IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs,

v. Case No. 17-CV-0264

STATE OF WISCONSIN DEPARTMENT
OF EMPLOYEE TRUST FUNDS, et al.,

Defendants.

**SUPPLEMENTAL DECLARATION OF COLIN ROTH
IN SUPPORT OF OPPOSITION TO
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

I, **COLIN ROTH**, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am employed as an Assistant Attorney General at the Wisconsin Department of Justice (DOJ). I am one of the attorneys for the State of Wisconsin Department of Employee Trust Funds, State of Wisconsin Group Health Insurance Board, and Robert J. Conlin in the above-captioned matter.

2. This declaration is based on my personal knowledge.

3. Attached hereto as Exhibit S is a true and correct copy of the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (7th Version). I obtained these standards of care from

WPATH's website, www.wpath.org, where these were presented as the most recent version of the standards of care.

4. Attached hereto as Exhibit T is a true and correct copy of Exhibit 7 to the deposition of Tara S. Pray, Dkt. 69.

5. Attached hereto as Exhibit U is a true and correct PDF copy of a letter entitled *Dear Colleague Letter on Transgender Students* dated May 13, 2016, issued by the U.S. Department of Justice, Civil Rights Division, and U.S. Department of Education, Office for Civil Rights. I obtained this document from the U.S. Department of Education website, https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201605-title-ix-transgender.pdf.

6. Attached hereto as Exhibit V is a true and correct PDF copy of what appears on the "Know Your Rights: Transgender People and the Law" page, which is a link on the ACLU's website found at, https://www.aclu.org/know-your-rights/transgender-people-and-law.

7. Attached hereto as Exhibit W is a true and correct PDF copy of what appears on the "National Equality Map" page, which is a link on the Transgender Law Center website found at, https://transgenderlawcenter.org/equalitymap.

8. Attached hereto as Exhibit X is a true and correct PDF copy of the Wikipedia entry entitled, *Transgender rights in the United States*. I obtained this document from Wikipedia's website, https://en.wikipedia.org/wiki/Transgender_rights_in_the_United_States.

9. Attached hereto as Exhibit Y is a true and correct PDF copy of the "Values" page, which is a link on the Transgender Law Center website, found at https://transgenderlawcenter.org.

10. Attached hereto as Exhibit Z is a true and correct PDF copy of the "About Us" page, which is a link on the National Center for Transgender Equality website, found at https://transequality.org.

11. Attached hereto as Exhibit AA is a true and correct PDF copy of the "LGBT Rights" page, which is a link on the ACLU website, found at https://www.aclu.org/issues/lgbt-rights.

12. Attached hereto as Exhibit BB is a true and correct PDF copy of the "About Us–History" page, which is a link on the Lambda Legal website, found at https://www.lambdalegal.org.

13. Attached hereto as Exhibit CC is a true and correct PDF copy of homepage for the Movement Advancement Project website, found at http://www.lgbtmap.org.

14. Attached hereto as Exhibit DD is a true and correct PDF copy of an online opinion editorial in The New York Times entitled, *Trump's Heartless Transgender Military Ban Gets a Second Shot*, NY Times (Mar. 28, 2018), found at https://www.nytimes.com/2018/03/28/opinion/trump-transgender-military-ban.html?rref=collection%2Ftimestopic%2FTransgender%20issues&action=click&contentCollection=timestopics&region=stream&module=stream_unit&version=latest&contentPlacement=28&pgtype=collection.

15. Attached hereto as Exhibit EE is a true and correct PDF copy of an online opinion editorial in the Washington Post entitled, *Trump's transgender troop ban is as insidious as ever*, Wash. Post (Mar. 28, 2018), found at https://www.washingtonpost.com/opinions/trumps-transgender-troop-ban-is-as-insidious-as-ever/2018/03/28/773283be-32b6-11e8-8abc-22a366b72f2d_story.html?utm_term=.c6ff0fb7dd0b.

16. Attached hereto as Exhibit FF is a true and correct PDF copy of an online editorial in the Los Angeles Times entitled, *Time for transgender rights opponents to give up the fight*, L.A. Times (Dec. 27, 2015), found at http://www.latimes.com/opinion/editorials/la-ed-transgender-ballot-initiative-20151227-story.html. Online comments at the end of this editorial are excluded from this copy.

17. Attached hereto as Exhibit GG is a true and correct copy of Pages 1–2 of the Federal Register, Vol. 81, No. 96, May 18, 2016, Part IV, Dept. of Health and Human Services, Office of the Secretary, which is found on the U.S. Government Publishing Office website at https://www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf.

I declare under penalty of perjury that the forgoing is true and correct. Executed on the 29th day of June, 2018.

s/ Colin T. Roth
COLIN ROTH

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professiona Association for Transgender Health

7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

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Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as 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) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to 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) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). 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.

The numbers yielded by studies such as these can 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 present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional

1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fact compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[C]	variable
Increased muscle mass/strength	6-12 months	2-5 years[D]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

[A] Adapted with permission from Hembree et al.(2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[C]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease[A] Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors[B]	Type 2 diabetes[A]	Destabilization of certain psychiatric disorders[C] Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignances that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;

2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII

Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

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APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones*:* Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: 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) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing, may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);
6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iteratations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the *SOC* and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the *SOC*.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;
2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;
3. Working meeting of the Writing Group;
4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;
5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

Members of the Standards of Care Revision Committee[1]

Eli Coleman, PhD (USA)* - Committee chair
Richard Adler, PhD (USA)
Walter Bockting, PhD (USA)*
Marsha Botzer, MA (USA)*
George Brown, MD (USA)
Peggy Cohen-Kettenis, PhD (Netherlands)*
Griet DeCuypere, MD (Belgium)*
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Randi Ettner, PhD (USA)
Evan Eyler, MD (USA)
Jamie Feldman, MD, PhD (USA)*
Lin Fraser, EdD (USA)*
Rob Garofalo, MD, MPH (USA)
Jamison Green, PhD, MFA (USA)*
Dan Karasic, MD (USA)
Gail Knudson, MD (Canada)*
Arlene Istar Lev, LCSW (USA)
Gal Mayer, MD (USA)
Walter Meyer, MD (USA)*
Heino Meyer-Bahlburg, Dr. rer.nat. (USA)
Stan Monstrey, MD, PhD (Belgium)*
Blaine Paxton Hall, MHS-CL, PA-C (USA)
Friedmann Pfaefflin, MD, PhD (Germany)
Katherine Rachlin, PhD (USA)
Bean Robinson, PhD (USA)
Loren Schechter, MD (USA)
Vin Tangpricha, MD, PhD (USA)
Mick van Trotsenburg, MD (Netherlands)
Anne Vitale, PhD (USA)
Sam Winter, PhD (Hong Kong)
Stephen Whittle, OBE (UK)
Kevan Wylie, MB, MD (UK)
Ken Zucker, PhD (Canada)

International Advisory Group Selection Committee

Walter Bockting, PhD (USA)
Marsha Botzer, MA (USA)
Aaron Devor, PhD (Canada)
Randall Ehrbar, PsyD (USA)
Evan Eyler, MD (USA)
Jamison Green, PhD, MFA (USA)
Blaine Paxton Hall, MHS-CL, PA-C (USA)

1 * Writing Group member
All members of the *Standards of Care, Version 7 Revision Committee* donated their time to work on this revision.

International Advisory Group

Tamara Adrian, LGBT Rights Venezuela (Venezuela)
Craig Andrews, FTM Australia (Australia)
Christine Burns, MBE, Plain Sense Ltd (UK)
Naomi Fontanos, Society for Transsexual Women's Rights in the Phillipines (Phillipines)
Tone Marie Hansen, Harry Benjamin Resource Center (Norway)
Rupert Raj, Shelburne Health Center (Canada)
Masae Torai, FTM Japan (Japan)
Kelley Winters, GID Reform Advocates (USA)

Technical Writer

Anne Marie Weber-Main, PhD (USA)

Editorial Assistance

Heidi Fall (USA)


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Asma Kadri

From: Larson, Arlene
Sent: Monday, December 8, 2014 10:39 AM
To: Ellinger; Lisa; Kox; Bill; Statz; Mary; Pray; Tara
Subject: Guidelines Workgroup Part 2 for mtng 12/11 8:30
Attachments: 16 GDG-UB grid 1.docx; 14.12 GDLNS & Winter Sub due Jan.docx

Lisa, Bill and Mary,

Attached are the documents we will use during our meeting this Thursday from 8:30-9:30 to prepare for the Benefit Consultant, Segal.

First is the typical study group grid that lists all 2016 topics that have brought to HBIPB for consideration so far. Tara and I went over our tickler files and have inserted all items that have been requested for consideration.

Second is a rough Guidelines Study Group/Winter Submission all plan memo. I took Emily's memo from last year and updated it as much as I felt comfortable. Areas in yellow highlight have NOT been updated or represent comments I want to discuss. I've gotten input from Sarah and Jeff on pages 2 and 3, and am waiting for input from Dan Hayes & Ombuds on pages 3 and 4.

Please bring a copy of both documents to our meeting.

If you have questions or concerns beforehand, let me know. Arlene

Arlene Larson
Manager of Federal Health Programs & Policy
Division of Insurance Services
Department of Employee Trust Funds
P.O. Box 7931 Madison, WI 53707-7931
(608) 264-6624 Fax (608) 267-0633
arlene.larson@etf.wi.gov

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ETF 3187

Roth Decl. Ex. T

CONFIDENTIAL

Date: **December 11, 2014**

To: **Lisa Ellinger, Bill Kox, Mary Statz, Tara Pray**

From: **Arlene Larson**

Subject: **Study Group potential topics for meeting Thursday, 12/11/14**

The following issues will be discussed at our pre-Benefits Consultant meeting to determine possible recommendations for the 2016 Guidelines, Uniform Benefits and Uniform Dental contract. The topics have been brought to HBIPB from ETF staff, employers and members.

Bold language in the Section column means this would be a new article in the contract.

New draft contract language appears as underlined text in the far right column. Language that may be removed appears as struck out.

THIS GRID FOR LATER USE Worksheet *(Benefit increases should equal ways to free up dollars)*:

Possible Benefit Increase	PMPM Cost
TOTAL	

=

Possible Way(s) to Free Up Dollars	PMPM Savings
TOTAL	

Attachment to ETF 3187

GUIDELINES – Possible Recommendations

Section	GUIDELINES Issues	Rationale/Considerations	Pursue?	Draft contract language
GUIDELINES - I Objectives	Should we add, within the 5th paragraph that begins with "Dual Choice", specific language regarding premium bids? Add language that informs health plans that if they submit a local bid that is not justified, the Board may assign the State rate in its stead for the local program.	Due to time constraints in the bid season, Locals have not gotten the attention they need when health plans should fall into Tier 2 or 3. A revised contract provision could give us more flexibility if a Local issue is found after final best bids.	□Yes □No	*"DUAL-CHOICE" refers to a program where eligible employees, ANNUITANTS under Wis. Stat. § 40.51 (16), and currently insured other retirees and CONTINUANTS have the opportunity to choose between at least two competing health benefit plans, the Standard Plan and one or more alternate health plans. The mechanics of "DUALCHOICE" are relatively simple. Once an alternate health plan receives approval from the BOARD on the benefit structure, its proposed premium rate is submitted as a sealed bid. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the BOARD. The BOARD reserves the right to reject any proposal, which fails to include adequate documentation on the development of premium rates. These Guidelines provide a detailed explanation of the required documentation.*
GUIDELINES - II.D. 6 General Requirements	Discuss ETF administration of wellness program through single Third Party Administrator in section that refers to HRAs.	Program consistency and efficiency for participant. Strong impact from single program administrator.	□Yes □No	
GUIDELINES - II.D. 13 General Requirements	Can we improve End of Life (EOL) care by 1) modifying language on hospice care by expanding to include those who have less than 1 year life expectancy, rather than 6 months 2) add language for palliative care and 3) expand requirements of Advance Care Planning Programs to be offered by health plans.	Improving EOL care is a strategic goal of the Department.	□Yes □No	*HEALTH PLANS and their contracting providers must provide a credible Advanced Care Planning (ACP) program that includes hospice care and a palliative care consultation in a manner that is consistent with the Disease Management initiatives of the DEPARTMENT.*
GUIDELINES - II. J. Time Table	Health plan requests that we add a due date for the Summary of Benefits & Coverage (SBC) required by the ACA to the timeline in the Guidelines.	Last year SBCs were due June 20, 2014, the same time as HEDIS & CAHPS.	□Yes □No	

State and/or Local Employer Contract – Possible Recommendations

Section	Contract Issues	Rationale/Considerations	Pursue?	Draft contract language
State contract definition 1.20	Clarify the definition of Standard Plan to exclude the HDHP Standard Plan.	This change will clarify provisions regarding Standard Plan coverage for enrollment of uninsured subscribers 30 days prior to retirement in order to preserve sick leave and comparable coverage.	□Yes □No	*1.20 "STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD that is not a HIGH DEDUCTIBLE HEALTH PLAN.*
State/Local Contract 3.3 (2) (b)	Align language between State and Local contracts for consistency as appropriate.	Question: there is an addition to the local contract with the highlighted sentence for 2015. Should this also be added to the state? For 2015, we added this local provision to help Blackhawk Tech and other locals minimize ACA penalties.	□Yes □No	(2)*(b) Notwithstanding paragraph (2) (a) above, an EMPLOYEE who is not insured but who is eligible for an EMPLOYER contribution under Wis. Adm. Code § ETF 40.10 (2) (a) may elect coverage prior to becoming eligible for an EMPLOYER contribution under Wis. Adm. Code § ETF 40.10 (2) (b) to be effective upon the date of the increase in the EMPLOYER contribution. The same enrollment opportunity is available to those who change from an appointment of less than, on average, 30 hours per week, to one that meets or exceeds that threshold. An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following receipt of the application by the EMPLOYER.*
State/Local Contract 3.3 (3) (b) & 3.3 (7) c)	Should we codify in the contract that employees have up to a year to add a child due to birth? Per Wis. Stat. 632.895 (5).	Employer (UW) comments: "It would be helpful if the contract stated that if family coverage is in force, a newborn may be added up to one year after birth."	□Yes □No	*3.3 (3) (b) Notwithstanding paragraph 3 (a) above, the birth or adoption of a child to a SUBSCRIBER under a single plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the EMPLOYER within 60 days of the birth, adoption or placement for adoption.* *(7) (c) An EMPLOYEE who deferred coverage may enroll if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption, marriage or domestic partnership, provided he or she submits an application within 60 days of the birth, adoption or placement for adoption, or within 30 days of the marriage or effective date of the domestic partnership.*

Section	Contract Issues	Rationale/Considerations	Pursue?	Draft contract language
State/Local Contract 3.3 (7) (b) & 3.18 (1) (g)	Should we allow retroactive terminations of coverage in cases where a dependent was enrolled in Medicaid but the family didn't notify the employer timely?	Case: claims were incurred OON and Medicaid refused to pay since the dependent had other group coverage. Modify contract to allow a subscriber to retroactively drop such a dependent if requested? The ACA's rescission prohibition is a concern. This should only be considered in cases where it's requested to facilitate claim payment.	□Yes □No	*3.3 Selection of Coverage (7) (b)* *If permitted by state or Federal law, an eligible EMPLOYEE may defer or disenroll from coverage if he/she is covered under medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care. Termination may be retroactive to the effective date of the other coverage upon request by the subscriber…* *3.18 Individual Termination of Coverage (1) (g) The effective date of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any preexisting condition of PARTICIPANT who continues under paragraph (4) below. Terminations due to enrollment in medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care may be retroactive to the effective date of coverage upon request by the subscriber.*
State Contract 3.3 (9) (c)	Due to a case discussed by Mary, Bill and Brian, relayed to Arlene 6/25/14	Need detail on 'why'.	□Yes □No	*(9) (c) PARTICIPANTS losing eligibility for other coverage or the EMPLOYER'S contribution towards the other coverage ceases, may elect coverage under any plan by filing an application with the DEPARTMENT within 30 days of the loss of eligibility or notice of loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility…*
State/Local Contract 3.3 (11)	Align language between State and Local contracts for consistency as appropriate.	Question: this may be related to the addition noted above in 3.3.2.b in the local that is not present in the state, but the local has the highlighted language (not new for 2015) and the state doesn't. Should the state have it?	□Yes □No	*Local: (11) A SUBSCRIBER who does not request coverage for a DOMESTIC PARTNER, or an adult child when first eligible under Wis. Stat. § 632.885, will thereafter be limited to enrolling the DOMESTIC PARTNER or child when the DOMESTIC PARTNER or child becomes newly eligible due to the loss of eligibility for other coverage or the loss of EMPLOYER contribution for the other coverage, increase in EMPLOYEE contribution share that exceeds the cost of coverage as a DEPENDENT under this program. The SUBSCRIBER can add the DEPENDENT by filing an application with the EMPLOYER within 30 days after the event and coverage for the DEPENDENT will be effective on the event date. This paragraph does not prevent a SUBSCRIBER from adding the eligible DEPENDENT during the DUAL-CHOICE enrollment period for coverage effective the following January 1.*
State Contract 3.3 (13)	Clarify that new hires must file an application for the HDHP at the same time as creating an HSA account.	Technical change. Already implied in meaning.	□Yes □No	*(13) For the purposes of selecting a HIGH DEDUCTIBLE HEALTH PLAN, a completed application requires the submission of a Health Savings Account application to the third party administrator within the same enrollment period (opportunity).*

Section	Contract Issues	Rationale/Considerations	Pursue?	Draft contract language
Local Contract 3.4 (1)	Align language with that in state contract for consistency as appropriate.	Technical change.	□Yes □No	*The BOARD shall establish enrollment periods, which shall permit eligible EMPLOYEES, and currently ~~covered~~ insured ANNUITANTS CONTINUANTS to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51(7)...*
State/Local Contract 3.4 (4)	Should we allow subscribers who move from a county to change to any health plan, and not be limited to those offered in the new county?	Any other health plan changes do not limit subscribers in this manner. 1. This provision results in administrative difficulty at ETF. Manual intervention is currently required. 2. When subscribers move to northern IL and work in WI, this provision becomes problematic.	□Yes □No	*(4) An EMPLOYEE, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines for a minimum of three months. ~~The newly selected plan must have in-network providers in the county to which the SUBSCRIBER moved, as shown in the annual DUAL CHOICE enrollment materials~~...*
Local Contract 3.16 (1)	Should CONTINUANT be deleted because the local employer makes this call?		□Yes □No	***3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE*** *(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, or CONTINUANT who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.*
Local Contract 3.16 (2)	The 2015 contract clarification requiring all Medicare eligible annuitants to enroll when first eligible did not specifically include employer paid local annuitants. The new language clarifies the applicability of the provision to them.	Technical change.	□Yes □No	*(2) The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the PARTICIPANT becomes is eligible for the Medicare hospital and medical insurance benefits (Parts A and B) become effective as the primary payor and coverage is provided under an annuitant non-employer group number or in the case of an employer paid annuitant, under an employer group number.*

Section	Contract Issues	Rationale/Considerations	Pursue?	Draft contract language
State/Local Contract 3.16 (3)	Align language between State and Local contracts for consistency as appropriate.	Technical change. Highlighted language on right appears in noted "State" or "Local" contract and not the other. Should we make the state and local contracts match?	□Yes □No	State 1st paragraph: *Except in cases of fraud which shall be subject to section 3.18 (5), coverage for any PARTICIPANT enrolled in Medicare coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage shall be limited in accordance with Uniform Benefits IV., A., 12., b. However, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six months. This may limit the amount of PREMIUM refund for the SUBSCRIBER. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity.* Local 2nd paragraph: *In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV,. A., 12., b. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER. In such cases, the HEALTH PLAN will make claims adjustments prospectively.*
State/Local Contract 3.16 (7)	Question: Should we strike all references to continuants in this section?		□Yes □No	*(7) If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, this plan shall pay as the primary payor for the first thirty months after he or she becomes eligible for Medicare due to the kidney disease, whether or not the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is enrolled in Medicare. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payor after this thirty-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty-month period during which this plan will again be the primary payor. No reduction in PREMIUM is available for active EMPLOYEES under this section.*

Section	Contract Issues	Rationale/Considerations	Pursue?	Draft contract language
State Contract 3.18 (1) **NEW (j)**	For a state employee transfer, should we require state employers to terminate health insurance coverage at the end of the month? Or, should we require that the pre-paid amount is run out and the transfer always occurs after the run-out?	The flexibility of the state contract may result in administrative difficulty in BAS. Currently a consensus followed by manual intervention is required by employers following transfer as they choose between these two options. There is no uniformity.	□Yes □No	*3.18 Individual Termination of Coverage (1) A PARTICIPANT'S coverage shall terminate at the end of the month on the earliest of the following dates:* *The end of the month in which the SUBSCRIBER terminates employment in order to begin coverage the first of the following month in an appointment eligible for health insurance with another state employer.*
Local Contract 3.21 **NEW (6)**	Should we require participating locals to pre-pay their premium contributions toward health insurance like the state, that is, paid one month in advance? Should we codify this practice in the state contract?	The current flexibility of the local contract may result in administrative difficulty in BAS. Manual intervention may be required to refund employer premiums and terminate coverage of a subscriber following death. At a minimum without a limitation, locals will need to report their pre-pay timing.	□Yes □No	3.21 EMPLOYER CONTRIBUTIONS TOWARD PREMIUM

Uniform Benefits - Possible Recommendations

Section	Uniform Benefits Issue	Rationale/Considerations	Pursue?	Approx. PMPM	Draft contract language OR Explanation of Pricing
Uniform Benefits Schedule of Benefits	Should we limit hearing aids to every 3 years, counted even if health plans changed as we have done for orthodontia lifetime maximums?	Hearing aid benefit is limited to no more than once every 3 years, but if a person changes health plans, this limitation is not communicated to the succeeding plan and a new hearing aid may be payable.	□Yes □No		
Uniform Benefits Schedule of Benefits	What changes should we consider for the Pharmacy Benefit Manager (PBM)?	Jeff's spoken about several.	□Yes □No		

