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Advancing the Care of Transgender Patients

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Introduction

Effectively caring for transgender patients and ensuring their safety are complicated challenges for jails and prisons throughout the United States. Transgender persons, overall, represent a small percentage of the US incarcerated patient population; however, they are disproportionately more likely to be justice-involved and experience significant health disparities. Nearly one-fifth of transgender women respondents in the National Transgender Discrimination Survey reported a history of ever being incarcerated (Reisner et al., 2014). Respondents who had ever been to jail or prison were more likely to be persons of color, poorer, and uninsured. These respondents also had significantly higher rates of negative health indicators, such as substance use disorders, tobacco use, and human immunodeficiency virus (HIV) infection. Although there are limited data on the mental health needs of incarcerated transgender patients specifically, the acute stressors posed by incarceration and the potential for victimization, may add significantly to the pre-existing psychological distress experienced by many transgender persons. The 2015 US Transgender Survey found that, in the month before the survey, 39% of transgender people reported experiencing serious psychological distress (compared to 5% of the US population), 7% attempted suicide in the past year (compared to 0.06% of Americans), and 40% had attempted suicide in their lifetimes (compared to 4.6% of the US population) (James et al., 2016).

The diagnosis of gender dysphoria is often included in the wider conversation surrounding the mental healthcare needs of transgender patients. The American Psychiatric Association (APA) defines gender dysphoria as a medical condition in which there is clinically significant distress or impairment associated with the incongruence between an individual's gender identity and the gender they were assigned at birth (APA, 2013). Many transgender persons are not dysphoric, yet still desire and require gender-affirming healthcare services. For other transgender persons, gender dysphoria is a significant emotional concern that requires access to culturally competent mental healthcare services. Correctional

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healthcare policies should not make a diagnosis of gender dysphoria a prerequisite for providing transgender patients access to gender-affirming healthcare services. Alternatively, gender dysphoria should be recognized as a potentially important mental health concern for incarcerated transgender patients that may be further exacerbated by the gender binary, highly structured environment of the correctional setting. Transgender persons are at extraordinary risk of sexual victimization by correctional staff or other incarcerated persons while residing in US jails or prisons. The Bureau of Justice Statistics National Inmate Survey for 2011–2012 indicated that nearly 40% of transgender persons in state and federal prisons reported being sexually victimized during the past year (Beck et al., 2014). Jenness and colleagues reported an even higher rate of 58% of transgender persons reporting sexual assaults in the California state prison system (Jenness & Fenstermaker, 2016). Some potential advances in protecting incarcerated transgender persons were made with the enactment of the Prison Rape Elimination Act (PREA) in 2003 (PREA, 2003). The PREA standards require, in part, correctional policies for screening and identifying newly incarcerated persons who may be vulnerable to sexual victimization, staff training on respectful treatment of sexual minorities, case-by-case housing assignments of transgender persons and review of this placement twice yearly, private showering facilities for transgender persons, and investigating sexual assaults that involve incarcerated persons. These standards, however, were not officially promulgated until 2012. Furthermore, a 2017 survey of state correctional system PREA policies indicated that many states failed to adopt policies for all 13 PREA provisions related to transgender persons (Malkin & DeJong, 2019). Perhaps, most importantly, correctional policies in and of themselves do not ensure meaningful implementation of the PREA standards. The actual impact of PREA on protecting incarcerated transgender persons remains to be determined.

Beyond ensuring the respectful treatment and safety of incarcerated transgender persons, correctional systems must also ensure access to medically necessary healthcare services. Defining medical necessity, however, is complicated by the rapidly evolving standard of care in the United States for providing healthcare services to transgender patients. As stated by Baker, "[i]n 2002, no Fortune 500 company offered employee coverage for gender transition, but by the end of 2016, 50% did" (Baker, 2017). Similarly, State Medicaid coverage increasingly includes gender-affirming services, such as hormone therapies and surgical procedures. A Williams Institute Report from 2019 indicated that 18 states and the District of Columbia Medical programs had specifically included coverage for gender-affirming care or were in the process of extending coverage (Mallory & Tentindo, 2019). Within this changing landscape of healthcare coverage, correctional systems must define the scope of services they will provide to their transgender patients. Providing quality of care to incarcerated transgender patients also requires having adequately trained healthcare professionals. Primary care providers often have had little training in transgender medicine. In the correctional environment, there may also be limited local access to knowledgeable subspecialists, such as endocrinologists or surgeons with expertise in gender-affirming procedures. Transgender women have reported access to adequate health care as their major concern during incarceration (Brown, 2014). Specific concerns include healthcare providers' transgender bias, as well as limited knowledge or experience caring for transgender patients (White Hughto et al., 2018).

