U.S. District Court

Southern District of Illinois

Cristina Nicole Iglesias, (
AKA - Cristian Noel Iglesias, (
#17248-018 (
(Case No.# 3:19-cv-00415-JPG
VS. (
(
Director of Federal Bureau - (
of Prisons, et al (

Motion For Preliminary Injunction

Comes now Plaintiff, Cristina Nicole Iglesias, AKA - Cristian Noel Iglesias - Federal Bureau of Prisons #-17248-018, Moves and Request that this Court issue a Preliminary Injunction, Ordering the Federal Bureau of Prisons to give her access to adequate medical care, including sex reassignment surgery. Order the Defendants to take all actions reasonably necessary to Provide Iglesias sex reassignment surgery promptly as Possible, and Order a transfer to a Bureau of Prisons female Prison.

- Background -

Plaintiff, is currently housed in the Federal Bureau of Prisons located at the United States Penitentary - marion, Illinois. Plaintiff, is a transsexual woman, a person [redacted] whose female gender identity is different from the male gender assigned to her birth. Plaintiff, suffers from Gender dysphoria (severe) and has cut herself in an attempt to rid herself of male Parts. Plaintiff, has suffered great torture her time in a males Prison because of her feminity. Plaintiff, has requested since 2015 to have the Gender Affirming surgery, Plaintiff has exhausted 2 differant times her Administrative Remedies, which go on with No change. Gender DysPhoria is a "serious medical condition codified in the International Classification of Diseases (10th - revision; World Health Organization) and the -

American Psychiatric Associations Diagnostic and Statistical manual of Mental Disorders - 5th Edition (DSM-V)." It is "characterized by an incongruence between one's experienced/expressed - gender and assigned sex at birth, and Clinically significant distress or impairment of fuctioning as a result." Id. The condition is associated with "severe and unremitting emotional pain." Id. Without treatment, People with Gender Dysphoria experience anxiety, depression, suicidality and other mental health issues, Id. Male to Female transsexuals without access to appopriate care may result in attempting auto-castration (which Plaintiff has done Priviosly) in order to alleviate their distress, Gender Dysphoria intensifies with age, Plaintiff, contends that she is "a woman trapped in a male's body" and that her "(Spirit) is imprisoned in a way that causes excruciating - Pain and frustration to a Point that therapy

and other remedies are the only way to relieve that agony. Plaintiff has suffered great anxiety caused by her Gender Dysphoria that she fears "the worst happening".

- WPATH Standards of Care -

The World Professional Association for Transgender Health (WPATH) has developed Standards of Care for Treatment or Health of Transsexual, Transgender, and Gender-Non conforming People ("standards of-Care") which are recognized as authoritative Standards of Care by the American Medical Association, the American Psychiatric Association and the American Psychological Association. The Standards of Care explain the treatment for Gender Dysphoria is individualized. *Note - the Federal Bureau of Prisons states they follow (WPATH).

"What helps one person alleviate Gender-Dysphoria might be different from what helps another person." They address (Standards of Care) a variety of therapeutic options, including changes in gender expression and role, hormone therapy, surgery and Psychotherapy.

One treatment for gender dysphoria is sexual-reassignment surgery ("SRS"). "Vaginoplasty is the definitive male-to-female sex reassignment-surgery." It involves the removal of the Patient's-male genital and creation of female genitals, and has two therapeutic Purposes, SRS for transsexual female Patients both remove the Principal Source of testosterone in the body and creates Congruence between the Patients gender identity and Primary Sex Characteristics, while many transsexual, transgender, and gender-non-conforming individuals find comfort with their gender-identity, role and expression without surgery, — Standards of Care explain!

for many others surgery is essential and medically necessary to alleviate their Gender-Dysphoria. 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 idenitity, Standards of Care at 36: ("For many indriduals with severe gender Dysphoria cannot be achieved withaut surgical intervention. to modify primary sex characteristics, ie, genital reconstructio See Standards of Care ("Follow-up studies have shown an undeniable benefical effect of sex reassignment Surgery on Postoperative outcomes. In any professional experience, the success rate is extremely high. "SRS" is not thought to be experimental now that it has been repeatedly Positively evaluated for over twenty years!

The Standards of Care set forth six eligibility criteria for vaginoplasty in male to Female Patients:

(1.) Persistent, well documented gender-dysphoria:

(2.) Capacity to make 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 patients gender goals (unless hormones are not clinically-indicated):

(6.) 12 continuous month of living in a gender-role that is congruent with patients' identity.

Standards of Care they also require two referrals from qualified mental health professionals who have independently evaluated Patient. "If the first referral is from Patients Psychotherapist, the second referral should be from a Person who has only had evaluative role with role with patient".

The Standards "in their entirety apply to all transsexuals, transgender, and gender nonconforming People, irrespective of their housing situation." They expressly Provide that "People should not be discriminated against in their access to appropriate healthcare based on where they live, including institutional enviroments such as prisons. The Standards of Care allow for "reasonable accomodations to the institutional enviroment," such as use of injectable hormones where diversion of oral Prescription is highly likely, but they make clear that 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 accomodations under the standards of Care.

Iglesias's Treatment:

Iglesias sought hormone therapies in 2015 and shortly after requested consideration for (S.R.S) in 2016. In 2016 Plaintiff was diagnosed with Gender Dysphoria. Iglesias's has bew on continous hormone therapy since 2015 with frequent adjustments, since that time Iglesias has become "biological-female". She lives as a women, and now since taking hormones is now hormonally-reassigned. The Bureau of Prisons allows Iglesias to have long hair in which she does and has had bras and panties

issued to her since 2015. The B.O.P allows certain items for her to purchase make-up (eyeshadow, Blush, foundation, lip gloss. Her apperance is that of a women with significant breast growth. She is housed in General Population in a males prison. Iglesias treatment includs psychotherapy for her trauma in which the plaintiff suffered many years of abuse due to her being feminate all her life including sexual-abuse and is currently in treatment for her Gender Dysphoria, she currently sees Dr. Owings on a weekly basis. She is compliant with all treatment. Plaintiff, still has "excrusiating Pain and-frustration" as a result of her gender-dysphoria, not withstanding no help-

from the Bureau of Prisons for the one treatment to help alleviate her Pain and frustration and torture.

Her medical Records reflect a Consistant diagnosis of gender dysphoria as well as Iglesias desire to obtain SRS. (Please see enclosed medical Records.)

Iglesias struggles with her constant and are more pronouced (emotions) from not being able to complete the required surgeries ("S.R.S".

Iglesias's Appeal seeking SRS.

Iglesias requested thru medical and Psychology Services on or around 2016.

Iglesias wound up filing appeals in 2016 requesting SRS which were denied. Iglesias filed again in 2018 and on march 2, 2018 was notified that I would notified when the TCCT reaches a decision, * NOTE- the Response was a template with old diagnosis of Gender Identity-Disorder, however, had Central office really reveiwed Plaintiff, she has had the Offically Recognized diagnoses Of Gender Dysphoria, this caused great stress, frustration, feeling of despair. On 6/10/19 Plaintiff went to her Chronic Care Clinic where she discussed her desire to have the S.R.S, however, Dr. Pass stated that there has been no guidence, nor any word from Central Office (T.C.C.T) as to how, -

where or when any surgery will be done if ever. The Bureau of Prisons has NO Policy against S.R.S, they have NO Policy TO offer guidence or to allow for it. (See enclosed the Clinical Practioners guidence December 2016,) it states how INSTITUTIONS refer someone but does not ofer where, how or whom will perform S.R.S, This causes great stress, frustration, it also exaspirates Iglesias's Gender-Dysphoria. There has been NO real Proof that the Bureau of Prisons has reveiwed Iglesias for S.R.S, This causes torture with causes Plaintiff to want to do self-treatment, causing the worsening of Plaintiffs, Gender Dysphoria-

- Puts Plaintiff at risk, depression, self-harm (including auto-castration) and suicide.

The Bureau of Prisons has a moral obligation to provide all necessary and adequate medical care including sex reassignment surgery. Gender Dysphoria is a severe medical condition. Interfering, hindering, or plain negligence of medical care and not having NO-Policy or guidence constitutes a 8th Admendment Violation "deliberate-indeference". The Appeal for the S.R.S was 3-2-18, I have and continue to ask for the S.R.S to no avail the Bureau of Prisons is status quo.

- Jurisdiction-

This Court has Jurisdiction because Plaintiff is in the Southern District of-

- Illinois and the Claims arise under Federal law.

Motion For Preliminary Injuction.

A. Legal Standard.

" A Plaintiff seeking a Preliminary Injuction must establish that she/he is likely to Succeedon the merits, that she is likely to suffer irreparable harm in the absence of Preliminary relief, that the balance of equities tips in her favor and that the injection is in the public interest." Winter, v. Natural Resources Defense Council, Inc. 555 - U.S. 7, 20 (2008). "Serious going to the merits balance of hardships that tips sharply towards the Plaintiff can support issuance of a Preliminary Injuction, so long as the Plaintiff also shows that there is a likelihood of irreparable injury and that the Injuction is in the Public Interest." Alliance for the Wild Rockies - V. Cottrell 632 F.3d 1127, 1135 (9th Cir. 2011).

"A Preliminary injuction is an extraordinary remedy never awarded as of right." Winter 555 U.S. at 24. It may take may two forms. "A Prohibitory injuction prohibits a party from taking preserves the Status quo pending a determination of the action on the merits." Marlyn Nutraceuticals, INC v. Mucos Pharma-GmbH & Co. 571 F.3d 873, 878 (9th Cir.).

A mandatory injuction orders a party to take action. Because a mandatory injuction "goes well beyond simply maintaining the status qou Pendente lite it is Particulary disfavored. In general, mandatory injuctions "are not granted unless extreme or very serious damage will result and are not issued in doubtful cases or where the injury complained of is capable of compensation in damages." Anderson v. U.S. 612 F.2d 1112, 1115

Under the Prison Litigation Reform Act ("PLRA")

In any civil action with respect to Prison conditions, to the extent otherwise authorized by law, the Court may enter a temporary Restraining Order or an Order for Preliminary injuctive-relief. Preliminary Relief must be narrowly drawn, extend no further than necessary to correct harm the Court finds requires Preliminary relief, and be the least intrusive means necessary to Correct that harm. The Court shall give substantial weight to any adverse impact on Public-Safety or the Operation of the Criminal-Justice system. 18 U.S.C § 3626(a)(2).

- Likelihood of Success on the Merits -

To obtain a Preliminary Injuction requiring defendants to Provide S.R.S, Islesigs must first establish she is likely to succeed on the merits of S.R.S. claims. She contends that Defendants violated her Constitutional Rights under 42 U.S.C 1985 and 4042 as well at the ADA 42 U.S.C 12101 et, seq. by denying her medically necessary treatment for Gender Dysphoria in violation of the Eighth's Amendment Prohibitation against "cruel and unusual Punishment" and the Fourteenth Amendmendment's Equal Protection Clause.

- Deliberate Medical Indifference- legal Standard:

"Deliberate Indifference to a serious medical needs of Prisoners constitutes the "unnecessary and wanton infliction of Pain" Proscribed by the 8th Amendment" Estelle V. Gamble, 429 U.S. 97. 104 (1976).

Such an indifference may be manifested by prison doctors in their response to the Prisoners needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with treatment once prescribed.

Second, she "must show defendant's response to the need was deliberately indifferent." This second prong "is satisified by showing a purposeful act or failure to respond to a Prisoners pain or possible medical need (b) harm caused by the indifference, "medical malpractice does not become a constitutional violation merely because the victim is a Prisoner," "However, the U.S. Supreme Court has also recognized that while "deliberate indifference" under Estelle requires more than showing of mere negligence, something less than (a showing of) acts or omissions for the very purpose of causing harm or -

- or "with knowledge that harm will result" will suffice." Mandala v. Coughlin 920 F. Supp. 342, 353, (E.D.N.Y.) 1996 (citing Farmer v. Brenna 511 U.S. 825, 835 (1994.)

- Serious Medical need -

Iglesias is likely to succeed in establishing a serious medical need. She has presented extensive and consistent evidence that notwithstanding years of treatment in the form of hormone therapy and counseling, she continues to experince symptoms of Gender Dysphoria. The "Psychological and emotional pain" Iglesias experiences as a result of her gender dysphoria means she is unable to complete (her) existence or complete who she is, See Lopez v. Smith, 203 F.3d. 1122, 1131 "chronic and substantial pain." is an example of a serious medical need.) The WPATH standards of care explain that some individuals are unable to obtain relief from -

- gender dysphoria without surgical intervention, and describes S.R.S as "essential and medically-necessary." for this group of patients. WPATH Standards of Care are not disputed by the B.O.P however, the B.O.P staff at USP-Marion have recommened S.R.S, the Administ-istrative Remedy # 920251-A1, dated: 3-2-18 states that USP marion sent the request to the (TCCT) meaning that in the eyes of medical and mental Health Staff here I qualify as I have been told by staff. But the T.C.C.T have failed to act on it. Plaintiff further contends that Clinical-Encounter Date: 6-10-19, states on page-4 Gender Dysphoria- discussed this quite a bit today- She declines offer of antidepressant medication- Says that the sessions with psychology are helpful, but that she needs the gender-affirming surgery - She understands that there has been no further direction-

- from our Central Office regarding how/when/where this surgery will be done.
* Enclosed a Exhibit (1) Page 1-4 by Dr. Pass. Clinical Director.
WPATH Standards of Care are the accepted Standards of Care for the treatment of transgender patients like Iglesias. Johnson, 708 F.3d, 520, 522-23 (4th Circuit) describing the Standards of Care as "the generally accepted protocols" for the treatment of gender dysphoria'. Soneeya v. Spencer, 851 F. Supp. 2d, 228, 231 (D. Mass 2012) Iglesias, has satisfied all of the eligibility criteria for S.R.S as the record demonstrates (1) her persistent gender-dysphoria (2) her capacity to make fully informed decision and consent to treatment. (3) her majority. (4) that significant medical-

- and mental health concerns are well controlled (5) that she has recieved 12 continous months of hormone therapy (6) that she lived in a female gender role for 12 continous months

Iglesias contends that just because the Defendants have provided a prisoner (her) with some treatment consistant with the Standards of Care, Plaintiff contends that the Defendants have provided her with Consitiutionally adequate treatment". De'lonta- 708 F.3d at 526, see also Fields V. Smith- 653 F.3d 550, 556 (7th Cir. 2011), Ortiz- V. City of Imperial, 884 F.2d 1312, 1314 (9th Ca Plaintiff alleging deliberate medical- IN difference "need not prove complete failure to- treat." "Note" The First Circuit has opined that there is "no material difference" between a providers letter confirming eligibility, but not reccomending S.R.S, and what the Standards of Care refers to as a Letter of reccomendation, Kosilek V.S- Peneven 774 F.3d 5d 63,88 (1st Circuit).

Moreover, Bureau of Prisons, have Provided no credible support for the idea that Iglesias must demonstrate that she is likely to commit suicide or attempt auto-castration (Please note Iglesias has attempted to auto-castration in 2009 and the Bureau of Prisons did nothing and has thoughts of auto-castration that she claims is always Plan-B if the B.O.P. or Court fails to provide S.R.S. She is not required to demonstrate that she is a risk of death or imminent self harm. and that her pain is new or risk of injury, -Deliberate medical INdifference- Iglesias has shown the likelyhood of Proving that Prison officials are -

- deliberately indifferent to the serious medical need. "Deliberate indifference to medical needs may be shown by circumstantial evidence when facts are sufficient to demonstrate that a defendant actually knew of a risk of harm." Lolli v. County of Orange, 351 F.3d 410, 421 (9th Cir 2003) citing Farmer, 511 U.S. at 842.

Iglesias has presented evidence suggesting that Prison officials deliberately ignored her symptoms and continue to do so of Gender Dysphoria and are being deliberately in different to the Recognized Standards of care. Iglesias clearly stated in her Appeals she-

she suffered great anxiety, depression etc.

- Irreparable Harm -

Iglesias has clearly demonstrated and established she is suffering irreparable harm and that it will likely to get worse in the absence of a Preliminary Injuction. Iglesias has stated in Administrative Remedies and in the Complaint that she is in "— excruciating pain and "psychological and great emotional pain" as the result of her Gender Dysphoria, Emotional distress, anxiety, depression and other psychological-problems' can constitute irreparable injury. Iglesias is at risk of worsing of her gender-dysphoria without the S.R.S.

Furthermore, the deprivation of Iglesias' constitutional rights under the 8th Amendment -

- is itself sufficent to establish irreparable harm. See. Elrod v. Burns, 427, U.S. 347, 373. (1976). "(Unlike monetary injuries, constitutional-violations cannot be adequately through damages and therefore constitute irreparable harm.

The Bureau of Prisons cannot say that Iglesias cannot establish irreparble injury because " she can point to no relevant circumstance that make the Provision (S.R.S) suddenly urgent." The mere fact that the B.O.P has acknowledged the Administrative Remedies and have Not answered as to when I will be notified or given the S.R.S. from 3-2-18 constitutes Irreparable Harm.

- Balance of the Equities -

The Courts "must balance the competing claims of injury and must consider the -

- Consider the effect of each party of the granting or withholding of the requested relief." Winter, 555 U.S. at 24, "In excersing their sound discretion, Courts of equity should pay particular regard for the Public consequences in employing that extraordinary remedy of Injunction. Plaintiff ask this Court to issue a Preliminary Injeanction because she has proven that if the Bureau of Prisons does not act, she will worsen and her Gender-Dysphoria will continue to cause her to suffer unnecessary pain if denied S.R.S. and continue irreparable harm. NO B.O.P Offical can state that the Balance of Equities outweigh in her interest. The Court must not allow Political views out-

The Right thing to do under the 8th Amendment "Cruel & Unusal - Punishment. She has proven that the Bureau of Prisons has failed to provide the necessary treatment S.R.S.

The Court should also note that there is no safety or Security Concerns to Provide S.R.S. and Cannot override what is in Iglesias interest ~~interest~~ in recieving Constitutionaly adequate Care. The Bureau of Prisons may have never housed Someone undergoing S.R.S, but it does ~~have~~ experience housing inmates who require surgery and housing one post-operative male to female transsexual individual. And Iglesias also contends that housing her in a female Prison (Please note the B.O.P already houses transsexual / transgender female in female prison is in the best interest of Justice. She would be safer and She -

- Contends that after transitioning, with breast development she would feel safer, she has suffered sexual abuse due to her being a transsexual female in a males Prison, See Admin. Remedy # 897368-A1, Iglesias also contends it is torture to see B.O.P documents that say male instead of female (see Admin. Remedy #- 945168-A-3 Dated: 2-5-19,

There are no Public Interest in seeing Iglesias continued suffering during the Pendency of this litigation. - PLRA.

Iglesias feels she has shown this Court that she will likely to succeed on the merits of her 8th- Amendment claim, that she will likely to suffer irreparable harm without an injuction, that the balance of the Equities tips in her favor and that an Injuction is in the Public Interest. An Injuction granting her access to adequate medical care, including referral to a qualified Surgeon for S.R.S and transfer to a Bureau of Prisons female Institution, is narrowly drawn, extends no further than necessary to correct the Constitutional violation and is the least intrusive means to correct the violation. See 18 U.S.C § 3626. There is no evidence granting this relief will have any adverse impact on Public Safety or Operation- of the Criminal Justice system. 18 U.S.C 3626(a)(2)

Plaintiff, Request this Court issue an Preliminary Injuction to ensure that Iglesias will not have to continue to suffer irreparable harm and will have adequate medical / - mental Health care including the S.R.S. she needs.

An Injuction granting her access to adequate medical care, including referral to a qualified surgeon for S.R.S and a transfer to a Bureau of Prisons female institution. Planiffiff, moves this Court Grant Preliminary Injuction Ordering the Federal Bureau of Prisons to grant access to adequate medical care, including referral to a qualified surgeon for S.R.S and transfer to a female Institution.

9/3/19
Date:

Cristina Iglesias

Cristian Iglesias #17248-018
United States Penitentary-Marion
P.O. Box - 1000
Marion, Illinois 62959

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United Sta District Court
750 Missouri AVE
E Saint Louis, IL 62201
United States

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SOUTHERN DISTRICT OF ILLINOIS
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United States Penitentiary
Marion, IL 62959
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Legal Mail X

Exhibit - A

Bureau of Prisons

Health Services

Clinical Encounter

Dr. Randall Pass MD/CD

Date: 6-10-19

1-4 Pages

Exhibit (A)

Bureau of Prisons
Health Services
Clinical Encounter

Inmate Name: IGLESIAS, CRISTIAN NOEL			Reg #: 17248-018
Date of Birth: 06/10/1974	Sex: M	Race: WHITE	Facility: MAR
Encounter Date: 06/10/2019 09:10	Provider: Pass, Randall MD/CD		Unit: X02

Chronic Care - Chronic Care Clinic encounter performed at Health Services.

SUBJECTIVE:

COMPLAINT 1 **Provider:** Pass, Randall MD/CD

Chief Complaint: Chronic Care Clinic

Subjective: 44 year old here for CCC appointment regarding:
1) TRANSGENDER ~ on injectable estradiol, plus oral finasteride and spironolactone ~ recent hormone levels with estradiol 173 and testosterone 13
2) Also on daily aspirin to reduce CV risk
3) Obesity ~ weight has really increased over the last 2 years
4) Follows regularly with Psychology, has a lot of angst related to her inability to obtain the gender affirming surgery that she wishes

Care Level 2, no medical restrictions, works in Unicor
Optometry ~ seen in March
Immunizations ~ UTD with hepatitis, influenza, tetanus, and pneumonia vaccines
Releases in 2023

Pain: Not Applicable

Seen for clinic(s): Endocrine/Lipid, General

ROS:

General

Constitutional Symptoms

No: Unexplained Weight Loss, Weight Gain

Psychiatric

General

Yes: Mood-Down

No: Suicide/Self-Harm Thoughts, Homicide/Other Harm Thoughts

OBJECTIVE:

Temperature:

Date	Time	Fahrenheit	Celsius	Location	Provider
06/10/2019	09:24 MAR	97.2	36.2		Pass, Randall MD/CD

Pulse:

Date	Time	Rate Per Minute	Location	Rhythm	Provider
06/10/2019	09:24	66			Pass, Randall MD/CD

Respirations:

Date	Time	Rate Per Minute	Provider
06/10/2019	09:24 MAR	14	Pass, Randall MD/CD

Blood Pressure:

Date	Time	Value	Location	Position	Cuff Size	Provider
06/10/2019	09:24 MAR	109/63				Pass, Randall MD/CD

SaO2:

Date	Time	Value(%)	Air	Provider

Inmate Name: IGLESIAS, CRISTIAN NOEL
Date of Birth: 06/10/1974
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Sex: M Race: WHITE
Provider: Pass, Randall MD/CD
Reg #: 17248-018
Facility: MAR
Unit: X02

Date	Time	Value(%)	Air	Provider
06/10/2019	09:24 MAR	98		Pass, Randall MD/CD

Weight:

Date	Time	Lbs	Kg	Waist Circum.	Provider
06/10/2019	09:24 MAR	264.0	119.8		Pass, Randall MD/CD

Exam:

Diagnostics

Laboratory

Yes: Results

General

Affect

Yes: Pleasant, Cooperative

Appearance

Yes: Appears Well, Alert and Oriented x 3

Nutrition

Yes: BMI reviewed (enter in comments), Appears Obese

Pulmonary

Auscultation

Yes: Clear to Auscultation

Cardiovascular

Auscultation

Yes: Regular Rate and Rhythm (RRR), Normal S1 and S2

No: M/R/G

Peripheral Vascular

General

No: Non-Pitting Edema, Pitting Edema

Musculoskeletal

Gait

Yes: Normal Gait

Mental Health

Mood

Yes: Appropriate

ROS Comments

Working with Psychology to help with the gender dysphoria and her strong desire to have her male genitals removed

Other concerns:
-eyeglasses have not arrived
-wants to make sure mammogram is ordered -- she is concerned due to +FH of breast cancer -- reports she does daily self-breast exams and denies any areas of concern
-woke up this morning with "crick" in left upper back/neck

Exam Comments

BMI = 36
Has baseline CXR, EKG, and HIV testing on chart
Had mammogram last October
Recent labs:
-testosterone level 13

-estradiol level 173
-normal CMP, CBC, TSH, HbA1C
-cholesterol 196, HDL 40, LDL 106, TG 250

ASSESSMENT:

Gender Dysphoria In Adolescents And Adults, F64.1 - Current

Androgenic alopecia, L649 - Current

Transgender, validated male to female, 302.5b - Current - *on injectable estradiol 10 mg q2week, spironolactone 100 bid, Finasteride -*
2019: Estradiol level = 173, Testosterone level = 13

PLAN:

Renew Medication Orders:

Rx#	Medication	Order Date	Prescriber Order
143219-MAR	Finasteride 5 MG TAB	06/10/2019 09:10	Take one tablet (5 MG) by mouth each morning x 365 day(s)
	Indication: Transgender, validated male to female, Androgenic alopecia		
143218-MAR	Estradiol Cypionate 5MG/ML Inj (Depo) 5ML	06/10/2019 09:10	Inject 2 mL (10 mg) Intra-Muscularly every 2 weeks on Fridays x 180 day(s) Pill Line Only -- Next shot due on June 21st
	Indication: Transgender, validated male to female, Gender Dysphoria In Adolescents And Adults		

New Laboratory Requests:

Details	Frequency	Due Date	Priority
Lab Tests-E-Estradiol Lab Tests-T-Testosterone, Total Lab Tests - Short List-General-Comprehensive Metabolic Profile (CMP)	One Time	11/04/2019 00:00	Routine

Labs requested to be reviewed by: Brooks, Leslee PA-C

New Consultation Requests:

Consultation/Procedure	Target Date	Scheduled Target Date	Priority	Translator	Language
Mammogram	10/19/2019	10/19/2019	Routine	No	

Subtype:
Mammogram

Reason for Request:
Screening mammogram due in transgender inmate on hormonal treatment. Last mammogram was 10/9/18

Disposition:

Follow-up at Sick Call as Needed
Follow-up at Chronic Care Clinic as Needed
Discharged to Housing Unit-No Restrictions

Other:

Patient allergies reviewed and updates applied during this visit if indicated. See Chart: Allergies for most recent patient allergy list.