Section	Uniform Benefits Issue	Rationale/Considerations	Pursue?	Approx. PMPM	Draft contract language OR Explanation of Pricing
Uniform Benefits Definitions: Dependent	Should we change the criteria used to determine adult disabled dependents who are incapable of self-support? Specifically, should we remove the phrase that refers to the federal support test? This clause does not appear in code ETF 10.01 (2) (b).	If an adult dependent child has the means to support him or herself but chooses not to (because a family member, etc. supports them instead), should they *not* be eligible as a disabled dependent in our program?	□Yes □No		*3. All other children cease to be Dependents at the end of the month in which they turn 26 years of age, except that:* *a. An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible Dependent, regardless of age, as long as the child remains so disabled and he or she is dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as determined by the DEPARTMENT ~~as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed~~. ...*
Benefits & Services III., A., 3. &/or 16	Should we add coverage for services affiliated with cleft palate treatment? **(Getting more detail on the contract issue from Allen)**	Member requests coverage for 2 additional surgeries following 6 surgeries including removal of teeth.	□Yes □No		
Benefits & Services III., A., 5., a.	Should we explicitly cover the shingles vaccine in the medical program to age 50 as allowed by the FDA? Medicare Part D allows for coverage for Medicare prime members.	Member requests coverage starting at age 55. The CDC recommends coverage for those aged 60 and above.	□Yes □No		*Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.*
Benefits & Services III., C., 6.	Should we clarify our autism benefit regarding the $50,000/$25,000 limits, since the OCI adjusts them annually for inflation per the statute?	Two health plans found our language confusing in 2014. The inflationary provision appears in 632.895 (12m) (c)(1).	□Yes □No		*Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m)…Care up to $50,000 per year for intensive level and up to $25,000 per calendar year for non-intensive-level services is not subject to policy exclusions and limitations. These minimum coverage monetary amounts shall be adjusted annually beginning in 2011 as determined by the Office of Commissioner of Insurance. The therapy limit does not apply to this benefit.*

Section	Uniform Benefits Issue	Rationale/Considerations	Pursue?	Approx. PMPM	Draft contract language OR Explanation of Pricing
Exclusion IV.A.1.a.	Should we change our "sex transformation" exclusion language to 1."gender reassignment" 2. remove the exclusion and include benefits 3. Allow transgender people to change their sex in the system w/ or w/o surgery? 4. Allow members to select a gender other than M/F in system and on apps?	Employer (UW) requests change to enhance hiring. Member presents documentation stating that the coverage cost would be minimal. If we allow them to change sex in the system, hormones and other services may be paid that are currently denied.	□Yes □No		*1. Surgical Services* *a. Procedures, services, and supplies related to ~~sex transformation~~ gender reassignment surgery and sex hormones related to such treatments.*
Exclusion IV.A.1.b.	Should we request the actuary to price adding bariatric surgery to Uniform Benefits to update our understanding of applicable costs?		□Yes □No		*Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.*
Exclusion IV.A.7.g.	Should we tighten the exclusion for out of area prior authorized (PA'd) maternity services to limit PAs to 'one month prior' to birth?	Member complained after having birth in Hungary denied. States that plan prior authorized services before they left for several months overseas. Thus, should have been covered.	□Yes □No		*Maternity services received out of the Plan Service Area one month prior to the estimated due date, unless Prior Authorized (Prior Authorization will be granted only if the situation is out of the Participant's control, for example, family emergency).*
Exclusion IV.A.12., k.	Since Medicare began allowing for habilitative coverage in skilled nursing care to maintain a patient's condition and prevent deterioration, should we create a benefit?		□Yes □No		*Habilitation services and treatment, except as required by state law, including Wis. Stat. §§ 632.895 (5), (12m), and (16).*

Uniform Dental Benefits - Possible Recommendations

Section	Uniform Dental Issues	Rationale/Considerations	Pursue?	Draft contract language
Uniform Dental certificate of coverage	RFP will be issued in 2015	What do we want to say about this?	□Yes □No	

Standard Plan Benefits - Possible Recommendations

Section	Standard Plan Issues	Rationale/Considerations	Pursue?	Draft contract language
Standard Plan	Bariatric surgery criteria for coverage	Consider updating criteria used to gain access to the benefit. Should be updated due to WPS' medical policy changes.	□Yes □No	

Additional Changes – NOT Recommended

The following issues were raised but staff does not recommend pursing them at this time. We will be happy to provide additional information about any of these issues upon request.

Section	Not: recommended/iterated in contract/ETF's purview/for 2016	Rationale/Considerations	Pursue?	Approx. PMPM	Draft contract language OR Explanation of Pricing

NOTES:

Archived Information

U.S. Department of Justice
Civil Rights Division

U.S. Department of Education
Office for Civil Rights

Dear Colleague Letter on Transgender Students
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U.S. Department of Justice
Civil Rights Division

U.S. Department of Education
Office for Civil Rights

May 13, 2016

Dear Colleague:

Schools across the country strive to create and sustain inclusive, supportive, safe, and nondiscriminatory communities for all students. In recent years, we have received an increasing number of questions from parents, teachers, principals, and school superintendents about civil rights protections for transgender students. Title IX of the Education Amendments of 1972 (Title IX) and its implementing regulations prohibit sex discrimination in educational programs and activities operated by recipients of Federal financial assistance.[1] This prohibition encompasses discrimination based on a student's gender identity, including discrimination based on a student's transgender status. This letter summarizes a school's Title IX obligations regarding transgender students and explains how the U.S. Department of Education (ED) and the U.S. Department of Justice (DOJ) evaluate a school's compliance with these obligations.

ED and DOJ (the Departments) have determined that this letter is *significant guidance*.[2] This guidance does not add requirements to applicable law, but provides information and examples to inform recipients about how the Departments evaluate whether covered entities are complying with their legal obligations. If you have questions or are interested in commenting on this guidance, please contact ED at ocr@ed.gov or 800-421-3481 (TDD 800-877-8339); or DOJ at education@usdoj.gov or 877-292-3804 (TTY: 800-514-0383).

Accompanying this letter is a separate document from ED's Office of Elementary and Secondary Education, *Examples of Policies and Emerging Practices for Supporting Transgender Students*. The examples in that document are taken from policies that school districts, state education agencies, and high school athletics associations around the country have adopted to help ensure that transgender students enjoy a supportive and nondiscriminatory school environment. Schools are encouraged to consult that document for practical ways to meet Title IX's requirements.[3]

Terminology

- *Gender identity* refers to an individual's internal sense of gender. A person's gender identity may be different from or the same as the person's sex assigned at birth.

- *Sex assigned at birth* refers to the sex designation recorded on an infant's birth certificate should such a record be provided at birth.

- *Transgender* describes those individuals whose gender identity is different from the sex they were assigned at birth. A *transgender male* is someone who identifies as male but was assigned the sex of female at birth; a *transgender female* is someone who identifies as female but was assigned the sex of male at birth.

- *Gender transition* refers to the process in which transgender individuals begin asserting the sex that corresponds to their gender identity instead of the sex they were assigned at birth. During gender transition, individuals begin to live and identify as the sex consistent with their gender identity and may dress differently, adopt a new name, and use pronouns consistent with their gender identity. Transgender individuals may undergo gender transition at any stage of their lives, and gender transition can happen swiftly or over a long duration of time.

Compliance with Title IX

As a condition of receiving Federal funds, a school agrees that it will not exclude, separate, deny benefits to, or otherwise treat differently on the basis of sex any person in its educational programs or activities unless expressly authorized to do so under Title IX or its implementing regulations.[4] The Departments treat a student's gender identity as the student's sex for purposes of Title IX and its implementing regulations. This means that a school must not treat a transgender student differently from the way it treats other students of the same gender identity. The Departments' interpretation is consistent with courts' and other agencies' interpretations of Federal laws prohibiting sex discrimination.[5]

The Departments interpret Title IX to require that when a student or the student's parent or guardian, as appropriate, notifies the school administration that the student will assert a gender identity that differs from previous representations or records, the school will begin treating the student consistent with the student's gender identity. Under Title IX, there is no medical diagnosis or treatment requirement that students must meet as a prerequisite to being treated consistent with their gender identity.[6] Because transgender students often are unable to obtain identification documents that reflect their gender identity (*e.g.*, due to restrictions imposed by state or local law in their place of birth or residence),[7] requiring students to produce such identification documents in order to treat them consistent with their gender identity may violate Title IX when doing so has the practical effect of limiting or denying students equal access to an educational program or activity.

A school's Title IX obligation to ensure nondiscrimination on the basis of sex requires schools to provide transgender students equal access to educational programs and activities even in circumstances in which other students, parents, or community members raise objections or concerns. As is consistently recognized in civil rights cases, the desire to accommodate others' discomfort cannot justify a policy that singles out and disadvantages a particular class of students.[8]

1. Safe and Nondiscriminatory Environment

Schools have a responsibility to provide a safe and nondiscriminatory environment for all students, including transgender students. Harassment that targets a student based on gender identity, transgender status, or gender transition is harassment based on sex, and the Departments enforce Title IX accordingly.[9] If sex-based harassment creates a hostile environment, the school must take prompt and effective steps to end the harassment, prevent its recurrence, and, as appropriate, remedy its effects. A school's failure to treat students consistent with their gender identity may create or contribute to a hostile environment in violation of Title IX. For a more detailed discussion of Title IX

requirements related to sex-based harassment, see guidance documents from ED's Office for Civil Rights (OCR) that are specific to this topic.[10]

2. Identification Documents, Names, and Pronouns

Under Title IX, a school must treat students consistent with their gender identity even if their education records or identification documents indicate a different sex. The Departments have resolved Title IX investigations with agreements committing that school staff and contractors will use pronouns and names consistent with a transgender student's gender identity.[11]

3. Sex-Segregated Activities and Facilities

Title IX's implementing regulations permit a school to provide sex-segregated restrooms, locker rooms, shower facilities, housing, and athletic teams, as well as single-sex classes under certain circumstances.[12] When a school provides sex-segregated activities and facilities, transgender students must be allowed to participate in such activities and access such facilities consistent with their gender identity.[13]

- **Restrooms and Locker Rooms**. A school may provide separate facilities on the basis of sex, but must allow transgender students access to such facilities consistent with their gender identity.[14] A school may not require transgender students to use facilities inconsistent with their gender identity or to use individual-user facilities when other students are not required to do so. A school may, however, make individual-user options available to all students who voluntarily seek additional privacy.[15]

- **Athletics.** Title IX regulations permit a school to operate or sponsor sex-segregated athletics teams when selection for such teams is based upon competitive skill or when the activity involved is a contact sport.[16] A school may not, however, adopt or adhere to requirements that rely on overly broad generalizations or stereotypes about the differences between transgender students and other students of the same sex (*i.e.*, the same gender identity) or others' discomfort with transgender students.[17] Title IX does not prohibit age-appropriate, tailored requirements based on sound, current, and research-based medical knowledge about the impact of the students' participation on the competitive fairness or physical safety of the sport.[18]

- **Single-Sex Classes**. Although separating students by sex in classes and activities is generally prohibited, nonvocational elementary and secondary schools may offer nonvocational single-sex classes and extracurricular activities under certain circumstances.[19] When offering such classes and activities, a school must allow transgender students to participate consistent with their gender identity.

- **Single-Sex Schools**. Title IX does not apply to the admissions policies of certain educational institutions, including nonvocational elementary and secondary schools, and private undergraduate colleges.[20] Those schools are therefore permitted under Title IX to set their own

sex-based admissions policies. Nothing in Title IX prohibits a private undergraduate women's college from admitting transgender women if it so chooses.

- **Social Fraternities and Sororities**. Title IX does not apply to the membership practices of social fraternities and sororities.[21] Those organizations are therefore permitted under Title IX to set their own policies regarding the sex, including gender identity, of their members. Nothing in Title IX prohibits a fraternity from admitting transgender men or a sorority from admitting transgender women if it so chooses.

- **Housing and Overnight Accommodations**. Title IX allows a school to provide separate housing on the basis of sex.[22] But a school must allow transgender students to access housing consistent with their gender identity and may not require transgender students to stay in single-occupancy accommodations or to disclose personal information when not required of other students. Nothing in Title IX prohibits a school from honoring a student's voluntary request for single-occupancy accommodations if it so chooses.[23]

- **Other Sex-Specific Activities and Rules**. Unless expressly authorized by Title IX or its implementing regulations, a school may not segregate or otherwise distinguish students on the basis of their sex, including gender identity, in any school activities or the application of any school rule. Likewise, a school may not discipline students or exclude them from participating in activities for appearing or behaving in a manner that is consistent with their gender identity or that does not conform to stereotypical notions of masculinity or femininity (*e.g.*, in yearbook photographs, at school dances, or at graduation ceremonies).[24]

4. Privacy and Education Records

Protecting transgender students' privacy is critical to ensuring they are treated consistent with their gender identity. The Departments may find a Title IX violation when a school limits students' educational rights or opportunities by failing to take reasonable steps to protect students' privacy related to their transgender status, including their birth name or sex assigned at birth.[25] Nonconsensual disclosure of personally identifiable information (PII), such as a student's birth name or sex assigned at birth, could be harmful to or invade the privacy of transgender students and may also violate the Family Educational Rights and Privacy Act (FERPA).[26] A school may maintain records with this information, but such records should be kept confidential.

- **Disclosure of Personally Identifiable Information from Education Records**. FERPA generally prevents the nonconsensual disclosure of PII from a student's education records; one exception is that records may be disclosed to individual school personnel who have been determined to have a legitimate educational interest in the information.[27] Even when a student has disclosed the student's transgender status to some members of the school community, schools may not rely on this FERPA exception to disclose PII from education records to other school personnel who do not have a legitimate educational interest in the information. Inappropriately disclosing (or requiring students or their parents to disclose) PII from education records to the school community may

violate FERPA and interfere with transgender students' right under Title IX to be treated consistent with their gender identity.

- **Disclosure of Directory Information**. Under FERPA's implementing regulations, a school may disclose appropriately designated directory information from a student's education record if disclosure would not generally be considered harmful or an invasion of privacy.[28] Directory information may include a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance.[29] School officials may not designate students' sex, including transgender status, as directory information because doing so could be harmful or an invasion of privacy.[30] A school also must allow eligible students (*i.e.*, students who have reached 18 years of age or are attending a postsecondary institution) or parents, as appropriate, a reasonable amount of time to request that the school not disclose a student's directory information.[31]

- **Amendment or Correction of Education Records**. A school may receive requests to correct a student's education records to make them consistent with the student's gender identity. Updating a transgender student's education records to reflect the student's gender identity and new name will help protect privacy and ensure personnel consistently use appropriate names and pronouns.

  - Under FERPA, a school must consider the request of an eligible student or parent to amend information in the student's education records that is inaccurate, misleading, or in violation of the student's privacy rights.[32] If the school does not amend the record, it must inform the requestor of its decision and of the right to a hearing. If, after the hearing, the school does not amend the record, it must inform the requestor of the right to insert a statement in the record with the requestor's comments on the contested information, a statement that the requestor disagrees with the hearing decision, or both. That statement must be disclosed whenever the record to which the statement relates is disclosed.[33]
  - Under Title IX, a school must respond to a request to amend information related to a student's transgender status consistent with its general practices for amending other students' records.[34] If a student or parent complains about the school's handling of such a request, the school must promptly and equitably resolve the complaint under the school's Title IX grievance procedures.[35]

* * *

We appreciate the work that many schools, state agencies, and other organizations have undertaken to make educational programs and activities welcoming, safe, and inclusive for all students.

Sincerely,

/s/	/s/
Catherine E. Lhamon	Vanita Gupta
Assistant Secretary for Civil Rights	Principal Deputy Assistant Attorney General for Civil Rights
U.S. Department of Education	U.S. Department of Justice

[1] 20 U.S.C. §§ 1681–1688; 34 C.F.R. Pt. 106; 28 C.F.R. Pt. 54. In this letter, the term *schools* refers to recipients of Federal financial assistance at all educational levels, including school districts, colleges, and universities. An educational institution that is controlled by a religious organization is exempt from Title IX to the extent that compliance would not be consistent with the religious tenets of such organization. 20 U.S.C. § 1681(a)(3); 34 C.F.R. § 106.12(a).

[2] Office of Management and Budget, Final Bulletin for Agency Good Guidance Practices, 72 Fed. Reg. 3432 (Jan. 25, 2007), www.whitehouse.gov/sites/default/files/omb/fedreg/2007/012507_good_guidance.pdf.

[3] ED, *Examples of Policies and Emerging Practices for Supporting Transgender Students* (May 13, 2016), www.ed.gov/oese/oshs/emergingpractices.pdf. OCR also posts many of its resolution agreements in cases involving transgender students online at www.ed.gov/ocr/lgbt.html. While these agreements address fact-specific cases, and therefore do not state general policy, they identify examples of ways OCR and recipients have resolved some issues addressed in this guidance.

[4] 34 C.F.R. §§ 106.4, 106.31(a). For simplicity, this letter cites only to ED's Title IX regulations. DOJ has also promulgated Title IX regulations. *See* 28 C.F.R. Pt. 54. For purposes of how the Title IX regulations at issue in this guidance apply to transgender individuals, DOJ interprets its regulations similarly to ED. State and local rules cannot limit or override the requirements of Federal laws. *See* 34 C.F.R. § 106.6(b).

[5] *See, e.g., Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989); *Oncale v. Sundowner Offshore Servs. Inc.*, 523 U.S. 75, 79 (1998); *G.G. v. Gloucester Cnty. Sch. Bd.*, No. 15-2056, 2016 WL 1567467, at *8 (4th Cir. Apr. 19, 2016); *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011); *Smith v. City of Salem*, 378 F.3d 566, 572-75 (6th Cir. 2004); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000); *Schwenk v. Hartford*, 204 F.3d 1187, 1201–02 (9th Cir. 2000); *Schroer v. Billington*, 577 F. Supp. 2d 293, 306-08 (D.D.C. 2008); *Macy v. Dep't of Justice*, Appeal No. 012012082 (U.S. Equal Emp't Opportunity Comm'n Apr. 20, 2012). *See also* U.S. Dep't of Labor (USDOL), Training and Employment Guidance Letter No. 37-14, *Update on Complying with Nondiscrimination Requirements: Discrimination Based on Gender Identity, Gender Expression and Sex Stereotyping are Prohibited Forms of Sex Discrimination in the Workforce Development System* (2015), wdr.doleta.gov/directives/attach/TEGL/TEGL_37-14.pdf; USDOL, Job Corps, Directive: Job Corps Program Instruction Notice No. 14-31, *Ensuring Equal Access for Transgender Applicants and Students to the Job Corps Program* (May 1, 2015), https://supportservices.jobcorps.gov/Program%20Instruction%20Notices/pi_14_31.pdf; DOJ, Memorandum from the Attorney General, *Treatment of Transgender Employment Discrimination Claims Under Title VII of the Civil Rights Act of 1964* (2014), www.justice.gov/sites/default/files/opa/press-releases/attachments/2014/12/18/title_vii_memo.pdf; USDOL, Office of Federal Contract Compliance Programs, Directive 2014-02, *Gender Identity and Sex Discrimination* (2014), www.dol.gov/ofccp/regs/compliance/directives/dir2014_02.html.

[6] *See Lusardi v. Dep't of the Army*, Appeal No. 0120133395 at 9 (U.S. Equal Emp't Opportunity Comm'n Apr. 1, 2015) ("An agency may not condition access to facilities—or to other terms, conditions, or privileges of employment—on the completion of certain medical steps that the agency itself has unilaterally determined will somehow prove the bona fides of the individual's gender identity.").

[7] *See G.G.*, 2016 WL 1567467, at *1 n.1 (noting that medical authorities "do not permit sex reassignment surgery for persons who are under the legal age of majority").

[8] 34 C.F.R. § 106.31(b)(4); *see G.G.*, 2016 WL 1567467, at *8 & n.10 (affirming that individuals have legitimate and important privacy interests and noting that these interests do not inherently conflict with nondiscrimination principles); *Cruzan v. Special Sch. Dist. No. 1*, 294 F.3d 981, 984 (8th Cir. 2002) (rejecting claim that allowing a transgender woman "merely [to be] present in the women's faculty restroom" created a hostile environment); *Glenn*, 663 F.3d at 1321 (defendant's proffered justification that "other women might object to [the plaintiff]'s restroom use" was "wholly irrelevant"). *See also Palmore v. Sidoti*, 466 U.S. 429, 433 (1984) ("Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect."); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 448 (1985) (recognizing that "mere negative attitudes, or fear . . . are not permissible bases for" government action).

[9] *See, e.g.,* Resolution Agreement, *In re Downey Unified Sch. Dist., CA*, OCR Case No. 09-12-1095, (Oct. 8, 2014), www.ed.gov/documents/press-releases/downey-school-district-agreement.pdf (agreement to address harassment of transgender student, including allegations that peers continued to call her by her former name, shared pictures of her prior to her transition, and frequently asked questions about her anatomy and sexuality); Consent Decree, *Doe v. Anoka-Hennepin Sch. Dist. No. 11, MN* (D. Minn. Mar. 1, 2012), www.ed.gov/ocr/docs/investigations/05115901-d.pdf (consent decree to address sex-based harassment, including based on nonconformity with gender stereotypes); Resolution Agreement, *In re Tehachapi Unified Sch. Dist*., *CA*, OCR Case No. 09-11-1031 (June 30, 2011), www.ed.gov/ocr/docs/investigations/09111031-b.pdf (agreement to address sexual and gender-based harassment, including harassment based on nonconformity with gender stereotypes). *See also Lusardi,* Appeal No. 0120133395, at *15 ("Persistent failure to use the employee's correct name and pronoun may constitute unlawful, sex-based harassment if such conduct is either severe or pervasive enough to create a hostile work environment").