The correctional management and clinical care of incarcerated transgender persons are further complicated by a complex and rapidly evolving legal environment. Active correctional litigation is ongoing related to the housing of incarcerated transgender persons, access to gender-specific personal property, and access to a range of healthcare services. Court rulings, including those related to gender-

affirming surgery, have at times been in conflict. In the 2015 ruling, *Norsworthy v. Beard*, a federal district court ruled that the California Department of Corrections and Rehabilitation (CDCR) must provide sex reassignment surgery to patient Norsworthy, a transgender woman in a California state prison (Norsworthy, 2015). The decision, however, was never implemented, because Norsworthy was released on parole while the case was on appeal. But in the 2019 ruling, *Gibson v. Collier*, a federal court of appeals ruled that the Texas Department of Criminal Justice (TDCJ) was not required to provide sex reassignment surgery to patient Gibson, a transgender women in a Texas state prison, or even to make an individualized assessment of medical necessity (Gibson, 2019). These conflicting rulings may ultimately require resolution in the Supreme Court. Correctional policies and clinical guidance for treating incarcerated patients must evolve progressively within this legal landscape to both better ensure patient safety and better provide quality healthcare services.

Correctional Management

Correctional systems have increasingly focused on improving policies and procedures to better ensure the respectful treatment and personal safety of incarcerated transgender persons. Drivers of these improvements in correctional practices have included: the alarming data on sexual victimization of incarcerated transgender persons, the system's decision to comply with PREA standards, growing concerns about litigation, an increased social awareness of transgender identity and discrimination, and the advocacy of community organizations. Key policies of concern to transgender advocates have included: the use of preferred pronouns to address transgender persons, housing assignments that strongly consider gender identity, access to undergarments and commissary items consistent with gender identity, and gender accommodations for pat or strip searches. Designing correctional policies to address these concerns can be complicated by a variety of factors including: structural and security issues unique to a specific jail or prison, legislative, regulatory, and judicial mandates, and the varying individual preferences of incarcerated transgender persons. Despite these challenges, correctional systems must strive to create a culture of safety for transgender persons that is also gender-affirming. Engaging with local transgender community advocates to inform public policy can be particularly helpful in this regard.

In 2018, the National Center for Transgender Equality (NCTE) published expansive guidance to correctional agencies and advocacy organizations on developing policies to increase the respect for and safety of incarcerated transgender persons (NCTE, 2018). The guidance covers areas of correctional management that affect transgender persons from intake identification and risk assessments, to gender affirming treatment during incarceration, to reentry to the community. Each area of discussion includes specific examples from US jails and prisons that can help guide policymakers. Correctional policy guidance for managing incarcerated transgender persons, largely consistent with NCTE recommendations, has also been published by others (Bromdal et al., 2019; Kendig et al., 2019; Sevelius & Jenness, 2017). The recommendations from Kendig and colleagues are outlined in Box 25.1.

While sound correctional policies can help guide correctional practice, well-written policies alone do not ensure their implementation or a change in institutional culture. Leaders of national correctional organizations identified training of correctional staff at all levels as essential if gender-affirming policies are to be effectively implemented in US jails and prisons (Kendig et al., 2019). Their practical training considerations are enumerated in Box 25.2.

Box 25.1 Identifying Correctional Policy and Practice Considerations for Screening, Searching, Housing, and Managing Transgender Incarcerated Persons That Protect Them from Abuse and Create a Culture of Safety

Consensus Considerations:

Community engagement: Correctional systems should consider engaging transgender community members or advocates to help inform correctional policies and practices in managing transgender inmates.

Housing: Facility designation decisions for transgender inmates should be made on a case-by-case basis utilizing an interdisciplinary team, including representatives from the following areas: mental health, medical, security, and programing. When making these housing decisions, the team should consider relevant factors, including but not limited to, the inmate's gender identity, their history living daily life in accord with that identity, physical characteristics, security level, criminal and disciplinary history, medical and mental health needs, vulnerability to sexual abuse, and facility-specific factors. Consideration should also be given to the individual's own perception of where they would be safest. Facility designation decisions for transgender inmates should not be based solely on the inmate's genitalia or the sex they were assigned at birth.

