interest; (3) the application is timely; and (4) the existing parties may not adequately represent that applicant's interest. *Los Angeles*, 288 F.3d at 397 (quoting *Donnelly v. Glickman*, 159 F.3d 405, 409 (9th Cir. 1998)). Washington meets each of the four requirements.

1. Washington has significant protectable interests in protecting the State and its residents from discriminatory federal policy

The Transgender Military Service Ban harms Washington's significant quasi-sovereign, proprietary, and sovereign interests.

First, the Supreme Court has recognized that it is well within the quasi-sovereign interests of states to sue as *parens patriae* to protect their residents. *Alfred Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 601-04 (1982) (explaining that "*parens patriae* is

inherent in the supreme power of every State . . . often necessary . . . for the prevention of injury to those who cannot protect themselves"). In particular, the Court recognizes a state's interest "in securing residents from the harmful effects of discrimination." *Id.* at 609. Washington's *parens patriae* authority likewise allows it to ensure that its residents "are not excluded from the benefits that are to flow from participation in the federal system." *Id*. at 608.

In this matter, Washington has a quasi-sovereign interest in protecting its residents from a facially discriminatory policy that bans its transgender residents from military and National Guard service. A policy that restricts employment based on an immutable characteristic like sex and gender identity, and restricts access to health care based on those characteristics implicates the "the health and well-being—both physical and economic—of [Washington] residents." *See Snapp*, 458 U.S. at 607. Protecting its residents from overt federal discrimination is squarely within the interest and concern of the State. *Id.* at 609 ("This Court has had too much experience with the political, social, and moral damage of discrimination not to recognize that a State has a substantial interest in assuring its residents that it will act to protect them from these evils.").

Second, courts have repeatedly found that any non-trivial economic impact on the proprietary interests of government entities implicates a concrete, particularized state interest. *See Texas v. United States*, 787 F.3d 733 (5th Cir. 2015) (holding that Texas has standing to challenge a federal immigration directive based on the costs of issuing a driver's licenses to beneficiaries); *City of Sausalito v. O'Neill*, 386 F.3d 1186, 1199 (9th Cir. 2004) (holding that potential lost tourist revenues are a sufficient economic concern to trigger a government entity's legally cognizable and protectable proprietary interest); *Colo. River Indian Tribes v. Town of Parker*, 776 F.2d 846 (9th Cir. 1985) (holding that potential lost tax revenue was sufficient to prove that a government entity has a protectable proprietary interest).

Here, Washington seeks to intervene to protect its economic and proprietary interests. Washington collects employment taxes for all workers in Washington State, and, as such, the

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State's tax revenue will likely be impacted by the loss of military service and advancement opportunities for Washingtonians who are transgender. The loss of employment and advancement opportunities for transgender individuals in Washington would also have ripple effects down the economy, impacting property and sales tax revenues that would be contributed by transgender Washingtonian military service members and their families.[4] These impacts on Washington's tax base will negatively impact Washington's proprietary interest in its own economic health and growth.

Third, this case implicates Washington's sovereign interests in protecting its territory and maintaining its antidiscrimination laws. As the Supreme Court has held, a state has a sovereign interest in "preserv[ing] its sovereign territory." *Massachusetts v. EPA*, 549 U.S. 497, 518-19 (2007) (affirming that states have an "independent interest" in protecting the natural environments and resources within the state's boundaries) (quoting *Georgia v. Tennessee Copper Co.*, 206 U.S. 230 (1907)). In Washington, a critical part of the National Guard's mission is to prevent and minimize damage caused by natural disasters like wildfires, landslides, flooding, and earthquakes. Decl. D. Postman ¶¶ 6-11. Excluding transgender Washingtonians from the pool of candidates who can join the Washington National Guard may result in diminished numbers of service members who can provide emergency response and disaster mitigation in emergent situations when Washington needs assistance the most. Further, non-transgender individuals may likewise forego National Guard service in favor of an inclusive and nondiscriminatory employer. Any reduction in qualified service members negatively impacts the State's interest in responding to and mitigating harms to its territory.

In addition to protecting its natural resources, Washington has a sovereign interest in maintaining and enforcing its longstanding anti-discrimination laws. *See* Wash. Rev. Code § 49.60.010 (legislative finding that discrimination "menaces the institutions and foundation of

[4] *See e.g.* Decl. D. Postman ¶ 16 (noting that a transgender Guard member was moved to inactive status due to the soldier's gender transition).

a free democratic state"); Decl. D. Postman ¶ 4. "[T]he exercise of sovereign power . . . involves the power to create and enforce a legal code; both civil and criminal[.]" *Snapp*, 458 U.S. at 601. The Transgender Military Service Ban infringes on Washington's sovereign interest by overriding its longstanding anti-discrimination law, also known as the Washington Law Against Discrimination. Wash. Rev. Code §§ 49.60.010 – 49.60.505. The Transgender Military Service Ban injures Washington by permitting discrimination against Washingtonians and even requiring the State to discriminate against its own people by barring transgender people from joining the Washington National Guard. *Contra* Wash. Rev. Code §§ 49.60.030; 49.60.040(26); 49.60.180 (guaranteeing a civil right to be free from sex or gender identity discrimination, including in employment); Decl. D. Postman ¶ 4. The Transgender Military Service Ban impairs the State's unique interest in making and enforcing its civil rights protections.

In short, Washington faces a mix of harms to its interests as long as the Transgender Military Service Ban is in place. Washington easily satisfies the first factor for intervention as of right.

2. Disposition of this action will impair or impede Washington's interests

To determine whether an intervenor's interests would be impaired or impeded if a matter continued without the intervenor as a party, a court "must determine whether the [intervenor's] interests would as a practical matter be impaired or impeded by the disposition of th[e] action." *Sw. Ctr. for Biological Diversity v. Berg*, 268 F.3d at 822. "'If an absentee would be substantially affected in a practical sense by the determination made in an action, he should, as a general rule, be entitled to intervene.'" *Citizens for Balanced Use v. Mont. Wilderness Ass'n*, 647 F.3d 893, 898 (9th Cir. 2011) (quoting Fed. R. Civ. P. 24 advisory committee's note). *See also Lockyer*, 450 F.3d at 441 (affirming that the Ninth Circuit takes "the view that a party has sufficient interest for intervention purposes if it will suffer a practical impairment of its interests as a result of the pending litigation").

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A decision on the constitutionality of the Transgender Military Service Ban will have far-reaching impacts on Washington's ability to protect its residents' health, well-being, and economic security. Indeed, if the military is allowed to implement this facially discriminatory policy, the result will likely: (a) thwart Washington's ability to protect its residents from facially discriminatory federal policies; (b) prevent Washington's transgender military service members from obtaining needed medical care from military providers, with the result that the State may be required to pay for such services; (c) reduce Washington State tax revenue due to the extinction of military employment and advancement opportunities; (d) impede the Washington National Guard's ability to recruit and retain members to protect Washington's natural resources in times of emergent need; and (e) force Washington to violate it longstanding anti-discrimination law and discriminate against its own people in staffing the Washington National Guard. Disposition of this case will have lasting impact on those interests, and Washington should be allowed to represent its interests and the interests of Washingtonians in this matter.

3. Washington's motion to intervene is timely

There can be no question that Washington's motion is timely. To determine whether a motion to intervene is timely, courts consider (1) "the state of the proceeding at which an applicant seeks to intervene," (2) "the prejudice to other parties," and (3) "the reason for the length of the delay." *United States v. Alisal Water Corp.*, 370 F.3d 915, 921 (9th Cir. 2004). Here, this case is just beginning. The complaint was filed on August 28, 2017, and the defendants have yet to file a responsive pleading. Washington's motion meets the timeliness requirement.[5]

[5] Although a preliminary injunction motion has been filed, the briefing is not complete and the Court has not yet ruled. If Washington's request for intervention is granted, the State will confer with the parties and the Court regarding the appropriateness of the State's participation in any pending motions.

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4. Washington's interests as a state are inadequately represented by the current parties

Washington's unique state interests cannot adequately be represented by the parties to this action. To succeed in a motion to intervene, "[t]he burden on proposed intervenors in showing inadequate representation is minimal, and would be satisfied if they could demonstrate that representation of their interests 'may be' inadequate." *Arakaki*, 324 F.3d at 1086 (quoting *Trbovich v. United Mine Workers*, 404 U.S. 528, 538 n. 10 (1972)). *See also Citizens for Balanced Use*, 647 F.3d at 900 (noting that courts should not require an absolute certainty that a party's interests will be impaired or that existing parties will not adequately represent its interests). Three factors are relevant to determining whether a proposed intervenor's interests are adequately represented: (1) "whether the interest of a present party is such that it will undoubtedly make all of a proposed intervenor's arguments; (2) whether the present party is capable and willing to make such arguments; and (3) whether the proposed intervenor would offer any necessary elements to the proceeding that other parties would neglect." *Arakaki*, 324 F.3d at 1086 (citing *California v. Tahoe Reg'l Planning Agency*, 792 F.2d 775, 778 (9th Cir. 1986)).

The State's interests are multifaceted and complex, and include protecting its residents' health and economic well-being, ensuring that the State does not lose revenue and taxes, alleviating barriers to service in the Washington National Guard, and protecting the State from being forced to discriminate against its own residents. These state interests simply cannot be adequately represented or even argued by private plaintiffs. These interests are the exclusive concern of the State, and, as such, are necessarily distinct from the private plaintiffs' interests. Allowing this matter to move forward without the State as a party would significantly impede Washington's ability to protect its interests. Washington should be permitted to intervene as a matter of right.

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B. In the Alternative, Permissive Intervention Should Be Granted

If this Court finds that Washington does not meet the burden for intervention as of right, the Court should nonetheless grant Washington permissive intervention under Federal Rule of Civil Procedure 24(b)(1)(B). The rule provides in pertinent part that, "[o]n timely motion, the court may permit anyone to intervene who . . . has a claim or defense that shares with the main action a common question of law or fact." *Blum v. Merrill Lynch Pierce Fenner & Smith, Inc.*, 712 F.3d 1349, 1353 (9th Cir. 2013) (quoting Fed. R. Civ. P. 24(b)(1)). Generally, permissive intervention requires "(1) an independent ground for jurisdiction; (2) a timely motion; and (3) a common question of law and fact between the movant's claim or defense and the main action." *Id.* (quotation marks and citation omitted). In determining whether to exercise its discretion to grant permissive intervention, the Court considers "whether the intervention will unduly delay or prejudice the adjudication of the original parties' rights." Fed. R. Civ. P. 24(b)(3).

Washington meets these requirements. First, as discussed above, Washington has multiple interests that are injured by the Transgender Military Service Ban. Second, Washington's motion is timely. Third, there is a common question of law and fact between Washington's claims and the current plaintiffs' claims: both seek a judicial declaration that the Transgender Military Service Ban is unconstitutional. As such, Washington meets all of the requirements for permissive intervention and Washington's motion should be granted.

IV. CONCLUSION

For the foregoing reasons, Washington asks that this Court grant its motion to intervene and order the clerk to file its proposed Complaint in Intervention attached hereto as Exhibit A.

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DATED this 25th day of September 2017.

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CERTIFICATE OF SERVICE

I hereby certify that the State of Washington's Motion to Intervene and supporting documents were electronically filed with the United States District Court using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

September 25, 2017

/s/ La Rond Baker
LA ROND BAKER, WSBA #43610

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

No. 2:17-cv-1297-MJP

DEFENDANTS' OPPOSITION TO THE STATE OF WASHINGTON'S MOTION TO INTERVENE

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INTRODUCTION

The State of Washington ("Washington" or the "State") has moved to intervene in this action, which seeks to challenge the military's policy regarding service by transgender individuals. Washington's motion should be denied for several independent reasons.

As a threshold matter, intervention should be denied because the Court lacks jurisdiction to consider the underlying claims and, in this circumstance, intervention by a third party is not appropriate. As detailed in Defendants' pending Motion to Dismiss, none of the existing Plaintiffs has standing to bring this case. In addition, Washington has failed to establish that it has suffered any concrete injury, or that it faces an imminent threat of future injury. In these circumstances, it is axiomatic that Washington cannot intervene in a case that is not properly before this Court in the first place. *See Town of Chester, N.Y. v. Laroe Estates, Inc.*, 137 S. Ct. 1645, 1650-51 (2017).

Even if this case were to proceed, intervention should be denied because Washington does not meet the standard for permissive intervention, much less the stringent test for intervention as of right. First, Washington has failed to show that it has any direct, non-contingent, substantial, and legally protectable interest in this litigation to support intervention as a matter of right. Indeed, as explained below, the military's longstanding policy restricting the accession of transgender persons has been in place for decades without challenge from Washington.

Second, Washington's alleged interests are adequately represented by existing Plaintiffs. Just like Plaintiffs, Washington characterizes Defendants' policy for transgender persons in the military as an alleged "ban," and then seeks to enjoin the policy. Since Washington has the same ultimate objective as these plaintiffs, its professed interests are *presumed* to be adequately represented absent a compelling showing to the contrary. Washington has made no such showing here.

Finally, disposition of this action will not impair Washington's ability to protect its purported interests, because this case would not have any preclusive effect on the State.

BACKGROUND

On August 28, 2017, Plaintiffs filed this action, challenging Defendants' policy regarding military service by transgender persons. (ECF No. 1). On September 14, 2017, Plaintiffs filed an Amended Complaint (ECF No. 30), and a Motion for Preliminary Injunction (ECF No. 32). Plaintiffs claim that Defendants have implemented "an official federal policy of discrimination against transgender individuals in military service," which they call (incorrectly) a "Ban," ECF No. 30 ¶ 5, and further claim that this purported "Ban" violates principles of equal protection, due process, and free speech. *See id.* ¶¶ 214-38. The Amended Complaint seeks a declaration that the policy is unconstitutional on its face and as applied to Plaintiffs, *see id.* at 39 ¶ 1, and to enjoin the policy worldwide, *id.* at 39 ¶ 2. Plaintiffs' Motion for Preliminary Injunction asks the Court to "enter a preliminary injunction barring Defendants and those acting in concert with them or subject to their control from taking any action relative to transgender individuals, pending resolution of this case, that is inconsistent with the *status quo* that existed on July 25, 2017." ECF No. 32 at 24. Defendants have now moved to dismiss for lack of jurisdiction, and have opposed Plaintiffs' motion, showing, *inter alia*, that they lack irreparable harm and cannot show likely success on the merits.

The background of the challenged policy is set forth at length in Defendants' motion. *See* ECF No. 69 at 3-8. In short, the President issued a memorandum on August 25, 2017, setting forth his policy directive to the Secretary of Defense and the Secretary of Homeland Security and ordering a further study of policies concerning military service by transgender individuals. The President's memorandum states that no policy changes to the status quo will be effective until at least March 2018, should the President determine that any are necessary. *See id.* at 6-7. The President directed the Secretary of Defense to determine how to address transgender individuals currently serving in the military and that no action be taken against such individuals until after a policy review is completed. *Id.* at 7. The President's memorandum also "extends the deadline to alter the currently

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effective accession policy beyond January 1, 2018, while [the relevant Departments] continue to study the issue." *Id.* at 6.

On September 14, 2017, the Secretary of Defense issued Interim Guidance setting forth the policy that is in effect today. *See id.* at 8. The Interim Guidance reaffirms that for now, no current service member will be involuntarily separated, discharged, or denied reenlistment solely on the basis of a gender dysphoria diagnosis or transgender status, and service members who receive a gender dysphoria diagnosis from a military medical provider will be provided treatment for the diagnosed medical condition. *Id.* at 8-9. The Interim Guidance also confirms that the military's longstanding accessions policy, "which generally prohibit[s] the accession of transgender individuals into the Military Services, remain[s] in effect because current or history of gender dysphoria or gender transition does not meet medical standards," and that this prohibition remains "subject to the normal waiver process." *Id.* at 8. The Interim Guidance thus maintains the status quo by continuing the longstanding accession policy to permit further review by experts before any change in policy occurs.

On September 25, 2017, Washington filed a motion to intervene under Federal Rules of Civil Procedure 24(a)(2) and 24(b)(1)(B), attaching a Proposed Complaint in Intervention. Washington's Motion to Intervene, Ex. A (ECF No. 55) ("Proposed Complaint"). The Proposed Complaint raises the same equal protection and due process claims that already are set forth in the existing Plaintiffs' Amended Complaint, and seeks the same declaratory and injunctive relief. *See id.* ¶¶ 39-43.

STANDARD OF REVIEW

An applicant for intervention as of right under Federal Rule of Civil Procedure 24(a)(2) bears the burden of satisfying four criteria:

> (1) the applicant must timely move to intervene; (2) the applicant must have a significantly protectable interest relating to the property or transaction that is the subject of the action; (3) the applicant must be situated such that the disposition of the action may impair or impede the party's ability to protect that interest; and (4) the applicant's interest must not be adequately represented by existing parties.

Arakaki v. Cayetano, 324 F.3d 1078, 1083 (9th Cir. 2003). "Failure to satisfy any one of the[se] requirements is fatal to the application." *Perry v. Proposition 8 Official Proponents*, 587 F.3d 947, 950 (9th Cir. 2009). To justify intervention, an applicant's interest must be "direct, non-contingent, substantial and legally protectable." *Dilks v. Aloha Airlines*, 642 F.2d 1155, 1157 (9th Cir. 1981). Moreover, when an applicant for intervention and an existing party "share the same ultimate objective, a presumption of adequacy of representation applies," which can be rebutted "only by a compelling showing to the contrary." *Freedom from Religion Found., Inc. v. Geithner*, 644 F.3d 836, 841 (9th Cir. 2011). Finally, if an applicant's purported interest is unlikely to be impaired or impeded by resolution of the action or the applicant has "other means" to protect that interest, intervention as of right should be denied. *California ex rel. Lockyer v. United States*, 450 F.3d 436, 442 (9th Cir. 2006).

An applicant for permissive intervention under Rule 24(b)(1)(B) must demonstrate "(1) an independent ground for jurisdiction; (2) a timely motion; and (3) a common question of law and fact between the [applicant's] claim or defense and the main action." *Freedom from Religion Found.*, 644 F.3d at 843. Permissive intervention "is committed to the broad discretion of the district court." *Orange Cty. v. Air Cal.*, 799 F.2d 535, 539 (9th Cir. 1986). Thus, even if an applicant satisfies the three threshold requirements, the court still may deny permissive intervention. *Donnelly v. Glickman*, 159 F.3d 405, 412 (9th Cir. 1998). In exercising its discretion, the court may consider, among other things, "the nature and extent of the [proposed intervenor's] interest" and "whether the [proposed intervenor's] interests are adequately represented by other parties." *Spangler v. Pasadena City Bd. of Educ.*, 552 F.2d 1326, 1329 (9th Cir. 1977).

ARGUMENT

I. WASHINGTON'S MOTION SHOULD BE DENIED BECAUSE THE COURT LACKS JURISDICTION OVER THE UNDERLYING CLAIMS.

"For all relief sought, there must be a litigant with standing, whether that litigant joins the lawsuit as a plaintiff, a coplaintiff, or an intervenor of right." *Town of Chester*, 137 S. Ct. at 1651.

Because neither the existing Plaintiffs nor Washington has standing to bring the underlying claims in this case, the Court lacks jurisdiction and intervention must be denied.

While an intervenor may not need independent standing to establish intervention as of right, *see id.*, the Ninth Circuit has held that there is no right to intervene where the existing plaintiffs lack standing in the first place. *See Sanford v. Memberworks, Inc.*, 625 F.3d 550, 560-61 (9th Cir. 2010). Though this scenario typically arises in the class-action context, the rule applies at least as much in a an ordinary case. *See, e.g., Ly-Luck Rest. v. Dep't of Labor*, No. C-92-3852 SBA, 1993 WL 121780 (N.D. Cal. 1993) (dismissing case because neither plaintiffs nor proposed intervenors had standing). And, where neither the existing Plaintiffs nor the proposed intervenors has standing, intervention also is foreclosed. *Town of Chester*, 137 S. Ct. at 1651.

As detailed in Defendants' Motion to Dismiss and Opposition to Preliminary Injunction, none of the existing Plaintiffs has standing to bring this case because they have not suffered any concrete injury, nor do they face an imminent threat of future injury. *See* ECF No. 69 at 13-19. In sum, Plaintiffs allege that they fear being involuntarily separated from the military, denied reenlistment, or denied transition-related medical care, but none of those alleged injuries are occurring, or will occur, under the Interim Guidance. *See id.* at 15-17. And beyond that, it is unclear whether those currently serving members will be affected by the future policy regarding service by transgender individuals once it is finalized and implemented. *See id.* at 18. Plaintiffs also have not been denied accession into the military or a medical waiver. *See id.* at 16. Thus, Plaintiffs have not been injured, much less irreparably injured, by the Presidential Memorandum and Interim Guidance. Without such injury, Plaintiffs lack standing and their claims are not ripe.

For similar reasons, Washington also lacks standing to bring its proposed claims. For a state to establish standing, "more must be alleged than injury to an identifiable group of individual residents, the indirect effects of the injury must be considered as well in determining whether the

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State has alleged injury to a sufficiently substantial segment of its population." *See Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 607 (1982). Washington has not identified any citizen who actually has been harmed as a result of Defendants' current policy, much less a substantial group of such citizens. And, as detailed in the next section, Washington's other purported interests in this litigation either fail as a matter of law, or else are entirely speculative. *See infra* Part II. Thus, if the existing Plaintiffs were dismissed from this case for lack of standing, Washington could not maintain this action on its own because the State likewise lacks standing to pursue its claims.

Because a state cannot intervene where it would result in a case in which none of the plaintiffs has standing, Washington's motion should be denied.

II. WASHINGTON CANNOT INTERVENE AS A MATTER OF RIGHT.

A. Washington Lacks the Requisite Legally Protectable Interest in This Litigation.

Intervention as of right is inappropriate first because Washington lacks the requisite legally protectable interest in this litigation. To intervene as of right, an applicant must establish "a significantly protectable interest relating to the property or transaction that is the subject of the action." *Arakaki*, 324 F.3d at 1083. That interest must be "direct, non-contingent, substantial and legally protectable." *Dilks*, 642 F.2d at 1157. An interest is not sufficiently protectable if it is contingent on future occurrences. *See S. Cal. Edison Co. v. Lynch*, 307 F.3d 794, 803 (9th Cir. 2002). And "the interest must be one which the *substantive* law recognizes as belonging to or being owned by the applicant;" in other words, the proposed intervenor must be "the real party in interest regarding [its] claim." *Saldano v. Roach*, 363 F.3d 545, 551 (5th Cir. 2004). Further, "[a]n economic stake in the outcome of the litigation, even if significant, is not enough" to justify intervention. *Greene v. United States*, 996 F.2d 973, 976 (9th Cir. 1993).

Washington proffers several ways in which Defendants' policy for transgender persons in the military purportedly affects the State, ECF No. 55 at 5-8, but none of these alleged effects

provides Washington with a "direct, non-contingent, substantial and legally protectable" interest relating to the policy, such that it would be the real party in interest, *Dilks*, 642 F.2d at 1157. First, all of Washington's alleged interests are predicated on the policy's purported effects on individuals, which it *speculates* will affect the State's interests in the future. *See* ECF No. 55 at 7 (suggesting that "the State's tax revenue *will likely* be impacted") (emphasis added); *id.* ("The loss of employment and advancement opportunities for transgender individuals in Washington would also have *ripple effects down* the economy, impacting property and sales tax revenues.") (emphasis added); *id.* (arguing that the policy "*may* result in diminished numbers of service members who can provide emergency response and disaster mitigation in emergent situations.") (emphasis added). Such indirect interests do not warrant intervention both because they are "contingent upon the occurrence of a sequence of events," *Brennan v. N.Y.C. Bd. of Educ.*, 260 F.3d 123, 129 (2d Cir. 2001); *see S. Cal. Edison Co.*, 307 F.3d at 803, and because individuals—not the State—are the real parties in interest, *see Saldano*, 363 F.3d at 551; *Dilks*, 642 F.2d at 1157.[1] Moreover, as explained in Defendants' pending Motion to Dismiss, *see* ECF No. 69 at 6-7, the President has directed a panel of experts to study the policy questions at issue and provide recommendations. The fact that the policy remains under consideration, and may be subject to change in the future, only further highlights the speculative, contingent nature of Washington's alleged interests and claims.

Second, Washington's attempt to rely on the doctrine of *parens patriae* is misplaced. Although in some circumstances, a state may assert "*parens patriae*" standing to raise a claim on behalf of its citizens, *see Alfred L. Snapp*, 458 U.S. at 601-04 (holding Puerto Rico had standing to sue individuals and companies for violating federal worker protection laws), Washington may not do so here. A

[1] These speculative injuries are also insufficient to establish any present harm or an imminent threat of future harm needed for Washington to establish standing in its own right. *See Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560-61 (1992); *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 408 (2013). Absent standing, for the reasons set forth in Part I, intervention cannot be permitted in this case.

state may not assert *parens patriae* standing to challenge a federal statute's alleged violation of its citizens' rights. *See Commonwealth of Massachusetts v. Mellon*, 262 U.S. 447, 485-86 (1923) ("[I]t is no part of [a State's] duty or power to enforce [its citizens'] rights in respect of their relations with the federal government. In that field it is the United States, and not the State, which represents them as *parens patriae*."). Similarly, Washington cannot rely on *parens patriae* to intervene in a lawsuit challenging the federal government's policy for transgender persons in the military. *See Portland Audubon Soc'y v. Hodel*, 866 F.2d 302, 208 n.1 (9th Cir. 1989) (noting that "requirement that the applicant must 'assert an interest relating to the property or transaction which is the subject of the action" is similar to standing), *abrogated on other grounds by Wilderness Soc'y v. U.S. Forest Serv.*, 630 F.3d 1173 (9th Cir. 2011).

Washington's reliance on the doctrine of *parens patriae* also fails because it has not pointed to a single current service member in its state who is being harmed by the policy, much less a substantial segment of its population. Absent concrete harm to Washington residents, any purported indirect effects are speculative at best. *See Alfred L. Snapp*, 458 U.S. at 607 (explaining that, to establish *parens patriae*, "more must be alleged than injury to an identifiable group of individual residents, the indirect effects of the injury must be considered as well in determining whether the State has alleged injury to a sufficiently substantial segment of its population."). Indeed, Washington's own motion acknowledges the speculative nature of its claims. *See, e.g.*, ECF No. 55 at 6-7 (claiming that the State's "economic and proprietary interests *will likely* be impacted by the loss of military service and advancement opportunities for Washingtonians who are transgender") (emphasis added).

Finally, the fact that Washington has a state statute addressing unlawful discrimination, *see* ECF No. 55 at 7-8, does not provide it with the necessary protectable interest to support intervention. Courts have sometimes recognized that states have a legally protectable interest when

federal law invalidates or preempts state law.[2] However, Washington does not claim (nor could it) that the Defendants' current policy for transgender service members preempts or invalidates Washington's state statute. Moreover, the operative interim policy does not establish any new restrictions with respect to transgender service members – indeed, it bars any disparate treatment of current transgender servicemembers. *See* ECF No. 69 at 8-9. And given that the future policy is now being studied by military leaders, Washington's claim of injury to legal policies is especially speculative and unfounded. Finally, with respect to military accession, the operative Interim Guidance merely leaves in place the longstanding accession policy set forth in DoDI 6130.03, which was most recently modified in 2011. In other words, the current accession policy on transgender military service and Washington's state statute have coexisted for years – and, thus, Washington's statutory policy operates now just as it has done in the past. Washington's purported interest in intervening now in this lawsuit to vindicate its claimed interests is, therefore, unfounded.

Because the State lacks a legally protectable interest in this litigation, its Motion to Intervene should be denied.

B. Washington has the Same Ultimate Objective as the Existing Plaintiffs and Has Not Made the Compelling Showing Necessary to Overcome the Presumption of Adequate Representation.

Washington also cannot intervene as of right because its alleged interests are adequately represented by the existing Plaintiffs. A proposed intervenor must show that its interests are not adequately represented by existing parties. *See Perry*, 587 F.3d at 950-51, 955. "When an applicant for intervention and an existing party have the same ultimate objective, a presumption of adequacy of representation arises." *Arakaki*, 324 F.3d at 1086. That presumption can be rebutted "only by a compelling showing to the contrary." *Freedom from Religion Found.*, 644 F.3d at 841. To overcome

[2] *See, e.g., Wyoming ex rel. Crank v. United States*, 539 F.3d 1236, 1242 (10th Cir. 2008) (federal action directed at invalidating existing state firearms law); *Ohio ex rel. Celebrezze v. U.S. Dep't of Transp.*, 766 F.2d 228, 232 (6th Cir. 1985) (state criminal safety law pre-empted by federal regulation).

the presumption, a proposed intervenor "ordinarily must demonstrate adversity of interest, collusion, or nonfeasance." *Moosehead Sanitary Dist. v. S. G. Phillips Corp.*, 610 F.2d 49, 54 (1st Cir. 1979). Speculation regarding a purported inadequacy is not sufficient. *See League of United Latin Am. Citizens v. Wilson*, 131 F.3d 1297, 1307 (9th Cir. 1997). Moreover, "disagreement over litigation strategy or legal tactics" is insufficient to overcome the presumption. *Id.* at 1306.

Here, Washington seeks the same ultimate objective as the existing plaintiffs: to obtain a court order declaring Defendants' policy regarding transgender persons in the military unconstitutional, and to enjoin Defendants from enforcing the policy. *Compare* ECF No. 30 at 39, *with* ECF No. 55, Ex. A ¶¶ 39-43. Washington's proposed claims mimic those already asserted by the existing plaintiffs. *Compare* ECF No. 30 ¶¶ 214-30, *with* ECF No. 55, Ex. A ¶¶ 27-38. The interests of Plaintiffs and Washington are, thus, unquestionably aligned.

But a proposed intervenor and an existing party need not have identical interests for the presumption of adequate representation to arise. The relevant inquiry is whether they have the "same ultimate objective" or the same "ultimate bottom line." *Perry*, 587 F.3d at 949, 951. There is no question that they do here, as each seeks invalidation of the same policy for the same reasons. *See id.* 950-51 (presuming adequacy based on shared ultimate objective); *Freedom from Religion Found.*, 644 F.3d at 841 (same). Accordingly, adequate representation must be presumed, and Washington must make a compelling showing to overcome the presumption.

Washington has not met its burden here. Washington has not asserted "any substantive disagreement between it and the existing [plaintiffs]," *Wilson*, 131 F.3d at 1306, much less that their interests are "adverse" or that there is any "collusion" or "nonfeasance" by the existing plaintiffs, *Moosehead Sanitary Dist.*, 610 F.2d at 54. Nor does Washington prove that it "would offer any necessary elements to the proceeding that other parties would neglect." *Perry*, 587 F.3d at 954. At best, it suggests that the State has a unique motivation to seek invalidation of the policy. *See* ECF

No. 55 at 10 (arguing that its interests are protecting its residents, maintaining state revenue, and alleviating barriers to service in the Washington National Guard). But the adequacy of representation is judged by whether existing parties will make necessary arguments and seek the same outcome, not *why* the parties want to make those arguments and/or seek that outcome. *See Perry*, 587 F.3d at 950-52.

Washington has, therefore, failed to overcome the presumption of adequate representation here, and its motion to intervene should be denied.

C. Intervention as of Right is Not Appropriate Because Disposition of this Case Will Not Impair Washington's Ability to Protect its Alleged Interests.

Finally, intervention as of right should be denied because "disposition of th[is] action" will not "impair or impede [Washington's] ability to protect [its alleged] interest[s]." *Arakaki*, 324 F.3d at 1083. Washington contends that "[a] decision in favor of defendants would have far-reaching impacts on Washington's ability to protect its residents' health, well-being, and economic security." ECF No. 55 at 9. But Washington does not explain how its ability to protect its interests would be *impaired* or *impeded* by the disposition of this case. Since Washington is not a party, it "would not be exposed to any preclusive effect of the litigation." *Raines v. Seattle Sch. Dist. No. 1*, No. C09-203Z, 2009 WL 3444865, at *1 (W.D. Wash. Oct. 23, 2009). The pendency of this action would not prevent Washington from filing a separate lawsuit challenging the policy to vindicate its own alleged rights and interests. *See Lockyer*, 450 F.3d at 442 (impairment prong is not met where potential intervenor has "other means" or an "alternative forum" to protect its interests); *Silver v. Babbitt*, 166 F.R.D. 418, 429 (D. Ariz. 1994) ("Mere inconvenience caused by added expense and delay from having to file a separate lawsuit is not sufficient impairment to justify intervention as of right"), *aff'd*, 68 F.3d 481 (9th Cir. 1995). And any decision of the Court in this case would not bind any court handling any separate challenge brought by Washington. *See NASD Dispute Resolution, Inc. v. Judicial Council of State*

of Cal., 488 F.3d 1065, 1069 (9th Cir. 2007). Because the disposition of this case will not impair Washington's ability to protect its interests, intervention as of right is inappropriate.

III. WASHINGTON'S REQUEST FOR PERMISSIVE INTERVENTION SHOULD BE REJECTED.

While permissive intervention typically is committed to the court's discretion, *see Orange*, 799 F.2d at 539, this is the rare case in which it is foreclosed. As detailed above, Washington cannot be permitted to intervene in this case because neither the existing Plaintiffs nor the State has standing to bring the underlying claims in this case. The Court thus lacks jurisdiction to hear those claims, with or without Washington. *See supra* Part I.

But even if Washington's claims could properly come before this Court, the State's motion should be denied because the relevant factors all weigh against permissive intervention, including "the nature and extent of the intervenors' interest, their standing to raise relevant legal issues, the legal position they seek to advance, and its probable relation to the merits of the case" and "whether the intervenors' interests are adequately represented by other parties." *See Spangler*, 552 F.2d at 1329. As detailed above, Washington does not have a legally protectable interest in this case, and all of its purported interests are indirect and contingent upon the occurrence of a sequence of events that may not even happen. *See supra* Part II. Nor is there any indication that Washington's legal positions and interests will not be adequately represented by the existing Plaintiffs. The existing Plaintiffs present the same legal theories and seek the same far-reaching relief that Washington proposed, including a worldwide injunction of the challenged policy.

Accordingly, in addition to finding that Washington has no right to intervene in this case, the Court also should deny permissive intervention.

CONCLUSION

For the foregoing reasons, the Court should deny Washington's motion to intervene.

DATED: October 16, 2017

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on October 16, 2017, I electronically filed the foregoing Opposition to the State of Washington's Motion to Intervene using the Court's CM/ECF system, causing a notice of filing to be served upon all counsel of record.

Dated: October 16, 2017

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The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI; STAFF SEARGEANT CATHERINE SCHMID; D.L., formerly known as K.G., by his next friend and mother, LAURA GARZA; HUMAN RIGHTS CAMPAIGN; and GENDER JUSTICE LEAGUE, Plaintiffs, v. DONALD TRUMP, in his official capacity as President of the United States; the UNITED STATES OF AMERICA; JAMES N. MATTIS, in his official capacity as Secretary of Defense; and the UNITED STATES DEPARTMENT OF DEFENSE, Defendants.	Case No: 2:17-cv-1297-MJP STATE OF WASHINGTON'S REPLY TO DEFENDANTS' OPPOSITION TO MOTION TO INTERVENE

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I. INTRODUCTION

The Transgender Military Service Ban is a facially discriminatory policy that harms a range of unique state interests. The State of Washington ("State") should be permitted to intervene to protect and defend its residents, its proprietary interests, and its sovereign interests.

II. ARGUMENT

A. This Court Has Jurisdiction to Hear Challenges to Defendants' Transgender Military Ban

Defendants argue that intervention is improper because neither the State nor any of the existing plaintiffs has standing. Defs.' Opp'n at 5. Defendants are wrong on both counts.

1. The Existing Plaintiffs Have Standing

In opposing the State's request to intervene, Defendants incorporate their argument under Rule 12(b)(6) that the existing plaintiffs' suit should be dismissed for failure to assert a concrete or imminent injury. Defs.' Opp'n at 5. The State defers to the existing plaintiffs to respond to the particularities of Defendants' justiciability arguments, other than to note that the plaintiffs have alleged, shown, and briefed numerous ongoing, concrete injuries to individuals and organizations that thoroughly satisfy the injury-in-fact requirement. Am. Complaint at 6-22; *see Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560-61 (1992).

2. The State Has Standing to Protect Its Residents and Itself

Defendants next argue that the State's intervention request should be denied because the State lacks standing to bring this action in the first place.[1] Defs.' Opp'n at 5-6. In making this argument, Defendants repeatedly mischaracterize the Transgender Military Service Ban as a hypothetical or future policy decision that is insufficiently firm to cause harm. *See id.* at 7

[1] Defendants alternatively argue that the State lacks standing or a sufficiently protectable interest to justify Rule 24 intervention. Defs.' Opp'n 4-9. While the Supreme Court has declined to decide whether a would-be intervenor under Rule 24(a)(2) must satisfy Article III's standing requirements, *Diamond v. Charles*, 476 U.S. 54, 68-69 (1986), the Ninth Circuit has in the past acknowledged that the standing requirement is at least implicitly addressed by the requirement that the applicant must assert an interest relating to the property or transaction which is the subject of the action." *SW Ctr. for Bio. Diversity v. Berg*, 268 F.3d 810, 821 n.3 (9th Cir. 2001). Because the State amply meets Article III's standing requirements, it also demonstrates a protectable interest for purposes of intervention.

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(claiming "the policy remains under consideration, and may be subject to change in the future"); *see also* Defs.' Mot. to Dismiss at 17, ECF 69 (claiming the policy "is still being studied, developed, and implemented"). But the accession ban is already in place, and the restrictions on health care access are final and will be implemented in five months. Baker Decl. Ex. A, ECF 56. The harms that flow from this policy are occurring *now*. The State has standing to address the resulting injuries to its residents, propriety interest, and sovereign interests.

a. The State may sue as *parens patriae* to protect its transgender residents from a facially discriminatory policy

Defendants offer two arguments why the State may not bring this suit in its capacity as *parens patriae*. Both arguments fail.

First, Defendants briefly argue that states are altogether barred from suing the federal government in their role as *parens patriae*. Defs.' Opp'n at 7-8 (citing *Massachusetts v. Mellon*, 262 U.S. 447, 485-86 (1923)). This argument ignores the body of caselaw clarifying that the *Mellon* poses no obstacle to suit when states seek to prevent unlawful or discriminatory action *by* the federal government.[2] Indeed, in 2007, the Supreme Court rejected this precise argument and upheld a state's ability to sue the federal government in seeking to protect its quasi-sovereign interests. *Massachusetts v. E.P.A.*, 549 U.S. 497, 520 n.17 (2007). The State may sue the federal government where it alleges that the government discriminates against the State's residents.

Second, Defendants argue the State may not sue as *parens patriae* because injury to the State's residents is speculative and the State has not identified a current service member who is

[2] *See also Am. Rivers v. F.E.R.C.*, 201 F.3d 1186, 1205 (9th Cir. 1999) (state agency has *parens patriae* standing to sue federal agency); *Maryland People's Counsel v. F.E.R.C.*, 760 F.2d 318, 322 (D.C. Cir. 1985) (stating that there is "no doubt that congressional elimination of the rule of *Massachusetts v. Mellon* is effective"); *see also Nebraska v. Wyoming*, 515 U.S. 1, 20 (1995) (Wyoming has standing to bring cross-claim against the United States to vindicate its "quasi-sovereign" interests). Most recently, the Eastern District of Washington confirmed that courts "cannot ignore" the *Massachusetts v. E.P.A.* holding acknowledging "a state's ability to sue the federal government under [federal law] in seeking to protect its quasi sovereign interests." *Challenge v. Moniz*, 218 F. Supp. 3d 1171, 1178 (E.D. Wash. 2016) (citing cases and holding Washington has *parens patriae* standing to sue U.S. Department of Energy).

harmed by the ban. Defs.' Opp'n at 7-8. Defendants' argument misreads the State's claims and rests on an unreasonably narrow interpretation of harm caused by the ban.

The State seeks declaratory and injunctive relief from the existing ban on accession into the military. As Defendants concede, openly transgender people have been formally barred from joining the military since at least 2011. *Id.* at 9 (citing Dep't of Defense Instruction 6130.03 specifying "grounds for rejection for military service").[3] There are approximately 32,850 transgender adults living in Washington, and each of them is subject to a facially discriminatory government policy that singles them out for disfavored treatment.[4] The State seeks to challenge this policy—in place now and for the indefinite future—pursuant to its quasi-sovereign interests in protecting its residents from unlawful sex and gender based discrimination and ensuring that their employment and advancement opportunities are not unlawfully limited. *Alfred Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 601-04 (1982) (*parens patriae* interests include "securing residents from the harmful effects of discrimination" including in employment). "There is no 'numerical talisman' of affected citizens required to establish *parens patriae* standing and 'the indirect effects of the injury must be considered.'" *People v. Peter & John's Pump House, Inc.*, 914 F. Supp. 809, 812 (N.D.N.Y. 1996) (citing *Snapp*, 458 U.S. at 601-04)). This is more than sufficient to confer *parens patriae* standing.

b. The State has standing to protect its proprietary interests

The State alleges that the Transgender Military Service Ban will harm Washington's economy. The U.S. military is the second largest employer in Washington, with over 60,000 service members contributing to local businesses and the employment, property, and sales tax bases through earnings from military employment. Prop. Compl. in Intervention ¶¶ 8, 10, ECF 55.

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[3] *Available at* https://www.med.navy.mil/sites/nmotc/nami/arwg/Documents/WaiverGuide/DODI_6130.03_JUL12.pdf

[4] *See* Andrew R. Flores et al., The Williams Institute, *How Many Adults Identify as Transgender in the United States?* 4 (2016), *available at* http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf (last visited Oct. 20, 2017).

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Defendants argue that future economic or proprietary interests are insufficient to show standing for governmental entities. Defs.' Opp'n at 7. However, courts have consistently held the opposite, finding standing for governmental entities to sue when they are likely to suffer future economic harm. *See Texas v. United States*, 787 F.3d 733 (5th Cir. 2015) (holding that Texas has standing to challenge a federal immigration directive based on economic harm); *City of Sausalito v. O'Neill*, 386 F.3d 1186, 1199 (9th Cir. 2004) (holding that potential lost tourist revenues is sufficient economic concern to trigger a government entity's legally cognizable and protectable proprietary interest). The State's proprietary injuries provide a separate and sufficient basis for standing.

c. The State may sue to protect its sovereign interests

The State also has standing based on its sovereign interests in protecting its territory and maintaining its antidiscrimination laws. *See Massachusetts*, 549 U.S. at 518-19 (affirming that states have an "independent interest" in protecting the natural environments and resources within the state's boundaries). The State has an obvious interest in ensuring that its National Guard is not hampered in its ability to recruit members to combat landslides, wildfires, and flooding. *See* Baker Decl. Ex. I (citing recruitment and retention numbers and continuing recruitment challenges). Applying the ban to National Guard recruits threatens the State's ability to fully staff the Guard, and forces the State to discriminate against its own people in violation of state policy. *See* Wash. Rev. Code §§ 49.60.030(1); 49.60.040(26); 49.60.180.

Defendants never meaningfully address the State's sovereign interests in protecting its territory or avoiding forced discrimination against its own people. Instead, they argue that there is no *new* conflict with Washington antidiscrimination laws because the military has long barred accession into the military by transgender individuals. Defs.' Opp'n at 8-9. This misunderstands the State's claims. Washington challenges not just the directives issued by President Trump, but the military's longstanding practice of barring transgender individuals from military services solely because they are transgender.

B. The State Meets the Remaining Criteria for Intervention as a Matter of Right

In addition to demonstrating the protectable interests above, the State has demonstrated the remaining factors required for intervention as of right under Rule 24(a)(2).[5] Rule 24 should be liberally construed in favor of potential intervenors. *California ex rel. Lockyer v. United States*, 450 F.3d 436, 440 (9th Cir. 2006). In determining whether the State's interests may be impaired by the disposition of this litigation, and whether its interests will be adequately represented, the Court is "guided primarily by practical and equitable considerations." *United States v. City of Los Angeles, California*, 288 F.3d 391, 397 (9th Cir. 2002). Practical and equitable considerations favor the State.

1. The State's Ability to Protect its Interests Would Be Impeded If It Were Not Allowed To Intervene

A decision on the constitutionality of the ban will impact the State's economic security, the operation of its National Guard, and its residents' health, well-being, and economic security. Defendants argue that the State can simply file its own lawsuit to pursue its interests and that any decision of the Court in this case would not bind a court handling any separate challenge brought by Washington. Defs.' Opp'n at 13. Without addressing the judicial economy implications of this argument, it also ignores the practical realities of the effect of litigation. The matter before this Court will determine the constitutionality of the ban. Any ruling on this issue will impact future or subsequent challenges, at least in this district. Washington's interests will be impaired if it is not permitted to participate now. *See Lockyer*, 450 F.3d at 445 (granting intervention in constitutional challenge because intervenors would have no alternative forum in which they might contest that interpretation of the statute).

2. The Existing Plaintiffs Cannot Adequately Represent Washington's Interests

[5] Defendants do not contest that the State's motion to intervene is timely.

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Defendants argue that intervention should be denied because the State and the private plaintiffs have the same ultimate objective in this case. Defs.' Opp'n at 1. That misstates the test. *See Arakaki v. Cayetano*, 324 F.3d 1078, 1086 (9th Cir. 2003) ("The most important factor in determining the adequacy of representation is how the interest compares with the interests of the existing parties."). Defendants do not address the fact that the interests the State alleges are wholly different in kind and scope from the interests private plaintiffs seek to protect. As one example, the State will seek discovery to establish further evidence related to its proprietary and sovereign harms, and these are simply not interests the existing plaintiffs can pursue or protect.[6] The burden of showing inadequacy is "minimal," *Sw. Ctr. for Biological Diversity*, 268 F.3d at 823, and the State has more than met its low burden.

C. In the Alternative, Permissive Intervention Should Be Granted

In resisting permissive intervention, Defendants present the same the arguments used to counter the State's request to intervene as of right. Defs.' Opp'n at 12. Defendants' arguments fail for the reasons discussed above. Should the Court decline to grant intervention as of right, the State respectfully requests that the State be granted permissive intervention.

Respectfully submitted October 20, 2017.

ROBERT W. FERGUSON
Washington Attorney General

/s/ La Rond Baker
LA ROND BAKER, WSBA No. 43610
Assistant Attorney General
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[6] The existing plaintiffs "agree that Washington possesses significant protectable interests as a state that are distinct from those of private litigants and could be impacted by the disposition of this action." Pls.' Non-Opposition to State of Washington's Mot. to Intervene at 1, ECF 77.

CERTIFICATE OF SERVICE

I hereby certify that on October 20, 2017, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which will send notification of such filings to all counsel in this matter.

Dated this 20th day of October, 2017, at Seattle, Washington.

/s/ La Rond Baker
LA ROND BAKER, WSBA #43610
Assistant Attorney General
Civil Rights Unit
Attorney for Plaintiff – Intervenor
State of Washington

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al., Plaintiffs, v. DONALD TRUMP, in his official capacity as President of the United States; the UNITED STATES OF AMERICA; JAMES N. MATTIS, in his official capacity as Secretary of Defense; and the UNITED STATES DEPARTMENT OF DEFENSE, Defendants.	Case No: 2:17-cv-1297 DECLARATION OF DAVID POSTMAN IN SUPPORT OF WASHINGTON STATE'S MOTION TO INTERVENE

Pursuant to 28 U.S.C. § 1746(2), I, DAVID POSTMAN, hereby declare as follows:

1. I am over 18 years of age, have personal knowledge of the facts set forth in this declaration and am competent to testify about them.

2. I am the Chief of Staff for Washington State Governor Jay Inslee and have served as such since December 14, 2015. Prior to becoming Chief of Staff, I served as Governor Inslee's Executive Director of Communications from 2013 to 2015.

3. As Chief of Staff for the Governor, I oversee all operations of state government under the purview of the Governor. This includes, but is not limited to, management of the Governor's policy, legal, communications and legislative staff, as well as primary supervision of the

Governor's cabinet, including the Military Department. As Chief of Staff, I serve as the Governor's primary advisor and ensure that his priorities and policy directions are carried out by state agencies.

4. The Governor is the chief executive of the State. The Governor is responsible for overseeing the operations of the State and ensuring the faithful execution of its laws, including but not limited to the Washington Law Against Discrimination, which, among other things, prohibits discrimination based on gender or sexual orientation in employment. Chapter 49.60 RCW.

5. The Governor sets policy and priorities to protect both the physical and economic well-being of the State and its residents. The Governor implements these policies and priorities with the assistance of department and agency heads.

6. As chief executive of the State, the Governor is responsible for protecting Washingtonians in emergencies and disasters. The Washington National Guard is an integral part of Washington's emergency preparedness and disaster recovery planning as well as a member of Washington's militia. Wash. Rev. Code § 38.04.030.

7. As commander-in-chief, the Governor has the authority to deploy the Washington National Guard to respond to emergencies and disasters in order to safeguard lives, property, and the economy of Washington State by providing in-state disaster recovery and assistance. Wash. Rev. Code § § 38.08.020, 38.08.040. When the Governor deploys the Guard for in-state service, such activation is called State Active Duty.

8. Currently, there are more than 8,000 citizen soldiers and airmen in the Washington National Guard. Since 2007, the Guard has been deployed eight times intrastate to fight forest fires, battle flooding, and provide rescue services to communities devastated by landslides.

9. When the Governor deploys the Washington National Guard for emergencies that occur in State, the State pays Guard members for their service. When the Guard is on State Active

Duty, Guard members are paid with State funds at the same rate of pay for their rank or grade as their active duty counterparts. The State also ensures that all costs and expenses incurred by the Guard during State Active Duty are paid. The State also maintains records to ensure that accurate accounting records are kept.