[10] *See, e.g.*, OCR, *Revised Sexual Harassment Guidance: Harassment of Students by School Employees, Other Students, or Third Parties* (2001), www.ed.gov/ocr/docs/shguide.pdf; OCR, *Dear Colleague Letter: Harassment and Bullying* (Oct. 26, 2010), www.ed.gov/ocr/letters/colleague-201010.pdf; OCR, *Dear Colleague Letter: Sexual Violence* (Apr. 4, 2011), www.ed.gov/ocr/letters/colleague-201104.pdf; OCR, *Questions and Answers on Title IX and Sexual Violence* (Apr. 29, 2014), www.ed.gov/ocr/docs/qa-201404-title-ix.pdf.

[11] *See, e.g.*, Resolution Agreement, *In re Cent. Piedmont Cmty. Coll.*, *NC*, OCR Case No. 11-14-2265 (Aug. 13, 2015), www.ed.gov/ocr/docs/investigations/more/11142265-b.pdf (agreement to use a transgender student's preferred name and gender and change the student's official record to reflect a name change).

[12] 34 C.F.R. §§ 106.32, 106.33, 106.34, 106.41(b).

[13] *See* 34 C.F.R. § 106.31.

[14] 34 C.F.R. § 106.33.

[15] *See, e.g.*, Resolution Agreement, *In re Township High Sch. Dist. 211, IL*, OCR Case No. 05-14-1055 (Dec. 2, 2015), www.ed.gov/ocr/docs/investigations/more/05141055-b.pdf (agreement to provide any student who requests additional privacy "access to a reasonable alternative, such as assignment of a student locker in near proximity to the office of a teacher or coach; use of another private area (such as a restroom stall) within the public area; use of a nearby private area (such as a single-use facility); or a separate schedule of use.").

[16] 34 C.F.R. § 106.41(b). Nothing in Title IX prohibits schools from offering coeducational athletic opportunities.

[17] 34 C.F.R. § 106.6(b), (c). An interscholastic athletic association is subject to Title IX if (1) the association receives Federal financial assistance or (2) its members are recipients of Federal financial assistance and have ceded controlling authority over portions of their athletic program to the association. Where an athletic association is covered by Title IX, a school's obligations regarding transgender athletes apply with equal force to the association.

[18] The National Collegiate Athletic Association (NCAA), for example, reported that in developing its policy for participation by transgender students in college athletics, it consulted with medical experts, athletics officials, affected students, and a consensus report entitled *On the Team: Equal Opportunity for Transgender Student Athletes* (2010) by Dr. Pat Griffin & Helen J. Carroll (*On the Team*), https://www.ncaa.org/sites/default/files/NCLR_TransStudentAthlete%2B(2).pdf. *See* NCAA Office of Inclusion, *NCAA Inclusion of Transgender Student-Athletes* 2, 30-31 (2011), https://www.ncaa.org/sites/default/files/Transgender_Handbook_2011_Final.pdf (citing *On the Team*). The *On the Team* report noted that policies that may be appropriate at the college level may "be unfair and too complicated for [the high school] level of competition." *On the Team* at 26. After engaging in similar processes, some state interscholastic athletics associations have adopted policies for participation by transgender students in high school athletics that they determined were age-appropriate.

[19] 34 C.F.R. § 106.34(a), (b). Schools may also separate students by sex in physical education classes during participation in contact sports. *Id*. § 106.34(a)(1).

[20] 20 U.S.C. § 1681(a)(1); 34 C.F.R. § 106.15(d); 34 C.F.R. § 106.34(c) (a recipient may offer a single-sex public nonvocational elementary and secondary school so long as it provides students of the excluded sex a "substantially

equal single-sex school or coeducational school").

[21] 20 U.S.C. § 1681(a)(6)(A); 34 C.F.R. § 106.14(a).

[22] 20 U.S.C. § 1686; 34 C.F.R. § 106.32.

[23] *See, e.g.,* Resolution Agreement, *In re Arcadia Unified. Sch. Dist*., *CA*, OCR Case No. 09-12-1020, DOJ Case No. 169-12C-70, (July 24, 2013), www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadiaagree.pdf (agreement to provide access to single-sex overnight events consistent with students' gender identity, but allowing students to request access to private facilities).

[24] *See* 34 C.F.R. §§ 106.31(a), 106.31(b)(4). *See also*, *In re Downey Unified Sch. Dist., CA*, *supra* n. 9; *In re Cent. Piedmont Cmty. Coll., NC, supra* n. 11.

[25] 34 C.F.R. § 106.31(b)(7).

[26] 20 U.S.C. § 1232g; 34 C.F.R. Part 99. FERPA is administered by ED's Family Policy Compliance Office (FPCO). Additional information about FERPA and FPCO is available at www.ed.gov/fpco.

[27] 20 U.S.C. § 1232g(b)(1)(A); 34 C.F.R. § 99.31(a)(1).

[28] 34 C.F.R. §§ 99.3, 99.31(a)(11), 99.37.

[29] 20 U.S.C. § 1232g(a)(5)(A); 34 C.F.R. § 99.3.

[30] Letter from FPCO to Institutions of Postsecondary Education 3 (Sept. 2009), www.ed.gov/policy/gen/guid/fpco/doc/censuslettertohighered091609.pdf.

[31] 20 U.S.C. § 1232g(a)(5)(B); 34 C.F.R. §§ 99.3. 99.37(a)(3).

[32] 34 C.F.R. § 99.20.

[33] 34 C.F.R. §§ 99.20-99.22.

[34] *See* 34 C.F.R. § 106.31(b)(4).

[35] 34 C.F.R. § 106.8(b).

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Transgender People and the Law [1]

Click on the dropdown menu below for the full FAQ.

1.

Question

Are there state and local laws that clearly prohibit discrimination against transgender people?

Answer

Yes. California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington, and the District of Columbia all have such laws. Their protections vary. For example, Nevada's law bans discrimination in employment, housing, and public accommodations like restaurants, hospitals, and retail stores; Maine's law covers those categories plus access to credit and education.

At least 200 cities and counties have banned gender identity discrimination, including Atlanta, Austin, Boise, Buffalo, Cincinnati, Dallas, El Paso, Indianapolis, Kansas City, Louisville, Milwaukee, New Orleans, New York City, Philadelphia, Phoenix, Pittsburgh, and San Antonio, as well as many smaller towns.

The governors of Indiana, Kentucky, Michigan, New York, and Pennsylvania have issued executive orders banning discrimination against transgender state workers. Some cities and counties have also protected their transgender public employees through local ordinances, charter provisions, or other means. People discriminated against by public entities on the basis of gender identity might also be able to argue that the government's action was unconstitutional.

2.

Question

Do laws banning sexual orientation discrimination protect transgender people?

Answer

In some cases, yes. If a law banning discrimination based on sexual orientation defines "sexual orientation" to include gender identity (as, for example, the ones in Colorado, Illinois, and Minnesota do), it protects transgender people as well as lesbian, gay, and bisexual people.

Also, most sexual orientation discrimination bans protect people not only based on their actual sexual orientation, but also on the basis of how people perceive them. This means that in most

places where sexual orientation discrimination is illegal, it's against the law to discriminate against a transgender person because of a belief that the victim is "gay"– even if that perception is wrong!

3.

Question

Do federal laws protect transgender people against housing and employment discrimination?

Answer

So far, Congress has been slow to pass laws that clearly protect people against discrimination based on gender identity. However, in recent years a series of court decisions and other developments have made more and more clear that federal laws against discrimination based on "sex" apply to discrimination based on gender identity.

Employment

Title VII of the 1964 Civil Rights Act prohibits discrimination on the basis of sex (among other characteristics) by an employer with 15 or more employees. Although there are some court decisions, mostly older ones, saying that Title VII does not prohibit gender identity discrimination, several federal appeals courts that have considered the issue recently have found some protections in the Civil Rights Act for transgender people. In addition, a federal district court in Washington, D.C. ruled that employment discrimination for transitioning from one gender to another is illegal sex discrimination under the Civil Rights Act. In 2014, U.S. Attorney General Eric Holder announced that his office agrees with this position and going forward the U.S. Department of Justice will consider discrimination against transgender people to be discrimination "because of sex" in violation of federal employment law.

Transgender people anywhere in the country who feel they have experienced employment discrimination can file complaints with the U.S. Equal Employment Opportunity Commission (EEOC). In a 2012 decision, the EEOC ruled that discriminating against someone because that person is transgender is discrimination based on sex, which violates Title VII. The EEOC investigates the reports of discrimination it receives, and can arrange mediation, broker a settlement between an employer and an employee, sue an employer, or give the person complaining permission to bring her own lawsuit.

Housing

Similarly, the U.S. Department of Housing and Urban Development (HUD) has stated that discrimination against transgender tenants or home buyers based on their gender identity or gender nonconformity may be illegal sex discrimination under the federal Fair Housing Act. More information is available here. [2]. HUD has also told homeless shelters around the country that where shelter housing is segregated by gender, they must allow transgender people access based on their gender identity. In addition, transgender people can't be discriminated against in shelters, or other programs for survivors of violence, that receive federal funding under the Violence Against Women Act.

4.

Question

Do state laws that bar sex or disability discrimination protect transgender people?

Answer

Some state courts and administrative agencies (such as in California, Connecticut, Hawaii, Massachusetts, New Jersey, New York, and Vermont) have ruled that their state sex discrimination laws cover discrimination against transgender people.

Federal laws that prohibit disability discrimination specifically exclude coverage for gender dysphoria, as do some state disability laws (e.g., Indiana, Iowa, Louisiana, Nebraska, Ohio, Oklahoma, Texas, Virginia). California, on the other hand, changed its disability law in 2000 to remove the exclusion and allow claims based on discrimination against someone for having gender dysphoria.

Courts or administrative agencies in a few states (e.g. Florida, Illinois, Massachusetts, New Hampshire, New Jersey, New York, and Washington) have ruled that state disability laws protect people against discrimination based on gender dysphoria.

5.

Question

Does the U.S. Constitution protect transgender people from discrimination?

Answer

Although the Supreme Court has never considered this question, we think the answer is yes. It's important to remember, however, that constitutional protections only cover discrimination or mistreatment by the government, not by private businesses or individuals.

A few federal courts have ruled that the Constitution's guarantee of equal protection under the law bars the government from discriminating against people based on their transgender status or gender transition. For example, a federal appeals court in 2011 ruled in favor of a transgender woman whose boss fired her from her state government job because he was uncomfortable with her gender transition. The court ruled that "discrimination against a transgender individual because of her gender nonconformity is sex discrimination, whether it's described as being on the basis of sex or gender." However, how courts view constitutional equality protections for transgender people is an area of the law that's still evolving.

At the ACLU, we believe that the First Amendment, which bars the government from censoring speech or expression, should also protect individuals' right to wear clothes or groom themselves in ways that express their personal sense of gender. There aren't a lot of court decisions on this yet, but we hope eventually to see courts rule that gender expression is protected by the First Amendment. We also believe that the rights to "liberty," "privacy," and "autonomy" courts have found to be protected under the Due Process Clause of the U.S. Constitution should extend to transgender people's ability to make decisions about self-expression, medical care, and more, but there isn't much law on that issue yet either.

State constitutions are also a source of protection against discrimination by state and local government, although some state constitutions provide exactly the same equality and liberty protections as the U.S. Constitution while others go farther.

6.

Question

Are there laws that specifically protect transgender students from harassment or discrimination?

Answer

More and more, schools are protecting transgender students from harassment or discrimination. Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maine, Maryland, Minnesota, New Jersey, New York, North Carolina, Oregon, Vermont, Washington, and the District of Columbia have state laws that specifically protect transgender students in public schools from harassment and/or discrimination. Some of these state laws explicitly apply to education, while other states (including Colorado, Delaware, Illinois, Maine, New Jersey, Nevada, Vermont, and Washington) include public schools in their bans on gender identity discrimination in public accommodations. In Colorado, Illinois, Maine, Nevada, New Jersey, and the District of Columbia, gender identity discrimination laws also cover some or all non-religious private schools. Several states also have more general laws that ban bullying and harassment of any sort but don't specifically mention gender identity. California passed a law in 2013 specifically allowing public school students access to gender-specific school activities (e.g., sports teams) and facilities (e.g., locker rooms) that match their gender identity, although we believe this was already required under prior California law. Several of the states where gender identity discrimination is prohibited in public schools (including Connecticut, Colorado, and Massachusetts) have issued rules or instructions explaining what schools must do to accommodate transgender students, in areas like updating educational records, accessing appropriate restrooms, and preventing bullying. Many individual school districts all over the country have also created policies to address these issues.

Title IX of the Education Amendment Acts of 1972 is the federal law that prohibits sex discrimination in educational programs that receive federal money. Title IX covers all public schools and universities, and some private ones. It has been interpreted to ban discrimination based on gender nonconformity, including a school's failure to protect a student from gender-related harassment. This means that Title IX should protect transgender students from harassment and discrimination based on gender identity. The U.S. Department of Education's Office of Civil Rights, which enforces Title IX, agrees, although the issue has not been fully resolved in court yet. Title IX also requires schools to respond appropriately to reports of sexual harassment or sexual violence against any student, including transgender students. A student who believes their rights under Title IX have been violated can file a complaint with the Office of Civil Rights [3].

7.

Question

Are there laws that protect transgender students' right to participate in high school and college sports?

Answer

Nondiscrimination laws that cover gender identity should protect student athletes who want to participate in gender-segregated sports consistent with their gender identity.

Several states' education agencies or school sports associations have adopted policies on this issue. For example, California, Connecticut, and Washington allow transgender students to participate in sports consistent with their gender identity regardless of the sex they were assigned at birth. A few states have more complicated procedures for deciding a student's eligibility for gender-specific school activities, including sports, by evaluating things like the students' school records, their medical history, and the "advantages of their participation." Several states have no clear policy on this issue, leaving school districts to establish their own policies to determine which team a transgender athlete will compete on and which locker room they will use.

The National Collegiate Athletic Association, which oversees competitive sports at over 1,000 colleges and universities, allows transgender students to participate in sex-segregated sports consistent with their gender identity as long as they're receiving hormone therapy. Under NCAA rules, a transgender woman must take testosterone suppression medication for at least a year before competing on a female team. For various reasons, this type of policy works better at the college level than it would in a K-12 school context.

8.

Question

Does the law protect a transgender person's right to use the restroom consistent with their gender identity?

Answer

There's no clear answer here because very few courts have considered this question and the results have been mixed. In two recent positive decisions, an administrative agency in Colorado in 2013 and the Maine Supreme Court in 2014 both ruled that under those states' gender identity discrimination laws, transgender girls had the right to use girls' restrooms at their public schools. On the other hand, a 2001 Minnesota Supreme Court decision found that even a law prohibiting gender identity discrimination didn't necessarily protect a transgender woman's right to use the women's restroom at work. And a federal appeals court in 2007 upheld the Utah Transit Authority's decision to fire a transgender bus driver, based on a claim that her employer could be sued for her use of women's public restrooms along her bus route. In a non-workplace context, a New York appeals court ruled in 2005 that it wasn't sex discrimination for a building owner to prevent transgender people from using gender identity-appropriate restrooms in a building where several businesses shared restrooms.

Authorities in some jurisdictions (e.g., Colorado, Iowa, Oregon, Washington State, San Francisco, New York City, and the District of Columbia), however, have specifically said that denying transgender people the right to use a gender identity-appropriate restroom violates their nondiscrimination laws. Some jurisdictions (e.g., Iowa, San Francisco, and D.C.) go farther and make clear that transgender people can't be required to prove their gender to gain access to a public restroom, unless everyone has to show ID to use that restroom. Other jurisdictions (e.g., Chicago) continue to allow businesses to decide whether a transgender patron may access men's or women's restrooms based on the gender on their ID, which may or may not reflect accurately the person's gender identity.

Many businesses, universities, and other public places are installing single stall, gender-neutral restrooms, which alleviate many of the difficulties that transgender people experience when seeking safe restroom access. Some cities (such as Austin, Philadelphia, Washington, D.C., and West

Hollywood) have local laws that require single-stall public restrooms to be labeled as unisex. While this is often a useful step towards addressing the concerns of transgender people and others, the ACLU believes that transgender people should have the right to use restrooms that match their gender identity rather than being restricted to only using gender-neutral ones.

9.

Question

Can a person change their name to reflect their gender identity?

Answer

Yes. In some states, through what is called "common law name change," people may change their name simply by using the new name in everyday interactions. This is free and easy, and can protect the individual from later claims that using the preferred name constituted "fraud," but doesn't create the kind of solid paper trail needed to change identity documents.

The other way to change one's name is to file a petition in court. Most judges will grant a name change as long as they're convinced that the petitioner is not trying to evade debts or the police. A number of states require anyone who wants to change their name to publish a legal notice of the change in a local newspaper. Name changes are often harder to obtain for people with past criminal convictions. In rare cases, judges have required a transgender person seeking a name change to prove that they had undergone medical procedures that show they intend to live permanently in the gender associated with the new name, but in most states this isn't required.

10.

Question

Can a transgender person get the name and gender marker changed on their driver's license or state ID card?

Answer

Yes. Every state has some kind of procedure for people to make these changes. A court ordered name change is usually necessary to change the name on a driver's license.

Requirements for changing the gender marker on a driver's license vary widely from state to state, but a majority of states don't require proof of gender confirmation surgery. Many states do require the applicant to submit a form or affidavit signed by their health care provider confirming their gender identity. A few states still require proof of surgery and/ or a court order to change the gender marker on a driver's license. Check with your state's motor vehicle agency to find out the exact procedure in your state.

11.

Question

Can a person get the name and gender marker changed on their birth certificate?

Answer

A court ordered name change is usually necessary to change the name on one's birth certificate.

In a majority of states, changing the gender marker on one's birth certificate requires proof of surgical treatment to change one's sex. What the law means by "surgical treatment" is often unclear. A growing number of states (e.g. California, New York, Oregon, Vermont, Washington, and the District of Columbia) allow an individual to change the gender marker on their birth certificate by showing proof of appropriate clinical treatment, which is not necessarily surgery.

Some states (e.g., Alabama) will only issue an "amended" birth certificate showing the name and gender marker changes. Other states (e.g., Idaho, Ohio, and Tennessee) simply do not allow gender markers to be changed on birth certificates at all.

12.

Question

Does changing the gender marker on a birth certificate legally change one's sex?

Answer

Although changing the gender marker on one's birth certificate should put to rest all questions about one's legal gender, there have been cases, usually involving marriages, where courts have ignored the corrected birth certificate. For example, when only different-sex marriage was allowed, courts in Kansas and Texas considered only the birth-assigned sex when ruling on a person's sex for the purpose of deciding whether their marriage was valid. These courts ignored the fact that the transgender people in these cases had corrected birth certificates from the other states in which they were born. Similarly, in an Illinois case, a court looked past a transgender man's reissued birth certificate, which had a male gender marker, and ruled that he should be considered female for purposes of state marriage law because there were other surgeries he hadn't undergone that would in the court's view "complete" his transition.

In contrast, a court in New Jersey recognized a transgender woman's gender identity, which was also reflected on her birth certificate, when deciding whether her marriage to a man was valid. Additionally, before the federal government began recognizing the marriages of "same-sex" couples, the Board of Immigration Appeals approved a visa based on marriage to a man for a transgender woman whose North Carolina birth certificate had a female gender marker.

Some people get a court order declaring a legal change of gender for added protection. (To save time and money, some advocates recommend doing this at the same time one requests a court ordered name change.) The good thing about a court order is that, unlike a birth certificate or other identity document, courts and agencies in other states are supposed to follow it. There is still no guarantee, however, that such a court order will cause other institutions and courts to view one's sex as legally changed.

13.

Question

Can a person change the name and gender on their passport?

Answer

Yes. A copy of the court order confirming the name change is required to change the name on one's passport. To change the gender on a passport, or to get a first passport with the correct gender marker, a transgender applicant must submit a letter from their doctor certifying that they have undergone "appropriate clinical treatment" for transition to the new gender. (This "appropriate clinical treatment" doesn't have to include surgery.) This letter can be used to obtain a new passport valid for 10 years. There is also a two-year passport available for applicants who present a letter stating that their clinical transition is "in process," but any transgender person who has begun treatment should be able to qualify for a full 10-year passport. Along with the physician letter, the applicant must submit the other parts of a standard passport application,. Detailed instructions for updating the name and gender on a passport are available from the U.S. Department of State [4].

14.

Question

Can a person change their name and gender marker with the Social Security Administration?

Answer

Yes. To change their name with the Social Security Administration (SSA) and get a new Social Security card, a person needs to submit a court order reflecting the name change. To change the gender marker in SSA's records, one can submit any of the following: a passport or state-issued birth certificate with the new gender marker, a court order of gender change, or a doctor's letter identical to that required for changing a passport gender marker (see previous).

15.

Question

Is it beneficial to change one's name and gender with the Social Security Administration?

Answer

Yes. Having an SSA record of one's gender that is consistent with the gender marker on other identity documents could help avoid problems such as when someone checks for a match between a person's SSA records and other identification. For example, many state agencies that issue driver's licenses will only do so if the information used on a driver's license application matches the person's SSA record.

16.

Question

Does gender transition affect the validity of one's marriage?

Answer

Generally, no. A marriage is valid unless and until one or both spouses get a divorce or annulment.

In the past, courts considering the validity of transgender people's post-transition marriages to people of a different gender have reached mixed results. Although it's still possible that an ex-spouse would try to contest the validity of a marriage entered into in a state that didn't at the time recognize the marriages of "same-sex couples," this issue is likely to come up less frequently as more and more jurisdictions recognize marriages regardless of gender.