Screening: Facilities should ensure that their existing risk screening tools initially identify transgender inmates and adequately assess transgender inmates' vulnerabilities to victimization. Risk screening information should be communicated to correctional staff, modified as needed to protect the inmate's privacy, and used throughout an inmate's incarceration. In order to accomplish this, there needs to be adequate communication and "systems compatibility" with booking/intake, medical, mental health, classification, housing, and program staff.

Pronouns and Names: Correctional agencies should encourage staff to use a transgender inmate's preferred pronoun.

Searches: Transgender inmates should be provided an opportunity to indicate a preference for the gender of the staff they would feel most comfortable with conducting pat or strip searches. Absent exigent circumstances, the correctional agency should honor this decision.

Commissary: Transgender inmates should have access to the same commissary items consistent with their gender identity and security classification. For example, a medium-security transgender woman who is housed in a men's facility should have access to the same commissary items that are available to medium-security women housed in a women's facility.

Undergarments: Transgender inmates should be permitted to have undergarments consistent with their gender identity, regardless of whether they are housed in a facility for men or a facility for women.

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Box 25.2 Training Correctional Staff to Enhance Respectful Attitudes Toward Transgender Inmates and Transgender Co-workers

Consensus Considerations:

Correctional agencies should create and sustain a leadership culture of safety for transgender persons. Staff training should align with the agency's vision, mission, and values and link to the agency's leadership expectations for interacting with transgender persons.

Correctional agencies should develop training content, design, delivery, and evaluation methodologies that engage correctional staff in understanding their role in responding to transgender individuals in consideration of the following:

- Training content should be consistent with best practices and professional standards guiding correctional practice and the treatment of transgender individuals.
- Training design for supervisory, mid-level, and line staff should be skilled-based and include scenario-based skill development and content.
- Training strategies should be tailored to the size and unique characteristics of the correctional facility. Examples of training strategies include, accessing web-based resources, regional trainings, and the involvement of community organizations and advocacy groups.
- Training delivery should be consistent with adult learning theory and best practices in responding respectfully to transgender individuals.

Key training concepts for consideration include the following:

- Select train-the-trainers using defined criteria that establish clear role expectations.
- Ensure trainers are knowledgeable and possess the communication skills to adequately convey key messages.
- Integrate, as feasible, transgender persons as trainers or contributors to the training curriculum, including available transgender correctional staff or transgender law enforcement peers from the local community.
- Support trainers with additional training materials, including videos that provide access to subject matter experts and the experiences of justice-involved transgender persons.
- Conduct training that emphasizes the importance of respecting incarcerated transgender persons as human beings in their routine activities within the correctional setting, rather than solely focusing on PREA compliance and sexual victimization.
- Provide correctional staff with confidential opportunities to communicate their concerns for managing transgender persons in compliance with policy. (Proven strategies include submitting note cards with questions for a private response and engaging in volunteer meetings that provide a trusting environment, e.g., chaplain prayer breakfasts).

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Healthcare Delivery

The landmark Supreme Court ruling *Estelle v. Gamble* provides incarcerated patient populations a constitutional right to health care (Estelle, 1976). The ruling, however, does not determine the scope of healthcare services that must be provided. Determining the approved healthcare interventions for incarcerated transgender patients is particularly challenging, since transgender coverage in the United States is rapidly evolving in both the public and private sectors (Baker, 2017). Furthermore, clinical recommendations for transgender care have historically been based on expert opinion, rather than evidenced-based guidelines. Increasingly, however, transgender medicine is guided by published, peer-reviewed data. Guidelines, such as those from the Endocrine Society (Hembree et al., 2017), the

University of California, San Francisco (Deutsch, 2016), and the World Professional Association for Transgender Health (WPATH) (Coleman et al., 2012) can help inform the care of incarcerated transgender patients across a wide range of medical and surgical interventions. The National Commission on Correctional Health Care (NCCHC) position statement also provides a basic template for recommended transgender care in US jails and prisons (NCCHC, 2020). A few correctional systems have integrated professional organizational and university recommendations into their own guidelines to delineate the scope of healthcare services provided to their transgender patients (California Correctional Health Services, 2020; Federal Bureau of Prisons, 2016).