10. Between 2007 and September 2017, the Governor has deployed the Washington National Guard eight times to respond to emergencies in Washington State. The State has paid the below amounts for these State duty activations:

YEAR	DEPLOYMENT	ACTIVATED WASHINGTON NAT'L GUARD MEMBERS	NG STATE ACTIVE DUTY EXPENDITURE
2007-2008	Flooding – Western Washington	480	$272,232.00
2009	Flooding - Thurston and Pierce Counties	340	$401,775.00
2012	Taylor Bridge Fire Complex	15	$396,410.00
2014	SR530 Landslide (Oso Mudslide)	700	$1,969,570.00
2014	Wildfire Support	800	$4,969,045.00
2015	Wildfire Support	1500	$8,058,795.00
2017	March Flooding Eastern WA	41	$59,526.00
2017	Sep 2017 Wildfire Activation (Note - includes the total for all fires)	356	Currently mobilized and costs not available yet
		4,232	

11. To ensure that Guard members have the appropriate knowledge, tools, and training when utilized in wildfire response, Washington State annually spends $392,000 to fund a special Fire Land training.

12. Although the federal government primarily funds the Washington National Guard and its operations, Washington State is responsible for funding the following three full-time positions: Adjutant General and two Assistant Adjutant Generals. The salary and benefits cost per year for these three positions is $605,615.00.

13. Washington State also provides $2,795,512 per year to maintain the buildings utilized by the Washington National Guard. This amount equals 25% of the funding necessary to keep the buildings operational.

14. In 2016, the Department of Defense ("DoD") directed that members who openly identified as transgender would be permitted to join and serve openly in the military. The Washington National Guard conducted training on this policy and was prepared to implement it on its effective date of July 1, 2017.

15. On June 30, 2017, the DoD issued a directive delaying accession by openly transgender individuals to the military, including the Guard, until January 1, 2018.

16. The Washington National Guard currently has one soldier that identifies as transgender. This individual has not taken steps to change their gender marker in the Defense Enrollment Eligibility Reporting System (DEERS). Due to this soldier's gender transition, the soldier desired to leave the Washington National Guard, and with the Washington National Guard's approval, this soldier voluntarily agreed to assume inactive status until the soldier's term of service expired. This member entered service on March 7, 2012 and is currently in an inactive status approaching their military Expiration of Term of Service (ETS) on March 6, 2018, which means that their military service obligation is complete.

Executed September 22, 2017 in Olympia, Washington.

DAVID POSTMAN
Chief of Staff for the Governor of Washington State

DEPARTMENT OF DEFENSE
HEADQUARTERS, UNITED STATES MILITARY ENTRANCE PROCESSING COMMAND
2834 GREEN BAY ROAD
NORTH CHICAGO, ILLINOIS 60064-3091

MECD

DEC 0 8 2017

MEMORANDUM FOR SECTOR COMMANDERS
BATTALION COMMANDERS
MEPS COMMANDERS
DIRECTORS AND SPECIAL STAFF OFFICERS

SUBJECT: Policy Memorandum 2-5, Transgender Applicant Processing

References:

(a) Deputy Secretary of Defense Memorandum, "Medical Standards for Appointment, Enlistment, or Induction of Transgender Applicants into the Military Services," dated December 8, 2017.
(b) DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services."
(c) DoDI 1300.28, "In-Service Transition for Transgender Service Members," dated June 30, 2016.
(d) USMEPCOM Regulation 40-1, "Medical Qualification Program," dated July 24, 2017.
(e) Army Regulation 601-270/OPNAVINST 1100.4C CH-2/AFI 36-2003/MCO 1100.75/COMDTINST M. 1100.2E, "Military Entrance Processing Station," RAR dated September 13, 2011.

PURPOSE. This memorandum provides interim policy guidance for processing transgender applicants for military service in accordance with Reference (a). This policy memorandum supersedes Policy Memorandum 2-5 dated August 11, 2016. This policy memorandum shall remain in effect until expressly revoked.

APPLICABILITY. This policy applies to all USMEPCOM personnel and activities.

BACKGROUND. The medical accession standards set forth in reference (a) will be implemented on January 1, 2018. The new standard permits accession of qualified transgender applicants. Implementation of the new standard, effective January 1, 2018, is mandatory. Prior to that date, the civilian and military team of USMEPCOM must prepare to implement the necessary procedural adjustments to ensure a seamless processing experience for transgender applicants. Based on references (a) – (e), this policy memorandum establishes standard operating procedures and specific processing guidance that will be applied across the command. It is an administrative tool, not a health management tool or health policy document and does not confer rights, procedural or substantive, for applicants. Any provision of USMEPCOM or individual Military Entrance Processing Station (MEPS) policy or guidance inconsistent with this memorandum is hereby superseded. The following guidance will remain in effect until expressly revoked.

USMEPCOM mission requirements and physical space limitations often will not afford the opportunity for completely private screening procedures. All applicants, including those who are transgender, may express concern about privacy in bathrooms, ortho-neuro rooms, applicant hotel rooms, or similar venues. In these cases, Commanders may employ reasonable alternate measures to provide greater privacy, should daily capacity allow. Commanders or their representatives should review standard operating procedures during the morning Commander's brief, highlighting the rights, sensitivities, and privacy needs of all applicants, while acknowledging that the daily production environment may limit a Commander's ability to provide individual screening procedures.

As always, every applicant will be treated with dignity and respect. Applicants will be evaluated per established DoD standards for the purpose of qualifying for Military Service. Out of respect for all applicants, an individual's gender identity history should not be disclosed without his/her permission, unless disclosure is made for official use in accordance with applicable law and policy. Requests for privacy should be reviewed and adjudicated so as to avoid stigmatizing of any applicant.

I have the utmost confidence that the actions of the USMEPCOM team will continue to exemplify our core values of Integrity, Teamwork, Professionalism, and Respect. Ultimately, Commanders are responsible for upholding and maintaining the high standards of the U. S. military at all times, and in all places.

POLICY.

Identity Validation: Per reference (e), identity validation is the responsibility of Military Service recruiting command personnel. To ensure appropriate enrollment in the Defense Enrollment Eligibility Reporting System (DEERS) following accession, for transgender applicants, Service recruiting command personnel are responsible for notifying USMEPCOM (or the servicing MEPS) of an individual's identity, using one of the following documents to validate an applicant's gender, consistent with reference (c): a certified true copy of a state birth certificate reflecting preferred gender, a certified true copy of a court order reflecting preferred gender, or a U.S. Passport reflecting preferred gender.

Processing: Due to the complexity of this new medical standard, during the routine preliminary screening of applicants required by reference (e), recruiters shall refrain from screening out transgender applicants based on the information contained in the Accessions Medical Prescreen Report (DD Form 2807-2), and will instead allow the MEPS medical provider to perform a medical pre-screening of all transgender applicants for military service.

For the purposes of military entrance processing, the applicant's preferred gender will be used on all forms asking for the "sex" of the applicant. For example, if the applicant was born male but currently identifies as female, female will be selected in the "sex" category. The only form on which any difference between birth sex and preferred gender will be indicated is the DD Form 2807-2.

For applicants who do not identify with either male or female, their birth sex will be used on all forms when asking for the "sex" of the applicant. For example: if applicant was born male and does not identify as male or female, male will be selected in the "sex" category.

Services will submit the USMEPCOM Form 680-3A-E, Request for Examination (UMF 680-3A-E), indicating in block 6 the preferred gender with which the applicant identifies, not the applicant's birth sex. If an applicant's preferred gender is different than the applicant's birth sex, recruiters must verify the applicant's preferred gender through review of the applicant's birth certificate, court order, or passport. These three means to verify a gender change are the only valid means by which to do so, per reference (c) and this policy guidance.

Pending release of the updated DD Form 2807-2, the current DD Form 2807-2 "SECTION III-APPLICANT COMMENTS" will be used to identify transgender applicants to the medical department. The following annotations will be placed in Section III for **ALL APPLICANTS**, "Birth Sex: (male or female)" and "Preferred Gender: (male or female)." If birth sex and preferred gender are different, the recruiter will:

a. Verify preferred gender using only a birth certificate, court order, or passport, per reference (c) and this policy guidance.

b. Obtain the letter/s from the appropriate licensed medical provider/s, attesting that the applicant has been medically stable according to the standards prescribed in reference (a).

c. Include with the prescreen submission the letter/s and all related medical documents provided by the applicant (e.g., documentation of counseling, surgery, hormone treatments) that facilitated the applicant's gender transition.

All projections and processing actions will be based on the preferred gender of the applicant. Transgender applicants will be addressed by their preferred gender name and pronoun. To avoid confusion, MEPS personnel will ask the applicant for his/her preferred name.

A transgender male (birth sex female, preferred gender male) will be projected by the Services as a male; a transgender female (birth sex male, preferred gender female) will be projected by the Services as a female. Room assignment, height/weight standards, ortho-neuro exam, specimen observation, underwear requirements, chaperone, and bathroom assignments will be made based on the applicant's preferred gender identified by the sponsoring Service. However, although an individual might identify with a preferred gender, he/she may retain the anatomical characteristics of their birth sex. Medical examinations and labs may need to be tailored to the specific anatomical characteristics presented by the applicant.

Transgender male applicants who have not undergone surgical/hormone therapy will wear undergarments consistent with their physical anatomy (as per routine in the USMEPCOM regulations for all applicants), will be administered a pregnancy test, and will receive medical review and examination specific to female anatomical characteristics during the physical examination portion of processing.

Transgender female applicants who have not undergone surgical/hormone therapy will wear undergarments consistent with their physical anatomy (as per routine in the USMEPCOM regulations for all applicants), will not be administered a pregnancy test, and will receive medical review and examination specific to male anatomical characteristics during the physical examination portion of processing.

The gender of the chaperone will be the same as the applicant's preferred gender. The examining provider must confirm whether the applicant "does" or "does not" want a chaperone before beginning the medical examination (where the applicant will be in a state of undress). When the gender of the examiner is the opposite of the applicant's preferred gender, a chaperone must be provided while the applicant is in a state of undress. When the examiner's gender is the same as the applicant's preferred gender, a chaperone will be provided on request of either the applicant or the medical provider. The applicant or medical provider may request a chaperone at any time, and the examination will not proceed further until a chaperone is provided.

FOR MEPS MEDICAL DEPARTMENT

In accordance with Reference (a):

a. As to a transgender male (birth sex female, preferred gender male), a history of sex reassignment surgery or major genital reconstruction is disqualifying, unless, as certified by a licensed surgeon whose scope of practice includes the attested surgical procedure(s) (to include OB/GYN, urology, or plastic surgery):

1) A period of 18 months has elapsed since the date of the most recent of any such surgery during which period no further surgical follow-up or monitoring was required; and

2) No functional limitations or complications persist, nor is any additional surgery required; and

3) The applicant is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

b. As to a transgender female (birth sex male, preferred gender female), a history of sex reassignment surgery or major genital reconstruction is disqualifying, unless, as certified by a licensed surgeon whose scope of practice includes the attested surgical procedure(s) (to include urology or plastic surgery):

1) A period of 18 months has elapsed since the date of the most recent of any such surgery, during which period no further surgical follow-up or monitoring was required; and

2) No functional limitations or complications persist, nor is any additional surgery required; and

3) The applicant is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

c. As to any transgender applicant, a history of medical treatment associated with gender transition is disqualifying, unless, as certified by a licensed medical provider who treats gender dysphoria, such as a primary care provider, endocrinologist, or licensed mental health provider (psychiatrist, clinical psychologist, clinical social worker with a master's degree or doctorate in clinical social work, or psychiatric nurse practitioner):

1) The applicant has completed all elements of a medical treatment plan associated with the applicant's gender transition; and

2) The applicant has been stable, without clinically significant distress or impairment in social, occupational, or other important areas of functioning, in the preferred gender for the previous 18 months; and

3) If the applicant is presently receiving cross-sex hormone therapy post gender transition, the individual has been stable without adverse side effects, functional limitations, or complications on such hormones for at least the 18 consecutive months immediately preceding examination by the MEPS medical department.

d. As to any transgender applicant, a history of gender dysphoria is disqualifying, unless, as certified by a licensed mental health provider (psychiatrist, clinical psychologist, clinical social worker with a master's degree or doctorate in clinical social work, or psychiatric nurse practitioner) who treats gender dysphoria, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for at least the 18 consecutive months immediately preceding examination by the MEPS medical department.

e. Licensed medical provider is defined as "a health care professional who is licensed, credentialed, and granted clinical practice privileges to provide health care services within the provider's scope of practice, in a medical treatment facility."

f. For the purpose of accession, transgender applicants must be stable in the preferred gender for a period of 18 consecutive months post gender transition. "Stable in the preferred gender" is defined as "medical and surgical interventions for gender transition are complete, with the exception of continued use of a stable cross-sex hormone protocol, if applicable, no functional limitations or complications persist, and the individual is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning."

g. The following action will be taken for applicants, who during processing at the MEPS, disclose that they are transgender, but who have not taken the legal and/or medical steps to transition to their preferred gender or to demonstrate stability in their preferred gender as defined in this guidance: Applicant will be interviewed by a MEPS medical provider. If the applicant discloses to the MEPS medical provider that his/her preferred gender is other than the applicant's birth sex, as recorded on the applicant's DD Form 2807-2, or discloses additional medical information that calls into question whether stability in their preferred gender has been demonstrated, the applicant will be placed in open status (S-O), if medical treatment records are requested; or in temporary disqualified status (S-3T), if medical treatment records substantiate stability, but do not substantiate that the applicant meets the requirement that he/she be stable for 18

months in the preferred gender. In the latter case, the applicant will be given a Reevaluation Believed Justified (RBJ) date on the DD Form 2808 of 18 months minus the period of previously documented stability. In addition, in cases in which a transgender applicant is temporarily disqualified because he/she does not meet the 18 month stability requirement in the preferred gender, the sponsoring Service may request a Medical Exception to Policy (ETP), using the procedures in reference (d) to submit the applicant for consideration for a medical waiver by the Service Medical Waiver Review Authority (SMWRA), as authorized by reference (a).

h. The following action will be taken for applicants, who during prescreening, disclose that they are transgender, but who have not taken the legal and/or medical steps to transition to their preferred gender or to demonstrate stability in their preferred gender as defined this guidance: The MEPS medical provider will determine if Processing is Authorized (PA) in accordance with paragraph 2-3 of reference (d). If medical treatment records substantiate stability, but do not substantiate that the applicant meets the requirement that he/she is stable for 18 months in the preferred gender, the applicant will be given a Return Justified (RJ) date on the DD Form 2807-2 of 18 months minus the period of previously documented stability. In cases during prescreening in which an RJ date has been assigned, or in cases in which the MEPS medical provider has determined Processing is Not Justified (PNJ), the SMWRA (upon request of the Service) may Request Processing (PRW) in accordance with the procedures contained in paragraph 2-3 of reference (d).

i. For consistency, as USMEPCOM implements this new standard, and given the complexity and inter-dimensionality of medical qualification decisions, copies of the medical processing records: DD Form 2807-2, Report of Medical History (DD Form 2807-1), Report of Medical Examination (DD Form 2808), and the supporting medical records for all transgender applicant will be submitted to the USMEPCOM Medical Plans and Policy Directorate (J-7) for review after MEPS medical providers have rendered a medical qualification determination in regard to that applicant. The J-7 review is instituted to ensure consistency in the application of the new standard and to gather best practices and lessons learned as they pertain to this guidance. Supplemental guidance may be provided following J-7 review. J-7 review will not delay accession of transgender applicants determined to be qualified under the foregoing standards.

j. The Services must submit DD Form 2807-2 with substantiating and supporting medical documents, as specified in the USMEPCOM Medical Prescreen Documents List, together with all other documentation requested by the MEPS provider, for an applicant to be considered for a medical examination at the MEPS, IAW USMEPCOM Regulation, Medical Qualification Program (UMR 40-1), para 2-2c.

The point of contact for operational aspects of this policy is the Accession Division, J-3/MEOP-AD, (847) 688-3680 ext. 7519, email osd.north-chicago.usmepcom.list.hq-j3-meop-accession-division@mail.mil. The point of contact for all medical related questions is the Clinical Operations Division, J-7/MEMD-COD, (847) 688-3680 ext. 7132, email osd.north-chicago.usmepcom.list.hq-j7-memd-clinical-ops-div@mail.mil.

David S. Kemp
CAPT, USN
Commanding

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

JUN 30 2016

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
DEPUTY CHIEF MANAGEMENT OFFICER
CHIEF OF THE NATIONAL GUARD BUREAU
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
DIRECTOR, COST ASSESSMENT AND PROGRAM EVALUATION
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
DIRECTOR, OPERATIONAL TEST AND EVALUATION
DEPARTMENT OF DEFENSE CHIEF INFORMATION OFFICER
ASSISTANT SECRETARY OF DEFENSE FOR LEGISLATIVE AFFAIRS
ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
DIRECTOR, NET ASSESSMENT
DIRECTORS OF THE DEFENSE AGENCIES
DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Directive-type Memorandum (DTM) 16-005, "Military Service of Transgender Service Members"

References: DoD Directive 1020.02E, "Diversity Management and Equal Opportunity in the DoD," June 8, 2015
DoD Directive 1350.2, "Department of Defense Military Equal Opportunity (MEO) Program," August 18, 1995
DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended

Purpose. This DTM:

- Establishes policy, assigns responsibilities, and prescribes procedures for the standards for retention, accession, separation, in-service transition, and medical coverage for transgender personnel serving in the Military Services.

- Except as otherwise noted, this DTM will take effect immediately. It will be converted to a new DoDI. This DTM will expire effective June 30, 2017.

Applicability. This DTM applies to OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the

Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

Policy.

- The defense of the Nation requires a well-trained, all-volunteer force comprised of Active and Reserve Component Service members ready to deploy worldwide on combat and operational missions.

- The policy of the Department of Defense is that service in the United States military should be open to all who can meet the rigorous standards for military service and readiness. Consistent with the policies and procedures set forth in this memorandum, transgender individuals shall be allowed to serve in the military.

- These policies and procedures are premised on my conclusion that open service by transgender Service members while being subject to the same standards and procedures as other members with regard to their medical fitness for duty, physical fitness, uniform and grooming, deployability, and retention, is consistent with military readiness and with strength through diversity.

Responsibilities

- The Secretaries of the Military Departments will:

  - Take immediate action to identify all DoD, Military Department, and Service issuances, the content of which relate to, or may be affected by, the open service of transgender Service members.

  - Draft revisions to the issuances identified, and, as necessary and appropriate, draft new issuances, consistent with the policies and procedures in this memorandum.

  - Submit to the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) the text of any proposed revisions to existing Military Department and Service regulations, policies, and guidance, and of any proposed new issuance, no later than 30 days in advance of the proposed publication date of each.

- The USD(P&R) will:

  - Take immediate action to identify all DoD, Military Department, and Service issuances, the content of which relate to, or may be affected by, the open service of transgender Service members.

- Draft revisions to the issuances identified in this memorandum and, as necessary and appropriate, draft new issuances consistent with the policies and procedures in this memorandum.

Procedures. See Attachment.

Releasability. **Cleared for public release**. This DTM is available on the DoD Issuances Website at http://www.dtic.mil/whs/directives.

Ash Carter

Attachment:
As stated

cc:
Secretary of Homeland Security
Commandant, United States Coast Guard

ATTACHMENT

PROCEDURES

1. SEPARATION AND RETENTION

a. Effective immediately, no otherwise qualified Service member may be involuntarily separated, discharged or denied reenlistment or continuation of service, solely on the basis of their gender identity.

b. Transgender Service members will be subject to the same standards as any other Service member of the same gender; they may be separated, discharged, or denied reenlistment or continuation of service under existing processes and basis, but not due solely to their gender identity or an expressed intent to transition genders.

c. A Service member whose ability to serve is adversely affected by a medical condition or medical treatment related to their gender identity should be treated, for purposes of separation and retention, in a manner consistent with a Service member whose ability to serve is similarly affected for reasons unrelated to gender identity or gender transition.

2. ACCESSIONS

a. Medical standards for accession into the Military Services help to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. Not later than July 1, 2017, the USD(P&R) will update DoD Instruction 6130.03 to reflect the following policies and procedures:

(1) A history of gender dysphoria is disqualifying, **unless**, as certified by a licensed medical provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months.

(2) A history of medical treatment associated with gender transition is disqualifying, **unless**, as certified by a licensed medical provider:

(a) the applicant has completed all medical treatment associated with the applicant's gender transition; and

(b) the applicant has been stable in the preferred gender for 18 months; and

(c) If the applicant is presently receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months.

(3) A history of sex reassignment or genital reconstruction surgery is disqualifying, **unless**, as certified by a licensed medical provider:

(a) a period of 18 months has elapsed since the date of the most recent of any such surgery; and

(b) no functional limitations or complications persist, nor is any additional surgery required.

b. The Secretaries of the Military Departments and the Commandant, United States Coast Guard, may waive or reduce the 18-month periods, in whole or in part, in individual cases for applicable reasons.

c. The standards for accession described in this memorandum will be reviewed no later than 24 months from the effective date of this memorandum and may be maintained or changed, as appropriate, to reflect applicable medical standards and clinical practice guidelines, ensure consistency with military readiness, and promote effectiveness in the recruiting and retention policies and procedures of the Armed Forces.

3. IN-SERVICE TRANSITION

a. Effective October 1, 2016, DoD will implement a construct by which transgender Service members may transition gender while serving, in accordance with DoDI 1300.28, which I signed today.

b. Gender transition while serving in the military presents unique challenges associated with addressing the needs of the Service member in a manner consistent with military mission and readiness needs.

4. MEDICAL POLICY. Not later than October 1, 2016, the USD(P&R) will issue further guidance on the provision of necessary medical care and treatment to transgender Service members. Until the issuance of such guidance, the Military Departments and Services will handle requests from transgender Service members for particular medical care or to transition on a case-by-case basis, following the spirit and intent of this memorandum and DoDI 1300.28.

5. EQUAL OPPORTUNITY

a. All Service members are entitled to equal opportunity in an environment free from sexual harassment and unlawful discrimination on the basis of race, color, national origin, religion, sex, or sexual orientation. It is the Department's position, consistent with the U.S. Attorney General's opinion, that discrimination based on gender identity is a form of sex discrimination.

b. The USD(P&R) will revise DoD Directives (DoDDs) 1020.02E," Diversity Management and Equal Opportunity in the DoD," and 1350.2,"Department of Defense Military Equal Opportunity (MEO) Program," to prohibit discrimination on the basis of gender identity and to incorporate such prohibitions in all aspects of the DoD MEO program. The USD(P&R) will prescribe the period of time within which Military Department and Service issuances implementing the MEO program must be conformed accordingly.

6. EDUCATION AND TRAINING

a. The USD(P&R) will expeditiously develop and promulgate education and training materials to provide relevant, useful information for transgender Service members, commanders, the force, and medical professionals regarding DoD policies and procedures on transgender service. The USD(P&R) will disseminate these training materials to all Military Departments and the Coast Guard not later than October 1, 2016.

b. Not later than November 1, 2016, each Military Department will issue implementing guidance and a written force training and education plan. Such plan will detail the Military Department's plan and program for training and educating its assigned force (to include medical professionals), including the standards to which such education and training will be conducted, and the period of time within which it will be completed.

7. IMPLEMENTATION AND TIMELINE

a. Not later than October 1, 2016, the USD(P&R) will issue a Commander's Training Handbook, medical guidance, and guidance establishing procedures for changing a Service member's gender marker in DEERS.

b. In the period between the date of this memorandum and October 1, 2016, the Military Departments and Services will address requests for gender transition from serving transgender Service members on a case-by-case basis, following the spirit and intent of this memorandum and DoDI 1300.28.

Assessing the Implications of Allowing Transgender Personnel to Serve Openly

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Preface

U.S. Department of Defense (DoD) policies have rendered both the physical and psychological aspects of "transgender conditions" as disqualifying conditions for accession and allow for the administrative discharge of service members who fall into these categories. However, in July 2015, Secretary of Defense Ashton Carter announced that DoD would "create a working group to study the policy and readiness implications of welcoming transgender persons to serve openly." In addition, he directed that "decision authority in all administrative discharges for those diagnosed with gender dysphoria[1] or who identify themselves as transgender be elevated to the Under Secretary of Defense (Personnel and Readiness), who will make determinations on all potential separations" (DoD, 2015b).

It is against this backdrop that DoD is considering allowing transgender personnel to serve openly. To assist in identifying the potential implications of such a change in policy, the Office of the Under Secretary of Defense for Personnel and Readiness asked the RAND National Defense Research Institute to conduct a study to (1) identify the health care needs of the transgender population, transgender service members' potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness implications of allowing transgender service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly. This report documents the findings from that study. This research should be of interest to DoD and military service leadership, members of Congress, and others who are interested in the potential implications of allowing transgender personnel to serve openly in the U.S. armed forces.

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[1] *Gender dysphoria* is "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth" (World Professional Association for Transgender Health, 2011, p. 2).

Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community.

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Summary

The U.S. Department of Defense (DoD) is reviewing its policy on transgender personnel serving openly and receiving gender transition–related treatment during military service. The prospect of transgender personnel serving openly raises a number of policy questions, including those regarding access to gender transition–related health care, the range of transition-related treatments to be provided, the potential costs associated with these treatments, and the impact of gender transition–related health care needs (i.e., surgical, pharmacologic, and psychosocial) on military readiness—specifically, in terms of the deployability of transgender service members. The Office of the Under Secretary of Defense for Personnel and Readiness asked the RAND National Defense Research Institute to conduct a study to (1) identify the health care needs of the transgender population, transgender service members' potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness implications of allowing transgender service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly. This report presents the study findings centered around the following research questions:

- What are the health care needs of the transgender population?
- What is the estimated transgender population in the U.S. military?
- How many transgender service members are likely to seek gender transition–related medical treatment?
- What are the costs associated with extending health care coverage for gender transition–related treatments?
- What are the potential readiness implications of allowing transgender service members to serve openly?
- What lessons can be learned from foreign militaries that permit transgender personnel to serve openly?
- Which DoD policies would need to be changed if transgender service members are allowed to serve openly?

In the following sections, we summarize the findings associated with each research question.

What Are the Health Care Needs of the Transgender Population?

For the purposes of this analysis, we use *transgender* as an umbrella term to refer to individuals who identify with a gender different from the sex they were assigned at birth. Under the recently established criteria and terminology in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the American Psychiatric Association (APA) publication that provides standard language and criteria for classifying mental health conditions, transgender status alone does not constitute a medical condition (APA, 2013). Instead, under the revised diagnostic guidelines, only transgender individuals who experience significant related distress are considered to have a medical condition called *gender dysphoria* (GD). Some combination of psychosocial, pharmacologic (mainly but not exclusively hormonal), or surgical care may be medically necessary for these individuals. Psychotherapy to confirm a diagnosis of GD is a common first step in the process, often followed by hormone therapy and, perhaps, gender reassignment surgery involving secondary or primary sex characteristics. Not all individuals seek all forms of care.

A subset of transgender individuals may choose to *transition*, the term we use to refer to the act of living and working as a gender different from that assigned at birth. For some, the transition may be primarily social, with no accompanying medical treatment; we refer to this as *social transition*. For others, medical treatments, such as hormone therapy and hair removal, are important steps to align their physical body with their target gender. We refer to this as *medical transition*. A subset of those who medically transition may choose to undergo gender reassignment surgery to make their body as congruent as possible with their gender identity. This process of surgical transition is also often referred to as *sex* or *gender reassignment* or *gender confirmation*.

What Is the Estimated Transgender Population in the U.S. Military?

Estimates of the transgender population in the U.S. military and the analyses presented in this report should be interpreted with caution, as there have been no rigorous epidemiological studies of the size or health care needs of either the transgender population in the United States or the transgender population serving in the military. As a result, much existing research relies on self-reported, nonrepresentative survey samples. We applied a range of prevalence estimates from published research to fiscal year (FY) 2014 personnel numbers to estimate the number of transgender individuals serving in the U.S. military. We estimate that there are between 1,320 and

6,630 transgender personnel serving in the active component (AC) and 830–4,160 in the Selected Reserve (SR). Combining survey evidence from multiple states and adjusting for the male/female distribution in the military gave us a midrange estimate of around 2,450 transgender personnel in the AC and 1,510 in the SR.

How Many Transgender Service Members Are Likely to Seek Gender Transition–Related Medical Treatment?

We developed two estimates of demand for gender transition–related medical treatments based on private health insurance data and self-reported data from the National Transgender Discrimination Survey (NTDS). Based on our analyses of available private health insurance data on transition-related health care utilization, we expect only a small number of AC service members to access transition-related health care each year. Our estimates based on private health insurance data ranged from 0.022 to 0.0396 annual claimants per 1,000 individuals. Applied to the AC population, these estimates led to a lower-bound estimate of 29 AC service members and an upper-bound estimate of 129 AC service members annually utilizing transition-related health care, out of a total AC force of 1,326,273 in FY 2014.

We also projected health care utilization using the estimated prevalence of transgender service members and self-reported survey data from the NTDS describing the proportion of the transgender population seeking transition-related treatments by age group. Based on these calculations, we estimated, as an upper-bound, 130 total gender transition–related surgeries and 140 service members initiating transition-related hormone therapy (out of a total AC force of 1,326,273 in FY 2014). To put these numbers in perspective, an estimated 278,517 AC service members accessed mental health services in FY 2014. Hence, we expect annual gender transition–related health care to be an extremely small part of the overall health care provided to the AC population.

What Are the Costs Associated with Extending Health Care Coverage for Gender Transition–Related Treatments?

To determine the budgetary implications of gender transition–related treatment for Military Health System (MHS) health care costs, we again used data from the private health insurance system on the cost of extending coverage for this care to the transgender personnel population. We estimate that AC MHS health care costs will increase by between $2.4 million and $8.4 million annually—an amount that will have little impact on and represents an exceedingly small proportion of AC health care expendi-

tures (approximately $6 billion in FY 2014)[1] and overall DoD health care expenditures ($49.3 billion actual expenditures for the FY 2014 Unified Medical Program; Defense Health Agency, 2015, p. 22). These estimates imply small increases in annual health care costs; results that are consistent with the low prevalence of transgender personnel and the low annual utilization estimates that we identified.

What Are the Potential Readiness Implications of Allowing Transgender Service Members to Serve Openly?

Similarly, when assessing the readiness impact of a policy change, we found that less than 0.0015 percent of the total available labor-years would be affected, based on estimated gender transition–related health care utilization rates.[2] This is because even at upper-bound estimates, less than 0.1 percent of the total force would seek transition-related care that could disrupt their ability to deploy.[3] Existing data also suggest a minimal impact on unit cohesion as a result of allowing transgender personnel to serve openly. However, we caution that these results rely on data from the general civilian population and foreign militaries, as well as previous integration experiences in the military (e.g., gays, lesbians, women), which may not hold for transgender service members.

What Lessons Can Be Learned from Foreign Militaries That Permit Transgender Personnel to Serve Openly?

There are 18 countries that allow transgender personnel to serve openly in their militaries: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom (Polchar et al., 2014). Our analysis focused on the policies of the four countries—Australia, Canada, Israel, and the United Kingdom—with the most well-developed and publicly available policies on transgender military personnel. Several common themes emerged from our analysis of their experiences:

- The service member's gender is usually considered to have shifted to the target gender in areas such as housing, uniforms, identification cards, showers, and restrooms when a service member publicly discloses an intention to live as the target

[1] AC beneficiaries make up less than 15 percent of TRICARE beneficiaries (Defense Health Agency, 2015).

[2] We define a labor-year as the amount of work done by an individual in a year.

[3] We note that the ability to deploy is not exactly equivalent to readiness. A service member's readiness could be measured by the ability to participate in required training and exercises, which could be affected by treatments as well. Our estimates include days of inactivity due to medical treatments, which could also apply in these settings.

gender and receives a diagnosis of gender incongruence. However, physical fitness standards typically do not fully shift until the medical transition is complete. In many cases, personnel are considered exempt from physical fitness tests during transition.

- Because the gender transition process is unique for each individual, issues related to physical standards and medical readiness are typically addressed on a case-by-case basis. This flexibility has been important in addressing the needs of transgender personnel.
- The foreign militaries we analyzed permit the use of sick leave for gender transition–related medical issues and cover some, if not all, medical or surgical treatments related to a service member's gender transition.
- In no case was there any evidence of an effect on the operational effectiveness, operational readiness, or cohesion of the force.

The case studies also suggested a number of key best practices:

- Ensure strong leadership support.
- Develop an explicit written policy on all aspects of the gender transition process.
- Provide education and training to the entire force on transgender personnel policy, but integrate this training with other diversity-related training and education.
- Develop and enforce a clear anti-harassment policy that addresses harassment aimed at transgender personnel alongside other forms of harassment.
- Make subject-matter experts and gender advisers serving within military units available to commanders seeking guidance or advice on gender identity issues.
- Identify and communicate the benefits of an inclusive and diverse workforce.

Which DoD Policies Would Need to Be Changed if Transgender Service Members Are Allowed to Serve Openly?

We reviewed 20 current accession, retention, separation, and deployment regulations across the services and the Office of the Secretary of Defense to assess the impact of changes that may be required to allow transgender individuals to serve openly. We also reviewed 16 other regulations that have been replaced by more recent regulations or that did not mention transgender personnel.[4] Based on the experiences of foreign militaries, we recommend that DoD issue clear and comprehensive policies.

[4] These additional policies can are listed in Appendix D of this report.

Accession Policy

We recommend that DoD review and revise the language in accession instructions to match the DSM-5 for conditions related to mental fitness, ensuring the alignment of mental health–related language and facilitating appropriate screening and review processes for disorders that may affect fitness for duty. Similarly, physical fitness standards should specify physical requirements (rather than physical conditions). Finally, physical fitness policies should clarify when the service member's target gender requirements will begin to apply.

Retention Policy

We recommend that DoD expand and enhance its guidance and directives to clarify retention standards for review during and after medical transition. For example, evidence from Canada and Australia suggests that transgender personnel may need to be held medically exempt from physical fitness testing and requirements (Canadian Armed Forces, 2012; Royal Australian Air Force, 2015). However, after completing medical transition, the service member could be required to meet the standards of the acquired gender.

Separation Policy

DoD may wish to revise the current separation process based on lessons learned from the repeal of Don't Ask, Don't Tell. The current process relies on administrative decisions outside the purview of the standard medical and physical review process. This limits the documentation and review of discharges, and it could prove burdensome if transgender-related discharges become subject to re-review and redetermination. When medically appropriate, DoD may wish to establish guidance on when such discharge reviews should be handled through the existing medical fitness processes. We also recommend that DoD develop and disseminate clear criteria for assessing whether and how transgender-related conditions may interfere with duty performance.

Deployment Policy

The degree of austerity will differ across deployment environments, and some locations may be able to meet the health care needs of some transgender individuals. Moreover, recent advancements can minimize the invasiveness of treatments and allow for telemedicine or other forms of remote medical care.

Given this, DoD may wish to adjust some of its processes and deployment restrictions in the context of medical and technological advancements (e.g., minimally invasive treatments, telemedicine). Such reforms could minimize the readiness impact of medical procedures that are common among the transgender population. For example, current regulations specifying that conditions requiring regular laboratory visits that cannot be accommodated in a deployed environment can leave service members ineligible for deployment and would affect all individuals receiving hormone treatments

(Office of the Assistant Secretary of Defense for Health Affairs, 2013, p. 3). These treatments require laboratory monitoring every three months for the first year as hormone levels stabilize (Hembree et al., 2009; Elders et al., 2014). To avoid this cost, DoD would need to either permit more flexible monitoring strategies[5] or provide training to deployed medical personnel.[6]

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5 Some experts suggest that alternatives, such as telehealth reviews, would address this issue for rural populations with limited access to medical care (see, for example, World Professional Association for Transgender Health, 2011).

6 "Independent duty corpsmen, physician assistants, and nurses can supervise hormone treatment initiated by a physician" (Elders et al., 2014).

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We thank them all, but we retain full responsibility for the objectivity, accuracy, and analytic integrity of the work presented here.

Abbreviations

AC	active component
APA	American Psychiatric Association
DoD	U.S. Department of Defense
DoDI	U.S. Department of Defense instruction
DSM-5	*Diagnostic and Statistical Manual of Mental Disorders*, fifth ed.
FY	fiscal year
GD	gender dysphoria
IDF	Israel Defense Forces
LGBT	lesbian, gay, bisexual, and transgender
MHS	Military Health System
MTF	military treatment facility
NTDS	National Transgender Discrimination Survey
SR	Selected Reserve
VHA	Veterans Health Administration
WPATH	World Professional Association for Transgender Health

CHAPTER ONE

Introduction

U.S. Department of Defense (DoD) policies have rendered both the physical and psychological aspects of "transgender conditions" disqualifying conditions for accession and allowed for the administrative discharge of service members who fall into these categories. However, in July 2015, Secretary of Defense Ashton Carter announced that DoD would "create a working group to study the policy and readiness implications of welcoming transgender persons to serve openly." In addition, he directed that "decision authority in all administrative discharges for those diagnosed with gender dysphoria[1] or who identify themselves as transgender be elevated to the Under Secretary of Defense (Personnel and Readiness), who will make determinations on all potential separations" (DoD, 2015b). It is against this backdrop that DoD is considering allowing transgender service members to serve openly. To assist in identifying the potential implications of such a policy change, the Office of the Under Secretary of Defense for Personnel and Readiness asked the RAND National Defense Research Institute to conduct a study to (1) identify the health care needs of the transgender population, transgender service members' potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness impacts of allowing transgender service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly.

Study Approach

Our study approach centered around the following research questions:

- What are the health care needs of the transgender population?
- What is the estimated transgender population in the U.S. military?

[1] *Gender dysphoria*, or GD, is "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth" (World Professional Association for Transgender Health [WPATH], 2011, p. 2).

- How many transgender service members are likely to seek gender transition–related medical treatment?
- What are the costs associated with extending health care coverage for gender transition–related treatments?
- What are the potential readiness implications of allowing transgender service members to serve openly?
- What lessons can be learned from foreign militaries that permit transgender personnel to serve openly?
- Which DoD policies would need to be changed if transgender service members are allowed to serve openly?

We explain our methodological approaches in detail in each chapter of this report, but, here, we present overviews of the various methodologies that we employed. We began our analysis by defining the term *transgender* and then identifying the health care needs of the transgender population. This entailed an extensive literature review of these health care needs, along with treatment standards and medical options—particularly for those who have been diagnosed with gender dysphoria (GD).

We then undertook a review of existing data to estimate the prevalence and likely utilization rates of the transgender population in the U.S. military. Based on our estimates of the potential utilization of gender transition–related health care services, we estimated the Military Health System (MHS) costs for transgender active-component (AC) service members and reviewed the potential effects on force readiness from allowing these service members to serve openly.

We adopted two distinct but related approaches to estimating health care utilization and readiness impact. The first is what we label the *prevalence-based approach*, in which we estimated the prevalence of transgender personnel in the military and applied information on rates of gender transition and reported preferences for different medical treatments to measure utilization and the implied cost and readiness impact. This approach has the benefit of including those who may seek other forms of accommodation, even if they do not seek medical care. It also provides detailed information on the types of medical treatments likely to be sought, which can improve the accuracy of cost and readiness estimates. However, this approach suffers from a lack of rigorous evidence in terms of the rates at which transgender individuals seek treatment and instead relies on the nonscientific National Transgender Discrimination Survey (NTDS). This approach also relies on prevalence measures from only two states, Massachusetts and California, which may not be directly applicable to military populations.

Using our second approach, which we label the *utilization-based approach*, we estimated the rates of utilization of gender transition–related medical treatment. This approach has the benefit of providing real-world measures of utilization, which may be more accurate and more rigorously collected than survey information. However, it suffers from a lack of large-scale evidence and instead relies on several case studies

that may not be directly applicable to the U.S. military. Given the caveats described, these approaches provide the best available estimate of the potential number of transgender service members likely to seek medical treatment or require readiness-related accommodations.[2] In both cases, we applied measures of population prevalence and utilization to fiscal year (FY) 2014 DoD force size estimates to provide estimates of prevalence within the U.S. military.

We also reviewed the policies of foreign militaries that allow transgender service members to serve openly. Our primary method supporting the observations presented in this report was an extensive document review that included primarily publicly available policy documents, research articles, and news sources that discussed policies on transgender personnel in these countries. The information about the transgender personnel policies of foreign militaries came directly from the policies of these countries, as well as from research articles describing the policies and their implementation. Findings on the effects of open transgender service on cohesion and readiness drew largely from research articles that specifically examined this question using interviews and an analysis of studies completed by the foreign militaries themselves. Finally, insights on best practices and lessons learned emerged both directly from research articles describing the evolution of policy and experience and indirectly from commonalities in the policies and experiences of our four in-depth case studies. Recommendations provided in this report are based on these best practices and lessons learned, as well as a consideration of the unique characteristics of the U.S. military.

Finally, for our analysis of DoD policies, we reviewed 20 current accession, retention, separation, and deployment regulations across the services and the Office of the Secretary of Defense. We also reviewed 16 other regulations that have been replaced by more recent regulations or that did not mention transgender personnel.[3] Our review focused on transgender-specific DoD instructions (DoDIs) that may contain unnecessarily restrictive conditions and reflect outdated terminology and assessment processes. However, in simply removing these restrictions, DoD could inadvertently affect standards overall. While we focused on reforms to specific instructions and directives, we note that DoD may wish to conduct a more expansive review of personnel policies to ensure that individuals who join and remain in service can perform at the desired level, regardless of gender identity.

Limitations and Caveats

A critical limitation of such a comprehensive assessment is the lack of rigorous epidemiological studies of the size or health care needs of either the U.S. transgender population or the transgender population serving in the military. Indeed, much of the

[2] We define *accommodations* as adjustments in military rules and policies to allow individuals to live and work in their target gender.

[3] These additional policies are listed in Appendix D of this report.

existing research on the transgender population relies on self-reported, nonrepresentative survey data, along with unstandardized calculations using results from available studies. Because there are no definitive data on this topic, the information presented here should be interpreted with caution and, therefore, we present the full range of estimates.

Organization of This Report

The report is organized around our seven research questions. Chapter Two defines what is meant by the term *transgender*, identifies the health care needs of the transgender population, explains the various treatment options for those diagnosed with GD, and examines the capacity of the MHS to provide treatment options to service members diagnosed with GD. Chapter Three estimates the number of transgender service members in the AC and Selected Reserve (SR). Chapter Four estimates how many transgender service members are likely to seek medical treatment. Chapter Five estimates the costs associated with extending health care coverage for gender transition–related treatments. Chapter Six assesses the potential readiness implications of allowing transgender service members to serve openly. Chapter Seven identifies lessons learned from foreign militaries that allow transgender personnel to serve openly. Chapter Eight offers recommendations regarding which DoD accession, retention, separation, and deployment policies would need to be changed if a decision is made to allow transgender service members to serve openly. Chapter Nine summarizes key findings presented in the report and suggests best practices for implementing policy changes.

Appendix A presents definitions of common terms related to gender transition and transgender identity. Appendix B provides a history of the historical nomenclature associated with transgender identity. Appendix C provides details on the psychosocial, pharmacologic, surgical, and other treatments for GD. Appendix D lists the DoD accession, retention, separation, and deployment policies that we reviewed.

CHAPTER TWO

What Are the Health Care Needs of the Transgender Population?

This report begins by describing the health care needs of the U.S. transgender population overall. To discern the potential impact of changing DoD policies to allow transgender military personnel to serve openly and to ensure appropriate health care for those who seek gender transition–related treatment, it is also important to consider whether the MHS has the capacity to provide this care.

Definitions of Key Terms and Concepts

A challenge to our efforts to understand the health care needs of the transgender population in general, as well as in the military, is the varied and shifting terminology used in the clinical literature. Consequently, here, we define a range of terms that we will use throughout this review.[1] Consistent with the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the American Psychiatric Association (APA) publication that provides standard language and criteria for classifying mental health conditions, we use the term *transgender* to refer to "the broad spectrum of individuals who . . . identify with a gender different from their natal gender" (APA, 2013).[2] *Natal gender* or *birth sex*, which is the sex that an individual was assigned at birth and typically correlates with primary sex characteristics (e.g., genitalia).

We refer to the subset of the population whose gender identity does not conform with the expressions and behaviors typically associated with the sex to which they were assigned at birth as *transgender* or *gender nonconforming*. Many identities fall under these umbrella terms, including individuals who identify as androgynous, multigendered, third gender, and two-spirit people. The *gender nonconforming* category also includes individuals who *cross-dress*, which means they wear clothing that is traditionally worn by a gender different from that of their birth sex. The exact definitions of each of these identities vary under the term *gender nonconforming*, and individuals may

[1] A comprehensive list of terms and definitions is provided in Appendix A.

[2] A brief history of the DSM language and diagnostic criteria for related conditions is presented in Appendix B.

fluidly change, blend, or alter their gender identity over time. For the purposes of this analysis, we use *transgender* as an umbrella term that refers to individuals who identify with a gender different from the sex they were assigned at birth.

Importantly, under the recently established criteria and terminology outlined in DSM-5, transgender status alone does not constitute a medical condition (APA, 2013). Instead, under the revised diagnostic guidelines, only transgender individuals who experience significant related distress are considered to have a medical condition called *gender dysphoria* (GD). Some combination of psychosocial, pharmacologic (mainly but not exclusively hormonal), or surgical care may be medically necessary for these individuals. Psychotherapy to confirm a diagnosis of GD is a common first step in the process, often followed by hormone therapy and, perhaps, by gender reassignment surgery involving secondary or primary sex characteristics. Not all patients seek all forms of care. However, recognized standards of care require documentation of 12 continuous months of hormone therapy and living in the target gender role consistently and in all aspects of life. Unfortunately, the diagnosis is newly established, and data from which to estimate the size of these subgroups are lacking. In the future, however, transgender individuals seeking gender transition–related treatment are likely to require a GD diagnosis as the clinical justification.

Among transgender individuals, a subset may choose to *transition*, the term used to refer to the act of living and working in a gender different from one's sex assigned at birth. For some individuals, this may involve primarily social change but no medical treatment; this is referred to as *social transition*. For others, medical treatments, such as hormone therapy and hair removal, are important steps to align their physical body with their target gender. This is referred to as *medical transition*. A subset of those who medically transition may choose to undergo *gender reassignment surgery* to make their physical body as congruent as possible with their gender identity. This process of *surgical transition* is also often referred to as *sex* or *gender reassignment* or *gender confirmation*.

Health Care Needs of the Transgender Population

The main types of gender transition–related treatments are psychosocial, pharmacologic (primarily but not exclusively hormonal), and surgical. While one or more of these types of treatments may be necessary for some transgender individuals with GD, the course of treatments varies and must be determined on an individual basis by patients and clinicians. Since little is known about currently serving transgender service members, the following discussion draws primarily from available research on nonmilitary transgender populations.[3]

[3] The 2015 DoD Health Related Behavior Survey of active-duty service members was being fielded concurrently to this research. It marked the first time a U.S. military survey asked questions relating to gender identity.

Diagnosis and Treatments for Gender Dysphoria

Treatments deemed necessary for transgender populations have shifted over time based on research advancements and the accumulation of clinical knowledge. The World Professional Association for Transgender Health (WPATH) regularly publishes revised versions of its *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*; the most current at the time of our research was version 7. The standards are designed to guide the treatment of patients experiencing GD while recognizing that not all expressions of gender nonconformity require treatment (WPATH, 2011, p. 2). Some transgender individuals (again, the proportion is largely unknown) experience significant dysphoria (distress) with the sex and gender they were assigned at birth, and they meet formal DSM-5 diagnostic criteria for GD, as described in Appendix B of this report. For those diagnosed with GD, treatment options include psychotherapy, hormone therapy, surgery, and changes to gender expression and role (i.e., how people present themselves to the world; WPATH, 2011, pp. 9–10). We discuss these treatment options in detail in Appendix C.

Not all patients will prefer or need all or any of these options; however, when clinically indicated, appropriate care can "alleviate gender dysphoria by bringing one's physical characteristics into alignment with one's internal sense of gender" (Herman, 2013b, p. 4). There have been no randomized controlled trials of the effectiveness of various forms of treatment, and most evidence comes from retrospective studies. The widely endorsed consensus-based practice guidelines outlined in the WPATH *Standards of Care* suggest that transition-related mental health care, hormone therapy, and surgery are generally effective and constitute necessary health care for many individuals with GD.[4] The appropriate treatment plan is best determined collaboratively by patients and their health care providers. Optimally, specialized transgender health care will be provided by an interdisciplinary team (WPATH, 2011, p. 26).

Military Health System Capacity and Gender Transition–Related Treatment

To discern the potential impact of changing DoD policies to allow transgender military personnel to serve openly and to ensure appropriate health care for GD, it is also important to consider whether the MHS has the capacity to provide this care.

We anticipate that these survey results will provide additional information regarding how many transgender personnel currently serve in the U.S. military and their health behaviors.

[4] These standards are endorsed by the American Medical Association, American Psychological Association, American Academy of Family Physicians, National Association of Social Workers, World Professional Association for Transgender Health, and American College of Obstetricians and Gynecologists (see Lambda Legal, 2012). Major insurers, including Aetna and UnitedHealthcare, have incorporated many of these standards of care into their policies (see, for example UnitedHealthcare, 2015).

Psychotherapy, Hormone Therapies, and Gender Transition–Related Surgery

Both psychotherapy and hormone therapies are available and regularly provided through the military's direct care system, though providers would need some additional continuing education to develop clinical and cultural competence for the proper care of transgender patients. Surgical procedures quite similar to those used for gender transition are already performed within the MHS for other clinical indications.

Reconstructive Surgery

Reconstructive breast/chest and genital surgeries are currently performed on patients who have had cancer, been in vehicular and other accidents, or been wounded in combat. The skills and competencies required to perform these procedures on transgender patients are often identical or overlapping. For instance, mastectomies are the same for breast cancer patients and female-to-male transgender patients. Perhaps most importantly, the surgical skills and competencies for some gender transition surgeries also overlap with skills required for the repair of genital injuries sustained in combat, which have increased dramatically among troops deployed to Afghanistan. From 2009 to 2010, the percentage of wounded troops with genitourinary injuries transiting through Landstuhl Regional Medical Center in Germany nearly doubled from 4.8 percent to 9.1 percent—a dramatic increase that led some health providers to call this the "new 'signature wound'" of Operation Enduring Freedom (D. Brown, 2011).[5] There are particular similarities to the procedures recommended to treat those experiencing dismounted complex blast injuries, which typically involve multiple amputations with other injuries, often to the genitals (Wallace, 2012). Providing high-quality surgery to treat the 5 percent of combat wounds that require penile reconstruction requires extensive knowledge and practice in reconstructive techniques (Williams and Jezior, 2013). Assuming the MHS continues to directly provide health services as it has in the past, there are at least two potential implications: First, military surgeons may currently have the competencies required to surgically treat patients with GD, and, second, performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries during a period in which fewer combat injuries are sustained.