To help protect against any potential legal problems, we recommend crafting a written relationship agreement that sets out each spouse's rights and responsibilities with respect to property, finances, health, and children. Furthermore, both spouses should have a last will and testament and assign one another durable powers of attorney for financial and medical decisions. Transgender parents with no biological or adoptive tie to their children should adopt the children through a second parent adoption to better protect their parental rights. Information on second parent adoption and other issues for transgender parents can be found in "Protecting the Rights of Transgender Parents and their Children: A Guide for Parents and Lawyers," [5] a joint publication of the ACLU and the National Center for Transgender Equality.

17.

Question

Does being transgender affect parental rights?

Answer

Sometimes.

Many parents who come out as transgender are able to maintain a close relationship with their children, including some who divorce but work out an amicable custody arrangement with their ex-spouse.

But other people who transition after having children may see their gender transition used against them by an ex-spouse in child custody fights. There is little custody case law concerning transgender parents and what exists is mixed. In some cases, transgender parents have fared well, with courts appropriately rejecting claims that transgender people can't be good parents and fairly considering what would be in the best interest of the child (e.g., looking at the nature of the child's relationship with each parent and each parent's ability to provide for the child's physical, emotional, and educational needs). In other cases, parents have been denied custody or visitation solely based on the court's conclusion that being in the care of a transgender parent would be harmful to the child. In some of these cases, the courts improperly based their decisions on imagined harm, rather than evidence. In others, the transgender parent didn't (perhaps for financial reasons) present testimony from expert witnesses such as psychologists, and the courts relied on the other side's experts' negative characterization of transgender parents. It is very important in any contested child custody case to submit evidence disproving the negative claims the other side may make about transgender parents. Again, more information is available here [6].

There have also been cases where the child's gender nonconforming or transgender identity became an issue in a custody battle. This usually happens when one parent accepts and supports the child's gender identity, but the other parent doesn't and argues that affirming the child's gender identity is harming the child. Here, too, refuting negative claims about the consequences of affirming a child's gender identity, preferably with expert testimony, is very important.

18.

Question

Do any government health care programs cover gender confirmation surgery or other transition-related medical treatment?

Answer

Medicare covers transition-related hormone therapy. A 2014 administrative ruling struck down the previous blanket Medicare policy of refusing coverage for any form of gender-confirmation surgery, though we're still working to clarify which specific procedures Medicare will cover. Also, many transgender people have had difficulty finding surgeons who are willing to perform gender confirmation surgeries at Medicare's low reimbursement rates.

Historically, Medicaid programs have denied coverage for transition-related treatment. However, this is beginning to change, as several states (e.g., California, Maryland, Massachusetts, New York, Oregon, and Vermont) have updated their Medicaid rules to provide hormone therapy for gender dysphoria, hormone blockers for transgender adolescents, and/or gender-confirmation surgeries.

19.

Question

Does private health insurance cover gender confirmation surgery or other transition-related medical treatment?

Answer

This partly depends on what the employer's or insured individual's contract with the health insurance company says. Many insurance contracts either definitely exclude transitionrelated services or are unclear about whether such services are covered. Some transgender people have successfully forced insurance companies to pay for transition-related surgery or other treatments when the contract didn't clearly exclude this coverage.

In several states (e.g., California, Colorado, Illinois, Massachusetts, New York, Oregon, Vermont, Washington State, and the District of Columbia), the state government has said that state laws against gender identity discrimination and/or discrimination based on medical diagnosis mean that insurance policies issued in those states must cover transition-related treatments if they cover the same treatment for other medical conditions. This has helped many transgender people living in those states to get coverage for gender confirmation surgeries.

As awareness grows that treatment for gender dysphoria is medically necessary for many transgender people and the cost of covering it is manageable, more employers are offering health insurance plans that cover transition-related medical treatment. Hundreds of employers are now offering health insurance plans that cover transition-related medical treatment, from Fortune 500 corporations to smaller firms and nonprofits. More and more government entities also cover transition-related care through their employee health plans. Some employers have set up programs to pay for transition- related health care not covered by their health insurance plans, although this approach may pose privacy risks. Additionally, many public and private universities now cover of transition-related medical treatment for students.

We are still working to ensure that health insurance obtained through federal and state exchanges under the Affordable Care Act will cover all medically necessary treatment for transgender people.

20.

Question

What does the law say about insurance companies denying coverage for routine medical treatments because someone is transgender?

Answer

Sometimes insurance companies refuse any coverage once they find out that the policy holder has been diagnosed with gender dysphoria. This is happening less often, in part because it would be improper denial of coverage based on a preexisting condition under the federal Affordable Care Act.

Another issue arises when insurance companies ask people to state their gender and then limit coverage to treatment that the insurer thinks matches that gender (aka “gender congruent” care). This obviously causes problems for transgender people who need screenings or treatment the insurer sees as inconsistent with their gender (e.g., Pap smears for a transgender man). Although some transgender people have tried to avoid this problem by leaving their “old” gender marker on medical records, that approach can also make it harder to receive appropriate care and respect in health care settings. Sometimes, transgender people and their health care providers have been able to fix these problems by simply explaining the situation to an insurer and getting a human to override a computer-based denial.

The ACLU believes that state laws against insurance discrimination based on gender identity and/or sex, as well as nondiscrimination provisions in the federal Affordable Care Act, generally ban denial of coverage for “gender incongruent” health care. There have been few court decisions on this so far.

21.

Question

Are there laws that prohibit hate or bias crimes against transgender people?

Answer

Yes. Since 2009, the federal hate crimes law has covered gender identity, which means that the federal government assists local law enforcement in investigating and prosecuting crimes where the victim was targeted because of their gender identity, and people who commit such crimes may be subject to tougher penalties. Similarly, more than a dozen states have hate crime laws that clearly protect transgender people. In several states, transgender people are also sometimes protected when hate crime laws cover perceived sexual orientation, or under laws covering hate crimes based on “sex.”

22.

Question

Is crossdressing against the law?

Answer

In general, no. Bans on crossdressing have been successfully challenged and many cities have taken steps in recent years to remove even unenforced laws banning crossdressing from their books. However, a few localities around the nation still have such laws in place. Anyone ticketed or arrested under a crossdressing law should think about fighting back in court, because there's a good chance that the law will be ruled unconstitutional.

23.

Question

Can a transgender person run into legal trouble for using a restroom that is consistent with their gender identity?

Answer

It rarely comes up, but in places without strong antidiscrimination protections, transgender people can sometimes face criminal penalties for using a restroom that is consistent with their gender identity. In Dallas, for example, a transgender woman was ticketed for disorderly conduct in 2012 for using the women's restroom at a hospital. An Idaho transgender woman in 2013 was informed by the police that she was unwelcome for the next year at a local supermarket, because she had used the women's restroom there. In contrast, a discrimination complaint filed by a transgender woman who was arrested in a train station for using the women's restroom ultimately resulted in a 2006 settlement securing a more inclusive policy on restroom use in New York's Metropolitan Transit Authority system.

24.

Question

Can a person be stopped and/or interrogated by the police based solely on their gender identity or gender expression?

Answer

This shouldn't happen but has often been a problem. Police often target for suspicion anyone who looks "different" or does not conform to their expectations, which can include visibly transgender people. Transgender women of color, in particular, have often faced extra scrutiny from law enforcement officers who assume that they must be engaging in sex work. Fortunately, in recent years law enforcement officials have begun to acknowledge that such practices are unfair and do not help prevent crime. In 2014, the U.S. Department of Justice advised federal law enforcement agencies, including the FBI and ICE, that they may not profile or target individuals based on their gender identity. Several local police departments have also adopted policies that prohibit profiling of transgender people and/or that instruct officers on things they should do to treat transgender people respectfully, such as using preferred names and pronouns. Examples include Atlanta, Boston, Chicago, New York City, and Washington, D.C.

25.

Question

Do transgender people have the right to be searched by someone of the same gender identity?

Answer

It depends on the type of search and where it is taking place. If police stop someone on the street for questioning and do a quick "frisk" or "pat-down" without arresting the person, that person does not have a legal right to ask that a different officer perform the pat-down. However, if a transgender person has been arrested and/or taken to jail and is being strip-searched, they sometimes do have the right to request a search by an officer of the same gender, depending on state laws, local policies, and whether any sort of "emergency" exists. It is important for people in police custody to stay calm while making such a request and to bear in mind that arranging for an officer of the same gender to do the search may cause the arrest and booking process to take longer.

26.

Question

Are prison officials required to place a transgender inmate in the facility that matches the inmate's gender identity?

Answer

When considering this question, most courts have supported prison officials' decisions about where prisoners should be housed. Most prisons still categorically house transgender women (particularly those who haven't had genital surgery) in male facilities, and transgender men in female facilities. Nevertheless, a growing number of systems are developing more nuanced and respectful housing policies, in part because they fear being held liable in court if they fail to protect transgender inmates from rape and other forms of abuse.

The federal Department of Justice has enacted regulations pursuant to the Prison Rape Elimination Act (PREA) that require determination of appropriate housing for transgender inmates on a case-by-case basis, taking into account factors like personal preference and safety needs, not solely based on their genitals. These regulations also limit the use of "protective custody" (which has sometimes resulted in severe isolation and torture-like experiences for transgender inmates), restrict the use of segregated and potentially stigmatizing LGBTI units, require training for staff on communication with and treatment of transgender inmates, require improved avenues for reporting abuse and ban genital searches of transgender inmates just to determine their gender. These regulations currently apply to all correctional facilities that receive federal funding, including most state prisons and local jails, although some jurisdictions have publicly acknowledged that they are not complying with the PREA regulations.

27. Notes on Words and Phrases Used

Question

Do transgender prisoners have a right to get transition-related health care?

Answer

The Eighth Amendment to the Constitution prohibits cruel and unusual punishment, which courts have said includes "deliberate indifference" to a prisoner's medical needs. Using this argument, some prisoners have been able to persuade judges to order prison officials to provide hormone therapy and/or evaluate them for surgery. In 2011, a federal appeals court upheld a ruling striking down as unconstitutional a Wisconsin state law that banned hormone therapy and gender confirmation surgery for transgender inmates.

Under a policy enacted in 2011, transgender people detained in federal prisons, federal jails, federal halfway houses, and private prisons that contract with the U.S. Bureau of Prisons have the right to receive an evaluation for gender dysphoria, and gender-confirming medical treatment if the evaluation shows they need it. This is true whether or not a prisoner was prescribed hormone therapy before entering federal custody. Many state prison systems and some local jails now have similar policies. In practice, however, even prisoners in systems with good policies on the books often encounter numerous obstacles to getting the health care they need.

More information can be found in "Know Your Rights - Laws, Court Decisions, and Advocacy Tips to Protect Transgender Prisoners," [7] a joint publication of the ACLU and the National Center for Lesbian Rights.

28.

Question

May a transgender immigrant be granted asylum in the United States because of antitransgender harassment in their country of origin?

Answer

Yes. Transgender immigrants are sometimes granted asylum because they've been persecuted at home for not conforming to cultural expectations about gender roles. While many immigration courts have confused sexual orientation with gender identity, it's clear that transgender people are in many countries a persecuted group, and thus entitled to protection under U.S. asylum laws.

A transgender person, however, must do more than show that he or she is transgender and was persecuted because of it in order to get asylum. The individual also has to prove either that the government persecuted him or her or refused to do anything to stop the abuse.

29. Notes on Words and Phrases Used

When talking about transgender people, we sometimes use words that are unfamiliar or mean different things to different people. Here's what we mean by these terms:

Gender Identity

Gender identity is a person's internal sense of being a man or a woman (or both or neither).

Gender Expression

The way a person reveals their gender identity to the rest of the world is gender expression. A person's clothing, mannerisms, voice, hairstyle, etc. can all be a part of the person's gender expression.

Transgender

Transgender is frequently used to describe a broad range of identities and experiences that fall outside of the traditional understanding of gender. Some of those identities and experiences include people whose gender identity is different from the sex they were assigned at birth, people who transition from living as one gender to another or wish to do so (often described by the clinical term "transsexual"), people who "cross-dress" part of the time, and people who identify outside the traditional gender binary (meaning they identify as something other than male or female). Some transgender people describe themselves as gender variant or gender nonconforming.

Not everyone who doesn't conform to gender stereotypes, however, identifies as transgender. Many people don't conform to gender stereotypes but also continue to identify with the gender assigned to them at birth, like butch women or femme men.

(Gender) Transition

Transition or gender transition describes the social and sometimes medical process a transgender person goes through to bring their lived experience into line with their gender identity. Steps in the transition process can include changing the name and pronouns one goes by, updating formal documents to reflect a different gender marker and name from the ones assigned at birth, changing one's style of dress and other aspects of gender expression, and, in some but not all cases, pursuing medical treatments such as hormone therapy and/ or gender confirmation surgery that help make one's body look and feel more feminine or more masculine.

Some transgender people don't feel that the concept of transition fits their experience, either because they feel they were always transgender and "transition" steps aren't necessary to validate their true identity, and/or because they identify as neither male nor female and feel that transition doesn't accurately describe their process of coming out as agender, bigender, gender fluid, or another nonbinary identity.

Gender Dysphoria (Formerly Known as "Gender Identity Disorder")

"Gender Identity Disorder" was for many years the medical diagnosis given to people who experience a disconnect between the sex they were assigned at birth and their gender identity.

However, the American Psychiatric Association replaced the term "Gender Identity Disorder" with "Gender Dysphoria" in the 2013 5th edition of its widely used Diagnostic and Statistical Manual. This change was made in part because labeling a disconnect between one's gender identity and one's body a "disorder" stigmatizes transgender people. The criteria for diagnosing this condition have also been updated to clarify that gender nonconformity is not a mental illness, although some transgender people suffer negative mental health consequences from the disconnect between their bodies and identities and/or as a result of widespread discrimination and stereotyping.

Gender Confirmation Surgery

This term can refer to any of the surgical procedures that may be part of gender transition. Depending on a person's specific needs, gender confirmation surgery might involve several different types of genital reconstruction procedures, breast augmentation or reduction, removal of the uterus and ovaries (for transgender men) or the testes (for transgender women), and/or surgery to change the shape of the face and throat.

This term works better than the commonly used phrase "sex reassignment surgery" because that wording suggests that all transgender people need surgery to "reassign" their sex before their gender

identity can be respected, when in fact individual needs vary and not all transgender people need, want, or are able to access surgery. In addition, people and courts have often used the term "sex reassignment surgery" erroneously thinking that it refers to one specific genital surgery that completes a person's gender transition or "sex reassignment."

Public Accommodations

A public accommodation is an establishment that makes its premises, goods, and/or services available to the public. It may be publicly or privately owned. Legal definitions of public accommodations vary from state to state, but typical examples include restaurants, retail stores, hotels, places of entertainment like sports arenas or movie theaters, hospitals and medical offices, public parks, and public transportation. A private club is NOT a public accommodation, nor is a church.

If you feel you've been discriminated against on the basis of your gender identity or sexual orientation, we may be able to help. You can click here [8] to fill out our confidential online form.

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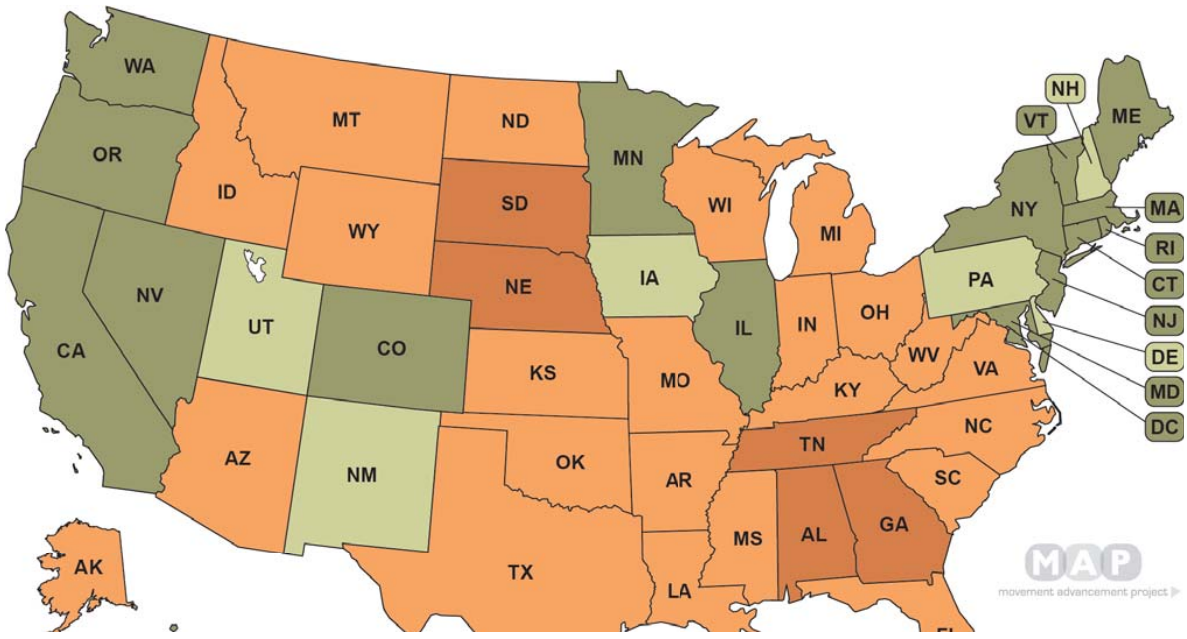
Source URL: https://www.aclu.org/know-your-rights/transgender-people-and-law

Links
[1] https://www.aclu.org/know-your-rights/transgender-people-and-law
[2] http://1.usa.gov/Ly5HTl
[3] http://1.usa.gov/1KdPjU3
[4] http://1.usa.gov/1aK739D
[5] http://www.aclu.org/transgender-parent-guide
[6] https://www.aclu.org/transgender-parent-guide
[7] http://www.aclu.org/transprisonrights
[8] https://action.aclu.org/secure/report-lgbthiv-discrimination

EQUALITY MAPS

OVERALL POLICY TALLY | SEXUAL ORIENTATION | GENDER IDENTITY | STATE DATA TABLE



Roth Decl. Ex. W

High Overall Policy Tally *(16 states + D.C.)*

Medium Overall Policy Tally *(6 states)*

Low Overall Policy Tally *(23 states)*

Negative Overall Policy Tally *(5 states)*

Percent of LGBT Population Covered by Laws

45%

45 % of the LGBT population lives in states with high overall policy tallies

7%

7 % of LGBT population lives in states with medium overall policy tallies

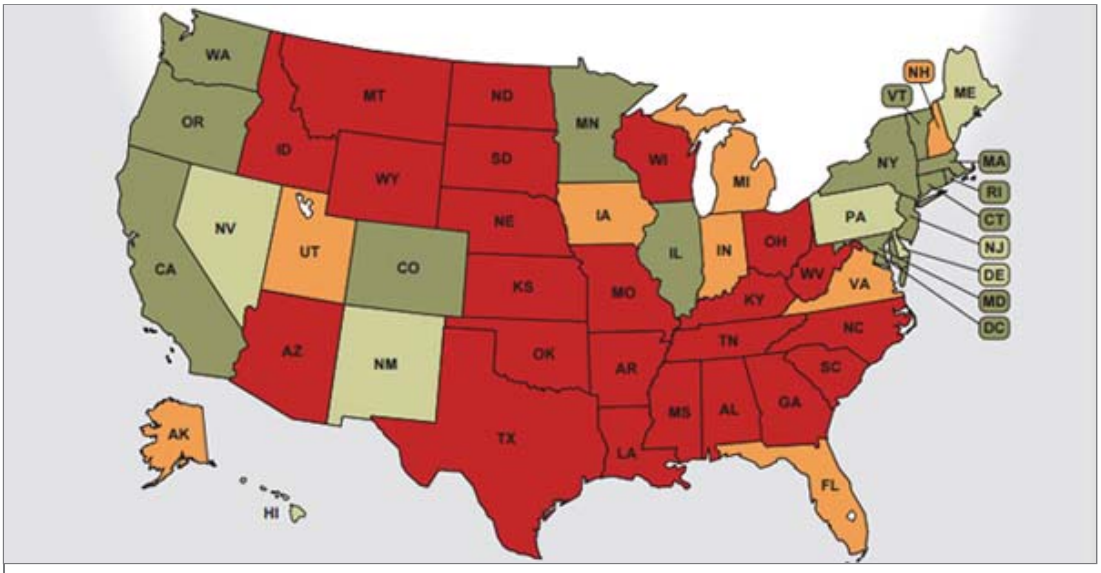
42%

42 % of LGBT population lives in states with low overall policy tallies

7%

7 % of LGBT population lives in states with negative overall policy tallies

RELATED RESOURCES

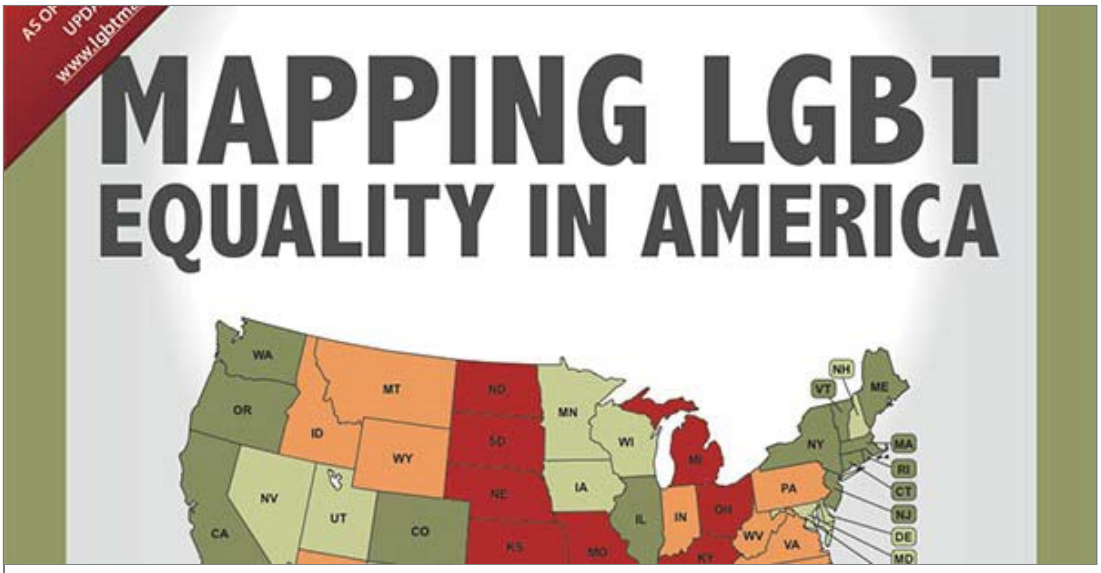


REPORT

MAPPING TRANSGENDER EQUALITY IN THE UNITED STATES

(/mapping-trans-equality)

To help make sense of the current policy landscape in the states, this report looks at legal equality for transgender people across the country. The gender identity tally is comprised of 25 state laws and policies in five key categories: Non-Discrimination, LGBT Youth, Health and Safety, Ability to Correct the Name and Gender Marker on Identity Documents, and Adoption and Parenting.



