TPI Factsheet: Trans Health in TDCJ

updated April, 2023

Introduction to this fact sheet

Trans Pride Initiative (TPI) has put together this fact sheet to bring together what we know about accessing hormones and other trans-affirming healthcare in TDCJ. We will try to keep this updated as these change. PLEASE let us know if you see something inaccurate!

There are two ways one can identify as trans in the TDCJ system. One is for security aspects, and that involves adding the TRGEN marker to one's records. The other is to be assessed as having gender dysphoria, which is required in TDCJ to access trans-related health care.

Requesting the TRGEN marker

You can identify as transgender in the TDCJ system in several ways, any of which should result in the TRGEN marker being placed in your file. This is done by letting the unit safe prisons staff or unit classification know that you are trans and wish to be identified as such in the system. You can do this at any UCC meeting, at intake into the TDCJ system, at intake on a unit transfer, or by sending an I-60 to unit classification or safe prisons. Policy SPPOM-03.01 and -03.02 cover this process, which basically involves an interview with safe prisons staff to "validate" your request, and the approval or denial. Once approved, you should be referred to medical if you wish to start hormones.

Starting hormones

Starting hormones in TDCJ generally involves telling someone in medical or mental health that you are transgender and would like to start hormone treatment (if you ask for the TRGEN marker to be added to your file, you should be referred to medical for this purpose, but if not, put in an SCR requesting to start hormones).

If you are new to the system and have been on hormones in the world, **you should be continued on the same regimen that you were taking in the world, and this should be done by unit medical where you are assigned.** However, in our experience, unit medical staff often resist doing this and may find ways to interfere. If you know someone on the outside who has access to scripts that you were given prior to incarceration, try to get them to send the scripts to unit medical. If someone you know can get your doctor to send their approval and scripts to unit medical, do that. You may have to sign a release for your free world doctor to get that done.

Unit medical cannot start you on hormones except for the above described exception. CMHC Policy G-51.11 is the healthcare policy covering medical interventions for trans persons, and that policy states that only the staff at the Gender Dysphoria Specialty Clinic (gender clinic) can prescribe hormone therapies. There are currently two gender clinics, one operated at Hospital Galveston under UTMB, and a second in west Texas under Texas Tech. Note that if medical mentioned sending you to an endocrinologist, that most likely is referring to the gender clinic. You may want to be certain by asking if it is an endocrinologist with the gender clinic. It is better to be sure than risk being misdirected!

Unit medical staff should respond to your request for hormones by referring you to the appropriate gender clinic. If they refuse, please let us know because according to policy G-51.11, only gender clinic staff can approve or deny hormone requests and hormone therapy.

Note the date medical refers you to the gender clinic. These are considered "routine specialty clinic appointments" and can take 180 days to complete. A couple months after being referred, you may want to start sending monthly I-60s to medical to ask if you have an upcoming appointment with the gender clinic. **Make sure to keep track of when you were referred (you can see this in your medical record) so that you know when the 180 days has passed.** If you have not seen the gender clinic after 180 days, let us know the date of referral and any information you have been given about appointments and we may be able to file a complaint.

Per the Correctional Managed Care formulary, the following are the steps for starting and monitoring hormones.

Step 1: Request for gender dysphoria evaluation or treatment.

Step 2: Initial assessment (unit medical)—

- Obtain prior history of GD treatment or work-up and assess for possible contraindications to therapy.
- Request medical and mental health records from free world providers who diagnosed or treated the patient.
- Complete physical exam.
- Baseline labs: CBC, lipids, CMP, prolactin, testosterone, estradiol, A1c, LH, FSH (see back for definitions).
- Refer to gender clinic (expedite referral if patient on hormone therapy at intake).
- Document patient education and written consent if continuing hormone at intake.
- Inform patient that evaluation by gender clinic is required prior to starting hormone treatment.
- Patients receiving treatment at intake should be continued on the same documented regimen unless medically contraindicated until evaluated by gender clinic.

Step 3: Diagnosis of gender dysphoria by gender clinic.

Step 4: If approved for hormones, go to Step 6.

Step 5: If not approved for hormones, inform patient.

Step 6: Patient scheduled for chronic care clinic after hormones started. If spironolactone prescribed, unit notified to monitor potassium levels and kidney function.

Step 7: Establish medical treatment plan—evaluate patient every three months for first year, then one or two times per year after for monitoring.

Hormone regimens

The following are the TDCJ regimens provided in the formulary. Dose ranges from other sources may vary some.