Cosmetic Surgery

Recognition of the requirement for reconstructive plastic surgery as a result of the wartime mission drives the existing DoD policy for cosmetic surgery procedures in the MHS; the services have requirements and manpower authorizations for specialists who can perform reconstructive plastic surgery (Office of the Assistant Secretary of Defense

[5] Experimental penis transplants, expected to be performed for the first time within the next year at Johns Hopkins School of Medicine, are being developed in the United States specifically for combat-wounded veterans; however, there may be benefits for transgender patients as well (Welsh, 2015).

for Health Affairs, 2005, p. 1). Cosmetic/reconstructive surgery skills need to be maintained with practice, and surgeons must also "meet board certification, recertification, and graduate medical education program requirements" (Office of the Assistant Secretary of Defense for Health Affairs, 2005, p. 1).

Current DoD policy draws a distinction between elective cosmetic plastic surgery performed "to improve the patient's appearance or self-esteem" and reconstructive plastic surgery performed on bodily structures that are abnormal due to health conditions to improve function or approximate a normal appearance (Office of the Assistant Secretary of Defense for Health Affairs, 2005, p. 3). While reconstructive surgeries constitute necessary treatment, access to elective cosmetic surgical procedures is subject to added constraints. For example, cosmetic procedures are performed on a space-available basis and restricted to those who will be TRICARE-eligible for at least six months. These procedures also require written permission from the commander of the service member's active-duty unit, and the patient must pay surgical, institutional, and anesthesia fees (Office of the Assistant Secretary of Defense for Health Affairs, 2005, p. 3).[6] DoD recognizes the need for these reconstructive surgery competencies and has crafted a policy to cover plastic surgeries to maintain providers' surgical skills and certification requirements.

Potential Consequences of Not Providing Necessary Gender Transition–Related Care

The discussion of the health care needs of transgender military personnel is incomplete without considering the potential unintended effects of constraining or limiting gender transition–related treatment. Little question remains that there are transgender personnel currently serving in the AC. Adverse consequences of not providing transition-related health care to transgender personnel could include avoidance of other necessary health care, such as important preventive services, as well as increased rates of mental and substance use disorders, suicide, and reduced productivity.

Research indicates that, "due to discrimination and problematic interactions with health care providers, transgender individuals frequently do not access health care, resulting in short and long-term adverse health outcomes" (Roller, Sedlak, and Draucker, 2015, p. 418).[7] Further, patients denied appropriate health care may turn to other solutions, such as injecting construction-grade silicone into their bodies to alter

[6] Interestingly, according to Elders et al. (2014, p. 19), there is no difference in leave policies related to recovery time between the two.

[7] For example, among NTDS respondents, 28 percent reported postponing or avoiding treatment when sick or injured, and 33 percent delayed or skipped preventive care due to discrimination or disrespect from health care providers (Grant et al., 2011, p. 76). In one study, transgender respondents had fewer self-reports of good health and were more likely to report limitations on daily activities due to health issues (Kates et al., 2015, p. 5).

their shape (State of California, 2012, p. 12). There are also potential costs related to mental health care services for individuals who do not receive such care (Herman, 2013b, p. 20). Multiple observational studies have suggested significant and sometimes dramatic reductions in suicidality, suicide attempts, and suicides among transgender patients after receiving transition-related treatment (State of California, 2012, p. 10). A study by Padula, Heru, and Campbell (2015) found that removing exclusions on transgender care "could change the trajectory of health for all transgender persons" at a minimal cost per member per month.[8]

However, we caution that it is not known how well these findings generalize to military personnel. Moreover, while the existing data offer some indication of the needs for and costs of gender transition–related health care, it is important to note that none of these studies were randomized controlled trials (the gold standard for determining treatment efficacy). In the absence of quality randomized trial evidence, it is difficult to fully assess the outcomes of treatment for GD.

[8] Specifically, they found that insurance provider coverage for transgender-related services resulted in "greater effectiveness, and was cost-effective relative to no health benefits at 5 and 10 years from a willingness-to-pay threshold of $100,000/[quality-adjusted life year]."

CHAPTER THREE

What Is the Estimated Transgender Population in the U.S. Military?

This chapter provides several estimates of the number of transgender service members in the U.S. military. To date, there have been no systematic studies of the number of transgender individuals in the U.S. general population or in the U.S. military. Current studies rely on clinical samples of health care service utilizers, nonrepresentative samples assembled in ways that are difficult to replicate, and self-reported survey data from a small number of states.

General Population Estimates of Transgender Prevalence

The transgender prevalence in the U.S. general population is thought to be significantly less than 1 percent (Gates, 2011, p. 6; APA, 2013, p. 454). However, there have been no rigorous epidemiological studies in the general U.S. population that confirm this estimate. Our subsequent estimates must be qualified, therefore, as somewhat speculative; they are based on numerous sources, including health services claims data, representative state-level health surveillance survey data, a convenience (i.e., nonrepresentative) sample recruited by an advocacy network, the experiences of foreign militaries, and selected other data sources.

The Williams Institute at the University of California, Los Angeles, School of Law, calculated that, based on estimates from Massachusetts and California, 0.3 percent of the U.S. population is transgender (Gates, 2011, p. 6). The Massachusetts data were collected between 2007 and 2009 as part of the Massachusetts Behavioral Risk Factor Surveillance System initiative. The survey suggests that 0.5 percent of the population in Massachusetts identifies as "transgender" (95-percent confidence interval: 0.3 to 0.6 percent; Conron et al., 2012). The California data combine information on the percentage of individuals who are transgender from the California Lesbian, Gay, Bisexual, and Transgender (LGBT) Tobacco Survey and the percentage of the overall population that is LGBT from the 2009 California Health Interview Survey. Gates

multiplies these values together to estimate that 0.1 percent of the population of California is transgender.[1]

To develop an estimate of transgender prevalence for the entire United States, Gates (2011) simply averages the Massachusetts and California values, yielding 0.25 percent, then rounds that up to 0.3 percent. This measure is very problematic, however. While survey-based estimates of transgender prevalence are likely to be accurate measures of true state-level transgender prevalence, it is not clear that taking an unweighted average from states with vastly different population sizes is appropriate for estimating national prevalence. For example, a weighted average calculation using the 2009 census population estimates for California and Massachusetts implies a 0.16 percent "national" prevalence estimate, as opposed to the 0.3 percent estimate calculated by Gates (2011)—a nearly 50-percent difference. We used this 0.16 percent weighted average as our combined, national estimate using the California and Massachusetts studies. This estimate was our midrange starting point, though we included both the 0.1 percent (from California) and 0.5 percent (from Massachusetts) as comparison points.

We note that there have been and continue to be other efforts to measure the prevalence of transgender identity in the general population. The two most prominent examples are the meta-analysis conducted by WPATH and a recent effort from the U.S. census. We did not use these estimates due to concerns that they systematically undercounted the prevalence of transgender identity for a variety of reasons detailed in the discussions that follow.

Separately, in 2007, the WPATH reviewed ten studies of prevalence with estimates for transgender individuals presenting for gender transition–related care, ranging from 1:11,900 to 1:45,000 for male-to-female transitions and 1:30,400 to 1:200,000 for female-to-male transitions (WPATH, 2011).[2] The studies cited were largely based on clinical usage. The WPATH authors note that these numbers should be considered "minimum estimates at best":

> The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who

[1] Although Gates (2011) states that 3.2 percent of the LGBT population is transgender, we note that an earlier document (California Department of Health Services, 2004) reporting analyses from the same survey states that 2 percent of this population is transgender. We were not able to obtain the raw data and could not verify which of the two values is correct. We used the 3.2-percent estimate to calculate the California transgender prevalence estimate.

[2] The studies were Wålinder, 1968; Wålinder, 1971; Hoenig and Kenna, 1974; Eklund, Gooren, and Bezemer, 1988; Tsoi, 1988; Bakker et al., 1993; van Kesteren, Gooren, and Megens, 1996; Weitze and Osburg, 1996; De Cuypere et al., 2007; and Zucker and Lawrence, 2009.

> present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked. (WPATH, 2011, p. 7)

Additionally, the information is based on utilization rates from the ten studies, mostly conducted in European countries, such as the United Kingdom, the Netherlands, Sweden, Germany, and Belgium. One study was conducted in Singapore. This raises concerns about the applicability of these estimates to the U.S. population due to differences in costs and social tolerance, both of which would likely make health utilization behavior in Europe significantly different from that in the United States. Moreover, the studies were conducted over a 30-year period in which utilization was dramatically increasing, suggesting that the estimates were not stable. This concern is reported in the WPATH report, with the authors noting that the trend (over time) was due to higher rates of individuals seeking care. In one example, the estimated transgender population doubled in just five years in the United Kingdom. If the numbers are increasing over time based on the use of clinics, then an estimate from ten to 15 years ago would likely be very low relative to utilization in those same places today, and again not representative of likely utilization in the United States.[3]

Harris (2015) used information on name and sex changes in Social Security Administration data files to estimate the number of transgender individuals in the U.S. population. Using information on male-to-female and female-to-male name changes, he estimates that there were 89,667 transgender individuals in the United States in 2010. Of this group, 21,833 (24 percent) also changed their sex, according to Social Security records; during some periods in U.S. history, this required documented proof of either initiation or completion of medical transition. Since name changes are not required, prevalence estimated in this manner is likely to be a lower-bound estimate of the true transgender prevalence rate in the United States. Using the 2010 population of adults age 18 and over as the denominator (234,564,071), 89,667 transgender cases implies a lower-bound transgender prevalence rate of 0.038 percent in the United States.

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[3] According to the WPATH authors,

> The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period. (WPATH, 2011, p. 7)

Prevalence-Based Approach to Estimating the Number of Transgender Service Members in the U.S. Military

Before discussing estimates of prevalence of transgender individuals in the U.S. military, it is important to note that, to our knowledge, no studies have directly measured the prevalence or incidence of transgender individuals currently serving in the active or reserve component.[4] To estimate prevalence in the military, we have constructed estimates using a combination of data sources.[5] One of those sources, the NTDS, provides detailed information on the choices and preferences of transgender individuals but it is not a randomized, representative sample of the military and thus is not generalizable.

We applied measures of population prevalence to DoD force size estimates to estimate prevalence in the U.S. military. We measured force size using information from DoD's 2014 demographics report (DoD, 2014; see Table 3.1). The demographics are separated into AC and SR. For much of the discussion of our medical care analysis, we focus on the AC. We did not include reserve-component service members, retirees, or dependents in the cost analyses because we did not have information on age and sex distribution within these beneficiary categories. Some of these beneficiary categories also have limited eligibility for health care provided through military treatment facilities (MTFs) and may receive their health care through TRICARE coverage in the purchased care setting or through other health insurance plans. For our readiness analysis, we included both the AC and SR because both components may be used for deployments. Although there are ongoing discussions regarding the feasibility of activating the Individual Ready Reserve, we excluded this population because we lacked the detailed information on gender and age needed to conduct our analysis.

Table 3.2 contains estimates of the number of transgender personnel in the AC and SR using the baseline prevalence from existing studies and shows the results of several tests that provide a range of estimates based on different assumptions in the literature. To estimate prevalence in the military, we conducted analyses using five values: (1) a lower-bound estimate of 0.1 percent based on a study in California

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[4] G. Brown (1988) found that eight out of 11 evaluated natal males with severe GD had a military background; he explains his findings by positing a "hypermasculine" phase among transgender individuals that coincides with the age of enlistment. Since the sample size in that study was extremely small, we do not consider this good evidence for this theory. Gates and Herman (2014) used estimates from the NTDS, combined with estimates of transgender prevalence (0.3 percent) from Gates (2011) and history of military service in the U.S. population from the American Community Survey, to estimate transgender prevalence in the military. Data from the National College of Health Administration showed that military experience was significantly higher among transgender individuals than among those who did not identify as transgender (9.4 percent versus 2.1 percent; Blosnich, Gordon, and Fine, 2015). However, these data were collected from only 51 institutions, and the response rate for the survey was only 20 percent, which again raises questions regarding the validity of the estimates.

[5] Our estimates were constructed using Gates (2011), which combined estimates from the Massachusetts Behavioral Risk Factor Social Surveys with the California LGBT Tobacco Survey, and Gates and Herman (2014), which used data from the NTDS, Gates (2011), and the American Community Survey.

Table 3.1
DoD Military Force Demographics

Category	Number	%
Active Component		
Sex		
Female	200,692	15
Male	1,125,581	85
Age		
<25	572,293	43
26–30	293,698	22
31–35	201,137	15
36–40	137,653	11
41+	121,492	9
Total	1,326,273	—
Selected Reserve		
Sex		
Female	149,759	18
Male	682,233	82
Age		
<25	285,494	34
26–30	156,983	19
31–35	124,179	15
36–40	86,151	10
41+	179,185	22
Total	831,992	—

SOURCE: DoD, 2014.

(Conron, 2012); (2) an upper-bound estimate of 0.5 percent based on a study in Massachusetts (Gates, 2011); (3) a population-weighted average of the California and Massachusetts studies, yielding a prevalence estimate of 0.16 percent; (4) an adjustment of this population-weighted approach based on the natal male/female distribution in the military, yielding a prevalence estimate of 0.19 percent; and (5) a doubling of the population-weighted, gender-adjusted value, yielding a prevalence estimate of 0.37 percent.

Table 3.2
Prevalence-Based Estimates of the Number of Transgender Active-Component and Selected Reserve Service Members

Component	Total Force Size (FY 2014)	0.1%[a] (CA study)	0.16%[b] (combined, population-weighted CA + MA studies)	0.19%[c] (gender-adjusted rate)	0.37%[d] (twice gender-adjusted rate)	0.5%[e] (MA study)
Active	1,326,273	1,320	2,120	2,450	4,900	6,630
Selected Reserve	831,992	830	1,330	1,510	2,930	4,160

SOURCES: Estimates for force size are based on RAND calculations using FY 2014 data from DoD, 2014.

[a] Based on estimates of prevalence from a California study (Conron, 2012).

[b] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

[c] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

[d] Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

[e] Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

Based on the 0.1 percent lower bound, we estimate that there are approximately 1,320 transgender individuals in the AC and approximately 830 in the SR. Using the Massachusetts study (0.5 percent) as an upper bound, we estimate that there are approximately 6,630 transgender service members in the AC and 4,160 in the SR. Because these estimates are based on selected populations in the state and the variation in these populations is significant, we were concerned that they were not representative of broader national numbers, especially as they pertain to the gender mix of the military. Therefore, we adjusted the population-weighted combination of these estimates to account for the male/female distribution in the U.S. military populations. This gender adjustment is critical, as most research indicates that male-to-female transitions are two to three times more common than female-to-male transitions (APA, 2013; Horton, 2008; Gates, 2011; Grant et al., 2011). This assumption of a two to one difference in underlying prevalence across genders applied to the 0.16 percent aggregate estimate implies a natal male-specific prevalence of 0.2 percent and a natal female-specific prevalence of 0.1 percent. Assigning these values to the male/female AC distributions increases the military prevalence estimate from 0.16 percent to 0.19 percent, which implies that there are 2,450 transgender individuals in the AC and 1,510 in the SR.

The estimate of 0.37 percent doubles the gender-adjusted rate based on information provided by the NTDS that 20 percent of the transgender population in its sample reported a history of military service, which is twice the rate of the general population,

as reported in the American Community Survey (Grant et al., 2011). We note that this is likely to be an overestimate of the overall transgender population for two reasons. First, given the highly tolerant environment in Massachusetts and California, the prevalence estimates in those two states are likely to overstate the nationwide prevalence.[6] Second, the evidence that transgender individuals are twice as likely to serve in the military is based on extrapolations from a nonrepresentative sample of individuals and not on direct, rigorous study of the transgender military population.

6 For example, both California and Massachusetts are rated as "top places for LGBT rights" (Keen, 2015).

CHAPTER FOUR

How Many Transgender Service Members Are Likely to Seek Gender Transition–Related Medical Treatment?

We adopted two distinct but related approaches to estimate the health care utilization and impact on readiness of allowing transgender personnel to serve openly in the U.S. military. The first is what we label the *prevalence-based approach*, in which we estimated the prevalence of transgender individuals in the military and applied information on rates of gender transition and reported preferences for different medical treatments to measure utilization and the implied cost and readiness impact. This approach has the benefit of including those who may seek other forms of accommodation, even if they do not seek medical care. It also provides detailed information on the types of medical treatments likely to be sought, which can improve the accuracy of cost and readiness estimates. However, this approach suffers from a lack of rigorous evidence in terms of the rates at which transgender individuals seek treatment and instead relies on the nonscientific NTDS. It also relies on prevalence measures from only two states—Massachusetts and California—that may not be directly applicable to military populations.

We refer to our second approach as the *utilization-based approach*, which we used to estimate the rates of utilization of medical treatment. This approach has the benefit of providing real-world measures of utilization based on health insurance claims, which may be more accurate and more rigorously collected than survey information. However, this approach suffers from a lack of large-scale evidence and instead relies on several case studies that may not be directly applicable to the U.S. military. Despite these caveats, these approaches provide the best available estimate of the range in the potential number of transgender service members likely to seek medical treatment or require readiness-related accommodations.[1]

In both cases, we applied measures of population prevalence and utilization to DoD force size demographics to provide estimates of prevalence within the U.S. military. As indicated in the previous chapter, our calculations of population prevalence and health care utilization used FY 2014 data from DoD's 2014 demographics report (DoD, 2014; see Table 3.1 in Chapter Three).

[1] Again, we define *accommodations* as adjustments in military rules and policies to allow individuals to live and work in their target gender.

Prevalence-Based Approach to Estimating the Number of Gender Transition–Related Treatments in the U.S. Military

To estimate the utilization of gender transition–related health care treatments, we scaled the prevalence of transgender service members identified in Chapter Three by the rates of transition and reported take-up of medical treatments. We based our transition rates on self-reported transitions in the NTDS data. According to the NTDS, 55 percent of transgender individuals reported living and working as their target gender; we refer to this as *social transition*.[2] For others, medical treatments, such as hormone therapy and hair removal, are important steps to align their physical body with their target gender. We refer to this as *medical* or *surgical transition*.[3]

Using the prevalence estimates from Table 3.2 in Chapter Three, we used information from the NTDS on the age of transition for individuals under 25, 26–30, 31–35, 36–40, and over 40 and calibrated our estimates with the age distribution in the military. Fifty-five percent of NTDS respondents reported that they had socially transitioned over their lifetime, and the data indicate that male-to-female transition ages differ from female-to-male transition ages. Nearly 54 percent of female-to-male transitions occurred before the age of 25, compared with only 23 percent of male-to-female transitions.

We focus on social transition because we assess this as most relevant for individuals who may need accommodations as they live and work in a different gender. This was also used as the basis in some foreign militaries, as discussed in Chapter Seven. Table 4.1 presents the estimated number of individuals who may seek to transition each year under each of our prevalence assumptions. We found that a lower bound of 40 AC and 20 SR service members and an upper bound of 190 AC and 110 SR service members will seek to transition each year and may need some sort of accommodations. The population-weighted, gender-adjusted estimate implies a middle range of 65 AC and 40 SR service members who will seek to transition each year.

Next, we combine the estimates of the number of transgender service members with information on the proportion undergoing transition and the age-specific proportion undergoing gender transition–related treatment to generate the number of annual treatments. Surgical preference rates vary by transition type (male-to-female versus female-to-male transition; see Table 4.2). Surgeries are distributed evenly across

[2] We note that an additional 27 percent of those who had not yet socially transitioned wished to transition at some point in the future. Because the timeline and desire for transition are difficult to translate to concrete numbers, we used the estimate of 55 percent of transgender individuals living and working full-time as their target gender as our planning parameter for readiness accommodations.

[3] In the NTDS sample, 65 percent of transgender individuals had medically transitioned, and 33 percent had surgically transitioned. Note that the rate of medical transitions is higher than the rate of social transitions because some individuals receive hormone treatments but do not live full-time as their target gender.

Table 4.1
Estimated Number of Transgender Service Members Who May Seek to Transition per Year

Estimate Source	Active Component (total force: 1,326,273)	Selected Reserve (total force: 831,992)
0.1% (CA study)[a]	40	20
0.16% (combined, population-weighted CA + MA studies)[b]	60	30
0.19% (gender-adjusted rate)[c]	65	40
0.37% (twice gender-adjusted rate)[d]	130	80
0.5% (MA study)[e]	190	110

SOURCES: Estimated proportions of subgroups based on Grant et al., 2011, p. 25. Estimates for the AC and SR are based on RAND calculations using FY 2014 data from DoD, 2014.

[a] Based on estimates of prevalence from a California study (Conron, 2012).

[b] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

[c] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

[d] Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

[e] Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

NOTE: The table excludes Individual and Inactive Ready Reserve members because comparable information on their demographics was not available for analysis.

four procedures for male-to-female transitions and primarily over two procedures for female-to-male transitions.

Recall, not all of the individuals seeking to transition would meet the diagnostic criteria for GD, which is a requirement for these surgeries. Moreover, even among individuals who transition in some manner, surgical treatment rates are typically only around 20 percent, with the exception of chest surgery among female-to-male transgender individuals (see Table 4.2).

Table 4.3 shows the estimated annual number of hormone therapy treatments and surgeries in the AC and SR calculated using the same prevalence assumptions described in Chapter Three (see Table 3.2). The surgeries included in the calculations are vaginoplasty, chest surgeries, orchiectomy, hysterectomy, metoidioplasty, and phalloplasty. Note that these estimates constitute the number of treatments, not necessarily the number of individuals. For hormone therapy recipients, the number of treatments and recipients is the same, and these estimates can be treated as counts of individuals. However, the number of individuals is likely smaller for surgical counts because the

Table 4.2
Lifetime Surgery Preferences Among NTDS Survey Respondents

Procedure	Have Had (%)	Want Someday (%)	Do Not Want (%)
Male-to-female			
Augmentation mammoplasty	21	53	26
Orchiectomy	25	61	14
Vaginoplasty	23	64	14
Facial surgery	17	Not reported	Not reported
Female-to-male			
Chest surgery	43	50	7
Hysterectomy	21	58	21
Metoidioplasty	4	53	44
Phalloplasty	2	27	72

SOURCE: NTDS data (Grant et al., 2011).

NOTE: These estimates are from cross-sectional data; individuals likely received each treatment only once and varied in the age at treatment initiation.

same individual may receive more than one type of surgical treatment.[4] Using the lower-bound estimate from the California study and the upper-bound estimate from the Massachusetts study (see Table 4.3), we estimated that there will be between 45 and 220 hormone treatments and between 40 and 200 transition-related surgeries annually in the AC and SR. The combined population-weighted and gender-adjusted estimate indicates a midrange of 80 hormone treatments and 70 transition-related surgical treatments annually. Although surgical procedures are most likely to be one-time events, hormone therapy treatment rates are likely to be used indefinitely, and the cost and manpower effects will apply until individuals leave the MHS. We did not have information on the length of service conditional on age and therefore could not calculate the total number of service members who would be receiving hormone therapy at any given point in time. We recommend that this line of analysis be explored in the future.

Utilization-Based Approach to Estimating the Number of Gender Transition–Related Treatments in the U.S. Military

While the prevalence-based approach provides a tractable means to estimate potential utilization of gender transition–related care, there are a number of concerns regard-

[4] For example, a female-to-male transition might include both chest surgery and phalloplasty.

Table 4.3
Estimated Annual Number of Surgeries and Hormone Therapy Users

	Active Component		Selected Reserve	
Assumption Regarding Underlying Prevalence	Annual Major Surgeries	Annual Hormone Therapy	Annual Major Surgeries	Annual Hormone Therapy
0.1% (CA study)[a]	25	30	15	15
0.16% (combined, population-weighted CA + MA studies)[b]	40	45	20	25
0.19% (gender-adjusted)[c]	45	50	25	30
0.37% (twice gender-adjusted rate)[d]	90	100	50	55
0.5% (MA study)[e]	130	140	70	80

SOURCE: RAND analysis.

[a] Based on estimates of prevalence from a California study (Conron, 2012).

[b] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

[c] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

[d] Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

[e] Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

NOTE: Hormone therapy is person-level; surgery statistics are counts of surgeries, and one person may have multiple surgeries.

ing the information on which these estimates rely. As stated previously, these concerns include both a reliance on prevalence estimates from just two states and a reliance on data from the NTDS, which were not collected from a random sample. Our utilization estimates were taken primarily from three sources:

- private health insurance utilization data on annual rates of enrollee transgender-related health care utilization in health insurance plans that cover transition-related health care, as reported by Herman (2013b)
- private health clinic data showing estimates of the rates of penectomies and bilateral mastectomies in the U.S. population in 2001, as reported by Horton (2008)[5]

[5] A penectomy is the surgical removal of the penis. A bilateral mastectomy is the surgical removal of both breasts.

- Veterans Health Administration (VHA) claims data, which were used to calculate prevalence and incidence rates of gender identity disorder (now referred to as GD in DSM-5) from 2006 to 2013, as reported by Kauth et al. (2014).

Each of these data sources provides information on a different outcome, which makes understanding the results more complicated. However, collectively, the information taken from these three studies provides a broad, useful picture regarding potential gender transition–related health care utilization in the AC population. In the following sections, we review each of these studies in detail, identify key estimates from each, and apply the estimates to the AC population identified in Table 3.2 in Chapter Three.

Private Health Insurance Utilization Estimates

Herman (2013b) reports on the experiences of 34 employers that provided gender transition–related health care benefits to their employees and dependents via their health insurance plans. This study specifically reports on the annual number of enrollees who accessed "transition-related care." This information is derived from health insurance claims data and thus is dependent on the treatments that were covered by the health insurance companies.[6] The firms surveyed typically covered major gender transition–related surgeries and hormone therapy, but they varied in their coverage of other transition-related treatments, such as vocal cord surgery.[7]

Firms reviewed by Herman (2013b) also typically did not report information on the number of dependents covered but included dependents in their utilization estimates. Data from several sources (e.g., Sonier et al., 2013; Gould, 2012) imply an approximate average one-to-one ratio of employees to dependents in privately insured firms in the United States. Thus, not accounting for the role of dependents in these utilization estimates would overstate utilization by approximately 100 percent.[8] For

[6] If firms do not cover particular treatments, it is not possible to file a claim for reimbursement. If individuals in these firms utilized services that were not covered, thus paying for treatments out of pocket or through some other form of health insurance, these utilization estimates will be biased downward.

[7] One hundred percent of firms covered major gender transition–related surgeries, including hysterectomy, oophorectomy, metoidioplasty, phalloplasty, urethroplasty, vaginectomy, orchiectomy, vaginoplasty, labiaplasty, and clitoroplasty. Ninety-two percent of firms covered bilateral mastectomy for female-to-male patients, but only 59 percent covered female-to-male chest reconstruction, and only 59 percent covered male-to-female augmentation mammoplasty (breast augmentation). All firms covered hormone therapies, specifically estrogen, progesterone, spironolactone, and testosterone.

[8] We used two different data sources to determine the typical number of dependents covered by the main policyholder in private health insurance firms in the United States. First, we used information from the Robert Wood Johnson Foundation on the number of people who are covered by employer-sponsored health insurance and are the main policyholders and on the number of people who are covered by employer-sponsored health insurance and are dependents. Using these figures, we estimated a 1-to-0.99 policyholder-to-dependent ratio in employer-sponsored private health insurance. The Economic Policy Institute also reports information on this question using data from the U.S. census Current Population Survey. Using this information, we calculated a policyholder-to-dependent ratio of 1 to 0.94.

firms that did not provide information on dependents, we imputed a one-to-one ratio of employees to dependents to identify the total number of enrolled individuals in a given health plan.

Table 4.4 presents the information from Herman (2013b) on the utilization of gender transition–related care in private health insurance firms. The first column shows available information on the identity of the firm. The second describes the number of firms in each category for which we had utilization estimates. The third contains our estimates regarding the total number of enrollees and dependents from all firms in that category. For confidentiality reasons, some surveyed data sources report only ranges for the number of employees in a firm. Therefore, we used the midpoint of the range to impute the number of employees in a particular firm, then assigned the total number of dependents based on this employee value. For example, we had utilization data from two firms in the "private 1,000–9,999 employees" category. Since we assume the midpoint value for firm size, this implies that there are 5,000 employees in each firm, or 10,000 total employees across the two firms. Assuming a one-to-one employee-to-dependent ratio implies an additional 10,000 covered individuals, resulting in a combined total of 20,000 enrollees.

The estimates presented in Table 4.4 indicate that utilization rates range from an annual low of zero individuals per 1,000 enrollees to an annual high of 0.064 individuals per 1,000 enrollees. To obtain a combined estimate of the different values, we constructed a weighted average using the existing utilization estimates, weighting by the number of covered individuals that generated each of the estimates in Table 4.4. A weighted average of all the estimates results in an overall utilization estimate of 0.0396 individuals per 1,000 enrollees.

Table 4.4
Enrollee Utilization of Gender Transition–Related Benefits in Private Health Insurance Firms

Private and Public Firms	Number of Firms	Total Contribution (enrollees + dependents)	Individual Claimants per 1,000 Enrollees
Private, fewer than 1,000 employees	1	1,000	0.0000
Private, 1,000–9,999 employees	2	20,000	0.0540
Private, 10,000–49,000 employees	5	250,000	0.0220
City and County of San Francisco	NA	80,000	0.0640
University of California	NA	100,000	0.0620
Weighted average per 1,000 enrollees			0.0396

SOURCE: Data from Herman, 2013b.

We conducted two sets of calculations using these estimates. First, we used the lowest non-zero utilization figure (0.022 claimants per 1,000 enrollees);[9] then, we used the weighted average calculation of 0.0396 per 1,000 enrollees. Applying the 0.022 claimants per 1,000 figure to the AC population of 1,326,273 implies that 29 AC service members would receive gender transition–related care annually. Applying the weighted average estimate of 0.0396 per 1,000 enrollees to the AC population implies that 53 service members would receive gender transition–related care annually.

Sensitivity Analyses

We also conducted two additional sensitivity analyses to determine the full potential scope of gender transition–related health care utilization in the AC. A key consideration when applying estimates from civilian populations to the military is that the underlying male/female distribution in the AC is different, with 85 percent of the AC population being male (versus approximately 50 percent in the civilian population). Studies suggest that the prevalence of transgender individuals is higher in the male population than in the female population (APA, 2013; Horton, 2008; Gates, 2011; Grant et al., 2011), so applying civilian estimates directly to the AC would underestimate the true utilization rates.

Accurately accounting for this issue required sex-specific utilization estimates that we could then multiply with the male/female AC distribution (85 percent male, 15 percent female). Unfortunately, we could not identify any sex-specific utilization estimates in the available private health insurance data; the aggregate cost and utilization estimates that we were able to identify already included underlying prevalence differences between the sexes. We posited that utilization would be twice as large for male-to-female transitions than for female-to-male transitions based on an assumption of linearity between transgender prevalence, for which we have sex-specific estimates, and total utilization (Horton, 2008).

Combining this assumption about differing utilization rates with the fact that the male/female labor force participation in the civilian population is close to 50 percent male and 50 percent female, we were able to solve for the sex-specific utilization estimates implied by the aggregate lower-bound (0.022) and weighted average (0.0396) values. Solving for the sex-specific utilization estimates in this manner, for the 0.022 aggregate estimate, we estimated a utilization rate of 0.0293 per 1,000 natal male enrollees and a utilization rate of 0.0146 per 1,000 natal female enrollees.[10] Similarly, for the 0.0396 weighted average figure, solving for the natal sex–specific utiliza-

[9] The unadjusted version of this figure (0.0044 percent) was also used in Belkin (2015) to estimate health care utilization in the military.

[10] The equation we solved to calculate the natal male–specific and natal female–specific utilization rates is as follows: $0.5(x) + 0.5(2x) = 0.022$. In this equation, the variable x is the natal female–specific utilization rate, and solving for x results in a value of 0.0146. Since the natal male–specific utilization rate is assumed to be twice the natal female rate, it equals 0.0293.

tion estimates, we identified a utilization rate of 0.0528 per 1,000 natal male enrollees and a utilization rate of 0.0264 per 1,000 natal female enrollees.

Applying these solved sex-specific estimates to the AC male/female distribution (1,125,581, or 85 percent male, versus 200,692, or 15 percent female) increased our initial lower-bound estimate of claimants from 29 to 36 and increased our estimate from applying the weighted average from 53 to 65.

Finally, the sociology and psychology literature speculates that there is a higher transgender prevalence in the military compared with the civilian population (G. Brown, 1988). Gates and Herman (2014) also calculated that transgender prevalence in the military is approximately twice the civilian prevalence (Gates, 2011; Gates and Herman, 2014).[11] Although we believe that the current body of empirical evidence validating this theory is weak, we take it seriously and consider the possible implications for transition-related health care utilization in the military. Assuming that transgender prevalence in the military is twice the transgender prevalence in the civilian population, and, again, assuming a direct relationship between prevalence and utilization, this would inflate our male/female distribution-adjusted estimates of individuals receiving transition-related care annually from 36 to 72, and from 65 to 129 in the AC. Table 4.5, which summarizes the results from applying the private health insurance estimates to the AC population, allows for a comparison of the different estimates.

Private Health Clinic Estimates

A second source of information regarding gender transition–related health care utilization comes from a survey of surgical clinics conducted by Horton (2008). In 2001, Horton surveyed all major clinics in the United States known to provide transition-related care to determine the number of penectomies and bilateral mastectomies performed on transgender patients. Table 4.6 reports surgery incidence estimates broken out by male-to-female transitions and female-to-male transitions. The third column shows estimates using clinic-reported data only. Horton also developed lower- and upper-bound estimates via assumptions regarding treatment counts for clinics with missing data, and these numbers are reported in the second and fourth columns of Table 4.6.[12] These data were collected in 2001 and coverage of gender transition-related benefits have increased over time, so it is also reasonable to assume that surgical tran-

[11] As stated previously, Gates and Herman (2014) used estimates from the NTDS and Gates (2011) for a transgender prevalence of 0.3 percent. That study also used data on history of military service in the U.S. population from the American Community Survey to estimate transgender prevalence in the military. Data from the National College of Health Administration show that military experience was significantly higher among transgender individuals than among those who did not identify as transgender (9.4 percent versus 2.1 percent; Blosnich, Gordon and Fine, 2015). However, data were collected from only 51 institutions, and the response rate for the survey was only 20 percent, which again raises questions regarding the validity of the estimates.

[12] Horton generated upper- and lower-bound estimates by assigning the largest and smallest surgical counts in the data to the clinics with missing values.

Table 4.5
Utilization Estimates from Applying Private Health Insurance Parameters

		Estimates Using Private Employer Data		
Annual Individual Claimants	Estimate from the Literature	Baseline	Sensitivity Analysis 1[a]	Sensitivity Analysis 2[b]
Active component, lower-bound estimate	0.022 claimants per 1,000 individuals	29	36	72
Active component, weighted average estimate	0.0396 claimants per 1,000 individuals	53	65	129

NOTES: Each cell in the "Estimates Using Private Employer Data" columns represents a unique prediction for utilization in the AC population. In the second column of the table, we describe the estimate from the literature that is applied to the AC population. See the text for details on each of the calculations.

[a] Sensitivity Analysis 1: We calculated a set of estimates that accounted for differences in the male/female distribution between the civilian and AC populations.

[b] Sensitivity Analysis 2: We calculated a set of estimates that accounted for differences in the male/female distribution between the civilian and AC populations and the possibility that transgender prevalence is twice as high in the military population as in the civilian population.

Table 4.6
Incidence of Penectomies and Bilateral Mastectomies Performed on Transgender Individuals

	Incidence Estimates (%)		
Transition Type	Low	Clinic-Reported Data	High
Male-to-female	0.00048	0.00053	0.00103
Female-to-male	0.00020	0.00030	0.00084

SOURCE: 2001 data from Horton, 2008.

NOTE: The table includes data on penectomies and bilateral mastectomies only.

sitions have also increased over time. Thus, these utilization rates of penectomies and bilateral mastectomies should be considered lower-bound estimates.

Applying these estimates to the AC male/female distribution results in low, medium, and high annual estimates of 5.8, 6.6, and 13.2 AC service members receiving these two surgeries, respectively. We reiterate here that these estimates are not directly comparable to the private health insurance estimates presented in the previous section because these estimates apply to only two specific procedures, while the private health insurance estimates include any gender transition–related procedures that private health insurance firms cover. One would expect estimates for two specific surgeries from 2001 to be lower than estimates generated from the private health insurance system in the later 2000s. Indeed, they are, but it is more difficult to make other direct

comparisons between these two estimates, given the private health insurance utilization data presented in Herman (2013b).

Veterans Health Administration Estimates

In this analysis, we used VHA data to calculate the expected annual incidence of gender identity disorder (the condition now known as GD in the DSM-5) in the AC population. As described previously, those with a gender identity disorder diagnosis are a subset of transgender individuals. Kauth et al. (2014) used VHA health claims data to identify incidence rates of new diagnoses. They also calculated prevalence rates of gender identity disorder in each year using previous yearly incidence rates. Because 2006 was the first year in their data set, the prevalence rate in the first year of their data is equivalent to the incidence rate. In the years after 2006, the prevalence rate is essentially a running total of the incidence rates in the previous years added to the most recent incidence rates.

The data in Table 4.7 imply that the incidence of gender identity disorder increased from 3.5 of 100,000 enrollees in FY 2006 to 6.7 of 100,000 enrollees in FY 2013 among veterans who use VHA health care (Kauth et al., 2014). Before applying these estimates to the AC population, we note two important points with respect to the analyses in Kauth et al. (2014). First, because the prevalence rate is simply a running total of new cases diagnosed since the first year of the study's data (2006), adding years of data prior to 2006 would mechanically increase the prevalence estimates. Thus, Kauth et al.'s prevalence calculations are a lower-bound for the total gender

Table 4.7
Prevalence and Incidence of Gender Identity Disorder Diagnoses in VHA Claims Data

Fiscal Year	New Diagnosis Rate (%)	Prevalence (%)
2006	0.0035	0.0035
2007	0.0034	0.0068
2008	0.0034	0.0098
2009	0.0038	0.0131
2010	0.0046	0.0172
2011	0.0051	0.0217
2012	0.0060	0.0270
2013	0.0067	0.0329

SOURCE: Kauth et al., 2014.

NOTE: The authors calculated new cases diagnosed and total existing cases in a given year based on the entirety of the data since 2006.

identity disorder prevalence rate in this population. Second, estimates based on claims data will likely be lower-bound estimates of incidence and prevalence, since individuals are identified only if they interact with the health care system for reasons related to gender identity disorder. These two caveats should be kept in mind when interpreting the extrapolations here.

Applying estimates from the 2013 data in Table 4.7 to the AC population, one would expect approximately 90 new cases of gender identity disorder each year and that approximately 440 AC service members would be diagnosed with this condition. Although the male/female distribution in the VHA system mirrors that of the AC, veterans who use VHA health care services may have lower socioeconomic and health status than veterans who do not use VHA health care, other military retirees, and AC service members. The VHA population also differs by age and, potentially, by other unmeasured characteristics related to underlying health status. For these varied reasons, these estimates may not be generalizable to the military population overall.

Summarizing the Estimates

Table 4.8 summarizes the key results after applying the estimates from the various data sets to the AC and SR populations. The largest estimate—270 treatments (surgeries and hormone therapies)—was calculated by combining the upper-bound population-level transgender prevalence estimate from Massachusetts with information from the NTDS data on the age of those receiving common transition-related treatments. When applied to the AC population, estimates from VHA and the private health insurance literature imply that only 30–90 AC service members will receive some type of gender transition–related treatment annually.

To understand the full implications of our estimates regarding the expected annual number of AC service members likely to obtain gender transition–related care, in Figure 4.1 we compare the above utilization estimates with the number of AC service members who self-reported visiting a mental health care provider in a given year (21 percent) and the number of AC service members who visited a mental health care specialist in a given year (7 percent; Hoge et al., 2006; McKibben et al., 2013). We chose this outcome because mental health care among military populations is an important, well-studied topic, and data were readily accessible for us to conduct the comparison. The mental health care utilization estimates represent unique service members accessing health care; thus, they compare most directly to the estimates using the private health insurance data and the NTDS hormone therapy estimates. For clarity's sake, we do not present all of the private health insurance and NTDS hormone therapy estimates in Figure 4.1. We do include the smallest, middle, and largest estimates using the private health insurance data and the largest hormone therapy estimate drawn from the NTDS data.

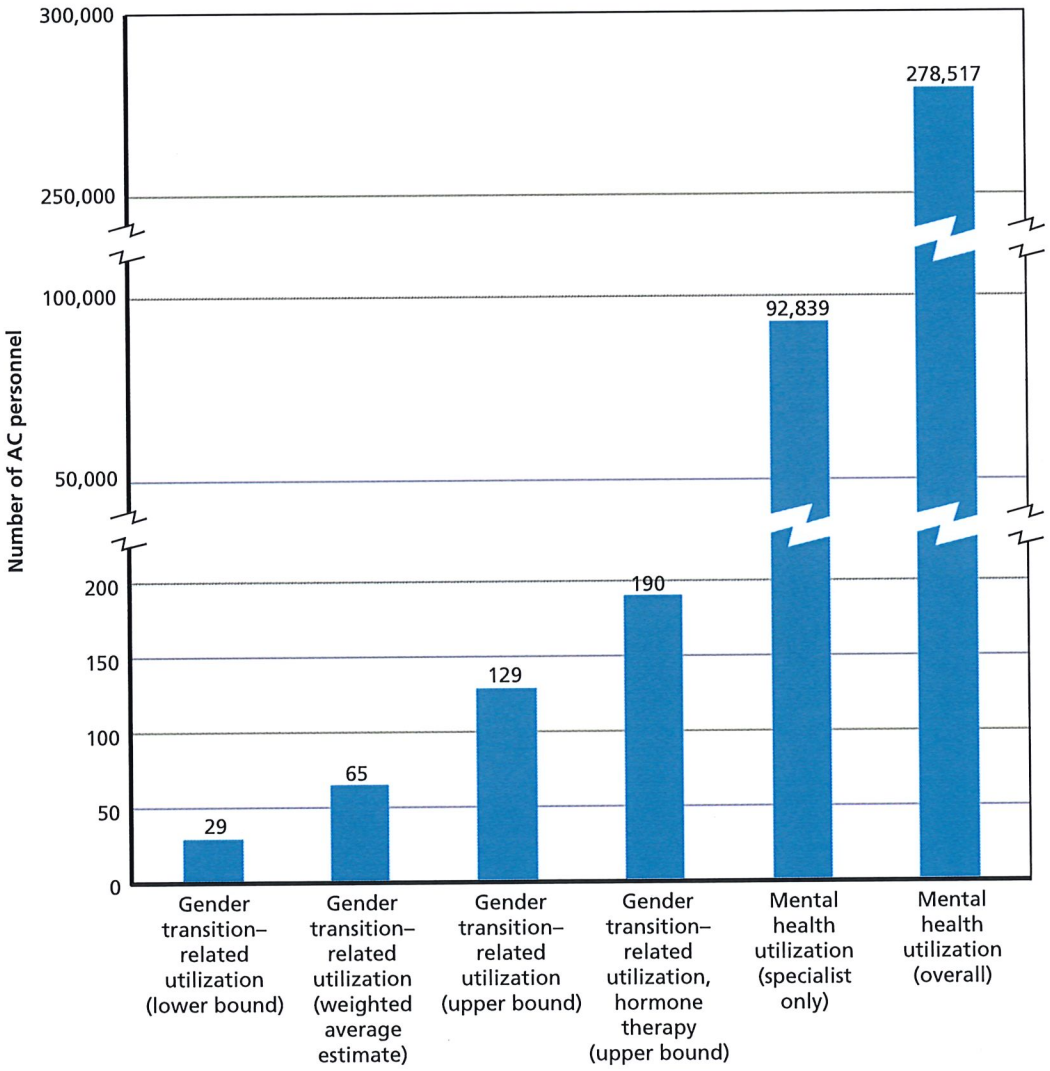
Table 4.8
Annual Gender Transition–Related Treatment Estimates from All Data Sources

	Active Component			Selected Reserve		
Estimate Type	Hormone Treatment	Surgical Treatments	All Treatments	Hormone Treatment	Surgical Treatments	All Treatments
Prevalence-based estimates (using NTDS data)						
Annual treatments based on CA study estimate (0.1%)	30	25	55	15	15	30
Annual treatments based on combined, population-weighted, gender-adjusted rate (0.19%)	50	45	95	25	30	55
Annual treatments based on MA study estimate (0.5%)	140	130	270	70	80	150
Utilization-based estimates						
Private health insurance annual individual claimants (0.022 per 1,000)	NA	NA	29	NA	NA	20
Private health insurance annual individual claimants (0.0396 per 1,000)	NA	NA	53	NA	NA	30
VHA-based annual new diagnoses (0.0067%)	90	NA	NA	60	NA	NA
Clinical utilization of penectomies and bilateral chest surgeries (0.0005%)	NA	10	NA	NA	5	NA

SOURCE: RAND analysis.

As Figure 4.1 shows, our estimates of the number of AC personnel who will use the gender transition–related health care benefits are overwhelmingly small compared with the number of AC personnel who access mental health treatment. Overall, based on our calculations, we expect annual gender transition–related health care to be an extremely small part of overall health care provided to the AC population.

Figure 4.1
Comparison of Annual Estimated Gender Transition–Related Health Care Utilization and Mental Health Care Utilization, Active Component



SOURCE: RAND analysis. Utilization rates in the figure are derived from both the prevalence-based and utilization-based approaches presented in Table 4.8.

NOTES: The non–hormone therapy transgender utilization estimates are from the application of estimates from the private health insurance data. The hormone therapy upper-bound transgender utilization estimate is from calculations using the NTDS data.

RAND *RR1350-4.1*

CHAPTER FIVE

What Are the Costs Associated with Extending Health Care Coverage for Gender Transition–Related Treatments?

In this chapter, we provide estimates for the costs associated with extending health care coverage for gender transition–related treatments. We focused on transgender service members in the AC because they have uniform MHS access. We did not include reserve-component service members in our analyses, but their MHS utilization and the associated cost will be negligible, given their highly limited military health care eligibility. Likewise, we did not include retirees or dependents in the cost analyses because we did not have information on age and sex distribution within these beneficiary categories. Some of these beneficiary categories also have limited eligibility for health care provided through MTFs and may receive their health care through TRICARE coverage in the purchased care setting or through other health insurance plans. Given these unknowns, it was only feasible to estimate the costs of gender transition–related care for AC service members; however, we recommend expanding these analyses in the future to include reserve-component members, as well as all individuals eligible for treatment under TRICARE. For the following analyses, we used demographic characteristics of the 2014 AC population to estimate the cost of providing such services.

Private Health Insurance Cost Estimates

To determine the potential costs of covering gender transition–related health care for transgender service members, we collected information on private health insurers' experiences with covering this care from two sources (Herman, 2013b; State of California, 2012). These actuarial estimates represent the expected increase in health care costs from covering a new set of treatments or a new group of beneficiaries. If employers decide to provide coverage for a particular treatment, these actuarial estimates are translated into premium increases for covered employees. These estimates should be thought of as the expected costs of extending coverage for gender transition–related care to transgender AC service members. Moreover, we note that the military may already be incurring the cost of some transgender treatments, as some patients and their providers use "omissions and ambiguities" to acquire needed care (Roller, Sedlak, and Draucker, 2015, p. 420). For example, a currently serving female-to-male patient

who had undergone a hysterectomy reported taking only the testosterone and not the estrogen prescribed as part of hormone therapy with his endocrinologist's knowledge and tacit support, while another was trying to get breast reduction surgery due to back pain rather than GD (Parco, Levy, and Spears, 2015, pp. 235–236).

Table 5.1 presents available data from public employers and private firms on the actuarial costs of covering gender transition–related care. It identifies the particular institution, the number of employees and dependents covered, and the identified premium increases due to expanding benefits.

Data from Table 5.1 show, generally, that the actuarial estimates of providing benefits for gender transition–related care increased total premiums (employee + employer share) by only a small fraction of a percent—and, in the most extreme cases, by only approximately 1 percent. Taking a weighted average of most of the information,[1] we estimated that extending insurance coverage to transgender individuals would increase health care spending by 0.038 percent. Applying this figure to total AC health care spending of $6.27 billion,[2] we find that covering gender transition–related care will increase AC health care spending by approximately $2.4 million (see Table 5.2).

The data in Table 5.1 suggest that the University of California, with 100,000 enrollees in its health plan, is one of the key drivers of the 0.038-percent weighted

Table 5.1
Actuarial Estimated Costs of Gender Transition–Related Health Care Coverage from the Literature

Public Employer Data	Actuarially Calculated Premium Increase	Total Contribution (employees + dependents)
City of Seattle	0.19% increase in health care budget	23,090
City of Portland	0.08% increase in health care budget	18,000
City of San Francisco	0% increase in health care budget	100,000
University of California	0% increase in health care budget	100,000
Private Employer Data	**Estimate**	**Total Contribution (employees + dependents)**
22 firms	Many employers reported no actuarial costs to adding benefit; estimates range from 0 to 0.2%	Mix of firm sizes
2 firms	Approximately 1% increase in premiums	5,800
1 firm	Much less than 1% increase in premium	77,000

SOURCE: Estimates are from Herman, 2013b, and State of California, 2012.

[1] We did not use information about the firm with 77,000 enrollees because it is not clear what "much less than 1 percent" implies with respect to the premium increase.

[2] Pharmaceutical and direct and purchased care inpatient and outpatient data calculated from TRICARE costs in Defense Health Agency, 2015.

average result. In addition to the actuarial increases, the University of California also reported a realized increase in health care spending of 0.05 percent, so we recalculated the weighted average figure by replacing the 0-percent estimate with the 0.05 percent estimate. This new calculation raised the overall cost estimate from 0.038 percent to 0.054 percent, or from $2.4 million to $3.4 million when applied to the AC. To summarize, our baseline estimates regarding expected gender transition–related health care costs in the AC are between $2.4 million and $3.4 million.