REPORT

REPORT

MAPPING LGBT EQUALITY IN AMERICA

(/file/Mapping%20Equality%20for%20LGBT%20Americans%20Post%20SCOTUS.pdf)

Mapping LGBT Equality in America (/file/Mapping%20Equality%20for%20LGBT%20Americans%20Post%20SCOTUS.pdf) sets out to identify and explain the key gaps in legal equality for LGBT Americans by introducing the major state and local laws and policies that protect or harm LGBT people, providing a breakdown of those laws and policies by state, and showing how protections for LGBT Americans vary based on sexual orientation and gender identity and expression.

STATE POLICY TALLIES

(/equality-maps/legal_equality_by_state)

Policy Tallies provide an overview of laws and polices that exist in each state. The major categories of laws covered by the policy tally include: Marriage and Relationship Recognition, Adoption and Parenting, Non-Discrimination, Safe Schools, Health and Safety, and the Ability for Transgender People to Correct the Gender Marker on Identity Documents.

Table: Cutoffs for Each Tally

	Sexual Orientation Tally	Gender Identity Tally	Total Tally
High	11 to 19	8 to 15	19 to 34
Medium			

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SIGN UP!

Roth Decl. Ex. W

WIKIPEDIA

Transgender rights in the United States

Transgender rights in the United States vary considerably by jurisdiction.

Transgender Pride Flag map of the Contiguous United States

Birth certificates are typically issued by the Vital Records Office of the state (or equivalent territory, or capital district) where the birth occurred, and thus the listing of biological sex as male, female or otherwise on the birth certificate (and whether or not this can be changed later) is regulated by state (or equivalent) law. However, federal law regulates sex as listed on a Consular Report of Birth Abroad, and other federal documents that list sex or name, such as the U.S. passport. Laws concerning name changes in U.S. jurisdictions are also a complex mix of federal and state rules. States vary in the extent to which they recognize transgender people's gender identities, often depending on the steps the person has taken in their transition (including psychological therapy, hormone therapy), with some states making sex reassignment surgery a pre-requisite of recognition.

The federal government does not have laws specifically protecting transgender people from discrimination in employment, housing, healthcare, and adoption, but some lawsuits argue that the Equal Protection Clause of the federal constitution or federal laws prohibiting discrimination based on gender should be interpreted to include transgender people and discrimination based on gender identity. U.S. President Barack Obama issued an executive order prohibiting discrimination against transgender people in employment by the federal government and its contractors.[1] In 2016, the Departments of Education and Justice issued a letter to schools receiving federal funding that interpreted Title IX protection to apply to gender identity and transgender students, advising schools to use a student's preferred name and pronouns and to allow use of bathrooms and locker rooms of the student's gender identity.[2] Recognition and protection against discrimination is provided by some state and local jurisdictions to varying degrees.

The Supreme Court decision in *Obergefell v. Hodges* established that equal protection requires all jurisdictions to recognize same-sex marriages, giving transgender people the right to marry regardless of whether their partners are legally considered to be same-sex or opposite-sex. The Matthew Shepard and James Byrd Jr. Hate Crimes Prevention Act added gender identity to the federal definition of a hate crime, but only some states and territories include gender identity in their hate crime laws.

Non-binary or genderqueer people may seek legal recognition of a gender identity other than that indicated by their birth sex; in 2016, Oregon became the first state to legally recognize non-binary people.[3] When a person's gender is not officially recognized, they may seek associated changes, such as to their legal name, including on their birth certificate.

Contents

Marriage

In *Obergefell v. Hodges*, the Supreme Court of the United States ruled that people have a right to marry without regard to gender. While this is commonly understood as a ruling allowing same-sex marriage, it also meant that a person's sex, whether assigned at birth or recognized following transitioning, can not be used to determine their eligibility to marry. Prior to this ruling, the right of transgender people to marry was often subject to legal challenge — as was the status of their marriages after transitioning, particularly in cases where an individual's birth sex was interpreted to mean a same-sex marriage had taken place.[4]

Cases

In 1959, Christine Jorgensen, a trans woman, was denied a marriage license by a clerk in New York City, on the basis that her birth certificate listed her as male;[5][6] Jorgensen did not pursue the matter in court. Later that same year, Charlotte McLeod, another trans female who underwent gender reassignment surgery, married her husband Ralph H. Heidel in Miami. She did not mention her birth gender, however, or the fact she was still legally a male. The first case in the United States which found that post-operative trans people could marry in their post-operative sex was the New Jersey case *M.T. v J.T., (1976)*. Here the court expressly considered the English *Corbett v. Corbett* decision, but rejected its reasoning.

In *Littleton v. Prange, (1999)*,[7] Christie Lee Littleton, a post-operative trans woman, argued to the Texas 4th Court of Appeals that her marriage to her genetically male husband (deceased) was legally binding and hence she was entitled to his estate. The court decided that plaintiff's gender is equal to her chromosomes, which were XY (male). The court subsequently invalidated her revision to her birth certificate, as well as her Kentucky marriage license, ruling "We hold, as

a matter of law, that Christie Littleton is a male. As a male, Christie cannot be married to another male. Her marriage to Jonathon was invalid, and she cannot bring a cause of action as his surviving spouse." She appealed to the Supreme Court of the United States but it denied certiorari in 2000.[4]

The Kansas Appellate Court ruling in *In re Estate of Gardiner* (2001)[8] considered and rejected *Littleton*, preferring *M.T. v. J.T.* instead. In this case, the Kansas Appellate Court concluded that "[A] trial court must consider and decide whether an individual was male or female at the time the individual's marriage license was issued and the individual was married, not simply what the individual's chromosomes were or were not at the moment of birth. The court may use chromosome makeup as one factor, but not the exclusive factor, in arriving at a decision. Aside from chromosomes, we adopt the criteria set forth by Professor Greenberg. On remand, the trial court is directed to consider factors in addition to chromosome makeup, including: gonadal sex, internal morphologic sex, external morphologic sex, hormonal sex, phenotypic sex, assigned sex and gender of rearing, and sexual identity." In 2002, the Kansas Supreme Court reversed the Appellate court decision in part, following *Littleton*.[9]

The custody case of Michael Kantaras made national news.[10] Kantaras met another woman and filed for divorce in 1998, requesting primary custody of the children. Though he won that case in 2002, it was reversed on appeal in 2004 by the Florida Second District Court of Appeal,[11] upholding Forsythe's claim that the marriage was null and void because her ex-husband was still a woman and same-sex marriages were illegal in Florida.[12] Review was denied by the Florida Supreme Court.[13]

In *re Jose Mauricio LOVO-Lara (2005)*,[14] the Board of Immigration Appeals ruled that for purposes of an immigration visa, "A marriage between a postoperative transsexual and a person of the opposite sex may be the basis for benefits under ..., where the State in which the marriage occurred recognizes the change in sex of the postoperative transsexual and considers the marriage a valid heterosexual marriage."[14]

In *Fields v. Smith* (2006), three transgender women filed a lawsuit against this state of Wisconsin for passing a law banning hormone treatment or sex reassignment surgery for inmates. The courts of appeal struck down the law issuing that transgender people have a right to medical access in prison.[15]

Parental rights

There is little consistency across courts in the treatment of transgender parent in child custody and visitation cases. In some cases, a parent's transgender status is not weighed in a court decision; in others, rulings are made on the basis of a transgender person being presumed to be an inherently unfit parent.

Courts are generally allowed to base custody or visitation rulings only on factors that directly affect the best interests of the child. According to this principle, if a transgender parent's gender identity cannot be shown to hurt the child, contact should not be limited, and other custody and visitation orders should not be changed for this reason. Many courts have upheld this principle and have treated transgender custody cases like any other child custody determination—by focusing on standard factors such as parental skills. In *Mayfield v. Mayfield*, for instance, the court upheld a transgender parent's shared parenting plan because there was no evidence in the record that the parent would not be a "fit, loving and capable parent."[16]

Other times, courts claiming to consider a child's interests have ruled against the transgender parent, leading to the parent losing access to their children on the basis of their gender identity. For example, in *Cisek v. Cisek*, the court terminated a transgender parent's visitation rights, holding that there was a risk of both mental and "social harm" to the children. The court asked whether the parent's sex change was "simply an indulgence of some fantasy". An Ohio court imposed an indefinite moratorium on visitation based on the court's belief that it would be emotionally confusing for the children to see "their father as a woman".[17]

Reproductive rights

Transgender people who haven't undergone sex reassignment surgery are still able to procreate. However, many states mandate sex reassignment surgery in order for a trans person's gender identity to be legally recognized. This has been criticized as forcible sterilization.[18] Some transgender people wish to retain their ability to procreate. Others do not require hysterectomy, phalloplasty, metoidioplasty, penectomy, orchiectomy, or vaginoplasty to treat their gender dysphoria. In these cases, the sexual reassignment surgery is considered medically unnecessary. Furthermore, sexual reassignment surgery is generally the final medical procedure in a complete sex change, and is a procedure which many trans people find financially prohibitive.[19]

Others advocate for a right to access assisted reproduction technology services and the preservation of reproductive tissue prior to sex reassignment surgery, which renders them infertile. This would include cryopreservation of semen in a sperm bank in the case of trans women and oocytes or ovum for trans men. For such individuals, access to surrogacy and in-vitro fertilization services is necessary to have children.[20]

Identity documents

Identity documents are a major area of legal concern for transgender people. Different procedures and requirements for legal name changes and gender marker changes on birth certificates, drivers licenses, social security identification and passports exist and can be inconsistent. Many states require sex reassignment surgery to change their name and gender marker. Also, documents which do not match each other can present difficulties in conducting personal affairs - particularly those which require multiple, matching forms of identification. Furthermore, having documents which do not match a person's gender presentation has been reported to lead to harassment and discrimination.[21][22]

Name change

Transgender people often seek legal recognition for a name change during a gender transition. Laws regarding name changes vary state-by-state. In some states, transgender people can change their name, provided that the change does not perpetrate fraud or enable criminal intent. In other states, the process requires a court order or statute and can be more difficult. An applicant may be required to post legal notices in newspapers to announce the name change - rules that have been criticized on grounds of privacy rights and potentially endangering transgender people to targeted hate crimes.[23] Some courts require medical or psychiatric documentation to justify a name change, despite having no similar requirement for individuals changing names for reasons other than gender transitioning.[24]

Birth certificates

U.S. states make their own laws about birth certificates, and state courts have varied in their application of such laws to transgender people.[25][26] A majority of states permit the name and sex to be changed on a birth certificate, either through amending the existing birth certificate or by issuing a new one. Many states, however, require medical proof of sex reassignment surgery in order to warrant a gender marker change. As of April 2015, Idaho, Kansas, Ohio, and Tennessee refuse to change the sex on a birth certificate.[27] Texas, by opinion of the local clerk's office, will make necessary changes to a birth certificate, including amendment of sex if a court order is presented. As of July 2014, New York State passed legislation easing changing recorded gender, and as of December 2014 New York City followed, completely eliminating the need for gender reassignment surgery when filing for birth gender change in New York.[28] In November 2016, Nevada changed the requirements for a person to change their gender on their birth certificates, eliminating the surgery requirement and requiring only an affidavit from the person making the change and an affidavit who can attest that the information is accurate. [29]

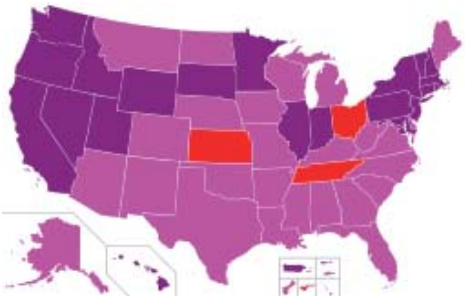
Cases

The first case to consider legal gender change in the U.S. was *Mtr. of Anonymous v. Weiner (1966)*, in which a post-operative transgender woman wished to change of her name and sex on her birth certificate in New York City. The New York City Health Department denied the request. She took the case to court, but the court ruled that the New York City Health Code didn't permit the request, which only permitted a change of sex on the birth certificate if an error was made recording it at birth.[30][31]

The decision of the court in *Weiner* was again affirmed in *Mtr. of Hartin v. Dir. of Bur. of Recs. (1973)* and *Anonymous v. Mellon (1977)*. Despite this, there can be noted as time progressed an increasing support expressed in judgments by New York courts for permitting changes in birth certificates, even though they still held to do so would require legislative action. It should be noted that classification of characteristic sex is a public health matter in New York; and New York City has its own health department which operates separately and autonomously from the New York State health department.

An important case in Connecticut was *Darnell v. Lloyd (1975)*,[32] where the court found that substantial state interest must be demonstrated to justify refusing to grant a change in sex recorded on a birth certificate.[33]

In *K. v. Health Division (1977)*,[34] the Oregon Supreme Court rejected an application for a change of name or sex on the birth certificate of a post-operative transgender man, on the grounds that there was no legislative authority for such a change to be made.



Legal requirements each state has for altering the sex on one's birth certificate.
- State does not require SRS to alter sex on birth certificate
- Altering sex on birth certificate requires SRS[1] [2]
- State does not alter sex on birth certificates for trans people

---- [1]Some Texas officials have refused to amend the sex on birth certificates to reflect a sex change after the ruling *Littleton v. Prange*; however, a judge can order an amendment.
[2]From May 2013 to March 2017 Missouri allowed, through court order via CASE 13AR-CV00240, a quiet workaround of Mo. Ann. Stat. § 193.215(9). The workaround from the original petitioning case has been reversed by mandate of the several courts and Missouri now requires sexual reassignment surgery to change gender.

Drivers' licenses

All U.S. states allow the gender marker to be changed on a driver's license,[35] although the requirements for doing so vary by state. Often, the requirements for changing one's driver's license are less stringent than those for changing the marker on the birth certificate. For example, the state of Massachusetts requires SRS for a birth certificate change,[36] but only a form including a sworn statement from a physician that the applicant is in fact the new gender to correct the sex designation on a driver's license.[37] The state of Virginia has policies similar to those of Massachusetts, requiring SRS for a birth certificate change, but not for a driver's license change.[38][39]

Sometimes, the states' requirements and laws conflict with and are dependent on each other; for example, a transgender woman who was born in Ohio but living in Kentucky will be unable to have the gender

The procedure each state uses to alter the sex on one's birth certificate.
- New birth certificate is issued with correct sex designation
- Old birth certificate is amended to correct sex designation
- State does not alter sex on birth certificates for transgender people

marker changed on her Kentucky driver's license. This is due to the fact that Kentucky requires an amended birth certificate reflecting person's accurate gender, but the state of Ohio does not change gender markers on birth certificates.[40]

Cases

In May 2015, six Michigan transgender people filed *Love v. Johnson* in the United States District Court for the Eastern District of Michigan, challenging the state's policy requiring the information on a person's driver's license match the information on their birth certificate.[41][42] This policy requires transgender people to change the information on their birth certificates in order to change their driver's licenses, which is not possible in Idaho and Ohio, where three of the plaintiffs were born, and requires a court order in South Carolina, where a fourth was born. The remaining two residents were born in Michigan, and would be required to undergo surgery to change their birth certificates.[41] The plaintiffs in the case are represented by the American Civil Liberties Union.[41][42]

In November 2015, Judge Nancy Edmunds denied the State of Michigan's motion to dismiss the case.[41]

Passports

The State Department determines what identifying biographical information is placed on passports. On June 10, 2010, the policy on gender changes was amended to allow permanent gender marker changes to be made with the statement of a physician that "the applicant has had appropriate clinical treatment for gender transition to the new gender."[43] The previous policy required a statement from a surgeon that gender reassignment surgery was completed.[44]

Third gender option

As of 2017, the U.S. federal government does not recognize a third gender option on passports or other national identity documents, though other countries including Australia, New Zealand, India, Nepal, Pakistan, Bangladesh, Germany, Malta, and Canada have begun recognizing this.[45][46][47][48][49] Third genders have traditionally been acknowledged in a number of Native American cultures as "two spirit" people, in traditional Hawaiian culture as the māhū, and as the fa'afafine in American Samoa.[50][51][52][53] Similarly, immigrants from traditional cultures that acknowledge a third gender would benefit from such a reform, including the muxe gender in southern Mexico and the hijra of south Asian cultures.[54][55] [56]

On June 10, 2016, an Oregon circuit court ruled that a resident, Jamie Shupe, could legally change their gender to non-binary. The Transgender Law Center believes this to be "the first ruling of its kind in the U.S."[3]

On September 26, 2016, intersex California resident Sara Kelly Keenan became the second person in the United States to legally change her gender to 'non-binary'. Keenan, who uses she/her pronouns cited Shupe's case as inspiration for her petition.[57] Keenan later obtained a birth certificate with an intersex sex marker. In press reporting of this decision, it became apparent that Ohio had issued an 'hermaphrodite' sex marker in 2012.[58]

On January 26, 2017, a bill was introduced in the California State Senate that would create a third, nonbinary gender marker on California birth certificates, drivers' licenses, and identity cards. The bill, SB 179, would also remove the requirements for a physician's statement and mandatory court hearing for gender change petitions.[59] This bill was signed into law on October 15, 2017; the non-binary option will become available on January 1, 2019.[60]

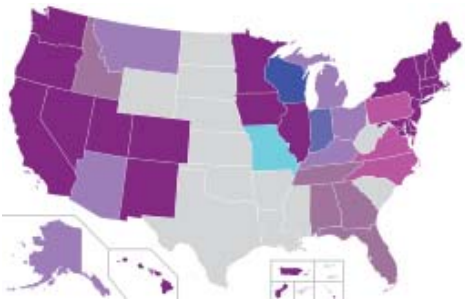
On June 15, 2017, Oregon became the first state in the U.S. to announce it will allow a non-binary "X" gender marker on state IDs and driver's licenses, beginning July 1. No doctor's note will be required for the change.[61] The following week, Washington D.C. announced that a non-binary "X" gender marker for district-issued ID cards and driver's licenses would

very shortly be offered with no medical certification required.[62] The D.C. policy change went into effect on June 27, making the district the first place in the U.S. to offer gender-neutral driver's licenses and ID cards.[63] In June 2018, Maine began issuing yellow stickers to cover part of the ID card with the statement "Gender has been changed to: X - Non-binary".[64]

Legislation to offer an "X" gender marker for residents' ID cards was introduced in New York state in June 2017[62][65] (and was expected to be introduced in New York City in June 2018),[66] and in Massachusetts in May 2018.[67]

Discrimination

Laws



Current U.S. LGBT employment discrimination laws.
- Sexual orientation and gender identity: all employment
- Sexual orientation: all employment, gender identity only in state employment
- Sexual orientation: all employment
- Sexual orientation and gender identity: state employment only
- Sexual orientation: state employment only
- No state-level protection for LGBT employees

Federal

There is no federal law designating transgender as a protected class, or specifically requiring equal treatment for transgender people. Some versions of the Employment Non-Discrimination Act introduced in the U.S. Congress have included protections against discrimination for transgender people, but as of 2015 no version of ENDA has passed. Whether or not to include such language has been a controversial part of the debate over the bill. In 2016 and again in 2017, Rep. Pete Olson [R-TX] introduced legislation to strictly interpret gender identity according to biology, which would end federal civil rights protection of gender identity. It remains legal at the federal level for parents to subject transgender children to conversion therapy.

On October 4, 2017, Attorney General Jeff Sessions released a Department of Justice memo stating that Title VII of the 1964 Civil Rights Act prohibits discrimination based on sex, which he stated "is ordinarily defined to mean biologically male or female," but the law "does not prohibit discrimination based on gender identity *per se*."[68]

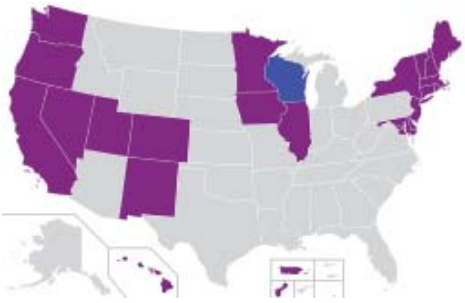
On January 30, 2012, HUD Secretary Shaun Donovan announced new regulations that would require all housing providers that receive HUD funding to prevent housing discrimination based on sexual orientation or gender identity.[69] These regulations went into effect on March 5, 2012.[70]

State and local

As of 2018, 22 states feature legislation that prohibit discrimination based on gender identity in either employment, housing, and/or public accommodations. None of these state laws has ever been defeated at the ballot box; the first statewide referendum on repealing existing protections for transgender people[71] is scheduled for November 2018 in Massachusetts.