Hormone treatments, gender-affirming surgeries, and other transition-related healthcare services are all potential components of treatment plans for transgender patients. The provision of hormones therapies, in particular, is often essential to the physical and emotional well-being of transgender patients. Abrupt discontinuation of hormones upon incarceration can result in hot flashes, anxiety, depressed mood, other disabling symptoms, and potentially dangerous consequences, such as suicide attempts and genital mutilation. The WPATH standards recommend that transgender patients should be maintained on hormone treatments upon incarceration, and that hormones should be initiated during incarceration if clinically warranted (Coleman et al., 2012). Implementation of the WPATH recommendations, however, has been highly variable in correctional systems. In the 2015 US Transgender Survey, 37% of respondents who had been taking hormones before incarceration were prohibited from taking those hormones while in jail, prison, or juvenile detention (James et al., 2016). A 2017 report of correctional healthcare policies indicated that 21 state correctional systems allowed transgender patients to continue hormone treatment, but only 13 states allowed initiation as well as continuation of hormone treatment (Routh et al., 2017). Since 2017, however, more and more correctional systems have rescinded "freeze-frame" policies to allow hormone initiation for transgender patients, potentially impacted by medical legal challenges (Keohane v. Florida Department of Corrections Secretary, 2020).

The provision of gender-affirming surgeries for incarcerated transgender patients has been even more controversial than hormone initiation. In 2016, the CDCR became the first correctional system to provide gender-affirming surgery for an incarcerated transgender patient as part of a legal settlement (Quine, 2015). Other incarcerated transgender patients in Massachusetts and Texas, however, have been denied gender-affirming surgery by federal appellate courts, albeit with very different reasoning in the different cases (Gibson, 2019; Kosilek, 2014). Despite the legal controversies, thoughtful engagement on criteria for approving gender-affirming surgeries for incarcerated transgender patients is warranted. WPATH criteria include: persistent, well-documented gender dysphoria (i.e., a feeling of persistent discomfort with one's biologic sex or assigned gender); capacity to make a fully informed decision and to consent for treatment; legal age of maturity; 12 continuous months of hormone therapy (unless hormones are not indicated for the individual); 12 continuous months living in a gender role that is congruent with the patient's gender identity; and if significant medical or mental health concerns are present, they must be well controlled. The CDCR adopts these clinical criteria in its Transgender Guide (California Correctional Health Care Services, 2020). The guidance also includes specific types of genital surgeries that will be considered for approval. Adopting correctional-specific eligibility requirements for gender-affirming surgery warrants some consideration, as clinical experience for these patients is in its very earliest stages. Osborne and Lawrence recommended additional sex reassignment criteria for male inmates with gender dysphoria: prominent genital anatomic gender dysphoria, a long period of expected incarceration after surgery, a satisfactory disciplinary record, and demonstrated capacity to cooperate with providers and comply with recom-

mended treatment a period of psychotherapy, if recommended by the responsible practitioners, and willingness to be assigned to a women's prison after surgery (Osborne & Lawrence, 2016). Other correctional systems, beyond California, have begun promulgating policies and clinical guidelines for gender affirming surgery for their patients. Over time, the collective correctional health care experience of providing these surgical procedures to incarcerated transgender patients should help refine the assessment and approval criteria in meaningful ways.

The legal advocacy for providing quality health care to incarcerated transgender patients has strongly focused on the provision of hormone treatments and gender-affirming surgery. Yet, for certain transgender patients, other transition healthcare services are equally or even more important. Transgender women often endure emotional distress related to the physical manifestations of their gender identity, such as their facial appearance and voice intonation. Facial feminization surgeries are a treatment priority for certain transgender women and can markedly impact quality of life (Ainsvvorth & Spiegel, 2010). These surgeries can include rhinoplasty, lip augmentation, brow lift, frontal cranioplasty, and other procedures that aim to better align a patient's facial features with the gender with which they identify. Often, there is no clear distinction with these surgeries between what is purely reconstructive and what is purely cosmetic, resulting in variable insurance coverage (Coleman et al., 2012). Transgender women may also consider voice and communication therapy a treatment priority for developing voice characteristics and non-verbal communication patterns that facilitate comfort with their gender identity and reduce social isolation (Hancock, 2017; Coleman et al., 2012). Yet, frequently these healthcare services are not readily available or covered by healthcare plans. The existence of myriad gender-affirming treatment interventions highlights the importance of adopting individualized treatment plans that are mindful of patient priorities and emotional needs. Additionally, correctional healthcare systems must navigate the difficult minefield of defining medical necessity and approving payment criteria for an evolving array of transgender healthcare services.