Sensitivity Analyses

To understand the potential full range of cost effects in the AC population, we conducted two additional sensitivity analyses similar to those described for our utilization ranges in Chapter Four. We used these sensitivity analyses to account for the skewed male/female distribution in the military population and for the possibility that transgender prevalence is higher in the military population. As in the utilization case, we were not able to identify any sex-specific effects on the premium increases. Thus, as in our utilization analysis, we assume that cost estimates are linearly related to prevalence,[3] and cost estimates for male-to-female transitions are twice the cost estimates for female-to-male transitions. Using this relationship, we again calculated natal male– and natal female–specific estimates from the aggregate estimates.

Given the assumption about differing cost effects, we calculated a natal male–specific cost estimate of 0.05 percent and a natal female–specific cost estimate of 0.025 percent for the aggregate premium estimate of 0.038 percent. Applying these sex-specific estimates to the AC male/female distribution increased our initial premium estimate from 0.038 percent to 0.047 percent. A similar calculation can be performed for our realized cost estimate of 0.054 percent. Assuming that gender transition–related health care costs are twice as large for male-to-female transitions as for female-to-male transitions, we calculated a natal male–specific cost effect of 0.072 percent and a natal female–specific cost effect of 0.036 percent. Applying these sex-specific estimates to the AC male/female distribution increased our initial premium estimate from 0.054 percent to 0.067 percent. Applying these newly calculated health care costs to the 2014 AC health care expenditures ($6.27 billion) increased our estimate of costs from the initial range of $2.4–3.4 million to a range of $2.9–4.2 million.

Finally, as noted previously, Gates (2011) and Gates and Herman (2014) calculated that transgender prevalence in the military is approximately twice that in civilian

[3] We also note that built into this linearity assumption and how it is applied in the two sensitivity analyses is the assumption that the cost of male-to-female transitions is the same as the cost of female-to-male transitions. Since there is no sex-specific information in the private health insurance cost data, the validity of the cost per case being equivalent is unknown. Padula, Heru, and Campbell (2015) estimated that a male-to-female surgical case is 33 percent more expensive than a female-to-male surgical case, but these estimates were not based on private employer data, so we did not directly incorporate this result into our calculations.

populations. Assuming that this estimate is valid, and, again, assuming that health care costs are linearly related to underlying prevalence, this would increase the above calculated value of $2.9 million to $5.8 million and the calculated value of $4.2 million to $8.4 million. Table 5.2 summarizes the results from the calculations described in this section.

To better understand the relative importance of our estimates regarding expected AC annual gender transition–related health care spending, we compared our cost estimates to the MHS spending on mental health in 2012 and to total AC health care spending in FY 2014. As Figure 5.1 shows, gender transition–related health care spending is expected to be extremely small compared with MHS spending on mental health (Blakely and Jansen, 2013) and overall AC health care expenditures (Defense Health Agency, 2015).

Summarizing the Estimates

A direct application of estimates from the private health insurance system implies a baseline spending range between $2.4 million and $3.4 million for AC gender transition–related health care. Sensitivity analyses that attempt to account for the fact that the male/female distribution in the AC population skews more heavily male than the civilian population and that transgender prevalence might be higher in the military increase this initial range to $5.8 million to $8.4 million. The implication is that even in the most extreme scenario that we were able to identify using the private health insurance data, we expect only a 0.13-percent ($8.4 million out of $6.2 billion) increase in AC health care spending.[4]

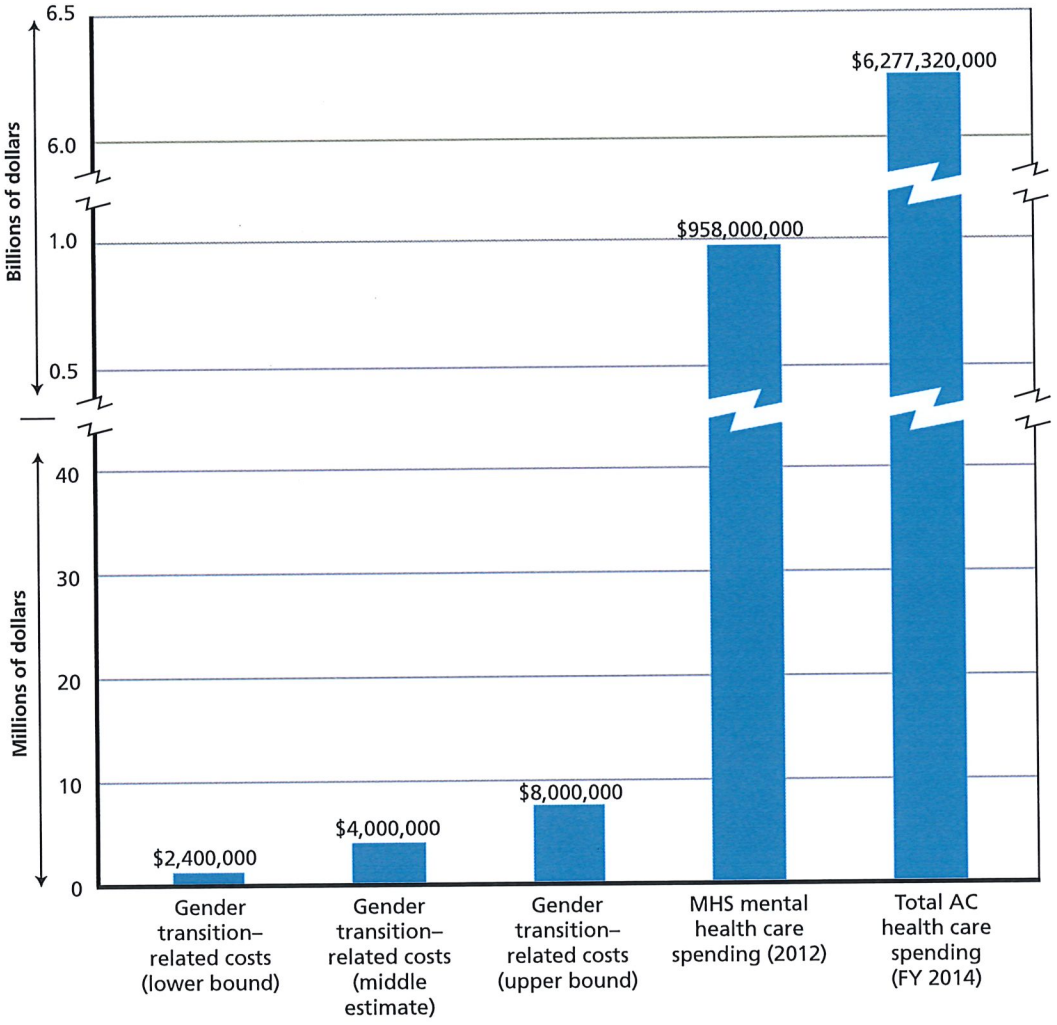
Table 5.2
Estimated Annual MHS Costs of Gender Transition–Related Health Care, Active Component

Analysis Type	Calculations Using Only Actuarial Premium Estimates 0.038% (actuarial)	Calculations Using Actuarial Premiums and Realized Values 0.054% (actuarial + realized)
Baseline	$2.4 million	$3.4 million
Sensitivity analysis 1: Adjusts for the male/female distribution in the AC population	$2.9 million	$4.2 million
Sensitivity analysis 2: Adjusts for the male/female distribution in the AC population and the assumption that transgender prevalence is twice as high in the military compared to the civilian population	$5.8 million	$8.4 million

SOURCE: RAND analysis.

[4] AC beneficiaries make up less than 15 percent of total TRICARE beneficiaries (Defense Health Agency, 2015).

Figure 5.1
Gender Transition–Related Health Care Cost Estimates Compared with Total Health Spending, Active Component



SOURCES: RAND analysis; Blakely and Jansen, 2013; Defense Health Agency, 2015. Estimates of premium increased and realized costs are reported in Table 5.1.

NOTES: The lower-bound estimate refers to premium increases only. The middle estimate includes premium increases and realized costs after adjusting for male/female distribution in the military. The upper-bound estimate includes premium increases and realized costs after adjusting for male/female distribution in the military and assuming the prevalence rate of transgender individuals in the military is twice that of civilian populations.

RAND *RR1350-5.1*

CHAPTER SIX

What Are the Potential Readiness Implications of Allowing Transgender Service Members to Serve Openly?

As DoD considers whether to allow transgender personnel to serve openly and to receive transition-related treatment during the course of their military service, it must consider the implications of such a policy change on the service members' ability to deploy and potential reductions in unit cohesion. In prior legal challenges to the transgender military discharge policy, DoD has expressed concern that the medical needs of these service members would affect military readiness and deployability. To address these concerns, this chapter provides estimates of the potential effects on force readiness from a policy change allowing these service members to serve openly.

A critical limitation of such an assessment is that much of the current research on transgender prevalence and medical treatment rates relies on self-reported, nonrepresentative samples. Thus, the information cited here must be interpreted with caution because it may have varying degrees of reliability. In addition, to estimate effects on readiness, we focused on transgender personnel in the AC and SR only. We did not include the Individual Ready Reserve because of the lack of publicly available, detailed demographic information. We used the same approach that applied to our analysis of health care utilization, applying both the prevalence-based and utilization-based approaches to force size. We note that the prevalence-based approach was the only approach that allowed us to estimate the number of transgender service members who may seek to live and work as their target gender. Transition does not necessarily imply the use of medical treatments, and we emphasize that some of these service members may still require accommodations in terms of housing and administrative functions (e.g., military identification cards, restrooms).

Impact on Ability to Deploy

The most salient and complex issue in allowing transgender personnel to serve openly is how DoD should regulate and manage operational deployment requirements for these personnel in the context of their transition to their target gender.

Pre-Transition

If transgender personnel are allowed to serve openly prior to transition, DoD will need to establish policies on when individuals may use the uniforms, physical standards, and facilities (e.g., barracks, restrooms) of their target gender. Additionally, DoD will need to clarify policies related to qualifications for deployment. Current deployment rules suggest that to qualify for deployment, individuals with diagnosed mental health disorders must show a "pattern of stability without significant symptoms or impairment for at least three months prior to deployment."[1] Ensuring appropriate screening will be critical to minimizing any mental health–related readiness issues. Secondary prevention measures prior to deployment, such as screening for GD, may be needed to ensure a pattern of stability and readiness for deployment.

During Transition

DoD would also need to determine when transitioning service members would be able to change uniforms and adhere to the physical standards of their target gender, as well as which facilities and identification cards they will use. Other countries have found that, in some cases, it may be necessary to restrict deployment of transitioning individuals to austere environments where their health care needs cannot be met. Deployment restrictions may also be required for individuals seeking medical treatment, including those seeking hormone therapy and surgical treatments.

We detail the constraints associated with transition-related medical treatments in Table 6.1. These constraints typically include a postoperative recovery period that would prevent any work and a period of restricted physical activity that would prevent deployment. The rightmost column of Table 6.1 presents the estimated number of nondeployable days we used to estimate the readiness impact. We note that these estimates do not account for any additional time required to determine medical fitness to deploy. Army guidelines, for example, do not permit deployment within six weeks of surgery. Nevertheless, there may be a significant difference between the estimated availability to deploy and the actual impact on deployability, as it is possible that transgender service members would time their medical treatments to minimize the effect on their eligibility to deploy.[2]

In addition to an expected, short-term inability to deploy during standard postoperative recovery time, some individuals experience postoperative complications that would render them unfit for duty. For instance, among those receiving vagino-

[1] Detailed guidance is provided in a memorandum from the Office of the Assistant Secretary of Defense for Health Affairs, 2013, p. 2.

[2] See for example, Personnel Policy Guidance Tab A (known as PPG-TAB A) that accompanies the medical guidelines document MOD TWELVE, Section 15.C, which articulates the minimal standards of fitness for deployment to the U.S. Central Command area of responsibility (U.S. Central Command, 2013).

plasty surgery, 6–20 percent have complications.[3] This implies that between three and 11 service members per year would experience a long-term disability from gender reassignment surgery. Among those receiving phalloplasty surgery, as many as 25 percent experience some medical complications (Elders et al., 2014).

Table 6.1
Gender Transition–Related Readiness Constraints

Transition Type and Treatment	Recovery Time	Leave and Deployment Implications	Estimated Nondeployable Days
Male-to-Female			
Hormone therapy only	Long-term, no recovery required	None (pending accommodations)	N/A
Augmentation mammoplasty	1 week no work, 4–6 weeks restricted physical activity	Up to 14 days medical leave, up to 60 days medical disability	75
Genital surgery (orchiectomy, vaginoplasty)	4–6 weeks no work, 8+ weeks restricted physical activity	Up to 45 days medical leave, up to 90 days medical disability	135
Female-to-Male			
Hormone therapy only	Long-term, no recovery required	None (pending accommodations)	N/A
Chest surgery	1 week no work, 4–6 weeks restricted physical activity	Up to 14 days medical leave, up to 60 days medical disability	75
Hysterectomy	2 weeks no work, 4–8 weeks restricted physical activity	Up to 21 days medical leave, up to 90 days medical disability	111
Genital surgery (metoidioplasty, phalloplasty)	2–4 weeks no work, 4–6 weeks restricted physical activity	Up to 21 days medical leave, up to 60 days medical disability	81

SOURCES: Treatment times based on RAND research compiled for this study. Estimates of numbers of treatments based on rates in Gates, 2011. Estimated nondeployable days based on RAND calculations using FY 2014 data from DoD, 2014.

NOTES: The total population in the table includes AC and SR personnel. Estimates of treatments are non-unique per person. Individuals may (and likely will) seek multiple treatments simultaneously. As such, deployment days are measured per treatment, not per individual. Estimates of nondeployable days do not include estimated delays generated by Medical Evaluation Board/Physical Evaluation Board review, which may be required depending on service rules.

[3] According to Elders et al. (2014, p. 15), summarizing findings from 15 studies, "2.1 percent of patients had rectal-vaginal fistula, 6.2 percent with vaginal stenosis, 5.3 percent had urethral stenosis, 1.9 percent with clitoral necrosis, and 2.7 percent with vaginal prolapse," and approximately 2.3 percent of patients experienced complications after vaginoplasty.

Taking the estimates for treatment and recovery time, we then applied the standards for leave and restricted physical activity.[4] We applied the recovery times and translated those into nondeployable days separated into medical leave, in which the service member is off the job, and medical disability, in which the service member can be at work but is subject to restricted physical requirements (e.g., no physical training, no heavy lifting). This provided us with the total number of nondeployable days per treatment type. We scaled this estimate by the number of days an individual can be deployed per year. For the AC, we assumed this to be 330 days per year (allowing 30 days of leave plus five days of processing time).[5] For the SR, we assumed 270 days per year (which allows nine months of deployment time). We counted each treatment separately and applied the number of treatments by treatment type shown in Table 6.1.

Note that because individuals may seek multiple treatments, sometimes at the same time, this number is not the same as the total number of individuals who will be nondeployable. Therefore, the estimates presented in Table 6.2 should be considered an upper bound in each category. Moreover, the prevalence-based estimates are significantly larger than the utilization-based estimates as shown in Table 4.8. Using the prevalence-based approach, we found that between eight and 43 of the available 1.2 million labor-years in the AC may be unavailable for deployment.[6] The combined, population-weighted, and gender-adjusted estimate implies that about 16 labor-years from the AC and about 11 labor-years from the SR may be nondeployable. This represents 0.0015 percent of available deployable labor-years across the AC and SR.

These estimates are based on surgical take-up rates ranging from 25 to 130 per year in the AC, with 55–270 total treatments, including hormone treatments. Similarly, the prevalence-based estimates imply 15–80 surgical treatments per year in the SR, with between 30 and 150 total treatments, including hormone therapy.

The utilization-based approach implies many fewer treatments. Although we could not estimate the impact on labor-years because we did not have information on specific treatments, based on usage rates in California, the utilization-based approach implies 30–50 total treatments, including surgeries and hormone therapy. Evidence from the VHA suggests that 90 service members in the AC and 50 in SR are diagnosed with GD in any given year. Such a diagnosis would be a prerequisite for any surgical treatments, suggesting that true utilization rates in the military may be significantly lower than suggested by the prevalence-based approach.

We caution that our labor-year estimates also likely overcount actual nondeployable time because our estimate captures "availability to deploy," rather than the deploy-

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[4] For reference, we used the Army Regulation 40-501 (revised 2011), which governs leave and disability, and the Navy Medical Policy 07-009 (2007), which provides guidance on pre-clearance, accommodations for deployment readiness, and additional requirements in the U.S. Central Command area of operations.

[5] We based this estimate on Army Regulation 600-8-101 (2015).

[6] We define a labor-year as the amount of work done by an individual in a year.

Table 6.2
Estimated Number of Nondeployable Man-Years Due to Gender Transition–Related Treatments

		Estimated Number of Nondeployable Labor-Years				
Component	Total Labor-Years Available (FY 2014)	0.1%[a] (CA study)	0.16%[b] (combined, population-weighted CA + MA studies)	0.19%[c] (gender-adjusted rate)	0.37%[d] (twice gender-adjusted rate)	0.5%[e] (MA study)
Active	1,199,096	8.2	13.7	16.2	32.3	42.8
Selected Reserve	615,446	5.9	9.9	10.7	21.3	29.9

SOURCES: Estimates for nondeployable labor-years are based on RAND calculations using FY 2014 data from DoD, 2014.

[a] Based on estimates of prevalence from a California study (Conron, 2012).

[b] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

[c] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

[d] Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

[e] Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

ment impact itself. This difference comes from three key assumptions that we make to calculate these estimates: (1) service members who are seeking treatment will also be deployed; (2) service members who are seeking treatment cannot time those treatments to avoid affecting their deployment eligibility; and (3) service members seek only one treatment at a time rather than having multiple treatments at the same time, which would allow concurrent (rather than sequential) recovery times. Thus, it is likely that a service member's care would have a substantial overall impact on readiness only if that service member worked in an especially unique military occupation, if that occupation was in demand at the time of transition, and if the service member needed to be available for frequent, unpredicted mobilizations.

Post-Transition

Having completed medical transition, a service member could resume activity in an operational unit if otherwise qualified. As in other cases in which a service member receives a significant medical treatment, DoD should review and ensure that any longer-term medical care or other accommodations relevant to the transgender service member's specific medical needs are addressed.

Impact on Unit Cohesion

A key concern in allowing transgender personnel to serve openly is how this may affect unit cohesion—a critical input for unit readiness. The underlying assumption is that if service members discover that a member of their unit is transgender, this could inhibit bonding within the unit, which, in turn, would reduce operational readiness. Similar concerns were raised in debates over whether to allow gay and lesbian personnel to serve openly (Rostker et al., 1993; RAND National Defense Research Institute, 2010), as well as whether to allow women to serve in ground combat positions (Schaefer et al., 2015; Szayna et al., 2015). Evidence from foreign militaries and surveys of the attitudes of service members have indicated that this was not the case for women or for lesbian and gay personnel (Schaefer et al., 2015; Harrell et al., 2007; RAND National Defense Research Institute, 2010). In examining the experiences of foreign militaries, the limited publicly available data we found indicated that there has been no significant effect of openly serving transgender service members on cohesion, operational effectiveness, or readiness. (For a more in-depth discussion of this topic, see Chapter Seven.) However, we do not have direct survey evidence or other data to directly assess the impact on the U.S. military.

Evidence from the General U.S. Population

According to recent research on the U.S. general population, attitudes toward transgender individuals are significantly more negative than attitudes toward other sexual minorities (Norton and Herek, 2013). However, heterosexual adults' positive attitudes toward and acceptance of transgender individuals are strongly correlated with their attitudes and acceptance of gay, lesbian, and bisexual individuals (Flores, 2015). As such, similar to changes seen in public attitudes toward homosexuality, tolerance and acceptance toward the transgender population could change over time. Additionally, evidence does indicate that direct interactions with transgender individuals significantly reduce negative perceptions and increase acceptance (Flores, 2015), which would suggest that those who have previously interacted with transgender individuals would be more likely to be tolerant and accepting of them in the future. Similar findings have arisen from surveys and focus groups with service members regarding attitudes toward the integration of women into direct combat positions (Szayna et al., 2015) and attitudes toward allowing gay and lesbian service members to serve openly in the U.S. military (RAND National Defense Research Institute, 2010).[7]

[7] A recent article examined the attitudes of military academy, Reserve Officers' Training Corps, and civilian undergraduates in the United States toward transgender people in general, in the workplace, and in the military (see Ender, Rohall, and Matthews, 2016).

Evidence from Foreign Militaries

While there are limited data on the effects of transgender personnel serving openly in foreign militaries, the available research revealed no significant effect on cohesion, operational effectiveness, or readiness. In the case of Australia, there is no evidence and there have been no reports of any effect on cohesion, operational effectiveness, or readiness (Frank, 2010). In the case of Israel, there has also been no reported effect on cohesion or readiness (Speckhard and Paz, 2014). Transgender personnel in these militaries have reported feeling supported and accommodated throughout their gender transition, and there is no evidence of any impact on operational effectiveness (Speckhard and Paz, 2014). In fact, commanders have reported that transgender personnel perform their military duties and contribute effectively to their units (Speckhard and Paz, 2014). Interviews with commanders in the United Kingdom also found no effect on operational effectiveness or readiness (Frank, 2010). Some commanders reported that increases in diversity had led to increases in readiness and performance. Interviews with these same commanders also found no effect on cohesion, though there were some reports of resistance to the policy change within the general military population, which led to a less-than-welcoming environment for transgender personnel. However, this resistance was apparently short-lived (Frank, 2010).

The most extensive research on the potential effects of openly serving transgender personnel on readiness and cohesion has been conducted in Canada. This research involved an extensive review of internal defense reports and memos, an analysis of existing literature, and interviews with military commanders. It found no evidence of any effect on operational effectiveness or readiness. In fact, the researchers heard from commanders that the increased diversity improved readiness by giving units the tools to address a wider variety of situations and challenges (Okros and Scott, 2015). They also found no evidence of any effect on unit or overall cohesion. However, there have been reports of bullying and hostility toward transgender personnel, and some sources have described the environment as somewhat hostile for transgender personnel (Okros and Scott, 2015).

To summarize, our review of the limited available research found no evidence from Australia, Canada, Israel, or the United Kingdom that allowing transgender personnel to serve openly has had any negative effect on operational effectiveness, cohesion, or readiness. However, it is worth noting that the four militaries considered here have had fairly low numbers of openly serving transgender personnel, and this may be a factor in the limited effect on operational readiness and cohesion.

Costs of Separation Requirements Related to Transgender Service Members

We considered the costs and benefits of providing appropriate care to transgender service members, the requirements for those who would serve openly if the current policy changed, and the costs of continuing the current administrative separation process. We analyzed the costs of separation under several assumptions: (1) some transgender personnel are currently serving but are not able to reveal their transgender status, (2) some individuals who would be desirable recruits could be excluded for reasons only related to their gender identity, and (3) some individuals who are transgender are or have been separated for reasons only related to their gender identity, which imposes separation costs.

Separation and a continued ban on open service (i.e., manpower losses) are the alternatives to meeting the medical needs of transgender individuals. As detailed in Chapter Two, the continued ban on open service may result in worsening mental health status, declining productivity, and other negative outcomes due to lack of treatment for gender identity–related issues. In addition, if DoD actively pursues separation, the process can be tedious, especially now that it requires the approval of the Under Secretary of Defense for Personnel and Readiness. Under current DoD regulations, transgender personnel can be declared administratively unfit for service if their gender identity affects their ability to meet operational or duty requirements. A June 2015 revision to DoD policy requires that a discharge justification be based on inability to meet duty requirements. However, any "administratively unfit" finding prohibits the individual from being medically evaluated for continued service.[8] Absent this process, transgender service members do not have recourse to allow mental health experts or medical professionals to review their case concurrently. This can result in unnecessary and inconsistent approaches to discharging transgender service members. As was the case in enforcing the policy on homosexual conduct, this can involve costly administrative processes and result in the discharge of personnel with valuable skills who are otherwise qualified (U.S. Government Accountability Office, 2011).

Moreover, the total cost in lost days available for deployment is negligible and significantly smaller than the lack of availability due to medical conditions. For example, in 2015 in the Army alone, there were 102,500 nondeployable soldiers, 50,000 of whom were in the AC (Tan, 2015). This accounted for about 14 percent of the AC—personnel who were ineligible to deploy for legal, medical, or administrative reasons.

[8] These boards provide an established process and mechanism for evaluating whether a service member with an ailment or diagnosis, such as a mental health diagnosis, could continue military service. The services use the Medical Evaluation Board and Physical Evaluation Board systems to determine whether personnel "with an ailment or diagnosis, such as a mental health diagnosis, can continue . . . military service," based on a thorough review of fitness to serve (DoDI 1332.38, 1996).

Of those, 37,000 could not deploy due to medical conditions.[9] Excluding those who were severely injured and required longer-term care, there were 28,490 service members who had either category 1 (up to 30 days) or category 2 (more than 30 days) restrictions. Assuming those in category 1 cannot deploy for 30 days and those in category 2 cannot deploy for 90 days, we estimate there are currently 5,300 nondeployable labor-years in the Army alone. Thus, we anticipate a minimal impact on readiness from allowing transgender personnel to serve openly.

[9] Rates of injury and nondeployability time as reported in Cox (2015).

CHAPTER SEVEN

What Lessons Can Be Learned from Foreign Militaries That Permit Transgender Personnel to Serve Openly?

As the U.S. military considers changes to its transgender personnel policy, revisions to several other policies may be necessary. Policies in need of change would cover a range of personnel, medical, and operational issues affecting individuals and units, including some policies that currently vary by gender. Examples of the latter would include housing assignments, restrooms, uniforms, and physical standards. While these are new questions for the U.S. military, there are other countries that already allow transgender personnel to serve openly in their militaries and have already addressed these policy issues.

We reviewed policies in foreign militaries that allow transgender service members to serve openly. Our primary source for the observations presented in this report was an extensive document review that included primarily publicly available policy documents, research articles, and news sources that discussed policies on transgender personnel in these countries. The information about the policies of foreign militaries came directly from the policies of these countries as well as from research articles describing the policies and their implementation. Our findings on the effects of policy changes on readiness draw largely from research articles that have specifically examined this question using interviews and analyses of studies completed by the militaries themselves. Finally, our insights on best practices and lessons learned emerged both directly from research articles describing the evolution of policy and the experiences of foreign militaries and indirectly from commonalities in the policies and experiences across our four case studies. Recommendations provided in this report are based on these best practices and lessons learned, as well as a consideration of unique characteristics of the U.S. military.

This review and analysis of the policies in foreign militaries can serve as a reference for U.S. decisionmakers as they consider possible policy revisions to support the integration of openly transgender personnel into the U.S. military. We include information on how, when, and why each country changed its policy. We also detail the policies of each country, covering such issues as the medical and administrative

requirements before gender transition can begin, housing assignments, uniform wear, and physical fitness standards.

Policies on Transgender Personnel in Foreign Militaries

According to a report by the Hague Center for Security Studies, there are 18 countries that allow transgender personnel to serve openly in their militaries: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom (Polchar et al., 2014). This chapter describes the policies of the four countries—Australia, Canada, Israel, and the United Kingdom—with the most well-developed and publicly available policies on transgender military personnel. It focuses explicitly on policies that describe how these foreign militaries treat transgender personnel and how they address this population's gender transition needs. While the focus of the chapter is on the specific policies integrating openly transgender military personnel in these four foreign militaries, we also provide some information about what happened after the policy change, including bullying and harassment, and summarize best practices and challenges that emerged from our four case studies.[1]

The formal policies on transgender personnel in the four countries address a number of aspects of the gender transition process.[2] Generally, these policies do not explicitly address such issues as the recruitment or retention of transgender personnel, though we provide information on the qualification of transgender personnel to serve when it is available. They do generally address such issues as the requirements for transitioning, housing assignments, restroom use, uniforms, identity cards, and physical standards. They also address whether the transitioning personnel remain with their old units or shift to new ones and how other members of a unit should be informed. Finally, the policies address access to medical care and what is or is not covered by the military health care system.

In addition to addressing these crucial issues, foreign military policies on transgender personnel typically lay out a gender transition plan, which describes the timeline or steps in the transition process. However, it is worth noting that each individual's

[1] We looked for information on the policies of the other 14 countries but were unable to find any publicly available documents in English.

[2] We note a few interesting points about other countries that we investigated but for which we were unable to find sufficient publicly available information to construct a complete case. The Netherlands was the first country to allow transgender personnel to serve openly in its military, opening its ranks in 1974. New Zealand opened its military to transgender personnel in 1993; although we could not find a written policy, a 2014 report by Hague Center for Strategic Studies referred to New Zealand's as the most friendly military to transgender personnel. The New Zealand Defence Force also has an advocacy group, OverWatch, that provides support to lesbian, gay, bisexual, and transgender personnel (see Polchar et al., 2014).

gender transition is unique. While some choose to undergo hormone therapy or gender reassignment surgery, this is not required for gender transition. As a result, the timelines outlined in the policies are intended to be examples only.

Australia

In 2010, the Australian Defence Force revoked the defense instruction that prohibited transgender individuals from serving openly, stating that excluding transgender personnel from service was discrimination that could no longer be tolerated (Ross, 2014). The Australian Department of Defence, with the advocacy group Defence Lesbian, Gay, Bisexual, Transgender, and Intersex Information Service, has produced guides to support commanders, transitioning service members, and the units in which transitioning members are serving (Royal Australian Air Force, 2015). The guide outlines five stages in the gender transition process: diagnosis, commencement of treatment, disclosure to commanders and colleagues, the post-transition experience, and, if applicable, gender reassignment surgery (Royal Australian Air Force, 2015). There is no public information on the number of transgender personnel in the Australian military or the costs associated with covering gender transition–related medical care.

A service member's gender transition begins after receiving a medical diagnosis of gender incongruence from a doctor approved by the Australian Defence Force. According to Australian Defence Force policy, once service members receive this diagnosis and present a medical certification form to their commanders, they can begin the "social transition," which policy defines as the time when an individual begins living publicly as the target gender. Under the current policy, after this point, the service member's administrative record is updated to indicate the target gender for the purposes of uniforms, housing, name, identification cards, showers, and restrooms (Royal Australian Air Force, 2015). This means that, after this point, the service member is assigned to housing of the target gender, may use the restrooms of the target gender, has an identification card with the target gender and new name, and can wear the uniform of the target gender.

During the social transition, the service member may undergo hormone therapy. However, neither hormone therapy nor gender reassignment surgery is required for the administrative changes to occur. Importantly, this shift in gender for military administrative purposes may not always match the legal transition (with respect to the Australian government) to the target gender (Royal Australian Air Force, 2015). Finally, when transgender service members choose to transition, they may choose whether to stay with their current unit or transfer to a different one. They may also choose how colleagues are informed of the gender transition—that is, whether they wish to tell colleagues themselves or have a senior leader do so.

Australia's policy also addresses matters related to physical standards and medical readiness. During the transition period, a service member may be downgraded in terms of physical readiness or declared unable to deploy for some time. However, this

determination is decided on a person-by-person basis and is only temporary. According to the guide provided to service members and commanders, most individuals are placed on "MEC [Medical Employment Classification] 3—Rehabilitation" status during their medical transition or if they require four consecutive weeks of sick leave. Others may be able to remain "MEC 2—Employable and Deployable with Restrictions" for the majority of the gender transition period. In most cases, this determination is made by a certification board, though commanders are also given discretion to downgrade transitioning service members or declare them unfit to deploy, contingent on a stated inability to accommodate the service member's needs or a determination that the transitioning service member's presence would undermine the unit's performance. However, there is no public information available on the types of justifications a commander might give in making such a determination.

The deployment status of each individual will vary during the gender transition based on the transition path chosen (for example, whether hormone therapy or surgery is undertaken). Some of these treatments are covered by military health care. In Australia, medical treatments associated with gender transition, including both hormone therapy and gender reassignment surgery, are covered, but treatments considered "cosmetic" might not be (Royal Australian Air Force, 2015). However, it is not clear what is classified as cosmetic or what might be considered medically necessary. Importantly, gender transition–related medical procedures are provided only at certain facilities, so service members who wish to receive these treatments may need to make special requests for specific assignments where their needs can be met. In general, personnel are permitted to take sick leave to facilitate their medical transition (Royal Australian Air Force, 2015).

Transitioning service members' deployment status will also depend on their ability to meet physical fitness standards. During the transition period, a service member may be considered medically exempt from meeting physical fitness standards, with a coinciding readiness classification of nondeployable. Once deemed medically able to complete the test by a medical professional, the service member may be asked to meet the standards of the target gender. However, which gender standards the individual is required to meet and when is determined by the medical officer overseeing the gender transition (Royal Australian Air Force, 2015). Thus, the point at which each transitioning service member is required to meet the target-gender standards varies.

Canada

In Canada, a 1992 lawsuit from a member of the armed forces resulted in the repeal of a regulation banning gay, lesbian, and transgender individuals from serving openly in the military (Okros and Scott, 2015). In 1998, the Canadian military explicitly recognized gender identity disorder and agreed to cover gender reassignment surgery. In 2010, Canadian military policy was revised to clarify transgender personnel issues, such as name changes, uniforms, fitness standards, identity cards, and records (Okros

and Scott, 2015). An updated policy, Military Personnel Instruction 01/11, "Management of Transsexual Members," was released in 2012 (Canadian Armed Forces, 2012). It stated, "The CF [Canadian Forces] shall accommodate the needs of CF transsexual members except where the accommodation would: constitute undue hardship; or cause the CF member to not meet, or to not be capable of meeting. . . . Minimum Operational Standards Relating to Universality of Service" (Canadian Armed Forces, 2012, p. 5). Other considerations that can be used to determine whether an accommodation is reasonable include cost and the safety of other service members and the public (Canadian Armed Forces, 2012, p. 5). Data suggest that there are approximately 265 transgender personnel serving openly and that the Canadian military pays for about one gender reassignment surgery per year (Okros and Scott, 2015).

Canada's policy on transgender personnel covers such issues as housing, identification cards, restrooms, physical standards, deployment, medical treatment, and uniforms. The process is similar in most ways to that in Australia, described earlier. In Canada, one of the first steps in the gender transition process is a medical assessment in which the individual is given a diagnosis of gender incongruence and assigned a temporary medical category that defines both employment limitations and accommodations that will be needed to support the service member during gender transition. After receiving this diagnosis, service members are responsible for informing their commanders and are asked to give commanders as much notice as possible before beginning their gender transition. After that, the service member, the service member's manager, and the unit's commanding officer are expected to meet to discuss the service member's gender transition plan and to addresses any necessary accommodations. The policy recommends frequent meetings between the service member and relevant leaders and medical professionals to ensure that the transitioning service member's needs are met. The policy also identifies subject-matter experts, such as chaplains and mental health professionals, who might be available to provide advice (Canadian Armed Forces, 2012).

The policy states that the gender transition plan should address housing, uniforms, deployments, and other administrative considerations. While the timeline will vary for each individual, in most cases, after receiving the diagnosis and informing the commander, the service member is able to begin living openly as the target gender. At this point, the service member is assigned to housing of the target gender, given ID cards with the target gender and new name, given uniforms of the target gender, and permitted to use restrooms of the target gender. However, while the individual is considered a member of the target gender for all administrative purposes within the military at this point, an official name and gender change in the military personnel system requires both medical certificates and legal documentation (Canadian Armed Forces,

2012).[3] Finally, medals and awards earned by the service member prior to transitioning cannot be transferred to the new name when the service member transitions to the target gender (Okros and Scott, 2015).

While the policy expects accommodations to be made to meet the needs of transgender personnel, it also notes that commanders must strike a balance between meeting the needs and legal rights of transgender personnel and the privacy needs of other service members in restrooms, showers, and housing. It does not, however, provide guidance on how this should be accomplished (Canadian Armed Forces, 2012). The policy also makes clear that incidents of harassment must be dealt with according to the Canadian military's discrimination and harassment policy. Finally, if the transgender service member is assigned to a new unit permanently or temporarily, any required accommodations are to be communicated to the new commanding officer prior to the service member's arrival (Canadian Armed Forces, 2012).

The medical assessment and gender transition plan developed at the start of transition are also used to determine a service member's readiness status and deployability. The policy states that service members can be downgraded temporarily in terms of their readiness, ability to deploy, and eligibility for remote assignments until gender transition is complete (Canadian Armed Forces, 2012). This determination is made primarily by the medical professionals overseeing the service member's gender transition. After the gender transition is complete, the continued need for a reduced medical standard is decided on a case-by-case basis based on the service member's overall health, chronic conditions, and need for access to medical care. After beginning the gender transition, and based on the medical assessment, the service member is considered medically exempt from physical fitness testing and requirements until legally assuming the acquired or target gender (which, as noted earlier, requires provincial recognition). At that point, the fitness standards for the acquired or target gender apply. More specifically, once personnel are removed from the medical exemption list, they have 90 days to meet the new standards (Canadian Armed Forces, 2012).

A reduced medical readiness determination during gender transition is intended primarily to ensure that the service member has uninterrupted access to medical care. Once gender transition is complete, transgender service members and their commanders are responsible for identifying the service member's specific needs and how they will be addressed (Canadian Armed Forces, 2012). Gender reassignment surgery will not, however, automatically result in permanent deployment restrictions. As in Australia, gender reassignment surgery and hormone therapy are covered by military health care. The Canadian military paid for one gender reassignment surgery in 1998 and has paid for one or two surgeries per year since then (Canadian Armed Forces, 2012).

[3] Also note that the requirements for the legal change vary by province but typically involve only a statement that the individual has assumed the target gender and a medical certification from a doctor of a diagnosis of gender incongruence.

Israel

The Israel Defense Forces (IDF) have allowed transgender personnel to serve openly since 1998 (Speckhard and Paz, 2014).[4] The IDF experience with transgender personnel is somewhat unique because Israel's military is composed largely of conscripts who serve two or three years and then serve in the reserves with extended periods of active service. As a result, a very high percentage of the population spends extended periods of time mixing military and civilian life. From the perspective of this report, this blending of civilian and military life creates unique challenges for transgender personnel, as they cannot be one person in their civilian life and then a different person in their military life. Some transgender individuals receive a discharge or exemption from their military service based on their gender incongruence, but this decision is currently at the discretion of the commander. There is no official IDF policy on transgender personnel, but according to one report, senior members of the IDF are working to draft one (Speckhard and Paz, 2014). In 2014, the IDF announced that it would support transgender individuals throughout the transition process. Under this new policy, transgender teens who have not yet begun to transition to another gender will be enlisted according to their birth sex, but after enlistment, they will be given support and assistance with the gender transition process (Zitun, 2014). As a result, Speckhard and Paz (2014) noted, experiences vary for transgender personnel in the IDF. Some individuals report that once they ask to transition, they are allowed to dress and serve as their target gender. However, it is unclear how generalizable this is.

Typically, IDF administrative records use the gender at that time of enlistment. Since conscription occurs at age 18, and because hormone treatment for gender incongruence cannot legally begin until age 18, the administrative records of most personnel show their birth gender. Under a newly announced policy, personnel enlisted using their birth gender who identify as transgender can immediately receive support and treatment to begin the gender transition (Zitun, 2014). Importantly, however, as of 2014, the military identification card carries the birth gender until a service member undergoes gender reassignment surgery, even if the service member is living publically as the target gender (Speckhard and Paz, 2014). It should be noted that, in Israel, only one hospital can perform gender reassignment surgery, and this surgery cannot be performed until age 21, though some people go abroad for it (Speckhard and Paz, 2014). This creates some complications for housing and other matters, discussed in more detail later. The new policy will also allow transgender recruits to receive support for gender transition after enlistment.

Available evidence suggests that, in the IDF, assignment of housing, restrooms, and showers is typically linked to the birth gender, which does not change in the military system until after gender reassignment surgery. Service members who are undergo-

[4] We do not know the exact date for this change because there was never a formal policy allowing or prohibiting transgender personnel from serving. It was in 1998 that the first openly transgender individual served in the IDF.

ing gender transition are accommodated, however, through the use of ad hoc solutions, including giving transitioning personnel their own showers, housing, or restrooms (Speckhard and Paz, 2014). Once transitioning personnel have completed gender reassignment surgery, they can be assigned to the housing, restrooms, and showers of their acquired gender. It is also worth noting that the majority of noncombat personnel are able to live at home, off base. As a result, the housing issue does not affect a large number of transitioning personnel (Speckhard and Paz, 2014). The issue of uniforms is usually easier to address, and service members are able to wear the uniform of the target gender once they begin their gender transition.

In addition to addressing housing and other administrative matters for conscripts and career soldiers, the IDF must address transitioning reservists. The limited information available suggests that the approach to addressing the needs of this group also varies from person to person. Usually, if reserve members are in the process of transitioning or have transitioned when called to active duty, they are permitted to return to service as their target or acquired gender (following the same administrative policies described earlier). For example, a service member who served in an all-male combat unit and is transitioning to female may be moved to another position. Again, many reservists serve their duty while living at home, so housing is not usually an issue. Restroom and shower assignments are addressed on an ad hoc basis (Speckhard and Paz, 2014). Finally, some personnel who have transitioned or are in the process of transitioning are exempted from their reserve duty. However, this is becoming less common as the IDF strives to accommodate the needs of these personnel rather than exempting them from service (Speckhard and Paz, 2014).

The IDF does not have a formal policy on physical standards for transgender individuals serving their conscription duty, reserve duty, or as professional soldiers. Available information suggests only that transgender personnel can serve in any unit or occupation for which they meet the requirements, with the exception of a few male-only combat units and certain security-related positions (Speckhard and Paz, 2014). Personnel transitioning from female to male are able to serve in male-only combat units only if they can meet the requirements set for other men. Personnel transitioning from male to female cannot serve in male-only combat units once they begin hormone treatment (Speckhard and Paz, 2014).

There do appear to be some limitations on the assignment of transgender personnel, particularly in combat units. Because of austere living conditions in these types of units, necessary accommodations may not be available for service members in the midst of a gender transition. As a result, transitioning individuals are typically not assigned to combat units (Speckhard and Paz, 2014). Transgender personnel are also limited from assignment to certain security-related positions due to concerns about blackmail, based on the assumption that these service members might be open about their gender identity in the military but might not have told others, including family members. Keeping

these types of secrets might make an individual susceptible to blackmail or extortion (Speckhard and Paz, 2014).

In the IDF, medical issues and matters related to the readiness of transgender personnel are addressed on a case-by-case basis, though a more formal policy is being developed. For conscripts, the only treatment that can be provided by the military is hormone therapy because gender reassignment surgery is possible in Israel only after age 21, by which point the conscription duty is usually completed (Speckhard and Paz, 2014). Those who choose to stay in the military full-time after the age of 21, as well as those in the reserve called to back to active service, may receive both hormone therapy and gender reassignment surgery. Those who choose to undergo surgery are permitted to take a period of sick leave for the surgery and recovery, as they can for any other medical treatment or surgery (Speckhard and Paz, 2014). Israel has nationalized health care that typically covers all treatments associated with gender transition, ranging from psychiatric care to pre- and postoperative care, hormone treatment, breast augmentation, and facial feminization. Apart from the approaches used to address physical standards for transitioning individuals (discussed earlier), there are no specific policies governing the readiness classification of transitioning IDF personnel, though some are in development (Zitun, 2014).

United Kingdom

The United Kingdom lifted the ban on transgender personnel in 2000 following a European Court of Human Rights ruling that the country's policy violated the right to privacy under the European Convention on Human Rights (Frank, 2010). The policy change was implemented with guidance to commanders, as well as a code of social conduct that allowed commanders to address inappropriate behavior toward transgender personnel by appealing to broader principles of tolerance and diversity and to guard operational effectiveness (Yerke and Mitchell, 2013). In 2009, the British Armed Forces released the "Policy for Recruitment and Management of Transsexual Personnel in the Armed Forces" to offer clearer guidance to commanders on how gender transition–related issues should be addressed (Yerke and Mitchell, 2013). While transgender personnel are able to serve openly, under the current policy, they can be excluded from sports that organize around gender to ensure the safety of the individual or other participants. The British Army also provides its official policy on transgender personnel on its website:

> The Army welcomes transgender personnel and ensures that all who apply to join are considered for service subject to meeting the same mental and physical entry standard as any other candidate. If you have completed transition you will be treated as an individual of your acquired gender. Transgender soldiers serve throughout the Army playing their part in the country's security. There is a formal network that operates in the Army to ensure that transgender soldiers can find advice and support with issues that affect their daily lives. (British Army, undated)

However, the military encourages those who have not yet started their gender transition to complete their transition before joining (UK Ministry of Defence, 2009).

The 2009 UK policy is similar to those in Canada and Australia in terms of the areas covered and approaches to addressing key issues, though the UK policy provides some additional room for individual differences. The policy also includes an extensive discussion of the legal and privacy protections afforded to transgender personnel. These protections are important because they also apply to administrative and medical records in the military system.

The UK policy defines five stages of gender transition: diagnosis, social transition (the individual begins living openly as the target gender), medical treatment/hormone therapy, surgical reassignment, and postoperative transition. However, it also recognizes that the process of gender transition may be different for each person. The policy suggests that each individual work with commanders and service authorities to develop a plan that includes a timeline for transition. The gender transition plan agreed to by the service member and commanders should specify the timing of changes, such as to housing assignments and uniforms. The specific point at which a service member transitions for the purposes of name, uniform, housing, restrooms, and ID cards may vary from person to person. Typically, when service members begin living publicly as the target gender (the social transition) they are reassigned to housing of the target gender, use the restrooms and uniforms of the target gender, and are given an ID card indicating that they are a member of the target gender. Importantly, this shift in gender for administrative purposes does not have to correspond to the point at which an individual transitions gender within the UK legal system, a process that involves a diagnosis of gender incongruence and two years of living as the acquired gender (UK Ministry of Defence, 2009). The policy also notes that it is unlawful to force transgender personnel to use separate toilet or shower facilities or occupy separate housing accommodations from the rest of the force.

The gender transition plan addresses other logistics of the transition. For example, it should specify scheduled time off required for medical procedures, including gender reassignment surgery. In general, medical treatment associated with gender transition is treated like any other medical issue experienced by a service member. However, while hormone replacement therapy is covered by military health care, gender reassignment surgery is not (UK Ministry of Defence, 2009). The policy notes that the timeline and timing of the transition must take into consideration the needs of the service. As a result, at least four weeks notice is typically needed prior to the start of a service member's gender transition. The gender transition plan should also specify whether service members wish to transition in their current post or transfer to a new position and whether they want to tell their colleagues about the gender transition themselves or would like someone else to do this. This decision may depend on the size of the unit. In a small unit, it may be easy to inform fellow service members personally. In a larger organization, it may not be necessary to tell every individual. Commanders of units

with transgender personnel are encouraged to consult members of the Service Equality and Diversity staff about how to approach education and management in matters associated with transgender service members.

The UK policy also addresses medical readiness and physical standards. Transgender personnel are evaluated for medical readiness and deployability on a case-by-case basis following a medical evaluation. During the transition period, specifically during hormone treatment and immediately before and after surgery, service members may receive a reduced Medical Employment Standard, which restricts deployability and sea service (UK Ministry of Defence, 2009). Transitioning service members who continue to meet physical standards throughout this period and are able to perform their jobs may retain normal readiness standards. Usually, those who do not undergo hormone therapy or gender reassignment surgery are able to maintain a fully deployable status throughout their gender transition (UK Ministry of Defence, 2009). Service members who are undergoing hormone therapy are able to deploy, as long as the hormone dose is steady and there are no major side effects. However, deployment to all areas may not be possible, depending on the needs associated with any medication (e.g., refrigeration). Some service members may also be required to have a psychiatric evaluation, but only if they show signs of mental health distress (UK Ministry of Defence, 2009). Individuals who have finished their gender transition and can meet the requirements of their legal gender are considered fully deployable. However, those who remain in a state of reduced readiness for an extended period may have to be discharged (UK Ministry of Defence, 2009). Importantly, the British military encourages individuals who are in the midst of their gender transition and are considering joining the military to wait until the gender transition is complete before joining, as the military may not always be able to provide the support the individual needs during gender transition.

The specific physical standards a transitioning individual must meet during and after the gender transition period are determined on a case-by-case basis. The policy allows that there may be a period of time—especially for individuals transitioning from female to male—during which a service member is not yet able to meet the standards of the target gender. In these cases, medical staff and commanders may assess the individual and determine the appropriate interim standards (UK Ministry of Defence, 2009). Once the gender transition is considered "complete," personnel are required to meet the standards of the target gender (UK Ministry of Defence, 2009). However, the policy recognizes that the point at which the gender transition is complete may vary: It may be complete after hormone therapy or after surgery, or simply after the individual begins living as the target gender. Therefore, the policy continues to allow for some flexibility in physical standards, even for members at the end of their gender transition process (UK Ministry of Defence, 2009). Modified standards may be set by medical staff and commanders, if necessary. Continued failure to meet whatever physical stan-

dards are determined to be appropriate (modified or otherwise) can lead to administrative discharge (UK Ministry of Defence, 2009).

The policy also addresses positions that are "gender-restricted" or have unique standards. The United Kingdom still has a number of combat occupations closed to women. Personnel who are transitioning from male to female may not serve in male-only occupations as long as this policy remains in place. Those transitioning from female to male may hold these jobs, assuming that they are able to meet the physical standards (UK Ministry of Defence, 2009). Transgender personnel may hold positions that have unique standards related to the occupation, as long as they can meet the physical and other requirements for the specific position. Finally, according to the policy, service members may request that their medals be transferred to a new name by submitting the request in writing. They are allowed to continue wearing qualifications earned while serving as their birth gender. However, this may indicate their transgender status to others (UK Ministry of Defence, 2009).