As of 2016, over 225 jurisdictions[72] including the District of Columbia had similar legislation. The only existing legislation to face repeal at the ballot box was in Anchorage, Alaska, where voters chose in April 2018 to keep the existing protections for transgender people.[73]

Some states and cities have banned conversion therapy for minors.



States that prohibit housing discrimination based on sexual orientation or gender identity. HUD regulations require all housing providers that receive HUD funding not to discriminate against an individual's sexual orientation or gender identity.

- Prohibits housing discrimination based on sexual orientation and gender identity
- Prohibits housing discrimination based on sexual orientation only
- Does not factor sexual orientation or gender identity/unclear

Map of U.S. cities and counties that have bans on sexual orientation and gender identity change efforts with minors.

- Ban on conversion therapy for minors on the basis of sexual orientation and gender identity
- No ban on conversion therapy for minors on the basis of sexual orientation

State	Date effective	Employment	Housing	Public accommodations
Minnesota	1993[74]	✓	✓	✓
Rhode Island	Dec 6, 1995 (public accommodation) July 17, 2001 (employment and housing)[75]	✓	✓	✓
New Mexico	July 1, 2003 (employment and housing) 2004 (public accommodation)	✓	✓	✓
California[76]	2004 (employment and housing) Oct 9, 2011 (public accommodations)	✓	✓	✓
District of Columbia	2005 (employment and housing) March 8, 2006 (public accommodations)	✓	✓	✓
Maine	December 28, 2005	✓	✓	✓
Illinois	2005 (employment and housing) 2006 (public accommodations)	✓	✓	✓
Hawaii	July 11, 2005 (housing and public accommodations) May 5, 2011 (employment)	✓	✓	✓
Washington	2006	✓	✓	✓
New Jersey	2006	✓	✓	✓
Vermont	2007	✓	✓	✓
Oregon	2007	✓	✓	✓
Iowa	2007	✓	✓	✓
Colorado[77]	2007 (employment and housing) 2008 (public accommodations)	✓	✓	✓
Nevada	2011	✓	✓	✓
Connecticut[78]	October 1, 2011	✓	✓	✓
Massachusetts[79]	2012 (employment and housing) 2016 (public accommodations)[79]	✓	✓	✓
Delaware	2013	✓	✓	✓
Maryland	2014	✓	✓	✓
Utah	2015	✓	✓	✗
New York[80]	January 20, 2016	✓	✓	✓
New Hampshire[81][82]	July 8, 2018	✓	✓	✓

Cases

In 2000, a court ruling in Connecticut determined that conventional sex discrimination laws protected transgender persons. However, in 2011, to clarify and codify this ruling, a separate law was passed defining legal anti-discrimination protections on the basis of gender identity.[83]

On October 16, 1976, a Supreme Court rejected plaintiff's appeal in sex discrimination case involving termination from teaching job after sex-change operation from a New Jersey school system.[84]

Carroll v. Talman Fed. Savs. & Loan Association, 604 F.2d 1028, 1032 (7th Cir.) 1979, held that dress codes are permissible. "So long as [dress codes] and some justification in commonly accepted social norms and are reasonably related to the employer's business needs, such regulations are not necessarily violations of Title VII even though the standards prescribed differ somewhat for men and women."[85]

In *Ulane v. Eastern Airlines Inc.* 742 F.2d 1081 (7th Cir. 1984) Karen Ulane, a pilot who was assigned male at birth, underwent sex reassignment surgery to attain typically female characteristics. The Seventh Circuit denied Title VII sex discrimination protection by narrowly interpreting "sex" discrimination as discrimination "against women" [and denying Ulane's womanhood].[86]

The case of *Price Waterhouse v. Hopkins* 490 U.S. 228 (1989), expanded the protection of Title VII by prohibiting gender discrimination, which includes sex stereotyping. In that case, a woman who was discriminated against by her employer for being too "masculine" was granted Title VII relief.[87]

Oncale v. Sundowner Offshore Services, Inc. 523 U.S. 75 (1998), found that same-sex sexual harassment is actionable under Title VII.[88]

A gender stereotype is an assumption about how a person should dress which could encompass a significant range of transgender behavior. This potentially significant change in the law was not tested until *Smith v. City of Salem* 378 F.3d 566, 568 (6th Cir. 2004). Smith, a trans woman, had been employed as a lieutenant in the fire department without incident for seven years. After doctors diagnosed Smith with Gender Identity Disorder ("GID"), she began to experience harassment and retaliation following complaint. She filed Title VII claims of sex discrimination and retaliation, equal protection and due process claims under 42 U.S.C. § 1983, and state law claims of invasion of privacy and civil conspiracy. On appeal, the *Price Waterhouse* precedent was applied at p574: "[i]t follows that employers who discriminate against men because they do wear dresses and makeup, or otherwise act femininely, are also engaging in sex discrimination, because the discrimination would not occur but for the victim's sex."[89] Chow (2005 at p214) comments that the Sixth Circuit's holding and reasoning represents a significant victory for transgender people. By reiterating that discrimination based on both sex and gender expression is forbidden under Title VII, the court steers transgender jurisprudence in a more expansive direction. But dress codes, which frequently have separate rules based solely on gender, continue. *Carroll v. Talman Fed. Savs. & Loan Association*, 604 F.2d 1028, 1032 (7th Cir.) 1979, has not been overruled.

Harrah's implemented a policy named "Personal Best", in which it dictated a general dress code for its male and female employees. Females were required to wear makeup, and there were similar rules for males. One female employee, Darlene Jesperson, objected and sued under Title VII. In *Jespersen v. Harrah's Operating Co.*, No. 03-15045 (9th Cir. April 14, 2006), plaintiff conceded that dress codes could be legitimate but that certain aspects could nevertheless be demeaning; plaintiff also cited *Price Waterhouse*. The Ninth Circuit disagreed, upholding the practice of business-related gender-specific dress codes. When such a dress code is in force, an employee amid transition could find it impossible to obey the rules.

In *Glenn v. Brumby*, the 11th Circuit Court of Appeals held that the Equal Protection Clause prevented the state of Georgia from discriminating against an employee for being transgender.[90][91]

In education

The Obama administration took the position that Title IX's prohibition on discrimination on the basis of "sex" encompasses discrimination on the basis of gender identity and gender expression. In 2016, the Fourth Circuit became the first[92] Court of Appeals to agree with the administration on the scope of Title IX as applied to transgender students, in the case of Virginia high school student Gavin Grimm (*G.G. v. Gloucester County School Board*).[93] The validity of the

executive's position is being tested further in the federal courts. In 2017 the ACLU, representing Grimm, stated that they had stopped Grimm's "request for an immediate halt to the Gloucester County School Board's policy prohibiting him and other transgender students from using the common restrooms at school" but were "moving forward with his claim for damages and his demand to end the anti-trans policy permanently."[94]

In 2014, Maryland Senate passed a bill that "bans discrimination based on sexual orientation and sexual identity but includes an exemption for religious organizations, private clubs and educational institutions.[95]

In 2016, guidance was issued by the Departments of Justice and Education stating that schools which receive federal money must treat a student's gender identity as their sex (for example, in regard to bathrooms).[96] However, this policy was revoked in 2017.[96]

Restroom access

An area of legal concern for transgender people is access to restrooms which are segregated by gender. Transgender people have, in the past, been asked for legal identification while entering or using a gendered restroom.[97][98][99] Recent legislation has moved in contradictory directions. On one hand, non-discrimination laws have included restrooms as public accommodations, indicating a right to use gendered facilities which conform with a person's gender identity.[100] On the other, some efforts have been made to insist that individuals use restrooms that match their biological sex, regardless of an individual's gender identity or expression.[101]

Comprehensive legislation

Numerous jurisdictions and states have passed or considered so-called "bathroom bills" which restrict the use of bathrooms by transgender people, forcing them to choose facilities in accordance with their biological sex. This includes Florida, Arizona, Kentucky and Texas.[102][103][104][105]

North Carolina passed a comprehensive bathroom restriction bill (also known as "HB2" or the *Public Facilities Privacy & Security Act*) on March 23, 2016, which was quickly signed into law by Governor Pat McCrory. The new law overrides a prior Charlotte, North Carolina non-discrimination ordinance on the same subject.[106]

In September 2016, California governor Jerry Brown signed a bill requiring all single-occupancy bathrooms to be gender-neutral, effective since March 1, 2017.[107] California is the first U.S. state to adopt such legislation.[108]

Schools

In *Doe v. Regional School Unit*, the Maine Supreme Court held that a transgender girl had a right to use the women's bathroom at school because her psychological well-being and educational success depended on her transition. The school, in denying her access, had "treated [her] differently from other students solely because of her status as a transgender girl." The court determined that this was a form of discrimination.[109]

In *Mathis v. Fountain-Fort Carson School District 8* (2013), Colorado's Division of Civil Rights found that denying a transgender girl access to the women's restroom at school was discrimination. They reasoned, "By not permitting the [student] to use the restroom with which she identities, as non-transgender students are permitted to do, the [school] treated the [student] less favorably than other students seeking the same service." Furthermore, the court rejected the school's defense—that the discriminatory policy was implemented to protect the transgender student from harassment—

and observed that transgender students are in fact safest when a school does not single them out as different. Based on this finding, it is no longer acceptable to institute different kinds of bathroom rules for transgender and cisgender people.[109]

In May 2016, guidance was issued by the Departments of Justice and Education stating that schools which receive federal money must treat a student's gender identity as their sex (for example, in regard to bathrooms).[96] However, this policy was revoked in 2017.[96]

In October 2016, the U.S. Supreme Court agreed to take on the case of whether a transgender boy, Gavin Grimm, could use the boys' bathroom in his Virginia high school. Gavin was assigned female at birth but is a transgender male. For a while, he was permitted access to the boys' bathroom but was later denied access after a new policy was adopted by the local school board. The ACLU took on the case, stating that girls objected when he tried to use the girls' bathroom in accordance with the new policy and that he was humiliated when the school directed him to use a private bathroom, unlike other boys. After challenging the policy, he won his case in the Court of Appeals in 2015 in a tie vote.[110][111] This marked the first ruling by an appeals court to find that transgender students are protected under federal laws that ban sex-based discrimination.[112] However, later in 2016 the U.S. Supreme Court agreed to put that ruling on hold.[113] Then in 2017 the U.S. Supreme Court vacated the decision of the 4th U.S. Circuit Court of Appeals and refused to hear the case.[114] Later in 2017, it was announced that the 4th Circuit would send the case back to the district court for the judge to determine whether the case was moot because Grimm graduated.[115]

Workplace

Rights to restrooms that match one's gender identity have also been recognized in the workplace and are actively being asserted in public accommodations. In Iowa, for example, discrimination in public accommodations on the basis of sexual orientation and gender identity has been prohibited by law since 2007 through the Iowa Civil Rights Act.[109]

In *Cruzan v. Special School District #1*, decided in 2002, a Minnesota federal appeals court ruled that it isn't the job of the transgender person to accommodate the concerns of cisgender people who express discomfort with sharing a facility with a transgender person. Employers need to offer an alternative to the complaining employee in these situations, such as an individual restroom.[109]

Hate crimes legislation

Federal hate crimes legislation include limited protections for gender identity. The Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act of 2009 criminalized "willfully causing bodily injury (or attempting to do so with fire, firearm, or other dangerous weapon)" on the basis of an "actual or perceived" identity. However, protections for hate crimes motivated on the basis of a victim's gender identity or sexual orientation is limited to "crime affect[ing] interstate or foreign commerce or occur[ring] within federal special maritime and territorial jurisdiction." This limitation only applies to gender identity and sexual orientation, and not to race, color, religion or national origin.[117] Therefore, hate crimes which occur outside these jurisdictions are not protected by federal law.

Seventeen states have hate crimes legislation which include gender identity or expression as a protected group. They are Vermont, Massachusetts, Connecticut, New Jersey, Delaware, Illinois, Maryland, Missouri, Minnesota, Colorado, New Mexico, Nevada, Rhode Island, Washington, Oregon, California, and Hawaii. The District of Columbia also has a trans-inclusive hate crimes law. Twenty-seven states have hate-crimes legislation which exclude transgender people. Six states have no hate-crimes legislation at all.[118]

Numerous municipalities have passed hate-crime legislation, some of which include transgender people. However, Arkansas recently passed laws which ban municipalities from enacting such protections for sexual orientation, gender identity or expression.[119]

US state hate crime laws as they pertain to sexual orientation and gender identity.
- Sexual orientation and gender identity recognized in state hate crimes law
- Sexual orientation recognized in state hate crimes law
- Sexual orientation recognized for data collection about hate crimes
- State hate crimes law noninclusive

[116]

Healthcare

Transgender people confront two major legal issues within the healthcare system: access to health care for gender transitioning and discrimination by health care workers.

Even though there is medical consensus that hormone therapy and sex reassignment surgery (SRS) are medically necessary for many transgender people, the kinds of health care associated with gender transition are sometimes misunderstood as cosmetic, experimental or simply unnecessary. This has led to public and private insurance companies denying coverage for such treatment.[120] Courts have repeatedly ruled that these treatments may be medically necessary and have recognized gender dysphoria as a legitimate medical condition constituting a "serious medical need"[121]

The idea that transition-related care is cosmetic or experimental has been ruled as discriminatory and out of touch with current medical thinking. The AMA and WPATH have specifically rejected these arguments, and courts have affirmed their conclusion.[122][123] In a case brought by Gay and Lesbian Advocates and Defenders (GLAD), O'Donnabhain v. Commissioner, for instance, the Internal Revenue Service lost its claim that such treatments were cosmetic and experimental when a transgender woman deducted her SRS procedures as a medical expense. Courts have also found that psychotherapy alone is insufficient treatment for gender dysphoria, and that for some people, SRS may be the only effective treatment.[121]

Transgender people also sometimes experience discrimination by healthcare professionals, who have refused to treat them for conditions both related and unrelated to their gender identity.[124][125][126]

The Affordable Care Act (ACA) of 2010 prohibits sex discrimination in federally funded health care facilities, and in 2012 the federal Department of Health and Human Services clarified that this includes discrimination based on transgender status. The relevant anti-discrimination part of ACA is Section 1557. A 2016 rule made it clear that discrimination based on gender identity is forbidden.[127] The ACA also forbids insurance providers from refusing to cover a person based on a pre-existing condition, including being transgender. Further protections are provided in jurisdictions that have laws prohibiting discrimination on the basis of sex, gender identity or gender expression in public accommodations - and under medical malpractice and misconduct law.[128]

Prisoners' rights

In September 2011, a California state court denied the request of a California inmate, Lyralisa Stevens, for sex reassignment surgery at the state's expense.[129]

On January 17, 2014, in *Kosilek v. Spencer* a three-judge panel of the First Circuit Court of Appeals ordered the Massachusetts Department of Corrections to provide Michelle Kosilek, a Massachusetts inmate, with sex reassignment surgery. It said denying the surgery violated Kosilek's Eighth Amendment rights, which included "receiving medically

necessary treatment ... even if that treatment strikes some as odd or unorthodox".[130]

On April 3, 2015, the U.S. Department of Justice intervened in a federal lawsuit filed in Georgia to argue that denying hormone treatment for transgender inmates violates their rights. It contended that the state's policy that only allows for continuing treatments begun before incarceration was insufficient and that inmate treatment needs to be based on ongoing assessments.[131] The case was brought by Ashley Diamond, an inmate who had used hormone treatment for seventeen years before entering the Georgia prison system.[132]

On May 11, 2018, the US Bureau of Prisons announced that prison guidelines issued by the Obama Administration in January 2017 to allow transgender prisoners to be transferred to prisons housing inmates of the gender which they identify with had been rescinded and that biological gender would once again determine where transgender prisoners are jailed.[133]

Immigration

In 2000, the US Ninth Circuit Court of Appeals concluded that "gay men with female sexual identities [sic] in Mexico constitute a 'particular social group'" that was persecuted and was entitled to asylum in the US (*Hernandez-Montiel v. INS*).[134][135] Since then, several cases have reinforced and clarified the decision.[136] *Morales v. Gonzales* (2007) is the only published decision in asylum law that uses "male-to-female transsexual" instead of "gay man with female sexual identity".[136] An immigration judge stated that, under *Hernandez-Montiel*, Morales would have been eligible for asylum (if not for her criminal conviction).[137]

Critics have argued that allowing transgender people to apply for asylum "would invite a flood of people who could claim a 'well-founded fear' of persecution".[135] Precise numbers are unknown, but Immigration Equality, a nonprofit for LGBT immigrants, estimates hundreds of cases.[135]

The United States has no process for accepting visa requests for third gender citizens from other countries. In 2015, trans HIV activist Amruta Alpesh Soni's request for a visa was delayed because her gender is listed as "T" (for transgender) on her Indian passport. In order to receive a visa, the State Department requires the gender identification on the visa to match the gender identification on the passport.[138]

Military

In 2015, the Pentagon reviewed its policy regarding transgender service members and announced that its ban would be removed.[139] It announced on June 30, 2016 that, beginning on that date, otherwise qualified service members could not any longer be discharged, denied reenlistment, involuntarily separated, or denied continuation of service because of being transgender.[140] It was also announced at the same time that, starting in July 2017, under Department of Defense regulations transgender persons may serve in the United States military so long as they have adapted to their identified gender for at least an 18-month period.[140] Prior to these announcements, discharges for gender transitioning were commonplace. In one case, a postoperative trans person was discharged from the Air Force Reserve, a decision supported by the Court of Appeals.[141]

President Donald Trump announced on July 26, 2017, that transgender individuals will not be allowed to "serve in any capacity in the U.S. military."[142] However, Chairman of the Joint Chiefs of Staff General Joseph Dunford stated “There will be no modifications to the current policy until the President's direction has been received by the Secretary of Defense and the Secretary has issued implementation guidance. In the meantime, we will continue to treat all of our personnel with respect."[143]

On August 1, 2017, the Palm Center released a letter signed by 56 retired generals and admirals, opposing the proposed ban on transgender military service members. The letter stated that if implemented, the ban "would cause significant disruptions, deprive the military of mission-critical talent and compromise the integrity of transgender troops who would be forced to live a lie, as well as non-transgender peers who would be forced to choose between reporting their comrades or disobeying policy".[144] On August 9, 2017,[145][146] five transgender United States military personnel sued Trump and top Pentagon officials over the proposed banning of transgender people from serving in the military. The suit asks the court to prevent the ban from going into effect.[145][146] Two major LGBT-rights organizations filed a petition in the United States District Court in Washington on behalf of the five transgender personnel.[146]

On August 25, 2017, Trump signed a presidential memorandum directing that an implementation plan be submitted to him by the Secretary of Defense and the Secretary of Homeland Security February 2018.[147]

On August 28, 2017, the American Civil Liberties Union (ACLU) of Maryland filed a federal lawsuit, *Stone v. Trump*, on behalf of several transgender military service members, alleging that the ban violated their equal protection rights.[148][149] The same date, Lambda Legal filed a federal lawsuit in Seattle on behalf of three trans people, the Human Rights Campaign, and the Gender Justice League, alleging that the ban violated equal protection, due process and free speech protections.[150][151]

On August 29, 2017, Secretary Mattis announced that currently serving transgender troops would be allowed to remain in the armed services, pending further study. Mattis stated he would set up a panel of experts from the Departments of Defense and Homeland Security to provide recommendations on implementing the President's policy direction.[152]

Taxes

IRS Publication 502[153] lists medical expenses that are tax-deductible to the extent they 1) exceed 7.5% of the individual's adjusted gross income, and 2) were not paid for by any insurance or other third party. For example, a person with $20,000 gross adjusted income can deduct all medical expenses *after* the first $1,500 spent. If that person incurred $16,000 in medical expenses during the tax year, then $14,500 is deductible. At higher incomes where the 7.5% floor becomes substantial, the deductible amount is often less than the standard deduction, in which case it is not cost-effective to claim.

IRS Publication 502 includes several deductions that may apply to gender transition treatments, including some operations.[153] The deduction for operations was denied to a trans woman but was restored in tax court.[154] The deductibility of the other items in Publication 502 was never in dispute.

See also

- Transgender disenfranchisement in the United States
- Identity documents in the United States
- History of transgender people in the United States
- LGBT rights in the United States
- Intersex rights in the United States
- Transgender rights
- Name change
- List of transgender-related topics

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Values

Mission: Transgender Law Center changes law, policy, and attitudes so that all people can live safely, authentically, and free from discrimination regardless of their gender identity or expression.

Transgender Law Center (TLC) is the largest national trans-led organization advocating self-determination for all people. Grounded in legal expertise and committed to racial justice, TLC

employs a variety of community-driven strategies to keep transgender and gender nonconforming people alive, thriving, and fighting for liberation.

At TLC, we believe:

- TGNC people hold the resilience, brilliance, and power to transform society at its root.
- No one is disposable.
- The people most impacted by the systems we fight must lead the work.
- Until TGNC immigrants and Black trans women are safe and free, none of us are.
- Liberation for everyone is both necessary and possible.
- Self-determination is a right we were all born to realize.
- Our survival is revolutionary.
- Because of those who came before us, we have already won.

Transgender Law Center | p. 510-587-9696 | EIN (tax identification number): 05-0544006 | info@transgenderlawcenter.org

SIGN UP!

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TRANSGENDER EQUALITY
Celebrating 15 Years

About Us

About Us

The National Center for Transgender Equality is the nation's leading social justice advocacy organization winning life-saving change for transgender people.

NCTE was founded in 2003 by transgender activists who recognized the urgent need for policy change to advance transgender equality. With a committed board of directors, a volunteer staff of one, and donated office space, we set out to accomplish what no one had yet done: provide a powerful transgender advocacy presence in Washington, D.C.

Today, NCTE has grown to a staff of 17 and works at the local, state, and federal level to change laws, policies and society. Download NCTE's brochure here. (/sites/default/files/docs/AboutNCTE.pdf)

Mission

The National Center for Transgender Equality is a national social justice organization devoted to ending discrimination and violence against transgender people through education and advocacy on national issues of importance to transgender people.