TRANSGENDER
*doing well on hormones, labs are perfect, will continue same medications without change
*annual mammogram due this October

Inmate Name: IGLESIAS, CRISTIAN NOEL
Date of Birth: 06/10/1974
Encounter Date: 06/10/2019 09:10
Sex: M Race: WHITE
Provider: Pass, Randall MD/CD
Reg #: 17248-018
Facility: MAR
Unit: X02

*gender dysphoria --discussed this quite a bit today -- she declines offer for antidepressant medication -- says that the sessions with Psychology are helpful but that she really needs the gender affirming surgery -- she understands that there has been no further direction from our central office regarding how/when/where this surgery will be done

Continues on daily aspirin for prevention of CV event and blood clot, at higher risk due to estrogen use

Obesity remains unchanged -- screening regularly for diabetes, dyslipidemia, etc.

Reassured her that glasses have been ordered and we will continue to track this

The "crick" in the neck seems to be a self-limited problem

Patient Education Topics:

Date Initiated	Format	Handout/Topic	Provider	Outcome
06/10/2019	Counseling	Plan of Care	Pass, Randall	Verbalizes Understanding
06/10/2019	Counseling	Test/X-ray Results	Pass, Randall	Verbalizes Understanding

Copay Required: No **Cosign Required:** No
Telephone/Verbal Order: No
Completed by Pass, Randall MD/CD on 06/10/2019 09:49

Exhibit - (B)

Bureau of Prisons
Health Services

Clinical Encounter -
Administrative Note

Dr. Randall Pass - MD/CD

Date: 6-11-18

EXHIBIT (B)

Bureau of Prisons
Health Services
Clinical Encounter - Administrative Note

Inmate Name:	IGLESIAS, CRISTIAN NOEL			Reg #:	17248-018
Date of Birth:	06/10/1974	Sex:	M Race: WHITE	Facility:	MAR
Note Date:	06/11/2018 10:05	Provider:	Pass, Randall MD/CD	Unit:	X02

Admin Note - Chart Review encounter performed at Health Services.

Administrative Notes:

ADMINISTRATIVE NOTE 1 **Provider:** Pass, Randall MD/CD

Inmate Iglesias has identified as transgender since she was a teenager. She has been officially diagnosed as being transgender within the BOP for at least 3 years, and has been on hormone treatment since 2015.

She is currently prescribed estradiol injections to increase estrogen levels, spironolactone to lower testosterone levels, and finasteride to help with male-pattern baldness. The hormone levels have been adjusted such that she has very low testosterone level (18) and high estradiol level (200), which are typical for a female.

Inmate Iglesias has taken all the steps that are available to her to feminize her appearance and is being medically treated as a female, consistent with the BOP policy on Medical Management of Transgender Inmates.

Copay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Completed by Pass, Randall MD/CD on 06/12/2018 11:36

Exhibit - C

Unit Team Request
To Staff

Date: 8/28/19

Exhibit - C

BP-S148.055 INMATE REQUEST TO STAFF CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) Unit Team - X - Ms. Lamer	DATE: 8/28/19
FROM: C. Iglesias	REGISTER NO.: 17248-018
WORK ASSIGNMENT: PM Evening Rec	UNIT: X - 228 U

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

I am Offically Requesting a transfer to a female Prison, FCI - Tallahassee, (my Region), or FMC - Carswell. I am Requesting either Prison due to the Cosmotalgy school. This is done due to my Re-entry interest as a transsexual female. Please process this Request.

Thank You,
C. Iglesias
17248-018
8/28/19

CC: File - USDC/S.D.I. - 3:19-cv-00415-JPG

(Do not write below this line)

DISPOSITION:

Signature Staff Member	Date

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Exhibit - D

Copy of Admin. Remedy

920251 - A1

Sexual Reassignment Surgery

Date: 3/2/18

2 - Pages

U.S. Department of Justice

Federal Bureau of Prisons

Exhibit - (D)

Central Office Administrative Remedy Appeal

Type or use ball-point pen. If attachments are needed, submit four copies. One copy each of the completed BP-229(13) and BP-230(13), including any attachments must be submitted with this appeal.

From: Iglesias, Cristian N. (LAST NAME, FIRST, MIDDLE INITIAL) 17248-018 (REG. NO.) X (UNIT) USP Marion (INSTITUTION)

Part A - REASON FOR APPEAL

I am appealing to the Bureau of Prisons regarding my request for sexual reassignment surgery at the earliest opportunity. delaying this process leads to emotional and psychological distress, depression, anxiety, stress, and thoughts of self mutilation (because of my gender dysphoria). The only appropriate treatment option at this tinme is sexual reassignment surgery. My gender dysphoria, making me a transgender female, causes me GREAT pain and psychological torture, due to having body parts that make me a biological male. TThe FBOP refusing or hindering in any way to give me sexual reassignment surgery is a violation of my Constitutional rights (under the 8trh amendment- Cruel & Unusual Punishment). Please approve me for sexual reassignment surgery as I clearly qualify for this procedure, and as you say: "I am continue adhering to institution rules as well as treatment and programing recommendations", witch i have been doing. The FBOP has an obligation to provide such treatment.

1-6-18
DATE

17248-018
SIGNATURE OF REQUESTER

Part B - RESPONSE

RECEIVED
JAN 18 2018
Administrative Remedy Section
Federal Bureau of Prisons

DATE

GENERAL COUNSEL

ORIGINAL: RETURN TO INMATE

CASE NUMBER: 922251-A1

Part C - RECEIPT

CASE NUMBER:

Return to: (LAST NAME, FIRST, MIDDLE INITIAL) (REG. NO.) (UNIT) (INSTITUTION)

SUBJECT:

DATE

SIGNATURE OF RECIPIENT OF CENTRAL OFFICE APPEAL

BP-231(13)

Exhibit - (D)

Administrative Remedy No. 920251-A1
Part B - Response

This is in response to your Central Office Administrative Remedy Appeal wherein you request sexual reassignment surgery without delay. You allege the Bureau of Prisons is violating your Constitutional rights by refusing or hindering this surgery.

We have reviewed documentation relevant to your appeal and, based on our findings, concur with the manner in which the Warden and Regional Director responded to your concerns at the time of your Request for Administrative Remedy and subsequent appeal. Further, Program Statement 6031.04, Patient Care, provides that inmates in the custody of the Bureau of Prisons with a possible diagnosis of Gender Identity Dysphoria (GID) will receive a current, individualized assessment and evaluation. Treatment options will not be precluded solely due to level of services received, or lack of services, prior to incarceration. If a diagnosis of GID is reached, a proposed treatment plan will be developed which promotes the physical and mental stability of the patient. Treatment plans will be reviewed regularly and updated as necessary.

The Transgender Clinical Care Team (TCCT) has acknowledged they have received your parent institution's request for you to receive gender reassignment surgery. Health Services will notify you when a decision has been made. Given the foregoing, we shall defer all surgical approvals until the TCCT reaches a decision.

The record reflects you have received medical care and treatment in accordance with evidence based standard of care and within the scope of services of the Federal Bureau of Prisons. You are encouraged to comply with proposed medical treatment so Health Services can continue to provide essential care and to contact medical personnel through routine sick call procedures should your condition change.

Considering the foregoing, this response is provided for informational purposes only.

3/2/18
Date

Ian Connors, Administrator
National Inmate Appeals

Exhibit - E

Medical Management of Transgender Inmates

Federal Bureau of Prisons

Clinical Guidance

12-6

(40-Pages)

Exhibit - (E)

MEDICAL MANAGEMENT OF TRANSGENDER INMATES

Federal Bureau of Prisons

Clinical Guidance

DECEMBER 2016

Federal Bureau of Prisons (BOP) Clinical Guidance is made available to the public for informational purposes only. The BOP does not warrant this guidance for any other purpose, and assumes no responsibility for any injury or damage resulting from the reliance thereof. Proper medical practice necessitates that all cases are evaluated on an individual basis and that treatment decisions are individual-specific. Referenced Program Statement versions within this guideline are for informational purposes only. Please refer to the most current versions of any referenced Program Statement(s). Consult the BOP Health Management Resources Web page to determine the date of the most recent update to this document: http://www.bop.gov/resources/health_care_mngmt.jsp

TABLE OF CONTENTS

1. PURPOSE

The Federal Bureau of Prisons (BOP) Clinical Guidance for *Medical Management of Transgender Inmates* provides recommendations for the medical management and treatment of transgender federal inmates, referred to in these guidelines as *individual(s) or person(s)*.

2. INTRODUCTION

NATURAL HISTORY

TRANSGENDER (TG) individuals are those whose gender identity is different from their biological sex. GENDER DYSPHORIA (GD), previously known as GENDER IDENTITY DISORDER (GID), is the *discomfort or distress* caused by a discrepancy between a person's GENDER IDENTITY and that person's GENDER assigned at birth. Not all TG will be diagnosed with GD, and a diagnosis of GD is not required for access to services. Data indicate significantly higher rates of mental health morbidity among TG individuals, compared with the general population—particularly anxiety, depression, and suicidality. Present-day treatment approaches involve supporting individuals in modifying their lifestyle—and if indicated, physically modifying their body—to better match the gender with which they psychologically identify.

DEFINITIONS

ASEXUAL: Refers to a person not attracted to either sex.

BISEXUAL: Refers to a person attracted to both sexes.

BOP TRANSGENDER CLINICAL CARE TEAM (TCCT): A multidisciplinary group of BOP personnel with TG subject matter expertise. The team provides assistance to institution staff and develops clinical treatment recommendations for the BOP TG population.

BOP TRANSGENDER EXECUTIVE COUNCIL (TEC): A group of BOP management personnel who mitigate executive level non-clinical issues. This group provides oversight to the BOP TCCT.

FEMALE-TO-MALE (FTM): Refers to a biological female who identifies as, or desires to be, a member of the male gender. The term *transgender male*, or *trans male* for short, is used to refer to the GENDER IDENTITY of a person who is FTM. (See the definition of TRANSGENDER below.)

GAY: Refers to a person who is romantically or sexually attracted to persons of the same gender. The term is mostly used to describe males. (See the definition of LESBIAN below.)

GENDER: A biopsychosocial construct used to classify a person as male, female, both, or neither. GENDER encompasses all relational aspects of social identity, psychological identity, and human behavior.

GENDER-AFFIRMING HORMONES: Hormonal therapy utilized to facilitate biological change(s) during TRANSITION. The term CROSS-SEX HORMONES is often utilized in the medical literature.

GENDER CONFORMITY: Behavior and appearance that adheres to the social expectations of a particular **GENDER**. (See the definition of **GENDER NONCONFORMITY** below.)

GENDER DYSPHORIA (GD): The condition of feeling that one's emotional and psychological identity as male or female is different from one's biological sex. By definition, **GD** implies that there is a state of distress or anxiety directly related to this conflict. In the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, released in May 2013, people whose assigned sex at birth is contrary to the one they identify with *and* who are experiencing a state of distress should be diagnosed with **GD**. This diagnosis is a revision of the criteria in the *DSM-IV* for **GENDER IDENTITY DISORDER**, and is intended to better characterize the experiences of affected individuals.

→ *Individuals identifying as TG do not necessarily have GD.*

GENDER EXPRESSION: Includes mannerisms, clothing, hair style, and choice of activities that individuals use to express their **GENDER IDENTITY**.

GENDER IDENTITY: Individuals' own sense of their **GENDER**, which they may choose to communicate to others by means of **GENDER EXPRESSION**.

GENDER IDENTITY DISORDER (GID): Strong, persistent feelings of identification with the opposite gender and discomfort with one's own assigned sex.

→ *The DSM-5 no longer uses this term. See the definition of* **GENDER DYSPHORIA** *above.*

GENDER NONCONFORMITY: Behavior or appearance that does not match the societal roles or expectations for one's assigned **GENDER**.

HETEROSEXUAL: Refers to a person attracted to the opposite gender.

HOMOSEXUAL: Refers to a person attracted to the same gender.

INTERSEX: Refers to a person whose sexual/reproductive anatomy or chromosomal pattern does not seem to fit the typical biological definition of male or female.

LESBIAN: Refers to a female who is attracted to other females.

MALE-TO-FEMALE (MTF): Refers to a biological male who identifies as, or desires to be, a member of the female gender. The term *transgender female*, or *trans female* for short, is used to refer to the **GENDER IDENTITY** of a person who is **MTF**. (See the definition of **TRANSGENDER** below.)

REAL-LIFE EXPERIENCE (RLE): When individuals live as the **GENDER** with which they identify.

SEX: A biological classification based on chromosomal composition, reproductive anatomy (primary sex characteristics), and phenotypic characteristics (secondary sex characteristics) that develop during pubertal maturation.

SEX REASSIGNMENT SURGERY: The surgical component of an individual's **TRANSITION**; also referred to as **GENDER-AFFIRMING SURGERY**.

SEXUAL ORIENTATION: The direction of one's sexual interest toward members of the same sex, the opposite sex, both, or neither.

TRANSGENDER (TG): A general term used for individuals whose **GENDER IDENTITY** does not conform to the typical expectations associated with the gender they were assigned at birth.

- While the term is often used synonymously with the term **GD**, being **TG** does not necessarily imply anxiety or distress about one's gender not matching one's assigned sex.
- The term **TRANSGENDER** also does *not* imply a particular **SEXUAL ORIENTATION**.
- A **MALE-TO-FEMALE (MTF) TRANSGENDER** person refers to a biological male who identifies as, or desires to be, a member of the female gender; a **FEMALE-TO-MALE (FTM) TRANSGENDER** person refers to a biological female who identifies as, or desires to be, a member of the male gender.

TRANSITION: The period during which **TG** individuals change their physical, social, and legal characteristics to the gender with which they identify. **TRANSITION** may also be regarded as an ongoing process of physical change and psychological adaptation.

SPECIAL CONSIDERATIONS

STIGMA

Stigma and prior negative experiences in institutions can impede transition services, and/or diagnosis and treatment of **GD**.

SUICIDALITY

Transgender adults with **GD** are at an increased risk of suicidal ideation and suicide prior to initiation of their gender transition, regardless of the clinical endpoint of their **TRANSITION**—whether that endpoint is living as the psychologically identified gender, hormone therapy, cosmetic treatments, breast augmentation/removal, and/or sex reassignment surgery. For many individuals, the risk of suicide may decrease after receiving the appropriate, individual treatment.

COMORBID CONDITIONS

- The most common comorbid conditions seen in **TG** adults with **GD** are anxiety and depression.
- Epidemiologic studies indicate a higher prevalence of HIV in the **TG** populations, specifically among **MtF** persons.

→ *See CDC, HIV Among Transgender People, #13 in the References section.*

GENERAL INTERACTIONS WITH TRANSGENDER INDIVIDUALS

Respect and trust are essential to a clinician-client (physician-patient) relationship. Respectful language and terms should always be used when discussing or referring to all individuals regardless of gender. Once an individual has identified as **TG**, use of pronouns or salutations preferred by the **TG** individual is appropriate, especially for those inmates with a Case Management Activity (CMA) Sentry assignment of **TRANSGENDER** (either TRN M2F or TRN F2M). This practice is more likely to facilitate a cooperative relationship between the **TG** individual and others, and generally reduces the stress of gender transition.

→ *Please note that this informal approach is distinct from a legal name change while in BOP custody; a legal name change must conform to the policy requirements in the Correctional Systems manual, currently Program Statement 5800.15 (or the most recent version).*

MULTIDISCIPLINARY TREATMENT APPROACH

A multidisciplinary approach is recommended for managing issues associated with the incarceration of **TG** individuals, including the provision of medical treatment when indicated. Institutional staff training programs should consider incorporating Continuing Medical Education on the clinical care of **TG** individuals.

The BOP offers **TRAUMA-INFORMED CORRECTIONAL CARE (TICC)**, which incorporates an understanding that inmate attitudes, behaviors, and concerns are likely to be affected by prior traumatic experiences. **TICC** includes both training and treatment programs, emphasizes the recognition of trauma in all forms, and incorporates the principle that all staff may have a role in reducing its impact. Subject matter experts within the BOP are available to assist providers and other staff working with **TG** inmates.

HOUSING ASSIGNMENTS, PROGRAM ASSIGNMENTS, AND PAT SEARCHES

- *Refer to the current version of BOP Program Statement 5324.11, Sexually Abusive Behavior Prevention and Intervention Program.*
- *Refer also to the Transgender Offender Manual Program Statement.*

3. INTAKE SCREENING REGULATIONS

Prison Rape Elimination Act (PREA) regulations, incorporated into *BOP Program Statement 5324.11, Sexually Abusive Behavior Prevention and Intervention Program*, state that the intake screening shall consider, at a minimum, the following criteria to assess individuals for risk of sexual victimization—whether the individual is known or perceived to be gay, lesbian, bisexual, **TG**, intersex, or gender nonconforming.

- ***See 28 C.F.R. § 115.41 (d).***

Individuals may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions about being gay, lesbian, bisexual, **TG**, intersex, or gender nonconforming.

- ***See 28 C.F.R. § 115.41 (h).***

Staff shall not search or physically examine any inmate, to include a **TG** or intersex individual, for the sole purpose of determining the individual's genital status. If the individual's genital status is unknown, and as appropriate, it may be determined during conversations with the individual, by reviewing medical records, or, if necessary, learning that information as part of a broader medical examination conducted in private by a medical provider.

- ***See 28 C.F.R. § 115.15 (e).*** *This provision does not limit searches of individuals to ensure the safe and orderly running of the institution.*

4. TRANSGENDER-IDENTIFYING CHARACTERISTICS

Transgender status is based on an individual's self-report of identifying characteristics. When an individual self-identifies as **TG**—or requests referral or evaluation for treatment—a medical and/or mental health evaluation is conducted according to policy, and as clinically appropriate to fully evaluate the individual's treatment needs.

The following criteria may be useful in identifying a person's status as **TG**:

A persistent and marked difference between a person's preferred gender and their biologic or natal sex, which may be experienced as or accompanied by:

- ***Strong feelings about primary or secondary sex characteristics;***
- ***Strong feelings about being treated as or becoming another gender; or***
- ***Belief that one's actions, feelings, or mannerisms are more characteristic of another gender.***

ELECTRONIC MEDICAL RECORD (EMR) CODES

For purposes of providing appropriate medical treatment and management, all individuals who identify as **TG**—whether or not they are receiving hormone treatment—need to have the appropriate code for transgender individuals entered into the EMR health problem list, as listed below in *Table 1.*

TABLE 1. EMR CODES FOR TRANSGENDER INDIVIDUALS

BOP Transgender Determination	EMR Codes[1,2]	Corresponding Sentry CMA Codes
Transgender, male to female	F64.0f	TRN M2F
Transgender, female to male	F64.0m	TRN F2M

[1] *EMR Transgender codes are solely for the use of clinical providers during the course of medical intervention and treatment. The respective codes are to be applied to inmates whose transgender identity has been confirmed and for whom medical treatment is appropriate, as described in the Transgender Offender Manual Program Statement and in this BOP Clinical Guidance.*

[2] *If an individual has undergone sex reassignment surgery, use code Z87.890 (Personal History of Sex Reassignment) along with the appropriate F64 code above.*

IMPORTANCE OF CODING TG INDIVIDUALS: Coding of the **TG** determination status is imperative for accurate individual records to ensure all individuals are receiving appropriate care and management. All BOP individuals who self-identify as **TG**, or are identified by history or current presentation as **TG**, need to be assessed by the appropriate psychology and/or health service staff in a timely fashion. Treatment and management of the **TG** individual are individualized and proceed from a thoughtful assessment, consideration of the individual's presentation and preferences, and attention to safety and security needs of the individual. This is all performed within the context of ensuring the safe and orderly operation of the institution.

5. Assessment and Management of the TG Individual – A Multidisciplinary Approach

Healthcare for **TG** individuals requires a multidisciplinary approach. The following process is recommended for transgender individuals (especially those newly identifying as **TG**) seeking medical intervention to assist with gender transition needs:

- **First Step – Mental Health Assessment:** The first step in the process is for the individual to be seen by psychology staff for a comprehensive mental health assessment. Psychology staff will be able to confirm an individual's **TG** identity, diagnose mental health conditions based on DSM criteria, address the inmate's mental health concerns, and provide individualized counseling support and other interventions as appropriate.

  → *See Section 6, Mental Health Assessment.*

- **Second Step – Medical Assessment:** The second step is for psychology staff to refer the individual for an evaluation by a medical provider if the patient desires medical intervention. If appropriate, the medical provider can initiate hormone therapy after the risks and benefits have been discussed with the individual, and the **BOP TCCT** has been consulted. Pharmacists may also play a role in treatment by counseling individuals on medications and recommending appropriate medication selection and/or lab monitoring to the medical provider. Psychiatrists may be consulted in cases of significant mental health challenges requiring medical intervention.

  → *See Section 7, Medical Assessment.*

- **Third Step – Individualized Treatment:** In many cases, treatment is designed to reduce characteristics of the natal sex and induce those of the identified gender, allowing individuals to project their **gender identity**. The treatment and management of the **TG** individual requires individualized care guided by treatment goals to allow for successful **transition** through education, counseling, real-life experience, medical evaluation, hormone treatment, and in some cases, sex reassignment surgery.

  → *See Section 8, Stepwise Approach to Medical and Mental Health Treatment of TG Individuals.*

Gender Dysphoria (GD) Criteria

Individuals identifying as transgender do not necessarily have GD. Although data are insufficient to know the prevalence rates of **GD** in the transgender population, anecdotally many clinicians report that most transgender individuals experience some degree of dysphoria in the absence of treatment. Because untreated or under-treated **GD** is associated with increased morbidity and mortality, screening for **GD** in **TG** individuals is essential. Without treatment, this population may experience higher rates of depression, anxiety, and suicidality. Treatment modalities may include psychotherapy, supportive changes in gender expression and role, hormone therapy, and surgical therapy. Where indicated, hormonal interventions may improve **GD**, mental health comorbidities, and overall quality of life.

The DSM-5 criteria may be used to make the diagnosis of GD, and include two major categories: **(1)** Gender incongruence, i.e. a significant difference between a person's experienced or expressed gender and their assigned gender, and **(2)** significant distress or dysfunction that results from the gender incongruence. Readers are referred to the DSM-5 or to the DSM website (subscription required for access to copyrighted material) for the specific DSM-5 criteria.

➔ *See DSM-5, #1 in the References section.*

A diagnosis of **GD** will be recorded in the EMR health problem list under the appropriate DSM code (F64.1). Referral to a mental health professional for co-management of **GD** is recommended.

6. MENTAL HEALTH ASSESSMENT

Transgender status is based on an individual's self-report. Therefore, the history or subjective component of the evaluation serves as the primary source for identifying a person as TG. When transgender individuals request mental health services or are referred to Psychology Services, or when medical intervention for **TG** transition is being considered, it is appropriate to conduct a mental health evaluation.

The mental health assessment typically includes: **(1)** Obtaining a history of gender identity and screening for **GD**; **(2)** screening for other mental health disorders related to autism, eating, mood, personality, psychosis, and substance use; **(3)** identifying a history of abuse or neglect and any current or past self-harm ideations or attempts; **(4)** performing an assessment of affective, cognitive, and psychosocial functioning, if indicated; **(5)** psychosocial treatment recommendations; and/or **(6)** medical referral, if indicated.

➔ *Please also refer to APA, Guidelines for psychological practice with transgender and gender nonconforming people, #12 in the References section.*

DIAGNOSTIC ASSESSMENT

Diagnostic assessments are completed in PDS-BEMR under the title Diagnostic and Care Level Formulation and include the following:

- **PRESENTING PROBLEMS/SYMPTOMS:** Outline the individual's concerns, including who made the referral and when.
- **RELEVANT HISTORICAL INFORMATION:** This psychosocial history may include a review of the individual's developmental history (including gender identity), sexual history (including sexual predation or victimization), trauma, mental health history, suicide attempts or self-harm, criminal history, educational experience and progress, family dynamics, peer relations, and social support expected upon release.
- **DIAGNOSTIC FORMULATION:** If applicable, list diagnostic impressions.
- **CARE LEVEL FORMULATION:** Provide a discussion of the individual's ongoing need for mental health services and assign a care level consistent with the individual's needs.