Effects on Cohesion and Readiness

As indicated in Chapter Six, while there is limited research on the effects of transgender personnel serving openly in foreign militaries, the available evidence indicated no significant effect on cohesion, operational effectiveness, or readiness. In the Australian case, there is no evidence and there have been no reports of any effect on cohesion, operational effectiveness, or readiness (Frank, 2010). In the Israeli case, there has also been no reported effect on cohesion or readiness (Speckhard and Paz, 2014). Transgender personnel in these militaries report feeling supported and accommodated throughout their gender transition, and there has been no evidence of any effect on operational effectiveness (Speckhard and Paz, 2014). As noted earlier, commanders report that transgender personnel perform their military duties and contribute to their units effectively (Speckhard and Paz, 2014). Interviews with commanders in the United Kingdom also found no effect on operational effectiveness or readiness (Frank, 2010). Some commanders reported that increases in diversity had led to increases in readiness and performance. Interviews with these same commanders also found no effect on cohesion, though there were some reports of resistance to the policy change within the general military population, which led to a less-than-welcoming environment for transgender personnel. However, this resistance was apparently short-lived (Frank, 2010).

The most extensive research on the potential effects of openly serving transgender personnel on readiness and cohesion has been conducted in Canada. This research involved an extensive review of internal defense reports and memos, an analysis of existing literature, and interviews with military commanders. It found no evidence of any effect on operational effectiveness or readiness. In fact, the researchers

heard from commanders that the increased diversity improved readiness by giving units the tools to address a wider variety of situations and challenges (Okros and Scott, 2015). They also found no evidence of any effect on unit or overall cohesion. However, there have been reports of bullying and hostility toward transgender personnel, and some sources have described the environment as somewhat hostile for transgender personnel (Okros and Scott, 2015).

To summarize, our review of the limited available research found no evidence from Australia, Canada, Israel, or the United Kingdom that allowing transgender personnel to serve openly has had any negative effect on operational effectiveness, cohesion, or readiness. However, it is worth noting that the four militaries considered here have had fairly low numbers of openly serving transgender personnel, and this may be a factor in the limited effect on operational readiness and cohesion.

Best Practices from Foreign Militaries

Several best practices and lessons learned emerged both directly from research articles describing the evolution of policy and the experiences of foreign militaries and indirectly from commonalities in the policies and experiences across our four case studies. The best practices that extended across all cases include the following:

The Importance of Leadership

Sources from each of our case-study countries stressed that leadership support was important to executing the policy change. Leaders provided the impetus to draft and implement new policies and were integral to communicating a message of inclusion to the entire force. Supportive leaders were also important in holding accountable those personnel who participated in discrimination (Okros and Scott, 2015; Speckhard and Paz, 2014). Each of the cases underscores the importance of having strong leadership support to back and enforce the policy change, along with clearly written policies that are linked to national policy wherever possible (Frank, 2010). The militaries found that presenting a "business case" for diversity and emphasizing the advantages of an inclusive military, including better retention and recruiting, can help reduce resistance to a policy change (Frank, 2010).

Awareness Through Broad Diversity Training

The most effective way to educate the force on matters related to transgender personnel is to integrate training on these matters into the diversity and harassment training already given to the entire force. This training addresses all forms of harassment and bullying, including that based on religion, race, and ethnicity (Frank, 2010; Okros and Scott, 2015; Belkin and McNichol, 2000–2001).

In the four cases we reviewed in-depth, we found that targeting only commanders with training and information on what it means to be transgender is not as effective in fostering an inclusive and supportive environment as training that targets the entire force and is integrated into broader forcewide diversity training. The foreign militaries that we examined train not only units with transitioning individuals but also the entire force by including gender identity alongside sexual orientation, religion, ethnicity, and other markers of difference in diversity training and education. However, efforts must be made simultaneously to protect the privacy of transitioning service members. In some cases, telling a unit that a transgender member is arriving before that individual arrives can be counterproductive (Frank, 2010).

The Importance of an Inclusive Environment

An all-inclusive military environment—not just as it pertains to transgender personnel, sexual orientation, or gender identity, but a culture that embraces diversity—can support the integration of openly serving transgender personnel. In this context, gender identity is just one marker of diversity.[5]

Ensuring Availability of Subject-Matter Experts to Advise Commanders

Most of the four countries we examined in-depth also make subject-matter experts (e.g., chaplains, psychiatrists) and gender advisers (individuals who have special training in gender awareness and gender mainstreaming in the military context) available to commanders tasked with the integration of transgender personnel. Gender advisers were originally intended to deal primarily with issues associated with integrating women into male-dominated military environments, but they could also help with other gender-related matters, including transgender personnel policy. They serve directly within military units and are a readily available resource to commanders. Adopting a similar practice of integrating advisers with expertise in the area of transgender personnel policy and gender transition-related matters might also support the integration of transgender service members in the U.S. military.

Lessons Learned and Issues to Consider for U.S. Military Policy

Based on these best practices and the broader experiences of four foreign militaries, there are some key lessons to be learned and possible issues to consider when crafting U.S. military transgender personnel policy. First, in each of the four foreign militaries, there were some reports of resistance, bullying, and harassment of transgender personnel who made their gender transition public. This harassment ranged from exclusion to more aggressive behavior. In most cases, this behavior was relatively limited; however,

[5] Remarks by a Canadian subject-matter expert in a phone discussion with RAND researchers, November 2015.

in some cases, it did contribute to a hostile work environment for transgender personnel and had the effect of discouraging these personnel from being open about their gender transition or gender identity (Okros and Scott, 2015; Frank, 2010). Although the foreign militaries we examined tended to adopt a policy of no tolerance for this type of harassment, some bullying behavior may have gone unreported (Okros and Scott, 2015; Frank, 2010). In the case of Canada, the issue of restrooms for transgender personnel is an ongoing topic of discussion, and restrooms have been a common site of harassment and discrimination (Okros and Scott, 2015).

A second lesson learned is related to problems caused by the lack of an explicit, clearly written policy. For instance, in the IDF, without a clear policy, some transitioning individuals are placed in difficult and uncomfortable situations. For example, in some cases, personnel who have been permitted to begin hormone therapy cannot be housed with members of their target gender or grow their hair and fingernails (in the case of individuals transitioning from male to female). Others have been isolated, assigned to separate housing, or asked to use separate restrooms (Speckhard and Paz, 2014). Recognizing these challenges, IDF leadership is working to design a clear and explicit policy. In the Israeli case, transgender individuals were allowed to serve openly before a formal policy was written. Only when it was faced with questions about the integration of transgender personnel did the IDF begin to create a formal policy.[6] In Canada, a similar policy gap arose when transgender personnel were allowed to serve openly following a national policy revision that ended discrimination based on sexual orientation or gender. However, the focus at that point was on gay and lesbian service members, and no formal policy was created to address transgender personnel explicitly. When matters related to the medical care of transgender personnel arose, Canadian defense leaders developed a policy that just addressed this narrow, pressing issue, and did not develop policies to address the other matters (e.g., housing, restrooms, name changes). Commanders complained that the original policy was too vague and lacked sufficient details. A new, revised policy was written in 2012, and commanders have responded with positive feedback.[7] The lack of a clear, written policy has also been an issue in Australia.

A third and final issue that has come up in at least two of the countries we surveyed is that of awards and medals. In the UK case, medals and awards received prior to gender transition can be transferred to the service member's post-transition name (UK Ministry of Defence, 2009). In the Canadian case, this is not possible, and the awards remain associated only with the original name. This is a cause for concern among transgender personnel in the Canadian military, but Canadian officials have responded that they cannot rewrite history (Okros and Scott, 2015). This is a policy area that the United States should consider alongside other administrative policies.

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6 Remarks by a Canadian subject-matter expert in a phone discussion with RAND researchers, November 2015.

7 Remarks by a Canadian subject-matter expert in a phone discussion with RAND researchers, November 2015.

CHAPTER EIGHT

Which DoD Policies Would Need to Be Changed if Transgender Service Members Are Allowed to Serve Openly?

This chapter reviews DoD accession, retention, separation, and deployment policies and provides an assessment of the impact of changes required to allow transgender personnel to serve openly. For our analysis of DoD policies, we reviewed 20 current accession, retention, separation, and deployment regulations across the services and the Office of the Secretary of Defense. We also reviewed 16 other regulations that have been replaced by more recent regulations or did not mention transgender policies.[1] DoDI 6130.03 establishes medical standards for entry into military service, including a list of disqualifying physical and mental conditions, some of which are transgender-related.[2] Current DoD policy also authorizes, but no longer requires, the discharge of transgender personnel for reasons related to both medical conditions that generate disabilities, as well as mental health concerns.[3] However, a July 2015 directive from the Office of the Secretary of Defense elevated decisions to administratively separate transgender service members to the Office of the Under Secretary of Defense for Personnel and Readiness (DoD, 2015b).

Note that our review focused on transgender-specific DoD instructions that may contain unnecessarily restrictive conditions and reflect outdated terminology and assessment processes. However, in simply removing these restrictions, DoD could inadvertently affect overall standards. While we focus on reforms to specific instruc-

[1] These additional policies are listed in Appendix D.

[2] The instruction specifies conditions that disqualify accessions, including "current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias"; "history of major abnormalities or defects of the genitalia including but not limited to change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis"; and "history of major abnormalities or defects of the genitalia such as change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis" (DoDI 6130.03, 2011, enclosure 4).

[3] "Sexual gender and identity disorders" are specified as medical conditions that may generate disabilities under DoDI 1332.38, enclosure 5 (2006). Mental health conditions are specified in DoDI 1332.14 (2014) and DoDI 1332.30 (2013) for enlisted and officers, respectively. DoDI 1332.18, issued on August 5, 2014, updated these guidelines and established general criteria for referral for disability evaluation and defers to service-specific standards for retention. However, a recent review of this revision suggests that service-specific regulations may still disqualify transgender personnel, and the new guidance may not overrule those service policies (Pollock and Minter, 2014).

tions and directives, we note that DoD may wish to conduct a more expansive review of personnel policies to ensure that individuals who join and remain in service can perform at the desired level, regardless of gender identity.

Accession Policy

The language pertaining to transgender individuals in accession instructions does not match that used in DSM-5.[4] This results in restrictions in DoD policy that do not match current medical understanding of gender identity issues and thus may be misapplied or difficult to interpret in the context of current medical treatments and diagnoses. Under current guidelines, otherwise qualified individuals could be excluded for conditions that are unlikely to affect their military service, and individuals with true restrictions may be more difficult to screen for and identify. Modernizing the terminology to match current psychological and medical understanding of gender identity would help ensure that existing procedures do not inadvertently exclude otherwise qualified individuals who might want to join the military. We recommend that DoD review and revise the language to match the DSM-5 for conditions related to mental fitness so that mental health screening language matches current disorders and facilitates appropriate screening and review processes for disorders that may affect fitness for duty. Similarly, physical fitness standards should specify physical requirements, rather than physical conditions. Finally, the physical fitness language should clarify when in the transition process the service member's target gender requirements will begin to apply.

Retention Policy

We recommend that DoD expand and enhance its guidance and directives to clarify and adjust, where necessary, standards for retention of service members during and after gender transition. Evidence from Canada and Australia suggests that transgender personnel may need to be held medically exempt from physical fitness testing and requirements during transition (Canadian Armed Forces, 2012; Royal Australian Air Force, 2015). However, after completing transition, the service member could be required to meet the standards of the acquired gender. The determination of when the service member is "medically ready" to complete the physical fitness test occurs on a case-by-case basis and is typically made by the unit commander.

[4] Two key changes are that the term *transsexualism* has been replaced, and *gender dysphoria* is no longer in the chapter "Sexual Desire Disorders, Sexual Dysfunctions, and Paraphilias" but, rather, has its own chapter (Milhiser, 2014).

Separation Policy

DoD may wish to revise the current separation process based on lessons learned from the repeal of Don't Ask, Don't Tell. The current process relies on administrative decisions outside the purview of the standard medical and physical review process. This limits the available documentation and opportunities for review, and it could prove burdensome if transgender-related discharges become subject to re-review. When medically appropriate, DoD may wish to establish guidance on when and how such discharge reviews should be handled. We also recommend that DoD develop and disseminate clear criteria for assessing whether transgender-related conditions may interfere with duty performance.

Deployment Policy

Deployment conditions vary significantly based on the unique environment of each deployment, with some deployed environments able to accommodate transgender individuals, even those who are undergoing medical treatments. Moreover, recent medical advancements can minimize the invasiveness of treatments and allow for telemedicine or other forms of remote medical care. Given medical and technological advances, DoD may wish to adjust some of its processes and deployment restrictions to minimize the impact on readiness. For example, current regulations specify that conditions requiring regular laboratory visits make service members ineligible for deployment, including all service members who are receiving hormone treatments,[5] since such treatments require laboratory monitoring every three months for the first year as hormone levels stabilize (Hembree et al., 2009; Elders et al., 2014). Such a change would require DoD to either permit more flexible monitoring strategies[6] or provide training to deployed medical personnel.[7] Similarly, the use of refrigerated medications is a disqualifying condition for deployment,[8] even though nearly all hormone therapies are available in other formats that do not require refrigeration.

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[5] Current regulations state that "medications that require laboratory monitoring or special assessment of a type or frequency that is not available or feasible in a deployed environment" disqualify an individual from deployment (Office of the Assistant Secretary of Defense for Health Affairs, 2013, p. 3).

[6] Some experts suggest that alternatives, such as telehealth reviews, would address this issue for rural populations with limited access to medical care (see, for example, WPATH, 2011).

[7] "Independent duty corpsmen, physician assistants, and nurses can supervise hormone treatment initiated by a physician" (Elders et al., 2014).

[8] The memo issued by the Office of the Assistant Secretary of Defense for Health Affairs states, "Medications that disqualify an individual for deployment include . . . [m]edications that have special storage considerations, such as refrigeration (does not include those medications maintained at medical facilities for inpatient or emergency use)" (Office of the Assistant Secretary of Defense for Health Affairs 2013, p. 3).

CHAPTER NINE

Conclusion

By many measures, there are currently serving U.S. military personnel who are transgender. Overall, our study found that the number of U.S. transgender service members who are likely to seek transition-related care is so small that a change in policy will likely have a marginal impact on health care costs and the readiness of the force. We estimate, based on state-level surveys of transgender prevalence, that between 1,320 and 6,630 transgender personnel may be serving in the AC, and 830–4,160 may be serving in the SR. Estimates based on studies from multiple states, weighted for population and the gender distribution in the military, imply that there are around 2,450 transgender service members in the AC and 1,510 in the SR.[1]

However, only a small proportion of these service members will seek gender transition–related treatment each year. Employing utilization and cost data from the private health insurance system, we estimated the potential impact of providing this care to openly serving transgender personnel on AC health care utilization and costs. Directly applying private health insurance utilization rates to the AC military population indicated that a very small number of service members will access gender transition–related care annually. Our estimates based on private health insurance data ranged from a lower-bound estimate of 29 AC service members to an upper-bound estimate of 129 annually using care, including those seeking both surgical and other medical treatments.

Using estimates from two states and adjusting for the male/female AC distribution, we also estimate a total of 45 gender transition–related surgeries, with 50 service members initiating transition-related hormone therapy annually in the AC.[2] We estimate 30 gender transition-related surgeries and 25 service members initiating hormone therapy treatments in the SR. These are likely to be upper-bound estimates, given the nonrepresentative sample selection procedures used in the NTDS. Furthermore, the best prevalence estimates that we were able to identify were from two of the more transgender-tolerant states in the country, and the empirical evidence that trans-

[1] Estimates are based on FY 2014 AC and SR personnel numbers.

[2] For hormone therapy recipients, the number of treatments and recipients is the same, and these estimates can be treated as counts of individuals.

gender prevalence is higher in the military than in the general population is weak. As a point of comparison, we also compared these estimated values to mental health utilization in the AC population overall. Using data from McKibben et al. (2013), we calculated that approximately 278,517 AC service members accessed mental health care treatment in 2014, the implication being that health care for the transgender population will be a very small part of the total health care provided to AC service members across the MHS.

With respect to health care costs, actuarial estimates from the private health insurance sector indicate that covering gender transition–related care for transgender employees increased premiums by less than 1 percent. Taking a weighted average of the identified firm-level data, we estimate that covering transgender-related care for service members will increase the U.S. military's AC health care spending by only 0.038–0.054 percent. Using these baseline estimates, we estimate that MHS health care costs will increase by between $2.4 million and $8.4 million. These numbers represent only a small proportion of FY 2014 AC health care expenditures ($6.27 billion) and the FY 2014 Unified Medical Program budget ($49.3 billion). This is consistent with our estimate of relatively low AC rates of gender transition–related health care utilization in the MHS.

Similarly, when considering the impact on readiness, we found that using either the prevalence-based approach or the utilization-based approach yielded an estimate of less than 0.0015 percent of total labor-years likely to be affected by a change in policy. This is much smaller than the current lost labor-years due to medical care in the Army alone.

Even if transgender personnel serve in the military at twice the rate of their prevalence in the general population and we use the upper-bound rates of health care utilization, the total proportion of the force that is transgender and would seek treatment would be less than 0.1 percent, with fewer than 130 AC surgical cases per year even at the highest utilization rates. Given this, true usage rates from civilian case studies imply only 30 treatments in the AC, suggesting that the total number of individuals seeking treatment may be substantially smaller than 0.1 percent of the total force. Thus, we estimate the impact on readiness to be negligible.

We conclude with some general recommendations and insights based on the experiences of foreign militaries that permit transgender individuals to serve openly—specifically, Australia, Canada, Israel, and the United Kingdom. Our case studies provide some guidance that policymakers should consider as they develop policies to govern the employment of transgender personnel in the U.S. military. These cases also suggested a number of key implementation practices if a decision is made to allow transgender service members to serve openly:

- Ensure strong leadership support.
- Develop an explicit written policy on all aspects of the gender transition process.

- Provide education and training to the rest of the force on transgender personnel policy, but integrate this training with other diversity-related training and education.
- Develop and enforce a clear anti-harassment policy that addresses harassment aimed at transgender personnel alongside other forces of harassment.
- Make subject-matter experts and gender advisers serving within military units available to commanders seeking guidance or advice on gender transition-related issues.
- Identify and communicate the benefits of an inclusive and diverse workforce.

APPENDIX A

Terminology

Augmentation mammoplasty: breast augmentation involving implants or lipofilling

Buccal administration: placement of medication between the gums and cheek

Chest surgery: surgery to create a contoured, male-looking chest

Clitoroplasty: surgical creation/restoration of a clitoris

Cross-dresser: someone who dresses in the clothes of the other gender, not always on a full-time basis

Female-to-male: those assigned female sex at birth who identify as male; transgender men; transmen

Gender: an individual's gender identity, which is influenced by societal norms and expectations; public, lived role as male or female

Gender assignment: initial assignment at birth as male or female; yields "natal gender" (APA, 2013, p. 451)

Gender atypical: behaviors not typical for one's gender "in a given society and historical era" (APA, 2013, p. 451)

Gender identity: "one's inner sense of one's own gender, which may or may not match the sex assigned at birth" (Office of Personnel Management, 2015, p. 2)

Gender dysphoria: "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (WPATH, 2011, p. 2).

Gender nonconformity: "the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex" (WPATH, 2011, p. 5, citing Institute of Medicine definition)

Gender transition–related surgery/gender-confirming surgery/sex reassignment surgery: surgery to mitigate distress associated with gender dysphoria by aligning sex characteristics with gender identity

Genderqueer: those who "define their gender outside the construct of male or female, such as having no gender, being androgynous, or having elements of multiple genders" (Roller, Sedlak, and Draucker, 2015, p. 417)

Gluteal augmentation: buttocks augmentation involving implants or lipofilling

Hormone therapy: "the administration of exogenous endocrine agents to induce feminizing or masculinizing changes" (WPATH, 2011, p. 33)

Hysterectomy: surgery to remove the uterus

Intersex: "a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male" (Intersex Society of North America, undated)

Labiaplasty: plastic surgery for altering or creating the labia

Lipofilling: injection of fat rather than artificial implants

Male-to-female: those assigned male sex at birth who identify as female; transgender females; transwomen

Mastectomy: surgical removal of one or both breasts

Metoidioplasty: surgically relocating a clitoris that has been enlarged by hormone therapy to a more forward position that more closely resembles that of a penis; average length is 1.5–2 inches

Oophorectomy: surgical removal of one or both ovaries

Orchiectomy: surgical removal of one or both testicles

Ovariectomy: surgical removal of one or both ovaries

Parenteral administration: intravenous injection (into a vein) or intramuscular infusion (into muscle) of medication

Penectomy: surgical removal of the penis

Phalloplasty: surgical creation/reconstruction of a penis using one of a variety of techniques including free or pedicled (attached) flap (see Rashid and Tamimy, 2013)

Primary sex characteristics: physical characteristics/sex organs directly involved in reproduction

Salpingo-oophorectomy: removal of the ovaries and fallopian tubes

Scrotoplasty: surgical creation/reconstruction of testicles; in transmen, native labia tissue is used; testicular implants can be used

Secondary sex characteristics: physical characteristics that appear at puberty and vary by sex but are not directly involved in reproduction (e.g., breasts)

Sex: a person's biological status as male or female based on chromosomes, gonads, hormones, and genitals (intersex is a rare exception)

Sexual orientation: sexual identity in relation to the gender to which someone is attracted: heterosexual, homosexual, or bisexual

Thyroid chondroplasty: removal or reduction of the Adam's apple

Transdermal administration: delivery of medication across the skin with patches

Transgender: "an umbrella term used for individuals who have sexual identity or gender expression that differs from their assigned sex at birth" (Roller, Sedlak, and Draucker, 2015, p. 417)

Transsexual: someone whose gender identity is inconsistent with their assigned sex and who desires to permanently transition their physical characteristics to match their inner sense of their own gender

Urethroplasty: surgical reconstruction or fabrication of the urethra.

Vaginectomy (colpectomy): surgical removal of all or part of the vagina

Vaginoplasty: surgical creation/reconstruction of a vagina

Vulvoplasty: surgical creation/reconstruction of the vulva

APPENDIX B

History of DSM Terminology and Diagnoses

A brief historical understanding of the evolving diagnostic nomenclature pertaining to transgender status is important to discussions of related health care. DSM-III (APA, 1980) first contained the diagnosis of transsexualism. DSM-III-R (APA, 1987) introduced gender identity disorder, non-transsexual type. In DSM-IV (APA, 1994), these two diagnoses were merged and called *gender identity disorder*. Gender identity disorder, together with the paraphilias (disorders of extreme, dangerous, or abnormal sexual desire, including transvestic fetishism, sometimes referred to as cross-dressing), constituted the DSM-IV section "Sexual and Gender Identity Disorders."

With DSM-5 (APA, 2013) came the migration from *gender identity disorder* to *gender dysphoria*. The clinical significance of the shift in DSM-5 was great: For the first time, without accompanying symptoms of distress, transgender individuals were no longer considered to have a diagnosable mental disorder. The historical parallel with homosexuality is hard to miss: In 1980, DSM-III similarly normalized the DSM-II diagnosis of homosexuality, moving instead to ego-dystonic homosexuality, a diagnosis reserved only for gay persons who felt related distress. In the next DSM iteration, DSM-III-R, all reference to homosexuality as a diagnostic term was removed. In the aftermath of depathologizing gender nonconformity, a similar move relating to transgender status appears to be underway.

As noted in this report, there is a consensus among clinicians and their professional organizations that transition-related treatment with hormones or surgery constitutes necessary health care, though there is a divide over whether it serves as "a strategy to diminish the serious suffering" of the patient or "a method to assist people in finding self-actualization" (Gijs and Brewaeys, 2007, p. 184). The conclusion that transition-related surgery "is an effective treatment for gender identity disorder in adults" is based primarily on retrospective studies of satisfaction rather than randomized controlled trials or prospective studies (Gijs and Brewaeys, 2007, p. 199). The prevalence of post-operative regret is very low, though "little empirical research has been done" on related risk and protective factors (Gijs and Brewaeys, 2007, pp. 201, 204). Overall, surgery is considered "the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals," but rigorous controlled-outcome studies evaluating its

effectiveness should be conducted despite feasibility and ethical challenges (Gijs and Brewaeys, 2007, pp. 215–216; Buchholz, 2015, p. 1786).

DSM-5 Diagnostic Criteria: Gender Dysphoria in Adolescents and Adults 302.85 (F64.1)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

APPENDIX C

Treatments for Gender Dysphoria

In this appendix, we provide additional details about psychosocial, pharmacologic, surgical, and other treatments for gender dysphoria (GD).

Psychotherapy

The emphasis of psychotherapy for this population today is on "affirming a unique transgender identity," rather than focusing on gender transition (Institute of Medicine, 2011, p. 52). Mental health professionals can also help patients presenting with GD navigate the process of coming out to family, friends, and peers; treat comorbid mental health conditions;[1] weigh options related to gender identity, gender expression, and transition-related treatment interventions; and conduct assessments, make referrals, and guide preparation for and provide support through the transition-related treatment process (WPATH, 2011, pp. 22–26). Referral from a mental health professional is necessary under the standards of care for those seeking breast/chest or genital surgeries, and the latter also requires confirmation from an independent mental health provider (WPATH, 2011, p. 27). Mental health providers may also serve an important role on behalf of their patients by providing education and advocacy within the community and supporting changes to identity documents (WPATH, 2011, p. 31).

Of note, treatment aimed at changing one's gender identity to align with the sex assigned at birth has proven unsuccessful and is no longer considered ethical care; mental health providers who are unwilling or unable to provide appropriate care should refer patients to a provider who is (WPATH, 2011, p. 32).

Hormone Therapy

Hormone therapy is necessary for many individuals with GD (WPATH, 2011, p. 33). It has two major goals: (1) reduce naturally occurring hormones to minimize secondary sex characteristics and (2) maximize desired feminization/masculinization using the principles and medications used for hormone replacement in non-transgender patients who do not produce enough hormones, such as women who have had hyster-

[1] Co-occurring mental health conditions could range from anxiety and depression, which are common among the transgender population, to more severe and rare illnesses, such as schizophrenia or bipolar disorder.

ectomies or men with low testosterone (WPATH, 2011, p. 33; Hembree et al., 2009). As with most medications, there are risks, which may increase in the presence of some health conditions or behaviors (such as smoking); these should be evaluated and managed (Hembree et al., 2009).

For those transitioning from female to male, hormone therapy should lead to "deepened voice, clitoral enlargement (variable, 3–8 cm), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and increased percentage of body fat." For those transitioning from male to female, hormone therapy should lead to "breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fat" (WPATH, 2011, p. 36). The timeline for these and other physical changes varies by individual; expected onset is within months, and maximum expected effect (such as body fat and muscle mass changes) is generally achieved in three or more years. Feminizing hormone therapy typically involves both estrogen and antiandrogens.[2] Masculinizing hormone therapy consists primarily of testosterone, which is available in oral, transdermal, parenteral (intravenous/intramuscular), buccal (cheek), and implantable administrations; brief use of progestin can help stop menstrual periods early in treatment (WPATH, 2011, p. 49). Detailed clinical practice guidelines are available from the Endocrine Society (Hembree et al., 2009).

Gender Transition–Related Surgery

As noted, gender transition–related surgery (also called sex reassignment surgery or gender-confirming surgery) is necessary for some transgender patients. Under the standards of care, mental health professionals must refer patients for surgery; in addition, criteria for both breast/chest and genital surgery include persistent and well-documented GD, the capacity to make informed decisions and to consent, and for other mental or general health concerns to be reasonably well controlled if present (WPATH, 2011, p. 59). Hormone therapy is not a prerequisite for breast/chest (also called "top") surgery, though it is recommended for 12–24 months for male-to-female patients to achieve optimal results (Hembree et al., 2009).

For genital (also called "bottom") surgery, 12 continuous months of hormone therapy are required prior to oophorectomy or orchiectomy (surgical removal of ovaries or testicles), unless contraindicated; health record documentation of "12 continuous months of living in a gender role that is congruent with their gender identity . . . consistently, on a day-to-day basis and across all settings of life" is also required for metoidioplasty (surgical relocation of an enlarged clitoris), phalloplasty (surgical creation of a penis), or vaginoplasty (surgical creation of a vagina; WPATH, 2011,

[2] Transdermal rather than oral estrogen is recommended. Common antiandrogens include spironolactone (an antihypertensive agent that requires electrolyte monitoring); cyproterone acetate (not approved in the United States); GnRH agonists, such as gosrelin, buserelin, or triptorelin (available as injectables or implants); and 5-alpha reductase inhibitors, such as finasteride and dutasteride (WPATH, 2011, p. 48).

pp. 60–61). Mastectomy is often the only surgery undertaken by the female-to-male population; for those who do undergo genital surgery, phalloplasty is relatively uncommon, as it often requires multiple procedures and has frequent complications (WPATH, 2011, pp. 63–64). Surgeons should work closely with patients and other care providers, if needed, to ensure that the advantages, disadvantages, and risks of various treatments and procedures are well understood.

Other Treatments

Aside from breast/chest and genital surgery, other surgical interventions may include liposuction, lipofilling, and various aesthetic procedures. For male-to-female patients, these may include "facial feminization surgery, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), [and] hair reconstruction"; female-to-male patients may seek pectoral implants (WPATH, 2011, pp. 57–58). There is ongoing debate regarding whether these and other transition-related treatments are "medically necessary" (and therefore covered by insurance). For example, in some circumstances, facial hair removal for male-to-female patients may constitute necessary transition-related treatment: One study found that those who have undergone the procedure were "less likely to experience harassment in public spaces," and harassment can "have a negative impact on the success of a person's treatment for gender dysphoria" (Herman, 2013b, p. 19). In addition, voice and communication therapy to develop vocal characteristics and nonverbal communication patterns congruent with gender identity may prevent "vocal misuse and long-term vocal damage" (WPATH, 2011, pp. 52–54).

APPENDIX D

Review of Accession, Retention, and Separation Regulations

Directive	Date	Department
Air Force Instruction 36-2002, *Regular Air Force and Special Category Accessions*	4/7/1999, revised 6/2/2014	Air Force
Air Force Instruction Guidance Memorandum AFI48-123_AFGM2015-01, "Guidance Memorandum: AFI 48-123, *Medical Examinations and Standards*"	8/27/2015	Air Force
Air Force Instruction Guidance Memorandum 48-123_AFGM4, "Air Force Guidance Memorandum to AFI 48-123, *Medical Examinations and Standards*"	1/29/2013	Air Force
Air Force Recruiting Service Instruction 36-2001, *Recruiting Procedures for the Air Force*	8/1/2012	Air Force
Air Force Instruction 41-210, *TRICARE Operations and Patient Administration Functions*	6/6/2012	Air Force
U.S. Army Recruiting Command, *Pocket Recruiter Guide*	7/1/2013	Army
Army Regulation 635-40, *Physical Evaluation for Retention, Retirement, or Separation*	3/20/2012	Army
Army Regulation 601-280, *Army Retention Program*	9/15/2011	Army
Army Regulation 40-501, *Standards of Medical Fitness*	8/4/2011	Army
Army Regulation 40-66, *Medical Record Administration and Healthcare Documentation*	1/4/2010	Army
Army Regulation 635-200, *Active Duty Enlisted Administrative Separations*	9/6/2011	Army
Army Regulation 601-210, *Active and Reserve Components Enlistment Program*	3/12/2013	Army
DoDI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*	4/28/2010, revised 9/13/11	DoD
DoDI 1332.18, *Disability Evaluation System (DES)*	8/5/2014	DoD
Office of the Under Secretary of Defense for Personnel and Readiness, *Disability Evaluation System (DES) Pilot Operations Manual*	12/2008	DoD

Directive	Date	Department
Marine Corps Order 1040.31, *Enlisted Retention and Career Development Program*	9/8/2010	Marine Corps
Marine Corps Order 6110.3, *Marine Corps Body Composition and Military Appearance Program*	8/8/2008	Marine Corps
Marine Administrative Message 064/11, "Amplification to Testing Accession Standards for the Purpose of Application to Marine Office Commissioning Programs"	1/26/2011	Marine Corps
Navy Military Personnel Manual 1306-964, "Recruiting Duty"	5/9/2014	Navy
Navy Medicine Manual P-117, *Manual of the Medical Department*, Chapter 15, Article 15-31, "Waivers of Physical Standards"	5/3/2012	Navy and Marine Corps

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APA—*See* American Psychiatric Association.

Army Regulation 40-501, *Standards of Medical Fitness*, December 14, 2007, revised August 4, 2011.

Army Regulation 600-8-101, *Personnel Processing (In-, Out-, Soldier Readiness, and Deployment Cycle)*, February 19, 2015.

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Current U.S. Department of Defense (DoD) policy bans transgender personnel from serving openly in the military. DoD has begun considering changes to this policy, but the prospect raises questions regarding access to gender transition–related health care, the range of transition-related treatments that DoD will need to provide, the potential costs associated with these treatments, and the impact of these health care needs on force readiness and the deployability of transgender service members. A RAND study identified the health care needs of the transgender population and transgender service members in particular. It also examined the costs of covering transition-related treatments, assessed the potential readiness implications of a policy change, and reviewed the experiences of foreign militaries that permit transgender service members to serve openly.

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The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 2:17-cv-01297-MJP

DECLARATION OF RAYMOND EDWIN MABUS, JR. IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

NOTE ON MOTION CALENDAR:
October 6, 2017
ORAL ARGUMENT REQUESTED

I, Raymond Edwin Mabus, Jr., declare as follows:

Background and Experience

1. I served as the United States Secretary of the Navy from May 19, 2009 to January 20, 2017.

2. Prior to serving as Secretary of the Navy, I earned a Bachelor's degree in English and Political Science from the University of Mississippi in 1969, a Master's Degree in political science from Johns Hopkins University in 1970, and a J.D. from Harvard Law School in 1976. Prior to attending law school, I served from 1970 until 1972 in the Navy aboard the cruiser USS Little Rock, achieving the rank of Lieutenant, junior grade. Following law school, I worked as a law clerk in the United States Court of Appeals for the Fifth Circuit. From 1977 until 1978, I worked as legal counsel for the Cotton Subcommittee of the Agriculture Committee of the United States House of Representatives. From 1979 to 1980, I was an associate at the law firm of

Fried, Frank, Harris, Shriver and Kampleman in Washington, D.C. and from 1980 to 1983, I was Legal Counsel and Legislative Assistant to the Governor of Mississippi. From 1984 to 1988, I served as Mississippi State Auditor (an elected position), and from 1988 to 1992 as Governor of Mississippi. From 1994 to 1996 I served as the United States Ambassador to Saudi Arabia. From 1998 to 2000 I served as President of Frontline Global Services, a consulting company. From 2003-2007 I served as Chairman of Foamex, Incorporated, a public manufacturing company, and from 2006 to 2007 as Foamex's Chief Executive Officer as well.

3. As Secretary of the Navy, I functioned as the chief executive of the Department of the Navy, with the authority to conduct all of its affairs. As Secretary, I had comprehensive oversight responsibility for (i) the Department of the Navy's annual budget, (ii) overseeing the recruitment, organization, training, supplying, equipping, mobilizing, and demobilizing of Navy personnel, and (iii) overseeing the construction, outfitting, and repair of naval equipment, ships, and facilities. I was also responsible for the formulation and implementation of policies and programs that are consistent with the national security policies and objectives established by the President and the Secretary of Defense.

4. In connection with my personnel-related oversight responsibilities, I oversaw the administration of recruitment, retention, and medical policies for active duty and reserve Navy personnel. As Secretary, I performed these duties before, during, and after the end of the "Don't Ask, Don't Tell" ban on gay service members serving openly in the military in 2011.

5. Also during this period, I oversaw the Navy and the Marine Corps through the end of United States military operations in Iraq and the surge of tens of thousands of United States troops in Afghanistan. I am keenly aware that the recruitment and retention of capable and qualified service members is of critical importance to the readiness of the Navy and the Marines.

The Navy

6. The Department of the Navy comprises two uniformed Services of the United States Armed Forces: the United States Navy and the United States Marine Corps. It is one of the three military departments of the Department of Defense ("DoD"). The Navy, with an annual budget of more than $160 billion, maintains more than 270 deployable battle force ships,

operates more than 3,700 military aircraft, and employs nearly 900,000 active duty, reserve, and civilian employees.

7. The mission of the Navy is to maintain, train and equip combat-ready Naval forces capable of winning wars, deterring aggression and maintaining freedom of the seas.

Development of DoD Policy Relating to Service by Openly Transgender Persons

8. On July 28, 2015, Secretary of Defense Ashton Carter ordered Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group to identify and address the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the "Working Group"). A true and accurate copy of this order is attached hereto as Exhibit A. The Working Group was ordered to present its findings and recommendations to the Secretary of Defense within 180 days. In the interim, pursuant to the July 28, 2015 order, no service member could "be involuntarily separated or denied reenlistment or continuation of active or reserve service on the basis of their gender identity, without the personal approval of the Under Secretary of Defense for Personnel and Readiness."

9. As Secretary of the Navy, I was responsible for supervising the Department of the Navy's participation in the Working Group. The Working Group met as a whole and also assigned various sub-groups to research and analyze discrete issues and report their findings. I met multiple times per week with my deputy to the Working Group, the Navy General Counsel, who would update me on the progress of the Working Group and the Navy's positions on the issues discussed.

10. The Working Group was tasked with evaluating the hurdles, impediments, and concerns potentially raised by open service of transgender service members. They sought to identify all potential impacts on the Services and develop recommendations to address them.

11. The Working Group met and engaged in a detailed, deliberative, carefully run process. The goal was to ensure that the input of the Services would be fully considered before any changes in policy were made and that the Services were on board with those changes.

12. The Working Group conducted a comprehensive review of relevant evidence,

including: research and data; information obtained from medical, personnel, and readiness experts; and information obtained from discussions with transgender service members and commanders who supervised transgender service members. The Working Group also considered the experiences of civilian employers and insurance companies.

13. The Working Group also considered a study that the DoD commissioned from the RAND Corporation. That study examined all of the available research about the healthcare needs of transgender service members, the anticipated costs of providing healthcare coverage for transition-related treatments, and the potential readiness implications of allowing transgender service members to serve openly. A true and accurate copy of the report, entitled Assessing the Implications of Allowing Transgender Personnel to Serve Openly ("RAND Report"), is attached as Exhibit B.

14. The RAND Report concluded that the cost of caring for the medical needs of transgender personnel would be extremely small and that there was no evidence that allowing transgender people to serve openly would negatively impact unit cohesion, operational effectiveness, or readiness. The RAND Report also concluded that the Military Health Service could provide appropriate transition-related healthcare to transgender persons. The RAND Report also identified various DoD policies that would need to be changed to permit transgender service members to serve openly, including "transgender-specific DoD instructions that may contain unnecessarily restrictive conditions and reflect outdated terminology and assessment processes."

15. Members of the Working Group discussed the full range of considerations relevant to assessing the potential impacts of permitting transgender service members to serve openly, including evidence relating to the costs of providing appropriate healthcare and evidence relating to the impact of service by transgender people on operational effectiveness and readiness. For example, the Working Group considered that while some transgender service members might be undeployable for short periods due to medical treatments, the overall loss of deployable time would not be significant and was consistent with the standard applied to other service members, who may take time off due to comparable medical treatments.

16. The Working Group also noted that many private and public health insurance plans now cover transition-related care and that all civilian federal employees have access to a health insurance plan that provides comprehensive coverage for such care. This was helpful to ascertain both the costs of providing such care and utilization rates, as well as to demonstrate the need for the military to keep pace with contemporary medical science and practice in the provision of healthcare to our service members.

17. The Working Group also consulted with representatives from the Armed Forces of other nations that permit openly transgender persons to serve. Those consultations confirmed that permitting such service is not disruptive to military readiness and has not led to significantly increased costs or posed any other significant problems. The RAND Report considered the experiences of other countries as well and found no evidence of any adverse impacts. Noting the most extensive research on how a policy of open service affects readiness and unit cohesion has been conducted in Canada, the RAND Report noted that "the researchers heard from commanders that the increased diversity improved readiness."

18. The Working Group considered that banning service by openly transgender people has numerous negative impacts, including requiring the discharge of highly trained and experienced service members, causing unexpected vacancies in operational units, and requiring the expensive and time-consuming recruitment and training of replacement personnel.

19. The Working Group also recognized that despite a ban on transgender service members, transgender persons continued to serve in the military, but were forced to lie about and hide their identities, to the detriment both of those service members and of the military as a whole. As a result, the Working Group recognized that the primary impact of the policy was to cause harms similar to those caused by "Don't Ask, Don't Tell."

20. During the period in which the Working Group was in operation, the proceedings of the Working Group were reported to and reviewed by upper level Department of Defense personnel at meetings attended by the Joint Chiefs of Staff, the Chairman, the Vice Chairman, the Service Secretaries, the Secretary of Defense, and the Assistant Secretary of Defense. At these meetings, the activities of the Working Group would be shared along with their preliminary

views. The meeting attendees would then discuss any comments they may have had on those views.

21. By the conclusion of its discussions and analysis, all members of the Working Group (including the senior uniformed military personnel) expressed their agreement that transgender people should be permitted to serve openly in the United States Armed Forces.

22. In or around April 2016, the Working Group communicated its view to the Secretary of Defense along with detailed recommendations regarding the full range of relevant policies and practical concerns, such as guidelines involving access to healthcare, housing and uniform standards, and when a transitioning service member should be authorized to conform to the standard of the gender to which they were transitioning.

23. On June 30, 2016, Secretary of Defense Ashton Carter accepted the recommendations of the Working Group, and issued Directive-type Memorandum (DTM) 16-005, entitled "Military Service of Transgender Service Members" ("DTM 16-005"), a true and accurate copy of which is attached as Exhibit C.

Change, Development, and Implementation of Navy Policy

24. Following the Secretary of Defense's announcement, the Navy's implementation of the new policy was straightforward. We focused on the administrative tasks of promulgating and implementing the appropriate processes. Having presided over the Navy during the rollout of prior policy changes such as the repeal of "Don't Ask, Don't Tell" and the complete integration of women into ground combat, I can confirm that the implementation of open service for transgender service members was relatively low-key, triggered fewer emotional responses, and was viewed as "no big deal."

25. To implement DTM 16-005 as applied to the Navy, on November 4, 2016, I issued SECNAV Instruction 1000.11 concerning Service of Transgender Sailors and Marines (the "Instruction"). A true and accurate copy of the Instruction is attached hereto as Ex. D.

26. The policy and guidance in the Instruction, which was effective immediately for all Department of Navy ("DON") personnel, established "policy for the accession and service of transgender Sailors and Marines, to include the process for transgender Service Members to

transition to transgender in-service." The policies and procedures in the Instruction "are based on the premise that open service by transgender persons who are subject to the same medical, fitness for duty, physical fitness, uniform and grooming, deployability, and retention standards and procedures is consistent with military service and readiness." The Instruction provides that "transgender individuals shall be allowed to serve openly in the DON," and that any "discrimination based on gender identity is a form of sex discrimination."

27. Pursuant to the Instruction, on November 7, 2016, Chief of Naval Personnel, Vice Admiral R. P. Burke, issued interim guidance in NAVADMIN 248/16 (the "Policy") regarding "policy, regulations and procedures related to the service of transgender Navy personnel." The Policy, which "applies to all Navy military personnel," remains in effect "until superseded or cancelled." A true and accurate copy of the Policy is attached hereto as Ex. E.

28. As with the Instruction, the Policy provides that "transgender individuals shall be allowed to serve openly in the Navy. The Policy was "premised on the conclusion that transgender persons are fully qualified and are subject to the same standards and procedures as other Service Members with regard to their medical fitness for duty, physical fitness, uniform and grooming standards, deployability, and retention." The Policy thus declares that "[n]o otherwise qualified Service Member may be involuntarily separated, discharged, or denied reenlistment or continuation of service solely on the basis of gender identity or an expressed intent to transition gender."

29. With respect to individuals serving in the Navy or Marine Corps, the Instruction and Policy state that transgender Sailors and Marines will be responsible to meet all standards for uniforms and grooming, body composition assessment, physical readiness testing, Military Personnel Drug Abuse Testing Program participation and other military standards according to their gender marker in DEERS, subject to the approval of an Exception to Policy ("ETP") request.

30. To allow DON commanders to address medical needs in a manner consistent with military mission and readiness, the Policy sets forth detailed procedures concerning medical treatment for transgender service members with a diagnosis from a medical military provider

indicating that gender transition is medically necessary. Service members with such a diagnosis must notify their commanding officer and request commanding officer approval for the timing of medical treatment associated with gender transition. The commanding officer is the final approval authority for a transition plan. Commanding officers must respond to a gender transition request "within a framework that ensures readiness by minimizing impacts to the mission (including deployment, operational, training, exercise schedules, and critical skills availability), as well as the morale, welfare, and good order and discipline of the command." Furthermore, the Policy provides that timing of a medical treatment plan "should consider the individual's planned rotation date (PRD), deployment or other operational schedules, and potential impact on major career milestones, whenever possible."

31. The Policy further provides detailed instructions regarding an in-service transition. The transition plan is considered complete once (1) a military medical provider documents that the service member has completed the care outlined in a medical treatment plan; (2) the service member obtains an appropriate document showing legal proof of gender change; (3) the service member's commanding officer provides written permission to change the gender marker in the Navy Personnel Administrative Systems/DEERS; (4) the service member submits for the gender marker change; and (5) the gender marker is changed in the Navy Personnel Administrative Systems/DEERS.

32. As set forth in the Policy, in order to have a gender marker changed in the Navy Personnel Administrative Systems/DEERS, the service member must submit the required documentation showing legal proof of gender change and the commanding officer's written approval to Navy Personnel Command.

33. The Policy also provides that "[a]ll Service Members are world-wide assignable as their medical fitness for duty permits." "Any determination that a transgender Sailor or Marine is non-deployable at any time will be consistent with established DON standards, as applied to other Sailors and Marines whose deployability is similarly affected in comparable circumstances unrelated to gender transition."

34. Both the Instruction and Policy provide that effective July 1, 2017, the Navy and

Marine Corps will begin accessing transgender applicants who meet all standards.

35. In addition, the Policy included policy changes related to: (1) privacy in berthing and showering facilities as set forth in OPNAVINST 3120,32D, Standard Organization Regulations of the U.S. Navy; (2) drug testing and urinalysis as set forth in OPNAVINST 5350.4D, Navy Alcohol and Drug Abuse Prevention and Control Program; and (3) physical fitness assessment standards as set forth in OPNAVINST 6110.1J, Physical Readiness Program.

36. On September 30, 2016, the Department of Defense issued Transgender Service in the Military, An Implementation Handbook ("DoD Handbook"). A true and accurate copy of the DoD Handbook is attached hereto at Exhibit F. The DoD Handbook is intended as a practical day-to-day guide to assist all service members in understanding the Department of Defense's policy of allowing the open service of transgender service members. To that end, the DoD Handbook instructs all service members:

> The cornerstone of DoD values is treating every Service member with dignity and respect. Anyone who wants to serve their country, upholds our values, and can meet our standards, should be given the opportunity to compete to do so. Being a transgender individual, in and of itself, does not affect a Service member's ability to perform their job.

The Impact of Reversing the Policy Permitting Service by Openly Transgender People

37. Numerous military personnel disclosed their transgender status to the military in 2016 and 2017 in reliance upon the Department of Defense's statements that it would not discharge them on that basis, as articulated in DTM 16-005 and other documents. I did not receive any reports that such disclosures harmed the operational effectiveness of any Navy units.

38. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve in any capacity in the Armed Forces due to "the tremendous medical costs and disruption that transgender in the military would entail."

39. On August 25, 2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. That memorandum stated: "In my judgment, the previous Administration failed to identify a sufficient basis to conclude that

terminating the Departments' longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects."

40. President Trump's stated rationales for reversing the policy and banning military service by transgender people make no sense. They have no basis in fact and are refuted by the comprehensive analysis of relevant data and information that was carefully, thoroughly, and deliberately conducted by the Working Group.

41. As discussed above, the RAND Report concluded that any costs associated with providing appropriate healthcare to transgender service members would be "exceedingly small." In fact, the maximum financial impact estimated by the RAND Report is an amount so small it was considered to be "budget dust," hardly even a rounding error, by military leadership.

42. The claim that permitting transgender people to serve openly would be "disruptive" has no foundation. The same claim was used to oppose racial integration of the military in the 1940s, the increased recruiting of women in the 1970s, and the repeal of "Don't Ask Don't Tell." In each case, the prediction that disruption would ensue has not been borne out. Studies have shown that diversity actually improves unit cohesion. Units become closer when individual service members are respected for who they are.

43. Any evidence that permitting such service would be disruptive is entirely lacking. Since the policy permitting open service went into effect, transgender service members have been able to serve openly and have caused no disruption.

44. In addition to being contrary to the overwhelming weight of the evidence considered by the Working Group and the Secretary of Defense, a reversal of the DoD policy permitting open service and the banning of accessions by transgender people, in my assessment, based on my experience as Secretary of the Navy, disserves the public interest, for several reasons.

///

45. **Loss of Qualified Personnel**. First, banning transgender service members will produce vacancies in the Services, creating an immediate negative impact on readiness. The United States Armed Forces rely on an all-volunteer force, some portion of which are transgender service members. The impact of the loss of those individuals, who serve at all levels of service, is significant. Banning transgender service members will cause the loss of competent and experienced individuals, who will be difficult to replace. The Navy has invested in their education, and training. In addition to losing any return on that investment, taxpayers will bear the cost of identifying, recruiting, and training replacement personnel. Our ability to replace those individuals will also be hampered by the parallel reduction in the size of our potential recruiting pool. Artificial exclusionary barriers like this weaken the military.

46. **Unit Cohesion**. Second, banning transgender service members negatively impacts unit cohesion, a fundamental component of readiness. The only relevant qualification for the job of serving in the Armed Forces is whether an individual is capable of performing the job. Diversity in the form of nationality, religion, race, who one loves, gender, or gender identity only strengthens the force. Conversely, when the military asks people to lie about who they are in order to enlist or remain in the military, it weakens the military and has a negative impact on unit cohesion. Members of units know each other well and develop strong bonds. Unit members can tell when other unit members are lying. A policy that forces unit members to be dishonest with one another, including a ban on service by openly transgender people, weakens these bonds.