By empowering transgender people and our allies to educate and influence policymakers and others, NCTE facilitates a strong and clear voice for transgender equality in our nation's capital and around the country.

Projects

Racial and Economic Justice Initiative (REJI)

NCTE's Racial and Economic Justice Initiative ensures the perspectives and priorities of transgender people of color, and those who live in urban and rural poverty, are part of the national policy and advocacy agenda. This includes federal policy, local and state advocacy, and collaborating with other racial, social, economic and criminal justice movements and initiatives. Currently, the Initiative's work includes reforming detention conditions for transgender people in correctional facilities and in immigration detention. Click here to learn more about REJI (/issues/racial-economic-justice).

Trans Legal Services Network (TLSN)

NCTE helps ensure every transgender person can navigate the complicated name and gender change process and confidently address other legal issues they may face. NCTE created the Trans Legal Services Network to increase support for organizations across the country who are serving or aiming to serve the legal needs of our communities. Comprised of over 50 organizations, the Network shares advice, provides technical support and legal resources to support their work and expand their services. Click here to learn more about TLSN (/about-transgender-people/transgender-legal-services-network).

Voices for Trans Equality (VTE)

Voices for Transgender Equality (VTE) empowers transgender people and allies so that they can better advocate for transgender rights. VTE allows community members to connect directly with NCTE, to receive resources and opportunities as well as to help NCTE stay informed about transgender rights issues in communities across the country. There's no cost to join, and members never have to share their stories or be public if that's not the right decision for them. Overall, this group will help ensure that trans people and allies are able to use their voices to demand dignity and respect for all. Click hear to learn more about VTE (http://www.transequality.org/voices).

Families for Trans Equality (FTE)

Families for Transgender Equality (FTE) is a network of families with trans youth, and groups that support these families, who all want to change policies and society to improve trans people's lives. There's no cost to join, and families never have to share their stories or be public if that's not the right decision for them. Overall, this group will help ensure that all families with trans youth are being treated well, and that trans youth are able to live their lives with dignity and respect. Click here to learn more about FTE (http://www.transequality.org/families).

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1133 19th St NW
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BREAKING
Federal Judge Orders Reunification of Families

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LGBT RIGHTS

The ACLU works to ensure that lesbian, gay, bisexual, and transgender people can live openly without discrimination and enjoy equal rights, personal autonomy, and freedom of expression and association.

WHAT'S AT STAKE CURRENT ISSUES

THE LATEST ACT

WHAT'S AT STAKE

The ACLU has a long history of defending the LGBT community. We brought our first LGBT rights case in 1936 and founded the LGBT Project in 1986. Today, the ACLU brings more LGBT cases and advocacy initiatives than any other national organization does. With our reach into the courts and legislatures of every state, there is no other organization that can match our

record of making progress both in the courts of law and in the court of public opinion.

Need help?

FILL OUT OUR CONFIDENTIAL ONLINE FORM

For non-LGBT issues, please contact your local ACLU affiliate.

The ACLU Lesbian Gay Bisexual Transgender Project seeks to create a just

MORE

SEARCH LGBT RIGHTS

Blogs
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Court Cases
Videos
Features
Reports

ALL LGBT RIGHTS

If you've been discriminated against based on sexual orientation, gender identity, or HIV status, the ACLU wants to hear about it.

REPORT LGBT/HIV DISCRIMINATION

WHAT YOU NEED TO KNOW

50
LOVE WINS! Same-sex couples now have the freedom to marry in all 50 states

31
In 31 states there are no explicit employment protections for transgender people

ADD YOUR NAME

FEATURED STORIES

The Supreme Court Cares About Religious Animus — Except When It Doesn't

Enforcing Nondiscriminatior Laws Is Not a Sign of Anti-Religious Bias

CURRENT ISSUES

LGBT Parenting

LGBT Relationships

LGBT Youth

LGBT Nondiscrimination Protections

Transgender Rights

MORE LGBT RIGHTS ISSUES

THE LATEST

MOST RECENT / MOST POPULAR

The Supreme Court Cares About Religious Animus — Except When It Doesn't
BLOG POST - SPEAK FREELY
JUNE 26, 2018

Enforcing Nondiscrimination Laws Is Not a Sign of Anti-Religious Bias
BLOG POST - SPEAK FREELY
JUNE 25, 2018

Supreme Court Sends LGBT Discrimination Case Back to Washington State Supreme Court for Review
NEWS/PRESS RELEASE
JUNE 25, 2018

Postmates, OkCupid, Broadway Stars, and More Partner with ACLU During LGBT Pride Month
NEWS/PRESS RELEASE
JUNE 22, 2018

Letter to Oscar Health Agency
LETTER
JUNE 21, 2018

2018-06-19 Letter to BOP re Changes to Transgender Offender Manual - Final
LETTER
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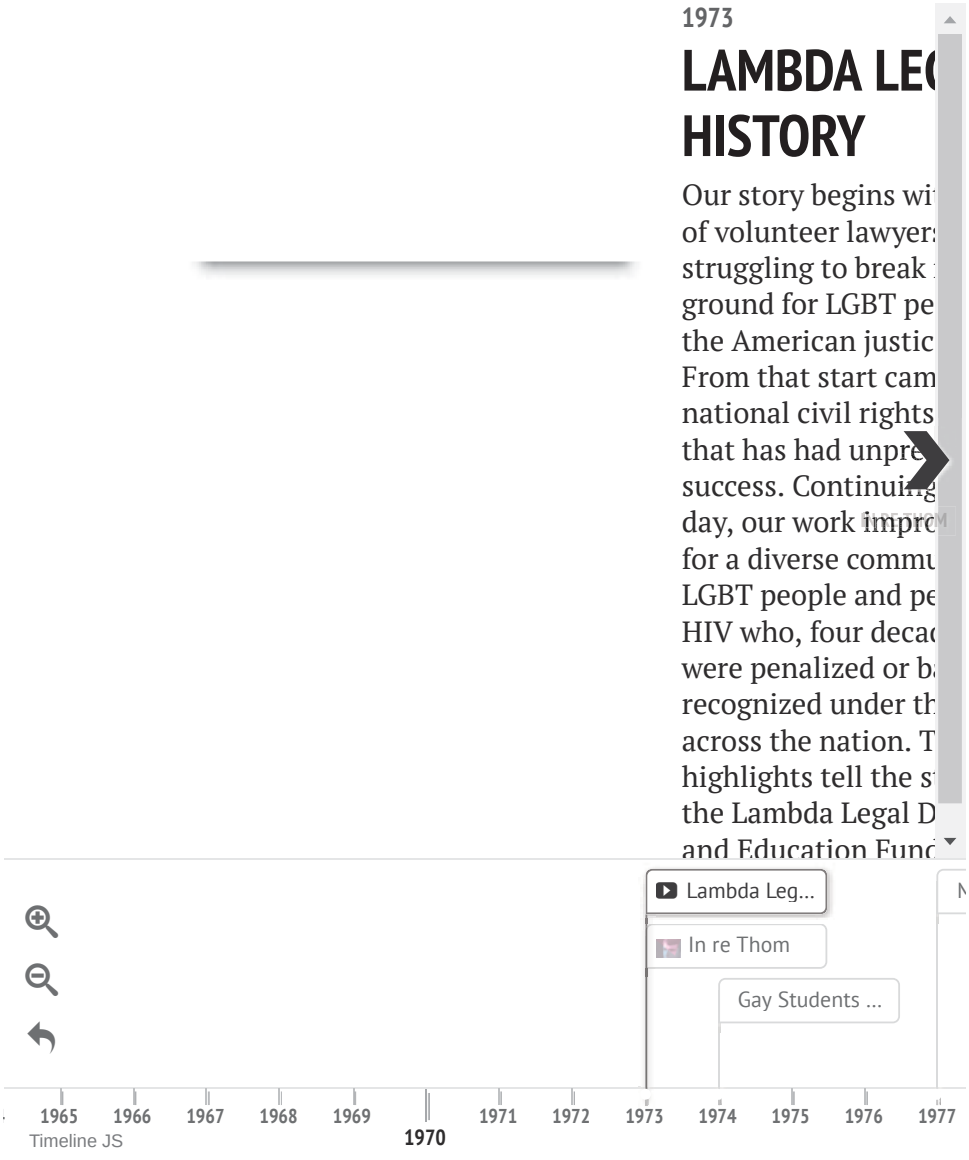
WE THE PEOPLE DARE TO CREATE A MORE PERFECT UNION

Lambda Legal
making the case for equality

Lambda Legal History



Lambda Legal was founded in 1973 as the nation's first legal organization dedicated to achieving full equality for lesbian and gay people. When founder Bill Thom filed an application in early 1972 to establish Lambda Legal Defense and Education Fund, he borrowed from the bylaws of another newly established organization—the Puerto Rican Legal Defense and Education Fund (now Latino Justice PRLDEF).

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Because of the overwhelming climate of prejudice against gay people, we became our own first client: A panel of New York judges turned down our application to be a nonprofit organization because, in their view, our mission was "neither benevolent nor charitable." With pro bono help, Thom appealed to New York's highest court, which finally allowed Lambda Legal to exist as a nonprofit organization.

Throughout the 1970s, Lambda Legal fought and won some of the nation's first cases on behalf of lesbian and gay parents and same-sex couples. In one of our first cases (*Gay Student Organization v. Bonner*), we successfully helped a gay student group at the University of New Hampshire fight a ban on their school activities. In the 1980s, we stepped up our efforts against government discrimination, while also focusing more on antigay bias in corporations and established community institutions.

In 1983, Lambda Legal won the nation's first HIV/AIDS discrimination case (People v. West 12 Tenants Corp.), helping establish that under disability laws it's illegal to discriminate against people who have HIV. We got insurance companies to cover HIV testing and treatments and pay benefits to those disabled by the disease. Lambda Legal also helped establish privacy rights for people with HIV, including the right to keep test results and medical records confidential.

In the 1990s we won a historic legal precedent holding schools responsible for harassment and violence against LGBTQ students (*Nabozny v. Podlesny*) and successfully defended the right of gay-straight alliances to exist in schools (*Colín v. Orange Unified School District*).

In 1992, we successfully kept Colorado's Amendment 2 from taking effect. The statewide initiative would have stripped lesbians and gay men of civil rights protections, nullifying existing bans on antigay discrimination and preventing others from being enacted. In 1996, we convinced the U.S. Supreme Court to declare the measure unconstitutional (*Romer v. Evans*). The Court's ruling made clear that lesbians, gay men and bisexuals have the same right to seek government protection against discrimination as any other group of people.

In 2000, we argued for a sheriff's culpability for his acts prior to the murder of Brandon Teena, who was brutally raped and later killed by two men who discovered he was transgender. This case (*Brandon v. Richardson County*) brought unprecedented visibility to the transgender community and was the subject of the film Boys Don't Cry. It also strengthened the principle that law enforcement officials must be held accountable for fair treatment of people who are the targets of hate crimes.

Lambda Legal helped convince state courts to strike down sodomy laws in New York, Kentucky, Tennessee, Montana and Georgia. And in 2003, in the historic case *Lawrence v. Texas*, we persuaded the U.S. Supreme Court to overturn all remaining state sodomy laws. That decision fundamentally changed the legal landscape and was at the time the most important legal victory for LGBT equality.

In 2009, we obtained a historic unanimous decision in Iowa Supreme Court, which ruled that denying marriage to same-sex couples is unconstitutional (*Varnum v. Brien*). This landmark victory makes Iowa the first state in the Midwest to offer marriage equality.

In 2015, we were co-counsel in one of the cases known collectively as *Obergefell v. Hodges*, in which the U.S. Supreme Court declared that denying same-sex couples the freedom to marry violates the U.S. Constitution. The Court's decision invalidates all state statutes and constitutional amendments barring same-sex couples from marriage.

With the generous support of thousands of friends around the country, what began in 1973 as a couple of volunteers working out of a spare room in a supporter's apartment has now grown to an expert staff of more than 100 in six offices around the country—New York, Atlanta, Dallas, Chicago, Los Angeles and Washington DC.

Our work is vital, and our strategy works: We make the case for equality in the nation's courts and in the court of public opinion. We make a big impact in people's lives by changing laws, policies and ideas. Until we achieve full equality under the law in every state in this country, we will keep fighting and moving history forward.

VIEW ALL OF LAMBDA LEGAL'S CASES

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HELPING SPEED **EQUALITY** FOR LGBT PEOPLE

THROUGH RIGOROUS DATA AND POLICY ANALYSIS

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WATCH NOW

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NEW REPORT

PUTTING CHILDREN AT RISK: HOW EFFORTS TO UNDERMINE MARRIAGE EQUALITY HARM CHILDREN

(http://www.lgbtmap.org/undermining-marriage-harms-kids-report)

READ MORE

OUR WORK

Lesbian, gay, bisexual and transgender Americans simply want the same chance as everyone else to earn a living, be safe in their communities, serve their country, and take care of the ones they love. MAP's policy and issue analyses demonstrate how current laws stand in the way of this very simple goal. MAP also provides detailed recommendations about what can be done to make things better.

READ MORE (POLICY-AND-ISSUE-ANALYSIS)

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FEATURED REPORTS

PUTTING CHILDREN AT RISK: HOW EFFORTS TO UNDERMINE EQUALITY HARM CHILDREN

(/undermining-marriage-harms-kids-report)

This report shows two overarching strategies to undermine marriage for same-sex couples and protections for LGBT parents, and shows how these coordinated efforts pose a profound threat to the children in LGBT families. These license to discriminate efforts are reflected in legislation, court cases, and agency guidance around the country.

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DIGNITY DENIED: RELIGIOUS EXEMPTIONS AND LGBT ELDER SERVICES

(/dignity-denied-lgbt-older-adults)

Religious exemptions laws jeopardize the security and safety of LGBT older adults, who rely on many religiously affiliated organizations for services like congregate meals, skilled nursing, and health care.

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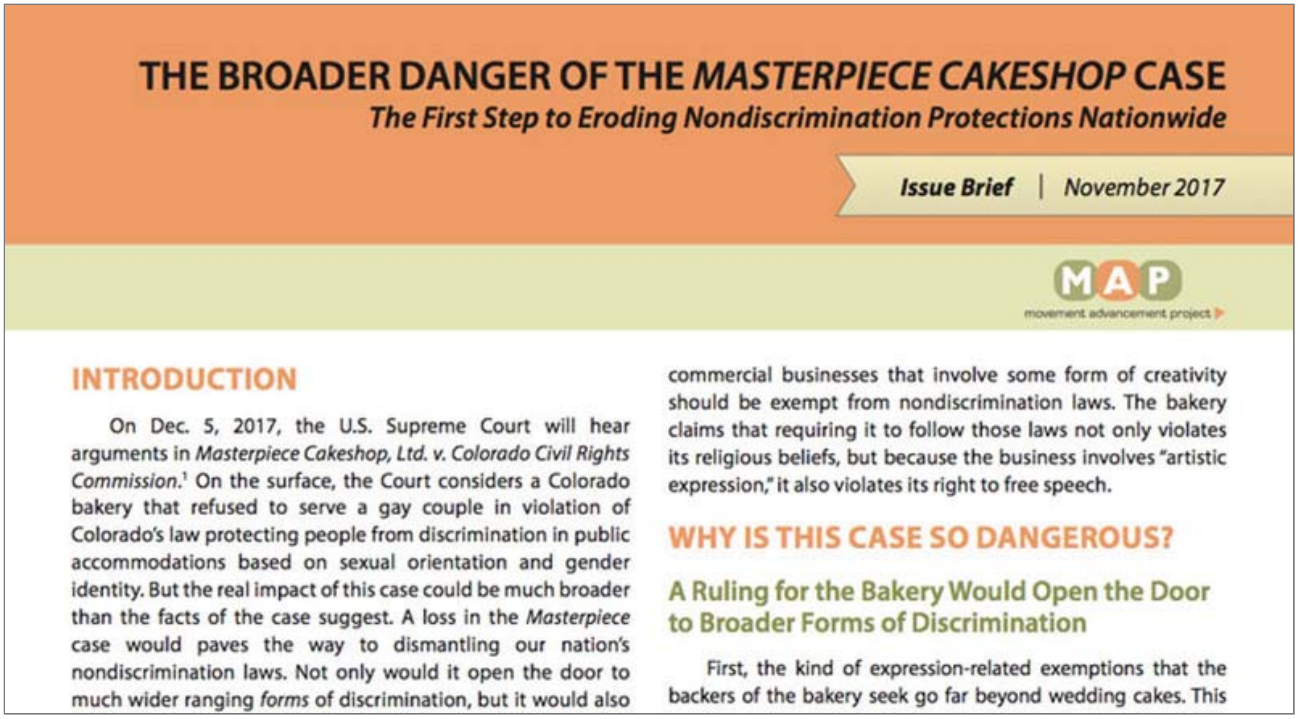
(/understanding-masterpiece-cakeshop-case)

In June 2018, the U.S. Supreme Court ruled in Masterpiece Cakeshop vs. Colorado Civil Rights Commission. This guide offers background on the case, the Court's ruling, and similar cases about service refusals.



THE BROADER DANGER OF THE *MASTERPIECE CAKESHOP* CASE

The First Step to Eroding Nondiscrimination Protections Nationwide

Issue Brief | *November 2017*

MAP movement advancement project

INTRODUCTION

On Dec. 5, 2017, the U.S. Supreme Court will hear arguments in *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission*.[1] On the surface, the Court considers a Colorado bakery that refused to serve a gay couple in violation of Colorado's law protecting people from discrimination in public accommodations based on sexual orientation and gender identity. But the real impact of this case could be much broader than the facts of the case suggest. A loss in the *Masterpiece* case would paves the way to dismantling our nation's nondiscrimination laws. Not only would it open the door to much wider ranging *forms* of discrimination, but it would also commercial businesses that involve some form of creativity should be exempt from nondiscrimination laws. The bakery claims that requiring it to follow those laws not only violates its religious beliefs, but because the business involves "artistic expression," it also violates its right to free speech.

WHY IS THIS CASE SO DANGEROUS?

A Ruling for the Bakery Would Open the Door to Broader Forms of Discrimination

First, the kind of expression-related exemptions that the backers of the bakery seek go far beyond wedding cakes. This

ISSUE BRIEF: THE BROADER DANGERS OF THE MASTERPIECE CAKESHOP CASE

(/issue-brief-the-broader-dangers-of-masterpiece)

This issue brief provides an analysis of the legal questions in the case, and the broad legal implications the case will have on people color, women, minority faiths, people with disabilities and others.

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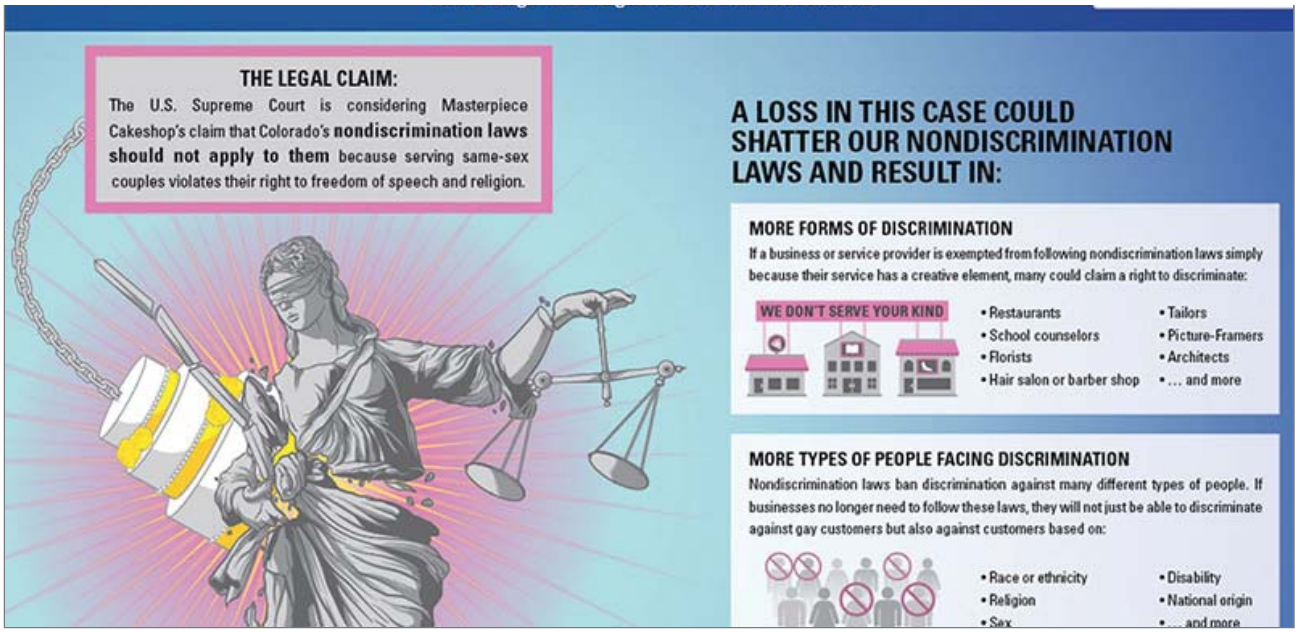

INFOGRAPHIC: MASTERPIECE CAKESHOP: THE DANGEROUS RIGHT-TO-DISCRIMINATE CASE

(/masterpiece-infographic)

This infographic was designed as part of the Open to All campaign and shows how a loss in Masterpiece would open the door to much wider ranging forms of discrimination and a wider array of people facing discrimination. It could lead to the erosion of federal and state nondiscrimination protections across the country. Learn more at www.OpentoAll.com

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LGBT POLICY SPOTLIGHT: CONVERSION THERAPY BANS

(/policy-spotlight-conversion-therapy-bans)

This report offers an overview of laws protecting LGBT youth from conversion therapy practices that attempt to change their sexual orientation or gender identity. These practices, which may include techniques such as shaming, hypnosis, inducing vomiting, and electric shocks, have been widely discredited and renounced, including by groups like the American Psychological Association. The brief also includes policy recommendations to ban harmful conversion therapy practices.