MENTAL HEALTH TREATMENT CONSIDERATIONS

The mental health team plays an important role in diagnosing individuals, as well as providing psychotherapy and counseling:

- **INDIVIDUAL'S UNDERSTANDING/EXPECTATIONS OF TREATMENT OPTIONS:** Prior to engaging in treatment, conversations regarding the individual's expectations of outcome are required in order to identify realistic goals.
  - ➔ *A collaborative education session for the inmate, with both psychology and medical services staff, is highly recommended.*
- **PSYCHOTHERAPY:** This is a general term for treating mental health problems by the individual discussing them with a mental health provider. Psychotherapy can be used to learn about and treat an individual's moods, thoughts, and behaviors. It can also be supportive to individuals experiencing distressing thoughts and/or feelings.
- **PSYCHIATRY SERVICES:** Individuals can also be referred to psychiatry services for mental health concerns or medication management of other mental illness in conjunction with **GD**.
  - ➔ *A psychiatry consult is not needed for a diagnosis of GD. The diagnosis may be made by another mental health provider, based on DSM-5 criteria.*

7. MEDICAL ASSESSMENT

Once Psychology Services has completed the mental health assessment and ascertained the individual's **TG** goals—or otherwise determined that the individual is in need of a medical evaluation—the psychologist will refer the individual to the appropriate Health Services staff for specific medical interventions. A medical assessment should include:

- **REVIEW OF THE MENTAL HEALTH ASSESSMENT**
- **ASSESSMENT OF OVERALL HEALTH**
- **ASSESSMENT OF PREVIOUS TREATMENT** (hormonal therapy, surgery, etc.).
- **CO-OCCURRING MEDICAL DISORDERS:** Given the increased risk for individuals with thrombotic, hepatic, and oncological conditions who undergo hormonal therapy, it is crucial that comorbid conditions be managed appropriately and carefully.
  - ➔ *Please note that comorbidities are not necessarily a contraindication to therapy and must be assessed for each individual. See more about drug risks in Table 3 (**MTF**) and Table 4 (**FTM**).*
- **INFORMED CONSENT:** Individuals must be counseled on the risks and long-term effects of hormonal therapy. Use of gender-affirming hormones in the management of **TG** individuals is considered an off-label use and does not currently have FDA approval. Due to the irreversibility of some of the treatment options and the side effects, the individual's informed consent is required before initiating treatment and must be documented within the medical record.
  - ➔ *See Section 12, Patient Education & Informed Consent.*

- **CONTRAINDICATIONS:**
  - ➔ *See the Treatment Summary Charts in Appendix 1a (**MTF**) and Appendix 1b (**FTM**) for medication-specific contraindications.*

  MTF

  - **ABSOLUTE:** History of estrogen-sensitive cancer (e.g., breast cancer); history of thromboembolic disease (unless provided with concurrent anti-coagulation therapy); history of macroprolactinoma.
  - **RELATIVE:** Liver, kidney, or heart disease/stroke (or risk factors for heart disease such as high cholesterol, diabetes, obesity, smoking); strong family history of breast cancer or thromboembolic disease; gallbladder disease.

  FTM

  - **ABSOLUTE:** Pregnancy; breast feeding; history of breast cancer (testosterone may have anti-proliferative effects on most, but not all, breast cancers).
  - **RELATIVE:** Androgen-sensitive epilepsy; migraines; sleep apnea; polycythemia (elevated red blood cell count); cardiac failure; renal failure or severe hypertension susceptible to salt retention and fluid overload; significant liver disease; coronary artery disease (CAD) or risk factors for CAD; history of uterine cancer; bleeding disorders (for injected testosterone); significant history of violent behavior.

8. Stepwise Approach to Medical and Mental Health Management of TG Individuals

Table 2 summarizes the step-by-step approaches to medical and mental health management of **TG** individuals in the BOP. It should be noted that ongoing release preparation and BOP Social Worker referral may facilitate a successful return to the community.

➔ *See Section 9, Hormone Treatment, Section 10, Medications for MtF Individuals, and Section 11, Medications for FtM Individuals for more detailed information on medical treatment.*

Table 2. Stepwise Approach to MtF and FtM Medical and Mental Health Management

1	Individual identifies as **TG** and seeks medical intervention to assist with transition; mental health assessment provided (see *Section 6*); continuation of counseling by psychology services if indicated; and implementation/initiation of **real-life experience (RLE)**.	
2	Referral to medical provider for medical evaluation; laboratory workup; discussion of realistic expectations of hormonal therapy; and informed consent for hormone treatment. See Section 7.	
3	Discussion with **BOP TCCT** and psychiatric clinical pharmacist consultant, followed by a non-formulary request submission.	
4	***MtF***	***FtM***
	Once non-formulary request has been approved, begin hormonal therapy with anti-androgen (spironolactone first, unless contraindicated) and estrogen (see *Appendix 1a* for choosing a preparation). Start low and titrate to appropriate level while using lowest effective dose. ➔ *See Hormone Therapy for MtF in Section 9.*	Once non-formulary request has been approved, begin hormonal therapy with testosterone (see *Appendix 1b* for choosing a preparation). Start low and titrate to appropriate level while using lowest effective dose. ➔ *See Hormone Therapy for FtM in Section 9.*
5	***MtF***	***FtM***
	If treatment has reached maximum estrogen dose without seeing desired effects, consider adding another anti-androgen such as finasteride, gonadotropin-releasing hormone (GnRH) agonist, or medroxyprogesterone. Consult **BOP TCCT**.	If still experiencing uterine bleeding after first few months of high-dose testosterone therapy, consider adding medroxyprogesterone or a GnRH agonist to suppress menstruation. Consult **BOP TCCT**.
6	Evaluation of individual by **BOP TCCT** for potential appropriateness of surgical intervention upon institution referral. ➔ *See Section 12 for general criteria for consideration of surgery.*	
7	Surgical intervention.*	

* For further considerations, please refer to the most recent guidelines from the World Professional Association on Transgender Health (WPATH), the Endocrine Society, and the American Association of Obstetricians and Gynecologists (Committee Opinion), available at: *http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351*.

Cases will be reviewed on a case by case basis by BOP Central Office through a referral from the **BOP TCCT**.

9. HORMONE TREATMENT: ELIGIBILITY, GOALS, OVERVIEW

Hormone supplementation is an important part of transitional treatment for many transgender individuals. Studies demonstrate improvement (in the range of 70–80%) in gender dysphoria, mental health, quality of life, and sexual function, for transgender treatment that included hormone therapy. The goals of hormone treatment are **(1)** to suppress endogenous hormones and physical characteristics of the natal sex and **(2)** to supplement hormones and enhance characteristics of the preferred gender, utilizing the principles of hormone replacement therapy for hypogonadal individuals of the **TG** individual's identified gender.

➔ *The information in this section is in part adapted from VA Pharmacy Benefits Management Services, Transgender Cross-Sex Hormone Therapy Use, (#2 in the References section) and Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (#3 in the References section).*

ELIGIBILITY AND READINESS FOR GENDER-AFFIRMING HORMONE THERAPY

WPATH CRITERIA: Current WPATH guidelines identify four eligibility criteria for hormone therapy, but also emphasize the need for individualized treatment plans that may include hormone therapy in selected cases that do not meet all four criteria. The WPATH criteria are as follows:

(1) Gender dysphoria that is persistent and documented.

(2) Medical and/or mental health conditions, if present, are reasonably well-controlled.

(3) Legal age of majority (currently 18 years in all states except Alabama and Nebraska, which use 19 years).

(4) Informed consent.

ENDOCRINE SOCIETY CRITERIA: As part of their eligibility criteria, the Endocrine Society also includes ICD-10 criteria for transsexualism as an alternate criterion for gender dysphoria, and requires three months of documented real life experience or psychotherapy. The Endocrine Society further describes readiness criteria to include further consolidation of the preferred gender identity and progress in the gender transition, as well as willingness and ability to take hormones as prescribed.

HORMONE THERAPY FOR MALE-TO-FEMALE (MTF)

Feminizing treatment is generally the more complex of the two gender-affirming regimens and consists of either one medication alone or a combination of an anti-androgen and an estrogen, with a potential progestin adjunct. Most clinical studies and guidelines recommend therapy with an anti-androgen and an estrogen, although androgen suppression may be used alone in individuals desiring a more androgynous appearance.

- **Individuals should have realistic expectations of the treatment results, as well as the timeline of when to expect them.** Medical staff should provide enough information on an ongoing basis to help individuals set these realistic expectations. Every case is different, and slow change can lead to frustration. It is important to discuss realistic expectations with the

individual in order to avoid any attempts to self-increase the dosage in hopes of speeding up results.

- Within the first six months of treatment, changes may be seen in body fat redistribution, loss of muscle mass, breast growth, testicular atrophy, decreased erections, decreased sperm production, and a slowing of body/facial hair growth.
- The maximum effect of treatment may not be seen for more than two years.
- Treatment does not provide voice alteration, and training to feminize the voice with a speech pathologist may be indicated, based on consultation with the **BOP TCCT**.

- Most treatment results are reversible upon cessation of treatment, but breast growth is permanent and infertility may be irreversible.
- Goal levels of treatment are serum estradiol <200 pg/ml (premenopausal level) and testosterone <55 ng/dl. Serum estradiol levels should not exceed those of a premenopausal female, but doses used to achieve an adequate level may be significantly higher than those used in hormone replacement therapy in menopausal women.
  - It is important to note that there are individuals who do not require estradiol as part of their hormonal therapy regimen and do well on an anti-androgen therapy alone. There are others who require very little estrogen to obtain desired body characteristics and adequately treat any presenting dysphoria.
  - Individuals should uniformly be treated with the lowest effective hormone doses. As previously stated, estradiol levels should not routinely exceed a premenopausal level of 200 pg/ml, but the average individual does not usually require levels near that threshold. The same holds true for testosterone levels. While the goal is <55 ng/dl, there is a subset of individuals who do poorly with levels below 35 ng/dl. The ideal levels for these individuals would be between 35–55 ng/dl.
  - ➔ *Dose adjustments, based on the individual's response, are made once hormone levels are in the target range.*

HORMONE THERAPY FOR FEMALE-TO-MALE (FTM)

Masculinizing treatment is the less complex of the two gender-affirming regimens and consists mainly of testosterone supplementation.

- **The individual's realistic expectations about treatment results and the associated timeline are essential prior to beginning treatment.**
- Within the first six months of treatment, body fat redistribution, an increase in libido, an increase in acne, clitoral enlargement, vaginal atrophy, cessation of menses, and infertility may be evident. Alterations in hair growth, voice depth, and muscle mass may take longer—reaching full effects of treatment in two to five years.
- Uterine bleeding should cease within a few months of high-dose testosterone therapy, but treatments such as gonadotropin-releasing hormone (GnRH) agonists, medroxyprogesterone, and endometrial ablation may be used to stop menses prior to starting testosterone therapy or to decrease estrogen levels.

- Most effects are reversible upon cessation of treatment, but changes in hair, voice depth, and fertility may be irreversible.
- Goal treatment levels are serum estradiol <50 pg/ml and serum total 350–700 ng/dl (male physiologic range; some sources quote a normal reference range of 400-800 ng/dl). If a peak testosterone level is drawn for injectable testosterone, the level should not exceed 1,000 ng/ml. Prior to the ninth month of treatment, total testosterone levels may read high, while free testosterone levels are within the normal range. This may be due to the possibility of high levels of sex hormone binding to globulin in some women.
  - ➔ *Dose adjustments, based on the individual's response, are made once hormone levels are in the target range.*

HORMONE THERAPY DURING PREGNANCY

Gender-affirming hormone therapy is contraindicated during pregnancy. While therapy may lead to potentially irreversible infertility, it does not function as contraception, and pregnancy is still possible during treatment.

➔ *Precautions should be taken to avoid pregnancy during treatment.*

10. MEDICATIONS FOR MTF INDIVIDUALS

MTF MEDICATIONS: DRUG CLASSES

➔ *See the **MTF Treatment Summary Chart** in Appendix 1a for summarized information on each of the medication groups below—including dosing, adverse effects, contraindications, interactions, and monitoring.*

ANTI-ANDROGENS

Anti-androgens reduce testosterone levels, allowing estrogen therapy to be used in lower doses while still reaching a maximum effect. Medications with anti-androgen effects include spironolactone, finasteride, GnRH agonists, and progestins.

- **SPIRONOLACTONE** is a potassium-sparing diuretic that directly inhibits testosterone secretion and androgen binding to the androgen receptor. Spironolactone can suppress facial and body hair growth, male pattern baldness, libido, and sexually stimulated erections. It decreases symptoms of benign prostate hypertrophy (BPH) and can lead to modest breast growth.
  - ➔ *The use of spironolactone is contraindicated in renal insufficiency and with a potassium value greater than 5.5 mEq/L. Spironolactone can cause hyperkalemia and hypotension. It is important to monitor potassium levels and blood pressure of individuals taking spironolactone, as stated in Appendix 1a.*
- **FINASTERIDE** inhibits the enzyme responsible for converting testosterone to its potent form. It can be used alone at high doses (5–10 mg/day) in individuals intolerant to spironolactone, or as an adjunct to spironolactone. Effects are similar to those of spironolactone treatment, but spironolactone treatment is considered first line due to observed responses. Finasteride can be used in low doses (1 mg/day) to treat male pattern baldness. Finasteride can reduce BPH symptoms by reducing the size of the prostate.
  - ➔ *Finasteride should not be used when prostate cancer is suspected, due to its ability to lower prostate-specific antigen levels.*

- **GnRH Agonists** include goserelin, nafarelin, and leuprolide. These medications suppress pituitary gonadotropin levels and gonadal steroids. They are most often used in adolescents for suppression of puberty, but can be used to decrease testosterone levels and the amount of estrogen needed for **MtF TG** individuals. One advantage of using GnRH agonists in adolescents is that their effects are generally fully reversible. GnRH agonists do not carry the risk of thromboembolic disease.

- **Progestins** are a group of hormones that include medroxyprogesterone. Use of medroxyprogesterone is controversial and not routinely recommended, but it can be used alone in individuals intolerant to other agents, or as an adjunct for individuals receiving maximum estrogen doses without desired effects. Medroxyprogesterone has anti-androgen effects at high doses, but is not more effective than spironolactone. It is purported to aid in breast development at a cellular level, but its effect is mainly on the uterus, and evidence as an effective agent in gender-affirming hormone therapy is lacking.
  - ➔ *Medroxyprogesterone treatment comes with risk of developing mood disorders (depression/irritability), lipid abnormalities, weight gain, and edema. There is also a concern of increased cardiovascular risk.*

- **Other anti-androgenic agents** include flutamide and cyproterone acetate, but are not commonly used in the U.S. Cyproterone acetate is widely used in Europe, but is not available in the United States. Flutamide blocks androgen binding, but comes with a risk of hepatotoxicity and has little to no efficacy in reducing testosterone levels.

Estrogens

Estrogens are used to provide feminization in the form of physical appearance and sexual characteristics. Effects include development of breasts, redistribution of body fat, softening of the skin, shrinkage of the testes, and testicular atrophy. Many formulations of estrogen are available, including parenteral, transdermal, and oral. Estrogen may have positive health effects more generally, including increased high-density lipoprotein, decreased low-density lipoprotein, and preservation of bone mineral density.

➔ *A list of adverse events and necessary lab monitoring can be found in Appendix 1a.*

- All estrogens come with a risk of thromboembolism, but lower doses and transdermal formulations are considered safer and should be used in populations at higher risk of thromboembolism (>35 years old, smoker, obese). Synthetic estrogens, especially ethinyl estradiol, have been shown to have a higher risk of thromboembolism.
- Intramuscular (IM) injections can cause greater peaks and troughs in estrogen levels, causing more mood issues than oral and transdermal preparations, making oral and transdermal preparations preferable.
- Use of estrogen should be individualized and adjusted regularly, based on serum estradiol levels and individual-specific concerns. Estrogen should be started at low doses and titrated up as needed, based on hormone levels and individual tolerance. If discontinuation is necessary, consider tapering therapy to alleviate mood disturbances.
  - ➔ *Conjugated and synthetic estrogen formulations cannot be measured through serum estradiol concentrations and are no longer recommended for gender-affirming hormone therapy.*

MTF MEDICATIONS: DRUG EFFECTS TIMELINE

➔ *Refer to the Endocrine Society guideline, Table 14, page 3145 (reference 3 in the References section of this guidance) for specific expectations of feminizing effects of medication therapy.*

In general, a person may expect decreased libido and spontaneous erections to occur within one to three months of starting therapy, with a maximum effect in three to six months. Effects that usually develop in the first three to six months of treatment include redistribution of body fat, decrease in muscle mass and strength, softening and decreased oiliness of skin, breast growth, and decreased testicular volume with a maximum effect in one to three years. A decrease in terminal hair growth usually does not occur until six to 12 months into treatment, with a maximum effect not occurring for at least three years or more. The timelines for male sexual dysfunction and decreased sperm production are either variable or unknown. Voice changes do not occur with hormone treatments.

MTF MEDICATIONS: DRUG RISKS

Table 3 lists conditions that can be exacerbated by gender-affirming estrogen therapy. See *Appendix 1a* for more information on the adverse effects of estrogen therapy and androgen suppression.

TABLE 3. MEDICAL CONDITIONS EXACERBATED BY GENDER-AFFIRMING ESTROGEN THERAPY (MTF)

Very high risk of serious adverse outcomes:	
• Thromboembolic disease	
Moderate to high risk of adverse outcomes:	
• Macroprolactinoma • Breast cancer • Severe liver dysfunction *(transaminases >3x upper limit of normal)*	• Coronary artery disease • Cerebrovascular disease • Severe migraine headaches

MTF MEDICATIONS: MONITORING

Gender-affirming hormone therapy has the same risks associated with hormone replacement therapy in biological males and females. Appropriate monitoring is crucial. Weight, blood pressure, physical exams, risk factors, medications, complete blood counts, renal and liver function, and lipid and glucose metabolism should be monitored for all **TG** individuals receiving gender-affirming hormone therapy.

- Clinical and laboratory monitoring is appropriate every three months during the first year, and then once or twice yearly thereafter, except as noted.
  - ➔ *Monitor for development of feminine characteristics, for target blood levels, and for adverse effects of medication and other treatment.*

- Cardiovascular risk assessment is recommended periodically for all patients treated with hormones in accordance with established guidelines and BOP guidance when available.
  - ➔ *Specific parameters that need to be monitored include weight and body mass index, blood pressure, lipids, and blood sugar/glycohemoglobin levels, in accordance with established guidelines.*

- Serum testosterone and estradiol levels are obtained before starting those respective medications, and then every three months while on treatment.
  - ➔ *Target levels are < 55 ng/dl for testosterone and < 200 pg/ml for estradiol. Higher levels of testosterone indicate inadequate suppression; higher levels of estradiol are associated with increased risks for thromboembolic disease, liver dysfunction, and development of hypertension.*
- Serum electrolytes, most importantly potassium, and renal function are obtained prior to starting spironolactone, every three months during the first year of treatment, periodically thereafter, or more frequently with increases in dosage or as clinically indicated.
  - ➔ *Dose adjustment or discontinuation of spironolactone is recommended for elevated potassium levels or serum creatinine > 4 mg/dL.*
- Screening for colon, and prostate cancer is recommended in accordance with established guidelines and BOP guidance when available.
- Breast cancer screening guidelines for women are followed for **MtF TG** individuals treated with hormone therapy.
- Screening for osteoporosis with a DEXA scan may be appropriate in some cases.
  - ➔ *In the absence of sufficient data to formulate evidence-based guidelines, it is considered appropriate to screen those who are at least five years post-gonadectomy, those who are 50 to 65 years old and have risk factors for osteoporosis, and all those who are 65 years or older.*
  - ➔ *Bone density measurements for transgender women (**MtF**) are compared with standards for biological females.*
- Baseline and periodic monitoring of liver enzymes and prolactin levels may be appropriate in those treated with estradiol but there is insufficient data available to make a specific recommendation.

11. Medications for FtM Individuals

Drug Classes and Medication Information

➔ *See the **FtMTreatment Summary Chart** in Appendix 1b for a full list of the different formulations of testosterone—including summarized information on dosing, adverse effects, contraindications, interactions, and monitoring.*

Testosterone

Androgen supplementation is used to induce male sex characteristics, including cessation of menses, voice changes, increased facial/body hair growth, increased muscle mass, and clitoral enlargement. Other effects include increased libido and energy.

- Several formulations are available, ranging from IM injections to transdermal patches and gels. The IM injections release slowly from the muscle, but may induce cyclical side effects that coincide with varying plasma concentrations. To avoid these effects, transdermal preparations can be used; alternatively, for testosterone cypionate and enanthate, a lower dose of IM testosterone can be given once-weekly (instead of every two or more weeks).
- Transdermal patches may take longer than IM doses to reach adequate levels. As a result, testosterone levels should be checked after completing at least one week of therapy with a patch. Precautions should be taken to avoid unintentional exposure.

- While oral formulations are available, they are not used, due to extensive liver metabolism and the associated potential for hepatic complications.
- Androgen use should be individualized and adjusted based on serum testosterone levels, tolerance, and efficacy. As with estrogen, dosing should start low and be titrated up to an appropriate level while keeping the dose as low as possible to minimize side effects.
- Ovulation may still be possible even when undergoing long-term testosterone therapy.
  - ➔ *Measures should be taken to avoid pregnancy in those undergoing hormonal therapy.*

Due to the classification of all testosterone preparations as DEA-controlled substances and their associated risk of potential abuse and/or diversion, transdermal patches or gels should be avoided in the correctional environment, if possible.
➔ ***INJECTABLE TESTOSTERONE is the preferred formulation in the correctional environment.***

PROGESTINS AND GNRH AGONISTS

Medroxyprogesterone and GnRH agonists are not typically used, but may be beneficial in individuals wishing to cease menstruation and decrease estrogen levels prior to testosterone treatment. These medications may also have a use in individuals receiving high-dose testosterone therapy who still experience uterine bleeding after the first few months of treatment.

➔ *See Appendix 1a and Appendix 1b for information on Medroxyprogesterone and GnRH agonists.*

DRUG EFFECT TIMELINE FOR FTM MEDICATIONS

➔ *Refer to the Endocrine Society guideline, Table 13, page 3145 (reference 3 in the References section of this guidance) for specific expectations of masculinizing effects of medication therapy.*

In general, a person may expect the following to occur:

- Effects that develop within the first six months of treatment include increased skin oiliness and acne, fat redistribution, cessation of menses, clitoral enlargement, and vaginal atrophy, with onset within the first three months. Maximum effect usually occurs in one to two years, but may take up to five years in some cases.
- Effects that develop in the six-to-12 month time frame include increased facial and body hair, scalp hair loss, increased muscle mass and strength, and deepening of the voice, with maximum effect often occurring in one to two years.

FTM MEDICATIONS: DRUG RISKS

Table 4 lists conditions that can be exacerbated by gender-affirming testosterone therapy. See *Appendix 1b* for more information on the adverse effects of testosterone therapy.

TABLE 4. MEDICAL CONDITIONS EXACERBATED BY GENDER-AFFIRMING TESTOSTERONE THERAPY (FTM)

Very High Risk of Serious Adverse Outcomes	Moderate-to-High Risk of Adverse Outcomes
• Breast or uterine cancer • Erythrocytosis (hematocrit >50%)	• Severe liver dysfunction (transaminases >3x upper limit of normal)

FTM MEDICATIONS: MONITORING

Gender-affirming hormone therapy has the same risks associated with hormone replacement therapy in biological males and females. Some of the adverse effects experienced with chronic testosterone therapy are erythrocytosis, liver dysfunction, hypertension, excessive weight gain, salt retention, lipid changes, excessive or cystic acne, and adverse psychological changes. Appropriate monitoring is crucial. Weight, blood pressure, physical exams, risk factors, medications, complete blood counts, renal and liver function, and lipid and glucose metabolism should be monitored for all **TG** individuals receiving gender-affirming hormone therapy.

- Clinical and laboratory monitoring is appropriate prior to starting treatment, every three months during the first year, and then once or twice yearly thereafter, except as noted.
  - ➔ *Monitor for development of masculine characteristics, for target blood levels, and for adverse of effects of medication and other treatments.*
- Cardiovascular risk assessment is recommended periodically for all patients treated with hormones, in accordance with established guidelines and BOP guidance when available.
  - ➔ *Specific parameters that need to be monitored include weight and body mass index, blood pressure, lipids, and blood sugar/glycohemoglobin levels.*
- A pregnancy test is obtained prior to starting treatment for all biological females with child bearing potential.
- Serum testosterone levels are obtained before starting treatment with testosterone, and then every three months while on treatment.
  - ➔ *Target testosterone levels are 350–700 ng/d. Higher levels may be associated with increased risk of side effects and complications.*
  - ➔ *Timing of the testosterone level is determined by the route of administration. Trough testosterone levels are obtained prior to the next dose of **injectable** testosterone. Testosterone levels are recommended three to five hours after an **oral** dose, and any time after one week of therapy on **topical** testosterone.*
- Serum estradiol levels are obtained before starting hormone therapy, and then every three months while on treatment until estradiol levels are < 50 pg/ml and cessation of menses has been six months.
- A complete blood count (CBC) and liver panel are obtained prior to starting hormone therapy, every three months during the first year of treatment, once or twice yearly thereafter, or more frequently as clinically indicated.
  - ➔ *Dose adjustment or discontinuation of testosterone is indicated if the hematocrit is > 54%.*
- Screening for colon cancer is recommended in accordance with established guidelines and BOP guidance when available.
- Breast cancer screening guidelines for women are followed for **FTM TG** individuals treated with hormone therapy and who have not had mastectomies.
- Cervical cancer screening is performed annually in those who are treated with hormone therapy and have cervical tissue (i.e., no hysterectomy).