47. **Erosion of Trust in Command**. Third, arbitrary decisionmaking erodes trust in military leadership. I was dismayed by the abrupt reversal, because so much careful thought had gone into development of the policy, with consensus at the highest levels of military leadership. Furthermore, the initial directive to reverse policy through the Twitter medium was delivered entirely outside the normal pathway of legitimate orders issued through the chain of command, and the most recent memorandum of August 25, 2017 was also issued in a highly unusual manner. It is also unprecedented to reverse policy in such an abrupt manner. I cannot recall another instance in United States military history of such a stark and unfounded reversal of

policy, or of any example in our nation's history in which a minority group once permitted to serve has been excluded from the military after its members had been allowed to serve openly and honestly.

48. Even individuals who had reservations at the time the Working Group was announced trusted in the process and believed it was a fair and deliberative process that met the high standards of the military. This abrupt reversal leaves the impression among service members that military decision making is instead arbitrary and subject to political whims.

49. For transgender service members themselves, the reversal represents the ultimate mistreatment and breach of trust. In DTM-005 and in other documents issued by the Department of Defense, the military informed transgender service members that they could come forward to disclose their transgender status and serve openly, rather than facing discharge. Many transgender service members came forward based on those statements. They risked their jobs, housing, and progress towards retirement benefits in reliance on our word that we would treat their disclosures fairly and in good faith. Using that information now as a basis for separating these soldiers from their service is an unprecedented betrayal of the trust that is so essential to achieving the mission of all of the armed forces. The reversal penalizes transgender service members for doing what DoD encouraged them to do. Transgender service members, their chain of command, and their colleagues who may lose people on whom they rely, must now deal with this enormous distraction, thus detracting from military readiness.

50. This sudden reversal also undermines the morale and readiness of other groups who must now deal with the stress and uncertainty created by this dangerous precedent, which represents a stark departure from the foundational principle that military policy will be based on military, not political, considerations. In 2011, the "Don't Ask, Don't Tell" policy prohibiting gay, lesbian, and bisexual people from openly serving in the military (Department of Defense Directive 1304.26) was repealed. More recently, DoD also removed remaining barriers for women serving in certain ground combat positions. The sudden reversal of the DoD's policy with respect to transgender service members sets a precedent suggesting that these policies may

be abruptly reversed for baseless reasons as well.

51. This sudden reversal may also have a chilling effect on the confidence of other service members that they will continue to be able to serve. Religious and ethnic minorities who have seen an increase in discrimination under the current administration may fear that the military may seek to ban them next, creating a culture of fear that is anathema to the stability and certainty that makes for an effective military.

52. This sudden reversal undermines the confidence of all service members that important military policy decisions will be made under careful review and consistent with established process. Rational decisionmaking in the adoption of and change to policy impacts the military's ability to recruit and retain competent, high-performing people. The sudden reversal of policy makes recruitment and retention more difficult, as does the damage done to the military's image and reputation as promoting fairness and equality and of being open to all qualified Americans. That image and reputation are critical to the military's ability to attract talented and idealistic young people. Actions that tarnish that reputation cause real harm.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: September 13, 2017

Raymond Edwin Mabus, Jr.

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that on September 14, 2017, I caused true and correct copies of the foregoing documents to be served by the method(s) listed below on the following interested parties:

By Hand Delivery:

US Attorney's Office
700 Stewart St., Suite 5220
Seattle, WA 98101-1271

By Registered or Certified Mail:

Attorney General of the United States
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

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1400 Defense Pentagon
Washington, DC 20301-1400

Secretary of Defense James N. Mattis
1000 Defense Pentagon
Washington, DC 20301-1000

President Donald J. Trump
1600 Pennsylvania Ave. NW
Washington, DC 20500

I hereby certify under the penalty of perjury that the foregoing is true and correct. Executed on September 14, 2017 at Seattle, Washington.

s/Rachel Horvitz
Rachel Horvitz, *Paralegal*

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 2:17-cv-01297-MJP

DECLARATION OF RAYMOND EDWIN MABUS, JR. IN SUPPORT OF PLAINTIFFS' OPPOSITION TO MOTION TO DISMISS

I, Raymond Edwin Mabus, Jr., declare as follows:

1. As set forth in my earlier declaration signed and dated September 13, 2017, I was part of a Working Group that comprehensively reviewed military policy with regard to transgender people serving across the service branches. It was based upon that review and the recommendations of that group that the Department of Defense announced in June 2016 that it would begin allowing transgender people to serve openly in the military.

2. As further set forth in that declaration, I am aware that in a series of announcements made on Twitter on July 26, 2017, and then again in a formal memorandum issued by the White House on August 25, 2017, President Trump announced the reversal of military policy stating that transgender individuals would no longer be able to serve in any capacity. The memorandum set March 23, 2018 as the date when military policy would revert to the pre-June 2016 policy whereby

transgender individuals are subject to discharge upon disclosure of their transgender status.

3. Based on my experience in military personnel and operations, the recently announced policy change is presently causing significant harms to current service members who have disclosed that they are transgender. Those harms are not speculative or future harms. They are current harms that prevent transgender service members from serving on equal terms with non-transgender service members and that impose substantial limitations on their opportunities within the military.

4. Consideration of the ways in which deployment decisions are made highlights the current limitations and lost opportunities being experienced by transgender service members. Consistent with naval operations, ships may deploy for up to 9 months at a time. Commanders making decisions about how to staff naval operations must consider the length of time that a sailor will be available for a deployment. If a sailor may not be available for the full length of a deployment, command knows that they will have to expend significant resources to backfill staffing needs in order to address the diminishment of resources. Rather than face those challenges, command will predictably make assignments based on certainty about sailors' ability to serve the full length of deployment.

5. Because of the announcement of the ban on transgender people being able to serve after March 2018, command lacks the requisite certainty that transgender service members will be able to complete the terms of their deployments where they extend beyond that date.

6. Similarly, command must regularly make personnel decisions that relate to "permanent change of station" (PCS) moves. PCS moves are made to ensure maximum utilization of personnel and to achieve military missions. PCS moves involve transporting service members and their families to a different base and duty station, often across the country or the world. The introduction of any uncertainty with regard to a service member's future service, or status, changes command's consideration of PCS moves and military operations staffing. Based on my experience, the announced ban on transgender people serving is impacting PCS moves.

7. As a result of the announced ban, transgender service members are losing

opportunities for assignments that they are capable of doing. These include lost opportunities for deployment, training, and assignments. These lost opportunities are based not on individual assessment of the service member's merit but rather based on whether the person is transgender. These lost opportunities, in addition to depriving transgender members of the military of the ability to serve on equal footing with their peers, hinder transgender service members opportunities for advancement and promotions as well.

8. The impact of this immediate harm reaches beyond the individual service member and affects the institution of the military as a whole. The military is designed to be a meritocracy where individuals receive opportunities and tackle assignments based on their ability to do the job. The institution is weakened when people are denied the ability to serve not because they are unqualified or because they cannot do the job but because of who they are.

9. The ban on transgender service members weakens the military in a second way as well. With an all-volunteer force, which is the current structure of the military, a small segment of the population is responsible for the security of the whole. In this circumstance, it becomes even more important to have a diverse military in order to maintain a strong connection between those who serve to protect society and the society that the force is protecting. Banning a segment of the community from service weakens the bond of that connection between the military and society and sends a message that certain segments of the community are not within the scope of the mission. That message interferes with and diminishes military readiness and lethality.

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10. I know of no instance either prior to June 2016 or since when a transgender person seeking to enlist was granted a waiver to the ban on service. In any case, it would be futile for a transgender person to seek a waiver to join the military at this point in time since, according to the announced policy, they would be subject to administrative discharge as soon as March 2018.

I declare under penalty of perjury that the foregoing is true and correct.

DATED: October 23, 2017

Raymond E. Mabus, Jr.

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 2:17-cv-01297-MJP

DECLARATION OF MARK J. EITELBERG IN SUPPORT OF PLAINTIFFS' OPPOSITION TO MOTION TO DISMISS

I, Mark J. Eitelberg, declare as follows:

1. I am a Professor Emeritus at the Naval Postgraduate School in Monterey, California. I have personal knowledge of the matters stated in this declaration and can competently testify to these facts.

2. I received a Master of Public Administration degree from New York University in 1973 and a Ph.D. in Public Administration in 1979, also from New York University. I joined the faculty of the Naval Postgraduate School as an Adjunct Research Associate Professor in 1982. I was tenured as an Associate Professor in 1995 and promoted to Professor of Public Policy in 1999. I retired from federal service in April 2017. Upon retirement, in recognition of my distinguished service, I was designated Emeritus Professor of the Naval Postgraduate School. I served with the New Jersey Army National Guard and the U.S. Army Reserve from 1970 to 1976, the last two years as Staff Sergeant.

3. My teaching and research at the Naval Postgraduate School focused on military manpower and personnel policy analysis and military sociology/psychology. Among my research interests are the following: population participation ("representation") in the military; the All-Volunteer Force; military force management and manpower policy; military manpower selection, classification, and utilization; and equal opportunity and diversity management. My honors include the Robert M. Yerkes Award (for outstanding contributions to military psychology by a non-psychologist) from the Society for Military Psychology, a division of the American Psychological Association, and the Department of the Navy Superior Civilian Service Award. I have served on the Board of Editors of the journals Armed Forces & Society and Military Psychology. I was Editor-in-Chief of Armed Forces & Society from 1998 through 2001. A true and correct copy of my curriculum vitae and a list of my publications are attached to this declaration as Exhibit A.

4. I am aware that, on June 30, 2016, the Department of Defense announced it would begin allowing transgender persons to serve openly in the military. As stated in the official announcement and news release (NR-246-16): "Effective immediately, service members may no longer be involuntarily separated, discharged or denied reenlistment solely on the basis of gender identity. Service members currently on duty will be able to serve openly." This change in policy followed a careful review by a comprehensive working group that included high-ranking uniformed and civilian personnel as well as medical experts and other highly knowledgeable persons. The new policy assured current service members that they could reveal their gender identity if they chose to do so. The policy also established procedures for transgender service members to receive appropriate medical care for gender transition. Subsequently, many transgender service members informed their chain of command and their peers that they are transgender.

5. I am also aware that, in a series of informal comments on July 26, 2017, and later in a formal memorandum on August 25, 2017, President Donald Trump directed that the policy allowing transgender individuals to serve openly in the military "return to the longstanding policy and practice" that prohibited transgender persons from serving in any capacity. Up to this point, for over one year previously, transgender service members were told that the Department of Defense had "ended" its ban on transgender Americans serving in the U.S. military. Under this policy and a

forthcoming implementation plan, transgender service members will once again be subject to discharge by the Department of Defense on March 23, 2018.

6. Based on my knowledge, experience, and research in the fields of military manpower and personnel policy, military sociology, and military psychology, the newly announced policy is significantly harming service members who have disclosed they are transgender. This is not merely a potential problem or future hardship due to the scheduled March 23, 2018 date on which they will become subject to being separated. The new policy prevents transgender service members from serving equally with their peers; it imposes substantial limitations on their opportunities within the military; and it negatively impacts their day-to-day relationships with co-workers and other service members.

7. Military service opportunities are generally structured through career tracking by occupational area within each separate service, with scheduled training and skill-level assessments, operational assignments (or tours) and deployments, windows for advancement, and increased responsibilities based on experience, time-in-service, conduct, and performance. At the same time, as with any occupation, discretionary judgments or decisions within a service member's chain of command can have a strong impact on one's job opportunities or daily life. Naturally, these decisions are influenced by expectations regarding a service member's future in the military. From an operational perspective, commanders understandably are reluctant to invest significant resources in the training or development of individuals who might leave military service in the near future, or to entrust them with important assignments. This dynamic is similar to what occurs in other large organizations when an employee is known to be departing several months in advance. Transgender service members who informed others of their gender identity based on the government's pledge that they could serve openly as of June 30, 2016, believing that "ending the ban" would not be temporary, have no secure future in the military beyond March 23, 2018.

8. Transgender service members leaving military service would likely be held in their present duty location, pending a confirmed date of their involuntary separation. Lost opportunities and personal problems would ensue, particularly if the service member has a family, children in school, or other dependents. Previously scheduled training, deployment, change of duty station, or

other planned career events would be canceled by the military to save related costs, minimize organizational disruption, and simplify discharge. Some of these service members would continue to work in their present positions until separation; others would be temporarily "stashed" in another work unit; and some might be placed in a "make-work" situation or "holding pattern" while awaiting separation. If the person has a particularly important skill, knowledge, or expertise, she or he may be asked to train a replacement. In other cases, an individual scheduled for discharge may be gradually relieved of duties or assignments as their responsibilities are delegated to others. Depending on the supervisor's views and management style, this might mean the person slated for discharge will be required to perform tasks no one else wants or be assigned less challenging, repetitive tasks that do not enhance their skill development.

9. Such reductions in responsibility have an impact even on service members whose departure from the military is voluntary and who have begun to make plans for their post-military life. The impact is much more severe for those who had been planning to remain in the military but are unexpectedly facing the prospect of involuntary separation, because their accumulated efforts to excel or advance and their career aspirations essentially disappear upon discharge. The potential harm to these women and men economically is undeniable; added to this is the psychological distress of being told that their performance in service to the nation is meaningless when measured against their gender identity. They had volunteered to serve their country, to accept the associated risks, and to perform well and honorably. The military considered them qualified to serve when they joined. Surely, many would want to understand why their gender identity now makes them unqualified to serve their country, and to such a degree that they should be removed from the military.

10. The President's memorandum also harms transgender service members in another way. According to the memorandum, "the previous Administration failed to identify a sufficient basis to conclude" that terminating the ban on transgender persons "would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources." Consequently, "meaningful concerns" remain regarding the "negative effects" of removing a ban on transgender persons. In essence, the President's directive reestablishes the reasons for prohibiting military service by transgender persons prior to the policy change of June 30, 2016, negating the conclusions of the

comprehensive working group that supported removing the ban as well as any training, guidance, regulations and forms, protocols, and supporting networks developed by the military to facilitate transition.

11. In reversing the previous policy, the President's directive instructs commanders and other service members that transgender individuals are detrimental to the military. No further explanation is provided, merely a statement that the present basis for concluding otherwise is insufficient. Although commanders would attempt to ensure that transgender personnel continue to be treated with dignity and respect, as emphasized in training, the President's directive to discharge transgender personnel erodes the value that members serving with them place on their contributions or performance. Reestablishing reasons for discharging transgender personnel legitimizes any bias or prejudice that may have existed among non-transgender members prior to training. As a result, the directive harms transgender personnel and restricts them artificially from being able to serve as equals with their peers.

12. In previous cases of involuntary discharge, service members slated for separation are viewed commonly as a nuisance and may be harassed by co-workers or treated differently by commanders prior to the member's departure. Additionally, as a service member approaches involuntary discharge, documented cases indicate that superiors may be less than complimentary in evaluating the member's performance, perhaps motivated to confirm the basis for separation. For transgender personnel facing involuntary discharge under the new policy, this could mean an unfairly low or negative performance rating rather than one based solely on merit. Consequently, the announced ban has the current effect of inducing conscious and unconscious bias among peers and commanders that ultimately harms transgender personnel by limiting their service opportunities and chances for advancement and promotion.

13. The President's memorandum identifies the potential disruption of unit cohesion as a key factor in reversing the policy of June 2016 and discharging transgender service members. Clearly, unit cohesion is a critical element in the military. Historically, this purported concern has been used to justify U.S. military policies of racial and gender segregation. More recently, unit cohesion served as a reason for the policy known as "Don't Ask, Don't Tell" (DADT). DADT itself

stimulated considerable research by scholars to better understand unit cohesion and how it can be improved in the military. Previous studies have identified "task cohesion" (compared with "social cohesion") as most important in accomplishing a military mission. Strong bonds among service members are important in undertaking a mission and are particularly apparent in smaller military units, among persons on deployments, and among those who serve under dangerous conditions.

14. As noted, the President's directive places transgender personnel in a "holding pattern," subject to involuntary discharge on March 23, 2018. Knowing this, military commanders and co-workers are obviously less likely to bond with transgender service members and more inclined to keep them at a distance. Transgender personnel are thus more prone to be viewed as unimportant to a unit's cohesiveness and treated as such when working with their peers. Mutual trust and respect erode as co-workers see transgender personnel as "them," on the way out. Clearly, working relationships, as well social relationships, will suffer. Transgender personnel may feel isolated and alone. Added to this is the understanding among co-workers and commanders alike that transgender personnel are identified by the new policy as a potential detriment to military effectiveness and unit cohesion. Based upon current understanding of unit cohesion, the President's directive will damage the bond between transgender personnel and their co-workers and thus disrupt the very unit cohesion that it seeks to protect. It also puts transgender troops in harm's way while serving, especially when deployed in active combat.

15. Being branded as disruptive or unworthy of service also carries consequences that are unique to the military context and differ from the dignitary harms suffered by those who face discrimination in civilian life. Military service is widely understood as an integral element of citizenship, and many regard it as a civic duty. Historically, the military has served as a path for members of minority groups, immigrants, and social outcasts to gain recognition as true and loyal citizens. When the military adopts a policy that degrades or demeans a group of service members, the message goes out to the larger society that such treatment is acceptable. This is especially observable during times when the military is held in high esteem by the general public. Indeed, according to annual Gallup polling, the U.S. military is "the most trusted institution" in the country. This has been true from 1989 to 1996 and from 1998 to 2017, with 72 percent of adult Americans presently

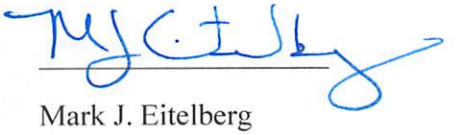
expressing "a great deal" or "quite a lot" of confidence in the military. Barring individuals who are physically, medically, intellectually, educationally, emotionally, and morally qualified to serve based on a personal characteristic that is irrelevant to their ability sends a powerful message that the government distrusts or disapproves of the excluded group or sees them as unfit. African-Americans, Japanese-Americans, women, and gay and lesbian people once faced such official disapproval. Barring demographic groups from equal service gives them the overt stigma of civic inferiority.

16. Being labeled unworthy to serve also impairs service members' ability to carry out their duties safely and effectively. Since people serving in the military depend upon each other so much, particularly under life-threatening circumstances, being isolated or mistrusted can have enormous consequences. If personnel see certain members in the unit as not being of equal value, they may not work as effectively with them or protect them as well as they would other unit members. And, unlike in civilian life, it is often difficult to escape the military workplace, which may be on a ship at sea, deployed overseas, or living on a base in close quarters with one's peers.

17. One final harm should be mentioned. The President's memorandum brands transgender personnel in a way that will follow them well into the future. Stained by the claim they are disruptive or damaging to a working unit's effectiveness—followed by their consequent separation from the military—transgender personnel may be irreparably harmed in finding post-service employment. Military recruiting advertisements often say that "it's a great place to start" and that military training and experience are invaluable to those seeking employment in the civilian job market. A natural result of the ban for transgender personnel is to diminish their opportunities for civilian employment following military service.

I declare under penalty of perjury that the foregoing is true and correct.

DATED: October 29, 2017



Mark J. Eitelberg

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 2-17-cv-01297-MJP

DECLARATION OF GEORGE R. BROWN, M.D., D.F.A.P.A. IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

NOTE ON MOTION CALENDAR:
October 6, 2017
ORAL ARGUMENT REQUESTED

I, George R. Brown, M.D., D.F.A.P.A., declare as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. The purpose of this declaration is to offer my expert opinion on: (1) the medical condition known as gender dysphoria; (2) the prevailing treatment protocols for gender dysphoria; (3) the United States military's pre-2016 ban on the enlistment and retention of men and women who are transgender; (4) the subsequent lifting of that ban; and (5) the unfounded medical justifications for banning individuals who are transgender from serving in the United States military.

3. I have knowledge of the matters stated in this declaration and have collected and cite to relevant literature concerning the issues that arise in this litigation.

PROFESSIONAL BACKGROUND

4. I am a Professor of Psychiatry and the Associate Chairman for Veterans Affairs in the Department of Psychiatry at the East Tennessee State University, Quillen College of Medicine. My responsibilities include advising the Chairman; contributing to the administrative, teaching, and research missions of the Department of Psychiatry; consulting on clinical cases at the University and at Mountain Home Veterans Health Administration ("VHA") Medical Center, where I also hold an appointment; and acting as a liaison between the VHA Medical Center and the East Tennessee State University Department of Psychiatry. The majority of my work involves researching, teaching, and consulting about health care in military and civilian transgender populations.

5. I also hold a teaching appointment related to my expertise with health care for transgender individuals and research at the University of North Texas Health Services Center ("UNTHSC"). My responsibilities include teaching and consultation with UNTHSC and the Federal Bureau of Prisons staff regarding health issues for transgender individuals.

6. In 1979, I graduated *Summa Cum Laude* with a double major in biology and geology from the University of Rochester in Rochester, New York. I earned my Doctor of Medicine degree with Honors from the University of Rochester School of Medicine in 1983. From 1983-1984, I served as an intern at the United States Air Force Medical Center at Wright-Patterson Air Force Base in Ohio. From 1984-1987, I worked in and completed the United States Air Force Integrated Residency Program in Psychiatry at Wright State University and Wright-Patterson Air Force Base in Dayton, Ohio. A true and correct copy of my Curriculum Vitae is attached hereto as Exhibit A.

7. I first began seeing patients in 1983. I have been a practicing psychiatrist since 1987, when I completed my residency. From 1987-1991, I served as one of the few U.S. Air Force teaching psychiatrists. In this capacity, I performed more than 200 military disability evaluations and served as an officer on medical evaluation boards at the largest hospital in the Air Force.

8. During the last 33 years, I have evaluated, treated, and/or conducted research in person with 600-1,000 individuals with gender disorders, and during the course of research, conducted chart reviews of more than 5,100 additional patients with gender dysphoria. The vast majority of the patients I have worked with have been active duty military personnel or veterans.

9. For three decades, my research and clinical practice has included extensive study of the health care for transgender individuals, including three of the largest studies focused on the health care needs of transgender service members and veterans. Throughout that time, I have done research with, taught on, and published peer-reviewed professional publications specifically addressing the needs of transgender military service members. *See* Brown Ex. A (CV).

10. I have authored or coauthored 38 papers in peer-reviewed journals and 19 book chapters on topics related to gender dysphoria and health care for transgender individuals, including the chapter concerning gender dysphoria in Treatments of Psychiatric Disorders (3d ed. 2001), a definitive medical text published by the American Psychiatric Association.

11. In 2014, I coauthored a study along with former Surgeon General Joycelyn Elders and other military health experts, including a retired General and a retired Admiral. The study was entitled "Medical Aspects of Transgender Military Service." *See* Elders J, Brown GR, Coleman E, Kolditz TA, *Medical Aspects of Transgender Military Service*. ARMED FORCES AND SOCIETY, 41(2): 199-220, 2015; published online ahead of print, DOI: 10.1177/0095327X1454 5625 (Aug. 2014) (the "Elders Commission Report"). The military peer-reviewed journal, Armed Forces and Society, published the Elders Commission Report. A true and correct copy of that report is attached hereto as Exhibit B.

12. I have served for more than 15 years on the Board of Directors of the World Professional Association for Transgender Health ("WPATH"), the leading international organization focused on health care for transgender individuals. WPATH has more than 2,000 members throughout the world and is comprised of physicians, psychiatrists, psychologists, social workers, surgeons, and other health professionals who specialize in the diagnosis and treatment of gender dysphoria.

13. I was a member of the WPATH committee that authored and published in 2011 the current version of the WPATH Standards of Care ("SoC") (Version 7). The SoC are the operative collection of evidence-based treatment protocols for addressing the health care needs of transgender individuals. I also serve on the WPATH committee that will author and publish the next edition, the Standards of Care (Version 8).

14. Without interruption, I have been an active member of WPATH since 1987. Over the past three decades, I have frequently presented original research work on topics relating to gender dysphoria and the clinical treatment of transgender people at the national and international levels.

15. I have testified or otherwise served as an expert on the health issues of transgender individuals in numerous cases heard by several federal district and tax courts. A true and correct list of federal court cases in which I have served as an expert is contained in the "Forensic Psychiatry Activities" section of my Curriculum Vitae, which is attached hereto as Exhibit A.

16. I have conducted and continue to provide trainings on transgender health issues for the VHA as well as throughout the Department of Defense ("DoD"). After the DoD announced the policy that allowed for transgender individuals to serve openly in the Armed Forces in 2016, I conducted the initial two large military trainings on the provision of health care to transgender service members. The first training in Spring 2016 was for the Marine Corps. The second training in Fall 2016 was for a tri-service (Army, Navy, and Air Force) meeting of several hundred active duty military clinicians, commanders, and Flag officers.

17. Since the issuance of DoD Instruction ("DoDI") 1300.28 in October 2016, I have led trainings for a national group of military examiners (MEPCOM) in San Antonio, Texas and for Army clinicians at Fort Knox, Kentucky. Among other things, DoDI 1300.28 implemented the policies and procedures in Directive-type Memorandum 16-005, established a construct by which transgender service members may transition gender while

serving, and required certain trainings for the military.

18. I have been centrally involved in the development, writing, and review of all national directives in the VHA relating to the provision of health care for transgender veterans. I also coauthored the national formulary that lists the medications provided by the VHA for the treatment of gender dysphoria in veterans. Finally, I regularly consult with VHA leadership regarding the training of VHA clinicians on transgender clinical care of veterans nationally.

GENDER DYSPHORIA

19. The term "transgender" is used to describe someone who experiences any significant degree of misalignment between their gender identity and their assigned sex at birth.

20. Gender identity describes a person's internalized, inherent sense of who they are as a particular gender (*i.e.*, male or female). For most people, their gender identity is consistent with their assigned birth sex. Most individuals assigned female at birth grow up, develop, and manifest a gender identity typically associated with girls and women. Most individuals assigned male at birth grow up, develop, and manifest a gender identity typically associated with boys and men. For transgender people, that is not the case. Transgender women are individuals assigned male at birth who have a persistent female identity. Transgender men are individuals assigned female at birth who have a persistent male identity.

21. Experts agree that gender identity has a biological component, meaning that each person's gender identity (transgender and non-transgender individuals alike) is the result of biological factors, and not just social, cultural, and behavioral ones.

22. Regardless of the precise origins of a person's gender identity, there is a medical consensus that gender identity is deep-seated, set early in life, and impervious to external influences.

23. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2013) ("DSM-5") is the current, authoritative handbook on the diagnosis of mental disorders. Mental health professionals in the United States, Canada, and other countries

throughout the world rely upon the DSM-5. The content of the DSM-5 reflects a science-based, peer-reviewed process by experts in the field.

24. Being transgender is not a mental disorder. *See* DSM-5. Men and women who are transgender have no impairment in judgment, stability, reliability, or general social or vocational capabilities solely because of their transgender status.

25. Gender dysphoria is the diagnostic term in the DSM-5 for the condition that can manifest when a person suffers from clinically significant distress or impairment associated with an incongruence or mismatch between a person's gender identity and their assigned sex at birth.

26. The clinically significant emotional distress experienced as a result of the incongruence of one's gender with their assigned sex and the physiological developments associated with that sex is the hallmark symptom associated with gender dysphoria.

27. Only the *subset* of transgender people who have clinically significant distress or impairment qualify for a diagnosis of gender dysphoria.

28. Individuals with gender dysphoria may live for a significant period of their lives in denial of these symptoms. Some transgender people may not initially understand the emotions associated with gender dysphoria and may not have the language or resources for their distress to find support until well into adulthood.

29. Particularly as societal acceptance towards transgender individuals grows and there are more examples of high-functioning, successful transgender individuals represented in media and public life, younger people in increasing numbers have access to medical and mental health resources that help them understand their experience and allow them to obtain medical support at an earlier age and resolve the clinical distress associated with gender dysphoria.

TREATMENT FOR GENDER DYSPHORIA

30. Gender dysphoria is a condition that is amenable to treatment. *See* WPATH SoC (Version 7); Elders Commission Report at 9-16; Agnes Gereben Schaefer et al., *Assessing the Implications of Allowing Transgender Personnel to Serve Openly*, RAND Corporation (2016) at 7 ("RAND Report") (a true and correct copy of the report is attached hereto as Exhibit C).

31. With appropriate treatment, individuals with a gender dysphoria diagnosis can be fully cured of *all* symptoms.

32. Treatment of gender dysphoria has well-established community standards and is highly effective.

33. The American Medical Association ("AMA"), the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that medical treatment for gender dysphoria is medically necessary and effective. *See* American Medical Association (2008), Resolution 122 (A-08); American Psychiatric Association, Position Statement on Discrimination Against Transgender & Gender Variant Individuals (2012); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009). Additional organizations that have made similar statements include the American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American College of Nurse Midwives, American College of Obstetrics and Gynecology, American College of Physicians, American Medical Student Association, American Nurses Association, American Public Health Association, National Association of Social Workers, and National Commission on Correctional Health Care.

34. The protocol for treatment of gender dysphoria is set forth in the WPATH SoC and in the Endocrine Society Guidelines.[1] First developed in 1979 and currently in their seventh version, the WPATH SoC set forth the authoritative protocol for the evaluation and treatment of gender dysphoria. This approach is followed by clinicians caring for individuals with gender dysphoria, including veterans in the VHA. As stated above, I was a member of the WPATH committee that authored the SoC (Version 7), published in 2011. A true and correct copy of that document is attached hereto as Exhibit D.

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[1] *Available at* https://academic.oup.com/jcem/article/94/9/3132/2596324/Endocrine-Treatment-of-Transsexual-Persons-An.

35. Depending on the needs of the individual, a treatment plan for persons diagnosed with gender dysphoria may involve components that are psychotherapeutic (*i.e.*, counseling as well as social role transition – living in accordance with one's gender in name, dress, pronoun use); pharmacological (*i.e.*, hormone therapy); and surgical (*i.e.*, gender confirmation surgeries, like hysterectomy for those transitioning to the male gender and orchiectomy for those transitioning to the female gender). Under each patient's treatment plan, the goal is to enable the individual to live all aspects of one's life consistent with his or her gender identity, thereby eliminating the distress associated with the incongruence.

36. There is a wide range in the treatments sought by those suffering from gender dysphoria. For example, some patients need both hormone therapy and surgical intervention, while others need just one or neither. Generally, medical intervention is aimed at bringing a person's body into some degree of conformity with their gender identity.

37. As outlined further below, treatment protocols for gender dysphoria are comparable to those for other mental health and medical conditions, including those regularly treated within the United States military. *See* RAND Report at 8-9; Elders Commission Report at 13 ("the military consistently retains non-transgender men and women who have conditions that may require hormone replacement").

PRE-2016 MILITARY POLICY

38. Prior to 2016, military policy treated transgender individuals with gender dysphoria differently than people with other curable conditions.

Former Enlistment Policy

39. DODI 6130.03 established the medical standards for accession/entry into military service. Enclosure 4 of the enlistment instruction contains an extensive list of physical and mental conditions that disqualify a person from enlisting in the military. For instance, persons with autism, schizophrenia, or delusional disorders (or a history of treatment for these conditions) are excluded from enlistment. Prior to 2016, that list also contained "change of sex"

and "transsexualism," which were outdated references to transgender individuals and individuals with gender dysphoria. *See* Elders Commission Report at 7.

40. The enlistment policy allows for the possibility of waivers for a variety of medical conditions. The instruction, however, specifies that entry waivers will not be granted for conditions that would disqualify an individual from the possibility of retention. As discussed further below, because certain conditions related to being transgender ("change of sex") were formerly grounds for discharge from the military, men and women who are transgender could not obtain medical waivers to enter the military. *Id.* at 7-8.

41. Under military instructions, the general purpose of disqualifying applicants based on certain physical and mental conditions is to ensure that service members are: (1) free of contagious diseases that endanger others, (2) free of conditions or defects that would result in excessive duty-time lost and would ultimately be likely to result in separation, (3) able to perform without aggravating existing conditions, and (4) capable of completing training and adapting to military life. *Id.* at 7.

42. Because gender dysphoria, as described above, is a treatable and curable condition, unlike other excluded conditions, its inclusion on the list of disqualifying conditions was inappropriate. Individuals with gender dysphoria (or under the language at the time – those who had a "change of sex") were disqualified from joining the military, despite having a completely treatable, or already treated, condition.

43. The enlistment policy treated transgender individuals in an inconsistent manner compared with how the military addressed persons with other curable medical conditions. The result of this inconsistency was that transgender personnel were excluded or singled out for disqualification from enlistment, even when they were mentally and physically healthy.

44. For example, persons with certain medical conditions, such as Attention Deficit Hyperactivity Disorder ("ADHD") and simple phobias, could be admitted when their conditions could be managed without imposing undue burdens on others. Individuals with ADHD are prohibited from enlisting unless they meet five criteria, including documenting that they

maintained a 2.0 grade point average after the age of 14. Similarly, individuals with simple phobias are banned from enlisting, unless they meet three criteria including documenting that they have not required medication for the past 24 continuous months.

45. In short, even though the DoD generally allowed those with manageable conditions to enlist, the former regulation barred transgender service without regard to the condition's treatability and the person's ability to serve.

Former Separation Policy

46. The medical standards for retiring or separating service members who have already enlisted are more accommodating and flexible than the standards for new enlistments.

47. Until recently, the medical standards for separation were set forth in DoDI 1332.38. On August 5, 2014, the DoD replaced DoDI 1332.38 with DoDI 1332.18, which permits greater flexibility for the service branches to provide detailed medical standards.

48. The separation instructions divide potentially disqualifying medical conditions into two different tracks. Service members with "medical conditions" are placed into the medical system for disability evaluation. Under this evaluation system, a medical evaluation board ("MEB") conducts an individualized inquiry to determine whether a particular medical condition renders a service member medically unfit for service. If a service member is determined to be medically unfit, the service member may receive benefits for medical separation or retirement, or may be placed on the Temporary Duty Retirement List with periodic reevaluations for fitness to return to duty. While in the U.S. Air Force, I served as an officer on at least two hundred of these MEBs.

49. Under the separation instruction, service members with genitourinary conditions, endocrine system conditions, and many mental health conditions are all evaluated through the medical disability system. *See* DoDI 1332.38 §§ E4.8, E4.11, E4.13; AR 40-501 §§ 2-8, 3-11, 3-17, 3-18, 3-31, 3-32; SECNAVIST 180.50_4E §§ 8008, 8011, 8013; U.S. Airforce Medical Standards Directory §§ J, M, Q.

50. By contrast, under the separation instructions, a small number of medical and psychiatric conditions are not evaluated through the medical evaluation process. Instead, these conditions are deemed to render service members "administratively unfit." Service members with "administratively unfit" conditions do not have the opportunity to demonstrate medical fitness for duty or eligibility for disability compensation.

51. Under DoDI 1332.38, the "administratively unfit" conditions were listed in Enclosure 5 of the instruction. Since August 5, 2014, when DoDI 1332.18 replaced 1332.38, the "administratively unfit" conditions are determined by the service branches, as set forth in AR 40-501 § 3-35; SECNAVIST § 2016; and AFI36-3208 § 5.11.

52. Enclosure 5 of DoDI 1332.38 included, among other conditions, bed-wetting, sleepwalking, learning disorders, stuttering, motion sickness, personality disorders, mental retardation, obesity, shaving infections, certain allergies, and repeated infections of venereal disease. It also included "Homosexuality" and "Sexual Gender and Identity Disorders, including Sexual Dysfunctions and Paraphilias." *See* Elders Commission Report at 8.

53. Similarly, the "administratively unfit" conditions in the service branches included "psychosexual conditions, transsexual, gender identity disorder to include major abnormalities or defects of the genitalia such as change of sex or a current attempt to change sex," AR 40-501 § 3-35(a); "Sexual Gender and Identity Disorders and Paraphilias," SECNAVIST § 2016(i)(7); and "Transsexualism or Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT)," AFI36-3208 § 5.11.9.5. The service branches retained these bars to service by transgender individuals after DoDI 1332.18 replaced DoDI 1332.38.

54. DoDI 1332.14 controlled administrative separations for enlisted persons. Under the instruction, a service member may be separated for the convenience of the government and at the discretion of a commander for "other designated physical or mental conditions." Before 2016, this particular separation category included "sexual gender and identity disorders." *Id.*

55. Because service members with gender dysphoria were deemed to be "administratively unfit," they were not evaluated by MEBs and had no opportunity to

demonstrate that their condition did not affect their fitness for duty. They were disqualified from remaining in the military despite having a completely treatable condition.

56. This was inconsistent with the treatment of persons with other curable medical conditions, who are given the opportunity to demonstrate medical fitness for duty or eligibility for disability compensation. For example, mood and anxiety disorders are not automatically disqualifying for retention in military service. Service members can receive medical treatment and obtain relief in accordance with best medical practices. Mood and anxiety disorders result in separation only if they significantly interfere with duty performance and remain resistant to treatment. In contrast, transgender individuals were categorically disqualified from further service without consideration of their clinical symptoms and any impact on their service.

57. The result of this inconsistency was that transgender personnel were singled out for separation, even when they were mentally and physically healthy, solely because they were transgender.

OPEN SERVICE DIRECTIVE

58. The DoD lifted the ban on open service by transgender military personnel following a June 30, 2016 announcement made by then-Secretary of Defense Ash Carter ("Open Service Directive").

59. Based on my extensive research and clinical experiences treating transgender individuals over decades, the Open Service Directive is consistent with medical science.

60. The Open Service Directive also aligns with the conclusions reached by the RAND National Defense Research Institute, the Elders Commission, and the AMA.

61. The RAND Report concluded that the military already provides health care comparable to the services needed to treat transgender individuals: "Both psychotherapy and hormone therapies are available and regularly provided through the military's direct care system, though providers would need some additional continuing education to develop clinical and cultural competence for the proper care of transgender patients. Surgical procedures quite similar

to those used for gender transition are already performed within the [Medical Health System] for other clinical indications." *See* RAND Report at 8.

62. The earlier Elders Commission, on which I served, concluded that "[t]ransgender medical care should be managed in terms of the same standards that apply to all medical care, and there is no medical reason to presume transgender individuals are unfit for duty. Their medical care is no more specialized or difficult than other sophisticated medical care the military system routinely provides." *See* Elders Commission Report at 4.

63. Additionally, in a unanimous resolution published on April 29, 2015, the AMA announced its support for lifting the ban on open transgender service in the military, based on the AMA's conclusion that there is no grounding in medical science for such a ban.[2]

Enlistment Policy for Transgender Individuals

64. The Open Service Directive's enlistment procedures – which were adopted but not yet put into effect – are carefully designed to ensure that transgender individuals who enlist in the military do not have any medical needs that would make them medically unfit to serve or interfere with their deployment.

65. Under these standards, transgender individuals whose condition was stable for 18 months at the time of enlistment would be eligible to enlist, assuming a licensed medical provider certified that they met certain conditions. DTM-16-005 Memorandum and Attachment (June 30, 2016). For example, those seeking to enlist who had been treated with any counseling, cross-sex hormone therapy, or gender confirmation surgeries must have medical confirmation that they have been stable for the last 18 months. Similarly, those applicants taking maintenance cross-sex hormones as follow-up to their transition would also need certification that they had been stable on such hormones for 18 months.

Retention Policy for Transgender Individuals

66. Under the Open Service Directive, gender dysphoria is treated like other curable

[2] *Available at* http://archive.palmcenter.org/files/A-15%20Resoultion%20011.pdf.

medical conditions. Individuals with gender dysphoria receive medically necessary care. Service members who are transgender are subject to the same standards of medical and physical fitness as any other service member.[3]

67. The Open Service Directive also permits commanders to have substantial say in the timing of any future transition-related treatment for transgender service members. The needs of the military can also take precedence over an individual's need to transition, if the timing of that request interferes with critical military deployments or trainings.

MEDICAL JUSTIFICATIONS FOR BANNING TRANSGENDER SERVICE MEMBERS ARE UNFOUNDED

68. Based upon: (1) my extensive research and experience treating transgender people, most of whom have served this country in uniform, (2) my involvement reviewing the medical implications of a ban on transgender service members, and (3) my participation in implementing the Open Service Directive allowing transgender individuals to serve openly, it is my opinion that any medical objections to open service by transgender service members are wholly unsubstantiated and inconsistent with medical science and the ways in which other medical conditions are successfully addressed within the military.

Mental Health

69. Arguments based on the mental health of transgender persons to justify prohibiting individuals from serving in the military are wholly unfounded and unsupported in medical science. Being transgender is not a mental defect or disorder. Scientists have long abandoned psychopathological understandings of transgender identity, and do not classify the incongruity between a person's gender identity and assigned sex at birth as a mental illness. To the extent the misalignment between gender identity and assigned birth sex creates clinically significant distress (gender dysphoria), that distress is curable through appropriate medical care.

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[3] *Available at* https://www.defense.gov/Portals/1/features/2016/0616_policy/Guidance_for_Treatment_of_Gender_Dysphoria_Memo_FINAL_SIGNED.pdf.

70. Sixty years of clinical experience have demonstrated the efficacy of treatment of the distress resulting from gender dysphoria. *See* Elders Commission Report at 10 ("a significant body of evidence shows that treatment can alleviate symptoms among those who do experience distress"). Moreover, "empirical data suggest that many non-transgender service members continue to serve despite psychological conditions that may not be as amenable to treatment as gender dysphoria." *Id.* at 11.

71. The availability of a cure distinguishes gender dysphoria from other mental health conditions, such as autism, bipolar disorder, or schizophrenia, for which there are no cures. There is no reason to single out transgender personnel for separation, limitation of service, or bars to enlistment, based only on the diagnosis or treatment of gender dysphoria. Determinations can and should be made instead on a case-by-case basis depending on the individual's fitness to serve, as is done with other treatable conditions.

72. The military already provides mental health evaluation services and counseling, which is the first component of treatment for gender dysphoria. *See* RAND Report at 8.

73. Concerns about suicide and substance abuse rates among transgender individuals are also unfounded when it comes to military policy. At enlistment, all prospective military service members undergo a rigorous examination to identify any pre-existing mental health diagnoses that would preclude enlistment. Once someone is serving in the military, they must undergo an annual mental and physical health screen, which includes a drug screen. If such a screening indicates that a person suffers from a mental illness or substance abuse, then that would be the potential impediment to retention in the military. The mere fact that a person is transgender, however, does not mean that person has a mental health or substance abuse problem or is suicidal.

Hormone Treatment

74. The argument that cross-sex hormone treatment should be a bar to service for transgender individuals is not supported by medical science or current military medical protocols.

75. Hormone therapy is neither too risky nor too complicated for military medical personnel to administer and monitor. The risks associated with use of cross-sex hormone therapy to treat gender dysphoria are low and not any higher than for the hormones that many non-transgender active duty military personnel currently take. There are active duty service members currently deployed in combat theaters who are receiving cross-sex hormonal treatment, following current DoD instructions, without reported negative impact upon readiness or lethality.

76. The military has vast experience with accessing, retaining, and treating non-transgender individuals who need hormone therapies or replacement, including for gynecological conditions (*e.g.*, dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, male hypogonadism, hysterectomy, or oophorectomy) and genitourinary conditions (*e.g.*, renal or voiding dysfunctions). Certain of these conditions are referred for a fitness evaluation only when they affect duty performance. *See* Elders Commission at 13.

77. In addition, during service when service members develop hormonal conditions whose remedies are biologically similar to cross-sex hormone treatment, those members are not discharged and may not even be referred for a MEB. Examples include male hypogonadism, menstrual disorders, and current, or history of, pituitary dysfunction. *Id.*

78. Military policy also allows service members to take a range of medications, including hormones, while deployed in combat settings. Id. Under DoD policy only a "few medications are inherently disqualifying for deployment," and none of those medications are used to treat gender dysphoria. *Id.* (quoting Dept. of Defense, Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications, 2006 at para. 4.2.3). Similarly, Army regulations provide that "[a] psychiatric condition controlled by medication should not automatically lead to non-deployment." *See* AR 40-501 § 5-14(8)(a).

79. Access to medication is predictable, as "[t]he Medical Health Service maintains a sophisticated and effective system for distributing prescription medications to deployed service members worldwide." *See* Elders Commission at 13. At least as to cross-sex hormones, clinical monitoring for risks and effects is not complicated, and with training and/or access to

consultations, can be performed by a variety of medical personnel in the DoD, just as is the case in the VHA. This is the military services' current practice in support of the limited medical needs of their transgender troops in CONUS (Continental United States) and in deployment stations worldwide.

80. The RAND Corporation confirms the conclusions I draw from my experience with the military and the Elders Commission. Specifically, the RAND Report notes that the Medical Health System maintains and supports all of the medications used for treatment of gender dysphoria and has done so for treatment of non-transgender service members. In other words, all of the medications utilized by transgender service members for treatment of gender dysphoria are used by other service members for conditions unrelated to gender dysphoria. *See* RAND Report at 8 ("Both psychotherapy and hormone therapies are available and regularly provided through the military's direct care system, though providers would need some additional continuing education to develop clinical and cultural competence for the proper care of transgender patients"). Part of my role with the DoD over the past 18 months has been to provide this continuing education.

Surgery

81. Nor is there any basis in science or medicine to support the argument that a transgender service member's potential need for surgical care to treat gender dysphoria presents risks or burdens to military readiness. The risks associated with gender-confirming surgery are low, and the military already provides similar types of surgeries to non-transgender service members. *See* Elders Commission Report at 14; RAND Report at 8-9.

82. For example, the military currently performs reconstructive breast/chest and genital surgeries on service members who have had cancer, been in vehicular and other accidents, or been wounded in combat. *See* RAND Report at 8. The military also permits service members to have elective cosmetic surgeries, like LeFort osteotomy and mandibular osteotomy, at military medical facilities. *See* Elders Commission Report at 14. The RAND Report notes that the "skills and competencies required to perform these procedures on transgender patients are

often identical or overlapping. For instance, mastectomies are the same for breast cancer patients and female-to-male transgender patients." *See* RAND Report at 8.

83. There is no reason to provide such surgical care to treat some conditions and withhold identical care and discharge individuals needing such care when it is provided to treat gender dysphoria. Based on risk and deployability alone, there is no basis to exclude transgender individuals from serving just because in some cases they may require surgical treatment that is already provided to others.

84. The RAND Report also notes the benefit of military medical coverage of transgender-related surgeries because of the contribution it can make to surgical readiness and training. *Id.* ("performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries during a period in which fewer combat injuries are sustained").

85. The suggestion by some critics that when it comes to enlistment, individuals would join the military just to receive surgical care, is completely unfounded. The level of commitment and dedication to service makes it unlikely that someone would enlist and complete a years-long term of initial service simply to access health care services. Moreover, because medically-necessary care for gender dysphoria is now increasingly available in the civilian context, there would be limited need to join the military in order to obtain treatment.

Deployability

86. Critics have also cited non-deployability, medical readiness, and constraints on fitness for duty as reasons to categorically exclude transgender individuals from military service. Such arguments are unsubstantiated and illogical.

87. Transgender service members – including service members who receive hormone medication – are just as capable of deploying as service members who are not transgender. DoD rules expressly permit deployment, without need for a waiver, for a number of medical conditions that present a much more significant degree of risk in a harsh environment than being transgender. For example, hypertension is not disqualifying if controlled by medication, despite

the inherent risks in becoming dehydrated in desert deployment situations. Heart attacks experienced while on active duty or treatment with coronary artery bypass grafts are also not disqualifying, if they occur more than a year preceding deployment. Service members may deploy with psychiatric disorders, if they demonstrate stability under treatment for at least three months. *See* DoDI 6490.07, Enclosure 3.

88. Moreover, although a service member undergoing surgery may be temporarily non-deployable, that is not a situation unique to people who are transgender. Numerous non-transgender service members are temporarily or permanently non-deployable, including pregnant individuals, who are not separated as a result. *See* Elders Commission Report at 17.

89. Finally, the RAND Report ultimately concluded that the impact of open service of men and women who are transgender on combat readiness would be "negligible." *See* RAND Report at 70. Based on the available evidence of over 18 foreign militaries, RAND found that open service has had "no significant effect on cohesion, operational effectiveness, or readiness." *Id.* at 60. This includes the experience of Canada, which has permitted open service for over 20 years. *Id.* at 52.

CONCLUSION

90. There is no evidence that being transgender alone affects military performance or readiness. There is no medical or psychiatric justification for the categorical exclusion of transgender individuals from the Armed Forces.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 12, 2017

George R. Brown, M.D., D.F.A.P.A.