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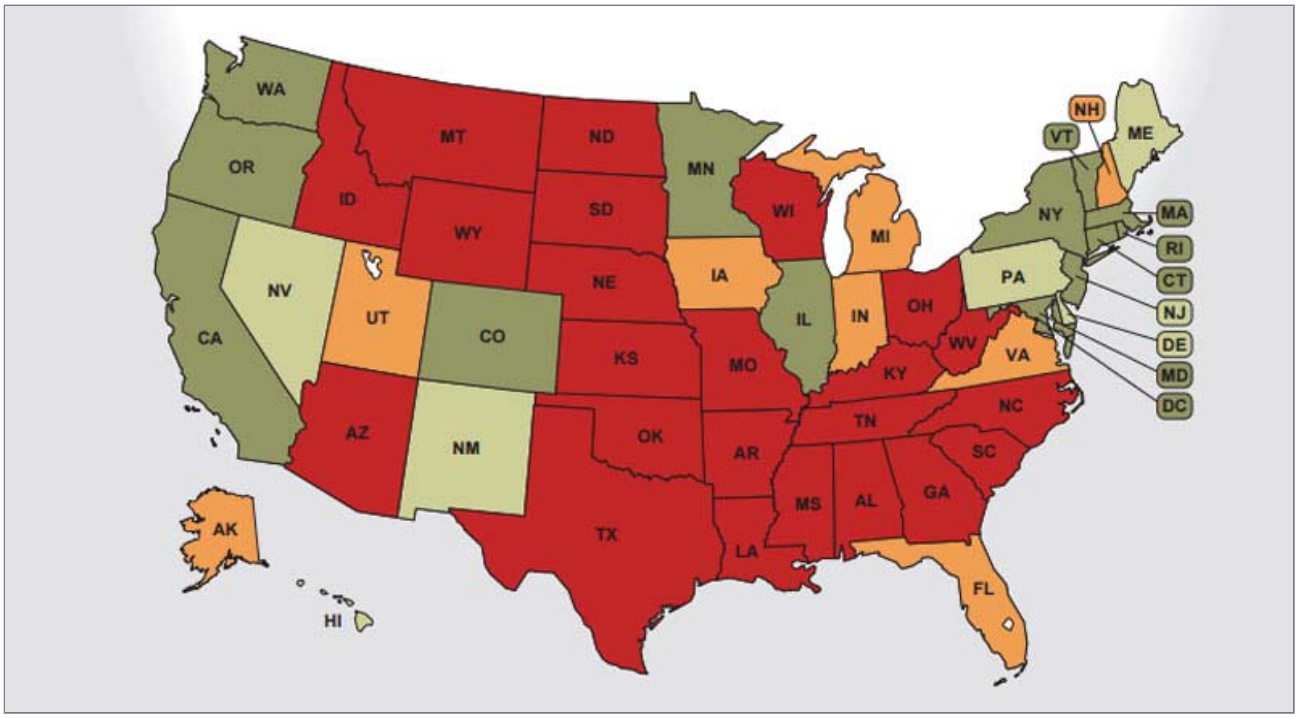
UNJUST: LGBTQ YOUTH INCARCERATED IN THE JUVENILE JUSTICE SYSTEM

(/criminal-justice-youth-detention)

This report examines how LGBTQ youth who are incarcerated in juvenile detention and correctional facilities face bias in adjudication, and mistreatment and abuse in confinement facilities. LGBTQ youth also lack supportive services when leaving the criminal and juvenile justice systems, often forcing them back into negative interactions with law enforcement.



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To help make sense of the current policy landscape in the states, this report looks at legal equality for transgender people across the country. The gender identity tally is comprised of 25 state laws and policies in five key categories: Non-Discrimination, LGBT Youth, Health and Safety, Ability to Correct the Name and Gender Marker on Identity Documents, and Adoption and Parenting.

TALKING ABOUT RELIGIOUS EXEMPTIONS & SERVICE DISCRIMINATION

(/talking-about-religious-exemptions-service-discrimination)

Several states have proposed legislation to allow businesses to discriminate against customers who don't conform to the specific religious beliefs that marriage should be restricted to a man and a woman, and that sex should be restricted to such marriages. Learn how to have effective conversations and broaden people's understanding of these laws and how they encourage discrimination against same-sex couples, unmarried couples and individuals, single parents, and others.

VIEW ALL OF OUR REPORTS

(/LGBT-PEOPLE)

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Founded in 2006, the Movement Advancement Project is an independent think tank that provides rigorous research, insight and analysis that help speed equality for lesbian, gay, bisexual and transgender (LGBT) people.

MAP's work helps educate and persuade public audiences (such as policymakers, allied organizations and funders, media and the American public) and helps support LGBT movement audiences (including LGBT organizations and advocates, and LGBT funders). You can read more about MAP and the work we do on our About (/our-work-and-mission) page.

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The New York Times

EDITORIAL

Trump's Heartless Transgender Military Ban Gets a Second Shot

By The Editorial Board

March 28, 2018

It often seems that there is no end to President Trump's cruel determination to transform America into a country that divides and dehumanizes its people. After his denigration of Muslims, refugees and undocumented immigrants, the latest example of this disgraceful proclivity is a presidential policy banning most transgender people from serving in the military — the second attempt to do so in less than a year. It puts thousands of servicemen and servicewomen at risk of losing their careers and means countless others may never get a chance to put on the uniform.

The policy Mr. Trump announced Friday states, "Transgender persons who require or have undergone gender transition are disqualified from military service," unless the Pentagon grants an exception. This exacerbates uncertainties about how such a policy would be enforced and "makes it clear that transgender service members are not welcome," the American Civil Liberties Union said.

The policy can't yet take effect because federal courts have issued temporary injunctions that stay the ban on transgender service members that Mr. Trump abruptly decreed in a series of tweets last July, without consulting the nation's top generals.

Transgender Americans first secured the right to defend their nation as equals in 2016, under President Barack Obama, who made gender identity a protected category in the Pentagon's equal opportunity policy. Mr. Trump's announcement last summer was an attempt to reverse that Obama-era policy — and a clear effort to pander to Vice President Mike Pence, other right-wing zealots and regressive generals. The United States "will not accept or allow" transgender people in the military "in any capacity," Mr. Trump tweeted at the time. The president, who avoided fighting in the Vietnam War by getting five deferments, also suggested that transgender enlistees are unfit to serve, tweeting that the military "must be focused on decisive and overwhelming victory."

In October, after a federal judge in Washington, D.C., temporarily blocked the move and said the ban was probably unconstitutional, Mr. Trump directed the Pentagon to find a way to carry out a version of the ban, and in February, Defense Secretary Jim Mattis provided a recommendation. Mr. Mattis, a former Marine general, said that there were "substantial risks" related to transgender people who serve in the military and that allowing some of them to serve would amount to an exemption from certain mental, physical and sex-based standards, potentially undermining troops' readiness and disrupting unit cohesion.

Although Mr. Mattis is considered Mr. Trump's most responsible foreign policy adviser, his handling of this matter has been disappointing. His report to Mr. Trump dismissed a RAND Corporation study that found that allowing transgender people to serve would have "minimal impact" on Pentagon readiness and health care costs.

It also seemed at odds with the comments of Gen. Joseph Dunford Jr. of the Marines, chairman of the Joint Chiefs of Staff, who told the Senate Armed Services Committee last fall that transgender troops have served with honor — not to mention research predicting there would be little to no impact on unit cohesion, operational effectiveness or readiness if transgender people were allowed to serve. Two senior Republican senators, John McCain of Arizona, who is a former P.O.W., and Orrin Hatch of Utah, as well as a group of 56 retired generals and admirals, have voiced similar views.

The number of affected troops is small; an estimated 2,000 to 11,000 identify as transgender, out of a total military force of 1.3 million active-duty members. But Mr. Trump's discriminatory and inhumane order adds immeasurably to the suffering of this minority population yearning to come out of the shadows, be treated as human beings, feel respected and be permitted to serve their country.

As is often the case in America, the rights of vulnerable people now rest with a federal court, this one in the Western District of Washington State, near Seattle. During a hearing there on Tuesday, a judge gave lawyers seven days to file additional documents before deciding on a request by two advocacy groups, Lambda Legal and OutServe-SLDN, to permanently end Mr. Trump's transgender ban.

That should happen as quickly as possible so that transgender troops and those who wish to enlist in the military in the future know they will be judged on their skills and abilities, not on discrimination and prejudice.

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A version of this article appears in print on March 28, 2018, on Page A22 of the New York edition with the headline: Mr. Trump's Transgender Military Ban

The Washington Post

Opinions

Trump's transgender troop ban is as insidious as ever

by Editorial Board March 28

PRESIDENT TRUMP announced a ban on transgender people in the military with a series of tweets last year that surprised many, including senior military leaders. There had been no study, no analysis, no consultation. That arbitrariness was one reason four federal judges have temporarily blocked the policy from going into effect. So when the latest iteration of the ban was rolled out last week, the White House made a point of stressing that it was accompanied by a 44-page Defense Department report and had the backing of Defense Secretary Jim Mattis.

That, though, doesn't make the process any less questionable. It also doesn't make discrimination against transgender people any more acceptable. So let's hope the courts see through this charade and strike down policies that would unjustly bar transgender people from the military.

The ban unveiled Friday by the White House, which won't go into immediate effect because of the pending court challenges, is slightly more nuanced than the total ban the president staked out in his July tweets. But the effect is no less insidious, in that it would prevent most transgender people from serving in the military and likely would lead to mistreatment and dismissal of some active-duty members.

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Anyone with a history of gender dysphoria (the experience of incongruity between birth gender and gender identity) would be disqualified save for limited and undefined circumstances. Also disqualified would be transgender people who have undergone gender transition. Eligible for enlistment and retention are transgender people who agree to serve in their birth gender. As Shannon Minter of the National Center for Lesbian Rights observed, "It means you can't be transgender."

The White House defended the newly revised ban as enhancing military "readiness, lethality and effectiveness" and said it was developed after extensive study by uniformed and civilian leaders. Isn't it curious, though, that the conclusion reached was essentially the same as the one the president seemingly pulled out of thin air last year?

Transgender advocates are right to call this a case of reverse engineering, with a process designed to reach the president's announced conclusion. Consider that the administration did not name the members of the so-called expert panel that is said to have studied this issue and Mr. Mattis did not answer questions about it, citing pending litigation. Groups such as the American Psychological Association and two former U.S. surgeons general have assailed the report as distorting scientific research. Also striking is that the Rand Corp., which studied this issue in 2016 *before* the Obama administration lifted a previous ban, reached a different conclusion: namely, that allowing transgender people to serve in the military would "have minimal impact on readiness and health care costs" for the Pentagon.

The immediate issue for the federal courts hearing the challenges to the ban will be whether to make their injunctions permanent. It is likely the issue will eventually be decided by the Supreme Court. Until that happens — and unless Congress

intervenes — there will be continued, and unjust, uncertainty for the transgender men and women who want to serve their country.

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Time for transgender rights opponents to give up the fight

By THE TIMES EDITORIAL BOARD
DEC 27, 2015 | 5:00 AM

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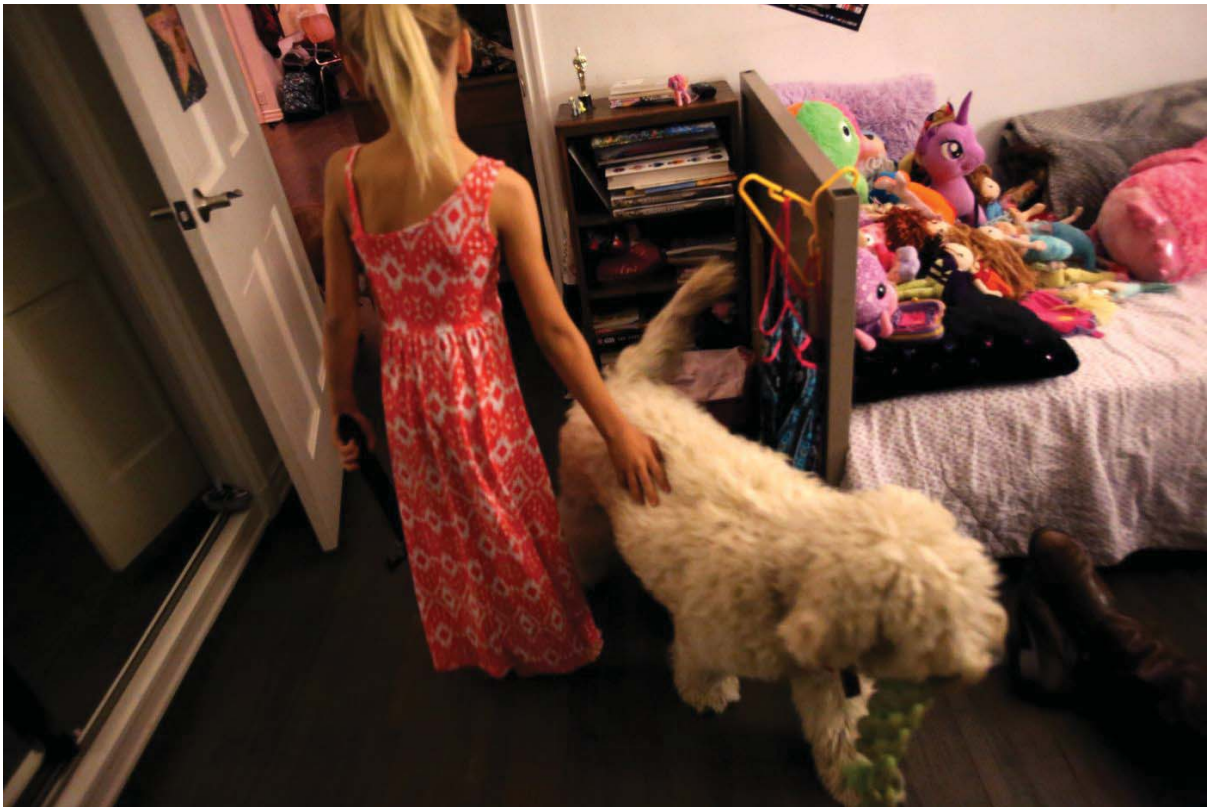

An 8-year-old transgender student who lives in Los Angelespets one of her dogs at home on Nov. 5. (Los Angeles Times)

Ever since California's law to protect the rights of transgender students went into effect two years ago, opponents have tried to whip up fear and confusion about what they see as the scary new bathroom rules, under which they say that any child of any gender may wander into any old restroom whenever they want. Voters, however, aren't buying it. For the second time, backers of a ballot initiative to overturn the law have failed to gather enough signatures to qualify for the ballot. It's time they gave up the fight.

The law covering transgender students has been in place for two years ... and there have been few complaints,

Lawmakers in 2013 passed the School Success and Opportunity Act, which was billed as a groundbreaking change for transgender rights, but really just clarified existing anti-discrimination policies in the state education code that were not always understood or followed. The law made it clear that transgender

concerns or reports of misconduct or abuse.

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students may use the bathrooms and locker rooms — and can participate on the sports teams — that correspond to the gender with which they identify. The law's goal was to accommodate children born male or female, but who identify differently. It also addressed delicate issues transgender students confront daily, and eliminated the confusion and discomfort that might arise if, say, a teen who identifies and dresses as a girl was forced to use the boys' bathroom.

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Opponents have argued that the law overrides the wishes of non-transgender students who do not want to use the bathroom or get undressed around members of the opposite sex. They have warned that the law means girls will be exposed to male genitalia against their will, and they say that if men are allowed to intrude into private spaces reserved for women, it opens the way to co-ed restrooms and safety risks. The opponents' proposed initiative — the Personal Privacy Protection Act — would have required people to "use facilities in accordance with their biological sex" in government buildings. Yet even this year, when the number of signatures needed to qualify for the ballot is the lowest it's been in 40 years, the coalition couldn't muster enough support and missed the deadline for the November 2016 election.

The message, we hope, is that Californians have rejected fear in favor of tolerance for people whose sexuality falls outside traditionally accepted norms. And why shouldn't

they? The law covering transgender students has been in place for two years (and L.A. schools have had similar policies for even longer), and there have been few complaints, concerns or reports of misconduct or abuse.

Public understanding of transgender issues has grown significantly in just the last two years, with movies and television shows such as Amazon's "Transparent." Olympic gold medalist and reality TV star Caitlyn Jenner put a familiar face on being transgender. One in five voters surveyed in a recent national poll personally knows or works with someone who is transgender, and, of those, 66% of respondents had favorable feelings toward that person. California's law is clearly on the side of equality and, as more transgender people openly share their experiences, broad public understanding and acceptance is sure to follow.

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Part IV

Department of Health and Human Services

Office of the Secretary

45 CFR Part 92

Nondiscrimination in Health Programs and Activities; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Part 92

RIN 0945–AA02

Nondiscrimination in Health Programs and Activities

AGENCY: Office for Civil Rights (OCR), Office of the Secretary, HHS.

ACTION: Final rule.

SUMMARY: This final rule implements Section 1557 of the Affordable Care Act (ACA) (Section 1557). Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. The final rule clarifies and codifies existing nondiscrimination requirements and sets forth new standards to implement Section 1557, particularly with respect to the prohibition of discrimination on the basis of sex in health programs other than those provided by educational institutions and the prohibition of various forms of discrimination in health programs administered by the Department of Health and Human Services (HHS or the Department) and entities established under Title I of the ACA. In addition, the Secretary is authorized to prescribe the Department's governance, conduct, and performance of its business, including, here, how HHS will apply the standards of Section 1557 to HHS-administered health programs and activities.

DATES: *Effective Date:* This rule is effective July 18, 2016.

Applicability Dates: The provisions of this rule are generally applicable on the date the rule is effective, except to the extent that provisions of this rule require changes to health insurance or group health plan benefit design (including covered benefits, benefits limitations or restrictions, and cost-sharing mechanisms, such as coinsurance, copayments, and deductibles), such provisions, as they apply to health insurance or group health plan benefit design, have an applicability date of the first day of the first plan year (in the individual market, policy year) beginning on or after January 1, 2017.

FOR FURTHER INFORMATION CONTACT: Eileen Hanrahan at (800) 368–1019 or (800) 537–7697 (TDD).

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through *Federal Digital System (FDsys),* a service of the U.S. Government Printing Office. This database can be accessed via the Internet at *http://www.gpo.gov/fdsys.*

I. Background

Section 1557 of the ACA provides that an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (Title VI), 42 U.S.C. 2000d *et seq.* (race, color, national origin), Title IX of the Education Amendments of 1972 (Title IX), 20 U.S.C. 1681 *et seq.* (sex), the Age Discrimination Act of 1975 (Age Act), 42 U.S.C. 6101 *et seq.* (age), or Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794 (disability), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Act or its amendments. Section 1557 states that the enforcement mechanisms provided for and available under Title VI, Title IX, Section 504, or the Age Act shall apply for purposes of addressing violations of Section 1557.

Section 1557(c) of the ACA authorizes the Secretary of the Department to promulgate regulations to implement the nondiscrimination requirements of Section 1557. In addition, the Secretary is authorized to prescribe regulations for the Department's governance, conduct, and performance of its business, including how HHS applies the standards of Section 1557 to HHS-administered health programs and activities.[1]

A. Regulatory History

On August 1, 2013, the Office for Civil Rights of the Department (OCR) published a Request for Information (RFI) in the **Federal Register** to solicit information on issues arising under Section 1557. OCR received 402 comments; one-quarter (99) were from organizational commenters, with the remainder from individuals.

On September 8, 2015, OCR issued a proposed rule, ''Nondiscrimination in Health Programs and Activities,'' in the **Federal Register**, and invited comment on the proposed rule by all interested parties.[2] The comment period ended on November 9, 2015. In total, we received approximately 24,875 comments on the proposed rule. Comments came from a wide variety of stakeholders, including, but not limited to: Civil rights/advocacy groups, including language access organizations, disability rights organizations, women's organizations, and organizations serving lesbian, gay, bisexual, or transgender (LGBT) individuals; health care providers; consumer groups; religious organizations; academic and research institutions; reproductive health organizations; health plan organizations; health insurance issuers; State and local agencies; and tribal organizations. Of the total comments, 23,344 comments were from individuals. The great majority of those comments were letters from individuals that were part of mass mail campaigns organized by civil rights/advocacy groups.

B. Overview of the Final Rule

This final rule adopts the same structure and framework as the proposed rule: Subpart A sets forth the rule's general provisions; Subpart B contains the rule's nondiscrimination provisions; Subpart C describes specific applications of the prohibition on discrimination to health programs and activities; and Subpart D describes the procedures that apply to enforcement of the rule.

OCR has made some changes to the proposed rule's provisions, based on the comments we received. Among the significant changes are the following.

Section 92.4 now provides a definition of the term ''national origin.''

OCR decided against including a blanket religious exemption in the final rule; however, the final rule includes a provision noting that insofar as application of any requirement under the rule would violate applicable Federal statutory protections for religious freedom and conscience, such application would not be required.

OCR has modified the notice requirement in § 92.8 to exclude publications and significant communications that are small in size from the requirement to post all of the content specified in § 92.8; instead, covered entities will be required to post only a shorter nondiscrimination statement in such communications and publications, along with a limited number of taglines. OCR also is translating a sample nondiscrimination statement that covered entities may use in fulfilling this obligation. It will be available by the effective date of this rule.

In addition, with respect to the obligation in § 92.8 to post taglines in at least the top 15 languages spoken nationally by persons with limited English proficiency, OCR has replaced the national threshold with a threshold

[1] 5 U.S.C. 301.

[2] 80 FR 54172 (Sept. 8, 2015).