(List continues on next page.)

- Screening for osteoporosis with a DEXA scan may be appropriate in some cases.
  - ➔ *In the absence of sufficient data to formulate evidence-based guidelines, it is considered appropriate to assess bone mineral density prior to starting treatment in those with risk factors for osteoporosis, those who are at least five years status post-gonadectomy, and all those who are 60 to 65 years or older.*
  - ➔ *Bone density measurements for transgender men are compared with standards for biological males.*

12. GENDER-AFFIRMING (A.K.A. SEX REASSIGNMENT) SURGERY

Although individuals may live successfully as transgender persons without surgery, gender-affirming surgery may be appropriate for some and is considered on a case-by-case basis.

CRITERIA: In addition to the eligibility and readiness criteria for hormone therapy, general criteria for consideration of surgery include at least 12 months of successful use of hormone therapy, participation in psychotherapy as clinically indicated, full-time real life experience in their preferred gender, and consolidation of gender identity. The inmate must request consideration for and demonstrate via informed consent a practical understanding of gender-affirming surgery including, but not limited to, permanence, potential complications, and short- and long-term treatment plans.

Requests for surgery are submitted to the **BOP TCCT** for initial review and recommendation to the Medical Director, who is the approving authority. Each referral should include comprehensive medical and mental health summaries, a comprehensive psychosocial assessment (preferably by a licensed clinical social worker), and a criminal history and institutional adjustment report.

13. PATIENT EDUCATION & INFORMED CONSENT

Patient education and informed consent are crucial to the treatment process. Sample consent and counseling documents can be found in *Appendix 2* and *Appendix 3*. Psychology and medical staff should allow individuals to read the appropriate consent forms, as well as discuss the forms with the individuals to ensure that they understand them thoroughly. Informed consent must be documented within the electronic medical record.

➔ *See Section 7, Medical Assessment* and *Section 8, Stepwise Approach to Medical and Mental Health Management of TG Individuals for more information.*

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APPENDIX 1A. TREATMENT SUMMARY CHART FOR MTF THERAPY

★ GOAL LEVELS FOR MTF: SERUM ESTRADIOL <200 PG/ML AND SERUM TESTOSTERONE <55 NG/DL ★						
Anti-Androgen Drugs	**Dose**	**Mode of Action**	**Adverse Effects**	**Contraindications**	**Interactions**	**Notes/Monitoring**
SPIRONOLACTONE	**Starting:** 25–50 mg BID **Typical:** 50 mg BID **Max:** 200 mg BID	Potassium-sparing antihypertensive that directly inhibits testosterone secretion and androgen binding to the androgen receptor	• Mild diuretic • Hyperkalemia • Excretion of sodium, calcium, and chloride • Decreased libido	• Renal insufficiency • Potassium >5.5 mmol/L • Avoid after orchiectomy	• Digoxin • ACE inhibitors • ARBs • Potassium-sparing diuretics	• **Baseline labs:** BMP • **Follow-up labs:** Serum potassium and renal function in 1 week, monthly for three months, and every three months during first year. • **When stable:** BMP every 6 to 12 months
FINASTERIDE	**Low:** 1 mg daily **High:** 5–10 mg daily	5α reductase inhibitor, which blocks the conversion of testosterone to the more active 5α dihydrotestosterone	Sexual dysfunction	None pertinent	Antiretrovirals and diltiazem may increase finasteride levels.	• **High dose:** Unable to take spironolactone • **Low dose:** Treatment of male pattern baldness • Use in combo with spironolactone for rare individuals not achieving desired effects • May be used after orchiectomy if hirsutism or male pattern baldness are present
APPENDIX 1A, PAGE 1 OF 3 (See APPENDIX 1C for sources and abbreviations.)						

★ GOAL LEVELS FOR MTF: SERUM ESTRADIOL <200 PG/ML AND SERUM TESTOSTERONE <55 NG/DL ★						
Anti-Androgen Drugs	**Dose**	**Mode of Action**	**Adverse Effects**	**Contraindications**	**Interactions**	**Notes/Monitoring**
GNRH AGONISTS: **GOSERELIN** **NAFARELIN** **LEUPROLIDE**	**Goserelin:** 3.6 mg SQ monthly **Nafarelin:** 600 µg intranasal daily **Leuprolide:** 3.75–7.5 mg IM monthly	Neurohormones that block the GnRH receptor, thus blocking release of FSH & LH, leading to highly effective gonadal blockade	• Loss of BMD • Hot flashes • Sexual dysfunction • Diarrhea	None pertinent	None noted	• MTF: Use anti-androgen to decrease estrogen use • Fully reversible when used in adolescents to delay puberty
PROGESTERONE, MEDROXYPROGESTERONE	**Starting:** 2.5 mg daily **Typical:** 5–10 mg daily **Max:** 20 mg daily	• Anti-androgen effect at high doses • May help breast development at cellular level	• Increased CV risk • Weight gain • Edema • Mood disorder • Increased facial and body hair	See below; same contraindications as estrogen.	Antiretrovirals	• Not as effective as spironolactone • Adjunct for individuals on maximum estrogen doses with unsatisfactory effects • **Monitoring:** Same as estrogen; see below
APPENDIX 1A, PAGE 2 OF 3 *(See APPENDIX 1C for sources and abbreviations.)*						

★ GOAL LEVELS FOR MTF: SERUM ESTRADIOL <200 PG/ML AND SERUM TESTOSTERONE <55 NG/DL ★

Estrogen	Dose	Adverse Effects	Contraindications	Notes	Monitoring
ESTRADIOL	**Starting:** 2–3 mg daily **Typical:** 4 mg daily **Max:** 8 mg daily	**Common:** • Increase in weight, VTE, dyslipidemia, insulin resistance, prolactin levels, edema, N/V, migraine • Decrease in erections • Melasma and skin irritation from estradiol patches **Less Common:** • LFT abnormalities • Increase in CV events especially in those older than 50 taking progesterone with estrogens • Increased triglycerides in those taking oral estrogens • Increased risk of pancreatitis, cholelithiasis, diabetes mellitus, hypertension, and hyperkalemia (in spironolactone users) **Rare or plausible but have not been observed:** • Liver damage • Prolactinoma • Breast cancer (compared with men never exposed to estrogen)	**Absolute:** • Estrogen-dependent cancer **Precautions:** • History of VTE • Coronary artery disease • Hyperlipidemia • Diabetes mellitus • Cigarette smoking • Highly sedentary lifestyle • Migraine • Seizure disorder • Retinopathy • Heart failure • Valvular heart disease • Family history of estrogen-dependent tumor	• **Interactions:** CYP 3A4, 1A2 inhibitors/inducers • Transdermal formulations better for older individuals or those with risk factors for VTE • Stop estrogens two weeks prior to surgery or immobilizing event. Restart after mobilization or one week after surgery • Consider adding aspirin therapy to those at high risk for VTE • Individuals who enter the BOP on conjugated estrogen should be switched to a different form of estrogen due to inability to monitor estrogen levels with this preparation • IM injections cause greater peaks and troughs in estrogen levels making oral and transdermal preparations preferable	• **Baseline:** fasting glucose, lipids, LFTs, prolactin, BMP, BMD if at risk for fracture • **Follow-up:** glucose and lipids every 2–3 months after starting or dose increase and 1 year after starting • Check serum testosterone and estradiol every 3 months in first year then 1–2 times per year after for feminization and adverse events • Optional: LFTs and prolactin after 1 year • Routine prostate and breast cancer screening
ESTRADIOL VALERATE (PROGYNOVA)	**Starting:** 2–3 mg daily **Typical:** 4 mg daily **Max:** 8 mg daily				
ESTRADIOL SUBLINGUAL (ESTRADIOL MICRONIZED, ESTRACE)	**Starting:** 0.5–1 mg **Typical:** 2 mg daily **Max:** 4 mg daily				
ESTRADIOL VALERATE (DELESTROGEN)	**Starting:** 20–40 mg IM q2wk **Average:** 40 mg IM q2wk **Max:** 40–80 mg IM q2wk **Endocrine guidelines:** 2–10 mg IM q1wk				
ESTRADIOL CYPIONATE (DEPO-ESTRADIOL)	**Starting:** 20–40 mg IM q2wk **Average:** 40 mg IM q2wk **Max:** 40–80 mg IM q2wk **Endocrine guide:** 2–10 mg IM q1wk				
ESTRADIOL PATCH (CLIMARA, ESTRADERM, ALORA, VIVELLE-DOT)	**Starting:** 0.1 mg/24hr **Average:** 0.2 mg/24hr **Max:** 0.4 mg/24hr **Endocrine guide:** 0.1–0.4 mg twice weekly				
ESTRADIOL GEL (DIVIGEL, ELESTRIN, ESTRASORB, ESTROGEL)	Roughly equivalent to patch dosing				
CONJUGATED EQUINE ESTROGENS (PREMARIN)	**Starting:** 1.25–2.5 mg daily **Typical:** 5 mg daily **Max:** 10 mg daily				

APPENDIX 1A, PAGE 3 OF 3 (See APPENDIX 1C for sources and abbreviations.)

APPENDIX 1B. TREATMENT SUMMARY CHART FOR FTM THERAPY

★ GOAL LEVELS FOR FTM: SERUM ESTRADIOL <50 PG/ML AND SERUM TESTOSTERONE 320–1000 NG/DL ★					
Drug	**Dose**	**Adverse Effects**	**Contraindications**	**Notes**	**Monitoring**
TESTOSTERONE CYPIONATE (in cottonseed oil) **TESTOSTERONE ENANTHATE (in sesame oil)**	**Starting:** 50–100 mg q2wk or 25–50 mg/wk **Typical:** 200 mg q2wk or 100 mg/wk **Max:** 400 mg q2wk or 200 mg/wk	**Common:** • Increase in weight, oily skin, acne, and male pattern baldness • Vaginal atrophy • Infertility (possibly irreversible) • Dyslipidemia • Mood changes • Skin irritation with patch • Risk of exposing partners or children to testosterone with topicals **Less Common:** • Increase in edema, blood pressure, and aggressiveness • Erythrocytosis • Abnormal LFTs • Sleep apnea **Rare or plausible but not observed:** • Increased risk of CV disease, breast/ ovarian cancer, and endometrial hyperplasia	**Absolute:** • Pregnancy • Breast cancer (testosterone may have anti-proliferative effects on most, but not all, breast cancers) • Breastfeeding **Precautions:** • Erythrocytosis • Cardiac, hepatic, renal, or vascular disease with edema or risk of edema • Sleep apnea or high risk of sleep apnea due to obesity or chronic lung disease • Dyslipidemia	• **Interactions:** Warfarin Cyclosporine Insulin • Causes drop in blood glucose in DM individuals • May notice cyclic variation in mood with IM dosing Q 2–4 weeks. Use a lower, more frequent dose, or transdermal • Transdermal reaches same levels as IM, but in longer timeframe • Menses typically stop in early months of treatment, but may persist when using transdermals **Use in Corrections: Injectable testosterone is the preferred formulation in the correctional environment due to potential risk of abuse and/or diversion. Testosterone is a DEA Controlled Substance**	• **Baseline:** CBC, lipids, urine hCG, glucose, & LFTs (if PCOS suspected) • **Follow-up:** 2–3 months after starting or changing dose CBC, lipids • **1 year after start or change:** CBC, lipids, LFTs (optional) • Serum testosterone: every 2–3 months in first year then 1–2 times/year for virilization/AEs • Serum estradiol: q 2–3 months in first 6 months or until no uterine bleeding for 6 months • **When to check specific formulations:** **IM:** Testosterone levels just prior to next dose. Adjust to mid-normal range of 350–700 ng/dl **Patch:** Testosterone levels after week 1 • Continue screenings for cervical and breast cancer if tissue still present
TESTOSTERONE PATCH **Available strengths: 2 mg, 2.5 mg, 4 mg, 5 mg**	**Starting:** 2–2.5 mg/day **Typical:** 5 mg/day **Max:** 7.5 mg/day				
TESTOSTERONE GEL (TESTIM 1%, ANDROGEL 1%)	**Starting:** 2.5 mg every morning **Typical:** 5 mg every morning **Max:** 10 mg every morning				
TESTOSTERONE GEL (ANDROGEL 1.62%) **TESTOSTERONE SOLUTION (AXIRON axillary solution)**	No published or anecdotal experience with these preparations				
MEDROXYPROGESTERONE AND GNRH AGONISTS	See *page 2* of APPENDIX 1A for dosing and other information.			Used to suppress menstruation if persists after early months of testosterone treatment	
(See APPENDIX 1C for sources and abbreviations.)					

APPENDIX 1C. TREATMENT SUMMARY CHARTS: SOURCES AND ABBREVIATIONS

SOURCES FOR TREATMENT SUMMARY CHARTS: *See References 2, 3, 4, 5, 8, 9, and 10.*

ABBREVIATIONS:

AEs	Adverse events
ARB	Angiotensin II receptor blocker
BMD	Bone mineral density
BMP	Basic metabolic panel, including glucose, calcium, sodium, potassium, CO_2, chloride, blood urea nitrogen, and serum creatinine
CBC	Complete blood count
CV	Cardiovascular
DM	Diabetes mellitus
FSH	Follicle-stimulating hormone
FtM	Female-to-male
GnRH	Gonadotropin-releasing hormone
hCG	Human chorionic gonadotropin
IM	Intramuscular
LFT	Liver function test
LH	Luteinizing hormone
MtF	Male-to-female
N/V	Nausea and vomiting
PCOS	Polycystic ovarian syndrome
q	"Every" (*Example:* q2wk = every 2 weeks)
SQ	Subcutaneous
VTE	Venous thromboembolism

APPENDIX 2. FEMINIZING GENDER-AFFIRMING HORMONE TREATMENT FOR TG PATIENTS – CONSENT AND COUNSELING FORM

A sample ***Consent and Counseling Form*** for feminizing gender-affirming hormone treatment for **TG** patients appears on the next five pages.

FEMINIZING GENDER-AFFIRMING HORMONE TREATMENT FOR TRANSGENDER PATIENTS

CONSENT AND COUNSELING FORM

INSTITUTION NAME: _____

PATIENT NAME: _____ **ID #:** _____

You want to take estrogen and other medications to feminize your body. Once you start these medications, some of them will need to be taken for the rest of your life in order to maintain their effects. Before using these medications, you need to know more about how they might affect you, including possible benefits, side effects, risks, and warning signs. We have listed them here for you. It's important that you understand all of this information before you start. We are happy to answer *any* questions you might have, so please ask!

WHAT ARE THE DIFFERENT MEDICATIONS THAT CAN HELP TO FEMINIZE YOU?

Estrogen is the female gender-affirming hormone and there are different types of estrogen that can help you appear more like a woman. There are also medications—called androgen antagonists or anti-androgens or androgen blockers—that can help you appear less like a man. Androgen is the male gender-affirming hormone.

WARNING — WHO SHOULD NOT TAKE ESTROGEN?

It should NOT be used by anyone who has a history of:

- An estrogen-dependent cancer
- Blood clots that could or did travel to the lungs

It should be used WITH CAUTION, and only after a full discussion of risks, by anyone who:

- Has a strong family history of breast cancer or other cancers that grow faster when estrogens are present
- Has diabetes
- Has eye problems such as retinopathy
- Has heart disease, heart valve problems, or a tendency to have easily clotted blood
- Has hepatitis
- Has high cholesterol
- Has kidney or liver disease
- Has migraines or seizures
- Is obese
- Smokes cigarettes

Please review and initial each statement to show you understand the benefits, risks, and changes that may occur from taking these medications. At the end of the document, indicate your preference regarding hormone therapy, then sign and date it.

FEMINIZING EFFECTS:

_____ I know that estrogen or anti-androgens—or both—may be prescribed to help me appear less like a man and more like a woman.

_____ I know that it can take several months or longer for the effects to become noticeable. I know that no one can predict how fast—or how much—change will happen.

_____ I know that if I am taking estrogen, I will probably develop breasts.

- I know it can take several years for breasts to get to their full size.
- I know the breasts will remain, even if I stop taking estrogen.
- I know I should examine my breasts for irregularities as soon as they start growing. I should also have a clinician examine them every year.
- I know I might have a milky discharge from my nipples (galactorrhea). If I do, I know I should have it evaluated by my clinician because it could be caused by the estrogen or by something else.
- I know that no one knows if taking estrogen increases the risk of breast cancer.

_____ I know that the following changes are usually not permanent—they are likely to go away if I stop taking the medicines:

- I know my body hair will become less noticeable and will grow more slowly, but it won't stop completely, even if I take the medicines for years.
- I know I will probably have less fat on my abdomen and more on my buttocks, hips, and thighs. It will be redistributed to a more female shape, changing from an "apple" shape to more of a "pear" shape.
- I know that if I already have male pattern baldness, it may slow down, but will probably not stop completely. It is also unlikely that hair that has been lost will grow back.
- I know I may lose muscle and strength in my upper body.
- I know my skin may become softer.

_____ I know that my body will make less testosterone. Upon release, this may affect my sex life in different ways and my future ability to cause a pregnancy:

- I know my sperm may no longer reach maturity. This could make me less able to cause a pregnancy. I also know I might never produce mature sperm again, but I know that it's also possible that my sperm could still mature. So, I know that I might get someone pregnant if we have vaginal intercourse, and we don't use birth control. The options for sperm banking have been explained to me.
- I know my testicles may shrink down to half their size. Even so, I know that I will need regular checkups for them.
- I know it is likely that my penis won't be hard in the morning as often as it has been before. it is also likely that I will have fewer spontaneous erections.
- I know I may lose the ability to obtain an erection for intercourse.
- I know I may have less sex drive.
- I know this treatment may (but is not assured to) make me permanently unable to make a woman pregnant.

_____ I know that some parts of my body will not change much by using these medicines.

- I know the hair of my beard and moustache may grow more slowly than before. It may become less noticeable, but it will not go away.
- I know the pitch of my voice will not rise, and my speech patterns will not become more like a woman's.
- I know my Adam's apple will not shrink.
- Although these medicines can't make these changes happen, there are other treatments that may be helpful.

RISKS OF TAKING FEMINIZING MEDICATIONS:

_____ I know that the side effects and safety of these medicines are not completely known. There may be long-term risks that are not yet known.

_____ I know that I should not to take more medicine than I am prescribed. I know it increases health risks. I know that taking more than I am prescribed won't make changes happen more quickly or more significantly. I know my body can convert extra estrogen into testosterone, and that can slow down or stop my appearing more womanly.

_____ I know these medicines may damage the liver and may lead to liver disease. I know I should be checked for possible liver damage as long as I take them.

_____ I know these medicines cause changes that other people will notice. Some transgender people have experienced harassment, discrimination, and violence because of this. Others have lost the support of loved ones. I know I can reach out to psychology services to help me find support resources. I also know that the BOP does not tolerate harassment, discrimination, and violence in any circumstances. If I feel I am the recipient of any of these actions, I will notify a BOP staff member.

RISKS OF TAKING ESTROGEN:

_____ I know that taking estrogen increases the risk of blood clots that can result in:

- Chronic problems with veins in the legs
- Heart attack
- Pulmonary embolism (blood clot to the lungs), which may cause permanent lung damage or death
- Stroke, which may cause permanent brain damage or death

_____ I know that the risk of blood clots is much worse if I smoke cigarettes, especially if I am over 40. I know the danger is so high that I should stop smoking completely if I start taking estrogen and that I should not start to smoke again when I am released from a BOP institution.

_____ I know that taking estrogen can increase the deposits of fat around my internal organs. This can increase my risk for diabetes and heart disease.

_____ I know that taking estrogen can raise my blood pressure. I know that if my blood pressure goes up, my clinician can work with me to try to control it with diet, lifestyle changes, and/or medication.

_____ I know that taking estrogen increases my risk of getting gallstones. I know that I should talk with my clinician if I get severe or long-lasting pain in my abdomen.

_____ I know that estrogen can cause nausea and vomiting. I know that I should talk with my clinician if I have long-lasting nausea or vomiting.

_____ I know that estrogen can cause headaches or migraines. I know I should talk with my clinician if I have headaches or migraines often, or if the pain is unusually severe.

_____ I know that it is not yet known if taking estrogen increases the risk of prolactinomas. These are non-cancerous tumors of the pituitary gland. I know they are not usually life-threatening, but they can damage vision and cause headaches. I know this possibility needs to be checked periodically by a clinician for at least three years after I start taking estrogen.

_____ I know that I am more likely to have dangerous side effects if:

- I smoke.
- I am overweight.
- I am over 40 years old.
- I have a history of blood clots.
- I have a history of high blood pressure.
- My family has a history of breast cancer.

RISKS OF TAKING ANDROGEN ANTAGONISTS:

_____ I know that spironolactone affects the balance of water and salts in the kidneys, which may:

- Increase the amount of urine I produce, making it necessary to urinate more frequently.
- Increase thirst.
- Reduce blood pressure.
- Cause (although rarely) high levels of potassium in the blood, possibly leading to changes in heart rhythms that may be life-threatening.

_____ I know that some androgen antagonists make it more difficult to evaluate test results for cancer of the prostate. I know that if I am over 50, I should have my prostate evaluated every year with a prostate-specific antigen test, as applicable.

PREVENTION OF MEDICAL COMPLICATIONS:

_____ I agree to take feminizing medications as prescribed, and I agree to tell my clinician if I have any problems or if I am unhappy with the treatment.

_____ I know that the dose and type of medication that is prescribed for me may not be the same as for someone else.

_____ I know that I need periodic physical exams and blood tests to check for any side effects.

_____ I know that feminization medications can interact with other drugs and medicines—including alcohol, diet supplements, herbs, other hormones, and street drugs—causing complications. I know that I need to prevent complications because they can be life-threatening. That's why I need to be honest with my clinician about whatever else I take or use. I also know that this will not interfere with my getting medical care; I will continue to get medical care here no matter what information I share about what I take.

_____ I know that it can be risky for anyone with certain conditions to take feminizing medicines. I agree to be evaluated if my clinician thinks I may have such a condition. Then, we will decide if it's a good idea for me to start or continue using these medications.

_____ I know that I should stop taking estrogen two weeks before any surgery or when I may be immobile for a long time. This will lower the risk of getting blood clots. I know that I can start taking estrogen again a week after I'm back to normal or when my clinician says it's okay.

_____ I know that using these medicines to appear more womanly is an "off-label" use. I know that this means that using these medicines for this purpose is not approved by the Food and Drug Administration (FDA). I know that the medicine and dose that is recommended for me is based on the judgment and experience of the clinician.

_____ I know that I can choose to stop taking these medicines at any time. I know that if I decide to do that, I should do it with the help of my clinician. This will help me make sure there are no negative reactions. I also know that my clinician may suggest that I cut the dose or stop taking it altogether if certain conditions develop. This may happen if the side effects are severe or if there are health risks that cannot be controlled.

MY SIGNATURE BELOW CONFIRMS THAT:

- My clinician has talked with me about:
  - The benefits and risks of taking feminizing medication.
  - The possible or likely consequences of hormone therapy.
  - Potential alternative treatments.
- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with my clinician.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to take, refuse, or postpone therapy with feminizing medications.
- I am 18 years old or older.

BASED ON ALL THIS INFORMATION:

_____ I want to begin taking estrogen.

_____ I want to begin taking androgen antagonists (e.g., spironolactone).

_____ I do not wish to begin taking feminizing medication at this time.

_____ _____
Patient's Signature *Date*

_____ _____
Prescribing Physician's Signature *Date*

Your health is important to us. If you have any questions or concerns, please come to sick call and an appointment with your PA/Physician will be made.

APPENDIX 3. MASCULINIZING GENDER-AFFIRMING HORMONE TREATMENT FOR TG PATIENTS – CONSENT AND COUNSELING FORM

A sample ***Consent and Counseling Form*** for masculinizing gender-affirming hormone treatment for TG patients appears on the next four pages.

MASCULINIZING GENDER-AFFIRMING HORMONE TREATMENT FOR TRANSGENDER PATIENTS
CONSENT AND COUNSELING FORM

INSTITUTION NAME: _____

PATIENT NAME: _____ ID #: _____

You have expressed a desire to take testosterone to masculinize your body. Before beginning treatment, there are several details about treatment that you need to be familiar with, including the possible advantages, disadvantages, risks, warnings, and alternatives. These topics are covered below. It is important that you understand all of this information before initiating treatment. We are happy to answer *any* questions you might have, so please ask!

WHAT IS TESTOSTERONE?

Testosterone is the hormone responsible for male features. It builds muscle, causes the development of facial hair, and is responsible for the deepening of a person's voice during puberty. Testosterone also may increase sex-drive.

HOW IS TESTOSTERONE TAKEN?

Testosterone is usually injected every one to four weeks. It is not used as a pill because the body may not absorb it properly, and it can cause liver problems. Some people use skin creams and patches, but these are not used in the correctional environment.

The doses used for injections differ from product to product, and from patient to patient. Doses may range from 100 mg to 400 mg. The injections are administered into a large muscle to slow the release of the hormone. There can be unwanted swings in hormone levels. This can be controlled by changing how often the dose is given, how much of a dose is given, or by changing formulations.

WARNING — WHO SHOULD NOT TAKE TESTOSTERONE?

Testosterone should ***not*** be used by anyone who is pregnant or has uncontrolled coronary artery disease.