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that on September 14, 2017, I caused true and correct copies of the foregoing documents to be served by the method(s) listed below on the following interested parties:

By Hand Delivery:

US Attorney's Office
700 Stewart St., Suite 5220
Seattle, WA 98101-1271

By Registered or Certified Mail:

Attorney General of the United States
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Department of Defense
1400 Defense Pentagon
Washington, DC 20301-1400

Secretary of Defense James N. Mattis
1000 Defense Pentagon
Washington, DC 20301-1000

President Donald J. Trump
1600 Pennsylvania Ave. NW
Washington, DC 20500

I hereby certify under the penalty of perjury that the foregoing is true and correct. Executed on September 14, 2017 at Seattle, Washington.

s/Rachel Horvitz
Rachel Horvitz, *Paralegal*

Counts of Active Duty and Reserve Service Members and APF Civilians
By Location Country, Personnel Category, Service and Component
As of June 30, 2017

LOCATION STATE / COUNTRY	ACTIVE DUTY						NATIONAL GUARD / RESERVE							
	ARMY	NAVY	MARINE CORPS	AIR FORCE	COAST GUARD	TOTAL	ARMY NATIONAL GUARD	ARMY RESERVE	NAVY RESERVE	MARINE CORPS RESERVE	AIR NATIONAL GUARD	AIR FORCE RESERVE	COAST GUARD RESERVE	TOTAL
ALABAMA	4,505	126	147	2,776	831	**8,385**	9,766	4,713	292	705	2,224	1,355	113	**19,168**
ALASKA	9,806	51	25	7,167	1,971	**19,020**	1,746	395	56	48	2,021	341	43	**4,650**
ARIZONA	3,976	393	4,272	8,786	5	**17,432**	5,279	3,416	877	640	2,482	2,135	1	**14,830**
ARKANSAS	117	4	172	3,328	19	**3,640**	6,158	1,810	149	139	1,843	454	0	**10,553**
ARMED FORCES EUROPE	544	34,146	20	231	193	**35,134**	0	0	127	0	0	0	0	**127**
ARMED FORCES PACIFIC	0	49,348	2,239	0	0	**51,587**	0	1	245	0	0	0	0	**246**
ARMED FORCES THE AMERICAS	0	6,763	0	0	26	**6,789**	0	0	58	0	0	0	0	**58**
CALIFORNIA	6,734	46,013	56,077	17,042	4,632	**130,498**	13,846	16,328	7,783	5,435	4,378	7,508	858	**56,136**
COLORADO	25,002	775	226	9,293	40	**35,336**	3,603	3,705	863	395	1,580	2,974	10	**13,130**
CONNECTICUT	101	3,834	63	35	660	**4,693**	3,483	1,314	391	265	1,004	1	103	**6,561**
DELAWARE	71	16	14	3,242	35	**3,378**	1,513	479	124	164	1,094	1,515	6	**4,895**
DISTRICT OF COLUMBIA	1,586	2,537	2,157	1,624	1,682	**9,586**	1,358	479	177	618	1,248	267	156	**4,303**
FLORIDA	5,388	20,908	3,777	21,484	4,786	**56,343**	9,447	10,212	5,515	1,608	2,017	6,369	810	**35,978**
GEORGIA	45,918	3,624	1,312	8,388	469	**59,711**	10,789	7,655	1,374	741	2,687	2,743	76	**26,065**
HAWAII	16,627	7,917	6,783	4,931	1,239	**37,497**	2,996	2,416	601	282	2,172	694	127	**9,288**
IDAHO	53	39	33	3,114	5	**3,244**	3,042	753	152	110	1,317	23	0	**5,397**
ILLINOIS	950	13,536	385	4,265	137	**19,273**	9,810	6,300	2,324	1,325	2,894	1,436	55	**24,144**
INDIANA	563	110	191	82	35	**981**	11,483	3,002	391	622	1,789	1,585	9	**18,881**
IOWA	92	22	72	29	34	**249**	6,799	2,118	147	131	1,728	0	0	**10,923**
KANSAS	17,612	73	92	2,981	101	**20,859**	4,286	2,629	110	193	1,988	606	20	**9,832**
KENTUCKY	30,385	8	96	209	157	**30,855**	6,501	4,307	241	268	1,219	3	66	**12,605**
LOUISIANA	8,030	421	687	5,157	1,182	**15,477**	9,626	1,910	1,167	1,583	1,492	1,409	145	**17,332**
MAINE	45	148	26	10	586	**815**	1,974	438	103	169	1,097	0	56	**3,837**
MARYLAND	8,441	10,251	1,861	8,173	897	**29,623**	4,225	6,047	3,411	544	1,834	1,818	168	**18,047**
MASSACHUSETTS	357	392	187	1,008	1,688	**3,632**	5,863	3,315	262	821	2,114	2,207	393	**14,975**
MICHIGAN	431	221	248	105	1,136	**2,141**	7,989	2,964	860	944	2,197	2	113	**15,069**
MINNESOTA	159	157	123	47	121	**607**	10,906	3,092	591	446	2,158	1,334	27	**18,554**
MISSISSIPPI	431	4,373	468	5,870	335	**11,477**	9,547	1,771	797	72	2,582	1,478	113	**16,360**
MISSOURI	8,798	344	1,648	4,156	197	**15,143**	8,397	4,817	1,160	715	2,193	980	81	**18,343**
MONTANA	60	6	27	3,208	0	**3,301**	2,566	687	105	65	957	22	0	**4,402**
NEBRASKA	168	405	77	5,410	16	**6,076**	3,288	1,246	281	132	968	289	0	**6,204**
NEVADA	148	941	54	9,034	0	**10,177**	3,271	1,476	383	194	1,103	1,240	0	**7,667**
NEW HAMPSHIRE	49	219	57	140	300	**765**	1,625	1,079	238	191	1,029	1	8	**4,171**
NEW JERSEY	641	457	378	4,411	1,798	**7,685**	5,819	4,019	1,196	1,212	2,306	2,293	217	**17,062**
NEW MEXICO	285	75	73	11,318	4	**11,755**	2,839	759	203	77	971	217	1	**5,067**
NEW YORK	17,074	2,264	666	347	1,047	**21,398**	9,863	8,040	1,624	1,787	5,539	1,328	368	**28,549**
NORTH CAROLINA	40,669	4,172	41,207	6,172	1,725	**93,945**	10,113	6,183	1,111	988	1,360	1,667	187	**21,609**
NORTH DAKOTA	21	6	19	6,774	1	**6,821**	2,917	278	59	54	992	25	0	**4,325**
OHIO	481	285	276	5,265	409	**6,716**	10,445	5,485	1,179	1,031	4,882	3,569	229	**26,820**
OKLAHOMA	10,820	1,303	421	6,571	35	**19,150**	6,409	2,072	467	321	2,161	1,782	2	**13,214**
OREGON	117	167	118	133	1,029	**1,564**	5,660	580	451	361	2,190	76	105	**9,423**
PENNSYLVANIA	858	737	389	204	334	**2,522**	15,476	7,611	866	1,379	3,799	1,243	114	**30,488**
RHODE ISLAND	121	2,242	237	56	315	**2,971**	1,992	507	589	105	1,028	2	45	**4,268**
SOUTH CAROLINA	9,642	6,580	9,375	7,470	827	**33,894**	9,094	4,249	598	423	1,314	2,061	153	**17,892**
SOUTH DAKOTA	63	2	14	3,273	0	**3,352**	3,000	332	84	0	1,042	23	0	**4,481**
TENNESSEE	329	1,343	136	158	156	**2,122**	9,128	3,672	1,189	735	3,273	3	40	**18,040**
TEXAS	64,631	6,179	2,091	36,927	1,766	**111,594**	17,270	18,446	5,011	3,307	3,086	5,631	323	**53,074**
UTAH	177	32	100	3,554	0	**3,863**	5,372	3,033	371	250	1,373	1,355	0	**11,754**
VERMONT	49	12	18	62	36	**177**	2,582	164	49	0	969	0	8	**3,772**
VIRGINIA	22,508	40,023	10,856	11,836	4,110	**89,333**	6,876	7,778	5,392	1,876	1,302	1,900	465	**25,589**
WASHINGTON	25,304	11,346	682	5,684	2,090	**45,106**	5,934	5,993	2,146	611	1,959	1,853	344	**18,840**
WEST VIRGINIA	57	4	48	29	68	**206**	4,137	1,609	77	75	2,120	0	16	**8,034**
WISCONSIN	451	49	124	80	295	**999**	7,112	3,849	377	480	2,091	0	81	**13,990**
WYOMING	37	1	7	3,089	0	**3,134**	1,508	87	68	0	1,170	38	0	**2,871**
UNKNOWN	5,800	0	0	0	0	**5,800**	0	0	0	0	0	0	0	**0**
	397,282	**285,400**	**150,851**	**254,738**	**39,560**	**1,127,831**	**324,728**	**185,620**	**54,462**	**34,637**	**100,336**	**65,855**	**6,255**	**771,893**

Sources: Active Duty Master File, RCCPDS, APF Civilian Master, CTS Deployment File, Civilian Deployment

DEPARTMENT OF THE NAVY
OFFICE OF THE SECRETARY
1000 NAVY PENTAGON
WASHINGTON DC 20350-1000

SECNAVINST 1000.11
ASN (M&RA)
4 Nov 16

SECNAV INSTRUCTION 1000.11

From: Secretary of the Navy

Subj: SERVICE OF TRANSGENDER SAILORS AND MARINES

Ref: (a) DoD Instruction 1300.28 of 1 July 2016
(b) DTM 16-005, Military Service of Transgender Service Members of 30 June 2016
(c) ASD(HA) Memo, Guidance for Treatment of Gender Dysphoria for Active and Reserve Component Service Members of 29 July 2016
(d) USD Memo, Clarification of Procedures to Identify Sex Code Changes for Transgender Service Members of 21 September 2016
(e) SECNAVINST 5300.28E
(f) DoD Instruction 6130.03, CH 1 of 13 September 2011
(g) DoD Instruction 1332.18 of 5 August 2014

Encl: (1) Responsibilities
(2) Service Implementing Policy and Procedures

1. Purpose. To establish Department of the Navy (DON) policy for the accession and service of transgender Sailors and Marines, to include the process for transgender Service Members to transition gender in-service.

2. Definitions. Definitions are provided in reference (a).

3. Applicability. This instruction applies to all DON military personnel. Specific considerations for Reserve Component personnel are included in reference (a). Refer all DON civilian transgender questions to the DON Office of Civilian Human Resources or the DON Office of the General Counsel. Refer all questions regarding transgender contractors to the Contracting Officer's Representative.

4. Policy

a. Consistent with the policies and procedures set forth in references (a) and (b), transgender individuals shall be allowed to serve openly in the DON.

b. References (a) through (d) provide Sailors and Marines an in-service process to transition to their preferred gender. These policies are based on the premise that open service by transgender persons who are subject to the same medical, fitness for duty, physical fitness, uniform and grooming, deployability, and retention standards and procedures is consistent with military service and readiness.

c. The DON recognizes a Sailor's or Marine's gender by their gender marker in the Defense Enrollment Eligibility Reporting System (DEERS). Coincident with that gender marker, the Navy and Marine Corps shall apply, and the Service Member is responsible to meet, all standards for uniforms and grooming; body composition assessment (BCA); physical readiness testing (PRT); Military Personnel Drug Abuse Testing Program (MPDATP) participation; and other military standards applied with consideration of the Service Member's gender.

(1) For facilities subject to regulation by the military, the Sailor or Marine will use those berthing, bathroom, and shower facilities associated with the Service Member's gender marker in DEERS.

(2) As the tactical situation allows, Commanders are expected to implement appropriate policies to ensure the privacy protection of individual Sailors and Marines out of courtesy to all and to maintain good order and discipline.

(3) Reference (e) clarifies policy for the direct observation of urinalysis specimen collection. MPDATP policy considers the terms "sex" and "gender marker" as equivalent. Therefore, transgender Service Members providing a urinalysis specimen will be observed by an individual with the same gender marker indicated in DEERS. In selecting an observer, a Commander may employ reasonable accommodations to respect the privacy interests of the Service Members. The selection of an observer must be made in a manner that ensures the integrity of

the urinalysis program and provides both the Service Member being tested and the observer an environment free from harassment/discrimination.

d. Sailors and Marines with a diagnosis from a military medical provider indicating that gender transition is medically necessary will be provided the medically necessary care and treatment. A medical treatment plan developed by the military medical provider will outline the severity of the Service Member's medical condition, the urgency of any proposed medical treatment, projected timeline for completion of gender transition, and estimated periods of non-deployability and absence. Medical advice to Commanders and Commanding Officers will be provided in a manner consistent with processes used for other medical conditions that may limit the Service Member's performance of official duties.

e. Any medical care and treatment provided to an individual Sailor or Marine in the process of gender transition will be provided in the same manner as other medical care and treatment. Nothing in this instruction will be construed to authorize a Commander or Commanding Officer to deny medically necessary treatment to a Sailor or Marine.

f. Any determination that a transgender Sailor or Marine is non-deployable at any time will be consistent with established DON and Service standards, as applied to other Sailors and Marines whose deployability is similarly affected in comparable circumstances unrelated to gender transition.

g. Commanders and Commanding Officers will assess expected impacts on mission and readiness after consideration of the advice of military medical providers and will address such following this instruction and references (a) and (b). In applying the tools described in reference (a), a Commander or Commanding Officer will not accommodate biases against transgender individuals. If a Sailor or Marine is unable to meet standards or requires an exception to policy (ETP) during a period of gender transition, all applicable tools, including those described in references (a) through (d), will be available to Commanders and Commanding Officers to minimize impacts to the mission and unit readiness. Gender transition dates in the transition plan may be adjusted per reference (a) and enclosure (2) as necessary to support organizational needs.

h. When the military medical provider determines that a Service Member's gender transition is complete, and at a time approved by the Commander or Commanding Officer in consultation with the transgender Sailor or Marine, the Service Member may submit a request for gender marker change in DEERS, per reference (d). Once the gender marker is changed in DEERS, the Service Member will be recognized in the preferred gender and held to preferred gender standards from that point forward.

i. Policy for service during initial entry training and considerations associated with the first term of service are outlined in reference (a).

j. All Sailors and Marines are entitled to equal opportunity in an environment free from sexual harassment and unlawful discrimination on the basis of race, color, national origin, religion, sex, or sexual orientation. It is the Department of Defense (DoD) and DON's position, consistent with the U.S. Attorney General's opinion, that discrimination based on gender identity is a form of sex discrimination. All personnel will continue to treat each other with dignity and respect. There is zero tolerance for harassing, hazing, or bullying in any form.

5. Responsibilities. See enclosure (1).

6. Accessions

a. Per reference (b), no later than 1 July 2017, the Navy and Marine Corps will begin accessing transgender applicants who meet all standards. The gender identity of an otherwise qualified individual will not bar them from joining the Navy or Marine Corps, from admission to the United States Naval Academy, or from participating in Naval Reserve Officers Training Corps or any other accession program.

b. Medical standards for accession into the Naval service (in reference (f)) help to ensure that those entering service are free from medical conditions or physical defects that may require excessive time lost from duty due to necessary medical treatment or hospitalization, or result in separation from the Service for medical unfitness.

c. A history of gender dysphoria is disqualifying, unless, as certified by a licensed medical provider, the applicant has

been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months.

d. A history of medical treatment associated with gender transition is disqualifying, unless, as certified by a licensed medical provider:

(1) The applicant has completed all medical treatment associated with the applicant's gender transition; and

(2) The applicant has been stable in the preferred gender for 18 months; and

(3) If the applicant is presently receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months.

e. A history of sex reassignment or genital reconstruction surgery is disqualifying, unless, as certified by a licensed medical provider:

(1) A period of 18 months has elapsed since the date of the most recent such surgery; and

(2) No functional limitations or complications persist, nor is any additional surgery required.

f. The 18-month periods may be waived or reduced, in whole or in part, in individual cases for applicable reasons. Requests for waiver or reduction of the 18-month periods shall be sent to the Assistant Secretary of the Navy (Manpower and Reserve Affairs) (ASN (M&RA)) for adjudication.

(1) ASN (M&RA) may approve requests for waiver or reduction. ASN (M&RA) may also delegate this approval authority to the Deputy Chief of Naval Operations (Manpower, Personnel, Training, and Education) (DCNO (N1)) and the Deputy Commandant (Manpower and Reserve Affairs (DC (M&RA)). This approval authority may not be further delegated.

(2) Any requests for waiver or reduction with a recommendation for disapproval shall be sent to the Secretary of the Navy (SECNAV) for decision.

7. Records Management. Records created as a result of this instruction, regardless of media and format, shall be managed per SECNAV Manual 5210.1 of January 2012.

8. Reports. The reporting requirements within enclosure (1), paragraphs 1a and 1i are exempt from information control per SECNAV M-5214.1 of January 2012, Part IV, paragraphs 7j and 7o respectively.

RAY MABUS

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RESPONSIBILTIES

1. CNO and CMC shall:

a. Issue policy and procedures addressing the military service of transgender Service Members, to include establishing a process by which transgender Sailors and Marines may transition gender while serving, consistent with mission, training, operational, and readiness needs, and a procedure whereby a Service Member's gender marker will be changed in DEERS. Additional detail on Service implementing policy and procedures is outlined in enclosure (2).

b. Ensure uniform standards, grooming standards, BCA standards, PRT standards, MPDATP standards, and other standards applied with consideration of a Service Member's gender, are applicable to the Service Member's gender marker as reflected in DEERS.

c. Direct the use of berthing, bathroom, and shower facilities according to the Service Member's gender marker as reflected in DEERS, for facilities that are subject to regulation by the military.

d. Provide appropriate privacy for all Sailors and Marines. This may be achieved through expenditure of funds to modify bathroom and shower facilities at Navy and Marine Corps military installations that do not provide reasonable privacy.

e. Ensure that policies and procedures governing Service urinalysis testing program are performed using accepted and established operating procedures which conform to the requirements outlined in reference (e).

f. Ensure medically necessary treatment to transgender Active Duty Service Members is available, in alignment with reference (c).

g. No later than 15 November 2016, create a Service-wide training and education plan, to include specialized training for Commanders and Commanding Officers. The training of Sailors and Marines across the DON shall be completed no later than 1 July 2017.

h. No later than 1 February 2018, provide an assessment of Navy and Marine Corps transgender service policy, summarizing the impact on military readiness, effectiveness, unit cohesion, recruiting, and retention. The assessment should be informed by surveys and data collected and include any recommended adjustments to DoD and DON policy.

i. Beginning in 2018 and triennially thereafter, support Naval Inspector General Special Inspections of Service compliance with DoD, DON, and Service transgender service policy and procedures.

j. Ensure that all Sailors and Marines are able to perform their duties free from unlawful discrimination and harassment.

k. Ensure the protection of personally identifiable information and personal privacy considerations in the implementation of references (a) through (f), this instruction, and Service regulations, policy, and guidance.

2. Assistant Secretary of the Navy (Manpower and Reserve Affairs) shall:

a. Assess Navy and Marine Corps compliance with references (a) through (d) with coordination from Chief of Naval Operations (CNO) and Commandant of the Marine Corps (CMC) (no later than 1 February 2018) and review of triennial Inspector General Special Inspections.

b. Review requests for waiver or reduction of the 18-month periods of stability for new accessions and submit all requests with a disapproval recommendation to SECNAV for decision.

3. Naval Inspector General shall, beginning in 2018 and triennially thereafter, conduct a Special Inspection of Navy and Marine Corps compliance with references (a) through (d), this instruction, and Service regulations, policy, and guidance.

4. Chief, Bureau of Medicine and Surgery shall:

a. Provide or arrange consultation for medically necessary treatment to Active Duty Service Members per references (c) and (d), ensuring standardized healthcare.

b. Ensure referral for a determination of fitness in the disability evaluation system per reference (g).

c. No later than 15 November 2016, develop an education and training plan for both privileged and non-privileged medical personnel.

d. For Reserve Component Service Members not on active duty for more than 30 days, review and approve medical diagnosis and treatment plans, in alignment with references (a), (c), and (d).

SERVICE IMPLEMENTING POLICY AND PROCEDURES

1. The CNO and CMC shall establish policy and procedures per references (a) through (d) and this instruction, outlining the actions a Commander may take to minimize impacts to the mission and ensure continued unit readiness in the event that a transitioning individual is unable to meet standards or requires an ETP during a period of transition. Such policies and procedures may address the means and timing of transition, procedures for responding to an ETP prior to the change of a Service Member's gender marker in DEERS, appropriate duty statuses, and tools for addressing an inability to serve throughout the gender transition process. Any such actions available to the Commander or Commanding Officer will consider and balance the needs of the individual and the needs of the command in a manner comparable to the actions available to the Commander or Commanding Officer in addressing comparable Service Member circumstances unrelated to gender transition. Such actions may include:

a. Adjustments to the date on which the Sailor's or Marine's gender transition, or any component of the transition process, will commence.

b. Advising the Sailor or Marine of the availability of options for extended leave status or participation in other voluntary absence programs during the transition process.

c. Arrangements for the transfer of the Sailor or Marine to another organization, command, location, or duty status (e.g. Individual Ready Reserve), as appropriate, during the transition process.

d. ETPs associated with changes in the Service Member's physical appearance and body composition during gender transition, such as accommodations in the application of standards for uniforms and grooming and MPDATP participation.

e. Establishment of, or adjustment to, local policies on the use of berthing, bathroom, and shower facilities subject to regulation by the military, during the transition process.

f. Other actions, including the initiation of administrative or other proceedings, comparable to actions that

could be initiated with regard to others whose ability to serve is similarly affected for reasons unrelated to gender transition.

2. The CNO and CMC shall establish policies and procedures, consistent with references (a) through (d) and this instruction, whereby a Sailor's or Marine's gender marker will be changed in DEERS based on a determination by the military medical provider that the Service Member's gender transition is complete; receipt of written approval from the Commander or Commanding Officer, issued in consultation with the Service Member; and production by the Service Member of documentation indicating gender change. Guidance on such documentation is outlined in reference (a).

United States Department of Defense

TRANSGENDER SERVICE IN THE U.S. MILITARY

An Implementation Handbook

September 30, 2016

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

SEP 30 2016

MEMORANDUM FOR ALL SERVICE MEMBERS

SUBJECT: Transgender Service in the U.S. Military: An Implementation Handbook

In July 2015, the Secretary of Defense directed the Department of Defense to identify the practical issues related to the open service of transgender Americans in the military, and to develop an implementation plan addressing those issues in manner consistent with military readiness. On June 30, 2016, the Secretary announced a new policy allowing open service by transgender Service members:

"This is the right thing to do for our people and for the force. We're talking about talented Americans who are serving with distinction or who want the opportunity to serve. We can't allow barriers unrelated to a person's qualifications to prevent us from recruiting and retaining those who can best accomplish the mission."

This handbook will assist our transgender Service members in their gender transition, help commanders with their duties and responsibilities, and help all Service members understand Department policy allowing the open service of transgender Service members. It is the product of broad collaboration among the Services, and is intended as a practical day-to-day guide. For further information, you are encouraged to contact your chain of command and/or Service Central Coordination Cell.

Peter Levine
Acting

TRANSGENDER SERVICE IN THE U.S. MILITARY

AN IMPLEMENTATION HANDBOOK

September 30, 2016

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TRANSGENDER SERVICE IN THE US MILITARY:

An Implementation Handbook

Our mission is to defend this country, and we don't want barriers unrelated to a person's qualification to serve preventing us from recruiting or retaining the Soldier, Sailor, Airman, or Marine who can best accomplish the mission. We have to have access to 100 percent of America's population for our all-volunteer force to be able to recruit from among them the most highly qualified—and to retain them…Starting today: Otherwise qualified Service members can no longer be involuntarily separated, discharged, or denied reenlistment or continuation of service just for being transgender.

—Statement by Secretary of Defense Ash Carter[1]

1 U.S. Secretary of Defense Ash Carter, "Secretary of Defense Ash Carter Remarks Announcing Transgender Policy Changes," June 30, 2016.

BACKGROUND

The handbook is designed to assist our transgender Service members in their gender transition, help commanders with their duties and responsibilities, and help all Service members understand new policies enabling the open service of transgender Service members. The handbook includes advice, questions and answers, and scenarios.

This handbook outlines some of the issues faced by commanders, transgender Service members, and the Military Services; it does not have all of the solutions – individual circumstances will vary. It is an administrative management tool, and is not a health management tool or policy document. Additional key parts of this handbook include: Annex A, which contains questions and answers to help with understanding specific terms and words; Annex B, which provides step-by-step details of the gender transition process; Annex C, which highlights situation-based scenarios that may be useful for training situations; and Annex D, which provides links to additional resources. For specific policies refer to Department of Defense Instruction (DoDI) 1300.28,[2] Directive-type Memorandum (DTM) 16-005,[3] Service policies, and/or Service Central Coordination Cells (SCCC).[4]

2 DoD Instruction (DoDI) 1300.28, "In-Service Transition for Service Members Identifying as Transgender," June 30, 2016.

3 Directive-type Memorandum (DTM), 16-005, "Military Service of Transgender Service Members," June 30, 2016.

4 See Annex D for SCCC contact information.

INTRODUCTION

Sex and gender are different. Sex is whether a person is male or female through their biology. Gender is the socially defined roles and characteristics of being male and female associated with that sex. There are a number of people for whom these associations do not match. This feeling may arise in childhood, adolescence or adulthood and may result in gender dysphoria. Sometimes people's gender identity does not match their sex at birth.

Gender dysphoria is a medical diagnosis that refers to distress that some transgender individuals experience due to a mismatch between their gender and their sex assigned at birth. The condition can manifest in a person as strong and persistent cross-gender identification and a discomfort with their biological sex, or a sense of inappropriateness in the gender role of that sex. Transgender Service members may face challenges centered on their own personal situation and/or others' unfamiliarity with gender identity issues.

POLICY

In July 2015, the Secretary of Defense directed the Department of Defense to identify the practical issues related to transgender Americans serving openly in the military and to develop an implementation plan that addresses those issues consistent with military readiness. On June 30, 2016, the Secretary announced a new policy[5] allowing open service of transgender Service members and outlined three reasons[6] for this policy change:

- The Army, Navy, Air Force, Marine Corps, and Coast Guard need to avail themselves of all available talent in order to remain the finest fighting force the world has ever known. The mission to defend this country requires that the Services do not have barriers unrelated to a person's qualification to serve or preventing the Department of Defense (DoD) from recruiting or retaining Service members.
- There are transgender Service members in uniform today. DoD has a responsibility to them and their commanders to provide clearer and more consistent guidance.
- Individuals who want to serve and can meet the Department's standards should be afforded the opportunity to compete to do so.

This handbook will explain the framework by which transgender Service members may transition gender while serving.

5 DoDI 1300.28 and DTM 16-005.

6 U.S. Secretary of Defense Ash Carter Remarks, June 30, 2016.

TERMS AND DEFINITIONS

The following terms are associated with open service by transgender individuals. The list is not all-inclusive. The definitions are consistent with those in the new policy.

Cross-sex hormone therapy. The use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth. A common medical treatment associated with gender transition.

Gender dysphoria. A medical diagnosis that refers to distress that some transgender individuals experience due to a mismatch between their gender and their sex assigned at birth.

Gender identity. One's internal or personal sense of being male or female.

Gender marker. Data element in the Defense Enrollment Eligibility Reporting System (DEERS) that identifies a Service member's gender. A Service member must meet all military standards associated with the member's gender marker in DEERS and use military berthing, bathroom, and shower facilities in accordance with the DEERS gender marker.[7]

Gender transition is complete. A Service member has completed the medical care identified or approved by a military medical provider in a documented medical treatment plan as necessary to achieve stability in the preferred gender.

Gender transition process. Gender transition in the military begins when a Service member receives a diagnosis from a military medical provider indicating that the member's gender transition is medically necessary, and concludes when the Service member's gender marker in DEERS is changed and the member is recognized in the preferred gender.

Human and functional support network. Support network for a Service member that may be informal (e.g., friends, family, co-workers, social media.) or formal (e.g., medical professionals, counselors, clergy).

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7 While the gender marker change is reflected in DEERS, the Services' personnel data systems are the means to input gender; as such, the remainder of this handbook refers to 'Services' personnel data systems'.

Medically necessary. Those health care services or supplies necessary to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medical care.

Non-urgent medical care. The care required to diagnose and treat problems that are not life or limb threatening or that do not require immediate attention.

Preferred gender. The gender of a transgender Service member when gender transition is complete and the gender marker in DEERS is changed.

Real life experience (RLE). The phase in the gender transition process when the individual commences living socially in the gender role consistent with their preferred gender. RLE may or may not be preceded by the commencement of cross-sex hormone therapy, depending on the individual gender transition medical treatment plan. The RLE phase is also a necessary precursor to certain medical procedures, including gender transition surgery. RLE generally encompasses dressing in the new gender, as well as using preferred gender berthing, bathroom, and shower facilities.[8]

Service Central Coordination Cell (SCCC). Service-level cell of experts created to provide multi-disciplinary (e.g., medical, legal) advice and assistance to commanders with regard to service by transgender Service members and gender transition in the military.[9]

Stable in the preferred gender. Medical care identified or approved by a military medical provider in a documented medical treatment plan is complete, no functional limitations or complications persist, and the individual is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning. Continuing medical care, including but not limited to cross-sex hormone therapy, may be required to maintain a state of stability.

Transgender Service member. A Service member who has received a medical diagnosis indicating that gender transition is medically necessary, including any Service member who intends to begin transition, is undergoing transition, or has completed transition and is stable in the preferred gender.

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8 RLE intended to occur off duty; however, exceptions to policy may be granted. Consult Service policy for specifics.

9 A complete listing with SCCC contact information can be found at Annex D.

THE BASICS

Sex and gender are different. Sex is the assignment made at birth as male or female, based on anatomy. Gender identity is an individual's internal sense of being male or female. Gender role or expression is the socially defined roles and characteristics of being male and female associated with that sex. For most people, gender identity and expression are consistent with their sex assigned at birth. However, in transgender individuals, gender identity and/or expression differs from their sex assigned at birth.

Gender dysphoria is a medical diagnosis that refers to distress that some transgender individuals experience due to a mismatch between their gender and their sex assigned at birth.

Broadly, the term "transgender person" refers to individuals whose internal sense of being male or female (gender identity) is different from the sex they were assigned at birth. Some transgender individuals feel compelled to align their external appearance with their gender identity and undergo transition to the preferred gender. Gender transition care is individualized and can include psychotherapy, hormone therapy, RLE, and sex reassignment surgery.

Traditionally, society has had little understanding of what it means to transition gender. Many transitioning people have been subjected to hostility, ridicule, and discrimination. Every person has the right to have their gender identity recognized and respected, and all Service members who receive a diagnosis that gender transition is medically necessary will be provided with support and management to transition, within the bounds of military readiness.

Gender transition is the process a person goes through to live fully in their preferred gender. Gender transition in the military may present challenges associated with addressing the needs of the Service member while preserving military readiness. The oversight and management of the gender transition process is a team effort with the commander, the Service member, and the military medical provider (MMP). DoD values the contributions of all Service members and tries to ensure all are as medically ready as possible throughout their service. Individual readiness is a key to Total Force readiness.

Gender Transition Approval Process Overview

Gender transition is highly individualized. Figure 1 outlines the main components. Generally, the gender transition process includes:

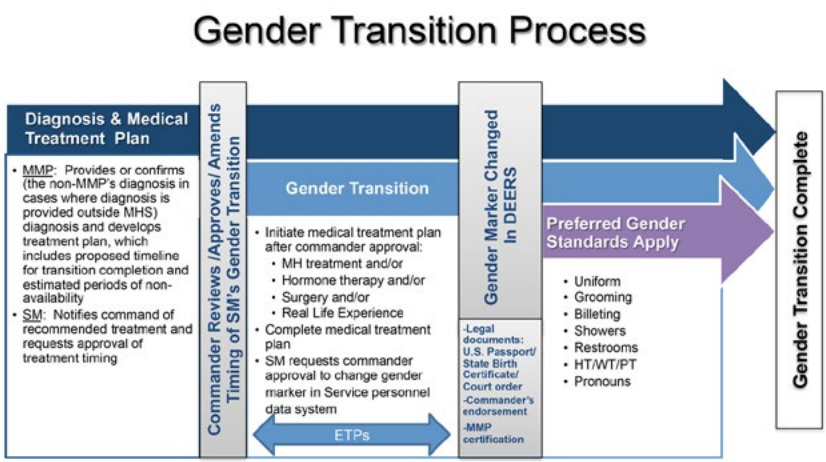
- Diagnosis and medical treatment plan received from or validated by an MMP;
- Gender transition (initiate medical treatment plan, complete medical treatment plan, Service member requesting gender marker change); and
- Compliance with gender standards post-gender marker change.

The process depicted is only a framework and Service members may progress on varying timelines. The commander, informed by the recommendations of the MMP, the SCCC, and others, as appropriate, will respond to the request to transition gender while ensuring readiness by minimizing impacts to the mission (including deployment, operations, training, exercise schedules, and critical skills availability), as well as to the morale and welfare and good order and discipline of the command.

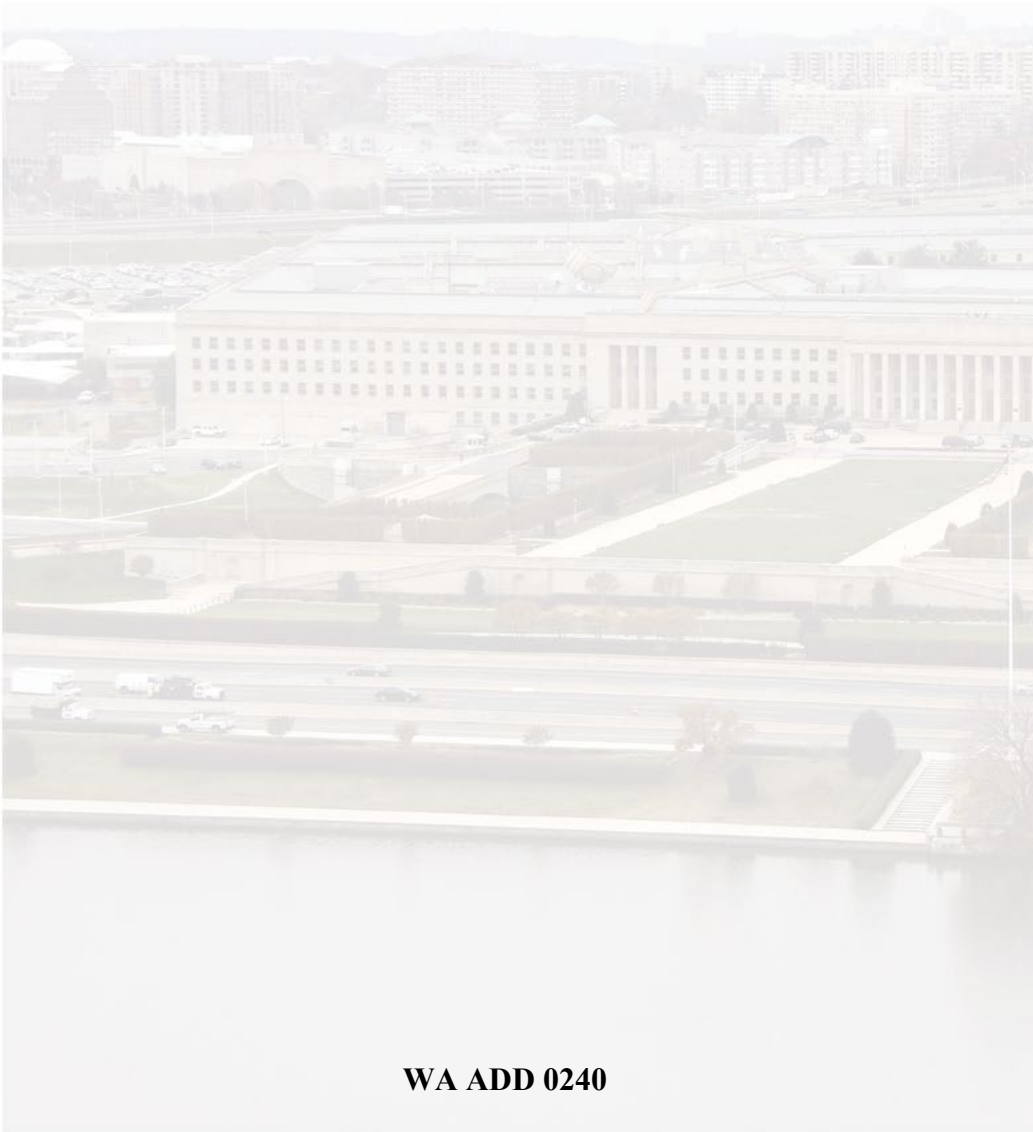
Within this framework, the commander plays a key role in making recommendations and taking action on:

- The timing of medical treatment associated with gender transition;
- Timing of RLE (e.g., non-duty hours, duty hours with an exception to policy (ETP))
- Requested ETPs associated with gender transition; and
- A change to the Service member's gender marker in their Service's personnel data system.

Figure 1: Gender Transition Process



Key Acronyms:
DEERS – Defense Enrollment Eligibility Reporting System
HT/WT/PT – Height/Weight/Physical Training
MH – Mental Health
MHS – Military Health System
MMP – Military Medical Provider
SM – Service Member



FOR THE TRANSGENDER SERVICE MEMBER

"…the reality is that we have transgender Service members serving in uniform today, and I have a responsibility to them and their commanders to provide them both with clearer and more consistent guidance than is provided by current policies."

—Statement by Secretary of Defense Ash Carter[10]

DoD's revised transgender Service member policy ensures your medical care is brought into the military health system (MHS), protects your privacy when receiving medical care, and establishes a structured process whereby you may transition gender when medically necessary.

In-Service Transition

Gender transition in the military begins when you receive a diagnosis from an MMP indicating that gender transition is medically necessary and concludes when you change your gender marker in your Service's personnel data system. Your commander is a critical part of your transition and much of this section will highlight his/her role. The table below outlines responsibilities for both Active and Reserve Component Service members requesting in-service transition. To make a request, you must:

10 U.S. Secretary of Defense Ash Carter Remarks, June 30, 2016.

Active Component & Reserve Component Uniformed Full-Time Support Personnel	Reserve Component (All Others)
1. Secure a medical diagnosis and a medical treatment plan from your MMP. If the diagnosis and treatment plan are from a non-military medical provider (non-MMP), you are required to notify your MMP at the earliest practical opportunity to bring your care into the MHS. Your MMP will review, and if appropriate validate the non-MMP's diagnosis and treatment plan.	1. Secure a medical diagnosis and a medical treatment plan from your non-MMP.
2. Notify your commander of the diagnosis and medical treatment plan indicating that gender transition is medically necessary. Work with your commander and your MMP to develop a transition plan that includes a timeline for treatment and an estimated date for a change of your gender marker in your Service's personnel data system.	2. Notify your commander of the diagnosis and medical treatment plan, indicating that gender transition is medically necessary. Work with your commander to have an MMP validate the non-MMP's diagnosis and treatment plan and develop a transition plan that includes a timeline for treatment and an estimated date for a change of your gender marker in your Service's personnel data system.
3. Notify your commander of any changes to the medical treatment plan, the projected schedule for such treatment, any exceptions to policy (ETP) you may request, and the estimated date on which your gender marker would be changed in your Service's personnel data system.	3. Same as AC.
4. Obtain one of the following to change your gender marker in your Service's personnel data system: ■ A certified true copy of a state birth certificate reflecting your preferred gender; or ■ A certified true copy of a court order reflecting your preferred gender; or ■ A U.S. Passport reflecting your preferred gender.	4. Same as AC.

Active Component & Reserve Component Uniformed Full-Time Support Personnel	Reserve Component (All Others)
5. Obtain your MMP's confirmation that gender transition is complete.[11]	5. Obtain a non-MMP confirmation that your gender transition is complete, then validate with an MMP (in concert with commander).
6. Obtain written approval from your commander to change your gender marker in your service's personnel data system.	6. Same as AC.
7. Submit paperwork to your personnel administrative office once you have all the required documentation and your commander's written approval to obtain your gender marker change.	7. Same as AC.
8. Meet all applicable military standards in your preferred gender (to include using military berthing, bathroom, and shower facilities), when your gender marker is changed in your Service's personnel data system.	8. Same as AC.
9. Adhere to the ongoing medical treatment plan developed by your MMP to address continuing medical needs, including follow-up visits related to continuous hormone treatment and routine health screening.[12]	9. Adhere to the ongoing medical treatment plan developed by your non-MMP to address continuing medical needs, including follow-up visits related to continuous hormone treatment and routine health screening.

11 In DoDI 1300.28, gender transition is complete when a Service member has completed the medical care identified or approved by a military medical provider in a documented medical treatment plan as necessary to achieve stability in the preferred gender.

12 The MMP (or non-MMP, if you are not on active duty) may determine certain aspects of your medical care and treatment to be medically necessary, even after your gender marker is changed in your Service's personnel data system (e.g., cross-sex hormone therapy). A gender marker change does not prohibit you from receiving further care and treatment.

Communication

It is vital that you are open and honest with your leadership when discussing the gender transition process. This will enable you to convey your needs as well as address any questions or concerns from your leadership.

Communication with colleagues is equally important as they may not be familiar or comfortable with gender transition. It is important to remember that while you have had many months, probably years, to understand your need to transition, this may be the first time your colleagues have encountered gender transition. They may have difficulty understanding the reasons and the process.

There are many ways to respectfully disclose your gender identity to your colleagues. How and when you wish to tell your coworkers is something you will need to discuss with your commander and/or your MMP. It is important to state what information you are open to discussing and what information you wish to remain private. Communication strategies could include:

- Ask your leadership to convene a unit meeting and make an announcement on your behalf. Have health professionals and/or chaplains available to answer questions;
- Share a letter from you with your unit;
- Distribute a letter or notification via email; and/or
- Make the announcement in person at a unit meeting.

Finding a Mentor

Similar to seeking a mentor to assist and guide in career/professional development, it may be advisable to seek a mentor to assist you in your transition. A mentor should be someone familiar with the process you are undertaking. If possible, choose someone from your peer group or military pay grade. If you cannot find your own potential mentor(s), consider seeking recommendations from your commander, a chaplain, or medical professional. Below are some areas where a mentor may be beneficial:

- Providing advice on military issues related to the correct wear of your preferred gender uniform and related grooming issues;
- Being a supportive sounding board;

- Providing frank and honest advice; and
- Being a unit point of contact, or conduit, for questions from the workplace related to gender transition.

Considerations

Below are some career considerations that you may wish to take into account.

Period of Adjustment
Early on in your transition you may need to consider that adjusting your appearance and grooming can take some time. During this period of transition, it may be appropriate to discuss periods of authorized absence with your commander and the MMP.

For most of your transition, you should not need to use convalescent leave; however, you may require some time to recover from certain medical or surgical treatments. Accordingly, when convalescent leave is recommended, ensure you have coordinated with your unit leadership, administrative personnel, and medical personnel.

Impact Transitioning May Have on Your Career
Transitioning gender may have an impact on several different aspects of your career including deployability, assignment considerations, medical classification, and aspects of individual readiness (e.g., physical fitness, body composition assessment, and professional military education attendance). Since the impact to your career could be significant, it is strongly recommended you discuss this with your commander and/or mentor.

Assignments
You may need to discuss with your MMP and commander whether you want to transition while in your current unit or upon arrival at a new unit. There are advantages and disadvantages to both. The latter has the advantage of leaving your old life at your last duty station and arriving at your next assignment ready to start your new life. However, the disadvantage is that you will have to re-establish your support network in the new location.

Completing transition within a normal Permanent Change of Station cycle of 3-4 years is possible, but may or may not be desirable depending on your circumstances. Below are some issues to consider:

- Specialized medical care may not be available at all duty locations. Assignments near installations with such care may need to be considered;
- Moving locations means potentially moving away from a stable environment, including medical specialists and social support. However, making a fresh start may be easier for some transitioning members;
- Your duty locations may impact decisions about when to commence RLE in your preferred gender; and
- Not all duty assignments will be able to support a gender transition.

Individual Medical Readiness (IMR)

Medical care for gender transition is managed in the same way as other medical conditions. You may be non-deployable for some periods during your gender transition process. It is your responsibility to inform your leadership regarding your medical condition when, as a result of any medical treatment, you will be or have become non-deployable.[13]

Physical Readiness Testing (PRT)

PRT is a fundamental requirement of your military service. You are required to meet the PRT standards based upon your gender marker in your Service's personnel data system and in accordance with Service regulations. Similar to other circumstances where Service members may not meet standards, it is important that you consult regularly with your MMP to ensure you can meet standards (i.e., fitness). If you are unable to meet the standards, it may be necessary to request an ETP.

Privacy

Maintaining dignity and respect for all is important. You will need to consider both your own privacy needs and the privacy needs of others. This includes, but is not limited to, maintaining personal privacy in locker rooms, showers, and living quarters. One strategy might include adjusting personal hygiene hours. If you have concerns, you are encouraged to discuss them with your chain of command.

Military Records

Your records prior to transition (e.g., awards, performance evaluations) are historical and will not be changed after completion of your gender transition.

13 DoDI 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014.

Your Service has a board process that may consider changes to historical military records.[14] All records generated after your Service's personnel data system gender marker is changed will reflect your preferred gender.

Expectation Management
The military developed a process to allow you to transition gender while you serve. Keep the lines of communication open and be patient with the process. Your timeline may need to be flexible due to operational requirements.

Tips for Transitioning Service Members

The following tips have been provided by Service members from an allied foreign military who have transitioned gender.[15]

- Honesty. "If you wish to be respected you must also give that same respect to your coworkers up and down the chain. How you treat others and inform others will be directly related to the way you are treated. It is incredibly hard to open up and trust people with a personal secret you have probably carried for your entire adult life; however from my experiences if you keep an open-door philosophy and answer honest questions with polite and clear non-emotional detail, most will accept and understand."
- Be professional. "The hormones you may [take] to change will have a varied and perhaps profound effect on not only your physical body, but more importantly your emotional stability. Try not to allow this to cloud or affect your judgement, it will be hard for some to see this happening, trust in your friends when they point out little slips and errors in your emotional well-being, they have your interests at heart!"
- Empower those around you. "Knowledge equals power which equals understanding; empowering those around you to understand will help them feel less threatened and confused, which can assist in being treated with respect and understanding rather than confusion and possibly even contempt and hostility."
- Be confident. "Know yourself, make as much effort as possible to be part of the team and not hide or be hidden away to avoid embarrassment. Stepping

14 See Annex D for a list of Service links to boards for correction of military records.

15 Australian Air Force, Air Force Diversity Handbook: Transitioning Gender in the Air Force, April 2013, 19.

out in to the work arena will be hard, but the sooner you face this challenge the sooner your well-being can return."

- Trust. "Trusting others when you're vulnerable is hard for most serving people. We are proud, strong, and generally rather too stubborn to allow others to take charge of us when we feel we can manage ourselves. The problem is you may not understand all that is happening around you, particularly with your coworkers. So listen and trust in your commanders based on their good sound knowledge."
- Planning. "Map out your transition as best you can, try and forecast as much as possible and pass this on to the relevant commanders. Learn and understand not only what's happening now in your world, but look and think about where you will be and what you may need."

FOR THE COMMANDER

"We owe commanders better guidance on how to handle questions such as deployment, medical treatment and other matters. And this is particularly true for small unit leaders, like our senior enlisted and junior officers."

—Statement by Secretary of Defense Ash Carter[16]

The Commander's Impact

In the course of your duties, you may encounter a transgender Service member who wants to transition gender. It is important that you are aware of your obligations and responsibilities with regard to the support and management of Service members who are transitioning gender. You are responsible and accountable for the overall readiness of your command. You are also responsible for the collective morale and welfare and good order and discipline of the unit and for fostering a command climate where all members of your command are treated with dignity and respect.

Commander's Roles and Responsibilities

In-Service Transition

When you receive a request from a Service member for medical treatment or an ETP associated with gender transition, you must consider the individual needs associated with the request and the needs of your command. The table below outlines your responsibilities for Active and Reserve Component Service members requesting in-service transition. In making a decision on the request, your responsibilities include:

16 U.S. Secretary of Defense Ash Carter Remarks, June 30, 2016.

Active Component & Reserve Component Uniformed Full-Time Support Personnel	Reserve Component (All Others)
1. Complying with the provisions of DoDI 1300.28[17] and with Military Department and Service regulations, policies, guidance, and with your SCCC, as appropriate.	1. Same as AC.
2. Evaluating a Service member's request to transition gender. Ensure, as appropriate, a transition process that: ■ Considers the individual facts and circumstances presented by the Service member; ■ Considers military readiness and impacts to the mission (including deployment, operations, training, and exercise schedules, and critical skills availability), as well as to the morale and welfare and good order and discipline of the unit; ■ Is consistent with the medical treatment plan generated or validated by the MMP; and incorporates consideration of other factors, as appropriate.	2. A Service member will likely provide a diagnosis and medical treatment plan from a non-MMP. In this instance, it still must be validated by the MMP. Consult your chain of command for guidance, if required. You must still evaluate Service member's request in light of the 3 bullets in the active duty column.
3. Reviewing a Service member's request for completeness.[18] If you determine the request to be incomplete, you must return it to the Service member, with written notice of the deficiencies identified, as soon as practicable, but not later than 30 days after receipt.	3. Same as AC.

17 DoDI 1300.28.

18 Refer to Figure 1 and Service policy for completeness determination; in all cases, it will include: completed medical treatment plan and commander approval of request.

Active Component & Reserve Component Uniformed Full-Time Support Personnel	Reserve Component (All Others)
4. Responding to any requests for medical treatment or an ETP[19] associated with gender transition, as soon as practicable, but not later than 90 days after receiving a request determined to be complete. Your response shall: ■ Be in writing; including notice of any actions taken by you; and ■ Be provided to both the Service member and their MMP.	4. Same as AC.
5. At any time prior to the change of the Service member's gender marker in Service's personnel data system, you may modify a previously approved approach to, or an ETP associated with, gender transition.	5. Same as AC.
6. Approving in writing[20] the request to change a Service member's gender marker in your Service's personnel data system upon receipt of the recommendation by the MMP and the requisite legal documentation from the Service member. The Service member is then able to take the approval and the legal documentation to the personnel administrative office to obtain the change to the gender marker.	6. Ensuring non-MMP's statement of completion is validated by an MMP, prior to your approval. The remaining process in active duty column should be followed.
7. When the gender marker in the Service's personnel data system is changed: ■ Apply uniform, grooming, body composition assessment (BCA), PRT, Military Personnel Drug Abuse Testing Program (MPDATP), and other standards reflecting the Service member's gender marker in the Service's personnel data system; and ■ Direct the use of berthing, bathroom, and shower facilities according to the Service member's gender marker as reflected in the Service's personnel data system in facilities that are subject to regulation by the military.	7. Same as AC.

19 Your Service will determine the approval level for ETPs. Refer to Service policy or your SCCC if there are concerns.

20 There is no prescribed format for approving a request to change gender marker. Refer to Service policy or your SCCC if there are concerns.

What You Should Expect From the Military Medical Provider (MMP)

The MMP plays a key role in the gender transition process. The MMP will:

- Provide the medical diagnosis applicable to the Service member; list the medically necessary treatments, including the timing of the proposed treatment and the likely impact of the treatment on the individual's readiness, and deployability; and
- Formally advise you when the Service member's medical treatment plan for gender transition is complete and recommend a time at which the gender marker may be changed in your Service's personnel data system.
- Validate the non-MMP's confirmation that Service member's gender transition is complete.

Policy Implications

You have broad responsibilities to maintain your unit's readiness. Select policy areas that may impact the transition process are highlighted below.

Non-Military Medical Care

If an active duty Service member's diagnosis and/or treatment plan are from a non-MMP, direct the individual to notify the MMP at the earliest practical opportunity to bring the care into the MHS. The MMP must consider, and if appropriate, validate the Service member's diagnosis before initiating any other steps in the transition process. If the request is from a non-active duty Service member, the non-MMP diagnosis and/or treatment plan must still be approved by an MMP.

Military Personnel Uniform and Grooming Standards

Exceptions for uniform and grooming standards may be considered per your Service's policy. You may consider current and preferred gender uniforms, form, fit and/or function, the Service member's professional military image, as well as impact on unit cohesion and good order and discipline. If you have questions, refer to your SCCC.