Testesterone based regimens

Testosterone, 100-200mg IM every 2 weeks.

Medroxyprogesterone, 5-10mg tab/day if menses persists; parenteral medroxyprogesterone, 150mg IM each 3 months if menses persists.

Estrogen based regimens

Estradiol, 2-6mg tab/day.

Parenteral estradiol cypionate, 5-30mg IM each 2 weeks or 2-10mg IM each week.

Spironolactone, 50-200mg tab/day.

Finasteride, 5mg tab/day.

Lab monitoring

Per the CMC formulary, estradiol blood levels should be titrated to not exceed 200pg/ml; for injection regimens, blood should be taken midway between injections when possible.

Testosterone blood levels should be titrated to serum levels of 400-700ng/dL, upper limit 1000ng/dl; blood should be taken midway between injections when possible.

Hormone monitoring frequency

Exam or lab	Baseline	Every 3 months first year	Every 6-12 months after first year
Vitals	✔	✔	✔
CMP	✔	✔	✔
CBC	✔	✔	✔
BG/A1c	✔	✔	✔
Lipid panel	✔	✔	✔
Liver function	✔	✔	✔
Prolactin	✔		✔
LH	✔		
FSH	✔		
Estradiol	✔	✔	✔
Testosterone	✔	✔	✔

Abbreviations: CMP—comprehensive metabolic panel; CBC—complete blood count; BG—blood glucose; LH—luteinizing hormone; FSH—folicle-stimulating hormone

Physical changes and health risks

These lists of hormone effects and risks are adapted from the World Professional Association for Transgender Health (WPATH) Standards of Care, version 8.

For testosterone-based regimens, possibly irreversible changes include deepening of the voice, development of facial and body hair, fat redistribution, genital changes, infertility, and male pattern baldness.

Testosterone based regimens

Effect	Onset	Maximum
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	6-12 months	>5 years
Scalp hair loss	6-12 months	>5 years
Increased muscle mass/strength	6-12 months	2-5 years
Fat redistribution	1-6 months	2-5 years
Cessation of menses	1-6 months	1-2 years
Clitoral enlargement	1-6 months	1-2 years
Vaginal atrophy	1-6 months	1-2 years
Deepening of voice	1-6 months	1-2 years

For estrogen-based regimens, possibly irreversible changes include breast growth, fat redistribution, genital changes, and infertility.

Estrogen and testosterone-lowering regimens

Effect	Onset	Maximum
Redistribution of body fat	3-6 months	2-5 years
Decrease in muscle mass/strength	3-6 months	1-2 years
Softening of skin/decreased oiliness	3-6 months	Unknown
Decreased sexaul desire	1-3 months	Unknown
Decreased spontaneous erections	1-3 months	3-6 months
Decreased sperm production	Unknown	2 years
Breast growth	3-6 months	2-5 years
Decreased testicular volume	3-6 months	Variable
Decreased terminal hair growth	6-12 months	> 3 years
Increased scalp hair	Variable	Variable
Voice changes	None	

Risks associated with hormone therapies

Estrogen regimens	Testosterone regimens
Likely increased risk	
Venous thromboembolism	Polycythemia
Infertility	Infertility
Hyperkalemia (if taking spiro)	Acne
Hypertrigyceridemia	Androgenic alopecia
Weight gain	Hypertension
	Sleep apnea
	Weight gain
	Decreased HDL cholesterol
	Increased LDL cholesterol
Likely increased risk with presence of additional risk factors	
Cardiovascular disease	Cardiovascular disease
Cerebrovascular disease	Hypertriglyceridemia
Polyuria/dehydration (if taking spiro)	
Cholelighiasis	
Possible increased risk	
Hypertension	
Erectile dysfunction	
Possible increased risk with presence of additional risk factors	
Type 2 diabetes	Type 2 Diabetes
Low bone mass/osteoporosis	Cardiovascular disease
Hyperprolactinemia	
No increased risk or inconclusive	
Breast and prostate cancer	Low bone mass/osteoporosis
	Breast, cervical, ovarian, uterine cancer

Please ask if you need any terms defined or explained!

TPI Factsheet Series

TPI is developing a series of fact sheets that provide basic information primarily about trans and queer issues in Texas prisons. We welcome your comments.

- ***What are my trans rights in TDCJ***
- ***Addressing prison violence***
- ***Sexual orientation and gender identity***
- ***Grievance Codes***
- ***Trans Health in TDCJ***