It should be used ***with caution and only after a full discussion of risks*** by anyone who has: acne, family history of heart disease or breast cancer, blood clot history, high levels of cholesterol, liver disease, or high red-blood-cell count. Caution should also be used in obese patients and persons who smoke.

MONITORING:

Periodic blood tests to check on the effects of the hormone will be required for treatment. Routine breast exams and pelvic exams with pap tests should be continued, when applicable.

BENEFITS AND RISKS OF TESTOSTERONE TREATMENT:

Benefits	Risks

• Appearing more like a man:
  • Larger clitoris*
  • Coarser skin
  • Deeper voice*
  • Increased body hair*
  • Increased facial hair*
  • Increased muscle mass
  • Increased strength
  • Elimination of menstrual periods
• Increased physical energy
• Protection against bone thinning (osteoporosis)
 	
**These are permanent changes.*
	• Acne (may permanently scar)
	• Blood clots (thrombophlebitis)
	• Emotional changes
	• Headache
	• High blood pressure (hypertension)
	• Increased red-blood-cell count
	• Infertility
	• Inflamed liver
	• Interaction with drugs for diabetes and blood thinning — e.g., Coumadin and Warfarin
	• Male pattern baldness
	• Increased abdominal fat
	• Increased risk of heart disease
	• Swelling of hands, feet, and legs
	• Weight gain

Please review and initial each statement to show that you understand the benefits, risks, and changes that may occur from taking these medications. At the end of the document, indicate your preference regarding hormone therapy, then sign and date it.

MASCULINIZING EFFECTS OF TESTOSTERONE:

_____ I know that testosterone may be prescribed to make me appear less like a woman and more like a man.

_____ I know that it can take several months or longer for the effects to become noticeable.

_____ I know that no one can predict how fast or how much change will take place.

_____ ***I know that the changes may not be complete for two to five years after starting testosterone.***

_____ ***I know the following changes are likely to be permanent, even if I stop taking testosterone:***

- Bigger clitoris — typically about half an inch to a little more than an inch
- Deeper voice
- Growth of facial hair (moustache and beard)
- Hair loss at the temples and crown of the head and the possibility of becoming completely bald
- More, thicker, and coarser hairs on abdomen, arms, back, chest, and legs

_____ I know that the following changes are usually ***not permanent*** and will likely go away if I stop taking testosterone:

- Acne (however, acne scars will be permanent)
- Elimination of menstrual periods (typically stop one to six months after starting testosterone)
- Increased abdominal fat (redistribution of fat to a more masculine shape)
- Decreased fat on buttocks, hips, and thighs
- More muscle mass and strength
- Vaginal dryness

_____ I know that the effects of testosterone on fertility are unknown. I have been told that I may or may not be able to get pregnant even if I stop taking testosterone. I know I might still get pregnant even after testosterone stops my menstrual periods. I know my birth control options upon release (if applicable). I know I cannot take testosterone if I am pregnant.

_____ I know that some aspects of my body will not be changed:

- Losing some fat may make my breasts appear slightly smaller, but they will not shrink very much.
- Although my voice may deepen, other aspects of the way I speak will not change.

_____ I know that there are other treatments that may be helpful to make my breasts smaller or my speech manlier. If I have concerns, I can discuss treatment options with my clinician.

RISKS OF TESTOSTERONE:

_____ I know that the medical effects and safety of testosterone are not completely known. There may be long-term risks that are not yet known.

_____ I know not to take more testosterone than prescribed. I know this would be a risk to my health. I know that taking more testosterone than I am prescribed will not make changes happen more quickly or more significantly. I know that my body can convert extra testosterone into estrogen, which can slow down or reverse the progress of my transition.

_____ I know that testosterone can cause changes that increase my risk of heart disease. I know these changes include:

- Less good cholesterol (HDL), which is needed to protect against heart disease, and more bad cholesterol (LDL), which may increase the risk of heart disease
- Higher blood pressure
- Increased deposits of fat around my internal organs

_____ I know that my risk of heart disease is higher if people in my family have had heart disease, if I am overweight, or if I smoke.

_____ I know that I should have periodic heart-health checkups for as long as I take testosterone. I know I must watch my weight and cholesterol levels and have them checked by my clinician.

_____ I know that testosterone can damage the liver and possibly lead to liver disease. I know I should be checked periodically for possible liver damage for as long as I take testosterone.

_____ I know that testosterone can increase my red blood cell count and hemoglobin. I know the increase is usually only to the level that is normal for a man. I know normal levels would have no health risks; however, higher increases can cause problems that can be life-threatening. These problems include stroke and heart attack. As such, I know I need to have periodic blood checks for as long as I take testosterone.

_____ I know that taking testosterone can increase my risk for diabetes. It may decrease my body's response to insulin, cause weight gain, and increase deposits of fat around my internal organs. I know I should have periodic checks of my blood glucose for as long as I take testosterone.

_____ I know that my body can turn testosterone into estrogen. I know that no one knows if this could increase the risk of cancers of the breast, ovaries, or uterus.

_____ I know that taking testosterone can thin the tissue of my cervix and the walls of my vagina. This can lead to tears or abrasions during vaginal intercourse. I know it does not matter if my partner is a woman or a man. This raises my risk of getting a sexually transmitted infection, including HIV. I know I should speak frankly with my provider regarding the best ways to prevent and check for infections. I am aware that sex between inmates, or between inmates and staff, is not permitted within the BOP.

_____ I know that testosterone can give me headaches or migraines. I know it is best to talk with my clinician if I get them frequently or if the pain is unusually severe.

_____ I know that testosterone can cause emotional changes. For example, I could become more irritable, frustrated, or angry. I know my provider can help me find resources to explore and cope with these changes.

_____ I know that testosterone causes changes that other people will notice. Some transgender people have experienced harassment, discrimination, and violence because of this. Others have lost the support of loved ones. I know I can reach out to psychology services to help me find support resources. I also know that in the BOP, harassment, discrimination, and violence are not tolerated under any circumstances. If I feel I am the recipient of any of these actions, I will notify a BOP staff member.

PREVENTION OF MEDICAL COMPLICATIONS:

_____ I agree to take testosterone as prescribed, and I agree to tell my clinician if I have any problems or am unhappy with the treatment.

_____ I know that the dose and type of medication prescribed for me may not be the same as it is for someone else.

_____ I know that I need periodic physical exams and blood tests to check for any side effects.

_____ I know that testosterone can interact with other drugs and medicines, including alcohol, diet supplements, herbs, other hormones, and street drugs. This kind of interaction can cause complications. I know that I need to prevent complications because they can be life-threatening. I need to be honest with my clinician about other items I am taking. I also know that this will not interfere with my getting medical care; I will continue to get medical care here no matter what information I share about what I take.

_____ I know that it can be risky for anyone with certain conditions to take testosterone. I agree to be evaluated if my clinician thinks I may have one of these conditions. Then, we will decide if it is a good idea to start or continue using testosterone.

_____ I know that using testosterone to appear more masculine is an "off-label" use. I know this means it is not approved by the Food and Drug Administration (FDA) for this purpose. I know the medicine and dose recommended for me is based on the judgment and experience of the clinician.

_____ I know that I can choose to stop taking testosterone at any time. I know if I decide to stop, I should discontinue with the help of my clinician to ensure there are no negative reactions. I know my clinician may suggest I cut the dose or stop taking it altogether if certain medical conditions develop. This may happen if the side effects are severe or if there are health risks that cannot be controlled.

MY SIGNATURE BELOW CONFIRMS THAT:

- My clinician has talked with me about:
  - The benefits and risks of taking testosterone.
  - The possible or likely consequences of hormone therapy.
  - Potential alternative treatments.
- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with my clinician.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to take, refuse, or postpone testosterone therapy.
- I am 18 years old or older.

BASED ON ALL THIS INFORMATION:

_____ I want to begin taking testosterone.

_____ I do not wish to begin taking testosterone at this time.

_____ _____

Patient's Signature *Date*

_____ _____

Prescribing Physician's Signature *Date*

Your health is important to us. If you have any questions or concerns, please come to sick call and an appointment with your PA/Physician will be made.

Exhibit - P

Transgender Offender Manual

Federal Bureau of Prisons

Date: 5/11/18

Pages - 1-18

Exhibit (F)

U.S. Department of Justice
Federal Bureau of Prisons

CHANGE NOTICE
OPI: RSD/WSP
NUMBER: 5200.04 CN-1
DATE: May 11, 2018

Transgender Offender Manual

Approved: Mark S. Inch
Director, Federal Bureau of Prisons

This Change Notice (CN) implements the following change to Program Statement 5200.04, **Transgender Offender Manual**, dated January 18, 2017. The purpose of the Change Notice is to ensure that the Transgender Executive Council (TEC) considers issues related to prison management and security in determining appropriate housing of transgender inmates, including risks posed to staff, other inmates, and members of the public. The clarifications to policy will establish appropriate expectations for the inmate population concerning designations.

The changes are marked with a highlight and inserted into the policy. Deleted text is struck through. In addition, the branch name has been changed from Female Offender Branch to Women and Special Populations Branch.

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population, consistent with maintaining security and good order in Federal prisons.

4. STAFF TRAINING

The **Women and Special Populations Branch** will be responsible for developing training materials and current information on the management of transgender inmates. Training will include information concerning best practices for maintaining the safety of transgender inmates, while also ensuring security and good order in Federal prisons and the safety of staff, inmates, and the public. This information will be made available to staff on the Women and Special Populations Branch Sallyport page.

5. INITIAL DESIGNATIONS

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and disciplinary history, current gender expression, medical and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). ~~The TEC will recommend housing by gender identity when appropriate.~~

In deciding the facility assignment for a transgender or intersex inmate, the TEC should make the following assessments on a case-by-case basis:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, etc.;
- The TEC will consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

7. HOUSING AND PROGRAMMING ASSIGNMENTS

In order for an inmate to be considered for transfer to another institution of the same sex as the inmate's current facility ~~location, including a facility housing individuals of the inmate's identified gender~~, the Warden should consult with the TEC prior to submitting a designation request to the DSCC, but this is not required.

In addition, the Warden may make a recommendation to the TEC to transfer a transgender or intersex inmate based on an inmate's identified gender.

In considering such recommendations, the TEC will apply all criteria of Section 5, above, and make the following assessments concerning the recommendation:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, re-designation to another facility of the same sex, etc.;
- The TEC will also consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, program participation, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history, as well as positive institution adjustments.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

9. HORMONE AND NECESSARY MEDICAL TREATMENT

Hormone or other necessary medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff should request consultation from Psychology Services regarding the mental health benefits of hormone or other necessary medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant clinical guidance. Questions concerning hormone treatment may be referred to the TCCT.

U.S. Department of Justice
Federal Bureau of Prisons

PROGRAM STATEMENT
OPI: RSD/FOB
NUMBER: 5200.04
DATE: January 18, 2017

Transgender Offender Manual

/s/
Approved: Thomas R. Kane
Acting Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population, consistent with maintaining security and good order in Federal prisons.

a. **Program Objectives.** Expected results of this program are:

- This policy is meant to provide guidance to staff in dealing with the unique issues that arise when working with transgender inmates.
- Institutions ensure transgender inmates can access programs and services that meet their needs as appropriate, and prepare them to return to the community.
- Sufficient resources will be allocated to deliver appropriate services to transgender inmates.
- Staff will be offered training, enabling them to work effectively with transgender inmates.
- To support staff's understanding of the increased risk of suicide, mental health issues and victimization of transgender inmates.

b. **Institution Supplement.** None required. Should local facilities make any changes outside changes required in national policy or establish any additional local procedures to implement national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

2. DEFINITIONS

Gender – a construct used to classify a person as male, female, both, or neither. Gender encompasses aspects of social identity, psychological identity, and human behavior.

Gender identity – a person's sense of their own gender, which is communicated to others by their gender expression.

Gender expression – includes mannerisms, clothing, hair style, and choice of activities.

Gender nonconforming – a person whose appearance or manner does not conform to traditional societal gender expectations.

Transgender – the state of one's gender identity not matching one's biological sex. For the purposes of this policy, a transgender inmate is one who has met with a Bureau of Prisons psychologist and signed the form indicating consent to be identified within the agency as transgender. This step allows for accommodations to be considered.

Cisgender – the state of one's gender identity matching one's biological sex.

Sexual orientation – the direction of one's sexual interest towards members of the same, opposite, or both genders (e.g., heterosexual, homosexual, bisexual, asexual). Sexual orientation and gender identity are not related.

Gender Dysphoria (GD) – a mental health diagnosis currently defined by DSM-5 as, "A strong and persistent cross-gender identification. It is manifested by a stated desire to be the opposite sex and persistent discomfort with his or her biologically assigned sex." Not all transgender inmates will have a diagnosis of GD, and a diagnosis of GD is not required for an individual to be provided services.

Intersex – a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical biological definitions of male or female. Not all intersex people identify as transgender; unless otherwise specified, this policy does not apply to intersex people who do not identify as transgender.

Transition – measures that change one's gender expression or body to better reflect a person's gender identity.

3. STAFF RESPONSIBILITIES

The following Bureau components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for transgender offenders.

a. **Central Office**

(1) The **Women and Special Populations Branch** is the agency's primary source and point of contact on classification, management, and intervention programs and practices for transgender inmates in Bureau custody. The Branch is responsible for the following functions as they relate to transgender inmates:

- Engaging stakeholders, including serving as the primary point of contact on issues affecting transgender inmates with judges, political figures, and advocacy groups.
- Ensuring the Bureau offers appropriate services to transgender inmates.
- Preparing budgetary requests to deliver national and pilot programs or services affecting transgender inmates.
- Providing guidance and direction to Regional staff and institution leadership on transgender issues.
- Developing and implementing staff training on transgender issues.
- Building a research-based foundation for the Bureau's work with transgender inmates.
- Presenting at internal and external conferences/events regarding the agency's transgender inmates' practices.
- Developing and monitoring monthly reports on the transgender population and institutional programs.
- Issuing an annual report on the state of transgender offenders in the Bureau that will be made available to all staff and stakeholders.
- Advising agency leadership on transgender inmate needs.
- Conducting an annual survey of transgender inmates in the Bureau and sharing results with internal and external stakeholders.
- Providing national oversight of pilot programs and initiatives serving transgender offenders.

(2) The **Health Services Division** oversees all medical and psychiatric activity as it applies to transgender inmates. Guidance on the most current research-driven clinical medical and psychiatric care of transgender inmates will be provided by the Medical Director.

The Health Services Division also has oversight of a Transgender Clinical Care Team (TCCT). This team will be comprised of Physicians, Pharmacists, and Psychiatrists. Social Workers, Psychologists, and other clinical providers can also be included when appropriate. The TCCT will offer advice and guidance to health services staff on the medical treatment of transgender inmates and/or inmates with GD. Medical staff can raise issues to the TCCT through the Health Services Division.

(3) The **Psychology Services Branch** oversees all psychological mental health programs and services as they apply to transgender inmates, to include providing advice and guidance on

identification and evaluation of transgender inmates, and making recommendations for treatment needs of transgender inmates and/or inmates with GD.

(4) **Central Office Branches/Divisions** of Correctional Services, Psychology Services, Education, Correctional Programs, Reentry Affairs, Residential Reentry Management, Health Services, Health Programs, Social Work, Office of General Counsel, and Trust Fund meet annually with the Women and Special Populations Branch to discuss transgender population needs and evaluate current gender-responsive services. The National Union and the Central Office LGBT Special Emphasis Program Manager will be invited to attend these meetings.

(5) The **Transgender Executive Council (TEC)** will consist of staff members from the Health Services Division, the Women and Special Populations Branch, Psychology Services, the Correctional Programs Division, the Designation and Sentence Computation Center (DSCC), and the Office of General Counsel. The TEC will meet a minimum of quarterly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with GD, including designation issues. Institution staff and DSCC staff may raise issues on specific inmates to the TEC through the Women and Special Populations Branch. The National PREA Coordinator is consulted as needed.

b. **Regional Offices**

- Provide oversight to institutions regarding services and other relevant trends managing transgender inmates.
- Assign transgender responsibilities to the Regional Female Offender/Transgender Coordinator Collateral Duty Assignment. This individual meets quarterly with the Women and Special Populations Branch to discuss staffing and programming needs.

c. **Institutions**

The institution CEO will establish a multi-disciplinary approach to the management of transgender inmates; specifically:

- Ensure transgender inmates have access to services.
- Enter tracking information for self-identified transgender inmates by updating SENTRY and other databases (e.g., PDS), as appropriate.
- Provide appropriate reentry resources that may be specific to the population.
- Advise the Local Union of transgender inmate management issues, as appropriate.

4. STAFF TRAINING

Staff will be provided specialized training in working with unique issues when managing transgender inmates, with refresher training at annual training. Institutions housing known transgender inmates should provide additional training, if needed.

The Women and Special Populations Branch will be responsible for developing training materials and current information on the management of transgender inmates. Training will include information concerning best practices for maintaining the safety of transgender inmates, while also ensuring security and good order in Federal prisons and the safety of staff, inmates, and the public. This information will be made available to staff on the Women and Special Populations Branch Sallyport page.

In addition, the Prison Rape Elimination Act (PREA) regulations incorporated into the BOP Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** have training requirements concerning pat searches and communication skills for transgender inmates. See 28 C.F.R. § 115.15(f) and 115.31 (a) (9). Please refer to this Program Statement regarding implementation of those training requirements.

Staff will be provided adequate time to complete these trainings during duty hours.

5. INITIAL DESIGNATIONS

The PREA regulations, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**, state in section 28 C.F.R. § 115.42 (c):

> **"In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates...the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems."**

Upon receipt of information from a Pre-Sentence Report, court order, U.S. Attorney's Office, defense counsel, the offender, or other source that an individual entering BOP custody is transgender, designations staff will refer the matter to the TEC for advice and guidance on designation.

Institution staff managing pretrial or holdover offenders may also refer cases to the TEC for review. Any TEC recommendations concerning pretrial inmates will be coordinated with the appropriate United States Marshal's Office.

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and disciplinary history, current gender expression, medical and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). ~~The TEC will recommend housing by gender identity when appropriate.~~

In deciding the facility assignment for a transgender or intersex inmate, the TEC should make the following assessments on a case-by-case basis:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, etc.;
- The TEC will consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

6. INTAKE SCREENING

The PREA regulations in 28 C.F.R. part 115, Subpart A, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** and the Program Statement **Intake Screening,** address intake screening. Screening of transgender inmates will be conducted in accordance with these policies and all other applicable policies and procedures.

7. HOUSING AND PROGRAMMING ASSIGNMENTS

During Initial classification and Program Reviews, Unit Management staff will twice-yearly review the inmate(s) current housing unit status and programming available for transgender inmates; this review will be documented by Unit Management.

The reviews will consider on a case-by-case basis that the inmate placement does not jeopardize the inmate's health and safety and does not present management or security concerns.

In making housing unit and programming assignments, a transgender or intersex inmate's own views with respect to his/her own safety must be given serious consideration.

Transgender inmates shall be given the opportunity to shower separate from other inmates.

The agency shall not place transgender or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree , legal settlement, or legal judgment for the purpose of protecting such inmates.

In order for an inmate to be considered for transfer to another institution of the same sex as the inmate's current facility ~~location, including a facility housing individuals of the inmate's identified gender~~, the Warden should consult with the TEC prior to submitting a designation request to the DSCC, but this is not required.

In addition, the Warden may make a recommendation to the TEC to transfer a transgender or intersex inmate based on an inmate's identified gender.

In considering such recommendations, the TEC will apply all criteria of Section 5, above, and make the following assessments concerning the recommendation:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, re-designation to another facility of the same sex, etc.;
- The TEC will also consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, program participation, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress

towards transition as demonstrated by medical and mental health history, as well as positive institution adjustments.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

8. DOCUMENTATION AND SENTRY ASSIGNMENTS

a. **Medical and Mental Health Information.** Medical and mental health information for transgender inmates will be maintained in the current electronic recordkeeping system in accordance with the Program Statement **Health Information Management.** Medical and mental health information is considered confidential, and may only be released in accordance with appropriate laws, rules, and regulations.

b. **Initial Screening.** For initial designations, designations staff will assign Case Management Activity (CMA) SENTRY assignments if information in the PSR or other documentation indicates a likely transgender identity. The screening codes will be:

SCRN M2F – inmate should be screened for male to female.
SCRN F2M – inmate should be screened for female to male.

Any inmate arriving at the designated institution with a screening code is to be referred to the Chief Psychologist or designee for review within 14 days. If the code was assigned in error, the screening code will be removed by the psychologist. If the inmate identifies as transgender, the psychologist will replace the screening code with an identifying code, as indicated below. Holdover facilities will be exempt from this initial screening requirement, as limited available records and brevity of stay do not allow for a comprehensive screening.

Any inmate who arrives without a screening code but identifies as transgender during intake, or at any time during the incarceration period, is referred to the Chief Psychologist or designee and interviewed within 14 days of the inmate notification. Inmates in pretrial status at Bureau facilities may also receive a SENTRY code.

c. **Notification to Staff and Tracking.** After consultation with Psychology Services, and if the inmate affirms his/her transgender identity, the screening code will be updated to a permanent assignment by a psychologist:

TRN M2F – inmate is male to female transgender (transgender female).
TRN F2M – inmate is a female to male transgender (transgender male).

The inmate must request to Psychology Services staff that the CMA assignment be entered, and the inmate consents that all staff will therefore be notified that the individual is transgender. The inmate's request will be documented on BP-A1110, Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (included as Attachment A to this policy). Psychology Services will maintain the form in the electronic mental health record and forward a copy of the form to the Unit Team. The Unit Team will maintain the form in the FOI Exempt section of the Central File.

Staff should consult the CMA assignment when interacting with the inmate; e.g., use of pronouns, searches, commissary items, etc., as indicated below.

If there are questions about the need to continue a CMA assignment, the Warden should contact the Women and Special Populations Branch. Should the CMA assignment change, staff members will not be disciplined for the continued provision of accommodations or use of pronouns.

9. HORMONE AND NECESSARY MEDICAL TREATMENT

Hormone or other necessary medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff should request consultation from Psychology Services regarding the mental health benefits of hormone or other necessary medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant clinical guidance. Questions concerning hormone treatment may be referred to the TCCT.

In the event this treatment changes the inmate's appearance to the extent a new identification card is needed, the inmate will not be charged for the identification card.

10. INSTITUTION PSYCHOLOGY SERVICES

Bureau psychologists are available to provide assessment and treatment services for transgender inmates, if appropriate. Guidance on assessment procedures will be provided by the Psychology Services Branch.

If an inmate identifies as transgender, the psychologist will provide the inmate with information regarding the range of treatment options available in the Bureau and their implications. In addition, based upon the psychologist's preliminary assessment and the inmate's expressed interest, a referral to the Clinical Director and/or Chief Psychiatrist may be generated. While the initial interview must be scheduled within 14 days, an assessment may take longer in some instances.

In addition to a referral to medical services, a transgender inmate may be offered individual psychotherapy. Individual psychotherapy goals might include: (1) helping the inmate to live more comfortably within a gender identity and deal effectively with non-gender issues; (2) emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin; (3) seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminality; and (4) addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may also be present; any effective treatment plan will fully address these symptoms.

If an institution has multiple transgender inmates, a support group facilitated by a mental health provider may also be a component of the treatment plan. Common concerns of transgender inmates, which may be addressed effectively in a group setting, include self-esteem issues and relationship issues.

Psychologists who provide mental health treatment for transgender inmates address all mental health needs, including suicide risk, if present.

Psychologists working with transgender inmates are encouraged to consult the Reentry Services Division in Central Office for additional resources.

11. PRONOUNS AND NAMES

Staff interacting with inmates who have a CMA assignment of transgender can use the authorized gender-neutral communication with inmates (e.g., by the legal last name or "Inmate" last name). Transgender inmates often prefer to be called by pronouns of their identified gender identity. Staff may choose to use these gender-specific pronouns or salutations per the inmate's request, and will not be disciplined for doing so.

An official committed name change while in BOP custody must be done consistent with the Program Statement **Correctional Systems Manual**, Chapter 4. The name entered on the inmate's Judgement and Commitment Order will remain the official committed name for all Bureau records (incident reports, progress reviews, sentence calculations, etc.). However, any additional names or aliases can be entered into SENTRY as appropriate.

12. PAT SEARCHES

Pat searches of transgender inmates will be conducted in accordance with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas.** The policy language, included here as a reference, states:

"Transgender Inmates – For purposes of pat searching, inmates will be pat-searched in accordance with the gender of the institution, or housing assignment, in which they are assigned. Transgender inmates may request an exception. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., "pat search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database; e.g., posted picture file). Inmates should be provided a personal identifier (e.g., notation on commissary card, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to pat searches."

It is recommended the inmate request the exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office.

Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated institution rules concerning contraband.

In exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas.**

13. VISUAL SEARCHES

For purposes of a visual search, inmates will be searched in accordance with the gender of the institution, or housing assignment, to which they are assigned. The visual search shall be made in a manner designed to ensure as much privacy to the inmate as practicable. Staff should consider the physical layout of the institution, and the characteristics of an inmate with a transgender CMA assignment, to adjust conditions of the visual search as needed for the inmate's privacy.

Transgender inmates may also request an exception to be visually searched by a staff member of the inmate's identified gender. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., "visual search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database; e.g., posted picture file). Inmates should be provided a

personal identifier (e.g., notation on commissary card, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to visual searches.

It is recommended the inmate request the exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office.

Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated institution rules concerning contraband.

Transgender inmates placed at an institution or in a housing unit that does not correspond with their identified gender, and who are granted an exemption as indicated above, will be searched by: bargaining unit staff of the inmate's identified gender who consent to participate in the search; management staff of the inmate's identified gender who consent to participate in the search; or available Health Services clinical staff.

Transgender inmates placed at an institution or in a housing unit of their identified gender will be searched by bargaining unit staff of the inmate's identified gender who consent to participate in the search; management staff of the inmate's identified gender; or available medical staff.

Institutions should consider using available body scanning technology in lieu of visual searches of transgender inmates.

In exigent circumstances, any staff member may conduct a visual search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas.**

14. CLOTHING AND COMMISSARY ITEMS

Consistent with safety and security concerns, inmates with the CMA assignment of transgender will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender. Institutional laundry will have available institutional undergarments that fulfill the needs of transgender inmates. Undergarments will not have metal components.

Standardized lists of Commissary items for transgender inmates are available in accordance with the Program Statement **Trust Fund/Deposit Manual.**

Additional items based on an individualized assessment of the transgender inmate may be approved by the Warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate.

Inmates who purchase and/or are provided items under this section will be subject to disciplinary sanctions, including the removal of these items, if they are found to have violated institution rules relating to the possession of these items.

15. REENTRY NEEDS

In accordance with the Program Statement **Release Preparation Program,** institution staff should assist transgender inmates in addressing these issues prior to release or placement in a Residential Reentry Center/Home Confinement.

During initial classifications and Program Reviews, Unit Management will formulate a pre-release plan that will assist transgender inmates in obtaining appropriate identification, finding housing and employment, and providing community resources to reintegrate into the community.

The Reentry Affairs Coordinator may assist staff with identifying these resources. Institution and/or Regional Social Workers should be contacted concerning the continuity of medical care.

The Women and Special Populations Branch and/or Social Workers can be contacted to provide guidance and resources for reentry needs of transgender inmates.

16. ADMINISTRATIVE REMEDIES

Inmates may use the procedures of the Program Statement **Administrative Remedy Program** concerning any issues relating to this policy.

REFERENCES

Program Statements

P1330.18	Administrative Remedy Program (1/6/14)
P4500.11	Trust Fund/Deposit Fund Manual (4/9/15)
P5100.08	Security Designation and Custody Classification Manual (9/12/06)
P5290.15	Intake Screening (3/30/09)
P5310.12	Psychology Services Manual (03/07/95)
P5310.16	Treatment and Care of Inmates with Mental Illness (5/1/14)
P5322.13	Inmate Classification and Program Review (5/16/14)
P5324.08	Suicide Prevention (4/5/07)
P5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/15)
P5325.07	Release Preparation Program (12/31/07)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5800.15	Correctional Systems Manual (9/23/16)

P6031.04 Patient Care (6/3/14)
P6090.04 Health Information Management (3/2/15)

Federal Regulations
28 CFR part 115

Additional Resources For Clinicians
Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version.
World Professional Association for Transgender Health (WPATH) standards.

BOP Forms
BP-A0148 Inmate Request to Staff
BP-A1110 Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates

*ACA Standards (see Program Statement, **Directives Management Manual**, sections 2.5 and 10.3)*

- American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4056M, 4-4084M, 4-4084.1M, 4-4133M, 4-4180M, 4-4194M, 4-4278M, 4-4281.1M, 4-4281.2M, 4-4281.3M, 4-4281.4M, 4-4281.5M, 4-4281.6M, 4-4281.7M, 4-4281.8M, 4-4362M, 4-4371M, 4-4406M.
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-29, 4-ALDF-2A-32, 4-ALDF-2A-34, 4-ALDF-6B-03, 4-ALDF-2C-03, 4-ALDF-4C-22M, 4-ALDF-4C-30M, 4-ALDF-4D-22, 4-ALDF-4D-22-1, 4-ALDF-4D-22-2, 4-ALDF-4D-22-3, 4-ALDF-4D-22-4, 4-ALDF-4D-22-5, 4-ALDF-4D-22-6M, 4-ALDF-4D-22-7, 4-ALDF-4D-22-8, 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1.
- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: None.
- American Correctional Association Standards for Correctional Training Academies: None.

Records Retention
Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

Attachment A. Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110)

I agree that Bureau of Prisons staff may enter a CMA assignment on SENTRY concerning my gender identity.

I understand that this CMA assignment will identify me as transgender to all staff members.

I understand that the purpose of the CMA assignment is to assist staff members in providing programs and taking measures as described in the Program Statement **Transgender Offender Manual.**

I understand that specific medical and mental health information will not be disclosed to all staff using the CMA assignment; specific medical and mental health information is maintained separately.

Inmate Name:

Register Number:

Signature:

Date:

Exhibit - G

Buzz Feed News

The Trump Administration Just Rolled back Rules that Protect Transgender Prisoners

Posted Date: 5-11-18

Pages-(5)

Exhibit - (G)

BuzzFeed News REPORTING TO YOU

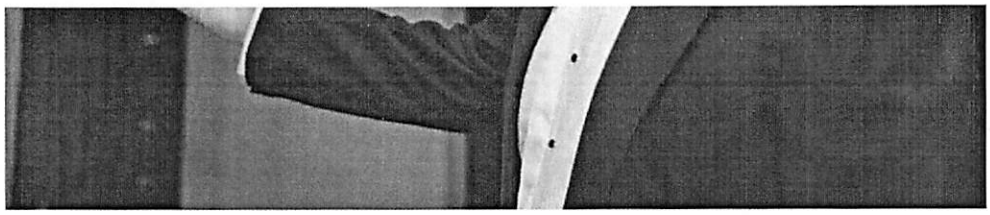
POLITICS

The Trump Administration Just Rolled Back Rules That Protect Transgender Prisoners

The Bureau of Prisons is making the change after four evangelical Christian women in a Texas prison sued.

Dominic Holden
BuzzFeed News Reporter

Last updated on May 11, 2018, at 8:13 p.m. ET
Posted on May 11, 2018, at 6:00 p.m. ET



Afp Contributor / AFP / Getty Images

The Trump administration on Friday rolled back rules that allowed transgender inmates to use facilities that match their gender identity, including cell blocks and bathrooms, thereby reversing course on an Obama administration effort to protect transgender prisoners from sexual abuse and assault.

The Bureau of Prisons now "will use biological sex" to make initial determinations in the type of housing transgender inmates are assigned, according to a notice posted Friday evening that modifies the previous policy.

"The designation to a facility of the inmate's identified gender would be appropriate only in rare cases," the new Transgender Offender Manual now says.

While the policy says a transgender inmate's safety should be considered, officials also must "consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution."

The policy apparently gives federal officials, for example, more leeway to place transgender women in cells alongside

men — a circumstance that transgender advocates argue leaves transgender inmates vulnerable to violence and rape.

The shift comes after four evangelical Christian women in a Texas prison sued in US District Court to challenge the Obama-era guidelines, and claimed sharing quarters with transgender women subjected them to dangerous conditions.

Their complaint alleged housing transgender women — whom it calls "men" — along with the general female population "creates a situation that incessantly violates the privacy of female inmates; endangers the physical and mental health of the female Plaintiffs and others, including prison staff; [and] increases the potential for rape."

Their lawsuit took aim at regulations established in 2012 to protect transgender inmates from violence under the Prison Rape Elimination Act and a guidance memo — issued days before Obama left office — on how to handle transgender inmates. The memo noted that transgender prisoners face an "increased risk of suicide, mental health issues and victimization."

The rules said officials must give "serious consideration" to the wishes of transgender and intersex inmates when assigning facilities, while also instructing prison staff to "consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems."

The policy said a transgender person's gender identity should also be taken into account when conducting searches, using pronouns, offering healthcare services, and supplying undergarments. The guidance also instructed officials to survey the transgender inmate population and issue an annual report on their condition.

Under Trump, however, the Justice Department filed a brief last August in the Texas lawsuit that said it would "will evaluate the issues in this case and how the challenged regulation and policies apply to Plaintiffs."

On Friday, having evaluated those issues, the Bureau of Prisons issued the guidelines that instruct officials to "use biological sex as the initial determination for designation" for screening, housing, and offering programming services, saying the policy is "consistent with maintaining security and good order in Federal prisons."

The new guidance also inserts the word "necessary" into a section of the manual on hormone and medical treatment, indicating the agency will make determinations about what sort of hormone therapies and other gender transition services are required.

Nancy Ayers, a spokesperson for the Bureau of Prisons, told BuzzFeed News the policy considers the needs of transgender inmates and other inmates in accordance with the Prison Rape Elimination Act regulation.

"The manual now addresses and articulates the balance of safety needs of transgender inmates as well as other inmates, including those with histories of trauma, privacy concerns, etc., on a case-by-case basis," she said.

The National Center for Transgender Equality, an advocacy group, condemned the move.

"The extreme rates of physical and sexual violence faced by transgender people in our nation's prisons is a stain on the entire criminal justice system," said Mara Keisling, executive director of the NCTE. "Instead of leaving the existing policy alone, the administration is clearly prepared to encourage federal prisons to violate federal law and advance its own inhumane agenda."

TOPICS IN THIS ARTICLE

Justice Department

Dominic Holden is a political reporter for BuzzFeed News and is based in New York.

Contact Dominic Holden at dominic.holden@buzzfeed.com.

Got a confidential tip? Submit it here.

Exhibit H

Inmate Chronological Disciplinary Record

NO Sanctions Since

1-7-15

Current Date: 8-29-19

Exhibit - (H)

```
  MARCS          *            INMATE DISCIPLINE DATA            *     08-29-2019
PAGE 001         *      CHRONOLOGICAL DISCIPLINARY RECORD       *     10:17:11

REGISTER NO: 17248-018 NAME..: IGLESIAS, CRISTIAN NOEL
FUNCTION...: PRT       FORMAT: CHRONO    LIMIT TO ___ MOS PRIOR TO 08-29-2019

--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 2659913 - SANCTIONED INCIDENT DATE/TIME: 12-01-2014 0654
DHO HEARING DATE/TIME: 01-07-2015 0900
FACL/CHAIRPERSON.....: OAD/MELTON M
REPORT REMARKS.......: I/M ADMITTED USING ANOTHER I/M'S PAC NUMBER TO SEND MY
                       TO OUTSIDE PERSON.
   219  STEALING - FREQ: 1
        DIS GCT    / 27 DAYS / CS
        COMP:060 LAW:P
        LP COMM    / 1 YEARS / CS
        COMP:    LAW:    TO DETER.
        LP PHONE   / 1 YEARS / CS
        COMP:    LAW:    TO PREVENT FURTHER INFRACTIONS.
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 2366662 - SANCTIONED INCIDENT DATE/TIME: 10-22-2012 0730
DHO HEARING DATE/TIME: 11-13-2012 1350
FACL/CHAIRPERSON.....: BMP/SAWYER S
REPORT REMARKS.......: INMATE NEITHER ADMITTED OR DENIED CHARGE
   296  MAIL ABUSE, DISRUPT MONITORING - FREQ: 1
        DIS GCT    / 27 DAYS / CS
        COMP:060 LAW:P
        DS         / 30 DAYS / CS / SUSPENDED 180 DAYS
        COMP:    LAW:
        LP EMAIL   / 3 MONTHS / CS
        COMP:    LAW:    FROM 11/13/12 TO 2/11/13
        LP PHONE   / 3 MONTHS / CS
        COMP:    LAW:    FROM 11/13/12 TO 2/11/13
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 2301265 - SANCTIONED INCIDENT DATE/TIME: 05-08-2012 0825
DHO HEARING DATE/TIME: 06-20-2012 1010
FACL/CHAIRPERSON.....: THP/D. LOCKETT
REPORT REMARKS.......: INMATE ADMITS THAT HE PUT ANOTHER I/M NUMBER ON HIS
                       BP199 AND TURNED IN TO STAFF ATTEMPTING TO PAY DEBT.
   219A STEALING - FREQ: 1
        DIS GCT    / 27 DAYS / CS
        COMP:060 LAW:P
        DS         / 30 DAYS / CS / SUSPENDED 180 DAYS
        COMP:    LAW:
        LP COMM    / 90 DAYS / CS
        COMP:    LAW:
        LP PHONE   / 90 DAYS / CS / SUSPENDED 180 DAYS
        COMP:    LAW:



G0002       MORE PAGES TO FOLLOW . . .
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  MARCS          *            INMATE DISCIPLINE DATA            *      08-29-2019
PAGE 002         *      CHRONOLOGICAL DISCIPLINARY RECORD       *      10:17:11

REGISTER NO: 17248-018 NAME..: IGLESIAS, CRISTIAN NOEL
FUNCTION...: PRT       FORMAT: CHRONO    LIMIT TO ___ MOS PRIOR TO 08-29-2019

--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 1951956 - SANCTIONED INCIDENT DATE/TIME: 12-05-2009 1800
UDC HEARING DATE/TIME: 12-08-2009 1435
FACL/UDC/CHAIRPERSON.: FLM/E/FENLON
APPEAL CASE NUMBER(S): 570968
REPORT REMARKS.......: REFUSED RESTRAINTS
   307  REFUSING TO OBEY AN ORDER - FREQ: 1
        LP OTHER    / 14 DAYS / CS
        COMP:    LAW:    LOSS OF TV/RADIO
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 1688211 - SANCTIONED INCIDENT DATE/TIME: 11-21-2007 1330
DHO HEARING DATE/TIME: 01-28-2008 0935
FACL/CHAIRPERSON.....: THA/S.MARKLE
APPEAL CASE NUMBER(S): 482828
REPORT REMARKS.......: INMATE ADMITTED GUILT
   203  THREATENING BODILY HARM - FREQ: 2 ATI: ON1
        DIS GCT     / 27 DAYS / CS
        COMP:060 LAW:P
        DS          / 30 DAYS / CS / SUSPENDED 180 DAYS
        COMP:    LAW:
        LP COMM     / 180 DAYS / CS
        COMP:    LAW:
        LP PHONE    / 180 DAYS / CS / SUSPENDED 180 DAYS
        COMP:    LAW:
        TRANSFER    / CS
        COMP:    LAW:    RECOMMEND DISCIPLINARY TRANSFER
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 1501255 - SANCTIONED INCIDENT DATE/TIME: 08-14-2006 1600
DHO HEARING DATE/TIME: 02-13-2007 0815
FACL/CHAIRPERSON.....: EST/SLATER E
APPEAL CASE NUMBER(S): 446340
REPORT REMARKS.......: INMATE ADMITTED CHARGE
   203  THREATENING BODILY HARM - FREQ: 1 ATI: SN1
        DIS GCT     / 27 DAYS / CS
        COMP:060 LAW:P   MEETS VCCLEA NON-VIOLENT SENTENCING GUIDELINES
        DS          / 30 DAYS / CS / SUSPENDED 180 DAYS
        COMP:    LAW:    IMPOSED TO DETER FUTURE MISCONDUCT
        LP COMM     / 6 MONTHS / CS
        COMP:    LAW:    IMPSOED AS PUNISHMENT RESTORE 8-11-07
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 1312087 - SANCTIONED INCIDENT DATE/TIME: 01-31-2005 1242
DHO HEARING DATE/TIME: 04-05-2005 1430
FACL/CHAIRPERSON.....: MIM/POSADA
REPORT REMARKS.......: DENIES THE OFFENSE



G0002       MORE PAGES TO FOLLOW . . .
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  MARCS          *            INMATE DISCIPLINE DATA            *     08-29-2019
PAGE 003         *      CHRONOLOGICAL DISCIPLINARY RECORD       *     10:17:11

REGISTER NO: 17248-018 NAME..: IGLESIAS, CRISTIAN NOEL
FUNCTION...: PRT       FORMAT: CHRONO    LIMIT TO ___ MOS PRIOR TO 08-29-2019

DHO HEARING DATE/TIME: 04-05-2005 1430 REPORT 1312087 CONTINUED
   219  STEALING - FREQ: 1
        DIS GCT    / 14 DAYS / CS
        COMP:050 LAW:N
        DS         / 30 DAYS / CS / SUSPENDED 180 DAYS
        COMP:    LAW:
        LP COMM    / 30 DAYS / CS
        COMP:    LAW:
        MON REST   / 250.00 DOLLARS / CS
        COMP:    LAW:
   313  LYING OR FALSIFYING STATEMENT - FREQ: 1
        DS         / 15 DAYS / CS
        COMP:    LAW:
        LP COMM    / 30 DAYS / CS
        COMP:    LAW:
   314  COUNTRFTNG OR FORGING DOCUMENT - FREQ: 1
        DS         / 15 DAYS / CS / SUSPENDED 180 DAYS
        COMP:    LAW:
        LP COMM    / 30 DAYS / CS
        COMP:    LAW:
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 1315304 - SANCTIONED INCIDENT DATE/TIME: 02-24-2005 1325
UDC HEARING DATE/TIME: 02-28-2005 0930
FACL/UDC/CHAIRPERSON.: MIM/UNIT D/ACOSTA
REPORT REMARKS.......: INMATE ADDMITTED TO THE CHARGES
   305  POSSESSING UNAUTHORIZED ITEM - FREQ: 1
        LP VISIT   / 30 DAYS / CS
        COMP:    LAW:    INMATE ADDMITTED TO THE CHARGES
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 1093166 - SANCTIONED INCIDENT DATE/TIME: 04-07-2003 1652
DHO HEARING DATE/TIME: 05-05-2003 0925
FACL/CHAIRPERSON.....: EDG/SLATER E
REPORT REMARKS.......: INMATE ADMITTED CHARGE
   297A PHONE ABUSE-DISRUPT MONITORING - FREQ: 2
        DS         / 20 DAYS / CS / SUSPENDED 180 DAYS
        COMP:    LAW:    IMPOSED AS PUNISHMENT
        LP PHONE   / 3 MONTHS / CS
        COMP:    LAW:    TO DEMONSTRATE SERIOUSNESS OF ACT RESTORE ON
                         11-20-03
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 1014254 - SANCTIONED INCIDENT DATE/TIME: 07-19-2002 1813
DHO HEARING DATE/TIME: 02-20-2003 0822
FACL/CHAIRPERSON.....: EDG/SLATER E
REPORT REMARKS.......: INMATE ADMITTED CHARGE



G0002       MORE PAGES TO FOLLOW . . .
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  MARCS          *            INMATE DISCIPLINE DATA            *     08-29-2019
PAGE 004 OF 004 *      CHRONOLOGICAL DISCIPLINARY RECORD       *     10:17:11

REGISTER NO: 17248-018 NAME..: IGLESIAS, CRISTIAN NOEL
FUNCTION...: PRT       FORMAT: CHRONO    LIMIT TO ___ MOS PRIOR TO 08-29-2019

DHO HEARING DATE/TIME: 02-20-2003 0822 REPORT 1014254 CONTINUED
   297  PHONE ABUSE-DISRUPT MONITORING - FREQ: 1
        DIS GCT    / 14 DAYS / CS
        COMP:040 LAW:S   TO DETER FUTURE MISCONDUCT
        DS         / 30 DAYS / CS
        COMP:    LAW:    TO DEMONSTRATE SERIOUSNESS OF ACT
        IMPOUND    / 30 DAYS / CS
        COMP:    LAW:    TO DETER FUTURE MISCONDUCT
        LP PHONE   / 180 DAYS / CS
        COMP:    LAW:    TO DETER FUTURE MISCONDUCT RESTORE ON 8-20-03
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 1063304 - SANCTIONED INCIDENT DATE/TIME: 01-09-2003 0025
DHO HEARING DATE/TIME: 02-20-2003 0815
FACL/CHAIRPERSON.....: EDG/SLATER E
REPORT REMARKS.......: INMATE ADMITTED CHARGE
   205  ENGAGING IN SEXUAL ACTS - FREQ: 1 ATI: IN1
        DIS GCT    / 14 DAYS / CS
        COMP:040 LAW:S   TO DEMONSTRATE SERIOUSNESS OF ACT
        DS         / 30 DAYS / CS
        COMP:    LAW:    TO DEMONSTRATE SERIOUSNESS OF ACT
        IMPOUND    / 30 DAYS / CS
        COMP:    LAW:    TO DETER FUTURE MISCONDUCT
        LP COMM    / 180 DAYS / CS
        COMP:    LAW:    TO DETER FUTURE MISCONDUCT RESTORE ON 8-20-03

G0005       TRANSACTION SUCCESSFULLY COMPLETED - CONTINUE PROCESSING IF DESIRED
```

Exhibit - I

Inmate Education Data Transcript

Proof of Clear conduct by Programming

Current Date: 8-27-19

Page - 1 - 2

Exhibit (T)

MARFM * INMATE EDUCATION DATA * 08-27-2019
PAGE 001 * TRANSCRIPT * 14:12:13

REGISTER NO: 17248-018 NAME..: IGLESIAS FUNC: PRT
FORMAT.....: TRANSCRIPT RSP OF: MAR-MARION USP

EDUCATION INFORMATION

FACL	ASSIGNMENT	DESCRIPTION	START DATE/TIME	STOP DATE/TIME
MAR	ESL HAS	ENGLISH PROFICIENT	11-14-1996 0928	CURRENT
MAR	GED HAS	COMPLETED GED OR HS DIPLOMA	07-07-2000 1345	CURRENT

EDUCATION COURSES

SUB-FACL	DESCRIPTION	START DATE	STOP DATE	EVNT	AC	LV	HRS
MAR GP	S & P STOCK ACE CLASS	07-29-2019	CURRENT				
MAR GP	ASQ QUALITY ASSURANCE	03-05-2019	06-21-2019	P	C	P	16
MAR GP	BUSINESS START-UP ACE CLASS	02-06-2019	05-07-2019	P	C	P	8
MAR GP	ACE VIDEO NATURAL WONDERS	02-04-2019	05-07-2019	P	C	P	8
MAR GP	UNICOR OSHA 10 - 24 WEEKS	01-31-2019	03-13-2019	P	C	P	10
MAR GP	NUTRITION	11-07-2017	01-05-2018	P	C	P	10
MAR GP	CDL MANUAL STUDY ACE CLASS	07-31-2017	09-19-2017	P	C	P	8
CUM	SHU LANDSCAPE MAINTENANCE	05-18-2017	05-31-2017	P	C	P	20
CUM	CLN TIME MANAGEMENT	05-01-2017	05-01-2017	P	C	P	3
CUM	CLN STRESS MANAGEMENT	04-17-2017	04-24-2017	P	C	P	5
CUM	MRSA IN AN ATHLETIC FACILITY	04-02-2017	04-16-2017	P	C	P	1
BTF GP	SHU WORLD HISTORY	02-16-2017	02-23-2017	P	C	P	8
BTF GP	SHU PERSONAL FINANCE	02-09-2017	02-16-2017	P	C	P	8
BUT GP	(G)DECISION MAKING-CAI	09-01-2016	11-15-2016	P	C	P	10
BUT GP	(V)CNDCTNG INTVWS SUCCFL RESLT	09-01-2016	11-15-2016	P	C	P	10
BUT GP	(A)WINDOWS VISTA 1-CAI	09-01-2016	11-15-2016	P	C	P	20
BUT GP	(W)BACK SAFETY	09-01-2016	11-15-2016	P	C	P	2
BUT GP	(V)RESUME SKILLS-CAI	09-01-2016	11-15-2016	P	C	P	10
BUT GP	(V)BLDG STRNG CUSTMR RELTNSHPS	09-01-2016	11-15-2016	P	C	P	10
BUT GP	(A)KEYBOARDING-CAI	09-01-2016	11-15-2016	P	C	P	25
BUT GP	(W)RECOGNIZE AVOID BURNOUT	09-01-2016	11-15-2016	P	C	P	5
BUT GP	(W)DRIVER SAFETY-CAI	09-01-2016	11-15-2016	P	C	P	2
BUT GP	(W)STRESS CONTROL-CAI	09-01-2016	11-15-2016	P	C	P	5
BUT GP	(W)MANAGE PERSONAL STRESS-CAI	09-01-2016	11-15-2016	P	C	P	5
BUT GP	(V)HVAC SYSTEM CONTROLS-CAI	09-01-2016	11-15-2016	P	C	P	60
BUT GP	(V)HVAC CONTROLS-CAI	09-01-2016	11-15-2016	P	C	P	60
BUT GP	(V)HVAC ASHRAE STANDS-CAI	09-01-2016	11-15-2016	P	C	P	60
BUT GP	(V)GREEN BUILDING-RESIDENTIAL	09-01-2016	11-15-2016	P	C	P	40
BUT GP	(V)GREEN BUILDING-REMODELING	09-01-2016	11-15-2016	P	C	P	40
BUT GP	(V)GREEN BUILDING-INFRASTRUCTR	09-01-2016	11-15-2016	P	C	P	40
BUT GP	(V)GREEN BUILDING-COMMERCIAL	09-01-2016	11-15-2016	P	C	P	40
BUT GP	NRDAP - NON RES DAP GROUP	09-14-2016	09-14-2016	P	C	P	26
BUT GP	HEALTH FAIR	07-12-2016	08-17-2016	P	C	P	1
BUT GP	ANGER MANAGEMENT	06-07-2016	08-09-2016	P	C	P	10
BUT GP	MONEYSMART-FINANCIAL EDUCATION	04-29-2016	07-20-2016	P	C	P	20
OAD RHU	SHU - GOVERNMENT LANGUAGE	06-11-2015	06-17-2015	P	C	P	4
OAD RHU	SHU - CLOTHING LANGUAGE	05-28-2015	06-04-2015	P	C	P	4
OAD RHU	SHU-RESTAURANT LANGUAGE	05-21-2015	05-28-2015	P	C	P	4
OAD RHU	SHU-ENTERTAINMENT LANGUAGE	05-14-2015	05-21-2015	P	C	P	4
OAD RHU	SUPERMARKET LANGUAGE	04-30-2015	05-07-2015	P	C	P	4

G0002 MORE PAGES TO FOLLOW . . .