Deployment

Service members will deploy if they are medically and otherwise qualified to do so. As with any Service member, exceptions may be considered by your Service and must be coordinated with the deployed commander, if unique medical needs exist. Individuals requiring close monitoring or ongoing care may not be available for deployment.

Physical Fitness

There are no separate standards for transgender Service members. Any exceptions to PRT standards will be administered by your Service. Individuals undergoing cross-sex hormone therapy may experience changes to their body shape and physical strength, which may have a notable effect on their ability to maintain standards. If that is the case, consult with the individual and the MMP as you would for any other Service member with a medical condition affecting their ability to meet physical fitness standards.

Privacy Accommodations

If concerns are raised by Service members about their privacy in showers, bathrooms, or other shared spaces, you may employ reasonable accommodations, such as installing shower curtains and placing towel and clothing hooks inside individual shower stalls, to respect the privacy interests of Service members. In cases where accommodations are not practicable, you may authorize alternative measures to respect personal privacy, such as adjustments to timing of the use of shower or changing facilities. This should be done with the intent of avoiding any stigmatizing impact to any Service member. You are encouraged to consult with your SCCC for guidance on such measures.

Military Personnel Drug Abuse Testing Program

The MPDATP[23] requires urinalysis specimens to be collected under the direct supervision of a designated individual of the same sex as the Service member providing the specimen. You have discretion to take additional steps to promote privacy, provided those steps do not undermine the integrity of the program. However, all collections must be directly observed. You are encouraged to use discretion and/or contact your SCCC for additional guidance.

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23 DoDI 1010.16, "Technical Procedures for the Military Personnel Drug Abuse Testing Program (MPDATP)," October 10, 2012.

Tips for Commanders

The below tips are provided by an allied foreign military and may prove useful:[24]

- Protect the service member's privacy. Information management is very important.
- Listen to the Service member's wishes with respect to disclosure to the workplace and the broader community.
- Consider consultation with the chaplain, behavioral health personnel, and medical providers.
- Seek guidance and advice from other commanders and supervisors who have experience with individuals who transitioned gender while serving.
- Encourage the Service member to articulate a plan to include a timeline and strategy for notifying coworkers and other command personnel.
- Assist the Service member with identifying a mentor with whom they are comfortable.
- Encourage open communication. Feel free to ask questions.
- Ensure bullying, bias, harassment, hazing, or any other unacceptable behavior is not tolerated.

24 Australian Air Force Handbook.

FOR ALL SERVICE MEMBERS

"I am 100 percent confident in the ability of our military leaders and all our men and women in uniform to implement these changes in a manner that both protects the readiness of the force and also upholds values cherished by the military—honor, trust, and judging every individual on their merits."

—Statement by Secretary of Defense Ash Carter[25]

The cornerstone of DoD values is treating every Service member with dignity and respect. Anyone who wants to serve their country, upholds our values, and can meet our standards, should be given the opportunity to compete to do so. Being a transgender individual, in and of itself, does not affect a Service member's ability to perform their job. Previous policy, however, required transgender Service members to hide their gender identity and forced them to receive their gender-related medical care outside the MHS.

The June 30, 2016, policy allows transgender Service members to openly acknowledge their gender identity, brings all of their medical care into the MHS, allows transgender Service members to transition their gender when medically necessary, and allows the commander to work with the Service member and an MMP to implement a gender transition plan that meets the individual's medical requirements and unit readiness requirements.

Understanding Gender Transition

The gender transition process is individualized. Gender transition can include social, medical, and legal components. Social transition, in the military context, will generally encompass living in the preferred gender after duty hours. (You may encounter a situation where you know a Service member by one name during duty hours and another after duty hours; this all depends on the individual's transition.) Medical treatment may include behavioral health care, use of hormones (which may change physical appearance), and/or surgery.

25 U.S. Secretary of Defense Ash Carter Remarks, June 30, 2016.

Other aspects of transition includes formally changing one's gender with federal, state, and military documentation.

Some individuals prefer that very few people know they are transgender Service members and hope that after transition they can quietly blend in with their new gender. Others are committed to educating the public about gender identity, are eager to answer questions, and continue to talk openly about being a transgender Service member long after transition.

Revealing gender identity at work may be one of the last steps transgender Service members take to live and work in their preferred gender. By the time they inform their chain of command they plan to change gender, they have often been dealing with this issue for many years. It is also important not to "out" a transgender Service member (i.e., do not talk about someone else's gender identity or status unless they are okay with it.) The bottom line is to treat others with the dignity, respect, and consideration you would like to be treated with by others.

Harassment and Bullying

Everyone plays a role in stopping bullying and harassment. You must be proactive and question behavior that is inappropriate at the time it occurs. You must report inappropriate behavior to your chain of command immediately. Remember, everyone is responsible for fostering the best possible command climate within your unit.

The impact harassment can have on Service members should not be underestimated; it has the potential to affect the member both personally and professionally. Inappropriate jokes, attitudes, or comments that marginalize transgender Service members are damaging to command climate. In an environment that permits inappropriate jokes and behavior, transgender Service members who have not disclosed their status may be unlikely to seek the care they need.

Respect for Personal Information

You are responsible for upholding and maintaining the high standards of the U.S. military at all times and at all places. Out of respect for all Service members, as mentioned earlier, you should not disclose someone's gender identity without their permission, unless the disclosure is made for official use.[26]

26 Services retain the authority provided by law and Department and Service regulations to counsel, discipline, and involuntarily separate, as appropriate under the circumstances, those Service members who fail to obey established standards.

Tips for Service Members

Your social interactions and developing friendships with peers contribute to a positive work environment. Do not make assumptions about an individual's gender or sexual orientation. Let others volunteer personal information.

Try to ensure planned social activities are inclusive of Service members and their families who may not fit into your perception of what is typical.

If you notice colleagues or peers are expressing opinions that may alienate others, speak up regarding how their statements may impact others. Often people may be unaware of how their statements, questions, and activities may alienate and offend their coworkers, team members, or staff.

You should be sensitive to the use of pronouns when addressing others. This will vary by individual and unit. If there is ever any question about pronoun usage, do not hesitate to ask the Service member how they wish to be addressed.

If you have questions or concerns, you are encouraged to talk with your chain of command.

Privacy

Maintaining dignity and respect for all is important. You will need to consider both your own privacy needs and the privacy needs of others. This includes, but is not limited to, maintaining personal privacy in locker rooms, showers, and living quarters. One strategy might include adjusting personal hygiene hours. If you have concerns, you are encouraged to discuss them with your chain of command.

ACRONYMS

AOR	*Area of Responsibility*
BCA	*Body Composition Assessment*
DEERS	*Defense Enrollment Eligibility Reporting System*
DES	*Disability Evaluation System*
DoD	*Department of Defense*
DoDI	*Department of Defense Instruction*
DTM	*Directive-type Memorandum*
ETP	*Exception to Policy*
HT/WT	*Height/Weight*
IMR	*Individual Medical Readiness*
ING	*Inactive National Guard*
IR	*Individual Readiness*
IRR	*Individual Ready Reserve*
MHS	*Military Health System*
MLOA	*Medical Leave of Absence*
MMP	*Military Medical Provider*
MPDATP	*Military Personnel Drug Abuse Testing Program*
MSA	*Military Service Academy*
MTF	*Military Treatment Facility*
PRT	*Physical Readiness Test*
RLE	*Real Life Experience*
ROTC	*Reserve Officers' Training Corps*
SCCC	*Service Central Coordination Cell*
SELRES	*Selected Reserve*

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DoDI 1215.13, *"Ready Reserve Member Participation Policy,"* May 5, 2015.

DoDI 1300.28, *"In-Service Transition for Service Members Identifying as Transgender,"* June 30, 2016.

DoDI 1332.14, *"Enlisted Administrative Separations,"* January 27, 2014, as amended.

DoDI 1332.18, *"Disability Evaluation System (DES),"* August 5, 2014.

DoDI 1322.22, *"Service Academies,"* September 24, 2015.

DoDI 6025.19, *"Individual Medical Readiness (IMR),"* June 9, 2014.

DoDI 6130.03, *"Medical Standards for Appointment, Enlistment, or Induction in the Military Services,"* September 13, 2011.

DoDI 6490.04, *"Mental Health Evaluations of Members of the Military Services,"* March 4, 2013.

U.S. Secretary of Defense Ash Carter, *"Secretary of Defense Ash Carter Remarks Announcing Transgender Policy Changes,"* Washington, D.C., June 30, 2016.

ANNEX A:
Questions and Answers

Listed below are responses to frequently asked questions organized by topic and applicable to multiple audiences.

The Basics

1. What does transgender mean?

A. Transgender is a term used to describe people whose sex at birth is different from their sense of being male or female. A transgender male is someone who was born female but identifies as male, and a transgender female is someone who was born male but identifies as female.

2. What is gender identity?

A. Gender identity is one's internal sense of being male or female.

3. What is gender dysphoria?

A. Gender dysphoria is a medical diagnosis that refers to distress that some transgender individuals experience due to a mismatch between their gender and their sex assigned at birth.

4. Is being a transgender person the same as being a transvestite or a cross-dresser?

A. No. "Transvestite" is an outdated term that is considered derogatory. A "cross-dresser" is a person who wears clothing of the opposite sex for reasons other than gender identity (see question #2). A transgender person who dresses according to their gender identity is not "cross-dressing."

5. What is the relationship between sexual orientation and gender identity?

A. There is no relationship between sexual orientation and gender identity.

6. What pronouns should I use with transgender Service members?

A. This will vary by individual and unit. Transgender Service members should work with their unit leadership to establish correct pronoun usage. If there is ever any question about pronoun usage, do not hesitate to ask the Service member how they wish to be addressed.

7. What happens when federal and state laws appear to conflict?

A. When not on federal property, Service members must abide by local laws. If there are any questions or concerns about how state laws may affect Service members and/or their dependents off federal property or in areas of concurrent federal and state jurisdiction, the installation legal assistance office should be consulted.

It is also the commander's responsibility to ensure the safety of unit personnel. This includes reminding Service members of risks through use of safety bulletins, alerts, or briefings regarding off-installation activities. Additionally, judge advocate and SCCC resources are available to enhance risk management strategies.

Health Care Issues

8. What hormones do transgender people need?

A. Not all transgender Service members need cross-sex hormone therapy. Male or female hormones may be prescribed by medical providers in order for transgender Service members to develop the physical characteristics of their preferred gender if that is part of their transition plan.

9. What if a deployed transgender Service member loses his or her medications?

A. In the event that a Service member lost his or her supply of hormones, and for some unlikely reason was not able to obtain replacements, any side effects, like irritability, decreased energy, or hot flashes, would take a few weeks to become evident. None of these side effects would be life threatening.

In-Service Transition Policy Issues

10. Have other countries allowed transgender individuals to serve openly in their militaries?

A. Yes. At least 18 countries: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, the Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom, allow transgender personnel to serve openly.

11. What about Service members whose beliefs just cannot allow them to accept this as normal?

A. In today's military, people of different moral and religious values work, live, and fight together. This is possible because they treat each other with dignity and respect. This will not change. There will be no changes regarding Service members' ability to freely exercise their religious beliefs, nor are there any changes to policies concerning the Chaplain Corps of the Military Departments and their duties. Service members will continue to treat with respect and serve with others who may hold different views and beliefs.

12. What is the Service Central Coordination Cell (SCCC)?

A. Each Service has an SCCC of medical, legal, and policy experts, primarily to advise field commanders and medical service providers. Contact information for the SCCCs can be found in Annex D of this handbook.

13. Will Reserve Component members receive any kind of medical care or financial assistance to pay for transition-related treatment? Can they be treated in a military treatment facility (MTF) throughout their transition?

A. Reserve Component members typically receive health care through private civilian health insurance. Those enrolled in TRICARE Reserve Select may be able to access mental health and hormone treatment through TRICARE and are eligible for care in MTFs on a space-available basis. Service members are encouraged to contact their civilian provider/TRICARE for eligibility benefits. A civilian diagnosis and medical treatment plan must be submitted to your chain of command and validated by an MMP. This may be accomplished by telemedicine if available or submission of civilian health documentation to an MMP for review per Service policy.

14. How will the military protect the rights of Service members who are not comfortable sharing berthing, bathroom, and shower facilities with a transitioning Service member? Are they forced to just accept a transgender person living and showering with them?

A. To the extent feasible, a commander may employ reasonable accommodations to protect the privacy interests of Service members, while avoiding a stigmatizing impact to any Service member. Commanders are encouraged to consult with their SCCC for guidance.

15. How long will a Service member's deployment eligibility be affected? Is this a way to get out of deployment? Can a Service member in the process of transitioning, which can be a lengthy process, still deploy if called upon?

A. A Service member's period of non-deployability will vary by individual based on the care needed. Availability for deployment and any anticipated duty limitations would be part of the conversation Service members have with their commanders and medical providers as part of a medical treatment plan. Medical recommendations concerning unanticipated calls for deployment would be made in the same way as other medical conditions and as part of the pre-deployment process.

New Accession Policy Issues

Recruiting

16. Does the new policy mean the Military Services will start recruiting transgender applicants immediately?

A. No, policy is being revised to allow the Military Services to recruit new personnel no later than July 1, 2017.[27]

When training of the Force is complete and the new DoDI 6130.03 is effective, the Military Services will begin accessing transgender applicants who meet all standards, holding them to the same physical and mental fitness standards as everyone else who wants to join the military.

Detailed accession policy can be found in in DoD DTM 16-005, "Military Service of Transgender Service Members."[28]

17. What should a recruiter do if a transgender applicant wants to enlist, but the new policy is not in place?

A. A recruiter should ensure the applicant meets all standards (e.g., physical fitness, medical fitness) prior to being accessed. This is also a good time to assist the applicant in understanding the accession requirements so they can prepare themselves for entry once the new policy is in place.

27 DTM 16-005.

28 Ibid.

Military Service Academy (MSA)/ Reserve Officers' Training Corps (ROTC)

18. Does the new accession policy mentioned above apply to the Service Academies and the Reserve Officers' Training Corps (ROTC)?

A. Yes, effective July 1, 2017, the gender identity of an otherwise qualified individual will not bar them from joining the military, from admission to the MSAs, or from participating in ROTC or any other accession program. However, they must adhere to accession standards prior to being commissioned.

19. If ROTC or MSA students seek to transition during college, would they need to be stable for 18 months prior to commissioning?

A. Yes. An individual participant who is transgender is subject to separation from ROTC in accordance with DoDI 1215.08[29] or from an MSA in accordance with DoDI 1322.22,[30] based on a medical condition that impairs the individual's ability to complete such training or to access into the Armed Forces, under the same terms and conditions applicable to participants in comparable circumstances not related to transgender persons or gender transition. ROTC and MSA cadets and midshipmen are required to meet medical accessions standards when they are appointed as commissioned officers.

20. What are the medical requirements that must be met by an MSA cadet or midshipman to be eligible for a commission?

A. Cadets and midshipmen are subject to medical accession standards enumerated in DoDI 6130.03[31] prior to being commissioned.

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29 DoDI 1215.08, "Senior Reserve Officers' Training Corps (ROTC) Programs," June 26, 2006.

30 DoDI 1322.22, "Service Academies," September 24, 2015.

31 DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," September 13, 2011. (Currently under revision to reflect DTM 16-005 changes.)

21. What are the medical requirements that must be met by a ROTC cadet or midshipman to be eligible for a commission?

A. In accordance with DoDI 1215.08,[32] E3.2 (Senior ROTC Programs), complete medical examinations must be conducted before enrollment in the scholarship program or at the time of or immediately before enrollment in Senior ROTC programs of the Army, Navy, and Air Force. Such examinations must, in all respects, be equal to the examination conducted to determine medical qualifications for appointment as a commissioned officer. Provided the cadet or midshipman meets the requirements in DoDI 6130.03,[33] they would be qualified to receive a commission.

22. Would a cadet or midshipman be able to undergo hormone therapy while at one of the MSAs or enrolled in ROTC?

A. It depends. Cadets and midshipmen must continue to meet medical accession standards while at the MSA or enrolled in ROTC. If the standards for appointment into the U.S. Military Services are not maintained, an ROTC cadet or midshipman may be placed on an involuntary Medical Leave of Absence (MLOA) by the Service Secretary or designee. When an MLOA is recommended, a medical record review will determine whether the health-related incapacity or condition presents clear evidence that, following medical treatment, the cadet or midshipman will be unable to meet the physical standards for appointment into the U.S. Armed Forces within a reasonable period of time. Military Service Academy cadets and midshipmen who cannot meet medical accession standards and become medically disqualified may be disenrolled.[34]

32 DoDI 1215.08.

33 DoDI 6130.03.

34 DoDI 1322.22.

ANNEX B:

Gender Transition Roadmap for U.S. Military Personnel

Below is a summary of the gender transition process for a Service member in accordance with the recently implemented DoD Instruction, "In-Service Transition for Transgender Service Members." The roles, responsibilities, and courses of action available to transgender Service members and their commanders are described below.

Service Member Responsibilities

Before Initiating Gender Transition

Request an assessment by an MMP in order to confirm a diagnosis stating gender transition is medically necessary.

- Collaborate with and assist the MMP with developing a medical treatment plan for submission to the commander. This plan should include a projected timeline for completion of gender transition, and estimated periods of non-deployability and absence.
- Notify the commander of the recommended treatment and request approval of the timing of the treatment plan. The written request should include the following:
  - Medical treatment plan outlining all medically necessary care and a projected schedule for such treatment; and an estimated date for the completion of gender transition and a gender marker change in the appropriate Service personnel data system.

Reserve Considerations

- All transgender Reserve Component Service members (except Selected Reserve (SELRES) Full-Time Support personnel who fall under Active Component rules/requirements) will submit to, and coordinate with, their chain of command evidence of a civilian medical evaluation that includes a medical treatment plan.
- To the greatest extent possible, commanders and Service members shall address periods of non-availability for any period of military duty, paid or unpaid, during the Service member's gender transition with a view

to mitigate unsatisfactory participation through the use of rescheduled training or authorized absences.

During Gender Transition

- Initiate gender transition after obtaining the commander's approval.
- Inform the commander of any medical issues that come up in the course of gender transition.
- Notify the commander of any changes to the approved timeline of the medical treatment plan.
- Request the commander process an ETP, if necessary.

When Gender Transition is Complete

- Through your MMP, inform the commander that gender transition is complete, along with a recommended time to change gender marker in the Service personnel data system.
- Request the commander's written approval to change the gender marker in the Service personnel data system. The request must comply with Service policies and must, at a minimum, be accompanied by one of the following legal documents to support gender change:
  - A certified true copy of a State birth certificate reflecting your preferred gender;
  - A certified true copy of a court order reflecting your preferred gender; or
  - A U.S. passport reflecting your preferred gender.
- Upon receipt of the commander's approval, submit supporting documentation to personnel servicing activity to change the gender marker in the Service personnel data system.

After Gender Marker Change in the Service Personnel Data System

- Meet applicable Service standards of the preferred gender, including medical fitness, physical fitness, uniform and grooming, deployability, and retention standards.

- Use military berthing, bathroom, and shower facilities associated with the preferred gender.
- Request ETPs, as needed, from the commander.

Commander Responsibilities

Before Initiating Gender Transition

No later than 30 calendar days after receiving a Service member's request to transition gender:

- Review Service member's request to ensure that it contains the required documentation in accordance with DoD and Service policies, to include a medical treatment plan with a projected timeline for completion of gender transition, estimated periods of non-deployability/absence, and estimated date of gender marker change;
- Coordinate with an MMP. If request to transition gender is from an RC Service member they will likely provide a diagnosis and medical treatment plan from a non-MMP. In this instance, it still must be validated by an MMP;
- Consult with the SCCC; and
- If the Service member's request is incomplete, return it with a written notice of additional required documentation.

No later than 90 calendar days after receiving a Service member's request to transition gender:

- Provide a written response to Service member's request for gender transition or an ETP, with a copy to the MMP; and
- In reviewing the Service member's gender transition request, ensure the decision:
  - Complies with DoD, Service policies, and guidance;
  - Considers the individual facts and circumstances presented by the Service member;

- Considers the needs of the command (including deployment, operations, training, exercise schedules, critical skills availability, morale and welfare, and good order and discipline of the unit);
- Minimizes impacts to the mission and readiness by balancing the needs of the individual with the needs of the command;
- Is consistent with the medical treatment plan; and
- Incorporates input provided by the MMP.

During Gender Transition

In cases where a transitioning Service member is unable to meet standards or requests an ETP during the gender transition, review Service policies outlining the actions a commander may take to balance the needs of the individual Service member and unit readiness. As permitted by Service policies, the commander may:

- Adjust the date on which the Service member's gender transition, or any component of the transition process, will commence;
- Advise the Service member regarding options for extended leave status or participation in other voluntary absence programs during the transition process;
- Arrange for the transfer of the Service member to another organization, command, location, or duty status (e.g., Individual Ready Reserve (IRR)), as appropriate, during the transition process;
- Review and forward ETP requests for application of standards for uniforms and grooming, PRT, and MPDATP participation;
- Establish, or adjust, command policies on the use of berthing, bathroom, and shower facilities;
- Refer for a determination of fitness in the disability evaluation system in accordance with DoDI 1332.18;[35]

35 DoDI 1332.18, "Disability Evaluation System (DES)," August 5, 2014.

- Initiate administrative proceedings, comparable to actions that could be initiated with regard to others whose ability to serve is limited by medical conditions unrelated to gender transition; and
- Consult the SCCC, with regard to:
  - Service by transgender Service members and gender transition in the military;
  - Implementing DoD, Military Department, and Service policies and procedures; and
  - Assessing the means and timing of any proposed medical care or treatment.
- Coordinate with the MMP regarding any medical issues that arise in the course of a Service member's gender transition;
- Ensure that requests for ETPs are processed within 90 days and provide a written response to both the Service member and their MMP; and
- Modify a previously approved timeline for gender transition or an ETP at any time prior to the change in a Service member's gender marker in the Service personnel data system.
  - A determination that modification is necessary and appropriate will be made in accordance with DoD/Service policies and procedures.
  - Notify Service member of such modification under established DoD procedures as described in the 'before intitiating gender transition' section at beginning of 'commander's responsibilities'.

When Gender Transition is Complete

- Review a Service member's request to change gender marker in the Service personnel data system to ensure that it complies with Service requirements, to include at a minimum:
  - A recommendation from the MMP stating that gender transition according to the medical treatment plan is complete and that the Service member is stable in the identified gender; and

- One of the following legal documents to effect gender change:
  - A certified true copy of a State birth certificate reflecting the Service member's preferred gender;
  - A certified true copy of a court order reflecting the Service member's preferred gender; or
  - A U.S. passport reflecting the member's preferred gender.

- If the Service member's request is complete, provide written approval to Service member authorizing gender marker change in the Service personnel data system.

After Gender Marker Change in the Service Personnel Data System

- Apply uniform standards, grooming standards, BCA standards, PRT standards, MPDATP standards, and other standards according to the Service member's identified gender listed in the Service personnel data system.
- Direct the use of military berthing, bathroom, and shower facilities according to the Service member's gender listed in the Service personnel data system.
- Review ETP requests as appropriate.

ANNEX C:
Scenarios

The following fictional cases illustrate scenarios that may be encountered when addressing individual issues.[36] The delineation of responsibilities in each scenario is intended only to provide a general discussion of issues that may arise. The scenarios are not all inclusive, nor are they directive in nature. All personnel are reminded to consult with their Chain of Command, SCCC, Service, and DoD guidelines before determining the best course(s) of action. Commanders are reminded of their responsibility to ensure good order and discipline throughout their entire unit.

Readiness

Scenario 1: Inability to Meet Standards during Transition

A senior officer, Tony, is transitioning to become Tanya. The officer is about halfway through the gender transition timeline agreed upon with his military medical provider (MMP) and commander and is taking feminizing hormone therapy. The officer is aware that male standards (berthing, uniform, BCA, PRT, etc.) will still apply until his transition is complete. However, midway through hormone treatment, it becomes increasingly difficult for Tony to meet the male body composition and physical readiness standards. Tony's commander is supportive, but several key unit training events have been scheduled over the next several months, making immediate accommodation difficult.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to individual medical readiness (IMR) that may impact the ability to meet standards. It is essential that communication among Service member, commander, and the MMP is ongoing.

Service member responsibilities

- If necessary, work with the MMP to obtain proper waiver for male physical readiness standards during the period of gender transition and ensure the commander is informed; and

36 The scenarios presented are fictitious and not intended to represent any actual person or event.

- Discuss alternatives with the commander, such as rescheduled training events or extended leave/absence until gender transition process is complete.

Commander responsibilities

The commander can exercise multiple options listed below, as permitted by DoD and Service policies:

- Advise Tony on the option of taking extended leave/absence during the gender transition process;
- Explore the possibility of transferring Tony to another organization with less rigorous operational requirements;
- Refer Tony for a determination of fitness in the disability evaluation system;[37] or
- Review approved ETPs consistent with Service policies for male physical readiness and male body composition standards and ensure they are followed until the change of gender marker in the Service personnel data system to a female is complete.

Scenario 2: Physical Standards

A Service member has completed their medical treatment plan and is requesting commander approval to change their gender marker in the Service personnel data system. The commander has concerns about the Service member's ability to meet height/weight (HT/WT) and physical readiness training (PRT) standards for the preferred gender.

Key takeaway(s)

This scenario illustrates the importance of ongoing communication among Service member, commander, and the MMP, and the requirement for the commander to approve in writing all gender marker change requests. This communication will assist the commander in determining the timing of the gender marker change in the Service's personnel data system.

37 DoDI 1332.18. (USCG reference is Physical Disability Evaluation System, COMDTINST M1850.2 (series))

Service member responsibilities

- Part of your transition process should include a provision to meet new HT/WT and PRT standards and consider whether an ETP will be required as you progress through the medical treatment plan.
- Continue communicating with your commander and your MMP on your ability to meet HT/WT and PRT standards.

Commander responsibilities

- Part of the Service member's transition process should include a provision to meet new HT/WT and PRT standards as they progress through their medical treatment plan.
- Counsel Service member on HT/WT requirements and personal fitness and the potential negative outcomes should they fail to meet those requirements.
- Consult with the MMP on Service member's ability to meet standards.
- Consider two possible courses of action for gender maker change in Service personnel data system: (1) grant gender marker change with ETPs or (2) delay gender marker change until all standards of the preferred gender are met.
- Consult DoD and Service policy as well as the SCCC.

Scenario 3: Pregnancy

Lieutenant Marty changed his gender marker in the Service personnel data system from female to male after completing an approved transition plan. Lieutenant Marty has not had sex reassignment surgery as part of the transition plan and is working with his MMP on a plan to start a family. Lieutenant Marty approached his commanding officer a few weeks ago and mentioned he was pregnant.

Key takeaway(s)

This scenario illustrates the importance of ongoing communication among Service member, commander, and the MMP with regard to Individual Medical Readiness (IMR). It also emphasizes the importance of understanding

special medical care that may be required and administrative benefits resulting from pregnancy.

Service member responsibilities

- It is your responsibility to notify the chain of command of any change to IMR.[38]
- Though you have changed your gender marker in the Service personnel data system, there are IMR requirements that may be contrary to what is listed in the personnel data system (i.e., gender reflects male, however you have female anatomical characteristics). Health matters specific to anatomical characteristics still require appropriate medical review as they may affect your overall health and readiness, thus you will still require annual female examinations.
- You will receive any/all treatment/check-ups/physicals as it relates to female genitalia, including, in this case, prenatal care. Upon giving birth, you will be entitled to all relevant medical care, administrative entitlements, and leave prescribed under Service policies.
- Be aware that colleagues may find this situation confusing. Consider how and when you would like to discuss the pregnancy with your chain of command and colleagues.

Commander responsibilities

- Comply with Service pregnancy policies.
- Understand and be prepared to address administrative entitlements with Lieutenant Marty (i.e., maternity leave).
- Even though Lieutenant Marty has maintained female anatomy, he must be screened for pregnancy prior to deployment. If Lieutenant Marty became pregnant on deployment he will be transferred in accordance with Service policy.
- Consider workplace communications at the appropriate time with consideration of Lieutenant Marty's wishes.
- Consult with the SCCC.

38 DoDI 6025.19.

Career

Scenario 4: Specialized Career Limitations

A male aviation officer with 12 years of service approaches his commanding officer and requests guidance on how to complete a transition from "Eric" to "Erica." He has been living as a female when not on duty, and has already started hormone therapy, prescribed by a civilian provider, sought consultation for surgical transition, and is about to have a legal name change.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, and the importance of bringing all medical care into the MHS, whether a member of the Active or Reserve Component. Even though the Service member has received gender transition-related treatment with a civilian medical provider, they must have their subsequent care within the military health system. Finally, the scenario highlights how performance of duty may be limited depending on specialty/career field.

Service member responsibilities

- Immediately notify the flight surgeon of care received by a civilian medical provider.
- You are required by policy to inform your commander of medical treatment that may impact your medical readiness status.
- You have a responsibility to maintain your health and fitness, meet IMR requirements,[39] and report medical (including mental health) and health issues that may affect your readiness to deploy or fitness to continue serving in an active/reserve status;
- Receive a diagnosis and a treatment plan from an MMP.
- Provide all medical documentation from your civilian provider to the MMP.
- Develop a transition timeline with the MMP and the commander.

39 Ibid.

Commander responsibilities

- Consider Service policies applicable to Service members regarding unauthorized medical care.
- Direct Service member to an MMP for diagnosis and review of procedures already performed.
- Consult the MMP and/or the SCCC regarding the impact of gender transition on the Service member's readiness status and ability to perform military duties, highlighting the immediate impact to the officer's ability to maintain aviation credentials.
- Consider the timing of medical requirements in the treatment plan and any impacts to the mission (including deployments, operations, training and exercises) as well as the morale and welfare, and good order and discipline of the unit.

Scenario 5: Entry-Level Training

After four months, Private Lee completes recruit and combat training. She then reports to Ft. Sill for Military Occupational Specialty training. Upon arrival, Private Lee tells her Platoon Sergeant she is currently feeling distress as she believes she should be a man. Although she pushed herself through to completion, recruit training increased her distress. Private Lee has expressed reluctance about seeing a mental health specialist and/or medical care provider.

Key takeaway(s)

This scenario illustrates the importance of receiving a proper diagnosis from the MMP prior to other actions being taken. The commander has tools available to facilitate medical care for a Service member's well-being and to ensure Service members complete initial entry training.

Service member responsibilities

- Discuss situation with the commander.
- Obtain an evaluation by an MMP.

Next, Private Lee received a diagnosis of gender dysphoria, and the commander is told her training will be interrupted as treatment is medically necessary. After one month, it is clear Private Lee's medical condition impairs her ability to train.

Commander responsibilities

- Consult with an MMP and determine need for a command-directed mental health evaluation.[40]
- Consult with the SCCC.
- Inform Private Lee potential courses of action may include: withdrawal from training due to her medical condition, a training delay, or an initial entry separation if within 180 days of accession.[41]

Reserve Component

Scenario 6: Individual Ready Reserve

Corporal Kennedy is a member of the IRR and does not have access to an MMP. He has recently completed the transition from female to male. Corporal Kennedy wants to be considered male by his Service. He has a new birth certificate showing his preferred gender.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. Even though the Service member did all of their gender transition-related treatment with a civilian medical provider, they must still adhere to established military medical and personnel processes.

40 DoDI 6490.04, "Mental Health Evaluations of Members of the Military Services," March 4, 2013.

41 DoDI 1332.14, "Enlisted Administrative Separations," January 27, 2014, as amended.

Service member responsibilities

- All IRR Service members have a responsibility to maintain their health and fitness, meet IMR requirements,[42] and report to their chain of command any medical (including mental health) and health issues that may affect their readiness to deploy or fitness to continue serving.
- Provide medical documentation indicating that transition is complete to their IRR command and ensure it is available to an MMP to confirm the diagnosis.
- Provide legal documentation of gender change (i.e., certified birth certificate, U.S. passport, certified court order) to IRR command.

Commander responsibilities

- Review documentation with an MMP to ensure completeness and compliance with Service instructions and DoD policy.
- If complete, provide letter authorizing gender marker change in the Service personnel database.
- Consult with SCCC.

Scenario 7: Standards and Exceptions to Policy

Sergeant Rich, a Selected Reservist, informs his commanding officer that he has been living as a female when he is not in a drilling status. He requests to be called Meena; to use the female bathroom; to be held to female physical, uniform, and grooming standards; and to have his gender changed in his official military personnel file.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. Even though the Service member has initiated their gender transition-related treatment with a civilian medical provider, they must still adhere to established military medical and personnel processes.

42 DoDI 1215.13, "Ready Reserve Member Participation Policy," May 5, 2015.

Service member responsibilities

- All Selected Reserve Service members have a responsibility to maintain their health and fitness, meet IMR requirements,[43] and report to their chain of command any medical (including mental health) and health issues that may affect their readiness to deploy or fitness to continue serving.
- Provide medical documentation to the MMP showing diagnosis and medical treatment received from civilian medical provider.
- Upon confirmed diagnosis by the MMP, work with the MMP and commander to develop a transition plan.
- Provide legal documentation of gender change (i.e., certified birth certificate, U.S. passport, certified court order).

Commander responsibilities

- Facilitate Sergeant Rich's consultation with the MMP and discuss need for any ETPs that may be required.
- Upon confirmed diagnosis by the MMP, work with Sergeant Rich and the MMP to develop a gender transition plan consistent with your unit's operational responsibilities.
- When transition is complete, as certified by the MMP, provide a letter authorizing gender marker change in the Service personnel database.
- Ensure your unit is properly trained to accept and understand Sergeant Rich's preferred gender.

Scenario 8: Satisfactory Reserve Participation

Sergeant Williams is a Selected Reserve member with an Army Reserve unit. He has been in consultation with his commander regarding his gender transition. The medical treatment portion of his gender transition will require him to miss up to 2 months of duty. Both the commander and Sergeant Williams are working through potential mitigation strategies to ensure he does not become an unsatisfactory participant.

43 DoDI 6025.19.

Key policy takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. The commander also has tools available to address the Service member's absence.

Service member responsibilities

- As part of the previously agreed to transition, continued communication with the commander is key to success.
- Be aware of participation requirements to ensure a satisfactory year is achieved.
- Consult with the commander regarding alternative training opportunities.

Commander responsibilities

- You have the necessary tools to develop an initial mitigation strategy; options available to you include: (1) rescheduled training; (2) authorized absences; or (3) alternate training.
- Individual Service policies will detail processes and procedures required to use the above mitigation tools.
- Consult with your SCCC.
- Ensure your unit is properly trained to accept and understand Sergeant Williams' preferred gender.

Scenario 9: Medical Compliance

Airman Bristol, a Selected Reserve member with an Air Force Reserve unit, has an approved transition plan. She has been contemplating an unscheduled medical procedure between unit training assemblies. It is highly unlikely that the surgical procedure will require her to miss training. Airman Bristol is uncertain if she needs to report the procedure to her chain of command.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. Even though the Service member has initiated their gender transition-related treatment with a civilian medical provider, they must still adhere to established military medical and personnel processes. The commander also has tools available to facilitate the Service member's well-being.

Service member responsibilities

- You have a responsibility to maintain your health and fitness, meet IMR requirements,[44] and report to your chain of command any medical (including mental health) and health issues that may affect your readiness to deploy or fitness to continue serving in an active status.
- Discuss with your commander to address potential adjustments to your transition plan and any readiness implications.

Commander responsibilities

- You should prepare Airman Bristol for any potential periods of non-availability and work with her to mitigate absences. Options available to you include: (1) rescheduled training; (2) authorized absences; or (3) alternate training.
- Consider potential adjustments to Airman Bristol's transition plan based on individual needs as well as readiness.
- Individual Service policies will detail processes and procedures required to use any of these mitigation tools.
- You must also balance the needs of the individual and the unit in terms of readiness. While Airman Bristol may have great flexibility in her Air Force Reserve unit as to the timing of the medical procedure, this may not always be the case. Continued dialogue between you and Airman Bristol is important to individual and unit readiness. For further information, you should consult your chain of command and/or SCCC.

44 Ibid.

Scenario 10: Unauthorized Medical Care

An Active Guard/Reserve (AGR) National Guardsman has completed nearly all aspects of gender transition with the assistance of a civilian medical provider. His gender transition and medical treatment have not been disclosed to the chain of command. He would like to be recognized in his preferred gender.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. Even though the Service member did all of their gender transition-related treatment with a civilian medical provider, they must still adhere to established military medical procedures.

Service member responsibilities

Even though you have completed nearly all aspects of gender transition by a civilian medical provider, you must:

- By policy, inform your commander of medical treatment that may impact your medical readiness status.
- Maintain your health and fitness, meet IMR requirements, and report medical (including mental health) and health issues that may affect your readiness to deploy or fitness to continue serving in an active/reserve status.
- Request and receive a diagnosis and a treatment plan from an MMP.
- Provide all medical documentation from your civilian provider to the MMP.
- Develop a transition timeline with the MMP and the commander.

Commander responsibilities

- Consider Service policies applicable to Service members regarding unauthorized medical care.
- Direct the Service member to military medical for diagnosis and review of procedures already performed.

- Consult the MMP and/or the SCCC regarding the impact of gender transition on the Service member's readiness status and ability to perform military duties.
- Consider the timing of medical requirements in the treatment plan and any impacts to the mission (including deployments, operations, training and exercises) as well as the morale and welfare, and good order and discipline of the unit.

Privacy and Cohabitation

Scenario 11: Use of Shower Facilities

A transgender Service member has expressed privacy concerns regarding the open bay shower configuration. Similarly, several other non-transgender Service members have expressed discomfort when showering in these facilities with individuals who have different genitalia.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander. It also depicts steps a commander may take to permit privacy, based on Service policy.

Service member responsibilities

- If you have any concerns about privacy in an open bay shower setting, you should discuss this with your chain of command.
- Consider altering your shower hours.

Commander responsibilities

- You may employ reasonable accommodations when/if you have a Service member who voices concerns about privacy. This should be done with the intent of avoiding any stigmatizing impact to any Service member. If permitted by Service policies, some of these steps may include:
    - Facility modifications, such as installing shower curtains and placing towel and clothing hooks inside individual shower stalls.

- In cases where accommodations are not practicable, you may authorize alternative measures to respect personal privacy, such as adjustments to timing of the use of shower or changing facilities.
- Take proactive steps through the chain of command to ensure that expressions of discomfort don't escalate into harassment or hazing.
- Consult the SCCC for guidance on how to institute such measures.

Scenario 12: Urinalysis

A transgender Service member is randomly selected to undergo a urinalysis test at their new command.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander. The commander must adhere to procedures outlined in the Military Personnel Drug Abuse Testing Program (MPDATP)[45] and Service policy.

Service member responsibilities

- Discuss your circumstances with command leadership during sign-in period to determine your options and allow the commander the ability to adjust as required/desired for your comfort and the comfort level of the observer, particularly if you have not undergone full surgical change.

Commander responsibilities

- Depending on Service regulations, you may consider alternate observation options if a request from a transgender Service member or an observer is made. Options could include observation by a different observer or medical personnel.
- You have discretion to take additional steps to promote privacy, provided those steps do not undermine the integrity of the program. However, all collections must be directly observed.

45 DoDI 1010.16.

- Consult with the SCCC; if unable to make special accommodation, spend time discussing with both the observer and the Service member.
- Ensure your observers are properly trained.

Good Order and Discipline

Scenario 13: Living Quarters

You are the leading Chief Petty Officer aboard ship. A high performing Petty Officer, who is transgender and completely transitioned, approaches you and states she can no longer tolerate her roommate. Through positive reinforcement, counseling, and mentorship, you attempt to resolve the issue at the lowest level in the chain of command. However, you notice her performance starting to diminish, and she and her roommate are making derogatory comments to co-workers about each other. The behavior has become disruptive to the entire unit and others are starting to complain. She puts in a request to be re-assigned to another berthing area onboard ship.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as standards of conduct. It also highlights existing tools available to resolve the situation.

Service member responsibilities

- Respecting each other's rights within a closed space is critical to maintaining good order and discipline.
- Standards of conduct apply equally to all Service members.

Commander responsibilities

- Take an active and positive leadership approach with a focus on conflict resolution and professional obligations to maintain high standards of conduct.
- Counsel the individuals and encourage them to resolve their personal differences. Make clear to both that respecting each other's rights within a closed space is critical to maintaining good order and discipline.

- If the issue cannot be resolved and alternative berthing arrangements can be made within command policy and without degrading good order and discipline of the unit, you may consider alternative arrangements.

Scenario 14: Proper Attire during a Swim Test

It is the semi-annual swim test and a female to male transgender Service member who has fully transitioned, but did not undergo surgical change, would like to wear a male swimsuit for the test with no shirt or other top coverage.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander. It also depicts steps a commander may take to permit privacy, based on Service policy.

Service member responsibilities

- You may be comfortable with your outward appearance; however, there may be a period of adjustment for others. It is courteous and respectful to consider social norms and mandatory to adhere to military standards of conduct.
- Discuss with your chain of command.

Commander responsibilities

- It is within your discretion to take measures ensuring good order and discipline.
- When administering the swim test, counsel the individual and address the unit, if additional options (e.g., requiring all personnel to wear shirts) are being considered.
- Consult with your SCCC.

Scenario 15: Living Quarters

Following her transition (which did not include any sex reassignment surgery) and gender marker change in the Service personnel data system from male to female, Petty Officer Kelleher was assigned to a Coast Guard cutter and

provided quarters in female berthing. Shortly after her arrival aboard the cutter, several females in Petty Officer Kelleher's berthing area complained to the Command Senior Chief about being uncomfortable around Petty Officer Kelleher as she still has male genitalia. The Command Senior Chief approached the commanding officer with these complaints hoping to achieve some sort of resolution.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as standards of conduct. It also highlights existing tools available to resolve the situation.

Service member responsibilities

- You are not required to modify or adjust your behavior based on the fact you do not "match" the physical appearance of those in your berthing area. You must, however, follow all relevant shipboard and/or Service regulations commensurate with your gender.
- If you suspect others feel uncomfortable, or begin to feel uncomfortable, you should immediately reach out to an appropriate member of your command and note your concern. Should you feel uncomfortable approaching your command, every effort should be made to use resources available through the command senior enlisted leader network (e.g., Command Master Chief, Command Sergeant Major).
- The preservation of personal privacy, dignity, and respect is a responsibility shared by all crew members.

Commander's responsibilities

- Prior to Petty Officer Kelleher's arrival, ensure crew has received baseline training on policy regarding service by transgender personnel.
- Immediately upon the gender marker change in the Service personnel data system, Petty Officer Kelleher will be responsible for meeting all applicable military standards in her preferred gender, and subject to regulation by the military, will use those berthing, bathroom, and shower facilities associated with the preferred gender.

- You are responsible for the collective morale and welfare and good order and discipline of the unit and for fostering a command climate where all members of your command are treated with dignity and respect.
- An initial approach to the complaints may entail meeting with the Command Senior Chief as well as the complaining members of the berthing area to determine the exact nature of their complaints. You should inform them that Petty Officer Kelleher's assignment to female berthing is required regardless of her physical appearance and that their lack of comfort is not reason to prevent Petty Officer Kelleher from residing in female berthing or make her subject to treatment different from others.
- Similarly, as with any other issue taking place in a berthing area that affects the morale and welfare and good order and discipline, you (or Command Senior Chief) may also want to speak with Petty Officer Kelleher to inform her of the perceived problem regarding her physical appearance and its effect on the other members in the berthing area. Such a conversation should be handled very carefully; coordination with the SCCC is advisable to gain assistance on strategies to successfully engage in such communication.
- In every case, you may employ reasonable accommodations to respect the privacy interests of Service members. Avoid stigmatizing actions that may single out any Service members in an attempt to resolve the complaints.

Real Life Experience (RLE)

Scenario 16: Attending a Unit Social Event

A Service member has been undergoing transition for the last three months, from male to female, and his gender marker has not been changed in the Service's personnel data system. Only the immediate chain of command is aware of this transition. The Service member desires to attend an off-post unit event dressed as a female.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as standards of conduct. It also

highlights existing tools available to resolve the situation, as well as emphasizing the RLE agreement that was discussed when developing the transition plan.

Service member responsibilities

- Your RLE should be conducted in accordance with your approved transition plan. If this specific situation is not addressed, discuss this with your commander and the MMP to potentially modify the transition plan.
- Devise a communication plan with the commander to inform unit members of the transition to your preferred gender prior to attending unit events.

Commander responsibilities

- Maintain good order and discipline.
- During transition planning, discuss and document expected conduct to include RLE and whether ETPs may be necessary.
- If approving the ETP, ensure the unit members are properly trained prior to the event. If granting an ETP is not practicable, discuss with the Service member and advise him not to attend such activities as a female until unit members are properly trained.

Scenario 17: Off Duty

A Service member has been undergoing transition for the last three months, from male to female, and has not yet changed his gender marker in the Service's personnel database system. The unit is aware of his transition. He is preparing to begin his RLE after duty hours (i.e., wearing make-up, wigs, and female clothing) and would like to do so in his barracks room, unit day room, and on the military installation. He is still using the male facilities.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as standards of conduct. It also highlights existing tools available to resolve the situation, as well as emphasizing the RLE agreement that was discussed when developing transition plan.

Service member responsibilities

- Your RLE should be conducted in accordance with your approved transition plan. If this specific situation is not addressed, discuss this with your commander and the MMP to potentially modify the transition plan (i.e., request an ETP if necessary).

Commander responsibilities

- During transition plan development, discuss and document expected conduct to include RLE.
- Consider ETPs if requested by Service member; ensure your unit is aware and properly trained prior to granting an ETP.
- Only at the Service member's request, consider authorizing extended leave, transfer to IRR, ING, or Career Intermission Program/ Temporary Separation in accordance with Service policy to allow the Service member to live in their preferred gender and conduct RLE. Care should be taken to not apply any undue pressure on the Service member to avail himself of these voluntary options.
- Consider notifying the installation commander that you have a transitioning Service member to mitigate any potential confusion at base access control points.

Overseas

Scenario 18: Liberty Call and Personal Safety

The USS SHIP is about to pull into port for 3 days of liberty. The diverse crew, which includes a transgender Service member, has been working hard in the Arabian Gulf and is excited about a few days off. There is concern for Service member safety ashore due to wide spread anti-LGBT sentiment. Additionally, there are criminal penalties for violations of social norms.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander. Additionally, emphasis is placed on using available tools to evaluate assignments that may be potentially risky for the Service member.

Service member responsibilities

- You must always remember that the laws and what is considered socially normal in the host country may be vastly different than in the U.S.
- Pay attention to any travel warnings given at your command as a pre-arrival brief. You should also consult the Foreign Clearance Guide,[46] Travel Precautions, and Information section for LGBT travel information for that country.
- You should ensure that when you visit the country that you are always accompanied by some of your shipmates and avoid areas that are listed as dangerous. Be cautious of potential risky situations and don't do anything you would not do at home.
- You should avoid all physical displays of affection in public.

Commander responsibilities

- While having a transgender Service member might be unique to your crew, the specific issues and concerns are analyzed similarly to any other safety issues that may be encountered by any member of your crew.
- Conduct a thorough analysis of the country you are visiting prior to arrival. At a minimum, you should review the U.S. State Department's country specific website and DoD Foreign Clearance Guide.
- Tailor your pre-briefs to the crew on the accepted country norms and places to avoid. Ensure a robust buddy system for liberty is prescribed. Educate your non-commissioned officers about any concerns regarding the port.

Scenario 19: Assignment Considerations

A newly reported transgender female Service member arrives in the CENTCOM Area of Responsibility (AOR) to serve as an advise-and-assist mentor to women police officers. The country of assignment specifically requires female trainers for their female police officers.

46 See Annex D.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as the personnel assignment officer. Additionally, emphasis is placed on using available tools to evaluate assignments that may be potentially risky for the Service member.

Service member responsibilities

- You must be mindful of challenges presented by beliefs and norms in the AOR and how they are different than the accepted norms in the U.S.
- You may need to adjust your expectations in the event that you are asked to shift to a different billet in support of the mission. It is important to maintain a flexible mentality when working with foreign nations to better meet the needs of the overall mission.

Commander responsibilities

- This situation is unique in that close proximity with women and men in foreign countries may be more complicated than in the U.S.
- Some nations view transgender people as culturally unacceptable and will not recognize the individual's preferred gender.
- Conduct a thorough analysis of the country prior to arrival. At a minimum, you should review the U.S. State Department's country specific website and DoD Foreign Clearance Guide.
- You are encouraged to discuss this situation with your chain of command and the SCCC.

Proceed with caution for the safety of the Service member and the possible attention local media interest would generate in assigning this individual to the billet. The individual may need to be reassigned.

ANNEX D:
Additional Resources and Links

DoD Public and CAC-Enabled Websites

Public DoD website, "Department of Defense Transgender Policy":
http://www.defense.gov/transgender

DoD CAC-enabled website:
https://ra.sp.pentagon.mil/DoDCCC/SitePages/HomePage.aspx

Foreign Clearance Guide:

https://www.fcg.pentagon.mil/

Passport

The Department of State has established procedures allowing a person to change the gender on their U.S. Passport. Significantly, an amended birth certificate is not required. Details on this process are contained in the attached information page, found at this link:
http://travel.state.gov/content/passports/english/passports/information/gender.html

Service Boards for Correction of Military Records

Air Force:
http://www.afpc.af.mil/board-for-correction-of-military-records

Army:
http://arba.army.pentagon.mil/abcmr-overview.cfm

Coast Guard:
http://www.uscg.mil/legal/BCMR.asp

Navy and Marine Corps:
http://www.secnav.navy.mil/mra/bcnr/Pages/home.aspx

Service Central Coordination Cells (SCCCs)

Air Force:
usaf.pentagon.saf-mr.mbx.af-central-coordination-cell@mail.mil

Army:
usarmy.pentagon.hqda-dcs-g-1.mbx.sccc@mail.mil

Coast Guard:
SCCC@uscg.mil

Marine Corps:
USMC.SCCC@usmc.mil

Navy:
usn_navy_sccc@navy.mil