Not only must correctional systems adopt policies and clinical guidance that adequately address the healthcare needs of transgender patients, but they must also ensure access to capable healthcare providers with cultural sensitivities and clinical competencies that may be lacking in some settings (Clark et al., 2017). The thousands of US jails and prisons that may potentially house transgender patients are often located in remote locations without ready access to local transgender medicine expertise or subspecialty support. Training strategies for providers must therefore leverage both local and virtually available educational opportunities. Potential options for training healthcare providers include: group education in transgender cultural competencies; investment in quality continuing medical education, both in-person and on-line; on-site provider-to-provider peer education; and virtual telementoring through proven strategies, such as the Extension for Community Healthcare Outcomes (ECHO) model adopted by the National LGBT Health Education Center (Arora et al., 2011; White Hughto et al., 2017). These training efforts are worthwhile investments. Adequately trained primary care providers can very capably care for transgender patients, with the support of mental health and medical subspecialists as needed (Coleman et al., 2012).

The evolving community standard of care in the United States for transgender patients, its related legal challenges, and the training needs of the correctional healthcare workforce, all pose significant challenges for US jails and prisons for the foreseeable future. Consensus recommendations, such as those from an academic medical center symposium in Box 25.3, can help inform transgender health care in the correctional setting; however, ongoing dialogue and updated guidance will be necessary in this dynamic healthcare arena (Kendig et al., 2019).

Box 25.3 Identifying Clinical Practice Considerations for Better Defining Medically Necessary Health Care for Incarcerated Transgender Patients and Improving Their Access to Quality Medical Care

Consensus Considerations:

Correctional chief executive officers, healthcare authorities, and legal advisors should stay abreast of the evolving landscape of healthcare services coverage for transgender patients in both the public and private sectors.

Correctional health authorities should adopt clinical practice guidelines for managing incarcerated transgender patients.

Chief medical officers and correctional healthcare administrators should recognize the wide range of healthcare services that are important to incarcerated transgender patients that include, but are not limited to, hormonal treatments, surgical interventions, voice training, hair removal, and mental healthcare interventions.

Treatment plans should be patient-centered, (individualized), for incarcerated transgender patients as mental health and medical needs are highly variable.

Hormonal treatments should be continued, and medically adjusted as clinically indicated, for newly incarcerated transgender patients who were on treatment at the time of incarceration.

Patients without a documented prescription should be considered for continuation of hormonal treatment on a case-by-case basis as clinically warranted.

Hormonal treatments should be initiated for incarcerated transgender patients who are deemed candidates for treatment by a qualified healthcare professional.

Surgical interventions for incarcerated transgender patients should be considered on a case-by-case basis, while weighing the clinical importance of the intervention for the patient and other relevant factors.

While gender affirming surgical interventions can incur significant costs, these treatments can be cost effective. Incarcerated transgender women with debilitating dysphoria related to their genital status can be costly to manage due to frequent hospitalizations, self-injurious behaviors, and associated litigation expenses.

An inter-disciplinary approach, as feasible, should be adopted to engage the entire healthcare team in transgender care with the support of subject matter experts as needed.

Mental healthcare staff, in certain settings, may need to take on the unusual role of patient advocate in coordinating an interdisciplinary healthcare treatment plan.

Correctional healthcare administrators should adopt one or more proven interventions for providing quality healthcare services for their transgender patients, which may include, but are not limited to:

- Training primary care providers to gain competencies in managing transgender patients through residential and online continuing medical educational programs.
- Employing or contracting subspecialists, for example, endocrinologists, to provide care for incarcerated transgender patients.
- Accessing transgender medicine expertise through telehealth options: teleconsultation, provider to provider case presentations by phone, televideo, provider to direct patient care or telementoring, subspecialist training to primary care providers through video case presentations.

Correctional health administrators should evaluate the adequate delivery of transgender care as part of the health system's improving organizational performance plan.