Exhibit (E)

MARFM * INMATE EDUCATION DATA * 08-27-2019
PAGE 002 OF 002 * TRANSCRIPT * 14:12:13

REGISTER NO: 17248-018 NAME..: IGLESIAS FUNC: PRT
FORMAT.....: TRANSCRIPT RSP OF: MAR-MARION USP

EDUCATION COURSES

SUB-FACL	DESCRIPTION	START DATE	STOP DATE	EVNT	AC	LV	HRS
OAD RHU	AEROBICS	06-27-2014	05-08-2015	P	C	P	3
OAD RHU	TRANSPORTATION LANGUAGE	04-23-2015	04-30-2015	P	C	P	4
OAD RHU	BANKING INFORMATION	04-09-2015	04-23-2015	P	C	P	4
OAD RHU	SHU MONEY AND CONSUMERS	04-02-2015	04-09-2015	P	C	P	4
OAD RHU	SHU PROBLEM SOLVING	03-26-2015	04-02-2015	P	C	P	4
OAD RHU	SHU HOUSING & SAFETY	03-19-2015	03-26-2015	P	C	P	4
OAD RHU	SHU PERSONAL DEVELOPMENT	03-12-2015	03-19-2015	P	C	P	4
OAD RHU	SHU THE WORLD OF WORK	02-26-2015	03-12-2015	P	C	P	4
OAD RHU	RHU HORTICULTURE	11-10-2014	03-16-2015	P	C	P	24
OAD RHU	SHU PERSONAL HEALTH	02-19-2015	02-26-2015	P	C	P	4
OAD RHU	SHU COMMUNITY AND GOVERNMENT	02-05-2015	02-12-2015	P	C	P	4
OAD RHU	SHU COMMUNICATION	01-30-2015	02-12-2015	P	C	P	4
OAD RHU	SHU TIME MANAGEMENT	01-22-2015	01-30-2015	P	C	P	4
OAD RHU	SHU YOUR WORK EXPERIENCE	01-15-2015	01-22-2015	P	C	P	4
TCP	SHU: PERSONAL FINANCE 101	10-01-2013	10-07-2013	P	C	P	7
TCP	SHU ACE: SS 1 US HISTORY	10-22-2013	10-29-2013	P	C	P	8
TCP	NEW YORK TIMES	07-10-2013	07-31-2013	P	C	P	4
COP CHG	RPP HEALTH/NUTRITION #1	03-01-2013	03-01-2013	P	C	P	1
FLM	THE UNIVERSE - PART 2	12-22-2010	03-15-2011	P	C	P	36
FLM	AMERICA AT WAR - PART 2	10-13-2010	12-21-2010	P	C	P	30
FLM	THE UNIVERSE - PART 1	03-03-2010	05-25-2010	P	C	P	36
FLM	PELOPONNESIAN WAR - PART 2	03-04-2010	05-05-2010	P	C	P	27
FLM	BATTLES OF THE ANCIENT WORLD	10-14-2009	12-08-2009	P	C	P	24
FLM	ENGINEERING AN EMPIRE	07-22-2009	10-13-2009	P	C	P	36
FLM	HISTORY OF WORLD WAR II	02-18-2009	04-28-2009	P	C	P	30
FLM	HISTORY OF EUROPEAN ART PART 2	12-18-2008	03-11-2009	P	C	P	36
FLM	THE VIKINGS - PART 2	05-01-2008	07-02-2008	P	C	P	27
EST	HEALTH FAIR-QUARTERLY (HN#1)	04-13-2007	04-13-2007	P	C	P	2
DEV MH	(HN) LEARNING ABOUT HIV	03-21-2006	03-21-2006	P	C	P	1
EST	SPANISH I - FCI (PG 6)	11-03-2005	12-30-2005	P	C	P	16
EST	INFECTIOUS DISEASE PREVT(HN#1)	10-27-2005	10-27-2005	P	C	P	1
EST	AEROBICS M-F 8-9 AM	07-18-2004	08-14-2004	P	C	P	12
EST	INFECTIOUS DISEASE PREVT(HN#1)	09-03-2003	09-03-2003	P	C	P	2

G0000 TRANSACTION SUCCESSFULLY COMPLETED

Exhibit - J

Transgender Pat Search
Exception Approval

Date: 7/3/17

Exhibit - (J)

U.S. Department of Justice
Federal Bureau of Prisons

United States Penitentiary

4500 Prison Road
Marion, IL 62959

July 3, 2017

MEMORANDUM FOR ALL STAFF

FROM: B. True, Warden

SUBJECT: Transgender Pat Search Exception Approval/Visual Search Denial
IGLESIAS, Christian, Reg. No. 17248-018

The above listed inmate requested pat search/visual search exception, on June 14, 2017, in accordance with P.S. 5200.04, Transgender Offender Manual, pg. 9, sec. 12. This inmate identified as Transgender, Male to Female, on May 19, 2017. Program Statement 5200.04 states "The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services." In addition, inmates granted an exception may have said exemption reversed "if found to have violated institution rules concerning contraband."

Review of this inmate's disciplinary history reveals a pattern of clear conduct and no noted violation of institution rules concerning contraband. The aforementioned departments were consulted regarding the request and recommended approval of a pat search exception (pat search by female staff only) but denial of a visual search exemption.

In accordance with P.S. 5200.04, "Exceptions must be specifically described (e.g., "pat search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database; e.g., posted picture file). Inmates should be provided a personal identifier (e.g., notation on commissary card, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to pat searches."

Please be reminded inmates granted an exception may have said exemption reversed "if found to have violated institution rules concerning contraband." Additionally, "in exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement Searches of Housing Units, Inmates, and Inmate Work Areas." Please contact your supervisor with any additional questions.

Exhibit - K

Administrative Remedy

897368-A1

Transfer to a female Prison

Date: 7/6/17

Page - 1 of 2

Exhibit K

U.S. Department of Justice
Federal Bureau of Prisons

Central Office Administrative Remedy Appeal

Type or use ball-point pen. If attachments are needed, submit four copies. One copy each of the completed BP-DIR-9 and BP-DIR-10, including any attachments must be submitted with this appeal.

From: Iglesias Cristian N. (LAST NAME, FIRST, MIDDLE INITIAL) | 17248-018 (REG. NO.) | C-1 (UNIT) | FCI Cumberland (INSTITUTION)

Part A—REASON FOR APPEAL I am appealing the Regional Directors response to my Reques to be transferred to a female Prison. I am a transgender female on hormone therapy and I have breast and am very effeminate in my manneri'sms and identify as a female and am recognized and validated transgender female With a Current CmA-as,trn m2F.f*In the response it appears that I jus Was recognized on 2-2-17, as a transgender female, the CmA SENTRY ssignment was due to new Program Statement - OPI: RSD/FoB-#5200.04 - Dated: 1-18-17. I have been recognized by the BoP since 2015. I am ransitioning to a female with the end result of having gender affirming surge art of my treatment is to live "real time experience" as a female and gender- onsolidation meaning female. I request this transfer to a female Prison so that an continue my treatment, the next Phase as well be safer for me. No PREA issues Please grant my request. * Exhibit Enclosed *

5-16-17 (DATE) | 17248-018 (SIGNATURE OF REQUESTER)

Part B—RESPONSE

RECEIVED
MAY 31 2017
Administrative Remedy Section
Federal Bureau of Prisons

DATE | GENERAL COUNSEL

ORIGINAL: RETURN TO INMATE | CASE NUMBER: 897368-A1

Part C—RECEIPT | CASE NUMBER:

Return to: (LAST NAME, FIRST, MIDDLE INITIAL) | (REG. NO.) | (UNIT) | (INSTITUTION)

SUBJECT:

DATE | SIGNATURE OF RECIPIENT OF CENTRAL OFFICE APPEAL

EXHIBIT K

Administrative Remedy Number 897368-A1
Part B - Response

This is in response to your Central Office Administrative Remedy Appeal wherein you request a transfer to a female facility.

Following our review, we find your complaint is repetitive to Central Office Administrative Remedy Appeal number 865332-A1, for which we have previously provided a response. That is, we do not find the appeal is materially or substantively different and, as such, we refer you to that response, rather than elaborating further with like conclusions.

Accordingly, we find your appeal repetitive and have closed it as such.

7/6/17
Date

Ian Connors, Administrator
National Inmate Appeals

Exhibit - L

Bureau of Prisons

Psychology Services

Diagnostic and Care Level-

Formulation

Dr. Sarah Hampton PhD

Date: 6-16-17

Current

Page 1 of 3

* Page 2 of 3 - States Diagnosis - Seeking Gender Affirming Surgery.

SENSITIVE BUT UNCLASSIFIED

Bureau of Prisons
Psychology Services
Diagnostic and Care Level Formulation

Inmate Name:	IGLESIAS, CRISTIAN NOEL			Reg #:	17248-018
Date of Birth:	06/10/1974	Sex:	M Facility: MAR	Unit Team:	UM NORTH
Date:	06/16/2017 10:43	Provider:	Hampton, Sarah PhD		

Relevant Historical Information

Inmate IGLESIAS is a 43-year-old WHITE anatomical male who identifies as female, serving a 98-month sentence for Mailing Threatening Communications. Her projected release date is 04/26/2023. Inmate Iglesias described a childhood in which her father was physically and emotionally abusive due to his difficulty accepting her femininity and sexual orientation. Following the divorce of her parents, she was raised primarily by her mother, who died during inmate Iglesias's incarceration. Inmate Iglesias has previously reported a history of head injury in a car accident at age 12 with loss of consciousness and subsequent seizures, for which she received anti-seizure medication until 2002. Sentry assignment is GED HAS. Inmate Iglesias reported that she withdrew from formal school in tenth grade due to running away. She denied a history of behavioral problems, learning disorder diagnosis, or special education placement. She said she obtained her GED in state prison. She denied a legitimate employment history, stating she was in state prison beginning at age 17 or 18, was in the community for two months, and has been in BOP custody since. Inmate Iglesias said she is single and has not fathered any children. Of note, she has been in BOP custody since 1994. She denied chronic medical concerns.

Inmate Iglesias has a lengthy history of reporting being the victim of sexual abuse while incarcerated, including but not limited to: 1993 (FL state prison), 2001 (BOP; Otisville, NY), 1993 (threat of an assault), 2001(reported being assaulted), 2013 (reported sexual harassment), 2015 (reported sexual harassment by staff), 2015 (reported sexual harassment by inmates), 2016 (reported sexual harassment by staff), 2016 (reported sexual harassment by staff), 2016 (reported sexual harassment by another inmate), 2016 (reported being sexually propositioned by other inmates), 2016 (reported being fondled by another inmate), and 2017 (reported being sexually propositioned by other inmates and received brief supportive services through a crisis response center). She has previously acknowledged engaging in consensual sexual behavior while incarcerated. Inmate Iglesias also has a lengthy history of requesting protective custody due to gang involvement and has previously been housed at the ADX. She said she used to "run with the Nietas for protection" but has been "Xed out." She does not have a noted history of violence but has incurred multiple incident reports, including 205 Engaging in Sexual Acts, 219 Stealing, and Threatening Bodily Harm. Inmate Iglesias said she communicates regularly with her aunt and uncle, sister, and other relatives.

MENTAL HEALTH HISTORY:
Inmate Iglesias described a history of emotional difficulties since childhood. She has previously been diagnosed with Adjustment Disorder With Depressed Mood and Major Depressive Disorder. In 2009, following a psychiatry consultation, she was diagnosed with Bulimia Nervosa due to reporting purging activity as well as a history of same behavior periodically over the past several years. Records indicate that inmate Iglesias's affective instability is better accounted for by diagnosis of Borderline Personality Disorder. Inmate Iglesias has a history of reporting symptoms of depression and/or anxiety, specifically when she perceives interpersonal stressors or perceives herself to have limited control over her environment. She has demonstrated a history of poor judgment, as she appears to repeat patterns of maladaptive behavior (e.g., unhealthy interpersonal relationships, accruing debt, etc.) despite her ability to acknowledge these patterns as being maladaptive and being provided with treatment (e.g., programming and therapy) to develop more adaptive coping skills and behaviors. She is also currently diagnosed with Gender Dysphoria.

Inmate Iglesias has reported a history of multiple inpatient hospitalizations while in the community due to suicidal ideation. From ages 13 to 16, she underwent outpatient counseling. She has also periodically engaged in counseling and taken psychotropic medication (e.g., Lithium, Fluoxetine, Mirtazapine, Buspirone, Oxcarbazepine, Citalopram) while incarcerated, vacillating between CARE2-MH and CARE3-MH status. She was coded as incomplete from the Challenge program in 2013, expelled from the RHU program in 2015, and incomplete from the Stages program in 2015.

SELF-HARM HISTORY:
Inmate Iglesias has denied a history of suicide attempts with intent to die but reported suicidal behavior including hanging at age 13, overdose on Lithium at age 18, and hanging in 2010 following the death of her mother. In 1991 and again in 1992, she made suicidal threats while in county jail and state custody. She has also reported that she

Inmate Name:	IGLESIAS, CRISTIAN NOEL			Reg #:	17248-018
Date of Birth:	06/10/1974	Sex:	M	Facility: MAR	Unit Team: UM NORTH
Date:	06/16/2017 10:43	Provider:	Hampton, Sarah PhD		

rehearsed strangulation in 2006 and again in 2015. She reported that she cut her penis in 2009. Overall, inmate Iglesias's risk for suicide has been assessed on approximately 33 occasions during her course of incarceration with the BOP (most often due to an overreaction to stressors, inadequate coping skills, conflict with other inmates, or frustration with circumstances) with 12 placements on suicide watch.

SUBSTANCE USE HISTORY:
Inmate Iglesias reported alcohol and marijuana use when she was younger. She said she experimented with Valium one time. Inmate Iglesias completed BOP drug education in 2012 and NRDAP in 2016.

Presenting Problem/Symptom

Inmate Iglesias stated, "I struggle every day waking up in this body," adding that she reportedly cut her penis in 2009. She identified mild anxiety surrounding her adjustment to USP Marion and what commissary items would be available for transgender inmates. Speech was normal in rate, volume, and tempo. Mannerisms were overtly feminine. She was alert and oriented to person, place, date, and situation. Grooming and hygiene were appropriate. The inmate denied delusional or psychotic symptoms. She denied recent or current thoughts of self-harm, and there was no overt evidence to suggest suicidal ideation. Inmate IGLESIAS was asked if she was currently suicidal, and she stated, "No." She is not currently prescribed psychotropic medication.

Diagnostic Reconciliation

As previously noted, features of affective instability appear primarily related to Borderline Personality Disorder diagnosis rather than Major Depressive Disorder.

Diagnostic Formulation

Inmate Iglesias meets the following criteria, warranting diagnosis of Gender Dysphoria in Adolescents and Adults (portions of the following were copied from a previous Diagnostic and Care Level Formulation note and have been updated accordingly):

1. Marked incongruence between experienced/expressed gender and primary and/or secondary sex characteristics
2. Strong desire to be rid of one's primary and/or secondary sex characteristics because of the incongruence
3. Strong desire for the primary and/or secondary sex characteristics of the other gender
4. Strong desire to be of the other gender
5. Strong desire to be treated as the other gender
6. Strong conviction that one has the typical feelings and reactions of the other gender

B. Her transgender condition is associated with clinically significant distress or impairment in social, occupation, or other important areas of functioning.

Inmate Iglesias also meets criteria for diagnosis of Borderline Personality Disorder. She has exhibited efforts to avoid abandonment (e.g., behavior following news that primary psychologist would be transferring to a different institution), periods of extreme and transient mood changes (marked affective instability apparent throughout review of PDS record), recurrent suicidal behavior and gestures (approximately 33 SRAs while in BOP custody with 12 suicide watch placements), a pattern of unstable and intense interpersonal relationships (e.g., associating with gangs, engaging in sexual behavior while incarcerated), identity disturbance, and marked impulsivity (e.g., suicidal behavior, incurring debts, associating with gangs, description of criminal behavior).

Care Level Formulation

Justification for CARE2-MH assignment:

History of suicidal behavior in the last five years (most recent suicide risk assessment May 2017).
Lengthy history of disruptive behavior and adjustment concerns.
The inmate requires monthly clinical intervention to maintain outpatient status.

Diagnosis:

Gender Dysphoria In Adolescents And Adults, F64.1 - Current - *Validated Transgender Male to Female, seeking Gender Affirmation Surgery*

Borderline Personality Disorder, F60.3 - Current - *Generally stable*

Inmate Name:	IGLESIAS, CRISTIAN NOEL			Reg #:	17248-018
Date of Birth:	06/10/1974	Sex:	M	Facility: MAR	Unit Team: UM NORTH
Date:	06/16/2017 10:43	Provider:	Hampton, Sarah PhD		

Completed by Hampton, Sarah PhD on 06/27/2017 12:17

Exhibit - N

Administrative Remedy

945168-A3

Change Records from

male to Female

Date: 2/5/19

Page 1 of 2

U.S. Department of Justice

Federal Bureau of Prisons

Central Office Administrative Remedy Appeal

Type or use ball-point pen. If attachments are needed, submit four copies. One copy each of the completed BP-229(13) and BP-230(13), including any attachments must be submitted with this appeal.

From:	LAST NAME, FIRST, MIDDLE INITIAL	REG. NO.	UNIT	INSTITUTION
	Iglesias, Cristian N.	17248-018	X	USP-Marion

Part A - REASON FOR APPEAL I am Appealing the Regional Director response, I am Requesting that Bureau of Prisons change my gender on all documents including Sentry, from Male to Female. As a transsexual / transgender femal diagnosed with gender dysphoria, it is torturous to be labeled as a male on documents. I have met all the requirements to have my Gender Changed. I have take all steps that are available to me (including requesting gender affirming surgery). *Please see attached medical document writted by Randall Pass MD LCD. A denial of this request would be a clear violation of the 8th Amendment to my constitutional Rights. "Cruel & Unusal Punishment" My gender Identity is female, my hormone levels are female and all documents including Sentr should Reflect female.

9-21-18
DATE

Cristian Iglesias
SIGNATURE OF REQUESTER

Part B - RESPONSE

DATE

GENERAL COUNSEL

ORIGINAL: RETURN TO INMATE

CASE NUMBER: 948165-A1, A2

Part C - RECEIPT

CASE NUMBER:

Return to: LAST NAME, FIRST, MIDDLE INITIAL | REG. NO. | UNIT | INSTITUTION

SUBJECT:

DATE

SIGNATURE OF RECIPIENT OF CENTRAL OFFICE APPEAL

Exhibit - N

Administrative Remedy No. 945168-A3
Part B - Response

This is in response to your Central Office Administrative Remedy Appeal wherein you request your gender be modified to reflect female in SENTRY and on all documentation.

We have reviewed the documentation related to your appeal and, based on this review, we concur with the manner in which the Warden and Regional Director addressed your concerns. Until the Transgender Executive Council deems you appropriate for placement in a female facility, there is no obligation to modify your SENTRY or documentation to reflect female. Staff determinations in this matter are consistent with the requirements of Pursuant to Program Statement 5200.04, Transgender Offender Manual.

Accordingly, your appeal is denied.

2/5/19
Date

IS
Ian Connors, Administrator
National Inmate Appeals

Exhibit - M

Standards of Care for Health of Transsexual, Transgender and gender-non conforming People

Pages 1-of 5

Exhibit M

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

Standards of Care

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

Eli Coleman, Walter Bockting, Marsha Botzer, Peggy Cohen-Kettenis, Griet DeCuypere, Jamie Feldman, Lin Fraser, Jamison Green, Gail Knudson, Walter J. Meyer, Stan Monstrey, Richard K. Adler, George R. Brown, Aaron H. Devor, Randall Ehrbar, Randi Ettner, Evan Eyler, Rob Garofalo, Dan H. Karasic, Arlene Istar Lev, Gal Mayer, Heino Meyer-Bahlburg, Blaine Paxton Hall, Friedmann Pfäfflin, Katherine Rachlin, Bean Robinson, Loren S. Schechter, Vin Tangpricha, Mick van Trotsenburg, Anne Vitale, Sam Winter, Stephen Whittle, Kevan R. Wylie & Ken Zucker

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

ISBN: X-XXX-XXXXX-XX

1 This is the seventh version of the *Standards of Care* since the original 1979 document. Previous revisions were in 1980, 1981, 1990, 1998, and 2001. Version seven was published in the International Journal of Transgenderism, 13(4), 165–232. doi:10.1080/15532739.2011.700873

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, & LWPES/ESPE 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

B. WPATH Standards of Care

The World Professional Association for **Transgender** Health ("WPATH") has developed Standards of Care for the Health of Transsexual, **Transgender**, and Gender-Nonconforming People ("Standards of Care"), which are recognized as authoritative standards of care by the American Medical Association, the American Psychiatric Association, and the American Psychological Association. Ettner Decl. ¶ 21; see also Deposition of Lori Kohler, M.D. ("Kohler Dep."), ECF No. 67 at 21, at 91-92. The Standards of Care explain that treatment for gender dysphoria is individualized: "What helps one person alleviate gender dysphoria might be very different from what helps another person." Standards of Care, Version 7, ECF No. 10-1 at 5. They address a variety of therapeutic options, including changes in gender expression and role, hormone therapy, surgery, and psychotherapy. Id. at 8.

One treatment for gender dysphoria is sex reassignment surgery ("SRS"). "Vaginoplasty is the definitive male-to-female sex reassignment surgery." Declaration of Dr. Marci L. Bowers ("Bowers Decl."), ECF No. 65 ¶ 15. It involves the removal of the patient's male genitals and creation of female genitals, and has two therapeutic purposes. Id. ¶ 19; Ettner Decl. ¶ 39. SRS for transsexual female patients both removes the principal source of testosterone in the body and creates congruence between the patient's gender identity and her primary sex characteristics. Ettner Decl. ¶¶ 38-39. The Standards of Care explain:

> 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. 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.Standards of Care at 36; see also Ettner Decl. ¶ 38 ("For many individuals with severe gender dysphoria, however, hormone therapy alone is insufficient. Relief from their dysphoria cannot be achieved without surgical intervention to modify primary sex characteristics, i.e. genital reconstruction."); Bowers Decl. ¶ 31 ("Although some **transgender** people are able to effectively treat their gender dysphoria through other treatments, sex reassignment surgery for many people is a medically necessary treatment needed to treat gender dysphoria and establish congruence with one's gender identity."). Studies have shown that SRS is a safe and effective treatment for individuals with gender dysphoria. See Standards of Care at 36 ("Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes."); Ettner Decl. ¶ 40 ("Decades of careful and methodologically sound scientific research have demonstrated that sex reassignment surgery is a safe and effective treatment for severe gender dsyphoria and, indeed, for many people, it is the only effective treatment."); Bowers Decl. ¶ 28 ("The vast majority of studies have shown that sex reassignment surgery is clinically effective. In my professional experience, the success rate of vaginoplasty is extremely high."); Defendants' Expert Report ("Levine Report"), ECF No. 72-4, at 6-7 (acknowledging that "SRS is not thought to be experimental now that it has been repeatedly positively evaluated for over twenty years").

The Standards of Care set forth six eligibility criteria for vaginoplasty in male-to-female 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 hormones are not clinically indicated for the individual);(6) 12 continuous months of living in a gender role that is congruent with the patient's identity.Standards of Care at 39. They also require two referrals from qualified

mental health professionals who have independently evaluated the patient. Id. at 19-20. "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." Id. at 20.

The standards "in their entirety apply to all transsexual, **transgender**, and gender-nonconforming people, irrespective of their housing situation." Id. at 43. They expressly provide that "[p]eople should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons." Id. The Standards allow for "[r]easonable accommodations to the institutional environment," such as the use of injectable hormones where diversion of oral prescriptions is highly likely, but they make clear that "[d]enial 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 [Standards of Care]." Id. at 44.

C. Norsworthy's Treatment

Norsworthy indicated to prison staff that she sought hormone treatment and even

Removal of facial and body hair through electrolysis or laser instruments provides a necessary treatment that allows perceptions of gender based on secondary sex characteristics, and particularly facial cues, to correctly identify transgender women as women.[1] One study noted a mean of 90% hair clearance using an Intense Pulsed Light Source (laser) and that clearance rates did not differ based on whether the individual had undergone any hormone therapy.[2]

Schroeter, C. A., Groenewegen, J. S., Reineke, T., & Neumann, H. A. M. (2003). Ninety percent permanent hair reduction in transsexual patients. *Annals of Plastic Surgery* 51(3): 243-248.

> Transsexualism as a condition requires hair removal. Twenty-five male-to-female transsexual patients were included in this study on epilation using the Intense Pulsed Light Source (IPLS). Patients received a varying number of treatments, depending on their response. A mean hair clearance rate of 90% was achieved in the studied patients. The average number of treatments per patient was nine. A negative correlation was found between hair removal and the age of the patient. Hair removal was also found to be more effective when the patients had not used any needle epilation. No difference in hair removal was found between transsexual patients, who were hormonal, and those who were not. Follow-up lasted an average of 44 months. This study proved that the IPLS has the potential to be effective, permanent, and painless especially in younger patients who have not used any mechanical methods for epilation before photoepilation.

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[1] Coleman E, Bockting W, Botzer M, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *Int J Transgenderism*. 2012;13(4):165–232; Ettner R, Monstrey S, Eyler AE. *Principles of Transgender Medicine and Surgery*. Haworth Press Binghamton, NY; 2007; Kreukels BP, Steensma TD, De Vries AL. *Gender Dysphoria and Disorders of Sex Development*. Springer; 2014.

[2] Schroeter, C. A., Groenewegen, J. S., Reineke, T., & Neumann, H. A. M. (2003). Ninety percent permanent hair reduction in transsexual patients. *Annals of Plastic Surgery* 51(3): 243-248.

Exhibit - N

Federal Bureau of Prisons

Trulincs Survey

Personal Inmate Information

Date: 12-5-18

Pages - 5 of 5

Exhibit 10

Date: 12/05/2018
Time: 09:37:35 AM

Location: MAR

Federal Bureau of Prisons
TRULINCS Survey
Personal Inmate Information

Survey Title: 2018 Survey of Transgender Inmates

Survey Description: You are receiving this survey because you have chosen to identify as transgender. This is the first annual survey of transgender inmates in the Bureau of Prisons. The questions ask about your interests and experiences. We would like to use your input to help us provide the best services.
Your participation is voluntary, and your answers are confidential.

Question 1. Please select the area that is your highest priority reentry-related need:

Response:

- ○ Childcare
- ● Mental Health Treatment
- ○ Spirituality
- ○ Finance
- ○ Housing
- ○ Medical Care
- ○ Mentoring
- ○ Clothing/Image
- ○ Education
- ○ Social Security
- ○ Drug Treatment
- ○ Job Training
- ○ Finding Work
- ○ Transportation
- ○ Other

Question 2. How safe do you feel in your current institution?

Response:

- ○ Very safe
- ○ Safe
- ○ A little safe
- ● Neither safe or unsafe
- ○ A little unsafe
- ○ Unsafe
- ○ Very unsafe

Date: 12/05/2018
Time: 09:37:35 AM

Location: MAR

Federal Bureau of Prisons
TRULINCS Survey
Personal Inmate Information

Question 3. Overall, I am satisfied with the medical treatment related to my transgender status.

Response:

- ○ Strongly Agree
- ○ Agree
- ● Somewhat agree
- ○ Neutral
- ○ Somewhat Disagree
- ○ Disagree
- ○ Strongly Disagree

Question 4. Overall, I am satisfied with the psychological treatment related to my transgender status.

Response:

- ○ Strongly Agree
- ○ Agree
- ● Somewhat agree
- ○ Neutral
- ○ Somewhat Disagree
- ○ Disagree
- ○ Strongly Disagree

Question 5. How often do staff misuse your preferred pronouns or means of address (he/she, etc.)?

Response:

- ● Happens daily
- ○ Happens at least once a week
- ○ Happens at least once a month
- ○ Happens on occasion
- ○ Never happens

Question 6. How often do other inmates misuse your preferred pronouns or means of address (he/she, etc.)?

Response:

- ○ Happens daily
- ● Happens at least once a week
- ○ Happens at least once a month
- ○ Happens on occasion
- ○ Never happens

Date: 12/05/2018
Time: 09:37:35 AM

Location: MAR

Federal Bureau of Prisons
TRULINCS Survey
Personal Inmate Information

Question 7. Which department is most helpful with your transgender related needs?

Response:

- ○ Education
- ● Psychology
- ○ Health Services
- ○ Unit Team
- ○ Chaplaincy

Question 8. Which department is least helpful with your transgender related needs?

Response:

- ○ Education
- ○ Psychology
- ○ Health Services
- ○ Unit Team
- ● Chaplaincy

Question 9. How satisfied are you with the kinds of items available in the commissary?

Response:

- ○ Very satisfied
- ○ Somewhat satisfied
- ○ A little satisfied
- ○ Neither satisfied or unsatisfied
- ● A little unsatisfied
- ○ Somewhat unsatisfied
- ○ Very unsatisfied

Question 10. Do you have pat or visual search exemptions?

Response:

- ● Yes
- ○ No

Question 11. Were you living as your same identified gender before coming to prison?

Response:

- ● Yes
- ○ No

Date: 12/05/2018
Time: 09:37:35 AM

Location: MAR

Federal Bureau of Prisons
TRULINCS Survey
Personal Inmate Information

Question 12. Have you had any surgical procedures to assist with your transition (such as breast implants or cosmetic facial surgery)?

Response:

- ○ Yes
- ● No

Question 13. Have you engaged in self-harm before arriving at the Bureau of Prisons (such as cutting yourself)?

Response:

- ● Yes
- ○ No

Question 14. Have you engaged in self-harm since arriving at the Bureau of Prisons (such as cutting yourself)?

Response:

- ● Yes
- ○ No

Question 15. Has your spouse, partner, or date ever committed an act of sexual violence against you (for example, unwanted touching or groping, forced sexual contact, or rape)?

Response:

- ● Yes
- ○ No

Question 16. Have you ever been sexually assaulted?

Response:

- ● Yes
- ○ No

Question 17. Before being incarcerated, did you ever exchange sex for money, food, drugs, shelter, or other goods?

Response:

- ○ Yes
- ● No

Date: 12/05/2018
Time: 09:37:35 AM

Location: MAR

Federal Bureau of Prisons
TRULINCS Survey
Personal Inmate Information

Question 18. If a support group were offered to address common transgender experiences, I would attend.

Response:

- (●) Strongly Agree
- ( ) Agree
- ( ) Somewhat agree
- ( ) Neutral
- ( ) Somewhat Disagree
- ( ) Disagree
- ( ) Strongly Disagree

Question 19. If concerns or questions arose in your mind while taking this survey then we encourage you to follow up with staff at your institution. You may also use the inmate remedy procedure if staff are not addressing your concerns.

Response: NA

End of Survey.

Exhibit - O

Individualized Reentry Plan

Program Review

Team Date: 05-09-2019

Exhibit - O

Individualized Reentry Plan - Program Review (File copy)

Dept. of Justice / Federal Bureau of Prisons

Plan is for inmate: IGLESIAS, CRISTIAN NOEL 17248-018

SEQUENCE: 00575002

Team Date: 05-09-2019

Facility:	MAR MARION USP		
Name:	IGLESIAS, CRISTIAN NOEL		
Register No.:	17248-018		
Age:	44	DNA Status:	FLM02226 / 02-04-2011
Date of Birth:	06-10-1974	CIMS Status:	YES
Proj. Rel. Date:	04-26-2023	CIMS Reconciled:	YES
Proj. Rel. Method:	GCT REL		

Inmate is subject to 18 U.S.C. 4042(B) Notification: **Yes**

CURRENT CONVICTION FOR A CRIME OF VIOLENCE

Inmate is subject to 18 U.S.C. 4042(C) Notification and Registration: **N/A**

Offense Sentences

Charge	Terms In Effect
18:2332A(B) THREATENED USE OF A WEAPON OF MASS DESTRUCTION	240 MONTHS

Detainers

Detaining Agency	Remarks

NO DETAINER

Current CMA Assignments

Assignment	Description	Start
BIR CERT N	BIRTH CERTIFICATE - NO	05-24-2018
COMPUTR OK	USE OF INMATE ACCESS PC O.K.	11-06-1996
DEPEND N	DEPENDENTS UNDER 21 - NO	05-24-2018
PHOTO ID N	PHOTO ID - NO	05-24-2018
PSY ALERT	PSYCHOLOGY ALERT	06-29-2015
RPP PART	RELEASE PREP PGM PARTICIPATES	03-30-2017
SSN CARD N	SOCIAL SECURITY CARD - NO	05-24-2018
TRN M2F	SELF REPORT TRANSGENDER M TO F	02-02-2017
VET P/S N	PARENT/SPOUSE VETERAN - NO	05-24-2018
VETERAN N	VETERAN - NO	05-24-2018
V94 CVA913	V94 CURR VIOL ON/AFTER 91394	06-30-2000
WA NO HIST	NO WALSH ACT OFFENSE HISTORY	03-23-2007

Current Work Assignments

Facl	Assignment	Description	Start
MAR	CBL ADMIN	INDUSTRIES ADMINISTRATION OFC	12-29-2018

Current Education Information

Facl	Assignment	Description	Start
MAR	ESL HAS	ENGLISH PROFICIENT	11-14-1996
MAR	GED HAS	COMPLETED GED OR HS DIPLOMA	07-07-2000

Education Courses

SubFacl	Action	Description	Start	Stop
MAR		ASQ QUALITY ASSURANCE	03-05-2019	CURRENT
MAR GP	C	BUSINESS START-UP ACE CLASS	02-06-2019	05-07-2019
MAR GP	C	ACE VIDEO NATURAL WONDERS	02-04-2019	05-07-2019
MAR GP	C	UNICOR OSHA 10 - 24 WEEKS	01-31-2019	03-13-2019
MAR GP	C	NUTRITION	11-07-2017	01-05-2018
MAR GP	C	CDL MANUAL STUDY ACE CLASS	07-31-2017	09-19-2017
CUM	C	SHU LANDSCAPE MAINTENANCE	05-18-2017	05-31-2017
CUM	C	CLN TIME MANAGEMENT	05-01-2017	05-01-2017
CUM	C	CLN STRESS MANAGEMENT	04-17-2017	04-24-2017
CUM	C	MRSA IN AN ATHLETIC FACILITY	04-02-2017	04-16-2017
BTF GP	C	SHU WORLD HISTORY	02-16-2017	02-23-2017

Individualized Reentry Plan - Program Review (File copy)

SEQUENCE: 00575002

Dept. of Justice / Federal Bureau of Prisons

Team Date: 05-09-2019

Plan is for inmate: IGLESIAS, CRISTIAN NOEL 17248-018

SubFacl	Action	Description	Start	Stop
BTF GP	C	SHU PERSONAL FINANCE	02-09-2017	02-16-2017
BUT GP	C	(G)DECISION MAKING-CAI	09-01-2016	11-15-2016
BUT GP	C	(V)CNDCTNG INTVWS SUCCFL RESLT	09-01-2016	11-15-2016
BUT GP	C	(A)WINDOWS VISTA 1-CAI	09-01-2016	11-15-2016
BUT GP	C	(W)BACK SAFETY	09-01-2016	11-15-2016
BUT GP	C	(V)RESUME SKILLS-CAI	09-01-2016	11-15-2016
BUT GP	C	(V)BLDG STRNG CUSTMR RELTNSHPS	09-01-2016	11-15-2016
BUT GP	C	(A)KEYBOARDING-CAI	09-01-2016	11-15-2016
BUT GP	C	(W)RECOGNIZE AVOID BURNOUT	09-01-2016	11-15-2016
BUT GP	C	(W)DRIVER SAFETY-CAI	09-01-2016	11-15-2016
BUT GP	C	(W)STRESS CONTROL-CAI	09-01-2016	11-15-2016
BUT GP	C	(W)MANAGE PERSONAL STRESS-CAI	09-01-2016	11-15-2016
BUT GP	C	(V)HVAC SYSTEM CONTROLS-CAI	09-01-2016	11-15-2016
BUT GP	C	(V)HVAC CONTROLS-CAI	09-01-2016	11-15-2016
BUT GP	C	(V)HVAC ASHRAE STANDS-CAI	09-01-2016	11-15-2016
BUT GP	C	(V)GREEN BUILDING-RESIDENTIAL	09-01-2016	11-15-2016
BUT GP	C	(V)GREEN BUILDING-REMODELING	09-01-2016	11-15-2016
BUT GP	C	(V)GREEN BUILDING-INFRASTRUCTR	09-01-2016	11-15-2016
BUT GP	C	(V)GREEN BUILDING-COMMERCIAL	09-01-2016	11-15-2016
BUT GP	C	NRDAP - NON RES DAP GROUP	09-14-2016	09-14-2016
BUT GP	C	HEALTH FAIR	07-12-2016	08-17-2016
BUT GP	C	ANGER MANAGEMENT	06-07-2016	08-09-2016
BUT GP	C	MONEYSMART-FINANCIAL	04-29-2016	07-20-2016
OAD RHU	C	SHU - GOVERNMENT LANGUAGE	06-11-2015	06-17-2015
OAD RHU	C	SHU - CLOTHING LANGUAGE	05-28-2015	06-04-2015
OAD RHU	C	SHU-RESTAURANT LANGUAGE	05-21-2015	05-28-2015
OAD RHU	C	SHU-ENTERTAINMENT LANGUAGE	05-14-2015	05-21-2015
OAD RHU	C	SUPERMARKET LANGUAGE	04-30-2015	05-07-2015
OAD RHU	C	AEROBICS	06-27-2014	05-08-2015
OAD RHU	C	TRANSPORTATION LANGUAGE	04-23-2015	04-30-2015
OAD RHU	C	BANKING INFORMATION	04-09-2015	04-23-2015
OAD RHU	C	SHU MONEY AND CONSUMERS	04-02-2015	04-09-2015
OAD RHU	C	SHU PROBLEM SOLVING	03-26-2015	04-02-2015
OAD RHU	C	SHU HOUSING & SAFETY	03-19-2015	03-26-2015
OAD RHU	C	SHU PERSONAL DEVELOPMENT	03-12-2015	03-19-2015
OAD RHU	C	SHU THE WORLD OF WORK	02-26-2015	03-12-2015
OAD RHU	C	RHU HORTICULTURE	11-10-2014	03-16-2015
OAD RHU	C	SHU PERSONAL HEALTH	02-19-2015	02-26-2015
OAD RHU	C	SHU COMMUNITY AND GOVERNMENT	02-05-2015	02-12-2015
OAD RHU	C	SHU COMMUNICATION	01-30-2015	02-12-2015
OAD RHU	C	SHU TIME MANAGEMENT	01-22-2015	01-30-2015
OAD RHU	C	SHU YOUR WORK EXPERIENCE	01-15-2015	01-22-2015
TCP	C	SHU: PERSONAL FINANCE 101	10-01-2013	10-07-2013
TCP	C	SHU ACE: SS 1 US HISTORY	10-22-2013	10-29-2013
TCP	C	NEW YORK TIMES	07-10-2013	07-31-2013
COP CHG	C	RPP HEALTH/NUTRITION #1	03-01-2013	03-01-2013
FLM	C	THE UNIVERSE - PART 2	12-22-2010	03-15-2011
FLM	C	AMERICA AT WAR - PART 2	10-13-2010	12-21-2010
FLM	C	THE UNIVERSE - PART 1	03-03-2010	05-25-2010
FLM	C	PELOPONNESIAN WAR - PART 2	03-04-2010	05-05-2010
FLM	C	BATTLES OF THE ANCIENT WORLD	10-14-2009	12-08-2009
FLM	C	ENGINEERING AN EMPIRE	07-22-2009	10-13-2009
FLM	C	HISTORY OF WORLD WAR II	02-18-2009	04-28-2009
FLM	C	HISTORY OF EUROPEAN ART PART 2	12-18-2008	03-11-2009
FLM	C	THE VIKINGS - PART 2	05-01-2008	07-02-2008
EST	C	HEALTH FAIR-QUARTERLY (HN#1)	04-13-2007	04-13-2007
DEV MH	C	(HN) LEARNING ABOUT HIV	03-21-2006	03-21-2006

Individualized Reentry Plan - Program Review (File copy)

SEQUENCE: 00575002

Dept. of Justice / Federal Bureau of Prisons

Team Date: 05-09-2019

Plan is for inmate: IGLESIAS, CRISTIAN NOEL 17248-018

SubFacl	Action	Description	Start	Stop
EST	C	SPANISH I - FCI (PG 6)	11-03-2005	12-30-2005
EST	C	INFECTIOUS DISEASE PREVT(HN#1)	10-27-2005	10-27-2005
EST	C	AEROBICS M-F 8-9 AM	07-18-2004	08-14-2004
EST	C	INFECTIOUS DISEASE PREVT(HN#1)	09-03-2003	09-03-2003

Discipline History (Last 6 months)

Hearing Date	Prohibited Acts

** NO INCIDENT REPORTS FOUND IN LAST 6 MONTHS **

ARS Assignments

Facl	Assignment	Reason	Start	Stop
MAR GP	A-DES	OTHER AUTH ABSENCE RETURN	10-09-2018	CURRENT
MAR GP	A-DES	OTHER AUTH ABSENCE RETURN	09-29-2017	10-09-2018
MAR GP	A-DES	TRANSFER RECEIVED	06-12-2017	09-29-2017
CUM	A-DES	TRANSFER RECEIVED	03-13-2017	05-30-2017
BUT GP	A-DES	OTHER AUTH ABSENCE RETURN	05-31-2016	01-18-2017
BUT GP	A-DES	TRANSFER RECEIVED	03-28-2016	05-31-2016
FAI	A-DES	TRANSFER RECEIVED	12-08-2015	03-16-2016
THA MH	A-DES	TRANSFER RECEIVED	11-23-2015	11-23-2015
THA MH	A-DES	TRANSFER RECEIVED	06-29-2015	10-06-2015
OAD RHU	A-DES	TRANSFER RECEIVED	05-14-2014	06-18-2015
EDG	A-DES	TRANSFER RECEIVED	03-12-2014	04-23-2014
TCP	A-DES	TRANSFER RECEIVED	06-18-2013	02-21-2014
COP	A-DES	TRANSFER RECEIVED	06-05-2013	06-05-2013
COP CHG	A-DES	TRANSFER RECEIVED	05-24-2013	06-05-2013
COP CHG	A-DES	TRANSFER RECEIVED	12-04-2012	04-19-2013
BMP	A-DES	TRANSFER RECEIVED	10-26-2012	11-28-2012
BMP	A-DES	TRANSFER RECEIVED	08-06-2012	10-25-2012
THP	A-DES	TRANSFER RECEIVED	01-31-2012	07-31-2012
SPG MH	A-DES	TRANSFER RECEIVED	06-01-2011	01-31-2012
FLM	A-DES	OTHER AUTH ABSENCE RETURN	10-18-2010	06-01-2011
FLM	A-DES	TRANSFER RECEIVED	03-12-2008	10-18-2010
THA CMU	A-DES	TRANSFER RECEIVED	05-30-2007	03-12-2008
EST	A-DES	TRANSFER RECEIVED	11-15-2006	05-08-2007
DEV MH	A-DES	OTHER AUTH ABSENCE RETURN	05-16-2006	11-02-2006
DEV MH	A-DES	TRANSFER RECEIVED	03-09-2006	05-16-2006
EST	A-DES	WRIT RETURN	10-12-2005	03-09-2006
EST	A-DES	TRANSFER RECEIVED	08-13-2003	12-07-2004
EDG	A-DES	TRANSFER RECEIVED	01-30-2003	07-31-2003
MIM	A-DES	TRANSFER RECEIVED	05-20-2002	01-17-2003
TDG	A-DES	TRANSFER RECEIVED	02-25-2002	05-13-2002
MNA M	A-DES	TRANSFER RECEIVED	01-16-2002	02-06-2002
DEV MH	A-DES	OTHER AUTH ABSENCE RETURN	10-23-2001	12-19-2001
DEV MH	A-DES	TRANSFER RECEIVED	09-05-2001	10-23-2001
MNA M	A-DES	TRANSFER RECEIVED	06-27-2001	09-05-2001
OTV GP	A-DES	OTHER AUTH ABSENCE RETURN	05-12-2001	06-06-2001
OTV GP	A-DES	TRANSFER RECEIVED	02-22-2001	05-11-2001
COL	A-DES	OTHER AUTH ABSENCE RETURN	02-20-2001	02-21-2001
COL	A-DES	US DISTRICT COURT COMMITMENT	06-06-2000	02-19-2001

Current Care Assignments

Assignment	Description	Start
CARE2	STABLE, CHRONIC CARE	12-08-2015
CARE2-MH	CARE2-MENTAL HEALTH	09-23-2016

Current Medical Duty Status Assignments

Assignment	Description	Start
NO POLLUT	ASSIGN TO POLLUTION FREE AREA	06-22-2016

Individualized Reentry Plan - Program Review (File copy)

SEQUENCE: 00575002

Dept. of Justice / Federal Bureau of Prisons

Team Date: 05-09-2019

Plan is for inmate: IGLESIAS, CRISTIAN NOEL 17248-018

Assignment	Description	Start
REG DUTY W	REGULAR DUTY W/MED RESTRICTION	06-22-2016
YES F/S	CLEARED FOR FOOD SERVICE	06-22-2016

Current PTP Assignments

Assignment	Description	Start
CHG INCOMP	CHALLENGE INCOMPLETE	02-14-2013
STA INCOMP	STAGES INCOMPLETE	11-02-2015

Current Drug Assignments

Assignment	Description	Start
DAP DECL	RESIDENT DRUG TRMT DECLINED	02-26-2018
ED COMP	DRUG EDUCATION COMPLETE	12-19-2012

FRP Details

Most Recent Payment Plan

FRP Assignment: **NO OBLG** **FINANC RESP-NO** **Start: 10-29-2010**

Inmate Decision: **AGREED** **$25.00** Frequency: **QUARTERLY**

Payments past 6 months: **$0.00** Obligation Balance: **$0.00**

Financial Obligations

No.	Type	Amount	Balance	Payable	Status
4	ASSMT	$300.00	$300.00	IMMEDIATE	EXPIRED
		** *NO ADJUSTMENTS MADE IN LAST 6 MONTHS* **			
1	ASSMT	$100.00	$100.00	IMMEDIATE	EXPIRED
		** *NO ADJUSTMENTS MADE IN LAST 6 MONTHS* **			
2	ASSMT	$50.00	$25.00	IMMEDIATE	EXPIRED
		** *NO ADJUSTMENTS MADE IN LAST 6 MONTHS* **			
3	ASSMT	$100.00	$75.00	IMMEDIATE	EXPIRED
		** *NO ADJUSTMENTS MADE IN LAST 6 MONTHS* **			

Payment Details

Trust Fund Deposits - Past 6 months: $862.57 Payments commensurate ? Y

New Payment Plan: ** No data **

Progress since last review

Completed the UNICOR OSHA 10-24 weeks course. Actively participating in the ASQ Quality Assurance, Natural Wonders and the Business Start-Up course.

Next Program Review Goals

Complete the ASQ Quality Assurance, Natural Wonders and the Business Start-Up course by 11/19. Meet with Counselor to obtain a certified copy of birth certificate and SSN card for central file, immediately.

Long Term Goals

Attend the Career Resource Center. Attending the center will allow you the opportunity to plan for your release and participate in job readiness activities. Build skill inventory and begin goal setting through the resource center prior to next review 12/19.

RRC/HC Placement

Comments

407/408 reviewed and current.
Judicial Recommendations: No.
Concerns with transgender status raised. Iglesias has requested a review for sexual reassignment surgery and transfer to a female institution. Her request has been relayed to management.

Individualized Reentry Plan - Program Review (File copy)
Dept. of Justice / Federal Bureau of Prisons
Plan is for inmate: IGLESIAS, CRISTIAN NOEL 17248-018

SEQUENCE: 00575002
Team Date: 05-09-2019

Name: IGLESIAS, CRISTIAN NOEL
Register No.: 17248-018
Age: 44
Date of Birth: 06-10-1974

DNA Status: FLM02226 / 02-04-2011

* requests rvw for sexual reassignment surgery at fed'l institution

Inmate (IGLESIAS, CRISTIAN NOEL. Register No.: 17248-018)

5/9/19
Date

Unit Manager / Chairperson

5-9-19
Date

Case Manager

5/9/19
Date

Exhibit - P

Male Custody Classification Form

Form Date: 2-12-19

Page - 1 of 1

MARCS 606.00 * MALE CUSTODY CLASSIFICATION FORM * 09-04-2019
PAGE 001 OF 001 15:49:17

(A) IDENTIFYING DATA

REG NO..: 17248-018 FORM DATE: 02-12-2019 ORG: MAR
NAME....: IGLESIAS, CRISTIAN NOEL
MGTV: NONE
PUB SFTY: THRT GOVT MVED:

(B) BASE SCORING

DETAINER: (0) NONE SEVERITY.....: (5) HIGH
MOS REL.: 50 CRIM HIST SCORE: (10) 21 POINTS
ESCAPES.: (0) NONE VIOLENCE.....: (1) > 10 YRS MINOR
VOL SURR: (0) N/A AGE CATEGORY...: (2) 36 THROUGH 54
EDUC LEV: (0) VERFD HS DEGREE/GED DRUG/ALC ABUSE.: (0) NEVER/>5 YEARS

(C) CUSTODY SCORING

TIME SERVED.....: (5) 76-90% PROG PARTICIPAT: (2) GOOD
LIVING SKILLS...: (2) GOOD TYPE DISCIP RPT: (5) NONE
FREQ DISCIP RPT.: (3) NONE FAMILY/COMMUN..: (4) GOOD

--- LEVEL AND CUSTODY SUMMARY ---

BASE	CUST	VARIANCE	SEC	TOTAL	SCORED LEV	MGMT SEC LEVEL	CUSTODY	CONSIDER
+18	+21	-2	+16		MEDIUM	N/A	IN	DECREASE

G0005 TRANSACTION SUCCESSFULLY COMPLETED - CONTINUE PROCESSING IF DESIRED