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Reentry and Public Health

Release from jail or prison to the community can be a challenging transition for many incarcerated patients and pose substantial healthcare risks. Released persons with chronic medical and mental health conditions may have lapses in care that result in emergency department visits or hospitalizations (Wang et al., 2013). Those with untreated opioid use disorder can be at an alarmingly high risk for drug overdose and death within 2 weeks of release (Binswanger et al., 2007; Ranapurwala et al., 2018). Certain persons are also at increased risk of acquiring sexually transmitted infections, including human immunodeficiency virus (HIV) infection, soon after release from a correctional setting (Wiehe et al., 2015). These and other health risks may affect transgender persons releasing from jail or prison for multiple reasons. The frequent lack of family support or limited housing options related to stigma can be very destabilizing and lead to disengagement from needed medical services. "Life chaos" – a perceived inability to anticipate and plan for the future – is associated with disrupted care for justice-involved transgender patients with HIV infection (Takada et al., 2020). Transgender persons may face other barriers to a safe and healthy community transition, such as: (1) inability to secure gender-affirming medical or mental healthcare services; (2) release to sex-segregated facilities or residential treatment programs where they may be vulnerable to physical or emotional abuse or stigma affecting access to treatment (Lyons et al., 2015); and (3) difficulty obtaining legal services to assist with navigating healthcare insurance coverage, name changes, and nondiscriminatory access to housing and public accommodations. These potential barriers to stable living and access to health care warrant intensive reentry services that target the unique challenges of transgender persons returning to their communities. A summation of reentry strategies for incarcerated transgender persons that were recommended by key correctional stakeholders are outlined in Box 25.4 (Kendig et al., 2019).

Investing in reentry services for incarcerated transgenders persons is not only a sound healthcare practice, but an important public health strategy. Community HIV prevention efforts can be advanced by targeting at-risk transgender women for HIV pre-exposure prophylaxis (HIV PrEP) prior to release from jail or prisons. Women as a group are largely undertreated with HIV PrEP in the United States (Huang et al., 2018). Innovative reentry interventions, such as peer navigation, can help transgender women with HIV infection achieve higher rates of sustained viral suppression upon their return to their families and communities (Cunningham et al., 2018). Linking incarcerated transgender persons with opioid use disorders to treatment services upon release can help reduce the risk of drug overdose and help prevent the transmission of blood-borne pathogens. A broader array of effective public health interventions is needed to better mitigate the multiple health risks faced by many transgender patients released from US jails and prisons.

Box 25.4 Identifying Effective Reentry Strategies for Transgender Persons

Consensus Considerations:

Unique needs: Correctional agencies should recognize that transgender people are at high risk of recidivism and have unique reentry needs that warrant tailored release plans.

Safety: Reentry programs should ensure that transgender people are being connected to safe housing and support services.

Medications: Correctional agencies should have policies and procedures in place to ensure that transgender patients have access to prescription medications at the time of release. Ideally,

releasing incarcerated transgender patients should have a referral to a health services provider who is culturally aware and clinically astute in caring for transgender patients.

Identity documents: A reentry priority for corrections should be providing legal support/referrals to transgender people for name and gender marker change on personal documents such as a driver's license, state ID cards, and birth certifications, to facilitate community reintegration.

Employment: Correctional agencies should provide tailored job training, formal education, and physical and mental health interventions to transgender people during incarceration to support their ability to gain employment upon release.

Parole: Correctional agencies should target parole locations, as feasible, that minimize housing and employment discrimination for releasing transgender people.

Community support: Linking incarcerated transgender persons with community transgender support groups, peers, or advocates can be helpful during incarceration and facilitate release planning to appropriate community services. Connectivity can be fostered not only through in-person meetings but also through virtual support groups.

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Conclusion

As correctional systems grapple with the unique and complex challenges of managing incarcerated transgender patients, they will need to stay abreast of the evolving medical and legal landscape that will inform future correctional management practices and standards of clinical care. Many thoughtful measures, however, can be advanced now, such as enacting policies that better implement PREA standards and enforce operational compliance, ensuring comprehensive and culturally competent gender-affirming healthcare services, and improving reentry strategies for incarcerated transgender persons. These efforts should be a priority for US jails and prisons if we are to effectively address the healthcare disparities and safety concerns faced daily by transgender persons behind bars.

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